# Integrating Community Health Workers in Ohio's Health Care Teams

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# EXECUTIVE SUMMARY

**Health care reform over the past decade has dramatically changed the ways in which Americans receive care. From the federal Affordable Care Act to statewide changes across the country, increased momentum has steered health care reforms toward improving the health disparities of populations that have struggled more than most.**

Overcoming health disparities requires addressing the social determinants of health. Community health workers (CHWs) are a proven strategy for addressing the social conditions that impact health outcomes and are being used across the country to improve population health and address health disparities.

**In our review, we found four conditions critical to creating a supportive environment for hiring CHWs and integrating them on health care teams.**

**FOUR CONDITIONS TO SUPPORT CHWS**

- **Standardized scope of practice**
- **Training and certification for CHWs**
- **Training for licensed providers on how to use and pay for CHWs**
- **Sustainable financing**

This report will address these four areas by highlighting the benefits of CHWs, defining CHWs and their scope of practice, describing the return on investment and positive patient outcomes yielded from CHWs, providing an overview of training programs for certified and non-certified CHWs as well as for providers, and reviewing payment models for CHWs. This report provides an overview of CHWs in Ohio and provides examples of other states that have adopted innovative strategies in the four areas.

This report is not intended to be a statewide assessment of CHWs. More research will be needed to uncover the hard data on exactly how many CHWs, both certified and non-certified, there are in Ohio, where these CHWs are employed, which health care settings are utilizing them the most, and what health care settings are not using them.

CHWs are frontline public health workers that have a close understanding of the community being served. They are often members of the communities they serve and, as a

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result, are uniquely positioned to serve as liaisons between health and social services for the people in need of such care. Their ability to facilitate access to services that extend beyond health care, in addition to overcoming social, cultural, and linguistic barriers to accessing quality health care, has improved the quality and cultural competency of service delivery to traditionally underserved populations.

In Ohio, CHWs are called by many titles and used in many different settings. Both non-certified and certified CHWs provide services to Ohio's population. In Ohio, Certified CHWs hold a certification from the Ohio Board of Nursing (OBN). To be certified, a CHW must have a high school degree or equivalent and complete one of the twelve OBN-approved training programs. According to the Ohio Board of Nursing, as of May 2016, there were 341 active, certified CHWs in Ohio.[1] The CHW role was created from models like Promotoras (a model for training community lay health educators to work in Hispanic communities) and peer educators (lay people trained to provide health screenings and provide health promotion activities). As a result, many CHWs in Ohio and across the country do not receive formal academic training and are not certified. Instead, their training may come from their employer and is based on the roles they play within their organizations. In Ohio, there are a number of CHWs with various titles trained by their organizations or by programs that train certain groups of CHWs for roles specific to their patients/clients. The number of these non-certified CHWs in Ohio is unknown. However, the Bureau of Labor Statistics reported that there were 590 CHWs and 1,810 health educators in Ohio as of May 2015.[2]

**"One of the challenges to improving Ohio's training and certification process is creating a process that includes all of Ohio's current CHWs and the roles they play in our health care system."**

One of the challenges to improving Ohio's training and certification process is creating a process that includes all of Ohio's current CHWs and the roles they play in our health care system. The report outlines some recommendations for addressing this challenge including a tiered process and grandfathering, both discussed later in the paper and in the recommendations.

Financially, the return on investment for CHWs is considerable, making them a wise investment for providers, particularly those working with populations with high health disparity rates. Several studies have found that CHWs are cost-effective — sometimes dramatically so. One randomized, controlled trial for pediatric asthma cases found that the return on investment for the CHW intervention was $1.90 for every $1 invested.[3] Another study found that by shifting urgent and inpatient care to primary care using CHWs, the return on investment was $2.28 for every $1 invested.[4] Their effectiveness in improving health outcomes is also significant.

CHWs have demonstrated significant improvements in key patient outcomes in treating diabetes, cardiovascular disease, asthma, premature births, and

musculoskeletal health as outlined in the return on investment section of the report.

## Yet in spite of CHWs' high yields on investment, few Ohio providers use them.

**Our research led us to focus our review on two key areas for increasing utilization by Ohio providers:**

**Provider training**

**Sustainable reimbursement**

Training for providers is critical to improving acceptance of CHWs by licensed professionals and the integration of CHWs on health care teams. For example, many providers here in Ohio don't know about CHW high rates of return on investment or the roles they can play on health care teams in helping patients achieve health outcomes and addressing health disparities. Ohio lacks a standardized method for training health care providers on how to use CHWs. States that have standardized training and credentialing for CHWs, coupled with training for providers and standardized reimbursement methods, report increased utilization of CHWs. In our

review, we spoke to representatives from CHW credentialing programs in other states with standardized training and certification programs and some that have standard payment mechanisms in place. All agree that provider education is critical. In fact, a key recommendation for fostering an environment supportive of CHW integration from the Center for Disease Control is to educate (privately and publicly funded) groups of health care providers on the roles that CHWs can play, how CHWs fit into the Ohio Comprehensive Primary Care (CPC) model, formerly the Patient-Centered Medical Home (PCMH) model and how to engage community-based organizations that employ CHWs.[5]

**The Ohio Comprehensive Primary Care (CPC) Delivery and Payment Model is charged with promoting high-quality, individualized, continuous, and comprehensive care.**

In order to ensure that high-quality care is available in populations where it is most difficult to deliver, CHWs must play an integral part in the CPC model. Ohio's emerging CPC model is an excellent place to begin to educate providers on the role of CHWs and expand their use as part of CPC health care teams. Ohio's CPC model could be greatly enhanced by providing standardized training for these providers that demonstrated how CHWs can pay for themselves and included information on roles they can play on the health care team and how they can increase cultural competency, bridge cultural gaps, and address health disparities.

