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Community Health Workers: Part Of The Solution

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ABSTRACT **Community health workers are recognized in the Patient Protection and Affordable Care Act as important members of the health care workforce. The evidence shows that they can help improve health care access and outcomes; strengthen health care teams; and enhance quality of life for people in poor, underserved, and diverse communities. We trace how two states, Massachusetts and Minnesota, initiated comprehensive policies to foster far more utilization of community health workers and, in the case of Minnesota, to make their services reimbursable under Medicaid. We recommend that other states follow the lead of these states, further developing the workforce of community health workers, devising appropriate regulations and credentialing, and allowing the services of these workers to be reimbursed.**

Community health workers are increasingly recognized as integral members of primary health care teams, especially in poor and underserved communities.[1–3] The umbrella term "community health workers" refers to people alternatively known as outreach workers, *promotores(as) de salud*, community health representatives, and patient navigators.[4] In 2009, the U.S. Department of Labor recommended the creation of a Standard Occupational Classification for community health workers,[5] which was subsequently included in a provision of the 2010 landmark national health reform law. The Patient Protection and Affordable Care Act also includes several sections that recognize the key role of community health workers in achieving important goals of health care reform.

Background On Community Health Workers

There are more than 120,000 community health workers on the job in neighborhoods, homes, schools, work sites, faith- and community-based organizations, health departments, clinics, and hospitals throughout the United States.[4] Many work in short-term funded projects addressing targeted health issues, such as grant-funded immunization or health literacy campaigns. Some are volunteers, but it is estimated that more than two-thirds are paid.[6]

ROLES The Children's Health Insurance Program (CHIP) identifies community health workers as providers of outreach, education, and enrollment in primary care.[7] As liaisons between health systems and communities, they facilitate access to and improve the quality and cultural competence of medical care, with an emphasis on preventive and primary care.[4,6]

RESPONSIBILITIES As members of care delivery teams, community health workers coach individuals in managing their own health and assist them in navigating the health care system. The workers help build individual and community capacity for health care through increasing health knowledge and self-sufficiency and serve as community health educators, informal counselors providing social support, and patient and community advocates.

Community health workers develop peer-to-peer relationships of trust with patients, rather

than provider-client relationships. It is these relationships, rather than clinical expertise, that contribute most importantly to the workers' ability to communicate openly with patients on issues related to health, and ultimately to improve health care access and outcomes.

CONTRIBUTIONS Community health workers' contributions to improving access to care and health knowledge, behaviors, and outcomes are well documented,[8] notably for conditions such as asthma, hypertension, diabetes, and HIV/AIDS; for procedures such as cancer screening and immunizations; and for maternal and child health in general.[9–14] In 2003 the Institute of Medicine recommended that community health workers serve as members of health care teams, to improve the health of underserved communities.[1]

As members of the community, these frontline workers are valued for their cultural competence and mediate between providers and other members of diverse communities. Evidence is accumulating that including community health workers in determining the appropriate use of services has a sizable positive return on investment.[8,15,16]

STATE ACTIONS Beginning in the late 1990s, several U.S. states, such as Maryland and Texas, sought through legislation and regulations to integrate community health workers into the health care workforce. These initiatives have had only modest impacts to date. (See Online Appendix Tables 1 and 2 for selected state examples and additional details.)[17] More recently, other states have undertaken new approaches to expand the roles of community health workers and strengthen financial support for them so that their positions are sustainable over time.

We focus on two examples, Massachusetts and Minnesota, both of which recently initiated comprehensive changes in policies and systems to support community health workers.

Case Studies Of Policy Change

MASSACHUSETTS Massachusetts has historically been a leader among the states in its support for community health workers. In 2000, it created the Massachusetts Association of Community Health Workers (MACHW),[18] an organization that does education, research, policy development, and advocacy to promote the workforce. Then, in 2006, the landmark health care reform law that Massachusetts adopted included two key policy provisions for community health workers. The Massachusetts Department of Public Health was directed to conduct a comprehensive statewide study of community health workers and provide recommendations for building a sustainable workforce. And, in 2007, the MACHW was given a seat on the state's expanded Public Health Council, an organization that advises the Department of Public Health on major policy decisions.

Community health workers subsequently played a highly visible role by helping more than 200,000 uninsured people enroll in health insurance programs, as mandated by the new law.[19] The state health department supported workforce development and funding for training and services for community health workers. State contracting policies required employers to support educational opportunities and provide supervision for the workers.

In early 2010, the results of the state study of community health workers required by the reform legislation were presented to the Massachusetts legislature.[19] The study found that community health workers increased access to primary care through culturally competent outreach and enrollment strategies. It also found that these workers improved the quality and cost-effectiveness of care by assisting patients with self-management of chronic illnesses, medication adherence, and navigation of the health care system.

Furthermore, the study deemed community health workers to be important members of teams that would deliver patient-centered primary care through new models. Based on these findings, the report recommended a community health worker "professional identity" campaign to increase recognition and understanding of the community health worker role; expanded training programs for the workers and their supervisors, with related certification; financing to pay for community health workers, including third-party payments; and a state Office of Community Health Workers to do workforce surveillance, research, coordination of training and career pathways, and policy development.[20]

Broad-based policies combined with consistent and powerful advocacy from the leaders of the workforce of community health workers, together with state public health partners, have secured the ongoing integration of community health workers in state health reform efforts.

