

On the Front Lines of Health Equity: Community Health Workers

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Introduction

Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people.” Achieving health equity requires valuing everyone fairly and justly and addressing avoidable inequalities and historical and contemporary injustices to eliminate health and health care disparities.¹ However, despite an increasing commitment to achieving health equity, research shows that disparities persist for racial and ethnic minorities, people living in rural areas, individuals with disabilities, and sexual and gender minority populations.

In an effort to advance more comprehensive, effective, and equitable care for patients and clients, some health care organizations are strengthening their policies and programs to focus more on the wide range of factors that influence a person’s health, including nonclinical factors that are often called the social determinants of health. Addressing social determinants of health is key to achieving health equity.²

Community health workers (CHWs) can play an integral role in helping health care organizations achieve health equity.³ CHWs are frontline health workers who are members or have a deep understanding of the communities they serve.⁴ Well-developed CHW programs address both the clinical and nonclinical needs of patients and clients, especially within organizations that aim to support vulnerable populations. CHWs can help health care organizations improve health care quality, reduce provider burden, and strengthen relationships and trust within the communities for which they provide care.

Organizations with successful CHW programs build valuable connections to the communities they serve.⁵ They may gain a more complete understanding of the conditions that affect their quality of life, including socioeconomic and environmental factors. These organizations are better able to understand that language, health literacy, transportation, disability, social isolation, and other factors that present barriers to care are organizations without successful CHW programs. With proper training and support, CHWs can help identify and address many of these major barriers by engaging people in ways that other providers may not.

While specific CHW job titles and scope of practice may vary, their roles share some common elements across most organizations. For example, CHWs typically act as liaisons between the community and health care organization. They work to improve the delivery of health education, follow-up care, and case management.⁶ The CHW job title is sometimes—but not always—used interchangeably with titles of lay health worker, *promotora*,ⁱ community health representative,

ⁱ A *promotore* or *promotora de salud* is the Spanish term for a CHW, and typically refers to a Hispanic/Latino(a) CHW who works in a Spanish-speaking community.

peer health educator, or care/patient navigator,ⁱⁱ among other titles. These roles may provide services for differing audiences, disease types, community make-ups, or other known issues.

Well-planned CHW programs help organizations integrate health care with social care, which can lead to better patient outcomes. The National Academy of Science report *Integrating Social Care into the Delivery of Health Care* is a good resource for organizations looking to understand how integrating health care with social needs helps to achieve better and more equitable health outcomes. The report identifies current and emerging approaches that expand and optimize social needs in the health care setting. It recommends methods and criteria that organizations should use to identify individual- and community-level social needs within their service area or among their patient/client populations. This perspective is especially appropriate for strategies that are population health-oriented and offer prescriptions for change. Approaches in this report may be integrated in new CHW programs.

Credentialing and funding entities may seek to standardize practices, implement core competencies, and manage performance of CHW programs. Doing so can help organizations recognize the changes and challenges of their communities and adjust the way they deliver care accordingly. To find a balance between program structure and flexible care delivery, organizations may seek to provide CHWs clear goals for their work along with opportunities to be flexible and responsive to the unique needs of each person.

This issue brief from the CMS Office of Minority Health provides an overview of the benefits that CHW programs can bring to health care organizations and the people they serve. It also serves as a resource for organizations, and may be useful for senior managers, program managers, and project directors seeking to implement a new CHW program in their health care setting. The information presented in this brief was gathered through a robust literature review and stakeholder interviews. Of note, research for this issue brief was conducted prior to the COVID-19 Public Health Emergency (PHE). The best practices described below may need to be modified during the PHE to ensure safety of all parties. Further research may also be needed to identify additional evidence regarding the utility of CHWs and best practices to implementing CHW programs that may emerge during the PHE.

ⁱⁱ Depending on an organization's infrastructure, the title "[patient navigator](#)" can refer to someone providing patient case management and may not be affiliated with CHW programs.

Benefits of CHW Programs

CHW programs can increase patient/consumer satisfaction and trust in the health care organization, while expanding capacity to advance care coordination. CHWs provide an opportunity for organizations to deliver care that considers where and how people live, paving the way towards a more personal and multidimensional approach to care.

