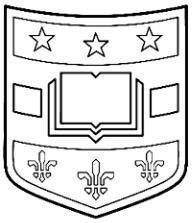
January 2024

Transforming Healthcare in Missouri

Bridging the Gaps with Community Health Workers from Global to Local and Back



Center for Advancing Health Services, Policy & Economics Research

INSTITUTE FOR PUBLIC HEALTH | INSTITUTE FOR CLINICAL & TRANSLATIONAL SCIENCES | DEPARTMENT OF MEDICINE

WASHINGTON UNIVERSITY IN ST. LOUIS

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Executive Summary

Community Health Workers (CHWs) are critical members of care delivery teams who facilitate access to consistent quality and culturally sensitive healthcare to the communities they serve. The services provided by CHWs are extensive, including advocating for efficient resource allocation, promoting reliable healthcare access, and/or delivering culturally appropriate health education.

Across the United States, various models of reimbursement for CHW services are being developed. In particular, as Medicaid coverage has expanded in many states since 2014, policymakers and other Medicaid stakeholders have observed the clinical and psychosocial advantages that enrollees can derive from CHW support. As of July 2022, 29 states reported allowing direct, Medicaid claims-based payment for services provided by CHWs using a variety of spending authorities and models, but Missouri provides only limited, indirect funding streams to support CHW work.

In September 2023, the Center for Advancing Health Services, Policy & Economics Research (CAHSPER) at Washington University in St. Louis convened a diverse stakeholder group including significant representation from MO HealthNet (Missouri Medicaid), Missouri policymakers, University and community partners, and a large number of CHWs representing different settings. The group gathered to discuss possibilities for new reimbursement models for CHW services. Participants heard from a keynote speaker who spoke to the need for, and pathway to, achieving long-term sustainability for CHWs, followed by a panel of Missouri CHWs practicing in rural, suburban, and urban communities. After a Q&A session with the panelists, three speakers discussed the emerging evidence at the state and local levels for CHWs, sharing data that demonstrate how CHWs bring significant value to health outcomes.

A brief policy overview provided details on quality metrics and other policy levers within Medicaid and Medicare that could be leveraged to tie CHW work to reimbursement mechanisms, after which attendees were divided into four breakout sessions of choice. Two groups looked at existing models for reimbursement, with one discussing existing global models and the other considering different U.S. state policies. A third group looked to refine models supporting aging patients, and the final group discussed pathways toward full CHW integration into the medical establishment.

This white paper summarizes the discussions of our keynote speaker, panelists, and stakeholder breakout sessions while highlighting prominent policy themes and takeaways.

Introduction

In September 2023, the Center for Advancing Health Services, Policy & Economics Research (CAHSPER) hosted "Transforming Healthcare in Missouri: Bridging the Gaps with Community Healthcare Workers from Global to Local and Back." This event, the eighth in the *Transforming Healthcare in Missouri* series, brought CHWs, providers, policymakers, community organizations, and insurance companies together to discuss tangible action items for building sustainability for community health workers in the healthcare industry. This meeting particularly focused on addressing the lack of direct Medicaid reimbursement for CHW services in Missouri and on quantifying the valuable work of CHWs in a manner that takes advantage of available policy mechanisms for a sustainable reimbursement infrastructure.

In addition to the keynote, CHW panel, and presentations on the current landscape for CHW data collection and reimbursement, all attendees were provided two fact sheets as relevant background material. One discussed and provided examples of existing global models for CHW reimbursement in low- and middle-income countries while the other focused on current U.S. models within Medicaid for CHW reimbursement. These different sources of background information aimed to supplement each attendee's unique expertise as they were divided into four facilitated breakout sessions. Each session focused on a different avenue towards building models for CHW sustainability.

Sessions included:

- Learning from Existing Global Models
- Learning from Other States' Policies for CHW Reimbursement
- Developing & Refining Models Supporting Aging in Place
- Developing and Refining Models for Full Community Health Worker Integration in the Medical Establishment

Each group included representation from multiple stakeholders that play an integral role in implementing models and/or legislation towards continuing CHW sustainability. The groups worked through a series of targeted questions that aimed to identify key information required for the development of interventions. One key objective was to address potential barriers faced when attempting to implement new approaches that form solutions towards this gap in service delivery to individuals and families. As the goal of the event was to be a forum for discussion and collaboration, the questions aimed to guide the conversation rather than dictate it. Major themes and innovative ideas discussed by our panelists, speakers, and breakout sessions are described below.

The goal of the event and this white paper is to document the opinions of the broad spectrum of Community Health Worker stakeholders, focusing in particular on the perspective of CHWs directly. This will allow for the introduction of specific recommendations on CHW sustainability for which there is a degree of consensus already attained, and which can leverage existing policy opportunities.

Ciearra “CJ” Walker, DrPH(c), MPH

President and CEO

St. Louis Community Health Worker Coalition

Ciearra "CJ" Walker, DrPH(c), MPH is the President & CEO of the St. Louis Community Health Worker Coalition, an organization focused on serving as a coalition of community health experts for all partners to emphasize community inclusion, increase quality of life, and promote upward mobility.

Walker set the stage for her keynote address with a three-pronged mission:

1. An emphasis on the imperative of recognizing and elevating the value of Community Health Workers (CHWs)
2. The Emerging Workforce for CHWs, Locally and Nationally
3. Empowering Action Steps for Strengthening CHW Sustainability

The premise of each of these goals, she stressed, was underlined by the need for a shared vocabulary in relation to the responsibilities and roles of CHWs in health outcomes, specifically considering social determinants of health (SDOH).

Walker positioned CHWs as system intermediaries, involved in community capacity development, outreach, advocacy, and direct services. Of particular significance are the soft skills CHWs bring to the table, including the ability to forge personal connections, be innovative problem-solvers, and help identify patient barriers and motivators. These skills are pivotal in empowering individuals to embrace healthy behaviors, surmount care obstacles, and access necessary resources, ultimately contributing to improved health outcomes. Walker noted that CHWs investigate the *why* of a disease, complementary to a clinician’s investigation of *what* the disease is – a theme that would emerge once again during the panel segment.

Walker then drew attention to the tangible successes of CHWs in the St. Louis region, emphasizing her aspiration to replicate these achievements across the entire state of Missouri. This transitioned into a discussion on policy considerations, particularly in the context of standardizing training, certification, and the scope of practice for CHWs. In many states, CHWs do not have a formal payment model, which makes funding for the workforce a constant challenge and limits capacity for growth in the workforce. Due to the additional complexity of widespread goals and services of CHWs, it can also be difficult to properly evaluate CHW programs.

To advance the position of CHWs and stimulate discussions concerning their role and sustainability, Walker introduced four vital strategies developed by the Integrated Health Network (IHN):

- Build capacity and formalize institutional CHW leadership
- Advocate for CHW long term sustainability
- Develop a workforce strategy that supports training and career pipeline
- Demonstrate the value of CHWs in the STL region through data

Furthermore, Walker emphasized the importance of forging partnerships within the CHW workforce. This was seen as a critical avenue for underlining CHWs' value for healthcare providers, especially in the context of clinical-community integration. She views it as a key approach to tackling the persistent, preventable health disparities faced by communities of color, moving beyond clinical care to deliver tailored services that recognize unique individual experiences and unmet social needs.

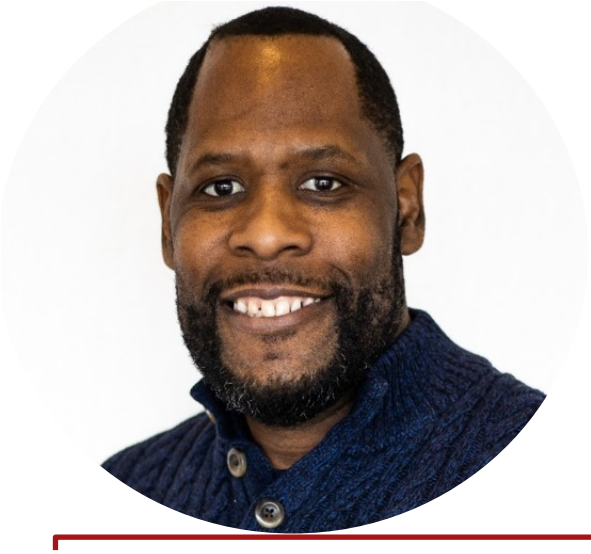
In conclusion, this keynote address reiterated the central mission of CHWs' work, included a call to move forward, and expressed a desire to transition away from repetitive conversations to those that focus on acting upon new effective measures for our state's community health workers.

Panel Summary

While the panel discussion adopted a conversational approach with panelists responding to multiple questions, we have structured the discussion here by summarizing each participant's remarks under an umbrella prompt to enhance readability.

Jay-Dee Bush, CTA, CHW-C

Community Health Worker Supervisor



Jay-Dee Bush is a native Missourian, originally from Columbia. He works as a CHW with the City of Columbia-Columbia/Boone County Public Health and Human Services, a nationally accredited public health department in the state of Missouri which serves both the city of Columbia and surrounding communities within Boone County, Missouri. Bush is also a Certified Diversity Facilitrainer (CDFT), who assesses, designs, and delivers effective, quality diversity and social justice education programs for the community.

Q: Talk about reducing barriers for patients – what does that mean to you? In your role as a Community Health Worker, how have you been able to identify these barriers and also support in reducing these barriers for your community?

"Public transportation is probably one of the largest barriers I see the people in my community face. If they can't get around, that's a large problem because they can no longer access the resources they need, any funds for over-the-counter medications, or just general food and necessities. One of the main things we do is actively travel to under-resourced communities to really talk and understand barriers through community health assessments. Still, it's really important to emphasize that many of these barriers, many of these struggles that our community is facing can't be quantified easily by these assessments. People cannot be treated as numbers, and there is a story that comes to mind instantly that can explain this.

