# Promoting Policy and Systems Change to Expand Employment of Community Workers (CHWs)

## Session 5: Sustainable Funding for CHW Positions

### Session Overview

The objectives for this session include:

- Identify sources of sustainable funding for CHW positions
- Identify issues facing employers making hiring decisions about CHWs
- Describe how to calculate a return on investment

### Audio Transcript

The objectives for this session include:

- Recall how short term funding keeps CHWs in silos
- Identify sources of sustainable funding for CHW positions
- Identify issues facing employers making hiring decisions about CHWs
- Describe how to calculate a return on investment

### Public Policy Arenas 4

Arenas of public policy affecting CHWs include:

- Workforce development
- Occupational regulation
- Standards for research and evaluation
- Sustainable funding for CHW positions

### Audio Transcript

Our third session on policy arenas focuses on financing. Numerous surveys of CHWs and other stakeholders in the field have found the lack of sustainable funding for CHW positions to be the biggest obstacle to further growth for the workforce.

We have noted in previous sessions that the current pattern of categorical short-term funding tends to keep CHWs in "silos" and limits the incentives for policy action in other areas. In this session, we will discuss the range of potential sources of sustainable funding for CHW positions. One possibility is that an employer may hire CHWs out of core budgets on the basis of anticipated return on investment. Because this mechanism for funding is one of the least understood, greater efforts are needed to educate and raise awareness among employers and other stakeholders.

Much discussion has centered on including CHWs in various provisions of the federal health-care reform act. We will review some of the opportunities for such funding embedded in this legislation.

### Short-Term Funding Keeps CHWs in "Silos"

The short-term, commonly non-renewable nature of project grants limits employers' interest in investing in CHW training and development and:

- Discourages long-term, holistic, patient-centered approaches
- Undermines development of CHW skills standards
- Makes CHWs identify with health issues, not their occupation
- Limits commitments to training, and career development
- Discourages CHWs from remaining in the field
- Leads to high turnover

### Audio Transcript

Currently, most of grants that support short-term projects employing CHWs focus on a specific health issue or condition and require a narrowly focused intervention with a specific population. This approach is at odds with the preference of most CHWs to work with families and individuals in a more patient-centered, holistic manner. It also does not help integrate CHWs into their employers' ongoing operations.

The tailoring of CHW positions to specific interventions and health issues tends to decentralize CHW training and make it specific to individual position requirements. As a result, establishing standards for core skills has been slow, and CHWs tend to identify themselves closely with a specific health issue and not with the broader CHW occupation—even though they may have a great deal in common with workers addressing other health issues.

The short-term, commonly non-renewable nature of project grants limits employers' interest in investing in CHW training and development. Why should an employer invest time and resources in staff members who will likely not be around after two or three years?

Furthermore, because CHW positions are treated as temporary and disposable, CHWs have incentive to consider other, more stable occupations rather than remain CHWs, so employers are faced with high turnover.

### Sources of Sustainable Funding for CHW Positions

If this pattern is to change, CHWs and other stakeholders will need to consider a variety of funding sources and structures. Sources of sustainable funding for CHW positions include:

- Employers who see CHWs as a good return on investment
- Third-party payers such as:
  - Medicare
  - Medicaid
  - Children's Health Insurance Program
- Mandates or incentives to state-funded providers

### Audio Transcript

If this pattern is to change, CHWs and other stakeholders will need to consider a variety of funding sources and structures. One major possibility, which has received relatively little attention, is within the budgeting process of health care employers themselves. A number of employers have found evidence that employing CHWs can enhance revenue and reduce costs enough to more than offset the cost of employing CHWs. Acceptance of this strategy, however, will require a major investment in educating employers and providing technical assistance to implement it.

The second major source of potential funding is large public programs working through third-party payers, such as Medicare, Medicaid, and the Children's Health Insurance Program. These programs can benefit from efforts to address a wide range of health conditions. All of them are under pressure to control costs, improve quality, and reduce or eliminate health disparities. The only obvious limitation in these sources for funding is that payments can be used only to serve beneficiaries of each program.

State governments also expend billions of dollars on various health and health care programs targeting specific populations and issues. Some of the funding for these programs comes from the federal government, and states can mandate that vendors employ CHWs or outsource CHW services in implementing program objectives.

### CHWs Classified as Providers for Billing Purposes

The American Medical Association (AMA) National Uniform Claim Committee:

- Maintains Health Care Provider Taxonomy code set
- Approved CHWs as a category in 2007 (code 172V00000X)
- Used CHW definition from HRSA's CHW National Workforce Study

### Audio Transcript

Before proceeding further, we should note that CHWs can already be classified as providers for billing purposes in public or private insurance programs. In 2007, the American Medical Association's National Uniform Claim Committee introduced CHWs as a category in its Health Care Provider Taxonomy. Interestingly, the committee used the same definition chosen by HRSA for the CHW National Workforce Study.

