ACHI
Arkansas Center for Health Improvement

ISSUE BRIEF

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

Community Health Workers: A Natural State Fit • November 2014

Arkansas is making good progress toward achieving an improved health care system that meets the needs of our citizens. Current state initiatives include: transition to a multi-payer, value-based payment system that incentivizes improved quality of care and improved cost efficiency; increased access to affordable health care coverage; strategically planning for a sufficient health care workforce; and accelerated use of health information technology. These initiatives are crucial for addressing the health of Arkansans and realigning our fragmented health care system. There remains an opportunity, however, to strengthen the connection between the health care system and community-based services by investing in an often overlooked and underutilized subset of the health workforce—community health workers (CHWs). This issue brief discusses CHW roles and opportunities in Arkansas, evidence about clinical and cost effectiveness, the potential for CHW inclusion in ongoing state initiatives, and environmental factors that may affect workforce utility. Both academic literature and energy within the state offer potential for CHWs to address workforce constraints, care coordination, and curb health care costs.

ABOUT COMMUNITY HEALTH WORKERS

A community health worker (CHW) is generally a community member who is involved in improving the overall health for disparate populations either through employment or on a voluntary basis. CHWs are not new to the health workforce; they have functioned in various capacities for decades.[1] In other cultures, CHWs are more widely used and are as well respected as physicians, though their training and scope of work is quite different. Yet, they are an underutilized and undervalued resource in the United States. Still, they have been found to be effective in reducing costs and hospital readmissions, as well as improving the health of communities.

It is nearly impossible to quantify CHWs domestically. They are often identified by many titles, including community connectors, health connectors, community health advisors, lay health advocates, lay health educators, *promotores*, outreach educators, community health representatives, peer health promoters, and patient navigators. Each CHW program is built around the needs of the specific community it serves, resulting in the various titles for CHWs. Despite the differences among CHW programs, they share the general tenet of working within a community as representatives of that community to improve health and empower individuals.[2,3]

In 2010, the U.S. Department of Labor categorized CHWs as a profession.[4] Those who were seeking this recognition believed it would thrust CHWs into a more important role in the workforce and would allow for easier quantification of CHWs. In 2009, the American Public Health Association (APHA) created a section just for CHWs, ranking their work among one of the major public health disciplines. The APHA offers the following definition of a CHW:[5]

> A Community Health Worker (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.
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> 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.

Community Health Worker Strengths

CHWs are a unique asset to the health care workforce. They do not face the same barriers in connecting with community members that traditional providers often do. Regardless of scope of practice, traditional health care providers sometimes have a difficult time trying to relate to their patients. CHWs are better able to bridge that gap by recognizing external influences that affect people's health and relating to community members more comprehensively. They often attend to underserved populations and achieve better health outcomes despite socioeconomic challenges.[3] They feel a strong connection to their community and are uniquely sensitive to linguistic and cultural differences between subgroups. The ability to bond and connect with patients is what often makes CHWs refer to their profession as a calling instead of a job; they receive a great sense of value from their work.

CHWs can and do provide a wide range of services. In some settings, they provide basic clinical services, such as measuring blood pressure or monitoring blood glucose levels. In others, they serve more of a social worker role by connecting community members to available resources. This type of role relies on the connection that stems from being part of the community. CHWs often go further than just sharing a telephone number, providing services that may include counseling, transportation assistance, coordinating appointments, and medication adherence. Some CHW programs focus on specific health conditions and offer assistance unavailable in traditional provider offices. CHWs can also serve in a care coordination role and extend the reach of health care practitioners into the community.

Workforce Potential

The success of existing CHW programs in Arkansas illustrates the potential for growth that could extend the existing workforce in Arkansas. Individuals currently employed or volunteering as CHWs are an invested and self-selected population. In 2012, the Arkansas Center for Health Improvement (ACHI) published the *Arkansas Health Workforce Strategic Plan: A Roadmap to Change,* which indicated that the current shortage and maldistribution of primary care providers in the state would worsen without intervention.[6] Suggested interventions included moving toward team-based care and payment models that incentivize more proactive, population-based care. CHWs may be a good fit for these interventions as they provide many preventive services at a low cost and can be team members with greater reach into the community.

Arkansas is recognized as a leader among the six states involved in the "Test Models" included in the Center for Medicare and Medicaid Services' State Innovation Model (SIM) grants.[7] A review of plans from the other "Test Model" states as well as the 19 SIM "Pre-test and Design" states has shown that the majority plan to integrate CHWs on some level. For example, Colorado's Health Care Innovation Plan[8] describes CHW integration into both public health and primary care settings. Additionally, Oregon's plan[9] describes integrating CHWs into their Coordinated Care Model.

