

Opportunities for Community Health Workers in the Era of Health Reform

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Executive Summary

Health reform in the United States seeks improve both Americans' health care experience and overall health as well as reduce health care costs through the Affordable Care Act (ACA) and private and nonprofit sector efforts (Berwick et al. 2008, Bisognano and Kenney 2012). The ACA and these simultaneous efforts have created a watershed moment for community health workers (CHWs). Both coverage expansions and a new focus on creating value in health care and public health offer new opportunities for CHWs. However, the question remains whether CHWs can sufficiently demonstrate to payers and providers of medical and public health services that they are effective in achieving these goals to spur the expansion of the profession as a part of health reform.

This paper begins with an assessment of the existing impediments to and enablers of the expansion of CHW employment. These include state differences in scopes of practice, the standardization of training and certification, and liability issues. It then catalogues how the ACA and other efforts affect prospects for sustainable employment for CHWs. It looks in turn at workforce issues, insurance enrollment needs, affordability and accessibility of services, and changes in approaches to public health and prevention. Each of these issues has different implications for CHWs. The paper concludes by highlighting particular promising opportunities for CHWs in both public and private sectors. These include both ACA-mandated roles such as navigators in health insurance exchanges/marketplaces and implied roles such as helping to coordinate post-inpatient care.

I. Introduction

The Affordable Care Act¹ (ACA) may constitute a landmark in the movement to integrate Community Health Workers (CHWs) within the mainstream of health care, public health, and social services. First, as frequently noted, some of the ACA's workforce provisions explicitly include CHWs as contributing health professionals. The Act also defines CHWs, making use of the Bureau of Labor Statistics' (BLS) recent recognition of CHW as an occupation (2010); lists useful roles they might play; and seeks to promote their training. While the ACA is not the first piece of federal legislation to specifically include CHWs, it is arguably the highest-profile legislation to do so. As some commentators have noted, one impediment to CHWs' growth as a profession has been a lack of name recognition or branding—a barrier that the ACA may help to break down (Rosenthal et al. 2010, Martinez et al. 2011).

Second, the ACA, alongside private sector trends, expands opportunities for CHWs to earn jobs and contribute to increased value in American public health and health care. This second set of implications is woven through numerous provisions that do not explicitly mention CHWs. The ACA broadly addresses perceived problems of access, quality, and cost of health care, and it also promotes prevention system-wide. The implication of this breadth of reform is that CHWs and their supporters have the opportunity to educate many more policymakers and potential employers about the potential benefits of deploying CHWs. As discussed in a companion paper, CHWs can perform a number of roles that add value in a wide range of health care contexts, and interest in CHWs has been growing among thought leaders (Bovbjerg et al. 2013b).

Third, it is opportunities that are created rather than a “done deal.” The ACA offers no direct new funding for the employment of CHWs within the prevailing fee-for-service delivery system. Nor does the ACA create requirements for health plans or medical providers to hire CHWs in particular roles. The opportunities arise because the ACA's enactment reflected powerful discontent with the current state of medicine and public health, as well as generations of discontent with disparities in access to health coverage. Though the ACA was a landmark piece of legislation, these discontents are important drivers of demand for change, independent of any specific ACA provision.

¹ The Patient Protection and Affordable Care Act, Public Law 111-148, 124 Stat. 119-1025, March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 124 Stat. 1029-1083, March 30, 2010, both accessible online from <http://www.gpo.gov>.

Federal and state policy makers have some clear strategies for improvement as they implement the ACA and strive to continue improving Medicaid, Medicare, and other existing programs, but consensus on the most effective interventions has not arisen. To an unusual extent, federal, state, and private decision makers are open to experimentation with new modes of financing and delivering clinical care and public health services. For example, the rapid approval of Minnesota's Medicaid State Plan Amendment authorizing payment for CHW services provides some evidence of this new openness. Thus, there is considerable opportunity for CHW-related initiatives to demonstrate increased productivity and value added.

This paper's next four sections catalog how the ACA and other relevant developments affect key sectors, and what those developments mean for CHWs' prospects of employment. Covered in turn are workforce issues, insurance enrollment needs and roles, ways for different providers and health plans to make health services more effective and affordable, and changes or expansions in current approaches to prevention and public health. Each section discusses background developments, ACA provisions, and implications for CHWs.

The concluding discussion highlights key opportunities for CHWs. The keys to seizing these evolving opportunities include defining the population or populations targeted, the particular health conditions or risk factors involved, the types of employers who would deploy CHWs, and the business or fiscal model that would enable an initiative to succeed.

II. Workforce Issues: Enablers and Impediments to Expansion of CHW Employment

Given the upcoming expansion of Medicaid eligibility, as well as the anticipated increase in demand for medical services, CHW roles have the potential to grow substantially, particularly in promoting insurance enrollment and participating as part of care management teams. Though the growth in demand for CHWs will ultimately be driven by the business models that succeed in the health reform era, policy and practice can influence the evolution and expansion of CHW roles, standardization of the skill sets needed, and may also help improve the quality of the jobs available to CHWs (e.g., by developing career paths and providing benefits). However, these opportunities also carry certain risks. For example, the push to standardize training and certification may help to "professionalize" the job and create opportunities for reimbursement,

but it may also create barriers to entry into the profession. And while improving the quality of the jobs available to CHWs may attract new, higher-quality workers, it may be challenging for employers to pay for higher quality jobs. Professionalizing the role also carries the risk—subtle, but significant—of shifting the allegiance of the CHW from the patient to the health care system, thus undermining one of the key characteristics of the role. This section explores issues regarding the community health workforce in the ACA era.

A. Backdrop: Growing Need for Health Care Workers

As Americans age and consume more medical care, the demand for health care grows. The frequency of chronic conditions, such as diabetes, grows as well. Americans will not have enough caregivers to meet their needs in the traditional fashion of one-on-one physician encounters, especially once more people obtain insurance under the ACA (Ormond & Bovbjerg 2011). Primary physicians already lack enough hours in the day to provide all of the currently recommended preventive services (Yarnall et al. 2003), and demand will only increase under ACA rules requiring insurers to cover them without cost sharing.

Deficits are especially acute in caring for patients with chronic conditions—noncommunicable illnesses that may be prevented but are rarely completely curable, such as heart disease, cancer, stroke, diabetes, and arthritis. According to the Centers for Disease Control and Prevention (CDC) (2009), such patients consume some three quarters of all health care spending under current approaches that emphasize acute care. It has become generally accepted that a better approach is to apply some version of Ed Wagner’s Chronic Care Model, in which community services and support augment clinical medical care and better encourage health-promoting behaviors (Bodenheimer et al. 2002a, 2002b). CHWs can play productive roles in this model, which can prevent or delay progression of conditions and avoid the need for some of the more disruptive and expensive medical care otherwise customary as conditions worsen, especially inpatient and emergency department hospital care.

Even before the ACA, many were complaining of a shortage of primary physicians, and it is implausible that new physicians can be trained quickly enough to address the impending demand for medical practitioners operating in accustomed models of care delivery. Many observers accordingly suggest that the delivery of care needs to be reconfigured in a variety of ways (Ormond & Bovbjerg 2011), especially in primary care, which also needs to grow in importance

relative to more specialized and resource-intensive services. Primary care doctors conventionally spend as much as half their time doing things that lesser skilled caregivers could do (Yarnall et al. 2003), and delegation of tasks to others can greatly improve productivity. Even small offices can benefit (Altschuler et al. 2012). In general, the value of using a caregiving team, rather than a physician-centric approach, is gaining recognition.

These developments, among other changes currently underway, can be hailed as a transformation of primary care. From the CHW perspective, the straightforward implication is that they have new opportunities to add value in these reconfigured practices, especially for disadvantaged populations, and in particular by connecting a practice more closely to its patients outside the medical office or clinic. Some observers have called for “health coaches” to help chronic patients make decisions and take more responsibility for their own care (Bennett et al. 2010).² Such roles as described are almost exactly like those conventionally played by CHWs, except that health coaches target chronic patients in general—a broader category than the disadvantaged populations CHWs traditionally target—and hence represent a growth opportunity. However, other health care workers—including nurses, social workers, health educators, and medical assistants—are also beginning to claim expertise and responsibility in these areas, especially where the populations targeted are outside CHWs’ usual underserved or disadvantaged clients.

