



Making the Connection: The Role of Community Health Workers in Health Homes

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The mission of the W.K. Kellogg Foundation is to support children, families, and communities, as they strengthen and create conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society.



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Health Homes Under the Affordable Care Act

One of the primary opportunities afforded by the Patient Protection and Affordable Care Act (ACA) for transforming the health care delivery system for Medicaid beneficiaries is the health homes option.¹ A health home is responsible for coordinating comprehensive care across all care settings, including medical care, behavioral health care, and social services. To be eligible for participation in a health home, a Medicaid beneficiary must: **1)** have at least two chronic conditions; **2)** have one chronic condition and be at risk for another; or **3)** have one serious and persistent mental health condition. Providers who participate in this care management model are accountable for improving patient outcomes while reducing costs, particularly those related to preventable hospital admissions, hospital readmissions, and emergency department (ED) visits. They are expected to use active outreach and engagement in order to locate, enroll, and retain members into the health home services. To encourage the adoption of health homes, the ACA authorized a 90% Federal match rate under the Federal Medical Assistance Percentage for a set of required services delivered by a health home.²

The Centers for Medicare and Medicaid Services (CMS) approved New York's first Medicaid State Plan Amendment³ for Phase I health homes with an effective date of January 1, 2012. Health homes are a central aspect of New York Governor Andrew Cuomo's Medicaid Redesign Team's efforts to improve health outcomes and reduce health care costs for Medicaid beneficiaries with complex medical and behavioral health conditions. There are an estimated 975,000 Medicaid members—nearly 20% of the State's more than 5 million Medicaid beneficiaries—who meet the Federal criteria for health homesⁱ and may be assigned over time to State-designated health homes. Health homes will also be available in the future to Medicaid beneficiaries who have long-term care needs and developmental disabilities.

According to CMS, designated health home providers must be able to provide six core services:

¹ Health homes were authorized under section 2703 of the ACA.

² To participate in health homes and receive the Federal match, state Medicaid agencies had to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services for approval.

³ SPA 11-56 approved February 2, 2012.

Health Homes Under the Affordable Care Act *(continued)*

- Comprehensive care management.
- Care coordination and health promotion.
- Comprehensive transitional care from inpatient to other settings, including appropriate follow up.
- Individual and family support, which includes authorized representatives.
- Referral to community and social support services, if relevant.
- The use of health information technology to link services.

These six core services required of health homes overlap with several of the roles and tasks commonly performed by community health workers (CHWs). This policy brief highlights the ways in which CHWs could help health homes achieve their goals and provides information for incorporating CHWs into the care management teams.

Potential Roles for CHWs and Core Health Home Services

The core services that designated health homes must deliver are well aligned with the roles and tasks that CHWs perform. Table 1 provides a list of the first five core services and examples of activities that the New York State Department of Health has identified as critical to the care management to be provided by a health home and indicates if CHWs can play a direct or supportive role in performing the activities. As the table illustrates, many of the activities that a care manager and the team are expected to perform as part of a health home could be performed directly by a CHW or supported by a CHW. (See sample health homes CHW job description in the Appendix.)

COMMUNITY HEALTH WORKERS: IMPROVING OUTCOMES AND REDUCING COSTS

CHWs are frontline public health professionals who are trusted members or have a close understanding of the communities they serve through shared ethnicity, culture, language, and life experiences. This relationship enables them to break down social/cultural barriers among communities and health care, behavioral health, and social service systems. CHWs have served in positions to help individuals and families navigate complicated care systems and help coordinate access to health care and social services. CHWs perform numerous roles, including outreach; patient navigation; care coordination; health education and promotion; home visiting; informal counseling; social support; translation and interpretation; and advocacy.

Ample studies demonstrate that CHWs serving in these roles have improved health outcomes for low-income populations, particularly for disease prevention and chronic disease management.^{ii,iii,iv,v,vi,vii} Numerous studies also have shown that CHW interventions can demonstrate cost-effectiveness and achieve cost savings.^{viii,ix,x} For example, a return on investment (ROI) analysis of a Denver Health CHW intervention with 590 underserved men showed a savings of \$95,941 annually and an ROI of 2.28:1.00.^{xi} In Baltimore, Maryland, African-American Medicaid patients with diabetes who participated in a CHW intervention had a 40% decrease in ED visits, a 33% decrease in ED admissions, a 33% decrease in total hospital admissions, and a 27% decrease in Medicaid expenditures. The CHW program produced an average savings of \$2,245 per patient per year and a total savings of \$262,080 for 117 patients.^{xii}