CHW programs can:

- ▶ [Provide culturally competent care](#)
- ▶ [Serve populations with limited English proficiency](#)
- ▶ [Serve rural populations](#)
- ▶ [Assist with chronic conditions](#)
- ▶ [Support behavioral health care](#)
- ▶ [Save organization spending](#)

- ▶ **CHWs can help increase organizational awareness of the nonclinical needs of the individuals they serve.** CHWs can document factors that influence a person's health status and/or contacts with the health care organization (e.g., Z codes) on patients' medical charts. The ICD-10 Cooperating Parties recently approved [updated guidance](#) that now allows reporting of codes from Z55-Z56 categories by all involved caregivers, including nonphysicians.⁷ This reversed a prior prohibition of Z code reporting without supporting physician documentation, which prevented hospital coders from assigning Z codes documented by nonphysicians including nurses, social workers, and CHWs. This update can help organizations gain and document a whole-person view of an individual's health.
- ▶ **CHWs recruited directly from communities increase organizational awareness of local community resources.**⁸ Because CHWs share the same or similar culture or community and/or speak the same language as their patients or clients, they may have more knowledge of local resources including food pantries, home-delivered meals, housing programs, transportation services, and other home and community-based services programs to meet needs. People who receive CHW services often report higher levels of satisfaction with the services received from participation in the CHW program than individuals with services from other providers within the same organization.⁹ CHWs' familiarity with the communities they serve can also help build trust between health care organizations and communities.

PROVIDING CULTURALLY COMPETENT CARE

Culturally competent health care incorporates strategies to tailor care delivery to the beliefs, values, and social environment of diverse communities and individuals. Health care organizations may employ CHWs as one of these strategies to design interventions that meet the needs of specific populations with the aim of delivering appropriate and equitable care. Programs may accomplish this by incorporating cultural and/or faith-based beliefs or norms into interventions,¹⁰ providing services in preferred languages,¹¹ and/or employing CHWs from the same geographic, linguistic, or racial and ethnic community they serve.¹²

SERVING POPULATIONS WITH LIMITED ENGLISH PROFICIENCY

CHW programs can improve outcomes for individuals with limited English proficiency by using materials and/or by speaking the language of the target population. These improvements include increased screening completion,¹³ more appropriate health care service utilization,¹⁴ improved health knowledge,¹⁵ and positive changes in health behaviors.¹⁶ For example, one study looked at a cancer awareness intervention for Vietnamese women in a low-income district in San Francisco, CA. The intervention included small-group sessions and materials in Vietnamese. Women who attended the sessions had significantly improved awareness of and participation in clinical breast examinations, mammography screenings, and pap smears.¹⁷ Another study of CHW programs found that Spanish-speaking patients with cervical cancer screening abnormalities received more timely diagnoses when the patient-navigator also spoke Spanish.¹⁸

SERVING RURAL POPULATIONS

CHWs can help health care organizations address the socioeconomic and environmental challenges of individuals living in rural areas. Limited public transportation in these areas can make it difficult for individuals to access health care.¹⁹ Lack of providers for some health services can make it difficult to effectively integrate care teams, as fewer care team members for various health services may be available in these communities.²⁰ CHWs can address these challenges by offering assistance with transportation or by helping their clients navigate the health care system.²¹ For example, patient navigators in rural Southern California helped patients find appropriate cancer treatment facilities, fill out required patient paperwork, and arrange transportation to essential care, which enabled more patients to access essential care.²²

Outside of the United States, similar strategies address provider shortages and lack of health care facilities in rural areas. For example, CHWs in Rwanda visited HIV-positive adults at home to provide social support at the start of antiretroviral treatment.²³ This intervention not only improved patients' adherence to treatment but also decreased prevalence of depression, improved quality of life, and increased perceptions of social support.²⁴

ASSISTING WITH CHRONIC CONDITIONS

Chronic diseases such as heart disease, stroke, dementia, and diabetes have long been leading causes of death and disability in the United States. These chronic conditions, often confounded by socioeconomic and environmental factors, negatively impact quality of life and lead to higher costs to health care organizations. These conditions disproportionately impact racial and ethnic minorities, individuals with disabilities, sexual and gender minorities, and people living in rural areas.