### CHW Financing Study

The CHW Financing Study:

- Is a landmark report on financing CHW positions
- Is the first and only systematic national study

**Audio Transcript**

Advancing Community Health Worker Practice and Utilization: The Focus on Financing is a landmark 2006 report on financing options for CHW employment produced by the National Fund for Medical Education, housed at the University of California, San Francisco's Center for the Health Professions.

This report is widely considered to be the first and only systematic study of the financing of CHW services on a national level. You can download a free copy using the web address on this slide.

The report includes a review of funding models, each with a different source and showing a range of mechanisms by which funding eventually reaches the CHW employer. The four main models are:

- Grants or contracts from federal or state government agencies
- Grants or contracts from charitable organizations
- Reimbursement or standard per-capita payment from public or private insurance groups
- Operating budgets of government general funds

Details of these and other models are summarized in a graphic on page nine of the report. The graphic is a bit too complicated to present in this training format, but it could be a useful reference as you study options for your state. In our last session, we will take an in-depth look at one funding example, the Minnesota Medicaid CHW reimbursement policy.

**Hiring Decisions of Employers**

The following are issues facing employers making hiring decisions about CHWs:

- Little is published on the budgetary rationale for hiring CHWs
- It is hard to get employers to accept CHWs as an employee category
- Different types of employers have different incentives and motivations
- Employers are best positioned to persuade their peers

**Audio Transcript**

As noted earlier, health care employers have always had the option of allocating funds from their budgets to hire CHWs, and some have done so. However, employers who have seen positive results from employing CHWs tend not to publicize the budgetary calculations that led them to continue and even increase their employment of CHWs.

A major educational effort may be needed to get employers who do not already budget for CHW positions simply to understand the nature of the CHW workforce, which, as we have said, is neither clinical nor administrative.

Also, because of the wide-ranging roles and functions of CHWs, the benefits received by the employing organization may take many forms. It is vitally important to recognize that different stakeholders in the system are motivated by different kinds of results. For example, CHWs show potential to reduce preventable hospitalizations. In talking to an

audience of hospital administrators, this may not be the most useful result on which to focus.

On the other hand, hospitals are under increasing pressure to reduce readmissions, and CHW services may well prove cost- effective for post-discharge follow-up. The benefits of potential cost reductions resulting from CHW activities may be felt only at the highest level of state government, so securing initiatives aimed at reducing costs in the system may require extraordinary leadership at high levels.

When communicating about the potential benefits of CHW services to various kinds of employers, it’s helpful to keep in mind that employers are most likely to be persuaded by the testimonials of other employers. In any effort to promote employing CHWs, it will be useful to recruit employers as champions.

### Cost-Effectiveness

Cost-effectiveness is determined by comparing two or more alternative interventions to determine which produces the most of the desired result.

For example:

- Determine the cost of added CHW services per additional low- birth-weight delivery prevented
- Compare this return with those of other interventions to prevent such deliveries

### Audio Transcript

Stakeholders may require evidence of two measures of the economic value of interventions involving CHWs: cost- effectiveness and return on investment.

Cost-effectiveness is determined by comparing two or more alternative interventions to determine which produces the most of the desired result, such as cases of disease prevented, for the least amount of added cost. In the example shown here, the desired result is to prevent or reduce low-birth-weight deliveries. Models of each intervention under consideration would be developed to estimate the total cost of each and how many low- birth-weight deliveries each prevented. The interventions would then be ranked in order of increasing effectiveness (total desired results) and compared on the basis of the marginal cost per additional result.

### Return on Investment (ROI)

ROI = Ratio of net return to added cost

Example

| | |
|---|---|
| Net return with CHWs | $200,000 |
| Cost of hiring CHWs | $100,000 |

(200,000 ÷ 100,000 = 2:1)

Return on investment is 2:1

For every dollar spent, 2 dollars are saved

### Audio Transcript

Return on investment or ROI, is a more straightforward calculation and appears to be discussed more often, because it is also easier to explain to decision makers. The net return is simply the estimated savings resulting from an intervention (or the estimated increase in a type of revenue) minus the estimated cost of the intervention. To calculate ROI, the net return is divided by the cost of the intervention.

In the example on the slide, net return attributed to employing CHWs is divided by the cost of hiring them. If a provider saves $300,000 as a result of the efforts of CHWs, and employing them costs $100,000, the net return is $300,000 minus $100,000, or $200,000. The return on investment is this net savings—$200,000—divided by the cost of the intervention—$100,000—for a return on investment of 2 to 1. In other words, for every dollar spent, two dollars were saved. The ROI is usually presented as a ratio with a colon as shown.