Several nationally known quality improvement agencies have recommended the inclusion of CHWs in programs aimed at improving health for people with complex social and medical needs. A 2012 Agency for Healthcare Research and Quality report on care coordination for adults with complex needs indicated that many programs also use CHWs in their teams.^{xiii} A 2011 Institute for Healthcare Improvement white paper on care coordination models for people with multiple health and social needs included CHWs as potential care coordinators and emphasized that, rather than a specific training credential, it is most critical that CHWs respond to the particular needs of the target population; be able to communicate with a range of people; and provide self-management support, patient advocacy, and patient navigation.^{xiv}

Potential Roles for CHWs and Core Health Home Services (continued)

TABLE 1: CORE HEALTH HOME SERVICES AND EXAMPLES OF ACTIVITIES ⁴	CHW IN A DIRECT ROLE	CHW IN A SUPPORTIVE ROLE
COMPREHENSIVE CARE MANAGEMENT		
Complete a comprehensive health assessment and reassessment, including medical, behavioral, rehabilitative, and long-term care and social service need.		✓
Complete/revise an individualized patient-centered plan of care with the patient to identify patient's needs and goals and include family members and other social supports as appropriate.		✓
Consult with multidisciplinary team on client's care plan, needs, and goals.		✓
Consult with primary care physician and/or any specialists involved in the treatment plan.	✓	
Conduct client outreach and engagement activities to assess ongoing emerging needs and to promote continuity of care and improved health outcomes.	✓	
Prepare client crisis intervention plan.		✓
CARE COORDINATION AND HEALTH PROMOTION		
Coordinate with service providers and health plans, as appropriate, to secure necessary care; share crisis intervention and emergency information.	✓	
Link/refer client to needed services to support care plan/treatment goals, including medical, behavioral health care, patient education, self-help/recovery, and self-management.	✓	
Conduct case reviews with interdisciplinary team to monitor/evaluate client status and service needs.		✓
Advocate for services and assist with scheduling of needed services.	✓	
Coordinate with treating clinicians to ensure that services are provided and to ensure changes in treatment or medical conditions are addressed.		✓
Monitor, support, and accompany the client to scheduled medical appointments.	✓	
Crisis intervention, revise care plan/goals as required.		✓
COMPREHENSIVE TRANSITIONAL CARE		
Follow up with hospitals/ED upon notification of a client's admission and/or discharge to/from an ED, hospital/residential/rehabilitative setting.	✓	
Facilitate discharge planning from an ED, hospital, residential, and rehabilitative setting to ensure a safe transition/discharge and that care needs are in place.		✓
Notify/consult with treating clinicians, schedule follow-up appointments, and assist with medication reconciliation.		✓
Link client with community supports to ensure that needed services are provided.	✓	
Follow up post-discharge with clients and their families to ensure client care plan needs/goals are met.	✓	
PATIENT AND FAMILY SUPPORT		
Develop/review/revise the individual's plan of care with the clients and their families to ensure that the plan reflects individual's preferences, education, and support for self-management.		✓
Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues, as needed.	✓	
Meet with client and family, inviting any other providers to facilitate needed interpretation services.	✓	
Refer clients and their families to peer supports, support groups, social services, and entitlement programs as needed.	✓	
REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES		
Collaborate and coordinate with community-based providers to support effective utilization of services based on client/family need.	✓	

⁴ This table was accessed on August 20, 2012 from the April 2012 New York State Medicaid Update Special Edition Volume 28, Number 4: http://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-04_pharmsped_edition.htm

Learning from the Past to Ensure Health Homes Achieve Their Goals

Medicaid beneficiaries assigned to health homes by definition have complex health and social needs, and improving their health outcomes and reducing costs will present significant challenges. Health home providers will need to operate outside of traditional silos and develop more integrated networks of care and services that can address the full continuum of medical, behavioral health, and social service needs of the populations they serve.

A preliminary report^{xv} by the Center for Health Care Strategies (CHCS) that summarizes the work of a learning collaborative of New York State’s Chronic Illness Demonstration Project (CIDP), a pilot that aimed to improve health outcomes and reducing costs among chronically ill Medicaid beneficiaries, provides important lessons on what is needed to meet the needs of New York’s high-cost/high-risk populations. Although CIDP is still being evaluated, CHCS revealed some of the critical program design elements that contributed to success among the six CIDP teams. Table 2 below lists those critical success factors and identifies related CHW roles that align with those factors. The unique roles and attributes of CHWs have been documented in several publications.^{xvi, xvii, xviii, xix} The Community Health Worker Network of NYC and Columbia University’s Mailman School of Public Health most recently published an in-depth analysis of CHW roles, tasks, and attributes.^{xx}