Chronic conditions often require home health, home and community-based services, remedial treatment regimens, medical monitoring, and medication adherence oversight. CHW programming can assist patients in using information and products given to them by clinical providers to help manage their chronic conditions. CHWs reinforce prevention strategies and help patients and populations develop strategies to overcome barriers to lifestyle and behavior change to achieve personal goals and prevent complications.²⁵ For example, one CHW program aims to improve outcomes for patients with sickle cell disease by pairing CHWs with patients and families/caregivers in need of support to access care and navigate the health care organization. The program addresses multifaceted care needs at the individual, caregiver, clinical services, and community levels with newborn screening, case management, social support, and health system navigation, resulting in improved patient satisfaction and reduced hospital stays.²⁶

SUPPORTING BEHAVIORAL HEALTH CARE

CHW interventions can effectively address mental health disorders in various populations. A 2017 systematic review of mental health interventions delivered by CHWs to racial and ethnic minority groups—including Native Americans, Asians, Africans, and Middle Eastern populations—found that these interventions reduced symptoms of mental disorders.²⁷ A systematic review of psychotherapy in Hispanic populations included two *promotora*-led interventions that decreased depressive symptoms in participants.²⁸

Although there is little research on the effectiveness of CHW interventions for substance use disorders (SUD), several organizations train and certify individuals recovering from SUD as peer recovery specialists, peer health navigators, or certified recovery specialists.^{29,30} These services are provided by individuals trained to draw from their own experiences with recovery to engage in the recovery process and reduce the likelihood of relapse. They can provide critical support for self-management and promote resiliency and whole health.³¹

SAVINGS FOR HEALTH CARE ORGANIZATIONS

Evidence shows that CHW programs can be cost effective, and CHWs can be a valuable addition to the health care workforce if an organization can identify a mechanism to cover the cost of launching programs. A retrospective cost-effectiveness analysis showed that patients receiving patient navigator services for colorectal cancer screening had a significantly higher rate of screening completion (79 percent) and a significantly lower rate of cancelled and/or skipped appointments compared to those who did not receive services from a patient navigator.³² A systematic review of CHW interventions determined they were cost-effective for cardiovascular disease prevention as well as preventing and managing type 2 diabetes.³³ One study found that every \$1 invested in CHW interventions provides a return on investment of more than \$2.28, mostly by shifting inpatient and urgent care to primary care.³⁴

CMS has developed a [Mapping Medicare Disparities Tool](#) to identify areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. Organizations can use this tool to assess the business case of a CHW program.

[CMS Office of Minority Health \(OMH\)](#) offers Health Equity Technical Assistance for health care organizations working to advance health equity. For help with a Disparities Impact Statement or for more information about other health equity resources, visit our website at go.cms.gov/OMH or email the Health Equity Technical Assistance program at HealthEquityTA@cms.hhs.gov.

Planning and Implementing a CHW Program

CHW programs are most likely to realize the benefits above when organizations take certain steps in the planning and implementation process. The following section provides details on each of the essential steps to help guide organizations interested in starting a CHW program.

Planning and Implementing a CHW Program



ASSESS COMMUNITY NEEDS

An organization must understand the needs of the communities they serve as they consider and structure a CHW program. Health care organizations often gain valuable insights when they engage and listen to their communities, especially those impacted by health disparities. Organizations can gather this information through a variety of methods, including listening sessions, focus groups, and community advisory boards.

CMS developed the [Disparities Impact Statement](#) to help organizations systematically identify, assess, and address disparities through a Plan-Do-Study-Act quality improvement model.

Organizations can use this tool in their strategic planning or needs assessment processes to gather information about their communities and identify gaps in patient/client experience.