In a real-life example, one Texas-based hospital system calculated return on a CHW initiative to divert emergency department users to more appropriate sources of care. The calculation was based on total cost of care for the identified patients. One region saved more than $16 for every dollar spent on its CHW program.

### Calculating Return on Investment

When calculating a return on investment, the following things must be considered:

- What costs control is desired?
    - Uncompensated care?
    - Avoidable hospitalizations and readmissions?
    - Costs due to poor provider-patient communication?
- How can you enhance revenue?

- Qualify patients for coverage?
- Bring in more patients who have coverage?
- Reduce loss to follow-up?

**Audio Transcript**

We have noted that stakeholders are interested in different results depending on their type of organization and its goals. We will return to this topic in the final session, but it is important to realize that a significant return may mean different things to different people. You may want to consider different ways of calculating ROI for different stakeholders.

Some stakeholders may want to reduce uncompensated care, avoidable hospitalizations or readmissions, or other costs, such as additional diagnostic testing resulting from poor provider- patient communication.

On the other hand, increasing revenue is of interest to many providers, particularly community health centers. They may be interested in qualifying more patients for Medicaid or other coverage, attracting and keeping patients who have coverage, or reducing loss to follow-up.

### Other Sustainable Funding Sources

Other sustainable funding sources for CHW positions include:

- Direct employment or contracting for CHW services by payers or intermediaries
- State mandates or incentives to include CHWs in major, ongoing categorical programs
- CHWs as a class of providers under major public insurance programs
- Direct state appropriation
- Existing block grant programs
- Preparedness and disaster response

**Audio Transcript**

A number of potential strategies exist beyond the major funding sources already described.

Third-party payers or intermediaries may contract for CHW services from community-based organizations. For example, a Medicaid managed care organization in Rochester, New York, has successfully contracted for years with a community-based organization to provide CHW services in prenatal care. This same managed care organization is currently evaluating the results of similar contracting arrangements for asthma management.

A number of states contract with private firms to provide services to Medicaid beneficiaries. Some of these companies, on their own initiative, have developed strategies using CHWs to achieve the required results.

States and the federal government may also choose to mandate or provide incentives for contracting organizations to include CHWs in service delivery for major categorical

programs, such as Federally Qualified Health Centers and the Ryan White HIV/AIDS Program. Various studies have suggested that federally qualified health centers tend not to employ CHWs out of their core Section 330 funding. Relatively simple policy changes could establish employment of CHWs as a priority.

A more direct strategy could be simply to qualify CHWs as a class of providers under major public insurance programs. Senior Medicare officials at the Centers for Medicare and Medicaid Services, or CMS, have already indicated their willingness to consider such a proposal. Minnesota's experience, which we will discuss in the next session, illustrates the openness of Medicaid officials at CMS to such proposals. Federal Medicaid officials have sponsored demonstrations in 20 states on strategies to divert frequent users of emergency rooms to more appropriate sources of care. Most of these demonstrations involve CHWs in some capacity. CMS Medicaid officials have encouraged these 20 states to look at the Minnesota strategy as an example of how to employ CHWs in such efforts.

Less attention has been given to state-funded efforts to engage CHWs in public health. For a number of years, Kentucky and New Mexico have funded CHW positions for categorical programs out of general state revenues. The Kentucky Homeplace program was recently terminated because of across-the-board state budget cuts, but for several years it was the largest single state appropriation for CHW services in the country. CHWs in the program helped people in Appalachian counties access health care and other services. The New Mexico Healthy Start program received state appropriations for several years, and when an attempt was made to terminate the program's funding, a groundswell of public opinion compelled legislators to restore the funding.

States and localities have the flexibility to use block grant funding to employ CHWs for a variety of purposes. A recent special funding effort for Social Services Block Grants in the area of Texas affected by Hurricane Ike resulted in the short- term employment of more than 100 CHWs, some of whom continued to work for the grantee organizations after the funding ended.

Preparedness efforts are a relatively untried area for support of CHW positions. Various commentators, including CHWs, have noted that the impact of disasters like Hurricane Katrina might have been mitigated if CHWs had been better integrated into preparedness and disaster response efforts. In many low- income communities, individuals and families maintain their fragile existence only with the help of formal and informal social networks. An event such as a hurricane can completely disrupt these social arrangements and cause emotional and social disruption on a major scale. If CHWs played a role in disaster response, including emergency communications, some of this disruption could be avoided.

Recent research has shown that many community residents do not trust official communications from government agencies in emergencies. CHWs, teamed with first responders, can direct relief efforts to the most vulnerable individuals in a given community.