CRITICAL SUCCESS FACTORS	UNIQUE CHW ROLES AND ATTRIBUTES
High-touch interdisciplinary teams that are highly accessible	The central purpose of CHWs is to provide high-touch support and coordination. CHWs share a common background with the communities they serve; hence they are perceived as highly accessible and knowledgeable to the population that they serve. CHWs are accessible both in the clinical care setting and in community settings.
Dedicated housing coordinator	CHWs coordinate access to social services, including housing.
Dedicated staff with social service expertise	CHWs coordinate access to social services and are often the primary source of information on social services that are available in the community and among care providers. CHWs have often been consumers of social services; consequently they have a firsthand knowledge of the intricacies of accessing these services. They also tend to live or work in the same communities of the population they serve; hence they have a local understanding of the availability of social services.

continued

Learning from the Past to Ensure Health Homes Achieve Their Goals *(continued)*

TABLE 2: CIDP ELEMENTS OF SUCCESS AND RELATED CHW ROLES	
CRITICAL SUCCESS FACTORS	UNIQUE CHW ROLES AND ATTRIBUTES
Inclusion of peers in the staffing model	CHWs are essentially trained peer health workers.
Client-centered service delivery model	CHWs are trained to provide support for the whole person and tailor service delivery to meet the full range of needs of each individual person.
Partnerships with community-based organizations	The role of CHWs is to develop and maintain partnerships with community-based organizations and connect people to those services as needed.
Ability to coordinate medical and behavioral health care as well as social services	CHWs coordinate access to behavioral health and social services, including assisting with scheduling appointments for these support services; preparing for visits; escorting people to their appointments; and serving as interpreters.

While other team members may also serve in these roles, the unique attributes of CHWs as trusted, accessible, and resourceful peers make them a valuable member of an interdisciplinary health home team. CHWs often share the same racial and ethnic background, socioeconomic status, and language as the people and families they serve. They also share or have a deep understanding of the cultural and social contexts where people live. These characteristics provide a foundation for building a trusting relationship with the people and families they serve, which in turn enables them to effectively tailor services to meet patients' specific needs.

Paying for CHWs in a Health Home

Health homes will be paid for services on a per-member per-month (PMPM) basis. There are two health home rate codes: one for outreach and engagement and one for active care management. Because health homes will be paid a capitated payment, they have the flexibility to develop care teams that include non-medical staff. This gives providers an opportunity to hire and retain CHWs to serve in care management teams and assign CHWs to deliver a set of services required by health homes. Including CHWs in the teams and allowing them to assume roles that they are most equipped to do can free up clinical staff to focus on those roles that are specific to their professional license. Because CHWs typically are paid at a lower rate than medical professionals, assigning relevant tasks to them will reduce the total cost per member served by the health home.

Outreach and Engagement

The outreach and engagement PMPM will be available for three months after an individual is assigned to a health home by the Department of Health. Health homes must conduct active outreach and overcome the challenges of locating, enrolling, and engaging people with complex health and social needs. Active outreach is more than sending letters and making phone calls, which are often not effective for many of these individuals, particularly those with housing instability. Health homes must be able to conduct outreach at other care delivery sites, in community settings, and in people's homes. The PMPM payment allows health homes to hire CHWs to conduct this type of outreach and engagement, which is precisely what CHWs are best suited to do.

Active Care Management

Once a member is actively engaged and assigned to a care manager, a health home can begin to bill for the care management PMPM.⁵ Health homes must provide at least one of the first five core health home services per month (i.e., comprehensive care management; care

⁵ The payment process differs depending on whether the patient is currently a New York fee-for-service or managed care patient or if the patient is already assigned to an existing care management program (e.g., New York State Office of Mental Health Targeted Case Management, COBRA HIV/AIDS Targeted Case Management, Managed Addiction Treatment Services, Chronic Illness Demonstration Project).

Paying for CHWs in a Health Home *(continued)*

coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; and referral to community and social support services). Health homes must document that they are providing active care management to support billing, including face-to-face, mail, electronic, and/or telephone contact; patient assessments; development and, presumably, implementation of a care management plan; and active progress toward achieving patient goals. The PMPM payment allows health homes to configure their care management team with the most cost-effective team members. As noted above, CHWs are well suited for a number of the care management activities, and the PMPM payment can be used for CHWs to work as part of the care management team and provide select core services and/or support to care managers in providing these services. For example, CHWs can support the team's effort to implement a transition care plan for a person being discharged from a hospital. The CHW can provide follow-up support as the person transitions to his or her home and can facilitate follow-up visits with the primary care provider and/or any necessary social or behavioral health services.