Organizations should ensure that these efforts include the voices and experiences of the high risk, high needs members of their community. CHWs are uniquely positioned to respond to the needs of these individuals. Incorporating community input into an organization's Disparities Impact Statement and person-centered care model helps ensure programs are tailored to the communities they serve.³⁵

DEFINE CHW CORE COMPETENCIES AND ROLES

According to the Bureau of Labor Statistics, CHW can serve a variety of roles. These roles include helping individuals and communities adopt healthy behaviors, conducting community-based program outreach for health care organizations, providing social support and informal

counseling, advocating for individual and community health needs, providing direct services (such as first aid and blood pressure screening), and collecting data on community health needs.³⁶ In 2016, the [Community Health Worker Core Consensus \(C3\) Project](#) conducted a study and consensus-building project to determine CHW core roles, skills, and qualities.³⁷ They identified 10 core CHW roles applicable to diverse settings (see Table 1). Health care organizations can consider these when choosing the most appropriate role for CHWs for their programs.

Table 1. C3 Core Roles and Sub-roles

Roles	Sub-roles
Care Coordination, Case Management, and System Navigation	<ul style="list-style-type: none"> Participate in care coordination and/or case management, including making referrals, providing follow up, and documenting/tracking individual and population level data Facilitate transportation to/from services and help address barriers to care Inform stakeholders on community assets, opportunities, threats, and challenges
Direct Service	<ul style="list-style-type: none"> Conduct basic screening tests and services (e.g., height and weight, blood pressure, first aid, diabetic foot checks) Assist individuals with basic socioeconomic or geographic needs (e.g., providing transportation, linking to outside social services)
Coaching and Social Support	<ul style="list-style-type: none"> Motivate individuals to obtain health care and other services Support individuals' self-management of disease screenings, prevention, and management of health conditions Plan and/or lead support groups
Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems	<ul style="list-style-type: none"> Educate individuals on how to use health and social service systems Educate health and social service systems about community perspectives and cultures (including implementing culturally and linguistically appropriate services standards) Understand medical terminology in relevant languages Increase individuals' health literacy and cross-cultural communication
Advocating for Individuals and Communities	<ul style="list-style-type: none"> Advocate for the needs and perspectives of communities Connect individuals to resources and advocate for basic needs (e.g., safety, food, and shelter) Conduct general policy advocacy within organizations
Individual and Community Capacity Building	<ul style="list-style-type: none"> Strengthen individual and community knowledge, skills, processes, and resources Train additional CHWs and build capacity of CHW workforce
Culturally Appropriate Health Education and Information	<ul style="list-style-type: none"> Conduct culturally and linguistically competent health promotion and disease prevention education Provide necessary information and clear instruction to individuals so they can understand and manage their health conditions

Roles	Sub-roles
Individual and Community Assessments	<p>Participate in design, implementation, and interpretation of individual-level assessments (e.g., home environmental assessment)</p> <p>Participate in design, implementation, and interpretation of community-level assessments (e.g., windshield survey of community assets and challenges, community asset mapping)</p>
Outreach	<p>Engage with/recruit individuals, families, and community groups to appropriate services and systems</p> <p>Follow up on health and social service encounters with individuals, families, and community groups</p> <p>Conduct home visits to provide education, assessment, and social support</p> <p>Present at local agencies and community events</p>
Evaluation and Research	<p>Document social determinants of health Z codes on medical charts</p> <p>Identify and engage community members as research partners, including conducting community consent processes</p> <p>Advance principles of community-based participatory research</p> <p>Engage stakeholders to act on findings</p>

Adapted from the “Understanding Scope and Competencies: A Contemporary Look at the United States Community Worker Field, Progress Report of the Community Health Worker (CHW) Core Consensus (C3) Project,” July 2016.³⁸

RECRUIT AND HIRE CHWS

After determining which community needs CHWs may help to address, organizations must then build the CHW workforce by recruiting, hiring, training, and supervising CHWs, as well as planning for retention.

An organization may recruit and hire CHWs through a number of pathways, which include both informal methods such as word of mouth or more formal recruitment processes, such as recruiters or job postings.³⁹ Other community-based organizations, social service agencies, and community stakeholders may help identify CHW candidates.