While Arkansas's SIM plan does not currently involve CHW work,[10] the plan references the health workforce strategic plan. Within Arkansas's strategic plan, the state endorsed the following recommendations that involve CHWs as a part of the workforce: [6]

1. Establish training guidelines and core competencies for all levels of direct care workers
2. Explore reimbursement methodologies and other incentives for the recruitment and retention of direct care workers in Arkansas
3. Explore the use of blended learning networks and other technologies that enable older people, their families, and care providers to exchange knowledge, learn together, and support each other in local care networks

Training

The idea of training and standardization of curricula for CHWs is a hot topic. Some SIM plans call for curriculum development and the establishment of training programs. Utah's plan[11] includes both

curriculum development and the inclusion of CHWs into behavioral health interventions. It is recognized that some form of credentialing will be essential in order for advanced payment methods to be used. The issues at hand in Arkansas include identifying which entity or agency, if any, should determine and create the CHW credentialing criteria, manage the credentialing, and define the level of input existing CHW organizations would have.

COMMUNITY HEALTH WORKERS IN ARKANSAS

There is growing collaboration between existing CHW groups in Arkansas. Since October 2012, a collaborative interest group has been formed by the Arkansas Department of Health, the University of Arkansas for Medical Sciences College of Public Health, CHW employer groups, and other stakeholders. These groups have hosted two annual conferences exploring the roles for CHWs in Arkansas and furthering the opportunities and utilization of CHWs in the state.

This interest group meets regularly in Little Rock and connects with CHWs around the state using video technology. The group is in the process of forming an official association to be known as the Arkansas Community Health Worker Association (ARCHWA). The mission of ARCHWA will be "To support CHWs in promoting improvements in health and health care." Its objectives will be to convene CHWs to share resources, give support, offer professional development opportunities, and increase and enhance recognition of the value of CHWs' knowledge, skills, and contributions to public health.

At the request of the interest group, the University of Arkansas for Medical Sciences College of Public Health conducted a preliminary survey that received responses from 15 employers across the state.[12] The survey indicated there are likely CHWs who go by other titles or do not currently recognize that their work falls into the same category as CHWs.

In and around the city of Helena, located in the Arkansas Delta, CHWs have been active in the community providing reimbursable services in an organized fashion for a decade. This primarily has been through the Tri-County Rural Health Network, a 501(c)(3) organization, and its Community Connector Program. Medicare and Arkansas Medicaid have contracted with the program to reduce fraud and connect elderly and disabled community members to available resources. A study of this program found net savings of $3.5 million over three years for just 919 Medicaid patients.[13] The return on investment for the program was $2.92 for each dollar spent on running the Community Connector Program.

COMMUNITY HEALTH WORKERS IN LITERATURE

A review of existing studies as well as operational programs shows that CHWs can be both clinically and cost effective. However, many of these studies examine programs in countries with very different demographics and health care systems compared to the US. The research projects involving domestic CHWs often highlight success in specific health conditions. The shortfalls cited in existing studies state limitations in terms of the long-term effects of CHW programs from both cost and clinical perspectives.[14]

The Agency for Healthcare Research and Quality completed a comprehensive analysis of academic literature and found that interventions targeting disease prevention, asthma management, and some cancer screenings proved to be the areas in which CHWs were most effective.[15] CHWs were shown to produce improved outcomes for these health conditions, especially in underserved areas. These same health issues, including asthma and hypertension, are often the targets of interventions developed and implemented across Arkansas.

A study of CHW interventions at a hospital in Philadelphia showed positive results for patients following hospitalization.[16] For example, those receiving attention and guidance from CHWs after hospitalization were more than 10 percent less likely to be readmitted within 14 days than were patients admitted for the same reasons who were not seen by CHWs. Patients seen by CHWs were also 50 percent more likely to receive attention from a primary care provider within 14 days.

This group of patients also reported greater satisfaction from and understanding of the communication delivered throughout the discharge process.

There are opportunities to reduce the country's ever-growing health care expenditures by transitioning to lower-cost interventions. Hospital emergency rooms are recognized as being one of the highest cost venues for care, yet it is estimated that up to 27 percent of emergency room visits in the United States could be avoided by better primary care intervention.[14] A study found that avoidable emergency room visits contributed to $5 billion in uncompensated care at hospitals in the state of Texas alone. An intervention at one of these hospitals found that hiring one CHW to work with triage before services were delivered in the emergency room, as well as following up with patients after delivery of service, reduced post-intervention emergency room visits. This resulted in savings ranging between $207 and $1,369 per patient, with an average reduction of 3.4 return visits. It is important to note that due to data limitations, it is unknown if these individuals went to different emergency rooms instead of seeking preventive care.[15]

A pilot program in New Mexico integrated CHWs into a broader range of health care service workers and saw cost savings across the board.[17] A study of the pilot followed 448 patients before and after CHW intervention. Cost reductions totaled $2.04 million stemming from improvements in inpatient services, emergency department use, and prescription management. The cost for the program was around $520,000. This shows that return on investment for the program was approximately 4:1.

Some CHW studies note that CHWs are more effective operating as part of a team rather than acting independently.[18] This should be taken into consideration with regard to potential new CHW programs as it may require additional costs. CHWs are also not necessarily recognized as legitimate health care professionals by other health care providers.[19] This issue is exasperated by the use of multiple titles and the lack of a uniform standard training and credentialing process.

