Reducing health disparities: Strategies to support effective Community Health Workers

Executive summary

Social, financial, and behavioral issues, also known as the social determinants of health, often drive poor health outcomes for lower-income individuals and families. More and more states are looking to Community Health Workers, trained laypeople who share life experience with the people they serve, to help address these issues. This paper highlights financing and policy strategies – including value-based payments, program accreditation, and incentives to implement solutions correlated with high-quality programs – that can help state legislators and Department of Health and Human Service officials optimize the use of this promising workforce.
Healthcare landscape

The healthcare landscape in the United States is changing rapidly, fueled in part by a growing awareness of the power of the social determinants of health. These are the deeply rooted social, financial and behavioral issues – unstable housing, chronic unemployment, loneliness – that too often correlate with poor health outcomes. As a recent Health Affairs article noted, “It’s startling how strongly someone’s health and longevity can be influenced by where he or she lives – a person’s ZIP code is a stronger predictor of his or her overall health than other factors, including race and genetics.” These health determinants translate into sobering statistics: Over half of all adults have a chronic condition, which is projected to cost nearly $800 billion in lost productivity by 2030.

To respond to this reality, federal policymakers are thinking creatively about how to align policy and financing levers to address these needs. As a teaser for changes on the horizon from the Centers for Medicaid and Medicare Services, Secretary Azar of the Department of Health and Human Services recently noted, “what if we provided solutions for the whole person, including addressing housing, nutrition and other social needs?”

CHW as a solution

States and local communities need a workforce to ensure these solutions get implemented in a holistic, person-centered way that extends beyond simply screening and referring people to resources. For one, there aren’t enough resources to address the need, as evidenced by the sobering statistic that the City of Philadelphia’s closed its Housing Authority waitlist once it topped 40,000 families. Second, when you ask people experiencing health disparities what they think they need to improve their health, only 15% of respondents say access to resources. In contrast, more than 70% say they need social and emotional support and help making health behavior change. While there are technology solutions that help with these things, adoption is often impeded by limited resources and needs to be catalyzed by a human-to-human connection.

Enter the community health worker (CHW): a natural helper and trusted community member who can serve as a liaison between healthcare organizations and communities. While CHWs perform a range of tasks and activities, there is increasing coalescence around 10 core roles, including coaching and social support, care coordination, and case management and system navigation. Studies have shown that CHW programs are effective at reaching underserved populations, facilitating access to services and promoting management of chronic diseases and other healthy behaviors. A CHW program in El Paso, Texas, increased awareness of cardiovascular disease risk factors and increased participants’ perceived self-efficacy in controlling these risk factors. Multiple studies have found CHW programs are effective at decreasing HbA1c levels in participants with diabetes. Clinical trials of a standardized CHW model have shown consistent improvements in mental health, patient-reported quality, and access to care, along with a 65% reduction in hospital days. The cost savings associated with these improvements translate into a 2:1 return on investment.
Patient success stories

Behind these aggregate outcomes are individual people whose lives have been improved by working with a Community Health Worker.

Take the 16-year-old in New Mexico who was “passively letting herself die” according to one of her service providers. In need of a kidney transplant, the young women had stopped taking her medications, a fact she hid from her mother. However, when she connected with a CHW, she confided that her cousins had been sending her upsetting text messages about her “rotten kidney,” telling her it would be better for everyone if she just let herself die. Once the situation was revealed, the CHW was able to find the girl a counselor and get her a new phone number to stop the taunting texts. Rejuvenated by these changes, the young woman restarted her medications, an important pre-condition for transplant eligibility.

Another example is a Veteran in Pennsylvania who struggled with depression due to difficulty finding employment given his incarceration history. During a doctor’s visit, he was connected with a Navy veteran who now worked as a CHW at the VA Medical Center. The two men bonded over their experience in the military and having grown up in the same area. The Veteran opened up to his CHW, confessing he spent most of his time alone in his house, smoking cigarettes. The CHW connected him to a weekly gathering of Veterans and also helped him find a job. As a result of these life changes, the Veteran cut down on his smoking and felt happier.

