

Making Community Health Workers (CHWs) Fundamental: New Research Strengthens the Case for State Policymakers to Include CHWs in Care Delivery Teams

There is considerable evidence that community health workers (CHWs) are an effective and versatile workforce that can improve health outcomes and reduce health care costs for diverse groups and health conditions.^{1,2} CHWs have a unique capacity to serve as bridges between communities and the health care system, to foster greater trust between patients and providers, and to enhance the health system's ability to provide higher-quality, culturally centered care that results in improved health.

However, despite CHWs' record of success, the health care system has largely failed to include this valuable workforce in care delivery, squandering a strategic opportunity to capitalize on CHWs' unique skills. In addition, CHW programs are typically grant funded, which limits the longevity and the scope of services offered. States should find ways to sustainably finance CHW services through Medicaid and integrate CHWs into care delivery teams to provide culturally competent care and link social supports to communities with the greatest need.

Evidence proving the health and cost benefits of implementing CHW programs is growing, and one of the primary organizations generating this CHW evidence is the Patient-Centered Outcomes Research Institute (PCORI). Since its creation in 2010, PCORI has funded a broad, multi-state, national portfolio of comparative effectiveness clinical research that tests the impact of CHW interventions on patient-centered

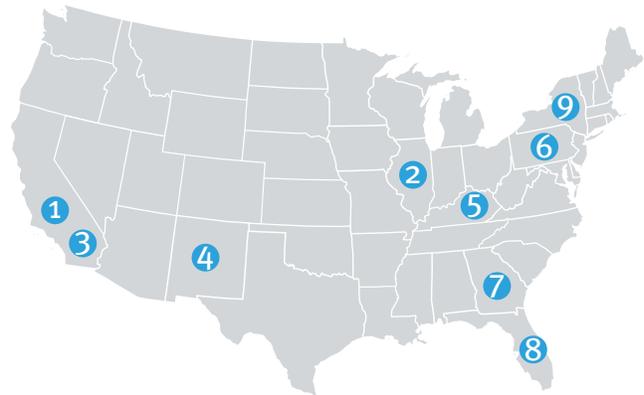
outcomes.³ The results of their research reinforce decades of previously published evidence from across the world showing that CHWs are a powerful intervention to improve health outcomes, avoid preventable utilization of health care, and reduce health care costs across diverse populations, health conditions, and settings.

This summary synthesizes key findings from PCORI's CHW research and provides evidence-based recommendations to guide state policymakers on how to make CHWs integral members of health care delivery teams to improve individual and population health and potentially generate health care savings. The recommendations are based on our review of nine PCORI-funded CHW studies, available in our report, [Advancing Health Equity Through Community Health Workers and Peer Providers: Mounting Evidence and Policy Recommendations](#).⁴

MAPPING SUCCESS: PCORI'S RESEARCH PROVES CHWS' EFFECTIVENESS AND VERSATILITY FOR DIVERSE POPULATIONS, HEALTH CONDITIONS, AND SETTINGS

The nine PCORI-funded CHW studies included in our analysis examined interventions led by CHWs across health conditions such as serious mental illness (SMI), chronic diseases, and traumatic physical injury. Study participants were of diverse ethnic, racial, linguistic, socioeconomic, and geographic backgrounds, including Black, Latinx, American Indian, monolingual Spanish-speaking, low-income, and rural patients. Key outcomes are summarized below:

1. **CALIFORNIA:** Decreased reported preference for emergency or urgent care by 40%. Improved relationships with primary care providers and increased preference for use of primary care. Participant group of racially and ethnically mixed adults (60% Latinx, 25% white, 8% Black, and 8% other or multiracial) living with SMI in an urban setting.⁵
2. **ILLINOIS:** Improved recovery and increased personal empowerment and better quality of life for Latinx adults living with SMI in an urban setting. A majority of participants were immigrants and with a Spanish-language preference.⁶
3. **CALIFORNIA:** Increased prescription of antidepressant medication by 57%, treatment acceptance by 79%; and significantly decreased emergency department (ED) admissions at 12 months of intervention for Latinx adults with depression and concurrent diabetes and/or heart disease living in an urban setting. A majority of participants were monolingual immigrants.⁷
4. **NEW MEXICO:** Increased patient activation,ⁱ a measure associated with lower ED use and hospitalization and improved health outcomes by 69% for Zuni Indians in a rural setting at risk of chronic kidney disease.⁸
5. **KENTUCKY:** Significant improvement in achievement of health goals, including improved lipid profile, blood sugar, blood pressure levels, body weight, and improved cholesterol, for white Appalachians at risk of cardiovascular disease.⁹
6. **PENNSYLVANIA:** Decreased days spent in the hospital by 69% and improved quality of primary care for Black adults in a high-poverty zip code in an urban setting with multiple chronic conditions.¹⁰



7. **GEORGIA:** Decreased time in the hospital during unplanned visits and increased self-efficacy, a measure associated with improved health outcomes and less avoidable utilization, for white male adults with spinal cord injury.¹¹
8. **FLORIDA:** Increased likelihood of follow up appointment attendance within four weeks of an ED visit by 14% for elderly adults with chronic illness.¹²
9. **NEW YORK:** Improved social quality of life for patients with higher levels of pain and anxiety among a group of racially and ethnically diverse female participants (57% Black, 21% white, and 19% Latinx) with depression.¹³

ⁱAssesses patients' knowledge, skill, and health care management confidence.