"I was working with a woman, a mother of three, who was running from a domestic violence situation. She had 3 teenage boys that lived in the same hotel facility as her and one morning she reached out to me. Not for the first time, she called me distraught saying she was just going to give up, it had become too difficult. I sat on the call and talked to her, just giving her the encouragement to keep pushing for her 3 teenage boys and giving her that affirmation that we would work through this. That mental stress and exhaustion was one of many barriers she was facing at that time, and you can't put a number for that on any assessment. There's no way to quantify that because people and their health is more than just a number.

"As a CHW, I can use these health assessments as one tool to understand people's barriers and struggles, but ultimately, it's me going out and conducting motivational interviewing that helps us understand their situation better. It also helps the patients dictate what it is they want to work on. Being there with patients and showing that empathy to listen and hold those conversations is how I can understand those barriers. It's also how we play a role in preventative care. When I see the barriers a patient is facing, it helps to understand what they are in danger of facing - a health condition is always easier to face earlier rather than later."

Keely Finney, LCSW

Community Health Worker and Founder of Rejuvenating Comprehensive Services (RCS)

Keely Finney's humble beginnings are rooted in the metropolitan area of St. Louis Missouri. Keely is a Community Health Worker who has over 20 years of experience in providing clinical and social services in her community. Within her sphere of influence, she is most known for supporting individuals as they work to understand and address trauma focusing on how it affects their thinking, beliefs, behaviors, and overall daily functioning.

Q: What are some of the things you do for patient care that fall outside the scope of a clinician?

"To help bridge the gap in addressing behavioral health and reduce general barriers of health, it's important for patients to have people that show them empathy and that can pull from lived experiences. This is what CHWs do every day to create relatable and effective solutions for their patients. Supporting patients comprehensively requires looking at the healthcare landscape through the lens of a partnership, where good leaders understand how to follow.

"In addition to being a CHW, I am also a clinician, so I can understand how having a clinical background can be helpful, but it's important to recognize that wearing the CHW hat adds a unique value. This is because CHWs focus on exploring the 'why' behind health issues, which contributes to a deeper understanding of the 'what.' Clinicians, they excel in finding solutions. Where CHWs excel is in understanding the underlying causes.

"For example, to help one of my patients stay self-sufficient I was working with them to find employment. But this comes with added thoughts of: can this individual keep this job when having issues with obtaining uniforms or reliable transportation to the job? How many other stressors might this person be facing when thinking about job security? All of these barriers of course then tie into their general self-sufficiency. It's this form of continuity barriers that ultimately transfer into continuity of healthcare which clinicians can't focus on.

"CHWs, we are trying to fill that gap, we try to figure out what is causing, and sometimes even worsening, the 'what' that clinicians are trying to solve. We work to empower patients. It's a partnership that will support patients best."

Juliet Simone, MPH, MBA

Chief Program Officer

Juliet Simone is the Chief Program Officer of The Oasis Institute, a non-profit organization which aims to promote healthy aging through lifelong learning, active lifestyles, and volunteer engagement. Juliet also holds a Master of Public Health degree with a specialization in Public Health Administration and Policy from the University of Minnesota and a Master of Business Administration from Webster University.

Q: Can you speak to the importance of being from the community that you serve? How has that helped you when providing care for people?

"Before I joined the Oasis Group, I was a graduate student working with a Needle Exchange Program in Minnesota. What we were seeing there was a lot of individuals coming in to exchange 10+ clean needles

at a time while others might just grab one or two. It became clear soon that the former of these two were people that were actually leaders in their community trying to care for those who used needles for some indication or the other. The program that I was helping to build empowered those folks who were coming in to spread the message to their communities about Hep-C prevention, HIV prevention, collapsed veins, all of those dangers commonly associated with resharing of needles. Essentially, the best idea as we saw it was to empower community leaders to spread these health messages that the public already knows but now has a trusted individual. This emphasis on who is spreading the message is what makes the difference to a community because there is the aspect of trust and relationship.

"Another example I want to share is with an entirely different population. This was when I worked as a Community Health Volunteer in Ancash, Peru as a part of the Peace Corps from 2010 to 2012. In the community I was working in, malnutrition emerged as a pressing issue. To address this, we similarly again worked hand in hand with community leaders. The strategy essentially was modeled around teaching messages in smaller communities down to the most niche levels in an area, and to do this we taught older adults who would deliver health messages to others in the community which was an extremely efficient model. When working on public health issues, our goal is to put into practice what healthcare teams generally recommend but in the context of a specific community and the relevant culturally competent methodologies to accomplish that message – integrating community-oriented leaders is extremely important to make this happen because that is how trusting relationship with people in a community can be cultivated.

"Besides these examples, CHWs being from the community they serve allows for consistency and accountability to be built. The healthcare model, in its current state, is not set up for clinicians to locate their patients and follow through routinely on patients' healthy living habits and medication adherence – that being said, it should be someone's responsibility. This is the role that CHWs can uniquely fill.

"CHWs by working consistently with patients allow for sustained behavior change as the repeated opportunities to work with a patient in their community build a longitudinal care dynamic that encourages individuals to make changes for their health. CHWs can provide individuals with the tools to identify what day-to-day changes need to be made and how they can be repeated for long-term positive change. It is this consistency and accountability that CHWs can accomplish through repeated exposure with the individuals in their community."

Vickie Misuraco, CHW-C

Community Health Worker

Mercy Hospital Lincoln

Vickie is a Community Health Worker at Mercy Hospital Lincoln, where she assists the uninsured and underinsured. Vickie also currently serves on the Lincoln County R3 Education Foundation Board.

Q: Can you talk about a gap that exists within your communities that CHWs work to mend?

"I work in a rural community and here of course one of the biggest challenges, one of the most significant gaps we face related to healthcare access is reliable transportation. There is no rural public transportation that people in the community can rely on. We have one cab service, just one guy who works "under the table", cash-only. The absence of public transportation really exacerbates a lot of the issues in the community as it leaves people with limited and unreliable options, often forcing people to walk on unsafe roads due to a lack of sidewalks or shoulders. As a Community Health Worker, I'll be on the phone often hours on end to work with the limited cab service we have, hoping patients can make it to the places they need to get to. The only help we have is providing gas cards to those who can find their own transportation, but this is a rare privilege when individuals have access to a vehicle.

"Of course, the lack of transportation has cascading consequences, namely people's ability to reach shelters. Accessing shelters often demands extensive travel, sometimes people having to go as far as St. Louis and then additional transportation to reach the specific available shelter. Moreover, securing a place in a shelter can be time-consuming. As a CHW I find myself at times making 3+ hour phone calls to get my people a shelter to stay in.

"This ability for CHWs to provide guidance to their community through building trusting relationships is what makes them invaluable. I feel like a patient perceives me, as a CHW, to be a friend rather than a provider or a counselor. This type of relationship helps build those open and clear conversations where patients feel free to articulate their concerns in layman's terms rather than try to align with specific jargon clinicians may use."

Kaleb Thompson, CHW-C, HRS

CHW-C, Harm Reduction Specialist

Kaleb Thompson is a credentialed Community Health Worker and credentialed Harm Reduction Specialist through the state of Missouri.

Q: Could you contextualize the value that CHWs bring to engage patients within the healthcare system?

"This discussion hits close for me because although I am a wanderer at heart, moving around all the time, being from South City, I have really seen the struggles that my particular community is going through. That is really touching for me. It's important that you [CHWs] have that engagement aspect when you are serving your community.

"Engagement with patients isn't just about surface-level conversations, it's about establishing connections because that is how people will open up to you. It's how people will talk to you about the underlying problems as opposed to the superficial things that you can see on the outside. That engagement and that relationship that you build with someone makes it so much easier to create a conversation with someone, even if it's just about how the community has changed or different restaurants in town, that's how you can really start to connect with a person through that engagement piece.

"This engagement piece is also what makes CHWs so unique in healthcare because often there is this communication gap that exists between healthcare providers and patients. For example, providers will write things a certain way or talk about symptoms in a certain way, this is the clinical side. But patients will experience or know how to express their symptoms in another way that they cannot communicate to their providers. This difference creates a critical communication gap and CHWs, we are here to bridge that gap to connect patients in the community to the rest of the complex healthcare system.

"Community engagement, along with the authenticity we [CHWs] bring, hold incredible importance. It makes our roles more effective. Another example I want to share to showcase just how important engagement can be for patient outcomes is in an issue like the opioid crisis.

"With a topic like this, it's even more important to understand the patient-provider relationship because most clinicians may not understand the complexities of this relationship and how it affects patient care. Patients often view providers as figures of authority, the power dynamic is very different, so honesty in discussions can be affected. CHWs can speak as normal people because patients recognize us as a part of their community, which helps us to engage them within the healthcare system."

Angela Herman-Nestor, MPA, CPHQ, PCMH-CCE

Director of Health Care Transformation and Quality Initiatives

Missouri Primary Care Association

Angela Herman-Nestor, MPA, CPHQ, PCMH-CCE, is the Director of Health Care Transformation and Quality Initiatives at the Missouri Primary Care Association. Angela shared evidence towards CHW's vital role in optimizing community health, frameworks to quantify CHWs' value, and the MPCA's ongoing efforts to support CHWs' long-term sustainability.