Training CHWs for Health Home Teams

CHWs have long been part of the care delivery system in New York and across the country. To date, training has been a mixture of specialized, on-the-job training provided by the employer, usually a hospital, community health center, managed care organization, or a community-based organization. In certain cases, CHWs have received specialized training offered by local CHW networks or academic institutions as part of a community health degree program. This is particularly true in services targeting low-income and complex patients. These entities offer training programs that can be used to support incorporating CHWs into health homes. There are basic programs that train CHWs in a set of core competencies and roles, including outreach and engagement; patient assessment; care and service coordination; patient navigation; effective communication; and informal counseling and social support. These competencies align well with those roles required for health home patients and create the foundation for the on-the-job training CHWs will need to function in the health home-specific program. A list of organizations currently offering training for CHWs and/or care management programs is provided in the resource section of this report.



CHWs and Health Homes: Now Is the Time to Make the Connection

The development of health homes creates a unique opportunity to develop and implement care management models that meet the complex needs of high-need and high-cost patients. Incorporating CHWs into care management teams is an effective—and cost-effective—approach to achieving the goals of health homes. The roles and tasks CHWs perform already align well with the six core services required of health homes. There are also readily available training resources to support their inclusion. Additionally, the care management PMPM payments that support health homes provide an opportunity and the flexibility to hire CHWs without having to rely on unsustainable grant funding. Health home providers can leverage this opportunity to build effective models that include CHWs working as part of their care management teams. These models can help achieve the Triple Aim of better health, better care, and lower costs.

BRONX-LEBANON HOSPITAL CENTER COMMUNITY HEALTH WORKER PROGRAM

In Bronx-Lebanon Hospital Center's Community Health Worker program, 16 CHWs are integrated into care teams that include physicians and nurses to provide care management to high-risk, complex patients. For example, a CHW was assigned to Lillian,⁶ a 59-year-old woman who is part of the Home Bound Primary Care program due to her many medical conditions. Lillian has uncontrolled diabetes, hypertension, and asthma. She is also obese and bedbound due to an ulcer on the bottom of her foot that is taking a long time to heal. After her husband died in a car accident, she has struggled with depression. She lost her apartment and is living with her daughter and two small grandchildren who have also experienced housing instability.

Because of the unique role that CHWs play, the CHW is able to work with Lillian to manage the full range of her complex medical, mental health, and social issues. Over time, this has included helping her manage her medications, schedule appointments, navigate the health care system, secure stable housing, resolve Medicaid issues, arrange for transportation, and address food issues. The close relationship that the CHW was able to develop with Lillian also enabled her to attend to her feelings of hopelessness. The CHW gained Lillian's trust and was able to increase her motivation to address her medical conditions as well.

The CHW is a part of Lillian's care team and gives the team feedback on Lillian's status. The CHW helps the team continuously tailor their services and the care plan to Lillian's specific barriers to care. When the CHW meets with Lillian, she routinely discusses her medication use. In one instance, she discovered that Lillian was not taking her asthma controller medication as prescribed. Instead, she was discontinuing use as soon as her symptoms improved. The CHW helped her understand how to take the medication and why it was important to take it everyday. In the three months that the CHW has been working with Lillian, she has not had an asthma attack. The CHW also scheduled several appointments for her with various providers and arranged transportation for her to the appointments.

Although she still is learning how to manage her conditions, Lillian has come out of the deep depression she was in, her glucose level has improved dramatically, she is taking care of her infected foot, she has a healthier diet, and she wants to get out of her bed.

⁶ Name has been changed.

Resources

New York City Training Programs⁷

COMMUNITY HEALTH WORKER NETWORK OF NYC TRAINING PROGRAMS: The network offers a two-week CHW training program based on a standardized CHW scope of practice and the needs expressed by both CHW employers and CHWs themselves, <http://www.chwnetwork.org/resources-materials/chw-training.aspx?>

CITY UNIVERSITY OF NEW YORK: LaGuardia, Kingsborough, and Hostos Community Colleges have CHW training programs, which include CHW core competencies and other topics, <http://www.cuny.edu/academics/conted/PATH/healthcare.html>.

CHW Program Development Resources

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) OFFICE OF RURAL HEALTH POLICY'S COMMUNITY HEALTH WORKERS EVIDENCE-BASED MODELS TOOLBOX: Information on and resources for CHW models, <http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf>.