Some organizations use the same hiring process for CHWs as for other types of employees. Other organizations recruit CHWs directly from the target population, looking for specific personality traits and other characteristics.⁴⁰ Job requirements for CHWs may also vary. Some organizations require an undergraduate degree, while others require a high school education.⁴¹ Cultural and linguistic competency, empathy, and problem-solving skills are important qualities for all CHWs, regardless of a CHW’s education. Some health care organizations may have other requirements or preferences for CHWs, such as using their own vehicles.⁴²

Regardless of how organizations identify individuals to fill CHW roles, hiring managers should seek out candidates who have the required qualifications as well as intrinsic motivation and passion for the work. The CHW role can be difficult because building trust with people in the

community setting, especially those who have more needs, often requires persistence. Some CHWs may also have to work outside of traditional office hours and visit nonclinical workspaces, including individual's/client's homes.⁴³

Conduct Training and ensure retention

Training ensures that CHWs continuously develop the skills necessary for their scope of work. Adequate training helps maximize the potential of CHWs to improve health outcomes, health care access, and health care utilization among underserved populations. Onboarding and continuing education can help build CHWs' understanding of the shared needs of the clinical services and local communities. This education can provide them with the tools and knowledge to address specific environmental, social, and health conditions, as well as helping individuals navigate the health care organization.

Some states, nonprofit organizations, and universities have developed and/or sponsor trainings and certifications.⁴⁴ Health care organizations can also train CHWs internally on skills specific to their unique job functions. CHWs themselves view well-organized, high-quality, and continuous training (both external and internal) as important to facilitating their work.⁴⁵ Research has found that CHWs also value comprehensive health and disease-specific training.⁴⁶ Organizations should also provide cultural competency training to CHWs so that they are comfortable interacting with individuals of different cultural identities. Although CHWs are typically recruited from the communities they serve, most health care organizations serve diverse communities; it is important that CHWs have training so they can build trust with the broad spectrum of individuals they may support (e.g., individuals with disabilities, sexual and gender minorities). Finally, organizations should train their other staff on what CHWs do and how their role and scope of practice complements the work of care teams members and clinical staff.⁴⁷ Building a common understanding helps to create an environment where CHWs are an integrated component of the team.

Certifications

Several states have established voluntary CHW certification programs to increase standardization and credibility of the profession. No state has yet to establish mandatory certification for all CHWs,^{48,49} but as of August 2017, Alaska, Texas, Oregon, Minnesota, and South Carolina require CHWs to be certified in order to be eligible for Medicaid reimbursement. Most state credentialing programs require verification or state approval of CHW training programs, curricula, and/or individual training instructors.⁵⁰

While some stakeholders in the field feel that certification is necessary to sustain and grow the profession, many CHWs and CHW advocates note the importance of balancing professional standards with a flexible approach that allows for adaptation to unique community characteristics and needs, and allowing for cost-effectiveness. One approach is to establish

minimum core competencies for certification rather than strict standards. This will allow programs to tailor their standards and training competencies to the populations they serve and to their clinical service lines, while also having a baseline set of competencies that are common across the profession. When establishing training and certification requirements, organizations should consider cost and language barriers that may prevent CHWs from accessing trainings and meeting certification standards.

Retention

Long-term retention of CHWs can increase the positive contributions they make to a health care organization. The CHW role is often demanding, and organizations may struggle with burnout and turnover if CHWs do not receive adequate organizational support.

Supervisors are often the primary source of support within an organization for staff and therefore are key to CHW retention. Supportive supervision opens lines of communication between staff, in this case CHWs and supervisors, through regular check-ins, eliciting feedback on program improvements, and working to ensure the safety and well-being of CHWs in community settings.⁵¹ Supervisors should understand not only the CHWs' roles and responsibilities, but also an individual CHW's personal and professional needs. Supervisors should assist with problem solving, answer questions, and advocate for CHWs within the organization.⁵² To prevent CHW burnout, supervisors should manage CHWs' workload, help them develop healthy boundaries with clients, and identify education and training needs.

In addition to supportive supervision, organizations can provide opportunities for CHWs to regularly meet with other CHWs in the same geographic area, health system, or others within other health care organizations. This promotes collaborative problem solving, knowledge sharing, and peer-to-peer support, which can increase effectiveness, internal motivation, and job satisfaction.