MINNESOTA Facing widespread shortages in the health care workforce and an increasingly diverse population, Minnesota has recognized that a strengthened workforce of community health workers would help deliver high-quality, culturally competent care in the state. Through the concerted efforts of the Community Health Worker Alliance,[21] a diverse set of public and private stakeholders, Minnesota has transformed the role of community health workers from an occasional "add-on" to a formal compo-

nent of its mainstream health care system.

The alliance is a project of the Healthcare Education-Industry Partnership,[22] a statewide stakeholder coalition. Alliance members include community health workers and representatives of state agencies, postsecondary educational institutions, state associations, nonprofit organizations, payers, and the health care industry. Formed in 2005, the alliance initially developed a community health worker "scope of practice" and a standardized, statewide credit-based curriculum offered at community and technical colleges. The group then tackled the issue of making a financial case for community health workers, in the form of identifying a return on investment for the dollars spent on training and employing them.

The alliance cited research[16] supporting the notion that greater investment in community health workers' services would be budget-neutral, and it sought policy changes from the state legislature on that basis. In 2007 the Minnesota legislature approved the direct hourly reimbursement of community health worker services under Medicaid.

Next, in 2008, the Centers for Medicare and Medicaid Services (CMS) approved a Medicaid State Plan Amendment authorizing the proposed hourly payments for community health workers who work under the supervision of Medicaid-approved physicians and advanced-practice nurses. The plan's authorized list of supervisors was later expanded to include dentists, public health nurses, and mental health providers. To qualify for reimbursement, workers must complete the state's fourteen-credit certificate program for community health workers. At that point, they become eligible to enroll in the Minnesota Health Care Plan as a Medicaid provider authorized to serve under the supervision of approved billing providers.

Minnesota is the only state thus far to establish Medicaid reimbursement for a full spectrum of community health worker activities across all covered health services. It is also the first state to establish a sustainable funding stream to support these workers. The highly regulated system allows the workers to serve as members of care coordination teams; offers job security; addresses critical state workforce needs; and helps effectively reach underserved populations, thereby helping eliminate health disparities.

Achieving Comprehensive Policy Change

The Patient Protection and Affordable Care Act emphasizes community-based preventive and wellness care and the use of community-based health teams and patient-centered medical homes. Other states should consider building on the Massachusetts and Minnesota examples as they seek to prevent disease, improve the quality of care, improve chronic care management, and reduce costs.

Community health workers can be vital to efforts to restructure the delivery of primary health care.

POLICY RECOMMENDATIONS To stimulate comprehensive changes in the health care workforce throughout the nation, we offer a set of policy recommendations as follows (an expanded list can be found in Table 3 of the Online Appendix):[17] (1) sustainable financing for community health worker services, especially though payment for their services in Medicaid, CHIP, and other major funding streams; (2) workforce development resources, including training and career development; (3) occupational regulation, such as standards for training and certification; and (4) guidelines for common measures to be used in research and evaluation related to community health workers.

The National Conference of State Legislatures notes similar areas for action.[23] Also, in their 2008 report on health equity in health care reform, Brian Smedley and colleagues suggest that policy makers "consider training and reimbursement for [community health workers'] services as part of statewide health care coverage expansion plans."[24] Several sections of the Patient Protection and Affordable Care Act specifically include community health workers as members of the health care workforce and address the workers' training and engagement in communities.[25]

PRINCIPLES TO FOLLOW We further recommend that in the development of policy initiatives for community health workers, the following principles should be followed: (1) promote and support the participation and leadership of community health workers in the development of policies that affect them; (2) minimize barriers to training and employment of the workers related to language, education level, citizen-

States can initiate policy changes by conducting assessments of the workforce of community health workers.

ship status, and life experience (there is no reason why recovering addicts, for example, should not be community health workers in substance abuse programs); (3) allow and encourage providers to contract with community-based organizations for community health workers' services; and (4) incorporate the full range of community health worker roles and competencies[4] in the positions for these workers. Positions should be designed to allow these workers the latitude to perform all of the roles of which they are capable, including outreach and education, advocacy, and health system navigation.

Community health workers can be vital to efforts to restructure the delivery of primary health care. The patient-centered medical home has been described as providing "accessible, comprehensive, family-centered, coordinated, compassionate and culturally effective care."[26] Although the workforce required for the medical home model has not been fully defined, close ties to the community and cultural competence are essential. Additionally, a successful medical home will require continuity of communication between provider and patient.

Community health workers are uniquely qualified to meet these responsibilities and to complement other members of the health care delivery team. These workers' valuable capacity to increase patient engagement will be important to consider in evaluations of quality improvement. They may serve in these capacities either as provider staff or through contracts with community-based organizations.

Conclusions

Past recommendations for the development of the workforce of community health workers, as cited in this paper, are slowly being implemented, but much progress is still needed. After many years of patchwork funding, current efforts to change workforce policies along multiple fronts represent a down payment on building more comprehensive systems of care.

States can realize the benefits of increased participation of community health workers in primary care by implementing the recommendations presented here. Further, as in Massachusetts and Minnesota, states can initiate policy changes by conducting statewide assessments of the workforce of community health workers; establishing working groups to review and respond to the resulting findings; and advocating for legislative or other appropriate actions to support the integration of community health workers into the health care system.

Policy developments should be accompanied by research and evaluation efforts. These should build on and use methods consistent with other research and evaluation ongoing in the field.[8] Community health workers offer unique skill sets that can improve patients' access to care and their health care outcomes. Recognizing and integrating these workers in the full scope of care, including appropriate reimbursement, will be a step toward improved care for many Americans. ■

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