The growing evidence base and powerful stories of CHW impact has led to growth of the CHW workforce, projected by the Bureau of Labor Statistics to grow by 16% in the next decade. And this trend is likely to continue as more and more states write CHWs into value-based arrangements. For example, New York’s DSRIP program recommends the use of CHWs and Connecticut’s Medicaid Shared Savings Program requires them. However, as interest in addressing the social determinants of health through the use of CHWs continues to gain traction, it’s important that states make strategic financing and policy decisions to encourage the effective use of this increasingly popular workforce.
CHW financing

Trends and challenges
On the financing side, some states have looked toward plan amendments or Medicaid waivers to support the use of CHWs. California used a Section 1115 waiver to expand family planning services to low-income women and adolescents. One drawback with this approach, however, is that it can constrain CHW activity. The California waiver, for example, only allowed the state to reimburse per-unit CHW counseling and services. Narrow sets of services feel like a holdover from the fee-for-service era and cut out the more grassroots and socially-focused work that people say they need and that we saw was effective in New Mexico and Pennsylvania.

A second disadvantage is that reimbursement rates are often based on individual salaries, which doesn't take into account critical infrastructure expenses like transportation to home visits, supervisor salaries and personnel to collect and analyze outcomes data.

Promising strategies
A more holistic solution aligned with healthcare's shift to value-based payments is underway in Pennsylvania, where CHWs are allowable in HealthChoices, the state's Medicaid managed care program. Managed care organizations can treat expenditures for CHWs as part of the cost of delivering care, which broadens the range of eligible CHW services. In addition, payment is based on meeting performance measures, which incentivizes effective interventions that move the needle on health, quality and cost outcomes.

CHW policy

Trends and challenges
On the policy side, the last decade has seen an emphasis on training and certifying individual CHWs, with one in three states implementing CHW training programs and nearly one in five creating a voluntary certification process. However, focus on individual training and certification alone is unlikely to be effective, as factors such as hiring, work practice and robust outcomes evaluation have been shown to be key drivers of quality.

Promising strategies
Two states are leading the way in this area.

- North Carolina’s Department of Health and Human Services recently recommended CHW program accreditation to develop and strengthen the state’s CHW workforce. Components of the proposed accreditation include CHW recruitment and hiring (important for ensuring CHWs come from the communities they serve and demonstrate listening skills and empathy); program-level protocols for how CHWs support the individuals they serve; and requirements for supervision and program monitoring.

- Louisiana’s latest request for Medicaid managed care proposals provides direction and incentive for factors that drive quality, including use of evidence-based CHW programs; attestation that CHWs share sociodemographic characteristics with Medicaid enrollees; and requirements for training and work practice manuals for CHWs and supervisors that tie to core competencies for their roles. With more than 1 million Louisianans enrolled in Medicaid and all state MCOs currently employing CHWs, these requirements have the power to be catalytic for transforming healthcare delivery and health outcomes.
Conclusion

As state legislators and policymakers look for solutions to address the social determinants of health, prioritize Community Health Worker financing and policy strategies that:

- Align with healthcare's overall shift to value-base care
- Cover the costs of individual salaries and critical infrastructure components including transportation, supervision and data collection/evaluation
- Require or incentivize CHW programs to train for competencies and invest in core drivers of program quality including effective hiring protocols and evidence-based work practices

These promising CHW investments increase our ability to actually reduce health disparities. Let’s continue to find and implement strategies that enable us to work toward a future America in which where we are born doesn’t determine how long – or how well – we all live.

This resource was developed from a workshop “One size does not fit all: Adapting evidence-based interventions to fit local contexts while also maintaining fidelity” presented at the Camden Coalition’s National Center for Complex Health and Social Needs conference Putting Care at the Center 2018.

Learn more about the National Center at www.nationalcomplex.care