Whatever their title, workers are needed who deeply appreciate the circumstances and challenges of living with chronic conditions and can build trust with such people. Accordingly, in contexts where CHWs address chronic diseases, they might share an affinity-based community in addition to or in place of an ethnic or residential community, and the disadvantages addressed would include not only socio-demographic attributes but also the travails of substantial burdens of chronic conditions, often multiple chronic conditions, especially as patients age.

² Health coaches are also employed by the care management teams being run through Cooper University Hospital in Camden, one of the Centers for Medicare & Medicaid Services (CMS) Innovation grant recipients noted further below (CMS 2012d).

B. CHW Workforce Provisions in the ACA

CHWs are mentioned a dozen times in three sections of the Affordable Care Act (appendix A). As previously noted, this inclusion may have raised the profile of CHWs nationally, evidenced by the selection of a leading CHW as one of 15 members of a new National Health Care Workforce Commission meant to advise federal workforce policy making. However, as has been the case with many discretionary parts of the ACA, the commission fell victim to budgetary and partisan wrangling battles and seems never to have been funded (Goldstein 2011, Daly 2012).

However, the ACA created other opportunities to promote and expand the CHW workforce, primarily through new grant programs. Since September 2010, the ACA's Health Profession Opportunity Grants (HPOG) program, administered by the Administration for Children and Families in the US Department of Health and Human Services (HHS), has supported demonstration grants to train recipients of Temporary Assistance for Needy Families (TANF) and low-income individuals for careers in healthcare (HHS 2012a, 2012b). The grant program supports the development or expansion of training programs for a variety of health care occupations, including CHWs. HPOG training programs offer case management and support services to ensure that participants, who typically have multiple barriers to employment, can complete their training and find a good job in healthcare.

In 2012, the ACA-authorized Centers for Medicare & Medicaid Services (CMS) Innovation Center funded 107 projects under its Health Innovation Awards grant program, of which 24 involve community health workers or patient navigators. These 24 grants range from \$1.3 million to \$26.5 million and will run for three years. In keeping with both the experimental nature of the grant program and the high degree of variability that characterizes CHW programs nationwide, these initiatives differ substantially in terms of their scope, structure, target population, and intervention strategy. Funded projects range from relatively small-scale programs aimed at integrating CHWs into care teams (in both primary care and hospital settings) to a regional medical home collaborative that involves providers, private payers, community-based organizations, and government departments. The collaborative is also testing an outcomes-based payment model for primary care teams that include CHWs (CMS 2012).

C. Other Potential Enablers and Barriers to Workforce Expansion

ACA Provisions

Though it provides limited appropriation of new educational funding, the ACA does not mandate coverage of CHW services, minimum wages, terms of employment, or otherwise attempt to influence workforce development. For a coverage expansion reform it pays a lot of attention to workforce and other coverage-related issues that prior reforms largely ignored, but the Massachusetts reform—on which the ACA was heavily modeled—went even further, requiring the state’s department of health to investigate how CHWs could usefully help meet post-reform needs (Mason et al. 2011).³

Nor did the ACA address possible impediments to CHW expansion. Two potential barriers are state-level statutory scopes of practice that limit what workers can do in health care, and the related threat of liability lawsuits that could limit some of the roles that CHWs might otherwise play, such as driving clients to medical appointment to ensure successful follow-through on a referral. As CHWs increasingly become part of mainstream medical care, the funding levels and sizes of employers will change, as may the climate of regulatory attention and liability.

Overall, compared with the limited workforce provisions of the ACA, other provisions considered in the next sections are more important for creating demand and driving CHW workforce policy.

Standardization of Training and Certification

Standardization of CHW training and certification, left unaddressed by the ACA, has been cited both as an enabler and as an impediment to employment. It has long been argued that CHWs need to have more standardized training and some type of more formal accreditation, but opinions vary on whether that accreditation should be nationwide or local and whether oversight should be governed by public or private bodies. Education and certification have traditionally been a state or local issue, which contributes to the wide variation in existing CHW roles and regulations.

³ <http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/workforce-development/comm-health-wkrs/community-health-worker-resources.html>

Core recommendation number five of the seminal report of the National Community Health Advisor Survey was "Establish a National CHA Certification" (Rosenthal et al. 1998). Overall support for some kind of certification requirements is growing. A strong majority of CHWs surveyed at the time said they valued training and supported certification, which the report's authors recommended primarily as a way to promote "individual advancement." This promotional philosophy has repeatedly been echoed by subsequent thought leaders—from the first American Public Health Association position statement of 2001⁴ to a recent leading article suggesting the new Massachusetts Board of Certification of Community Health Workers as a national model (Mason et al. 2011). Texas, Ohio, and Minnesota preceded Massachusetts in enacting state-approved training or certification, while Oregon and South Carolina are in the process of developing certification programs of their own. Although some disagreement remains about the risks associated with the professionalization of CHWs, many thoughtful observers support this approach (Matos et al. 2011), and the subject is discussed in numerous recent issue briefs at the national level (CDC 2011d).

Yet, as Arvey and Fernandez (2012) suggest, policy makers need to weigh the downsides as well as the benefits of certification. As noted in an earlier paper, even seemingly small requirements and modest fees may have large effects for people with low incomes, especially if they have to forgo vital income while training. Some benefits, while quite plausible, appear to be undocumented, per Arvey and Fernandez. For example, it is unknown whether certification generally leads to more third party payment (though some requirements had to be met to justify limited Medicare and Medicaid coverage of CHW services⁵). Higher wages, more secure jobs, and better outcomes for patients also need to be empirically verified as effects of certification.

One possibility is that certification may be less important for community-based jobs in public health roles. There, the paramount considerations seem to be CHWs' connections to their communities and their ability to engender trust among clients. In contrast, certification may be most important for jobs that are relatively integrated into health care delivery. There, greater knowledge and comfort working alongside medical professionals becomes more important

⁴ APHA (2001) was re-formulated and replaced by APHA (2009).

⁵ Medicare Part B can pay for community-based preventive services in the form of diabetes self-management and nutritional initial training and ongoing services from teams that include CHWs. The coverage is limited to beneficiaries trained with accepted protocols by private trainers accredited by an expert entity, quite a different model than general state accreditation (CMS 2011, Martin et al. 2005).

relative to connections with clients. Plausibly, the latter type of job will in the future grow more than the former, to the extent that CHWs move more into the mainstream of health care financing and delivery. It is also likely that state circumstances and cultures make a difference in what policies best meet local needs. Thus, for instance, any connection between certification and fiscal sustainability may differ between Massachusetts and Texas.

In sum, issues of training and certification are still intensely debated and appear ripe for additional inquiry. It would be instructive to know what similarities and differences exist between the opinions and experience of CHWs themselves and those of employers or health payers, especially how each group views the pros and cons of certification and the appropriate mix of formal and informal training.

III. Insurance Enrollment

A. Backdrop: Prior Experience with CHWs

Participant-observers of state coverage programs have long reported that programs' contracting with community groups that employ CHWs is a very productive part of effective outreach and enrollment for children and adults who are eligible for Medicaid or Children's Health Insurance Program (CHIP) (Moore 1999, Hill et al. 2009). A randomized controlled trial in Boston confirmed that community-based case managers were also far better than traditional Medicaid/CHIP outreach and enrollment methods for reaching uninsured Latino children (Flores et al. 2005). There, case managers were all bilingual Latinas who received one day's intensive training. Nearly 96 percent of eligible children were enrolled, compared with 57 percent in the control group. Enrollment was also faster, and families were more satisfied with the process. Those assigned to CHWs were also more than twice as likely to stay continuously insured over time.

This form of outreach helps overcome common barriers to enrollment such as lack of knowledge about coverage opportunities, lack of appreciation of the value of coverage, high time cost of enrollment, and mistrust of officialdom—especially among immigrant populations. Costs can be covered as part of Medicaid administration, for which states receive on average 60 percent federal reimbursement. (Federal grant funds have also been made available under the

ACA.) Complementary mechanisms include single point-of-entry enrollment for multiple programs, streamlining of forms and processes, providing materials in multiple languages, and permitting online enrollment—all of which can help boost participation. However, it is not clear from the available evidence which mechanism or combination of mechanisms contributes most effectively to enrollment results.

CHWs have played a key role in Massachusetts achieving its nation-leading rate of insurance participation (Dorn et al. 2009).⁶ There, under the state's 2006 health reform, high participation in Medicaid and CHIP (helped by CHWs and other measures) combines with high take-up of other coverage to make it the best-insured state. Only 4 percent of Massachusetts residents were uninsured during 2010 & 2011—half the rate of Hawaii, the second best-insured state. (Kaiser Family Foundation 2012). Hawaii has long mandated that sizeable employers provide coverage; Massachusetts since 2006 has required individuals to obtain affordable coverage.

