

Community Health Workers (CHWs): Roles and Opportunities in Montana March, 2016

What is a Community Health Worker?

*“The CHW 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 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. The 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.”* American Public Health Association Policy Statement 2009-1, November 2009

A January 2016 Issue Brief by DHHS, Office of the Assistant Secretary of Planning and Evaluation ⁽¹⁾ described CHWs as *“holding a unique position within an often rigid healthcare system in that they can be flexible and creative in responding to specific individual and community needs. Their focus is often on the social, rather than the medical, determinants of health – addressing the socioeconomic, cultural practices and organizational barriers affecting wellness and access to care.”* ⁽²⁾

Are there Community Health Workers in Montana?

In 2015, the Montana Area Health Education Center surveyed 93 organizations that expressed interest in CHW workforce development in Montana, with 69 organizations responding (72.5%). Nineteen organizations reported employing CHWs, although they may be called by other titles including Community Health Representatives (Tribal Health and I.H.S.), Snap-Ed Nutrition Educators, Promotoras, Outreach Workers, Navigators, and Resource Advocates. Additional models may include Peer Support Workers and Community Paramedics. They are employed by non-profits, healthcare organizations including Community Health Centers and Hospitals, Tribal Health Organizations and state agencies. Roles include arranging transportation, prevention, health screenings, insurance counseling, patient education, outreach, coordination with community resources and services, peer counseling and providing healthcare organizations with input from the communities they serve.

Payment models vary greatly and include government funds, foundation grants, reimbursement from payers, and internal funds. Some CHWs serve in a volunteer capacity. Currently, training is primarily on the job, and is closely related to the organization’s needs. An exception is Community Health Representatives, who are trained under a curriculum provided through the Indian Health Service. Many Montana organizations not currently employing CHWs were interested in doing so in the future. Promising efforts that will help guide the development of CHWs in Montana are currently underway. CHWs are being utilized in public health organizations; the Montana Healthcare Foundation has funded projects that are testing models of CHW or CHW-like roles in various settings; the Montana Geriatric Education Center has a CHW project focused on the aging population; and Mountain-Pacific Quality Health Foundation is

developing community coalitions for improving care coordination that utilize CHWs. A pilot project funded by the Federal Office of Rural Health Policy through the Montana Health Research and Education Foundation found success and cost savings through the utilization of CHWs in frontier critical access hospitals, working with a regional nurse care coordinator.

Roles in Healthcare Delivery

Nationally, CHWs are used in a variety of community and healthcare settings, with the primary goal of increasing access, delivering screening and preventive services, improving system navigation, care coordination and disease management. They enhance the cultural and community specific appropriateness of services, and help to address social determinants that impact health – including housing, safety, transportation, and poverty. Most profoundly, CHWs can reduce the social isolation and fears that exclude members of our communities from full participation in life and health. This is accomplished both through outreach as well as advocating for the community to the provider organizations.

CHWs are most often part of a team, assigned to specific duties, clients, and activities. It is important in new models of care coordination and addressing social determinants of health, that there are clear role expectations, feedback mechanisms, and methods of communicating and documenting the work of CHWs. Their work should be incorporated into larger systems of care and services. Roles can include helping parents manage complex services for their children, chronic disease management, working with migrant or immigrant populations, connecting chronically ill elderly populations to services, providing community based services through Community Paramedic or EMTs, or delivering prevention services in community based settings.

CHW Training and Credentialing

There are many excellent models of training for CHWs. Common competencies in many training programs are:

- The Community Health Worker Role: Advocacy and Outreach
- Organizations and Resources: Community and Personal Strategies
- The Community Health Worker's Role in Teaching and Capacity-Building
- The Community Health Worker: Legal and Ethical Responsibilities
- Community Health Worker: Coordination, Documentation and Reporting
- Communication Skills and Cultural Competence
- Health Promotion Competencies

As a CHW's chief qualification is their understanding of the community, training in specific roles often occurs after hiring through on-the-job training. In many states, there are specific model curricula or certification standards (NM, MN, FL, MA, OH, OR, TX, IN, MS, NE, NV, NY SC, WA). Training programs may reside at community colleges, generally as a certificate program, or be offered by qualified instructors within employment settings or from community training programs. Although length of training varies, it is helpful to think of the training time as being similar to certified nursing assistants or home health aides. There is often additional

training beyond core competencies in specific areas such as mental health, diabetes, other chronic diseases, maternal and child health, oral health, or specific cultures.

National Perspectives

CHWs are gaining interest at a national level. The focus on population health, care management, improved patient outcomes, and social determinants of health is creating innovative models of care. Patient Centered Medical Homes, Accountable Care Organizations, State Innovation Models, CMS Innovation Center projects, Patient Centered Outcome Research, and the CDC are providing a focus on care teams and approaches that include CHWs. CHWs are part of the care team in Integrated Behavioral Health and Medicaid Home Health models - which are growing in national prominence and under consideration for the Montana State Innovation Model Design.