CHWs as Critical Connectors in Healthcare

At the Missouri Primary Care Association, Community Health Workers are talked about as being a bridge, a critical piece in the healthcare delivery continuum that links individuals to other care teams. This is accomplished specifically by CHWs' focus on confronting the various social determinants of health inhibiting an individual's ability to acquire and maintain healthy living. To emphasize this point, Herman-Nestor shared a particularly striking anecdote where a diabetic patient's health outcomes remained suboptimal despite consistent insulin intake. At this time, a member of the MPCA's community health worker program was asked to visit the patient in their home where they discovered that the individual's treatment efficacy was hindered by an overlooked environmental factor – the lack of power to refrigerate the insulin. While the initial provider had inquired about the patient's access to a refrigerator, the topic of reliable power was overlooked. After identifying this barrier, the CHW, patient, and provider were able to collectively identify mechanisms for this individual to have power as a medical necessity and address the underscoring obstacle to the progress of the patient's health. This narrative was one of many shared to showcase the criticality of understanding patients' day-to-day living, and how CHWs do exactly that.

PRAPARE measures the following core categories:

- Personal Characteristics: Race, Ethnicity, Farmworker Status, Language Preference, veteran Status.
- Family and Home: Housing Status and Stability, Neighborhood
- Money and Resources: Education, Employment, Insurance Status, Income, Material Security
- Social and Emotional Health: Transportation Needs
- Other Measures include: Incarceration History, Refugee Status, Safety and Domestic Violence

This pivotal framework was developed by health centers *for* health centers as not only a standardized social risk assessment protocol, but also a tool that can help start and document certain conversations with patients. PRAPARE is a Health Information Technology (HIT) enabled tool allowing for widespread and standardized use in different centers to accelerate systemic change. As Federally Qualified Health Centers (FQHCs) utilize PRAPARE as the primary Social Determinants of Health (SDOH) screening, information is available in Azara DRVS, the population health management system used by Missouri FQHCs to document various quality metrics. Between July 2022 and June 2023, clinics screened 38,978 patients using PRAPARE, with approximately 52% of those patients screened as having 4 or more "at-risk" SDOHs. However, solely screening for SDOHs is not sufficient. A workforce is needed to assist patients in navigating resources to meet the different SDOH needs identified by the screening – this is where CHWs are particularly critical.

Strengthening the CHW Workforce

While the need for a stronger CHW workforce is clear, the implementation of this goal faces a primary challenge: employing more CHWs is impractical without a system for reimbursement. That model must be built upon quantifiable data and metrics from current CHW programs.

Currently, PRAPARE has been integrated into all 28 Missouri FQHCs as a model to quantify CHW effects on SDOH changes. The next steps include strategizing how to expand payer interest and reporting capabilities as well as investigating referral tracking and community engagement. These referrals for social needs need to be tracked in a similar way to clinical referral tracking within the industry, as this helps identify what progress is being made to meet patient needs. This aspect is essential to garner further federal funding support and momentum for CHW programs.

Another metric that may be of interest to support a value-based system for CHW reimbursement is Patient Activation Measure® (PAM). PAM is a 10- or 13-item questionnaire that assesses an individual's knowledge, skills, and confidence for managing their health and health care[1]. The measure assesses individuals on a 0 to 100 scale that converts to a change of score from baseline to follow-up and is often used as a component of risk adjustment to predict future utilization of ER and inpatient stays, particularly for ambulatory sensitive conditions[2].

Centers for Medicare & Medicaid Services (CMS) is proposing the inclusion of PAM within its merit-based Incentive Payment System (MIPS) for hospitals in 2024. While FQHCs fall under the Health Resources and Services Administration (HRSA) Federal Uniform Data System rather than MIPS, there could be value in exploring how to use this measure as a quantifier of patient activation and engagement by CHWs in a manner that harmonizes with and complements goals hospitals will create.

It is worth noting that PAM has a cost associated with its use. Ideally, MO HealthNet would be able to secure a statewide license that could be utilized by all FQHCs and other safety-net organizations to shape the care management and care coordination needs of their enrollee population.

Amanda Stoermer, MSW

Chief of Staff and Vice President of Health Equity & Culture

St. Louis Integrated Health Network

Amanda Stoermer, MSW is the Chief of Staff and Vice President of Health Equity & Culture at the St. Louis Integrated Health Network.

Shanequa Tolliver, CHW, MS, MHOE

Project Manager for the Community Health Worker Workforce Partnership

St. Louis Integrated Health Network

Shanequa Tolliver, CHW, MS, MHOE serves as the Project Manager for the Community Health Worker (CHW) Workforce Partnership at the St. Louis Integrated Health Network (IHN).

Stoermer and Tolliver, with the support of Tommy English, MPH, who serves as the Assistant Director of Evaluation & Quality at the Integrated Health Network, presented data to help attendees think about the value CHWs bring to patients and the larger community.

When thinking about the value that CHWs provide to healthcare delivery, there are three main categories that emerge: service referrals, chronic disease management, and improvements in social determinants of health. Of these three categories, demonstrating CHWs impact on social determinants of health is arguably the least studied. The IHN presented data from the Temporary Homebound Program to help illustrate the impacts CHWs have had on social determinants of health.

St. Louis Integrated Health Network's (IHN) Homebound CHW Program

St. Louis IHN's Homebound CHW program was operational from May to October 2020, built in under two weeks with funding support from the COVID Regional Response Team and the St. Louis Mental Health Board. The program triaged referrals from partner organizations to serve community members who were immunocompromised or were caring for family members who were immunocompromised and could not leave their home.

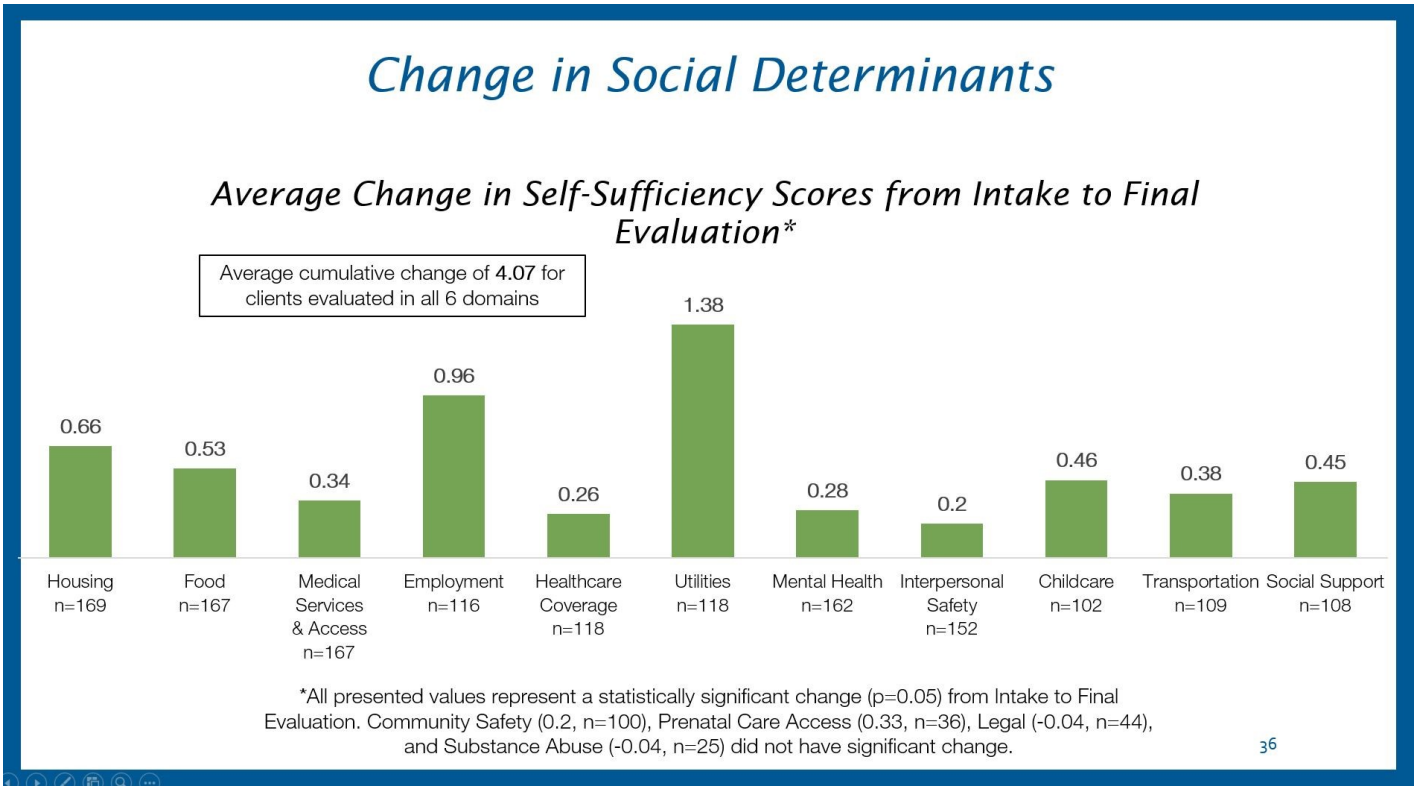
Patient Intakes and Evaluations

Of the 254 clients initially referred to the program, 65.7% requested utility assistance, 30% requested rent assistance, and the remainder experienced food insecurity, barriers to healthcare access, and other miscellaneous needs. On average, the program duration for clients was 31 days, with 194 of the 254 clients (76.3%) stating that their needs had been met through engaging in the Homebound Program.

An initial intake was conducted for each client with the Arizona Self-Sufficiency Matrix, which is a rubric that scores individuals' level of concern from 1 to 5, where 1 is in crisis and 5 is thriving. This provides a quantifiable measure of self-sufficiency in the domains of housing, food, medical services and access, employment, healthcare coverage, and utilities. Scores were evaluated again after client's engagement with the program in the same categories.