**Finally, the biggest challenge for expanding the use of CHWs continues to be the question of how to pay for them**.

Specifically, providing reimbursement for CHW services is a challenge because of a lack of sustainable funding. Primarily, resources to fund CHWs are available through a variety of federal, state, local, and private grants. However, some states are integrating CHWs into operating budgets for Medicaid using Medicaid 1115 waivers, State Plan Amendments (SPA), and state budgets. CHWs also receive funding through community-based organizations, hospitals, clinics, private insurers, and nonprofit organizations. Additionally, some states have created codes that allow for reimbursement of CHWs out of capitation rates.

In Ohio, CHWs are mostly paid for out of grant dollars with a few notable exceptions. For example, Medical Technical Assistance and Policy Program (MEDTAPP) grants fund training programs for CHWs, and these training programs use some of their dollars to contract with Federally Qualified Health Centers, local public health departments, hospitals, primary care practices, and community-based organizations to hire CHWs. Some local community-based organizations have been successful in identifying local, state, and national grants to hire CHWs. Pathways Community HUBs[6] have been successful in attracting and pooling public and private dollars to fund the services of CHWs. However, these funding sources are not permanent solutions to the reimbursement challenge.

**Our review on CHWs in Ohio revealed four major areas to support:**

- Standardized scope of practice
- Training and certification for CHWs
- Training for licensed providers on how to use and pay for CHWs
- Sustainable financing

**If enhanced, these areas would create a more supportive environment for CHW integration on PCMH health care teams and health care teams in other settings here in Ohio.**

The following recommendations focus on all four of these areas.

# KEY RECOMMENDATIONS

1. The Ohio Department of Health and the Ohio Board of Nursing works with the Ohio Association of Community Health Workers (OCHWA), Pathways Community HUBs, Medicaid Technical Assistance and Policy Program (MEDTAPP) training centers, and The Ohio Colleges of Medicine Government Resource Center to further define and standardize the roles and scope of work for certified and non-certified CHWs.

2. The Ohio Board of Nursing works with the Ohio Community Health Worker Association (OCHWA), ASIA Inc., the Ohio Hispanic Coalition, MEDTAPP Training Centers, Pathways HUBs, and the Ohio Commission on Minority Health to implement a tiered process that would allow for certification for the various roles CHWs may play in Ohio.

3. The Ohio Board of Nursing works with the Ohio Community Health Worker Association (OCHWA), ASIA Inc., the Ohio Hispanic Coalition, MEDTAPP Training Centers, Pathways HUBs, and the Ohio Commission on Minority Health to develop and adopt a grandfathering process for current certified and non-certified CHWs that gives credit for work and life experiences.

4. The Ohio Department of Medicaid includes language in their CPC design recommending primary care providers in the program to include CHWs as part of their care teams and allows for reimbursement for CHW services using codes and other reimbursement mechanisms.

5. Funding increases for Pathways HUBs are included in the Ohio state budget, and reimbursement of CHWs is included in the Ohio Department of Medicaid SIM grant CPC design.

6. The Ohio Department of Medicaid, managed care plans, Ohio's private insurers, and provider associations provide education and training to increase provider understanding on CHW roles, benefits, return on investment, and reimbursement methods.

7. The Ohio Department of Health and the Ohio Colleges of Medicine Government Resource Center implement a statewide capacity assessment to provide a more accurate picture of how many certified and non-certified CHWs are in Ohio, how many are employed, how many remain unemployed, what health care settings are using them and which ones are not, and what and how they are being paid.

# INTRODUCTION

**Health is an essential aspect of community vitality, yet the health of our nation is failing in many aspects, especially for our most underserved populations.**

In response to this truism, and as a result of the Affordable Care Act, our nation is undergoing the most sweeping health care changes in decades. These changes hold the promise for improving health care outcomes for patients, as well as lowering costs and making the delivery of care more efficient. With the changing dynamics of the health care system, we are now presented with an opportunity to reimagine the health care workforce and how we engage those from underserved populations in improving their health. Community health workers (CHWs) are a proven strategy for addressing the social conditions that impact health outcomes and are being used across the country to improve population health and address health disparities. Defined as frontline public health workers that have a close understanding of the community being served, CHWs are uniquely positioned to serve as liaisons between health and social services for the people in need of such care.[7] Often, they are members of the community they serve. CHWs are therefore uniquely capable of eliminating health disparities by facilitating access to services and improving the quality and cultural competency of service delivery. CHWs have long been effective in reaching traditionally underserved populations whose needs extend beyond mere treatment. All of these traits make CHWs uniquely positioned to overcome social, cultural, and linguistic barriers that have historically been difficult obstacles to overcome in health care delivery. The versatility of CHWs makes such obstacles manageable in a cost-effective manner.