Outreach by community organizations and CHWs is also part of New York's strategy for achieving high enrollment under the ACA. Using community-based enrollers helped expand Medicaid applications tenfold when New York City boosted Medicaid enrollment in the wake of the September 11th attacks (Haslanger 2003); another CHW-based intervention in NYC also reported enhanced enrollment in the early 2000s (Perez 2006). As part of its enrollment strategy under the ACA, the state recently contracted with the Community Service Society of New York (CSS) to operate a Community Health Advocates (CHA) initiative. CHAs go out into the community (including to small businesses and sporting events) to meet with individuals and groups; they also staff call-in lines and work with people online. Advocates educate community members about financing and care and they provide guidance for uninsured people seeking coverage. They can also help insured people obtain out-of-network services, help the uninsured apply for hospital financial assistance or locate low-cost providers, and otherwise help people navigate through health care financing and delivery. The cost per person served was reported as \$53 during 2011 (CSS 2011).

⁶ For Medicaid/CHIP, participation rate in 2009 averaged 84.8 percent nationally, ranging from a low of 62.9 percent in Nevada to a high of 97.0 percent in the District of Columbia. Massachusetts was second highest, at 96.0 percent; New York was 13th, at 90.4 percent (Kaiser Family Foundation 2012).

B. The ACA's Changes

The ACA's Coverage Expansions, in a Nutshell

The main thrust of the ACA is to enable millions of previously uninsured low- and moderate-income people to obtain health insurance. In an earlier political era, it would have been called national health insurance, although it mainly operates through states and private health plans. The ACA creates new structures, incentives, and subsidies to drive expansion of coverage in various ways (Bovbjerg & Dorn 2012).⁷ Under the ACA, insurance enrollment will continue to occur through the familiar channels of workplace coverage, Medicare and Medicaid—but with some new rules, incentives and funding. It will also occur through the new structure of federally subsidized, state-level insurance purchasing exchanges to help households and small business obtain coverage.⁸ Accordingly, a wide variety of policy makers working on coverage issues are positioned to influence the employment of CHWs.

In the private sector, employer-sponsored health insurance (ESI) in large or small groups will continue to cover the largest single share of all residents, including a much larger share of low-income people than is generally appreciated.⁹ Large plans tend to be self-insured—meaning that the employer retains the risk of paying for medical expenditures rather transferring that risk to an independent insurer (mainly PPOs or HMOs)—but blended arrangements also exist. Though the ACA mainly creates incentives for individual enrollment, it also encourages employers to provide insurance by imposing modest penalties for sizeable employers that do not provide affordable coverage.

Many small employers and households will obtain other private coverage through new “exchanges.” Under the ACA, these exchanges will be state-level structured marketplaces for obtaining private insurance that offer some standardization of policies, information and assistance for enrollment, and federal sliding-scale subsidies for small businesses and households with incomes from 100 to 400 percent of the federal poverty level (FPL). Some people will

⁷ Many other analyses explain the ACA's various provisions and their impacts—including this and other issue briefs in the series Urban Institute Real Time Policy Analysis, <http://www.rwjf.org/pr/product.jsp?id=22023>.

⁸ For many impacts of the ACA, the most recent estimates appear in Holahan et al. 2012.

⁹ Consider adults with incomes under 139 percent of the FPL in 2011, the main target of ACA expansion (139 percent is the level below which the ACA gives states strong incentive to expand Medicaid). Of them, the largest share had Medicaid (41 percent), but fully 17 percent had workplace coverage, while 32 percent were uninsured, according to KFF Statehealthfacts.org.

continue to buy private coverage outside of exchanges, which can offer somewhat wider variety of benefit levels and other features, but without the federal subsidies.

In the public sector, federal Medicare coverage will continue to cover a share of the disabled population and almost 100 percent of people aged 65 and above—many with low incomes. State-federal Medicaid programs will be greatly expanded, at state option. Eligibility standards for participating states are broadened from welfare-related categories to all low-income citizens (under 138 percent of the FPL), with a much lower state share of spending required to draw down federal matching funds. Associated state-federal CHIPs will continue to cover moderate-income children—by either providing options to enroll in specified private coverage or integrating into the Medicaid program—with high levels of federal matching payments available.

Many enrollees in these public programs will be enrolled within privately owned and operated insurance plans like Medicare Advantage plans and Medicaid managed care organizations (MCOs). States not using prepaid MCOs to manage care typically manage Medicaid services for most beneficiaries through primary care case management (PCCM). Under PCCM arrangements, medical practices act as medical homes to coordinate access to most forms of care and oversee quality and appropriateness of care (Berenson et al. 2011). Most Medicare enrollees and some Medicaid enrollees—often aged and disabled beneficiaries—have services paid for through the traditional program on an unmanaged fee-for-service basis.

CHW Roles in Medicaid/CHIP Outreach and Enrollment: Useful but Not Required

The ACA recognizes the role of CHWs in “serving as a liaison between communities and healthcare agencies” and more specifically in “proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs” (sec. 5313). However, it does not mandate that authorities in agencies such as Medicaid and CHIP use such community outreach. Each state will likely continue to decide what resources they want to put into outreach.

Interest continues in further improvements. The CMS Innovation Awards program (appendix C) has funded the National Health Care for the Homeless Council to develop an outreach and enrollment program aimed at the homeless. The intervention will train and integrate CHWs into 10 federally qualified health center (FQHC) sites in eight states, with the aim of reducing the

number of emergency room visits and increasing primary care linkages within the local homeless population.

The New “Navigators”: Potential CHW Roles in Exchange Enrollment

The ACA does require a new outreach and assistance role, a “navigator,” to help applicants seeking to understand the new health insurance exchanges (ACA sect. 1311). Navigators will help explain the available competing private insurance plans and help applicants decide on the best coverage for their circumstances (Rosenbaum 2011). This is a role often played in the past by insurance agents and brokers (also termed “producers”).

States running exchanges are required to have navigator programs. Entities need not be agents or brokers to qualify as navigators—they could be unions or “consumer focused” non-profits—but they must show “existing relationships” or that they can “readily establish” relationships with insurance customers like employers and employees, ordinary consumers, and self-employed people. Notably, those customers include people who were previously uninsured or under-insured, and further, information must be provided in a “culturally and linguistically appropriate manner”—provisions that suggest roles for CHWs. A different type of prior experience and new training seems likely to be needed, but CHWs’ abilities—to both give trustworthy guidance and train clients to help themselves—remain important.

Navigation in Using Insurance

“Navigation” in health care had the former meaning of helping insurance enrollees to understand insurance provider networks, make claims, deal with providers, and generally understand fee-for-service financing and provision of care. Not everyone hires such a person, or uses any publicly provided assistance, but many feel a need for help. This need will not diminish; indeed, it may increase as insurers change policies and procedures in response to the new rules and competitive pressures brought on by the ACA. People choosing a medical home may have less need of assistance, as some guidance is built in to the model. However, this assumes that people are able to locate and connect to a medical home in the first place

Under the ACA, new enrollees will disproportionately include disadvantaged populations traditionally served by CHWs, as those populations are more likely to have been previously uninsured. The skills, information, and support needed by new enrollees will likely change as

they shift from seeking care while uninsured to navigating the terrain of insured care. CHWs accordingly may have a new role to play for their former clients in their new insured status. The business model for providing such services is unclear. Navigators working through an ACA-exchange are supposed to refer enrollees' complaints and requests for continuing help to any available "office of health insurance consumer assistance" or "health insurance ombudsman" (section 2793 of the Public Health Service Act) or to any "appropriate State agency or agencies." The availability of such help today is unclear, and any prior public funding is not certain to grow commensurately with needs of the newly uninsured in new forms of insurance coverage.

However, the CMS Innovation Center evidently believes that post-enrollment navigation is worthwhile for some populations. It has funded expansion of an existing San Francisco program aimed at Medicaid and Medicaid-eligible patients who have been recently released from prison. Transitions Clinic works with the Department of Corrections to identify eligible patients and then deploys CHWs trained by City College of San Francisco to assist them in navigating the health system, finding primary care providers, and managing their chronic conditions. CHWs also help connect these patients to social service supports. The grant will expand this program to eleven community health centers in six states, the District of Columbia, and Puerto Rico (CMS 2012).