Quantifying Changes in Social Determinants of Health

Analysis of data, shown in the figure below, found that a statistically significant change in self-sufficiency score occurred between initial intake and final evaluation for 11 of the 15 categories. Engagement with the Homebound Program noted the largest improvements for clients in the social determinants of Utilities, Employment, and Housing.



The chart above details average changes in the self-sufficiency scores from intake to final evaluation across all measured categories in the self-sufficiency matrix.

Abigail Barker, PhD

Research Associate Professor

Brown School, Washington University in St. Louis

Associate Director for Policy Partnerships

Center for Advancing Health Services, Policy, & Economics Research | Institute for Public Health

Abigail Barker's work includes helping social science and clinical researchers add cost and cost-effectiveness analyses to their work to increase policy relevance, as well as creating data visualizations to allow stakeholders to interactively understand the tradeoffs of various health policy choices. She is also an economic consultant for the State of Missouri's Medicaid program, contributing to transformation initiatives including payment policy redesign.

Medicare and Medicaid have historically employed a fee-for-service (FFS) approach to reimburse healthcare services, which involves generating individual bills for each service provided. However, there are alternative payment models that Medicare and Medicaid have adopted:

1. **Capitation Rates (PMPM)**: In capitation models, health plans receive a fixed per-member, per-month (PMPM) payment intended to cover all aspects of a patient's healthcare. The idea is that health plans profit only if they keep per-person costs below the PMPM rate. To prevent denial of care, these programs emphasize quality reporting and measurement.

2. **Quality Measures:** Medicare and Medicaid employ various quality measures to assess healthcare service quality. Medicaid Managed Care Organizations (MCOs) in Missouri, for instance, use measures like HEDIS and CAHPS. In Medicare Advantage (MA), quality indicators are aggregated into "star ratings," with bonus incentives tied to these ratings.

3. **Pay for Performance (P4P):** P4P programs track performance on measures like chronic disease management. Organizations stand to earn money if they meet or exceed these measures, aligning financial incentives with quality care.

4. **Medicaid Value-Based Payment (VBP):** VBP directly links health outcomes to payment, aiming to improve quality while reducing the Total Cost of Care (TCC). These arrangements are gaining ground within Medicaid and in partnerships between state agencies and managed care plans.

5. **Primary Care Health Homes (PCHH):** Missouri Medicaid has successfully implemented a medical home model known as PCHH, which funds care coordination and addresses social needs for specific patient populations.

Key Takeaways:

- Community Health Workers (CHWs) and other providers play a pivotal role in value-based payment (VBP) and advanced payment models. They can provide services that align with these models and bill M&M for their work.
- The transition to VBP and other advanced payment models needs to be carefully tailored to accommodate the unique services and contributions of CHWs, ensuring that they are a good fit for these evolving healthcare payment approaches.

In summary, Medicare and Medicaid are moving away from traditional fee-for-service models toward value-based payment systems that prioritize quality and cost-effectiveness. CHWs and healthcare providers have a crucial role to play in these emerging models, and the integration of their services into these evolving payment structures is a vital consideration.

Learning from Existing Global Models

During this breakout session, participants discussed existing global models for CHW integration and reimbursement, the value and preferred financial compensation for a CHW, and the need for infrastructure to accomplish these goals.

Regarding existing models of CHW activity in the global context, participants noted that the U.S is far behind developing countries in terms of CHW utilization and integration. In South Africa, for example, CHWs are embedded in and trusted by communities, thereby creating a link for communication and providing maximum support to the people in their community. Alternatively, local CHWs in this breakout session commented that the U.S. healthcare system has embedded CHWs into the infrastructure with a prime focus of bringing *more* people to the hospitals. In an often corporate-driven healthcare structure, some CHWs expressed that they did not experience having much power, and their associations with certain hospitals have therefore not created an opportunity to help eliminate barriers for hospital patients. This connection can become detrimental rather than advantageous as it can reduce a CHW's capacity for true productivity. On the contrary, some session participants felt that the other countries discussed can be more successful in deploying CHWs in part due to an existing organized structure that centers meaningful shared power, shared leadership and self-determination regarding what community health workers can do.

This discussion of juxtaposition segues to the next discussion question: "What does value look like for CHWs? As value can be a blend of numbers and stories, how can we translate that into context to present at a legislative session?"

Participants noted that it is necessary to find a way to depict the significance of CHWs in underserved and rural areas. Rural communities are often lacking very common and specific needs that support health improvements. CHWs can help connect the gap and assist people in providing them with resources like transportation and finding jobs.

One community health worker within this session shared that her organization conducts "mom listening sessions" where they encourage mothers to talk about barriers they face and suggestions on how the system can be improved. Through these sessions, CHWs create an opportunity to hear the direct voice of those most in need within their communities. This approach can best represent those under-represented thereby leading to the shaping of a better system. For example, two CHWs attending this session noted security in their roles 1) Working within a hospital ER and clinic, funded through the hospital foundation charitable funds; and 2) Working for the Integrated Health Network, contracted by the City.

Learning from Existing Global Models (Continued)

"How do CHWs think payment should work?"

Every beneficiary's needs are different. Some will need assistance with just one service such as transportation, whereas others might need assistance for a long period of time. To this point, CHWs expressed a preference for payment according to services rendered to a patient/client instead of receiving a standard amount per client. This is preferred since some clients may have multiple requests which will require more assistance and effort on the part of the CHW to fulfill.

Additional feedback included:

- Receiving payment on a consistent schedule is preferred, versus being paid a variable amount depending on the volume of services provided to clients at a given time.
- Currently, a majority of CHWs are employed through grant funding. This can often lead to job-related stress due to the instability of ever-changing grant funding. Secure and stable funding is recommended.
- For example, two CHWs attending this session noted security in their roles 1) Working within a hospital ER and clinic, funded through the hospital foundation charitable funds; and 2) Working for the Integrated Health Network, contracted by the City.

"What infrastructure would be recommended to sustainably fund CHWs?"

A CHW Coalition representative noted that St. Louis does not have a federally funded Department of Health Promotion. In this participant's view, this lack may help explain the statistic that for every dollar, 95 cents go toward care delivery while only 5 cents go toward health promotion. Since health promotion is a key CHW priority, the current structure systematically falls short in providing resources to support CHW work. To change these funding proportions and increase awareness of CHWs' importance, a few attempts have been made by the Coalition to represent CHWs at legislative sessions, but these have so far been unsuccessful in securing an ongoing source of funding. The Coalition representative also reported that so far, Medicare will not directly reimburse CHWs because CHWs are not viewed as health care providers, even though they work towards health outcomes. The breakout participants also mentioned that dissonance in the integration of CHWs into the care team is another reason why it is sometimes difficult to make a financial pitch to legislative and funding decision-makers.

Learning from Existing Global Models (Continued)

Though it was reported that legislators like the idea of CHWs in the rural setting, they tend to believe that Primary Care Health Homes are one of the best places for CHWs. This model does not always exist in Missouri's rural settings, and program enrollment is capped due to funding allocations, so the potential for this to be a statewide solution is limited. Therefore, to secure some level of funding, the Coalition proposed having line items for CHWs at every Department (e.g., Department of Public Safety, Department of Senior Services, Department of Health and Senior Services) to budget for a multi-agency state commission. This will require providing a certified or proven model which can attract legislators' attention and persuade them that this model will actually work.

In the past, the Centers for Disease Control and Prevention (CDC) has provided $15 million across the country to sustain this work. They want to understand the CHW model of care, and are testing the hypothesis that if there is infrastructure and CHW workforce development, then is there is an opportunity for true system-level change. The infrastructure does not have to be through hospital systems or public health departments; it can be through individual organizations like the Integrated Health Network (IHN). Any statewide model that addresses sustainability can contribute valuable insights to our understanding of the changes that are required.

Learning from Other States' Policies for CHW Reimbursement

During this breakout session, participants explored CHW reimbursement models from other states to identify relevant features for potential policy changes in Missouri. The conversation began with an overview of existing reimbursement models, which varied from state coverage of CHW services to waivers.[3] This highlighted the diversity of existing models, such as Colorado's combination of Fee-for-Service (FFS) and Value-Based (VB) approaches. It prompted a discussion of the importance of sustainability for CHWs, as many CHWs in the room spoke to the predominant use of unpredictable grants as funding for their services.

One anecdote shared by a participant reflected a small Missouri community-based organization which received a grant to hire two CHWs to assist clients with high blood pressure, hypertension, and diabetes. They were initially informed that they could provide 20 minutes of education to individuals under a specific billing code for reimbursement from the state. However, they were later told that the state was not accepting these billing codes, leaving them unable to receive reimbursement. This situation raises questions about the inconsistency in reimbursement policies between physicians and CHWs, moreover, how CMS may currently be reimbursing physicians for CHW services, creating a barrier to CHWs' financial sustainability. When prompted on this topic, two major themes emerged:

Systemic Professionalization of CHWs: Physicians do not face reimbursement challenges by CMS because they follow the same licensing requirements as Medicaid providers. However, enrolling CHWs as providers is hindered by the requirement for state licensing and specific training, even when such criteria may not always be relevant. This complexity makes it difficult to officially recognize CHWs as providers and integrate them into legislative frameworks. To address this, Missouri Medicaid would have to change its' State Plan to include CHWs as a provider type, outline services for which CHWs could bill directly, and obtain CMS approval. The Medicaid agency could initiate this effort on its own or at the direction of the State legislature.

Defining Quantifiable Metrics for Reimbursement: While working on strategizing legislative action, it is essential to explore alternative opportunities for value-based care and define relevant metrics for presentation to the state. This involves creating a common language and measurement system that can be uniformly applied across the state. This theme fueled the second major question of this breakout session: How can CHWs be a part of a value-based payment?