ONGOING INITIATIVES

One of Arkansas's ongoing health care initiatives involves a patient-centered medical home (PCMH) model, which is a growing national trend. Arkansas's PCMH model was designed by a team of stakeholders comprised of physicians, industry experts, legislators, and patients.[20] The PCMH is part of a larger statewide initiative to achieve the "Triple Aim" of health care: improving health, improving the patient experience of care, and lowering the growth of health care costs. The model was designed to financially support practice transformation including expanded care coordination and timely access to care.

The PCMH model aims to hold physician practices accountable for proactively managing their panel of patients, not just treating them when they present as ill. Arkansas's PCMH model also makes the primary care provider responsible for a patient's total cost of care, including services provided outside of his or her individual practice. Practices can manage these responsibilities in a variety of ways, including hiring additional staff.

Patient-Centered Medical Homes and Community Health Workers

CHWs can play a significant role in PCMH models. A primary concern for physicians who are attempting to achieve PCMH practice transformation is the burden of increased paperwork and administrative tasks. Hiring additional care coordination staff could temporarily increase these tasks, but effective care coordination can increase capacity and benefit the entire practice, especially patients. CHWs can provide care coordination and ancillary services outside the practice that can help improve overall health.

Perhaps the best example of CHW integration into PCMHs comes from the Community Health Network of NYC. A recent report, written with the Columbia University College of Public Health and the New York State Health Foundation,[21] describes the process and outcomes of establishing CHWs in primary care workforce settings. The unique approach, detailed in, "A Bronx Tale," [22] has

had positive results, including consensus from some surprising parties such as medical residents whose job tasks were altered. In addition, there was a $2.30 return on every dollar invested in CHW integration into a primary care setting. Relevant to the total cost of care, the Bronx program also reduced hospitalizations for those patients with chronic health problems. Net savings are estimated to be $1,135 per patient per year.

Not only do these emerging models lead to improved patient health, they also lead to improved compensation for primary care physicians and overall lower costs. A pilot study using CHWs to assist in PCMH settings in Arkansas could provide a link between the existing strengths of the workforce and the needs for primary care improvement.

CENTERS FOR MEDICARE AND MEDICAID SERVICES RULINGS

In 2013, the Centers for Medicare and Medicaid Services (CMS) expanded its rulings on services eligible for reimbursement by non-clinical staff. The rule, 78 Federal Regulation 42160,[23] refers specifically to preventive services, typically those carried out in primary care settings. More importantly, it touches on services that could be performed by PCMH care coordination. The original rule maintained that preventive services could be reimbursed so long as they were performed by a physician. The change resulted in a less restricted reading, allowing preventive services to be simply recommended by a physician, not necessarily performed by one. While the change in wording is not extreme, it has significant impact. For PCMHs, this means that physicians and extenders can focus more of their energy on high-need patients, while care coordinators, and potentially CHWs, perform more routine tests and preventive measures, all for a fraction of the cost.

Specifically, the ruling states that reimbursement can be for services that "(1) prevent disease, disability, and other health conditions or their progression, (2) prolong life, and (3) promote physical and mental health and efficiency." It goes on to reference recommendations that come from the United States Preventive Services Task Force[24] which, among others, include blood pressure screening, tobacco intervention, and behavioral counseling.

Late last year, CMS also released language concerning the specific definitions of preventive services and who can perform them. State Medicaid programs can submit a State Plan Amendment (SPA) to CMS outlining changes to their benefit design and program processes at any time. Pursuant to Regulation 42160, CMS wrote that in order to follow the rule, SPAs must include "a summary of practitioner qualifications for practitioners who are not physicians or licensed practitioners. The summary should include any required education, training, experience, credentialing, or registration." The SPA is an opportunity for Arkansas Medicaid to expand efficient use of CHWs.

POTENTIAL BARRIERS

One barrier to utilization of CHWs is the disagreement among CHWs and advocates regarding which steps should be taken next. Academic entities call for strict curricula and training programs for CHWs, ensuring observance of existing protocols and recognition by authorities. Other advocates are pushing for a more grassroots approach that maintains the integrity of CHWs as unique representatives and allies of the community. A moderate curriculum, offered through community colleges, as was adopted in Minnesota and other places, has not always been effective. On the other hand, without some overarching guidance and standardized training, CHW movements rarely grow and constantly face sustainability challenges. A balance of effective leadership and oversight, along with standardized training and reimbursement are needed to eliminate these barriers.

CONCLUSION

It is likely that Arkansas community health worker groups and employers will continue to exist on some level without any system change. A strong commitment to the communities they serve will

keep them engaged. However, continuing to overlook the presence of CHWs and their potential is a disservice to Arkansas citizens and efforts to improve population health. Support may come in the form of a pilot program, workforce opportunities, endorsement or, at the very least, recognition of the association. Any and all support should continue to encourage the core competencies of CHWs and honor their input and contributions.

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