### Support of CHWs Under Federal Health Care Reform

Support of CHWs under Federal health care reform includes:

- National Health Care Workforce Commission (§5101)—includes CHWs as primary care professionals
- Grants to Promote the Community Health Workforce (§5313)—CDC grants:
  - To promote positive health behaviors and outcomes
  - In medically underserved communities

### Audio Transcript

The 2010 federal health care reform legislation, called the Patient Protection and Affordable Care Act or ACA, explicitly mentions CHWs in several places, and other provisions appear to suggest roles for CHWs. In recent conference presentations, several senior administration officials have offered extensive lists of the Affordable Care Act sections appropriate for CHW involvement. We will briefly review some of the more promising ones.

This slide and the next two highlight three areas in the legislation that specifically mention CHWs.

The Affordable Care Act discusses the need to increase the supply of qualified primary care professionals, including CHWs, to meet the needs created when increasing numbers of Americans obtain health insurance coverage. The Secretary of Health and Human Services has appointed a National Health Care Workforce Commission to create a national strategy for addressing this issue. One of the Commission members is a CHW herself, indicating that the administration is taking this part of the workforce very seriously.

For CHWs, one of the most promising sections of the act is the provision for grants to employ CHWs "to promote positive health behaviors and outcomes." This funding is to be awarded by CDC, but the Affordable Care Act does not directly appropriate funds for such grants.

### Support of CHWs Under Federal Health Care Reform (Cont.)

Support of CHWs under Federal health care reform includes:

- Area Health Education Centers (§5403)—CHWs added to mandate for interdisciplinary training
- Hospital Readmission Reduction (§3025)—high potential for CHW role
- Patient-Centered Medical Homes (§3502)—CHWs as part of "community health teams"
- Patient Navigator Program (§3509)—HRSA heavily favors employing CHWs
- Maternal, Infant, and Early Childhood Home Visiting Programs (§2951)—grants to states

### Audio Transcript

Area Health Education Centers, or AHECs, operate in 46 states and are charged with workforce development to meet needs in medically underserved areas. A number of

AHECs have been engaged in training and other services related to the CHW workforce for many years. In Massachusetts, for example, the AHEC program operates one of the key programs for CHW core skills training. Before the ACA, the AHECs did not have an explicit mandate to address the CHW workforce. The act includes a mandate for AHECs to include CHWs in the "interdisciplinary training of health professionals."

One section of the ACA deals with the cost of hospital readmissions. Although CHWs are not mentioned explicitly, they could have a role in these initiatives, particularly those concerning admissions related to chronic conditions.

The ACA also provides for creating "community health teams" in support of patient-centered medical homes. Again, CHWs are not mentioned in the legislation, but language about them could be inserted in state-level planning for implementation of this section.

The ACA reauthorizes grants under the Patient Navigator Program, created by law in 2005. A first round of grants under this legislation was funded in 2008, and HRSA solicited proposals for a new round in June 2010. Only nine local grants were to be awarded in 2010, so this program will not have an impact in most states.

One section of the act authorizes grants to states for prenatal and perinatal home visiting programs. This funding announcement has been implemented, so any efforts to include CHWs will need to be made at the state level.

### Opportunities in State Planning to Promote Employing CHWs

Opportunities in state planning to promote employing CHWS include:

- Standards for patient-centered medical homes and community health teams
- New models for global payment, pay for performance, and accountable care organizations
- Rules for medical loss ratios
- Standards for preventive care benefits

### Audio Transcript

With implementation of expanded health insurance coverage under the ACA come many opportunities to advocate for CHW services. Many sections of the ACA require state-level planning for implementation, and this phase is already under way in most states. This planning process affords an excellent opportunity for discussing potential CHW roles. We have mentioned initiatives to reduce hospital readmissions and the community health teams serving medical homes, but other opportunities exist.

Most states are looking at new models for global payment, pay for performance, and accountable care organizations. In the ongoing discussion about regulating health insurance companies, debate continues on requirements for minimal levels of "medical loss ratios," or the percentage of insurance premiums that are paid out in medical costs. Part of this debate is whether to classify the cost of efforts to improve the quality of health care as provision of care or as administrative services. CHW services may well fall within the rubric of quality improvement initiatives. Finally, the entire range of benefits to be required from health insurance plans, but especially preventive care, is

still under debate. There may be an opportunity to inject the role of CHWs into these discussions.

### Session Summary

The takeaways for this session include:

- Health care employers can justify hiring CHWs on the basis of return on investment
- Major third-party sources (e.g., Medicaid, Medicare) are open to proposals to reimburse for CHW services
- Important opportunities exist to integrate CHWs into implementation of the Affordable Care Act

### Audio Transcript

Consider for a moment what you take away from this session. Possibilities include:

- Health care employers can justify hiring CHWs on the basis of return on investment
- Major third-party sources such as Medicaid and Medicare are open to proposals to reimburse for CHW services
- Important opportunities exist to integrate CHWs into implementation of the Affordable Care Act

In our final session, we will look at the process of policy and systems change and at what we have learned from experiences in two leading states, Minnesota and Massachusetts.

Thanks for participating!