Learning from Other States' Policies for CHW Reimbursement (Continued)

Responses regarding Value Based integrable metrics that are indicative of CHW services are summarized below:

Observed Improvements in a Health-Related Measure:

Patient Health Outcomes: By connecting these measures to health outcomes such as reduced emergency room visits, improved management of chronic conditions (e.g., A1C and cholesterol levels), and overall well-being, the valuable role of CHWs in enhancing patient outcomes and healthcare utilization can be demonstrated.

Mental Health Outcomes: Assessing mental health outcomes, such as depression and anxiety, is vital for understanding the holistic impact of CHWs. Using tools like the Patient Health Questionnaire-9 (PHQ9) can help measure changes in mental health status before and after CHW interventions. This approach allows for the documentation of improvements in mental well-being, which is crucial for showcasing the comprehensive support CHWs provide.

Maternal Healthcare: Demonstration that employing a community-based doula leads to improved maternal health outcomes, including reduced mortality rates and lower instances of low birth weights.

Avoidance of a Negative Consequence

Vaccination Rates and Retrospective Checking: One of the ways to gauge the effectiveness of Community Health Workers (CHWs) is by examining vaccination rates and tracking the impact of CHW interventions. By retrospectively checking records, we can assess whether patients have received necessary vaccinations after being under the care of CHWs, thereby measuring the extent to which CHWs have improved vaccination adherence and public health.

Reducing No-Show Rates: The reduction of patient no-show rates is a critical aspect of CHW work. CHWs can be effective in improving patient engagement and attendance. By measuring the impact of CHWs on reducing no-show rates for appointments, not only can their contribution to improved healthcare access be demonstrated, but also the cost-saving potential of their interventions can be shown.

Learning from Other States' Policies for CHW Reimbursement (Continued)

Improvements in Patient Self-Sufficiency and Confidence:

Patient Activation Measure® (PAM) and Health Outcomes: Patient activation measures (PAM) are CMS-validated and self-reported indicators of a patient's self-sufficiency, comfort and confidence. CHWs play a significant role in enhancing patient experience and overall well-being and by tracking these values throughout the patient's healthcare journey, we can showcase how CHWs are delivering patient-centered care and creating a positive healthcare experience.

Motivational Interviewing Strategies and Goal Setting: CHWs often employ motivational interviewing techniques to help patients set and achieve health-related goals. By documenting the progress in goal setting, for example, including achievements related to cholesterol control, blood pressure management, and diabetes care (e.g., A1C levels), we can provide concrete evidence of how CHWs facilitate behavior change and contribute to improved health outcomes.

By integrating these specific examples and metrics into our evaluation of CHW impact, we can provide a well-rounded understanding of their contributions to healthcare outcomes and the value they bring to the healthcare system.

Medicaid guidelines, particularly in relation to in-person patient interactions, add an additional layer of complexity to the reimbursement process for CHWs. The work of CHWs involves a dual approach, with interactions happening both in person and remotely. This duality creates challenges, notably due to Medicaid's requirement for in-person interactions. Additionally, CHWs often face prolonged wait times when contacting the Department of Social Services (DSS), hindering their professional effectiveness. Administrative tasks like billing for patient transportation can be time-consuming and raise concerns about CHW reimbursement. To address these issues, a proposed policy is to secure a dedicated phone line for CHWs to use to assist Medicaid participants. This approach also entails organizing quarterly meetings with legal aid and transportation representatives, emphasizing the need for concrete evidence of inefficiencies. Moreover, providing CHWs with an exclusive phone number could enhance their professionalism and streamline communication. This idea is proposed as a potential solution to this issue.

Developing and Refining Models Supporting Aging in Place

During this breakout session, participants discussed developing and refining models that support aging in place. The goal of this session was to brainstorm and expand on the roles CHWs can play in enhancing the quality of life for aging individuals, with a specific focus on addressing the needs of seniors looking to stay in their homes and communities rather than moving to an institutional setting.

Participants in this breakout session were prompted to respond to the following question:

"What aspects of aging in good health are CHWs well-suited to help with? Give specific examples of CHW activities when possible."

Below, participant responses have been compiled and summarized to represent the main points of the group.

- **Advocating for Unhoused Elders:** CHWs can provide advocacy for elders who are unhoused, preventing them from placement in nursing homes when it may not be an appropriate option for them. CHWs can connect these individuals to alternate housing solutions, such as transitional programs or supportive housing, and ensure seniors have flexible and personalized care plans.

- **Enhancing & Supporting Social Work:** CHWs can complement the role of social workers by providing more holistic and personalized support to seniors. CHWs will be able to provide social and emotional support to seniors, reducing feelings of depression and isolation.

- **Bridging Generational Gaps:** CHWs can organize community events or town hall meetings to facilitate better interaction or understanding between older and younger generations and encourage the formation of social bonds. Opportunities may be created for generations to build stronger connections and address shared community issues.

- **Providing Crucial Education:** CHWs could offer education on life skills to all generations, such as health or legal education. CHWs can provide health education to address generational mistrust and help seniors in understanding the steps they can take to improve their health. Such education can reinforce healthy habits and promote lifestyle modifications to benefit both older and younger generations. They can support younger individuals in planning for their future and help seniors live more self-sufficient lives.

CHWs work with many unhoused individuals, which often raises questions about the root causes behind their situation. A significant factor is the lack of affordable housing, which can lead to more severe escalation such as evictions. Hospitals may discharge patients into nursing homes or transport them to shelters, which are often overcrowded and under resourced. Unfortunately, agencies do not always provide adequate follow-up support.

Developing and Refining Models Supporting Aging in Place (Continued)

Unaffordable housing, landlord disputes, and other housing insecurity inequities can exacerbate challenges for the aging population. According to group participants, the concept of permanent supportive housing is essential, but not all landlords understand this approach, resulting in evictions after just one missed payment. Centralized training for supportive housing is lacking, leaving organizations ill-equipped to provide proper support. Community Health Workers can step in to work with property owners to help ensure residents can cover costs to maintain their housing. The absence of sufficient laws to regulate "slumlords" further complicates the situation. CHWs may also assist elders who may become unhoused due to a multitude of situations, whether that be a lack of support from their families, or struggles in economic planning.

Quantifying the value of services provided by Community Health Workers (CHWs) will involve various aspects, including:

- **Housing:** Assigning numerical values to housing services is essential. Measuring the number of individuals housed, age categories, demographics, and overall numbers served is crucial for assessing the effectiveness of CHW interventions.
- **Resources:** Evaluating the success of CHWs in connecting individuals to essential resources, such as utility assistance or financial management, will require quantifiable data. Tracking the number of people linked to these resources can provide insights into the value of CHW services.
- **COVID-19:** CHWs played a significant role in mitigating the effects of the pandemic. Quantifying their impact can involve measuring divorce rates, deaths, elderly individuals who lost their homes, eviction rates, and individuals falling behind on bills. Additionally, assessing how CHWs supported business owners who struggled to maintain their businesses and homes during the pandemic is essential.
- **Age/Income:** The influence of income as a factor in CHW services should be evaluated. To determine which population CHWs should focus on, it is important to establish the age groups or income brackets that align with the community's needs.
- **Mental Health:** Recording mental health data, including symptoms and periods of depression, anxiety, post-traumatic stress symptoms and other relevant information, is often overlooked in older populations. Such information can be gathered and utilized to better understand and support the mental health needs of the communities being served, while quantifying the value of CHW services.

CHWs can serve as accessible role models in the community, inspiring seniors to overcome fears and challenges associated with aging. CHWs can ensure older generations are prepared to age with confidence and ensure engagement in spaces to include valuable pertinent input. CHWs have a multifaceted role in supporting aging in place, from advocating for seniors' needs to bridging generational gaps to promoting a sense of community and self-sufficiency. Their work is instrumental in creating a more inclusive and supportive environment for individuals of all ages.

Developing and Refining Models for Full CHW Integration in the Medical Establishment

Participants in this breakout session discussed the challenges associated with integrating CHWs into the medical establishment. Below, the participant discussion has been synthesized to represent the main points of the group.

- **Challenges in Reimbursement:** Overcoming financial obstacles associated with CHW services is a primary concern.
- **Effective Communication:** Establishing efficient communication channels between CHWs and healthcare providers is imperative.
- **Team Education:** Enhancing the care team's education is essential for improved patient care.
- **Patient-Provider Communication:** Strengthening communication between patients and healthcare providers can lead to improved health outcomes.
- **CHW Recruitment Challenges:** Identifying methods and locations for recruiting qualified CHWs can be challenging.
- **Importance of Soft Skills:** The significance of soft skills in medical settings, including computer proficiency, electronic health record (EHR) usage, presentation skills, and effective patient-provider communication, cannot be understated.
- **Integration in Maternity Care ("Birth World"):** Integrating CHWs into maternity care settings presents unique challenges.
- **Team Integration Concerns:** Ensuring seamless integration with the healthcare team is essential. Addressing situations where providers may not refer to CHWs during patient visits is critical, considering potential legal implications as the ultimate decision of care lies with the doctors. This emphasizes that providers' licenses are on the line, facing potential termination or suspension, making it crucial to address situations where providers may not involve Community Health Workers during patient visits, given the associated legal implications.
- **Financial and Social/Clinical Integration:** The necessity of program-based integration that considers both financial and social determinants of health.