Organizations can also provide cell phones, tablets, or laptops to CHWs so that they can stay in touch with the organization and other members of their team while working in the community and visiting people's homes. When CHWs choose to leave an organization and/or program, managers should try to ascertain individual's reasons for leaving and track turnover rate for different positions. They can use this information to make program adjustments where possible to prevent further attrition.

Providing professional advancement opportunities to CHWs can also encourage retention and ensure both program sustainability and job stability.⁵³

SECURE CHW PROGRAM FUNDING

Sustainable funding is crucial for maximizing the value of CHWs. Health care organizations can use a variety of mechanisms to fund CHWs, including opportunities currently available through state Medicaid programs, special state and Centers for Medicare & Medicaid Innovation (CMMI) models and programs, and federal grant programs.

Medicaid

States have considerable flexibility to define eligibility, benefits, and payment under their individual state Medicaid programs within the broad federal regulatory framework. States may elect to utilize CHWs when designing their Medicaid programs, but states first may want to define what kind of services they want CHWs to deliver through their Medicaid program. States could choose to utilize CHWs within either a fee-for-service or managed care delivery system. For example, CHWs may be covered as a provider type for a particular service like case management under state plan authority or through waivers like a section 1115 demonstration waiver. States could also consider utilizing CHWs in a Medicaid managed care delivery system.⁵⁴

- ▶ **State Plan Authority:** A Medicaid and Children's Health Insurance Program (CHIP) State Plan is an agreement between the federal government and a state describing the services the state will offer as part of its Medicaid and CHIP program. States may elect to cover CHWs under existing state plan authority. For example, a state may want to allow CHWs to conduct certain preventive care components, under the approval of a physician, or to deliver Targeted Case Management services which are benefits that are already part of their State Plan. In 2018 and 2019, Indiana and South Dakota submitted State Plan Amendments to CMS to allow CHWs to deliver preventive services in specific circumstances. If a state elects to exercise this option, the state must meet overarching state plan requirements, such as statewide, freedom of choice, and comparability when designing the nature and scope of services provided by CHWs. States that chose this option also have to define specific provider certification and credentialing requirements for CHWs to become a Medicaid certified provider in that state in order to be allowed to serve their Medicaid beneficiaries. As an example, the state of Massachusetts has a Board Certification process for CHWs through its Department of Public Health's Bureau of Health Professions Licensure.^{55, 56, 57}
- ▶ **Medicaid Managed Care:** "The majority of Medicaid enrollees, largely non-disabled children and adults under age 65, are in managed care plans, and over half of Medicaid benefit spending is in managed care"⁵⁸. In a Managed Care environment, the state Medicaid agency pays a predetermined capitation rate to the Medicaid Managed Care Organization (MCO) for providing a set of benefits to Medicaid enrollees following the

actuarial soundness requirements defined in 42 CFR § 438.4. The capitated rate has two components: an **administrative rate** to cover costs related to the operations of the program like care management and care coordination, population health and disease management, among others and a **medical rate** to cover the costs of delivering primary care, acute care, inpatient, and outpatient services and possibly other benefits, which vary per state like behavioral health. States could require MCOs to cover CHWs through their Managed Care contracts and define how they will pay for their services. Even if a state does not require Medicaid MCOs to cover CHWs, these MCOs could still choose to utilize CHWs as a provider type usually funded through the administrative portion of their capitated rate. MCOs that chose this option may need to work with their state Medicaid agencies to determine if approval is needed and to find out how to include these services in the rate setting process. In some cases, MCOs may be responsible for developing credentialing and re-credentialing processes and procedures to ensure that CHWs received the appropriate training and are not under legal investigation for fraud and abuse before they serve Medicaid beneficiaries. For example, New Mexico managed care plans include CHWs as members of their care coordination or case management teams. CHWs are also included in their Medicaid Managed Care rates. Michigan requires their Medicaid MCOs to offer CHW or peer-support specialist services, which “has enhanced care for enrollees who have significant behavioral health issues and complex physical co-morbidities”⁵⁹. Examples of CHW services provided by Michigan MCOs include conducting home visits, participating in office visits, arranging for social services, and helping enrollees with self-management skills. In 2020, Texas introduced a bill allowing MCOs participating in their STAR program to categorize services provided by CHWs as a “quality improvement cost” instead of an administrative expenditure.^{60,61, 62}