Additionally, the ACA will not eliminate the needs of the uninsured that many CHWs have traditionally sought to meet. Observations here are speculative but worthy of further consideration. After the ACA insures citizens and legal residents, the remaining uninsured will disproportionately consist of undocumented people. They may, accordingly, face heightened stigmatization and may feel greater reluctance to seek medical and social services. Moreover, some states will not expand Medicaid as envisioned by the ACA,¹⁰ and various exceptions to the ACA's call for everyone to insure themselves (with income-related subsidy) will allow others to remain uninsured.

The overall population of the uninsured will decline, but this fact by itself may not justify reducing CHW efforts of general outreach and community education. The effort needed to

¹⁰ The Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, 567 U.S. ____ (2012), allows states not to expand their current eligibility standards, ignoring the very favorable federal match that comes with expanding Medicaid, and yet retain all federal funding for the program's existing scope. As written, the ACA would have denied federal funding to states not complying with the ACA's intended Medicaid expansion to 138 percent of the FPL, a pattern used for all prior, but smaller, federal expansions of eligibility.

conduct education campaigns, media efforts, health fairs, and other such activities may be much the same in a local area—whether the target audience is 5,000 or 2,500. Concerning one-on-one services, screening to determine needs is similar, because it cannot be known before ringing a doorbell whether the household inside is insured or uninsured. Furthermore, intensive one-on-one help likely does not reach everyone who could benefit now. Thus, reducing the overall numbers of the needy in the future probably would mean that unmet need would decline, not that the existing level of effort needed to conduct CHW services would decrease.

IV. Better and More Cost-Effective Delivery of Health Care

A. Backdrop: Drivers of Change

As already noted, the ACA both reflects and promotes demands for fundamental change in health coverage and care. Demands for change will continue from the private sector even if in some areas the ACA’s enacted vision is scaled back for budgetary reasons. American health insurance and health care are already changing in ways that the ACA also advocates (Goldstein 2011).¹¹ These forces can usefully be summarized as the “triple aim” (Berwick et al. 2008). They appear to have found even more support in practical experience of system participants than in published literature.

As is typical, diagnosis has progressed further than prescription. Deficits have been well documented in the medical system’s access, quality, and cost, as well as the combined effects of medical care, public health, and all other factors on the health status of the population at large. The many prescribed responses are varied and only beginning to be documented. The ACA represents a quite comprehensive set of responses. It not only increases coverage to improve access to care, but also addresses the supply of clinics and health professions, as described in prior sections. Its systems-change provisions come next.

¹¹ See <http://www.economist.com/node/21551095> and <http://online.wsj.com/article/SB10001424127887324556304578120450099279338.html>.

B. ACA Provisions, In General

The main thrust of the ACA, as already noted, is to expand health insurance coverage. Benefits are also improved, notably by ending the ceilings insurers have often imposed on annual or lifetime benefits available. Other things equal, this change will increase the frequency of very high cost medical interventions, notably in institutional care. Another benefit change under the ACA is that proven preventive services are to be paid for by insurers without imposing cost sharing for patients.

Simultaneously, many other new provisions enhance accountability, seek shifts away from accustomed fee-for-service payment methods, create incentives for better care or better value, or create new information or metrics on performance. Some of these are written into law. Others are being pilot tested in many ways. Many other provisions increase state options to improve care or value under Medicaid or call for demonstrations and evaluation of new approaches of many types.

Some specific provisions of the ACA are tied to potential CHW employers, and the following subsections discuss them employer by employer. However, some of the law's impacts and opportunities are cross-cutting and apply across employer categories. Others affect employers whose identities will be clear only where payment regimes and loci of accountability are clear. For example, CHWs can help promote better self-management by people at high risk for or already suffering heart disease, diabetes, or other chronic conditions. What system actor might hire CHWs to help depends upon what financing and delivery models are operational in a particular area, and developments in that regard seem likely to remain in flux. This section includes medical providers and payers including self-insured employers and Medicaid HMOs.

A huge amount of innovation is being tested or implemented around the country. Some is driven by the ACA implementation and other federal initiatives, but even more relates to the efforts of states and private entities to improve value for money. There is far too much information to catalog developments completely. The following section attempts to crosswalk the major forces at work for potential CHW employers and the potential strengths of CHWs in ameliorating known deficits in quality or value, drawn heavily from our earlier environmental scan (Bovbjerg et al., 2013a). It then adds promising innovations as described by CMS's summary of its Health Care Innovation Awards (CMS 2012b).

The awards are a good source of information about potential growth areas for CHWs because they represent highly practical and highly rated approaches deemed likely to be sustainable (appendix C).¹² Among the 107 projects funded under the Center’s Health Innovation Awards grant program, summaries show that 24 involve community health workers or patient navigators (appendix C).

C. Insurers (Health Plans) and Self-Insured Employers

Insurers’ new business needs under health reform are not clear. However, it can be noted that their traditional business models have to change more than those of any other actors because the ACA requires them to change. Most notably, insurers will become far less able to match payouts to premiums through medical underwriting and various accustomed limits on benefits for a variety of reasons including risk adjustment. Moreover, exchanges create new insurance competition based more on transparency of features and better measures of value, so as to facilitate competition on those measures, not merely on price or good marketing techniques. Navigators are meant to help focus consumer choices on true value for them.

Overall, the goal of reform is to make insurers pay much more attention to root causes of medical spending and results. Likely responses include more of the cost sharing already seen (and built into the ACA’s metallic tiers, from platinum to bronze, in increasing amount of cost sharing). Other value-producing responses might include better vetting of participating providers or new ways of holding them responsible for results. Care coordination and some preventive measures, such as patient education, create potential niches for CHWs to fill. Truly primary prevention is less clearly in an insurer’s interest, as contracts typically only cover a year. Potential niches here include

- better and more efficient ways of promoting healthy pregnancy and baby care
- new brakes on high spending episodes or patients
- immunization uptake

¹² Our review found 24 relevant projects among the 107 Health Care Innovation Awards made by the Centers for Medicare and Medicaid Innovation through 2012. Summaries for these awards noted a role for CHWs or patient navigators. The word *promotores* does not appear in the summaries, possibly because public health initiatives are not funded through this mechanism. These awards are of substantial interest because they are the best of several thousand applicants, selected to address major problems for high risk populations. They are also selected for being capable of being scaled up to broader and deeper uses.

- screening and early detection of cancers

Insurers seem most likely to use CHWs in addressing high costs from “frequent flyers” or “super-utilizers,” as CMS Innovation awardee Cooper University Hospital calls them (appendix C). A Medicaid managed care program has reported on positive results in New Mexico and is said to be generalizing its approach to other states (Johnson et al. 2012). The “payoff” from improvements in treating chronic care or engaging in primary prevention seems too remote in time. As noted the ACA may tend to increase the extent of very high spending during hospital stays. This in turn will increase the incentive on payers to manage such costs in other ways, potentially including CHW assistance in educating patients in better and more appropriate use of health services. The same could hold true for hospitals if they are responsible for some or all of such high spending.

Insurers may also participate in collaborative initiatives. At least three CMS Innovation awards were granted to initiatives that use CHWs and also involve insurers.¹³ The participation of an insurer, Medicare, or Medicaid brings the potential to use insurance claims data to track utilization and use of pharmaceuticals as an indicator of health (and compliance) among other things. Well-coordinated electronic health records shared through a community exchange could serve the same function. How ready any of these data systems are for such uses, for which they were not really designed, remains an open question (on data issues in Community Care of North Carolina, see NC Med J).

Incentives of self-insured employers are different from those of other insurers in two key dimensions. First, employers (and their employees) benefit when people stay healthy and hence are more productive and sometimes also less contagious for coworkers. Second, longevity in most jobs, especially those in large firms that fully self-insure, is longer than in insurance plans. Hence, more of the payoff from prevention benefits the typical self-insurer than it does the typical insurer.¹⁴ This difference in incentives helps explain why large firms so often today promote wellness programs.

¹³ The three are Eau Claire Cooperative Health Centers, Finger Lakes Health System Agency, and Health Resources in Action (CMS 2012e).

¹⁴ Insurers often serve as a claims paying third party administrator for self-insured plans. This facilitates knowledge transfer between the two seemingly separate ways of “producing” health coverage.