Developing and Refining Models for Full CHW Integration in the Medical Establishment (Continued)

CHWs will be able to strengthen integrations with the medical establishment by:

- Contributing to the collection of social risk data (e.g., documentation of Z-codes, use of the Patient Activation Measure®) that allows more robust analysis of clinical and social data for decision-making in healthcare
- Reducing the risk of major diseases and complications, leading to a decrease in emergency room visits, readmissions, and medical costs
- Helping with real cost savings through medication pickup and adherence
- Building a strong relationship with patients to enhance patient honesty
- Relieving healthcare providers of non-medical tasks, allowing doctors to focus on the medical aspects of patient care

Conclusion

CHWs are critical members of care delivery teams who facilitate access to quality and culturally competent service for the community they serve. Often, CHWs share a relationship with the people in the community which fortifies trust in the healthcare system and motivates overall continuity of care. The specific utilization of CHWs has varied greatly from country to country. In some nations, CHWs are trained as generalists who can assist with a variety of conditions; more often they focus on one condition or disease. The United States has been relatively slow to adopt their services using either approach, or for that matter to integrate CHWs generally into our healthcare system.

The Affordable Care Act's enactment in 2010 increased awareness of the CHW workforce and its potential to enhance community health.[4] In Missouri, the Medicaid Primary Care Health Home (PCHH) program conducted a pilot study testing the benefits of inclusion of CHWs on PCHH teams in 2016. More recently, through specific training providers, the Missouri Department of Health and Senior Services (DHSS) has supported tuition reimbursement for CHW training. Federal funding from the CDC, by providing scholarships that allow training providers to offer courses at no cost and by expanding the workforce through additional CHW roles, has helped Missouri scale its CHW training and scholarship initiatives. The lessons and materials that CHW-led organizations like Community Health Workers Association of Missouri, the St. Louis CHW Coalition, the Kansas City Regional CHW Collaborative, and other local and regional initiatives have promoted cross-learning among Missouri communities and informed statewide CHW efforts.

The proof of CHWs' effectiveness in healthcare and population health was first seen in the U.S. as an antipoverty strategy by community organizations, faith-based organizations, and healthcare practitioners. As of May 2021, there were an estimated 61,000 CHWs working in the United States. The services provided by these CHWs are extensive, including advocating for efficient resource allocation, promoting reliable healthcare access, and/or delivering culturally appropriate health education – all of which are crucial to addressing the entrenched health disparities in our state and in the nation.

The largest-ever one-time federal investment in the CHW workforce was announced in September 2022, with $225 million in American Rescue Plan funds allocated to train nearly 13,000 CHWs.[5] Additionally, from state fiscal year (FY) 2023 through FY 2027, the Consolidated Appropriations Act of 2023 approved $50 million yearly to increase CHW workforce capacity.[6] These investments show a rising level of interest on the part of national and state governments in the potential contribution of CHWs to improving population health.

A Note on New Policy Developments

On November 2, 2023, the Centers for Medicare and Medicaid Services (CMS) issued their final ruling on policies relating to Medicare Part B issues and payments under the Medicare Physician Fee Schedule (MPFS), which would be effective on January 1st, 2024.[7] The MPFS has been utilized since 1992 for the payment of physicians and other professionals through Medicare.[7]

In the Calendar Year (CY) MPFS Final Ruling, CMS established that social workers, community health workers, and other personnel performing services that help address the social determinants of health were not consistently reflected in current payment policies and medical coding.[8] With the final ruling, CMS finalized the designation of community health integration (CHI) services as care management services, which would allow for these services to be furnished under a billing practitioner.[8] Additionally, CMS finalized the Healthcare Common Procedure Coding System (HCPCS) code G0019 which states that "CHI services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner requires 60 minutes per calendar month to bill the service."[8]

Ciearra “CJ” Walker, DrPH(c), MPH

President & CEO, St. Louis Community Health Worker Coalition

Ciearra, affectionately known as CJ, is a public health leader. A catalyst. A researcher. A member of community. A model of both/and. Ciearra Walker works at the intersection of public health and economic mobility to help transform institutions into racially responsive systems that promote generational community wellbeing - while simultaneously building power and cultivating leaders in neighborhoods of those same systems. “Connecting vision to actionable on-the-ground strategy” is said to be Ciearra’s differentiating gift.

Since 2018, she has worked to engage a growing network of 150 + local leaders and more than 35 organizations to design a multifaceted strategy that ensures long-term viability for the CHW workforce, ultimately resulting in the birth of the St Louis CHW Coalition (CHWCo). As the President and CEO of STL CHWCo she is led by an all CHW board, to employ a public health approach that offers place-based intervention to address social need, elevates resident voice, champions policy, and encourages community solutioning through authentic, institutional partnership.

Ciearra brings a unique blend of life experience and technical skill to the work that she does, demonstrating an ability to create grassroots, system- focused infrastructure that improves public impact. Ciearra is a current Doctoral student in the Public Health Leadership Program at the University of Illinois Chicago where she will earn a DrPH. With an interest in social epidemiology, her research explores the business of public health, illustrating community-based innovation and nontraditional partnership as levers for sustainability, allowing her to publish the CHW workforce innovation model she’s built over the last five years through her dissertation. On a purposeful mission to serve as a vehicle of opportunity for others, Ciearra roots herself in the reminder that where she is gives credit to where she’s been.

Jay-Dee Bush, CTA, CHW-C

Community Health Worker & Certified Diversity Facilitrainer (CDFT) City of Columbia/Boone County PHHS

Jay-Dee Bush is a Community Health Worker at the Columbia/Boone County Health Department. Jay-Dee is originally from East Saint Louis, IL but moved to Columbia in 2010 to pursue his bachelor's degree from the University of Missouri.

Jay-Dee is a first-generation college graduate which brings him great pride. Throughout his 8-year tenure at the City, he has worked for three different departments and all positions have been service-oriented. Jay-Dee experiences being a CHW as a natural fit. He notes, "I derive joy and a sense of personal fulfillment knowing that the work I do as a CHW is improving the health and well-being of my neighbors. It is my mission to lessen the health disparities that exist in Boone County through providing my neighbors with health resources, health literacy, and advocating for them to have a great overall quality of life." In his spare time, Jay-Dee enjoys running, performing and listening to spoken word poetry, listening to old school hip-hop and R&B, reading self-help books, spending quality time with his family, and playing basketball. He is married and has 2 children, a son and a daughter.

Keely Finney, MSW, LCSW, CHW

Founder of Rejuvenating Comprehensive Services

St. Louis Regional Health Commission Patient Advisory Board Member

Keely Finney's humble beginnings are rooted in the metropolitan area of St. Louis Missouri. Keely is a Community Health Worker who has over 20 years of experience in providing clinical and social services in her community. Within her sphere of influence, she is most known for supporting individuals as they work to understand and address trauma focusing on how it affects their thinking, beliefs, behaviors, and overall daily functioning.

Since 2013, Keely has served as the Founder and CEO of Rejuvenating Comprehensive Services (RCS), where community engagement and therapeutic evidence-based practices are utilized to improve social, emotional/mental, physical, and spiritual health. She started RCS, leaning into her expertise, and allowing her work and success with clients to speak for itself. RCS provides a breath of services, spanning clinical and social, to residents within St. Louis City and County communities. In 2019, Keely incorporated a sister agency, Motivating Purpose with Education and Readiness (MPWER), a nonprofit organization that works, individually and collectively with our consumers to get their minds in a state of readiness, personally accepting the challenge to manage their circumstance and improve overall well-being.

Kaleb Thompson, CHW-C, HRS

Community Health Worker, Family Care Health Center

Kaleb Thompson is a credentialed Community Health Worker and credentialed Harm Reduction Specialist through the state of Missouri. Kaleb has worked at Family Care Health Centers for the past year building relationships with the community while addressing social determinants of health and improving overall community health and wellness. Kaleb is also an active member of the JEDI Council (Justice, Equity, Diversity, and Inclusion), trauma informed care training team and community outreach team.

Juliet Simone, MPH, MBA, RPCV

Chief Program Officer, The Oasis Institute

Juliet Simone's early work history includes many roles in the medical field including volunteer work, for example as a Birth Control Educator at Annex Teen Clinic from 2006 to 2008, as a Community Health Volunteer in Ancash, Peru as part of the Peace Corps from 2010 to 2012, and in 2009, as a Syringe Exchange Volunteer at the Minnesota AIDS Project. In 2012, Juliet joined The Oasis Institute as a Community Health Manager, managing staff, building partnerships, and overseeing grant budgets. Juliet has also held the positions of National Health and Program Director and Chief Program Officer at The Oasis Institute.

Juliet has a diverse education history, including a Bachelor of Arts degree in Theatre/Theatre Arts Management and then a Master's degree in Public Health, specializing in Public Health Administration and Policy, from the University of Minnesota. In 2015-2017, Juliet obtained a Master of Business Administration from Webster University.

Vickie Misuraco, CHW-C

Community Health Worker, Mercy

Vickie is a lifelong Lincoln County resident. She has been married to her husband, Mike, for 22 years. She attended Lincoln County, Missouri schools and graduated from Buchanan High in 1993. She completed the Community Health Worker program through St Louis Community College in July. Vickie is employed at Mercy Hospital Lincoln as a Community Health Worker, where she assists the uninsured and underinsured. Vickie currently serves on the Lincoln County R3 Education Foundation Board.

Abigail Barker, PhD

Research Associate Professor
Brown School at Washington University in St. Louis

Associate Director for Policy Partnerships, Center for Advancing Health Services, Policy & Economics Research

Abigail Barker's role at the Center for Advancing Health Services, Policy, and Economics Research at the Institute for Public Health includes helping social science and clinical researchers add cost and cost-effectiveness analyses to their work to increase policy relevance, as well as creating data visualizations to allow stakeholders to interactively understand the tradeoffs of various health policy choices. She is also an economic consultant for the State of Missouri's Medicaid program, contributing to transformation initiatives including payment policy redesign.