The Association of State and Territorial Health Officials (ASTHO) tracks CHW training and Certification requirements. The CDC, in a 2014 cooperative agreement with the Arizona Prevention Research Center of the University of Arizona examined demographic information, training and work environment, job related roles and activities and target populations. ⁽³⁾ The CDC assessed and summarized the strengths and limitations of the evidence base behind a number of chronic disease policy interventions that included CHWs and determined the potential of these interventions for chronic disease policy. The greatest potential was CHW deployment into inter-professional teams under provider supervision for interventions focused on access, patient self-management, cost reduction and improved social outcomes, especially for groups with significant health disparities.⁽¹⁾ Another CDC report summarized evidence around CHW interventions designed to prevent chronic diseases, and evidence that CHWs could be a cost-effective way to improve outcomes. CHW interventions are currently being evaluated as part of numerous CMMI Innovation and Patient Centered Outcomes Research grants.

Six states used State Innovation Model Test Awards, Round 1 (CMS) funds to support a CHW component of the demonstration project (AK, ME, MA, MN, OR, and VT) and eleven states in Round 2 (CO, CT, DE, ID, IA, MI, NY, RI, OH, TN, WA). The models provide extensive documentation on the CHW roles, integration into care teams, integrated care model delivery, payment models, and addressing broad determinants of health outcomes for Medicaid participants.

Reimbursement

Short term grants and contracts create opportunities for innovation and establishment of CHW services, but potentially create unstable work environments. More predictable payment models include reimbursement through Medicaid (CMS-2334-F) for Essential Health Benefits for preventive services recommended by - rather than provided directly by - a physician or other licensed practitioner. State plan amendments are required to tap into this reimbursement. Per member, per month payments to managed care providers provides an option for CHW salaries, and state-initiated waivers, such as those allowed under 1115 of the Social Security Act provide opportunities to pilot budget-neutral demonstration projects.⁽¹⁾ Private payers may also include CHWs within per member, per month payments or other negotiated payment models. Outcomes of State Innovation Model awards, Center for Medicare & Medicaid Innovation (CMMI) projects

and Patient-Centered Outcome Research Institute (PCORI) grants may provide additional models and incentives for adopting CHW models into care teams.

CHW Stakeholder Meetings in Montana

Since 2015, the Montana Office of Rural Health/Area Health Education Council has convened a stakeholder group open to anyone with an interest in the development of community health workers in Montana. Over 60 organizations and individuals attended a meeting in Helena in May 2015, followed by a meeting with Billings stakeholders and a second Helena meeting in October. The groups reviewed the results of the CHW workforce survey, and consulted with national CHW expert, Carl Rush. Opportunities and recommendations from the stakeholders included:

1. Developing common curriculum and training for CHWs
2. Exploring reimbursement models and methods of funding CHWs
3. Identifying policy issues related to CHWs, including scope, certification, and integration into newly developing payment and healthcare delivery models

Opportunities for Montana

1. *Convene stakeholders to address curriculum and training (March, 2016, Helena)*
 - Develop consensus on the roles and competencies of Community Health Workers
 - Common competencies and role definition
 - Curriculum and training materials
 - Certification or credentialing options
2. *Examine the role of CHWs in the models under consideration by the Governor's Council on the Montana State Innovation Model Design*
 - Evaluate the use of CHWs with Medicaid populations and care coordination models including PCMH, CMS funded care coordination projects and ACOs
 - Develop policies and reimbursement models that support the use of CHWs through Medicaid and private payers
3. *Continue to engage stakeholders to develop the role and future of CHWs in Montana*
 - Provide a structure to engage CHWs, patients/clients, healthcare providers, community organizations, educational organizations, payers, and state agencies and other stakeholders to create policies, training, and standards that support CHWs in Montana
 - Create a knowledge base on the effectiveness of CHWs addressing social determinants of health, health outcomes, improving patient engagement, and achieving cost savings by creating a learning community among CHW stakeholders in Montana
 - Inventory and track CHW projects and outcomes
 - Provide a forum for discussing promising models and evidence-based approaches
 - Create a sustainability plan

1. Snyder, JE; *Community Health Workers: Roles and Opportunities in Healthcare Delivery System Reform*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services, January 2016
2. Brownstein JN, Hirsch GR, Rosenthal EL, Rush C. Community Health Workers "101" for Primary Care Providers and Other Stakeholders in Health Care Systems. *J Ambulatory Care Management* 2011 Jul-Sep;34(3):210-220.
3. The Arizona Prevention Research Center of the University of Arizona. The 2014 National Community Health Worker Advocacy Survey (NCHWAS). Acquired April 30, 2015 from: <http://azprc.arizona.edu/content/2014-national-community-health-worker-advocacy-survey-reports>