Key Recommendations for State Policymakers to Include CHWs in Care Delivery Teams

Findings from PCORI’s research provide important insight into actions that state policymakers can take to make CHWs a fundamental component of high-quality, patient-centered care delivery teams. Key recommendations based on the PCORI research that can advance CHWs at the state level include the following:

Use Existing Opportunities in Medicaid to Fund CHWs

As states consider interventions that address the social determinants of health and advance health equity as part of their health system reform efforts, several are introducing Medicaid-funded CHW services as an important tool to achieve these goals. States like Massachusetts, New York, Oregon, Utah, and Vermont have already begun to pay for CHW services in Medicaid.¹⁴ State policymakers should use the multiple pathways available for Medicaid to pay for CHW services, including through state plan amendments, Section 1115 waivers, and Medicaid managed care-contracted benefits, among others. To learn more about the specific mechanisms available, please see Families USA’s report, [How States Can Fund Community Health Workers Through Medicaid to Improve People’s Health, Decrease Costs, and Reduce Disparities](#).¹⁵

Define CHW Services Carefully to Make Sure They Are Truly Community-Based

As states, providers, and payers work to scale up and include CHWs as a core part of their health care system, policymakers and operational leaders must

be careful to avoid implementing “CHW services in name only.” For example, Medicaid and other state health programs have a long history of paying for care management and care coordination through managed care plans or other contractors, but that is generally not a truly community-based model. The CHW programs with the greatest impact embrace the true community-based nature of CHWs: ensuring that they work in community settings, that they share a sociocultural affinity with their clients, and that they have an intimate knowledge of their communities’ socioeconomic resources and supports.

Medicaid Alternative Payment Models Should Encourage Adoption of CHWs by Organizations Receiving Reformed Payment

State policymakers moving toward Medicaid alternative payment models (APMs) should use the Medicaid authorities described above to allow for Medicaid-reimbursed CHW services, then incorporate adoption of CHW services into well-designed APMs as part of health system transformation efforts. For example:

- » **Oregon’s** Coordinated Care Organizations (CCOs) serve the state’s Medicaid population. The CCOs reward providers for performance on a number of care quality and patient outcomes measures that CHWs can help them to achieve, with a significant emphasis on social determinants of health, effective prevention, and consumer education. The state formalized a CHW certification program as part of its expansion of the CCO model in Medicaid. The CHW program has now taken root in Oregon, as multiple CCOs have integrated CHWs into delivery teams to help meet these performance goals.¹⁶

- » In a more state-directed model, **Vermont** has integrated CHWs into “community health teams.” These teams provide interdisciplinary services that the state directly contracts, which are made available for primary care provider referrals on a multi-payer basis. Payers include Medicaid and other major insurers.^{17,18}

Deploy CHWs as Flexibly as Possible Given the Breadth of Their Potential Use, Especially Among Communities With the Highest Need

Most of the PCORI research summarized here involved people with significant health disparities. One major use is transitional care, with several successful studies involving individuals transitioning to the community from hospitalizations or emergency department visits for physical or mental illness. A second application strongly supported by PCORI research is using CHWs to maintain health for people with documented chronic physical or behavioral conditions.

Given the variety of clinical and use histories that have shown positive outcomes in these and previous studies, states should consider how to make CHW services a core element of outpatient health care delivery in high-need communities.

- » One successful approach is to design delivery systems that include CHWs as part of primary care interdisciplinary teams. This gives flexibility to primary care medical homes to deploy CHWs as needed to help patients with multiple chronic conditions better engage with primary care providers to prevent chronic disease symptoms. This, in turn, can potentially reduce the need for costly emergency care and utilization.

- » A second approach, particularly for states with dedicated transitional care programs, is to integrate CHWs into interdisciplinary transitional care teams to improve patients’ self-efficacy and prevent avoidable hospital utilization as they transition from inpatient to community settings.

The PCORI studies also provide important evidence that Medicaid-funded providers and programs should not limit CHWs to high-utilization individuals — but also partner them with people who are at risk of future hospitalization and who are not effectively engaged with the health care system. Notably, a highly successful intervention addressed population health for minority, geographically isolated adults.¹⁹ Almost 30 million adults in the U.S. are affected by chronic kidney disease (CKD), with prevalence greater among ethnic and racial minorities and those living in rural areas with limited access to health care.²⁰ This intervention used CHWs to conduct home visitations to provide healthy lifestyle education and CKD risk factor management for American Indian adults in rural New Mexico. The intervention lowered participants’ body mass index and blood sugar levels among other indicators, effectively reducing CKD risk.

Conclusion

The evidence is clear that CHWs are a powerful intervention that should be included in care delivery teams in ways that can be funded sustainably. State policymakers interested in the development of evidence-based, cost-effective, and community-based strategies to improve health outcomes and reduce costs should invest in programs that include CHWs.

Endnotes

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