Her own research focuses on econometric modeling and microsimulations on topics relating to health insurance markets, Medicaid, payment policy, and health reform. Her ongoing work for the Rural Policy Research Institute focuses on understanding how market-based insurance models perform, using the Affordable Care Act and Health Insurance Marketplaces data as well as Medicare Advantage data to inform rural health policy. A newer research area is nutrition and food policy, as these are potential levers that can affect health in a more upstream and potentially cost-effective manner.

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Abbreviations

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CDC: Centers for Disease Control and Prevention

CHI: Community Health Integration

CHW: Community Health Workers

CMS: Centers for Medicare & Medicaid Services

DSS: Department of Social Services

FFS: Fee-For-Service

FQHC: Federally Qualified Health Center

HCPCS: Healthcare Common Procedure Coding System

HEDIS: Healthcare Effectiveness Data and Information Set

HIT: Health Information Technology

IHN: Saint Louis Integrated Health Network

MCOs: Managed Care Organizations

MHD: MO HealthNet Division

MPCA: Missouri Primary Care Association

P4P: Pay for Performance

PCHH: Primary Care Health Home

PCMH: Patient Centered Medical Homes

PMPM: Per Member Per Month

PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

SDOH: Social Determinants of Health

TCC: Total Cost of Care

VBP: Value Based Payment

MA: Medicare Advantage

PHQ9: Patient Health Questionnaire 9

PAM: Patient Activation Measure ®

Transforming Healthcare in Missouri Part VIII:
Bridging the Gaps with Community Health Workers From Global to Local and Back

Fact Sheet

Global Models for Community Health Worker Reimbursement and Roles

Background

Community Health Workers (CHWs) are critical members of care delivery teams who facilitate access to quality and culturally competent service for the community they serve. Often, CHWs share a relationship with the people in the community which fortifies trust in the healthcare system and motivates overall continuity of care. The specific utilization of CHWs varies greatly from country to country. In some nations, CHWs are equipped with enough knowledge to deal with a variety of conditions; more often is the case where they focus on one condition or disease. The United States has been relatively slow to adopt their services in either method, or for that matter to adopt the use of CHWs generally into our system.

Existing Global CHW Reimbursement Models in Low and Middle-Income Countries

Despite the essential work they perform, the remuneration of community health workers (CHWs) has long been subject to global debate. The question now being considered is not *whether* we should reimburse CHWs, but *how* we should do so.

In 2018, the WHO advocated for this measure by updating the "Guidelines on Health Policy and System Support to Optimize Community Health Worker Programs," which now recommends[1]:

1. "Remunerating CHWs with a financial package commensurate with the job demands, complexity, manner of hours, training and roles that they undertake"; and
2. "Not paying CHWs exclusively or predominately according to performance-based incentives."

These guidelines have served as a standardized anchor to evaluate and accordingly redesign existing systems. In proposing changes to Missouri's CHW reimbursement model, we can look at the table below from a systematic review conducted by Ballard et.al in 2021 of existing CHW reimbursement models in low or middle-income countries (LMIC) that are in accordance with WHO guidelines[2].

Table 1. Models meeting the WHO guideline

REMUNERATION MODEL	SUMMARY	ADVANTAGES	DISADVANTAGES
Public sector (Brazil)	CHWs can be hired by states, federal districts, or municipalities.	**CHW**: Provides protections and employment benefits. Requirements of the legislation leaves little room for exploitation.	**CHWs & health system**: Brazilian law imposes several conditions that must be met when hiring CHWs, which does not make this type of hiring flexible.
	Pay for state-employed CHWs adheres to professional salary floor.	**Health system**: Compensation of CHWs is regulated by specific legislations, providing clarity.	
Private – with public sector wage floor (Nigeria)	CHWs are regarded as 'non-workers' under Nigerian labour legislation and as such, their remuneration is determined by their employment contract. This remuneration, however, must not be below the minimum wage established by the National Minimum Wage Act, 2019.	**CHWs**: Flexibility to negotiate desired terms with their contractors while ensuring that their compensation can never be lower than the national minimum wage.	**CHWs**: May lack negotiating power relative to employers. Lack of government intervention provides an opportunity for exploitation. For instance, CHWs are required to pay an annual fee to retain their ability to practice but are not offered much protection by the government associations.
	CHWs must register with national body and obtain certificate to practice.	**Health system**: The terms of engagement for a CHW are governed by the employment contract, and as a result, the employer may choose to offer additional allowances and incentives.	**Health system**: Potential lack of accountability.

CHW – community health worker

Evidence for Utilizing Task-Shifting Models

The use of CHWs is consistent with a model of delegation known as "task shifting." Essentially, task shifting is "the efficient redistribution of tasks among health workforce teams."[3] In this model, specific tasks are moved, where appropriate, from health workers with specialized training to those who have more general training for efficient use of all personnel. Academic theory has long conjectured the benefits of task-shifting in healthcare as opposed to a task-sharing model.

In 2017, Seidman et. al published a systematic review investigating this topic and concluded that task-shifting is a viable option not only for quality improvements but also for health system cost savings in LMICs. More specifically, among the studies included for review, **>90% found evidence for cost savings.** Of this group, 87% of studies reported cost savings either per outcome or per output which are indicators of efficiency improvements[4]. The table below further details how community health worker-led interventions result in cost savings and clinical improvements among a broad spectrum of community health, including TB, child and maternal health, and other disease classes.

Table 2. Full list of citations included in systematic review

Author and year	Country	Intervention	Indicator type	Main indicator	Result	Quality data
Tuberculosis						
Clarke, M., et al. (2006) [39]	South Africa	Training of lay health workers (LHWs) to support treatment and management of TB on farms, instead of clinic nurses or enrolled (non-professional) nurses	Input/process	Cost per minute of health worker time	91% reduction in cost from clinic nurses ($0.12 per minute) to LHWs ($0.01 per minute) and 87.5% reduction from enrolled nurses ($0.08 per minute) to LHWs	Farms with LHWs supporting had 42% better case finding rate and 10% better cure rate
Islam, M. A., et al. (2002) [36]	Bangladesh	BRAC TB control program using CHWs compared to government-run program	Input/process; outcome	Total annual cost for TB control program at the subdistrict (thana) level; Cost per patient cured.	31% reduction in total annual costs from government program ($10,697) to BRAC program ($7,351); 32% reduction in cost per patient cured	84.1% cure rate in BRAC TB program compared to 82.2% in government program
Khan. M. A., et al. (2002) [40]	Pakistan	Comparison of DOTS by health workers at health centers, DOTS by family members, atnd "DOTS without direct observation"	Outcome	Cost per case cured	45% reduction from health center DOTS ($310) to CHW DOTS ($172); unsupervised DOTS cost $164	Cure rates were 62% for unsupervised DOTS, 55% for family member DOTS, 67% for CHW DOTS, and 58% for Health Center DOTS
Prado, T. N., et al (2011) [42]	Brazil	Comparison of DOTS overseen by guardians with standard of care treatment by CHWs	Output	Total cost for DOTS course	28% reduction in costs from CHW DOTS ($547) to guardian-supervised DOTS ($389)	98% treatment completion in guardian-supervised DOTS compared to 83% treatment completion with CHW-supervised DOTS (p=.01)
Malaria						
CHanda, P., et al. (2011) [50]	Zambia	Comparison of home management (using CHW) with facility-based management of uncomplicated malaria	Output	Cost per case appropriately diagnosed and treated	31% reduction from facility-based management ($6.12) to home management ($4.22)	100% of cases treated appropriately through home management, and 43% of cases treated appropriately in facility
Hamainza, B. M., et al. (2014) [50]	Zambia	Comparison of CHW program to test and treat malaria with facility with facility-based testing and treatment	Output	Total cost per confirmed case	60% reduction in cost from facility-based approach ($10.75) to CHW approach ($4.34)	78% of CHW contacts received appropriate testing and treatment, while 53% of facility-based patients received appropriate testing and treatment based on guidelines.
Other Diseases and Health System Strengthening Activities						
Aung, T., et al. (2013) [62]	Myanmar	Comparison of costs to treat diarrhea by CHW, government facility, and private provider	Input/process	Total patient cost for consultation and correct ORS	7% reduction from private providers ($5.40) to CHWs ($5) and 67% reduction from government facilities ($15) to CHWs	CHWs provided appropriate ORS and amount of drinking water in 57.6% of cases, private providers in 47.1% of cases, and government facilities in 71.4% of cases

Applying Global Models to Missouri

As we think of the benefits Community Health Workers can provide in Missouri, it is integral to recall what fuels disparate health outcomes in our state – asthma, HIV, maternal mortality, etc. These are all chronic conditions or public health issues which can be managed *if* individuals have reliable healthcare access and continuity of care. As we review the interventions facilitated by CHWs in LMICs, it is clear that they are designed to address the nation's respective prominent public health vulnerabilities. Similar interventions can be developed here in Missouri to address the conditions that disproportionately impact our underserved citizens.

For these benefits to reach patients consistently, deploying CHW-focused strategies similar to those described above is critical. To achieve consistency, a method of reimbursement must be identified, authorizing payment for health insurer coverage of CHW work, either by the individual service or as a fully employed member of a clinical care team. This is essential for institutions to fully adopt the task-shifting model to efficiently achieve better health outcomes for individuals and communities at risk.