- ▶ **Section 1115 Demonstration projects:** 1115 Demonstrations are another avenue that states originally used to cover CHWs. Changes approved under Section 1115 demonstrations are temporary and typically cover a demonstration period of three to five years. Some states used a Delivery System Reform Incentive Payment (DSRIP) demonstration project, which was a type of Section 1115 demonstration tied to performance metrics to promote payment and system changes to achieve statewide population health goals. For example, New York state allowed nonprofit organization to employ CHWs to address pediatric asthma through a DSRIP-funded initiative. This initiative utilized a Performing Provider System arrangement in which health care providers agreed on a set of goals, were incentivized to work towards those goals, and DSRIP paid for services that supported those goals, including services provided by CHWs.⁶³ This same nonprofit also collaborated with MCOs outside of the DSRIP. DSRIP funding ended in March 2020.

Oregon is another state that is utilizing CHWs as part of its 1115 demonstration to advance health equity and help address the social determinants needs of its Medicaid beneficiaries. Oregon's 1115 demonstration is centered on contracting with Coordinated Care Organizations (CCOs) that receive a global budget to provide acute care, primary care, behavioral health, and oral care for its members. CCOs are required to work with CHWs, peer support specialists, doulas, and personal health navigators to better engage with members and help them navigate health care and social services.⁶⁴

Special Demonstrations and Models

Health plans, health systems, and accountable care organizations (ACOs) can utilize certain program flexibilities to cover services delivered by CHWs. Health plans and ACOs can use predictive analytics to identify individuals who could benefit most from CHW services. These members may be those with socioeconomic needs, high hospital and emergency department utilization, difficulty managing chronic conditions, and/or multiple chronic conditions. These organizations can then hire CHWs directly or contract with an outside organization to provide CHW services. Additionally, CMS's Accountable Health Communities model includes person-centered navigation in connecting beneficiaries to community services. Practices that participate in enhanced primary care models, like Comprehensive Primary Care Plus, often include CHWs in roles such as case managers, care coordinators, and health care navigators as part of expanded services.

- ▶ **Accountable Care Organizations (ACOs)** are “a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors”⁶⁵. ACOs that are part of the Medicare Shared Savings Program and CMMI model tests, such as the Medicare ACO Track 1+ Model and Next Generation Accountable Care Organization model, improve the value of care through integrated care teams and other process-based and outcome-focused innovations. CMS Integrated Care Teams in ACOs often include CHWs as case managers, care coordinators, and health care navigators, as well as in other capacities. For example, some ACOs in Utah are covering the costs of home-based preventive services.⁶⁶ Connecticut implemented a Medicaid Shared Savings Program through a CMS State Innovation Model (SIM) grant and required participating ACOs to use CHWs and participate in a technical assistance program developed by the state CHW Advisory Committee.⁶⁷

State Innovation Models

Several states used SIM funding through CMMI to advance CHW utilization. As discussed above, Connecticut required that ACOs in its SIM-funded Medicaid Shared Savings Program used CHWs and participated in a related technical assistance program. The Michigan Community Health Worker Alliance used a SIM grant to expand its CHW training and certificate program to more community colleges and community organizations throughout the state.⁶⁸ Vermont's SIM program employed CHWs as part of a nurse-led community health team that conducted outreach to individuals and established institutional connections among primary care offices and social service organizations. Vermont ACOs received a per-member, per-month payment for community health teams via a tax assessment on health insurance plans. While the SIM initiative has ended, the community health teams continue to operate as part of the Vermont Blueprint for Health, a state led program which "aims to integrate a system of health care for patients, improve the health of the overall population, and improve control over health care costs" focused on community-based health improvement strategies.⁶⁹

Medicare

CMS has updated coding and payment policies under Part B to better recognize ongoing changes in medical practice, including team-based approaches to care. Among these are payments and codes to describe care management and behavioral health integration services. Qualifying practitioners and providers can bill Medicare Part B for these services, as well as other potentially team-based services, such as diabetes self-management training and medical nutrition therapy services, if certain rules are met.