CHWs might play roles in wellness programs financed by self-insured firms or insurers. Most wellness programs traditionally operate at workplaces (or through incentives to lose weight on one's own, for instance), but they can also be sited in communities. Employees' residences might be so disparately located, however, that insufficient scale could exist for one employer in any one place. On its face, such arrangements might thus better serve multiple employers in a community than a single large firm. The YMCA anti-obesity approach is such an example. It appears to use nonprofessionals to promote moderate exercise and healthy eating so as to help enrollees avoid diabetes and heart problems (Bovbjerg et al. 2013a). Fifteen years ago, wellness programs were unusual, whereas today a survey of employers about their wellness plans has just been a full cover feature in *Business Insurance* (Dec 10 & 17 2012).

D. Hospital-Related Roles

Hospitals have a new incentive under the ACA to avoid re-admissions within 30 days of discharge. This is a very clear fiscal encouragement to develop better ways of improving post-hospital community-based care than the traditional discharge planning interaction with departing inpatients. Better care coordination and follow-up—including compliance with recommended subsequent visits and proper administration of drugs and the like—is often expected to utilize nurses. For some populations and some tasks, CHWs might perform better at lower expense.

Post-inpatient care coordination seems among the most clear-cut niches for CHWs to expand. The ACA also requires nonprofit hospitals to perform periodic Community Health Needs Assessments that involve local public health officials and other interested parties (sec. 9007). They are then obligated to develop an “implementation strategy to meet the community health needs [so] identified.” This admonition can be read as promoting efforts to address root causes of ill health, potentially going to environmental and social determinants of health. It could also be read to mean simply more traditional efforts at community benefits that may closely align with the hospital's business model. Much depends on the hospital's mission and management as well as IRS enforcement of the provision. So a less clearly defined niche is:

CHWs can help hospitals meet new requirements for identifying and addressing community health needs. Given the right incentives and mission, a hospital may also be interested in reducing inappropriate use of hospital care. This is clearly motivated when the care reduced is uncompensated, as it may be at safety net hospitals. The Cooper University Hospital Innovation

Award project (Camden, NJ, appendix C) and Duke Medicine in Durham, NC, take such an approach, for reasons that merit further investigation.¹⁵

Hospital incentives would be completely changed if their revenues came from accepting at least partial capitation or if they organized to operate within an Accountable Care Organization (below), as many appear to be doing.

E. Outpatient Roles (Clinics and Physician Offices)

CHWs or other additions to the workforce of a primary care office need to raise revenues or reduce costs to add value within a fee-for-service environment. Already mentioned was one CHW role in primary care (Bennett et al. 2010).

For selected chronic patients, CHWs/health coaches may add value by improving patient self-management, among other things. Whether this is a fiscal benefit to the practice depends on payment arrangements. Similarly, improved two-way communication and better compliance with recommendations may be very helpful to patients and to overall health spending, but seems most apt to help the “bottom line” of a fee-for-service medical practice if the practice needs to spend more professional time with a patient than insurers will pay for (though it is unclear whether such a situation is common).¹⁶

Simple delegation of some physician and nursing tasks to CHWs can also improve productivity. Where less-trained and lower-waged people substitute directly for physician or nursing time, there can be a clear fiscal benefit to a practice, even if paid on a fee-for-service basis (Altschuler et al. 2012).

The ACA has already provided major new funding for FQHCs, which, as already noted, are well positioned to serve as medical homes for low income patients newly insured under the ACA. FQHCs’ Medicaid rates seem often to be favorable compared with those paid to primary physicians, and their bottom lines will plausibly be helped by a reduction of the overall number of uninsured people in their catchment areas under the ACA. Thus, they may be able to add value by adding some CHW outreach or other services.

¹⁵ See this project’s companion case-study volume (Eyster and Bovbjerg 2013).

¹⁶ Some practices may benefit economically from the addition of new patients. CHW outreach to communities might be one form of attracting new people. The availability of paid preventive care services like some screening might help finance such outreach and attract patients. This is a hypothetical that bears examination; we found no such examples.

FQHCs might employ more CHWs after the ACA coverage expansions. Many FQHCs are already accustomed to using non-physician staff in their team-based approaches, so CHWs could fit in well. What tasks might add value is uncertain, as many FQHCs already benefit from substantial delegation and teamwork.

The ACA mandates that insurers pay for proven clinical preventive services without imposing cost sharing on patients. These services seem most often provided by primary caregivers' practices. Whether CHW training in self-management and prevention could constitute such services merits consideration.

Some CHW services might qualify as proven clinical preventive services that insurers must cover under the ACA. Our scan found one unusual situation in which Medicare already pays for some training in prevention and self-management for diabetic and pre-diabetic patients that can include CHWs as members of training teams (appendix D). That experience has not led to high usage, and the implications for the far larger ACA change in clinical prevention benefits are unclear.

Home visits to expecting families and other prenatal care can be valuable and CHWs might play a role in educating and encouraging families to prepare. The law also includes funding support for early childhood home visitation for expecting parents and families who have young children. Professionals come to the home to provide information and support. The aim is to reduce child abuse and neglect, promote the health of mothers and their children, and prioritize high-risk populations. Some research supports such positive outcomes in prenatal care, but with visits by nurses (Olds et al. 2010); CHWs' joining nurses has achieved positive results in some other contexts (Bovbjerg et al. 2013a). According to a case study in Durham, North Carolina, a home visiting program for frail, homebound elders living in targeted public housing achieved positive health results (Anderson and Bovbjerg 2013).

F. Accountable Care Organizations (ACOs)

ACOs are new entities being created under new rules set through ACA implementation. Their theory is much like that of early prepaid medical group practices and integrated systems in operation in various locations today. Effective groupings of medical actors capable of organizing comprehensive care can achieve better results at reasonable cost. ACOs can take various possible

configurations, including hospital rather than physician leadership, and they have new accountability incentives to produce quality and value. They share in savings achieved for populations for which they provide care.

ACOs can utilize CHW services where they are confident that more than offsetting savings will occur elsewhere. In many ways, the orientation to the health of a population resembles that of public health, considered in the next section.

G. Medicaid Programs and Other Organizations

The North Carolina Community Care of North Carolina (CCNC) Medicaid managed care, medical home approach relies in some areas on care coordination and physician support services for dealing with high-need patients. Some areas, like Durham, use CHWs. CHWs can help nurses with care coordination and other tasks.

The state is confident enough in its CCNC approach that it is expanding it into the management of care for people eligible for and enrolled in both Medicaid and Medicare. This population has notably high per capita costs and chronic problems that could benefit from a more coordinated approach. But their care, for reasons of program administration and history, has never been managed. Medicare-Medicaid “dual eligible” innovations hold the substantial promise of improving value for money and can involve CHWs. Who would employ the CHWs depends on the model implemented. The form that will be taken cannot be predicted, as it depends on changed financing incentives as well as what new models of delivery win out in an area.

V. Prevention and Public Health

A. Backdrop

CHWs have a long history in public health and prevention. Many of the traditional roles of CHWs have been organized and funded by public agencies and have been targeted at improving population health. The American Public Health Association (APHA) has an established interest group for CHWs through the creation of its CHW Section and defined them as public health

workers (APHA 2013). This definition is in contrast with the BLS characterization of them as health care workers.

CHW services are often provided by public health entities because they are often targeted to disadvantaged and uninsured populations. This association is only partly due to these groups' population health focus. It is also related to the fact that local health departments are often funded for their overall mission rather than on a service-based model like clinical care. On the one hand, this allows them greater flexibility in staffing than a funding model dependent on clinician-generated fee-for-service revenues. On the other, it leaves them vulnerable to budget cuts in times of stringency. Public health has historically been underfunded.

B. The Affordable Care Act

The ACA's emphases on prevention and population health are new in the history of health reform and national health initiatives, and they illustrate how far public health has advanced as federal policy. In the unsuccessful early-1990s push for health reform, public health advocates were jubilant when they won a simple mention of public health in the Clinton proposal. In 2010, in sharp contrast, public health was deeply imbedded into the ACA. Indeed, President Barack Obama had made prevention and public health a cornerstone of his approach to health policy early in his candidacy, well before the final reform bills took shape. Notably, such support was non-controversial as Senator John McCain's candidacy was also supportive, although in a less central way.

The ACA creates both opportunities and challenges for public health and prevention. One entire title of the ACA is devoted to prevention and public health, analogous to the separate titles on insurance reform, insurance exchanges, and Medicare and Medicaid. This brings unprecedented prominence to a mostly unheralded aspect of health. The ACA gives new prominence both to community health interventions (e.g., through the Prevention Fund and the new national prevention plan) and to clinical prevention through coverage requirements.