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Transforming Healthcare in Missouri Part VIII:
Bridging the Gaps with Community Health Workers From Global to Local and Back
Fact Sheet

Current U.S. Models for Community Health Worker Roles and Reimbursement

Background

Community Health Worker (CHW) is an umbrella term that encompasses several categories of frontline public health workers - including Community Navigator, Health Coach, Community Health Advisor, Community Health Aid, or Outreach Worker. The proof of CHWs' effectiveness in healthcare and population health was first seen in the U.S. as an antipoverty strategy by community organizations, faith-based organizations, and healthcare practitioners. As of May 2021, there were an estimated 61,000 CHWs working in the United States. The services provided by these CHWs are extensive, including advocating for efficient resource allocation, promoting reliable healthcare access, and/or delivering culturally appropriate health education - all of which are crucial to addressing the entrenched health disparities in our nation. The largest-ever one-time federal investment in the CHW workforce, the Biden Administration announced in September 2022 that it would be allocating $225 million in American Rescue Plan funds to train nearly 13,000 CHWs. Additionally, from state fiscal year (FY) 2023 through FY 2027, the Consolidated Appropriations Act of 2023 approved $50 million yearly to increase CHW workforce capacity. These investments show a rising level of interest on the part of national and state governments in the potential contribution of CHWs to improving population health. Examples of positive impacts of CHWs:

- CHW-pharmacist collaborations in Florida resolved 75.6% and 63.9% barriers related to medication adherence in hypertensive and antidiabetic patients respectively.[1]
- CHW-nurse practitioner intervention in Maryland led to better systolic blood pressure (decreased by a mean of 4.5 mmHg), LDL-cholesterol (decreased by a mean of 6.4mg/dL), and hemoglobin A1C (decreased by a mean of 0.42%) in patients with cardiovascular disease.[2]
- In a randomized control trial of a CHW engagement model in Pennsylvania, it was discovered that there was decrease in hospitalizations with a shorter average stay (-3.1 days) and an improvement in reported quality of care (OR: 1.8, CI: 1.4-2.4) to individuals with multi-chronic disease in high poverty areas.[3]

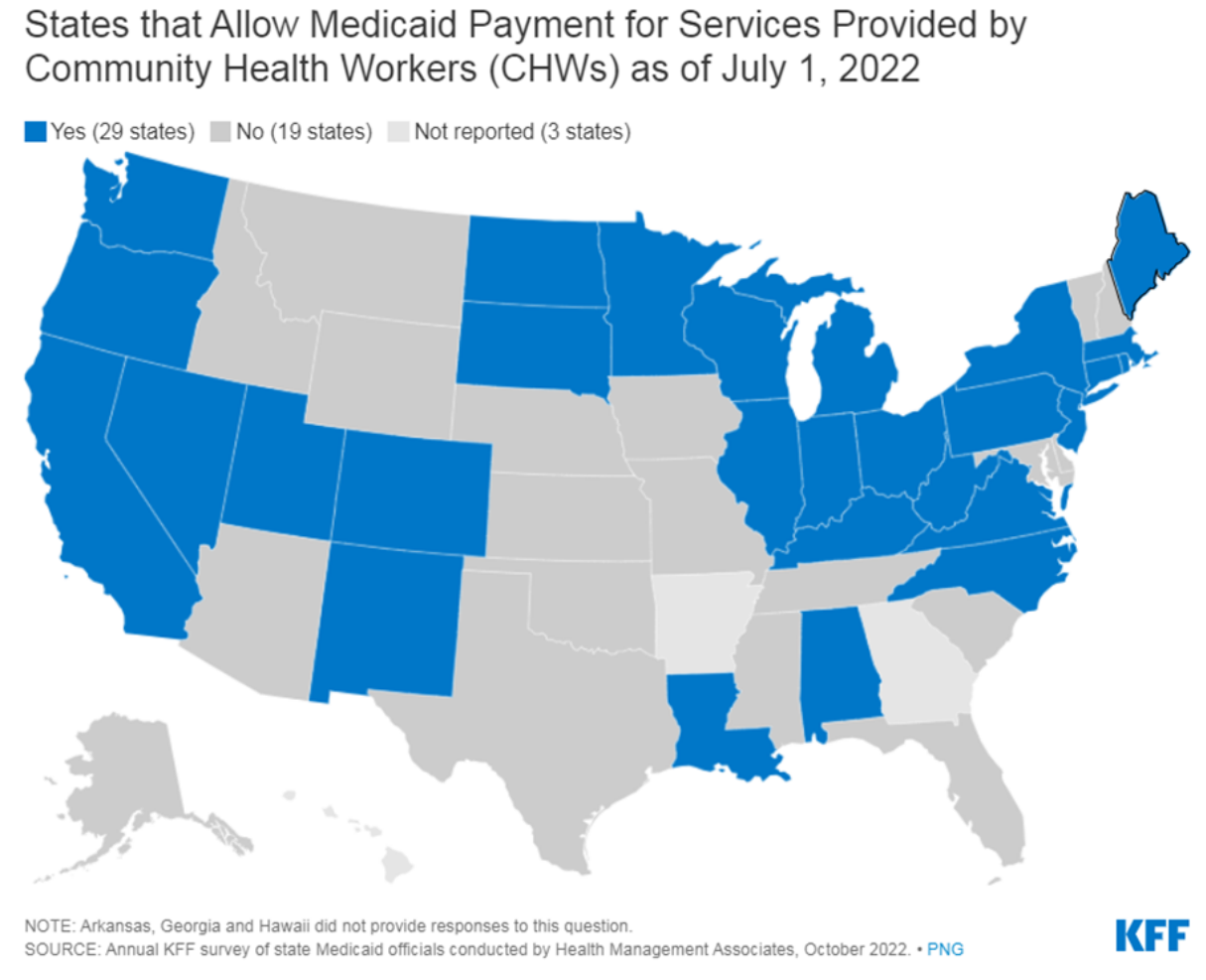
Funding for Community Health Worker Compensation in the United States

As of July 1, 2022, 29 states authorize Medicaid payment for the services provided by CHWs.[4]

- This includes 9 states (California, Indiana, Louisiana, Minnesota, North Dakota, Oregon, Rhode Island, and South Dakota) that authorize payment under their Medicaid state plan authority.
- Several states such as Arizona, California, Kentucky, Massachusetts, Montana, New Jersey, New York, Oregon, Utah, Vermont, and Washington report CHW coverage under section 1115 demonstration waivers.
- In Colorado, fee-for-service reimbursement and value-based payment models are authorized. Indiana, Minnesota, and South Dakota also allow reimbursement through FFS.
- In New Mexico, Michigan, Arizona, Nevada, and Minnesota, managed care organizations cover the CHWs through their contract with the state Medicaid agency.

Other states support CHW activity through grant mechanisms.

- The Arkansas Community Health Worker Association (ARCHWA) is responsible for CHW service funding.
- In Connecticut, Federally Qualified Health Centers (FQHCs), community-based organizations, the National Institutes of Health (NIH), Center for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) provide grant funding for services provided by CHWs.
- In Illinois, the Department of Healthcare and Family Services provide grant funding to Healthcare Transformation Collaboratives throughout the state to support CHWs for the services.
- The Missouri Department of Health and Senior Services funds CHW related activities through CDC 1815 and 1817 grants.
- In Montana, CDC funding supports the training and reimbursement of CHWs.
- In Ohio, Texas, Vermont, and Wisconsin, most of the CHW provided service reimbursement is funded through the grant opportunities.



Foundational Work to Support the Growth of the CHW Field

Organizations hiring CHWs to address community needs must develop the CHW workforce through recruitment, hiring, training, and supervision of CHWs as well as retention strategy.

- Training ensures that CHWs consistently acquire the abilities required to fulfill their duties. The knowledge and skills gained assist them in navigating the healthcare system and addressing certain environmental, social, and health concerns. Non-profit or healthcare groups host trainings on the use of the PRAPARE assessment, SDOHs, and COVID-19, among other tools.[5]
- To raise the level of professionalism and encourage common standards, several state governments have created voluntary CHW certification programs. A recent law in Ohio forms a board to accept CHW certifications. The North Dakota legislature recently mandated their DHHS to develop and execute CHW certification procedures, including standards, costs, necessary training, and experience. As of August 2017, Alaska, Texas, Oregon, Minnesota, and South Carolina required CHWs to be certified in order to be eligible for Medicaid reimbursement; however, no state has made certification mandatory for all CHWs.[6]
- Many organizations are providing supportive supervision, regular check-ins, technical tools such as tablets or computers, and professional advancement opportunities in order to encourage retention and stability.[7] Providing advanced tools like tablets, phones, or laptops to keep track of work, stay in touch with patients, or use during home visits, as well as promoting a collaborative work environment, also aid in retention.
- To develop CHW-informed public health policies and programs, states are forming advisory boards and workgroups. For instance, in 2023 Louisiana established an 11-person board to make recommendations on training, competencies, funding sources, tracking employment, and improving employer readiness to hire. A majority of the board members are current CHWs from community-based organizations.

The Affordable Care Act's enactment in 2010 increased awareness of the CHW workforce and its potential to enhance community health. The Primary Care Health Home (PCHH) teams of Missouri's Medicaid program, MO HealthNet, initiated a pilot program testing the benefits of inclusion of CHWs on PCHH teams in 2016. Through specific training providers, Missouri DHSS supported tuition reimbursement for CHW training. By providing scholarships that allow training providers to offer courses at no cost and by expanding the workforce through additional CHW roles, CDC funding helped Missouri scale its CHW training and scholarship initiatives. The lessons and materials that CHW-led organizations like Community Health Workers Association of Missouri, the St. Louis CHW Coalition, the Kansas City Regional CHW Collaborative, and other local and regional initiatives have promoted cross-learning among Missouri communities and informed statewide CHW efforts.

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