Community Health Workers in a Post-Health Care Reform Era: The Current Practice in MA Community Health Centers

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- Devoted to practical application of research to improve health and well-being.
- Focuses on social determinants of health in urban settings, promotion of health equity, and elimination of health disparities.
- Investigates five key interest areas including health care and payment reform.
CHW Project Background

• **Funding**: Blue Cross Blue Shield Foundation of Massachusetts; additional support from MA DPH

• **Purpose**: Assess current status of CHW 7 years into HCR with attention to:
  - Impact of payment reform
  - Creation of Board of Certification

• **Target**: Assess viewpoints and Practice of Primary Care Providers and Insurers

• **Guided by**: CHW advisory group & MACHW
Research Methods

• Surveyed CHC & BC/BS grantees statewide
  – Online survey distribution to 50 CHCs and a sample of BC/BS sites
  – Supplemental interviews with CHCs and BC/BS sites

• Respondents
  – Executive Directors/Presidents
  – Chief Medical Officers/Medical Directors

• Additional interviews with insurers
Phase 1 – CHC Survey Methods

- CHWs defined using the MDPH/Board functional description
- Multiple choice and narrative questions posed via survey
- Survey deployed over 6 weeks with follow-up by research staff
- **Results**: 70% of CHCs respond with representation from each region (35 CHCs)
RESULTS
CHCs routinely employ CHWs

- 91% currently employ one or more CHWs
- Respondents hire more full time than part time CHWs
- Number of CHWs per site:
  - Full time average = 5.3 (range 0-15)
  - Part time average = 0.9 (range 0-4)
Who are the CHWs?

- Community members, not RNs, social workers, or other health professionals
- 97% unlicensed (neither US nor foreign-trained licensees)
What are CHW roles?

- Health education/information 58%
- Case management 45%
- Linkages to community-based resources 29%
- Translation/Interpretation 29%
- Insurance enrollment 26%
## Top CHW Functions in Chronic Disease

<table>
<thead>
<tr>
<th>Chronic Disease Functions</th>
<th>% of CHCs reporting function</th>
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<tbody>
<tr>
<td>Chronic disease self-management training</td>
<td>75%</td>
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<tr>
<td>Behavioral/lifestyle coaching</td>
<td>54%</td>
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## Top Condition-Specific CHW Functions in Chronic Disease

<table>
<thead>
<tr>
<th>Chronic disease conditions:</th>
<th>% of CHCs reporting function</th>
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<tbody>
<tr>
<td>Diabetes</td>
<td>46%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>39%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>39%</td>
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Do CHWs interact with Primary Care teams?

• 83% regularly receive patient referrals from primary care staff
• 72% meet regularly with the primary care staff
• 52% provide interpreting services for the primary care team
Assessment of Value of CHWs
86% are confident that trained CHWs add value to CHCs

• Most valuable outcomes through:
  – Access to services/care  72%
  – Health system navigation  59%
  – Health education/outreach in community-based settings  59%
  – Direct services (counseling, social support, care coord.)  55%
CHWs greatest value: high cost and high risk patients

- 86% of CHCs reported CHWs improve health outcomes for high cost/risk patients (vs. 66% for non-high risk)
- 80% of CHCs reported CHWs reduce cost of care for high cost/risk patients (vs. 66% for non-high-risk)
- 69% of CHCs CHWs prevent high cost/risk conditions
How are CHWs trained?

• Current training
  – 34% of CHCs require formal external training for CHWs
  – An additional 48% of CHCs may require depending on skill level of candidate
  – 79% provide ongoing in-house training

• Training sites – In-house most commonly mentioned with CHEC second
What impact will the Board of Certification have?

• 39% report that Certification would increase likelihood of hiring a CHW
• 61% don’t see Certification as increasing the likelihood of hiring a CHW

• Comments:
  – “with proper local training, we’ve done well”
  – ‘we train them in-house due to language capability”
  – “community experience” is what counts
What is the source of funding?

• CHWs mostly grant-funded (min. 55%)
• Some funded by core operating funds (min. 14%)
• Small number by global insurance payments (min. 3%)
• 69% say transition from fee-for-service to global payments will make CHW use more feasible
What are the challenges faced?

• By far, #1 reason = lack of funding
• 79% would likely hire another full time CHW if insurance reimbursed
• Other issues: Lack of clarity about function with PC team (16%), lack of training (13%) and lack clarity about value (10%) mentioned but by fewer and as less significant issues
Summary of Findings

• CHWs are now routine members of CHC staffing often linked to PC providers
• Virtually all are unlicensed; with on-site and external training
• Funding sources remain largely grants but change possible with payment reform/core
• Many tasks provided; greatest value seen in serving high cost/high risk patients
• Certification seen as valuable to some but most like current hiring and training arrangements
Future research…

- What are the insurers thoughts and plans?
- What areas have potential for expansion, such as behavioral health?
- What are best practice models for integration into PC teams?
- What evidence exists to confirm impact on high cost/high risk patients?
- Will payment reform and the Board of Certification expand use over time?