An orientation toward population health is a theme that runs through many aspects of the ACA. Among public health programs, for example, the ACA emphasizes community-based prevention, building on the start made the previous year by the American Recovery and Reinvestment Act (ARRA) stimulus legislation. However, the ACA moves from ARRA's time-

limited support to long-term funding through the Prevention Fund, addressing the lack of sustainable funding that has been a strong impediment to establishing a career ladder for CHWs.

Many ACA provisions also directly benefit public health. Arguably, the two most important are the new policy development mechanism of the National Prevention Council and a sizeable new Prevention Fund¹⁷ (though the latter has been diminished under the budget stringency of the recession). The National Prevention Council is to develop a national strategy that promotes health across all agencies,¹⁸ reflecting the emerging goal of creating health in all policies¹⁹ by including all agencies that substantially influence health and the increasing understanding of the importance of the social determinants of health. As health moves beyond clinic walls, there may be roles for CHWs in a variety of non-health programs. The Prevention Fund was meant to create an “expanded and sustained national investment”²⁰ in place of the shifting and uncertain funding of annual public health appropriations at all levels of government.²¹

Most of the roles for CHWs that are listed relate to community or public health (sec. 5313). These include:

- liaison between communities and healthcare agencies;
- guidance and social assistance to community residents;
- provision of culturally and linguistically appropriate health or nutrition education; and
- advocate for individual and community health.

In expanding health coverage, the ACA greatly affects what public health needs to do, can do, and should do. It also raises the profile of public health generally and addresses specific public health issues—adding new funding, creating new entities to help set priorities, and encouraging innovation, especially for population health and chronic conditions. Many of the new roles and the new funding create opportunities to employ CHWs. The ACA’s health promotion objectives resemble the Healthy People objectives. The National Prevention Strategy

¹⁷ These two provisions start the ACA’s Title IV on Prevention of Chronic Disease and Improving Public Health. Sect. 3001 creates the National Prevention, Health Promotion and Public Health Council, and sect. 4002 establishes the Prevention and Public Health Fund.

¹⁸ Section 4002 of the ACA lists a dozen cabinet officers or other high level administrators who shall form the Council.

¹⁹ Kickbush et al. 2008, Collins and Koplan 2009.

²⁰ Harkin 2009, at S13661.

²¹ Even the extra federal funds for H1N1 and under ARRA, welcome though they were for state and local actors, were one-time boosts, not a reliable funding stream.

produced by the ACA-created National Prevention Council (2011) repeatedly recommends expansion of CHWs.

More people will be enrolled in both public and private coverage and, as discussed elsewhere, CHWs can assist in steering their clients to appropriate coverage options. In addition, Medicare and new private insurance policies are required to cover proven clinical preventive services at no cost to patients, and state Medicaid programs are encouraged to do so by a higher federal matching percentage.²² Making clients aware of both the availability and the importance of these services could be an important task for CHWs. They already have the trust of their clients and so their recommendations may carry a greater weight among the population than other means of transmitting health messages.

The coverage provisions indirectly help public health. They can raise public awareness of the value of clinical prevention and wellness and provide concrete rewards to practitioners who emphasize health promotion. Broader coverage also means that when public health screening finds a problem, a CHW can steer an affected individual to appropriate clinical therapy.

Other funding has become available under the ACA-established CMS Innovation Center, as discussed elsewhere. Many of these grants support CHWs in public health and prevention roles. In Michigan, CHWs' tasks will include connecting at-risk populations with local care and support services that address social determinants of health that impede achievement of positive health outcomes. Rutgers University will test a care management strategy for high-cost, high-need, low-income populations in four cities using care management teams that include nurses, social workers, and community health workers to provide clients with patient-centered support that addresses both health care needs and the underlying determinants of health.

The ACA also funds or proposes many other programs or interventions whose variety makes them difficult to summarize. Many of the provisions offer opportunities for CHWs, such as new CDC grants to states to promote healthy aging and grants to give small businesses access to wellness programs.

²² The US Preventive Services Task Force is to determine whether services' effectiveness is proven. The Task Force recommends that clinicians provide preventive services whose evidence of effectiveness is good, earning a grade of A or B. Also to be covered are immunizations recommended by CDC's Advisory Committee on Immunization Practices. The Health Resources and Services Administration also plays a role.

C. Effects on Prior Uses of CHWs in Population Health

Although the ACA seeks to promote public health in the ways just described, most actual population-health promoting services (like those of CHWs) remain at the state and local levels (operational responsibilities of the federal level are mainly related to populations of special federal concern, such as Native Americans and veterans). Accordingly, there is no new federal center for public health innovation, and existing roles for CHWs that relate to localized needs will continue to be as appropriate as they were before the ACA.

As discussed previously, the ACA's coverage expansions will alter the need for state or local funding of health services, but likely not very much the need or content of CHW-targeted interventions for population-oriented prevention among disadvantaged people. Thus, prior uses of CHWs seem likely to continue as before, and in the absence of targeted new federal support, the same funding challenges may remain. Assuming that clinical health spending shifts toward responsibility for population outcomes, the medical services sector may become more responsive to partnering with public health entities to address population health even outside their enrolled panels of patients. This seems rather a long-range possibility but a real one.

Apart from the ACA as already enacted, there do seem to be more stirrings of interest in paying more attention to CHWs. The HHS Promotores Initiative and the various strands of interest in CHWs at CDC, Health Resources and Services Administration, and BLS may yet produce change beyond that seen directly from the ACA.

VI. Conclusion

A companion paper reviewed evidence on how CHWs can contribute to better public health and health care, especially for the disadvantaged (Bovbjerg et al. 2013a). This paper has sought to lay out the health reform-related changes occurring in health care that are influencing or will influence opportunities for CHWs to contribute to improvements. Both were based on an environmental scan of selected writing, several case studies, and expert interviews.

The ACA was itself a significant catalyst for change, but it also reflects earlier reform efforts by private health payers and other levels of government— efforts which continue to influence change independent of the ACA. A key driver of these efforts is widespread concern about the

seemingly incessant increases in health prices and spending, and the related implications for governments, private employers, and households alike.

In addition, though the US health care services are often of very high technical quality, much evidence suggests that too many encounters feature too little care, too much care, or the wrong care. Spending levels appear too little connected to advances in the observed health of the population at large or in patient satisfaction, and, for all of its costs, US health outcomes do not compare favorably to other developed countries, nor do high-cost areas within the US seem to perform much better than lower-cost ones. Innovative delivery models appear capable of producing good results at a more reasonable cost.

These concerns driving change have been usefully summarized as the triple aim – better health, better care, and lower costs. One or more of these goals animates most current developments within medical service financing and delivery that have relevance for CHWs.

Some of the changes seen in ACA enactment and implementation are clearly specified, nearly certain to occur, and exist within a recognized business model capable of paying CHW wages. These suggest quite specific roles in which CHW services have clear opportunities to grow, such as:

- helping states reach out to eligible Americans for enrollment in Medicaid and CHIP, notably recent immigrants and others with traditionally low “take-up” levels, especially once coverage expansions begin in January 2014;
- serving as insurance-choice navigators, which state-level insurance-purchasing exchanges must provide to help applicant/enrollees make well informed choices among competing private insurance options; and
- helping hospitals avoid payment penalties—which are already being implemented—for having unduly high rates of readmission within 30 days of discharge.

Despite the relative clarity of these roles, employment is of course not guaranteed. Funders and employers still need to be persuaded that CHWs add value in ways that can improve their cash flow, as discussed in a companion paper (Bovbjerg et al., 2013b). Moreover, CHWs must demonstrate that they add value more cost-effectively than alternative options. And, plausibly, employers will need to have the managerial tools to track inputs and outputs in nearly real time,

so as to be able to adjust the “dosage” of different aspects of an intervention as it unfolds for new populations.

Other potential opportunities for CHWs are less specific. They represent market niches that CHWs might help fill, but exactly how they will develop depends on the evolution of payment models, organization of care delivery, and accountability for results and costs that are now under way. An especially important issue is how fast and in what ways payers move away from volume-based, fee-for-service reimbursement towards a more bundled form of payment based on outcomes. This may include global or partial capitation or some form of risk-sharing by providers.