Federal Grant Programs

Organizations can also apply for a variety of federal grants to fund CHW programs. Table 2 includes a list of discretionary grants active as of the writing of this report that may include CHWs in awardee programs, although keep in mind that a grant program focus areas may change over time. Please visit www.grants.gov/ for current federal grant opportunities. Technical assistance is also offered through the Health Equity Technical Assistance Program by contacting HealthEquityTA@cms.hhs.gov

Table 2. Grant Programs

Program Name	Funder
Black Lung Clinics Program	HRSA
Community Programs to Improve Minority Health Grant Program	OMH
Community Services Block Grant (CSBG)	ACF
Health Center Program	HRSA
Supported Activities: Prioritizing High Impact HIV Prevention	CDC
Indian Health Service, Health Information Management (HIM) Development Program	IHS
Behavioral Health Workforce Education and Training (BHWET) Program for Professionals Mental and Behavioral Health Education and Training Grants	HRSA
National Organizations of State and Local Officials: Health Legislation and Governance	HRSA
National Institute of Nursing Research (NINR)	NIH
Opioid Affected Youth Initiative	OJP
Opioid STR (State Targeted Response to the Opioid Crisis)	SAMHSA
Colorectal Cancer Control Program (CRCCP) Organized Approaches to Increase Colorectal Cancer Screening	CDC
Rural Health Research and Policy Programs Centers	HRSA
Ryan White HIV/AIDS Program (Part B: Grants to States and Territories and rebate funds)	HRSA
Special Projects of National Significance (SPNS) Program	HRSA
Telehealth Programs	HRSA
Viral Hepatitis Networking, Capacity Building, and Training Prevention and Control	CDC
Section 223 Demonstration Program for Certified Community Behavioral Health Clinics (CCBHC)	SAMHSA
*Acronyms for listed federal Health and Human Services agencies and offices: Health Resources and Services Administration (HRSA), Office of Minority Health (OMH), Administration for Children & Families (ACF), Indian Health Service (IHS), Office of Justice Programs (OJP), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC).	

Conclusion

In health care organizations across the country, CHWs provide culturally and linguistically appropriate health education, patient/client navigation, health insurance enrollment assistance, and prevention programs. CHWs also play a vital role in addressing socioeconomic factors by providing social and community-based services support, connecting people to community resources, and providing unique insights into their experiences. Integrating CHWs into care delivery can allow clinical providers, including behavioral health specialists, to dedicate more time to complex health care needs and enable members of the health care team to work to the top of their licenses. CHWs can also help tailor services for people who may face unique challenges. This benefit is especially valuable among geographically isolated and high risk, high needs populations. CHW interventions can result in cost-savings for organizations by eliminating barriers to care and shifting patients' care experiences from expensive urgent or emergency care to more cost-effective primary and preventive care. For example, CHWs have shown to provide a return on investment of more than \$2.28 for every \$1 invested by shifting inpatient and urgent care to primary care.⁷⁰

Effective planning, implementation, and management of CHW programs help ensure their success in addressing the complex socioeconomic factors that affect patient health. Organizations may benefit from well-defined core competencies and roles for CHW to guide their recruitment and hiring practices. Ensuring that organizations meet training and on-the-job needs of these valuable members of the health care team can help reduce stress on CHWs and reduce the risk of burnout. Planning should also include making the business case for CHW programs and identifying funding sources and reimbursement mechanisms to ensure sustainability.

For health care organizations looking to achieve health equity, meeting both health and social needs can ultimately improve health care quality advance person-centered care, and yield cost-savings for organizations. As health care organizations continue to improve support for their diverse populations, CHWs can help bridge gaps between the health care organization and the community, and help deliver care to all patients and clients including racial and ethnic minorities, people living in rural areas, individuals with disabilities, and sexual and gender minorities.

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