COMMUNITY HEALTH WORKER NATIONAL EDUCATION COLLABORATIVE: Information on CHW educational resources, services, curricula, promising practices, and delivery strategies, <http://www.chw-nec.org/>.

RURAL ASSISTANCE CENTER COMMUNITY HEALTH WORKERS TOOLKIT: Toolkit for developing a CHW program and links to other resources, <http://www.raconline.org/communityhealth/chw/module4/resources.php>.

Complex Care Management Resources

CALIFORNIA HEALTHCARE FOUNDATION'S COMPLEX CARE MANAGEMENT TOOLKIT: http://www.calquality.org/documents/CQC_ComplexCareManagement_Toolkit_Final.pdf.

INSTITUTE FOR HEALTHCARE IMPROVEMENT'S INNOVATION SERIES WHITE PAPER: "Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs:" <http://asmhc.org/members/a76/attachments/IHICareCoordinationModelWhitePaper2011.pdf>.

CARE MANAGEMENT OF PATIENTS WITH COMPLEX HEALTH CARE NEEDS: <http://www.thenationalcouncil.org/galleries/default-file/Care%20Management%20Synthesis%20Report.pdf>.

⁷ The training programs are local resources available in New York City. This is not an exhaustive list of resources, as there may be additional resources available that are not indicated here.

Appendix:

Sample CHW Health Homes Job Description

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his job description was developed for this paper based on input from CHW experts, publicly available CHW job descriptions, and health home requirements.

General Job Statement:

The Community Health Worker (CHW) will be an integral member of an interdisciplinary health home care management team. The CHW will work closely with health home patients, care managers, other care management team members, health care providers, social services providers, and community partners to effectively manage the care of designated health home patients.

Requirements:

- Conduct patient outreach and engagement activities to designated health home patients, including face-to-face, mail, electronic, and telephone contact.
- Conduct outreach and engagement activities that support patient continuity of care, including re-engaging patients in care if they miss appointments and/or do not follow up on treatment.
- Assist patients in completing patient consent forms.
- Conduct initial and periodic needs assessments, including assessing barriers and assets (e.g., transportation, community barriers, social supports); patient and family or caregiver preferences; and language, literacy, and cultural preferences.
- Support the development and execution of patients' care plans, including assisting patients in understanding care plans and instructions and tailoring communications to appropriate health literacy levels.
- Promote patient treatment adherence through assessing patient readiness to make changes; assisting patient in making changes to daily routines; identifying barriers; and assisting patients with developing strategies to address barriers.

Appendix *(continued)*

- Provide informal counseling, behavioral change support, and assistance with goal setting and action planning.
- Assist patients with navigating health care and social service systems, including arranging for transportation and scheduling and accompanying patients to appointments.
- Assist care managers in monitoring and evaluating patients' needs, including for prevention, wellness, medical, specialist, and behavioral health treatment; care transitions; and social and community service needs.
- Identify available community-based resources and actively manage appropriate referrals, access, engagement, follow-up, and coordination of services.
- Coordinate patients' access to individual and family supports and resources, including resources related to housing; prevention of mental illness and substance use disorders; smoking cessation; diabetes; asthma; hypertension; self-help/recovery resources; and other services based on individual needs and preferences.
- Provide support for chronic disease self-management to patients and their families.
- Coordinate access to the basic determinants of health (e.g., food, clothing, shelter, income, utilities).
- Use health information technology to link to services and resources and communicate among team members, providers, and patients and their families/caregivers.
- Collect and report on data for program evaluation.
- Provide information on patients to care managers, other care team members, and providers.
- Manually and/or electronically document activities and patient information and interventions in patient-tracking systems, care management software programs, and other program systems.
- Other duties as assigned.

Appendix *(continued)*

Qualifications:

- Direct experience with or knowledge of population or community to be served.
- Excellent oral communication skills.
- Ability to establish positive, supportive, and trusting relationships with and among patients and colleagues and to work collaboratively and effectively within a team.
- Ability to develop, adapt, and execute outreach plans.
- Knowledge of and ability to facilitate use of the health care system (e.g., primary care and specialty care linkages; appointment scheduling; laboratory and pharmacy services; medical interpreters; eligibility requirements; renewal/recertification; benefits; managed care).
- Knowledge of available social services and resources.
- Health education skills, knowledge of health promotion/wellness, knowledge of chronic disease prevention and management, and knowledge of health condition-specific treatment or management.
- Ability to collect and document data and information.
- Must be able to quickly develop proficiency in patient-tracking systems and care management software.
- Identify and apply appropriate role definition and skilled boundaries.

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