These less-defined opportunities include:

- helping primary care practices become more productive by undertaking non-clinical tasks, such as helping patients navigate the health system;
- helping the responsible provider (e.g. hospital or clinic) or payer (e.g., health plan, self-insured employment group) reduce utilization by promoting effective prevention and primary care, especially for chronic care and other high-cost patients;
- helping medical and health homes promote more effective diagnosis and treatment by improving knowledge about and approaches to addressing the social determinants of health, especially for chronic conditions and among disadvantaged subpopulations;
- helping avoid inappropriate utilization, especially by unusually high users of care, notably at hospital emergency departments and inpatient settings; and
- helping patients to manage their chronic conditions themselves, in line with some version of the chronic care model.

As the following types of shift occur, there will be more scope for primary prevention, better health literacy, improved two-way communication between caregivers and patients:

- The focus of care management shifts from individual patients to patient panels and population-based health care, through medical home or health home models or otherwise.
- The unit for payment shifts from individual procedure codes to episodes of care encompassing comprehensive services both within and outside the clinic walls.

- The unit of payment shifts from a single point in time to a longer-term episode of care or period of enrollment.
- Institution of mechanisms for shared savings provides greater incentives for investment in care when the return on such investment might accrue elsewhere.
- Current clinicians *and* insured patients accept a more team-based approach to care, the contributions of non-experts, and the chronic care model in lieu of standard physician encounters for all services.
- Covered services expand from clinical locales into community locales including workplaces, schools, churches, and other community-based organizations.
- Employers move from simply paying for services or insurance to paying for employee wellness through programs and even aspects of community prevention.
- In the realm of public health and primary prevention, our environmental scan suggests that the full range of potential roles is already in use. At least three major issues might affect CHW employment going forward:
 - Whether overall public health funding can be increased. This might occur through direct government appropriations of taxpayer dollars, although that is a steep challenge. It might also occur through sharing of responsibilities with private partners, which may be less of a challenge. The latter might occur, for instance, if ACOs, nonprofit hospitals, or other private entities take on more general responsibility for primary prevention now borne by public health, preferably in partnership with public health.
 - Whether the “technology” of primary prevention changes such that it is less difficult to encourage health promoting behaviors or self-management of chronic conditions. That is, if it becomes both easier and more socially acceptable “to make the right choice the easy choice.”
 - Whether CHWs are able to earn a larger share of available public health funds. This is another possible route to expansion but seems an even bigger challenge. The “expansion of coverage dividend” of reduced state and local governmental responsibility for safety net care will lead to windfall gains. In order for public health and CHWs to share in these gains calls for governments to share in them to begin with and then for governments to

allocate the savings to public health rather than other priorities, which is an aspect of point number one.

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Appendix A. Specific ACA Provisions Related to CHWs

The Affordable Care Act (ACA) contains numerous provisions relevant to the development and productive deployment of CHWs. This appendix sets out the ACA’s specific mentions of “community health worker”—its definition as a health profession and other CHW-relevant workforce provisions. Together, these sections of health reform help legitimize CHWs and may serve to expand health actors’ recognition of their utility in many roles, as a number of commentaries suggest (e.g., Rosenthal et al. 2010, Martinez et al. 2011).

The ACA mentions “community health workers” 14 times across three sections:

- Sec. 5313 defines CHW and calls for grants to programs using them to promote positive health behaviors among underserved populations. It limits them for purposes of its grants to people providing services in their own residential community
- Sec. 5101 includes them among the health professions for representation on the National Health Care Workforce Commission
- Sec. 5403 creates two new types of grant for Area Health Education Centers to foster training and placement of CHWs into jobs.

The provisions do not appropriate funds, but does authorize them. This facilitates future funding, but subjects that funding to annual appropriations processes.

1. Sec. 5101

Subtitle B—Innovations in the Health Care Workforce

SEC. 5101 [42 U.S.C. 294q]. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

- (1) serves as a national resource for Congress, the President, States, and localities;
- (2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;
- (3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors. ...

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out this section. ...

(i) DEFINITIONS.—In this section:

(1) HEALTH CARE WORKFORCE.—The term “health care workforce” includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(2) HEALTH PROFESSIONALS.—The term “health professionals” includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health

professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, *[possible intended addition by section 10501(a)(3)—which amended subsection (i)(2)(B):* optometrists, ophthalmologists,*]* public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, **community health workers**, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;

(B) national representatives of health professionals; ...

2. Sec. 5313

SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

“SEC. 399V [42 U.S.C. 280g–11]. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

“(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of **community health workers**.

“(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support **community health workers**—

“(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

“(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

“(3) to educate and provide outreach regarding enrollment in health insurance including the Children’s Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act and Medicaid under title XIX of such Act;

“(4) to identify and refer underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or [As revised by section 10501(c)(1)]

“(5) to educate, guide, and provide home visitation services regarding maternal health and prenatal care. ...

“(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

“(1) propose to target geographic areas—

“(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

“(B) with a high percentage of residents who suffer from chronic diseases; or

“(C) with a high infant mortality rate;

“(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

“(3) have documented community activity and experience with **community health workers**.

“(e) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage **community health worker** programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

“(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage **community health worker programs** receiving funding under this section to implement a process or an outcome-based payment system that rewards **community health workers** for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

“(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of **community health workers** under the programs funded under this section and for assuring the cost-effectiveness of such programs.

“(h) MONITORING.—The Secretary shall monitor **community health worker** programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

“(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

“(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014. LIKELY UNFUNDED

“(k) DEFINITIONS.—In this section:

“(1) COMMUNITY HEALTH WORKER.—The term ‘**community health worker**’ means an individual who promotes health or nutrition within the community in which the individual resides— [As revised by section 10501(c)(2)]

“(A) by serving as a liaison between communities and healthcare agencies;

“(B) by providing guidance and social assistance to community residents;

“(C) by enhancing community residents’ ability to effectively communicate with healthcare providers;

“(D) by providing culturally and linguistically appropriate health or nutrition education;

“(E) by advocating for individual and community health;

“(F) by providing referral and follow-up services or otherwise coordinating care; and

“(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

3. Sec. 5403

SEC. 5403. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended to read as follows:

“SEC. 751 [42 U.S.C. 294a]. AREA HEALTH EDUCATION CENTERS.

“(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

“(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or ...

“(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues... .

“(b) ELIGIBLE ENTITIES; APPLICATION.— ...

“(c) USE OF FUNDS.—

“(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

“(A) Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers. ...

“(B) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, and local workforce investment boards, and in health care safety net sites.

“(C) Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, Federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.

“(D) Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, **community health workers**, public and allied health professionals, or other health professionals, as practicable.

Appendix B. Additional Workforce Issues

Competing Logic Models for Licensure and Accreditation in Health Care

The logic supporting more standardized training and certification of CHWs is straightforward and familiar in traditional health care service delivery. Patients and clients can suffer severe injury from inappropriate caregiving, need to be protected from unsafe or unscrupulous caregivers, and are poorly equipped to judge credentials and quality of service themselves. Prospective CHWs need straightforward ways to document their competencies and to earn higher status and wages. Employers need to learn what knowledge and skills their prospective employees possess. Having written credentials reduces the time and effort needed to screen job applicants, and continuing education and additional certifications help standardize decisions about retention and advancement. The private and public insurers that pay for almost all health services need to determine whether they should pay for services from a particular kind of caregiver.

Educational requirements and licensure or certification of fitness to practice are the recognized forms of credentialing in US health care. Medical care is complex and education should help build relevant knowledge and the skills needed to provide effective services safely. Licensure or certification shows that basic standards of skill and knowledge have been met, at least as of the time of credentialing. Classically, licensure is public and mandatory; and unlicensed practice is a criminal offense. Certification differs in being private and voluntary. It serves as a credential, often alongside a license, for the use of employers as well as patients selecting a caregiver on their own. Yet payment rules may make certification essentially mandatory by refusing to pay for services provided by uncredentialed personnel working for hospitals or other employers who are entitled to payment for employees' work. Such credentialing can also help instill a sense of professionalism that motivates caregivers to adhere to high standards and a sense of duty toward patients and clients.

A competing logic also exists. The demands of actual patients and actual practice conditions in the field may differ from those of the classroom, a test, or any in-practice component of training. Educational performance and passage of a certification or licensure exam may inadequately document acquisition of knowledge and skills. Indeed, the skills needed to perform

many tasks in caregiving and health promotion may be difficult to capture through formal testing. Moreover, demands and needs change over time— as do the needed competencies among health-related personnel— and ongoing certification by authorities not close to actual caregiving might be inadequate to assure the right match of talent and task. Finally, licensure and certification serve as entry barriers for personnel in health care that prevent employers (or patients) from choosing the best people to meet particularized needs in certain circumstances. These requirements raise costs for consumers as well. Employers and patients (directly or through measures of satisfaction) may be better suited to match competencies to needs other than at a basic level.

In practice, a mix of formal education credentials and fitness-for-the-job assessments is relied on, even for physicians. The issue is always to find the appropriate mix. There is some indication that scopes of practice may rise to higher visibility. Larry Merlo, President and CEO of CVS Caremark Corp, told The Wall Street Journal that, given “a shortage of primary-care physicians [w]hat we can do is to harmonize the licenses of health-care professionals to a scope of practice that is based on their education, training and experience versus just the regulations within the state where thy practice.”²³

Return on Investment, Who Benefits from Education and Training, and the Case for Subsidy

Who benefits from the training has implications for who should finance it, but assessing return on investment to training CHWs is complicated. There are several logical places where the return might accrue, and all must be viewed over different time periods. And, as with all aspects of CHWs, it also matters which task, population, role, setting, and the like are the target of the training. Finally, training CHWs often involves two phases—formal training of a general nature followed by on-the-job training for the specific task at hand, and the latter may be longer than the former.

The most immediate beneficiary of training is the person trained. CHW is an entry-level position in health care, and for many CHWs it is the first step onto a career ladder. The trainee invests time and comes out with a marketable skill. Many CHW training programs are explicit about the employment goal of training. A CHW’s first employer then undertakes more targeted

²³ <http://online.wsj.com/article/SB10001424127887324556304578120450099279338.html>.

training to adapt the general CHW training to the specific task at hand. Such training can take four to six months or more, during which time the employers pays the CHW and receives service that only gradually meets the scope of the job. Ambitious CHWs, now firmly on the health care career ladder, may soon leave the first employer so that the full benefits of the on-the-job training may accrue to employers down the line.

Because the trainee so clearly benefits from the training it is tempting to assign training costs to the trainee. However, most CHWs are as economically vulnerable at their clients and may be deterred from training if there are substantial non-time costs. The new CHW's first employer also incurs training costs. Whether he can recoup these costs depends on how long the trainee stays on the job.

The recipient of CHW services is another beneficiary of CHW training. Recipients may see better access to care, greater understanding of how to deal with health risk factors, and enhanced success in condition self-management, among other benefits. Where these benefits lead to improved health, society at large also benefits from reductions in morbidity, mortality, and unnecessary health services expenditures. As with many public health investments, these benefits will only be seen over time. Beneficiaries of CHW services, like CHWs, are often low-income and could be hard-pressed to pay for CHW training that improves access to and effectiveness of the services they receive.

Insurers of this population also benefit from the contribution of CHWs to the effectiveness of health care. Savings to Medicaid accrue to taxpayers at both the state and federal levels. Savings to private insurers improve the medical loss ratio, which could allow reduced premiums for all subscribers. Finally, because CHWs' work addresses the environmental and social determinants of health, the community at large benefits—but again, only over time. Estimating the return on the public health effects of CHW work has all of the difficulties of estimating return on public health activities generally with the added complication of assigning effects to CHW actions.

Appendix C. The Center for Medicare and Medicaid Innovation and Its Grants for Promising Initiatives

The Center's Goals and Focus

- This center was created by the ACA (Section 3021) and funded within CMS. CMS refers to it as CMMI or the “CMS Innovation Center,” although the law uses the acronym CMI. The center seeks to learn in organized ways from community “pockets of innovation,” in order to build on those successes to deliver better value care to CMS beneficiaries. Such approaches “either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending.”²⁴ (CMS 2014).

Among the Center’s listed models of interest are a number within which CHWs could play a role and thereby increase their employment. Some of these areas result from specific ACA provisions; Affordable Care Organizations are one example. Other areas are more general, such as bundled payments.

Health Care Innovation Awards

These Innovation Center awards are of particular interest for CHWs. The Health Care Innovation Awards is \$1 billion grant program for “innovative projects across the country that test creative ways to deliver high-quality health care services and lower costs,” particularly for patients “with the highest health care needs.” They are important for CHWs because the models are practical ones, capable of beginning quickly, that bubble up from the field rather than being pushed out from Baltimore-Washington. Moreover, priority is “given to projects that rapidly hire, train and deploy new types of health care workers” with a financing “model for sustainability post-award.” Because the public programs serve such a diversity of enrollees, models that work well for them are likely to be applicable for much privately funded care as well.

As of 2012, CMMI had granted 107 Innovation Awards, of which fully 24 named community health workers or patient navigators as aspects of the innovation funded (CMS 2012a). Many more may have roles for CHWs that are not in the summaries reviewed. Key informant interviews with CMS staff will help improve this information. The 24 grants range from \$1.3

²⁴ About The CMS Innovation Center, webpage, <http://www.innovations.cms.gov/About/>.

million to \$26.5 million, and will run for three years. These initiatives differ substantially in terms of their scope, structure, target population, intervention strategy, and potential business cases, in keeping with both the pilot nature of the grant program and the high degree of variability that characterizes CHW programs nationwide. The projects have an evaluation component but have been selected in large part because of their promise to being nearly ready for practical applications to improve Medicare and Medicaid operations, with spillover applications within private health financing and delivery. Funded projects range from small-scale programs aimed at integrating CHWs into care teams (in both primary care and hospital settings) to a regional collaborative that aims to transform primary care delivery through outcomes-based payment reform.

For example, Cooper University Hospital was awarded \$2.8 million to *expand an existing care management program operated by a local nonprofit organization*. The Camden Coalition of Healthcare Professionals uses care management teams that include clinicians, social workers, and “health coaches” to target frequent flyers (also referred to as “super-utilizers”) in Camden’s three emergency departments. The coalition pioneered a real-time alert system that gathered billing data from the city’s three emergency departments and then used that data to identify patients with multiple visits over six months. The system would then notify care teams, who would offer care management services to those patients while they were in the hospital. This intervention model is being expanded to health systems in California, Colorado, Missouri, and Pennsylvania through a second Innovations grant managed by the Rutgers Center for State Health Policy.

Another grant will support the expansion of an existing program aimed at Medicaid and *Medicaid-eligible patients who have been recently released from prison*. Transitions Clinic, based in San Francisco, works with the Department of Corrections to identify eligible patients, then deploys CHWs trained by City College of San Francisco to assist them in navigating the health system, finding primary care providers, and managing their chronic conditions. CHWs also help connect these patients to social service supports. The grant will expand this program to eleven community health centers in six states, the District of Columbia, and Puerto Rico.

The largest grant involving CHWs was awarded to the Finger Lakes Health System Agency, which acts as the coordinating body of a regional collaborative of providers, payers, state and local government, and various community-based organizations in the Rochester, NY area.

Funding for this project will be used to *expand on an existing primary care medical home* program sponsored by private payers operating in the region. Over three years, the project will train 726 health workers, as well as pay the salaries of 76 care managers, community health workers and care coordinators based in participating practices.

Appendix D. One Example of Fee-for-Service Payment for CHWs as Part of a Team under Medicare

In an unusual and underappreciated way, Medicare Part B can pay for community based preventive services in the form of diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services for Part B beneficiaries who have a diagnosis of diabetes or renal disease (CMS 2011, AADE 2010, Indian Health Service 2010, 2012). Beneficiaries are trained with accepted protocols by educators accredited by one of two expert private associations. Both initial and follow-up education is covered as a preventive service to the beneficiary, but for only 10 hours in the initial year and 2 hours per year thereafter. MNT services may total 3 hours initially and additional time prescribed as medically necessary.

CHWs can be part of the educational and follow-up team in non-technical roles that help improve patients' self-management skills (AADE 2010 and 2011, CMS 2009). CHWs may also conduct outreach and provide pre-diabetes and diabetes education in established community forums—recruiting participants in training. Because these Medicare benefits are so time-limited, employment opportunities are not large. In communities where need is great (as for the Indian Health Service) scale could be sufficient to provide sustainable employment, taking referrals from numerous primary caregivers. Key limiting factors for now appear to be knowledge of this benefit among primary caregivers and willingness to refer. It is estimated that less than 1 percent of patients who could benefit are referred (CMS 2011).

On the face of it, the allowable hours seem very small, and the motivation for physicians to refer is unclear. More information would be helpful, including on whether other such examples exist and whether this provision has served as a precedent.