**The Bureau of Labor Statistics reports that there were 590 CHWs as of May 2014, and 1,810 Health Educators as of May 2015 in Ohio.[8] [9] According to the Ohio Board of Nursing, as of May 2016, there were 341 active certified CHWs in Ohio.[10]**

**This report seeks to highlight the benefits of CHWs by:**

- Defining CHWs and their scope of practice
- Describing the return on investment and positive patient outcomes yielded from CHWs
- Providing an overview of training programs for certified and non-certified CHWs
- Describing provider training
- Reviewing payment models for CHWs in Ohio and select states

This report is not a comprehensive statewide assessment of CHWs. More research is needed to uncover just how many CHWs there are in the state of Ohio, how many are employed, which health care settings are using them and which ones are not, and what they are being paid.


## DEFINITION OF COMMUNITY HEALTH WORKERS

The concept of a community health worker has been in existence for at least 60 years "as one strategy to address the growing shortage of health workers, particularly in low-income countries."[11] At its broadest, a CHW is an overarching term that encompasses a variety of paid and volunteer health aides providing basic health information and services throughout the world. A sampling of the many titles used to describe a CHW include such varied descriptors as worker, navigator, educator, manager, advocate, concierge, assistant, specialist, advisor, promotora, and doula. A list of CHW titles can be found in **appendix I.**

In 2006 the American Public Health Association (APHA) defined CHWs, including Promotores de Salud, Community Health Representatives, Community Health Advisors, and related titles, as follows:

**A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.[12]**

As a consequence of APHA defining the role of a CHW and advocacy efforts, the U.S. Department of Labor recognized CHWs as a standard occupation classification in January 2010.

# SCOPE OF PRACTICE

**In Ohio, the scope of practice is not clearly defined within the Ohio Board of Nursing (OBN) certification process. The core competencies set out by the OBN provide information on the types of skills on which CHWs receive training.**

However, most of the information on CHW roles is found in their respective job descriptions. This lack of defined scope can add to the confusion for those interested in hiring CHWs and determining how to use them. **Ohio could benefit from a central set of core roles for CHWs that those employing CHWs could use when integrating them in their health care teams.**

A CHW may work alone, as a member of a health care team, or as part of an organization's outreach and education efforts. Work settings may include non-profit organizations, clinics, and mobile settings like going door to door/making house calls, meeting clients in public places like libraries, street outreach, and working community events such as health fairs. Common employers include local public health departments, Federally Qualified Health Centers, and other community clinics, social service organizations, managed care plans, and hospitals.

## Common roles for CHWs include:

**Clerical:** Outreach for appointments with reminder calls, confirmation of a means of transportation to the appointment, and general follow-up afterwards.

**Educational:** Providing key information about a health concern, such as chronic disease management, and recommended action steps.

**Clinical:** Providing preventive services or services aimed at slowing the progress of chronic diseases as long as these services are initiated by a licensed provider, e.g. taking vitals and reason(s) for a person being seen by the medical provider, health screenings, and interpreting medical terminology.

**Hospital:** Assisting patients in their transition back to their homes and reducing the possibility of a re-admission to the hospital.

**Insurance Navigation:** Helping individuals and families enroll in health insurance and link to other health services and low-cost financial resources to pay for needed health services.

**Referral:** Connecting an individual and their family with available resources.

Roles and duties vary depending on the setting in which the CHW is working. The roles CHWs fill are as diverse as the populations they represent and for whom they advocate. Thus, their scope of work can be considered quite broad, as it can range from clerical tasks to interpreting to basic clinical skills.

## Common activities for CHWs include:

- Assisting individuals and communities to adopt healthy behaviors
- Bridging and providing cultural mediation between communities and health and social service systems that promote, maintain, and improve individual and community health
- Providing social support and informal counseling
- Ensuring people get the services they need
- Providing direct service, such as basic first aid and administering health screening tests
- Advocating for individual and community needs
- Providing culturally appropriate health education and information on available resources through outreach in community-based settings, such as homes, clinics, schools, shelters, local businesses, and community centers
- Building individual and community capacity, including collecting data to help identify community health needs
- Developing community projects to address health and social needs, like community gardening projects, exercise programs, and chronic disease self-management programs

For more information on roles and responsibilities for CHWs see **appendix I.**

**In Ohio, the salary for CHWs varies depending on the setting they work in and the role they play and generally ranges from $12.00-17.00 per hour.**

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# RETURN ON INVESTMENT AND HEALTH OUTCOMES

**The benefits to including CHWs on health care teams are many, and the return on investment is great. The return on investment accrues in improved cost effectiveness and in improved health outcomes. Educating providers on return on investment is critical in gaining broader acceptance of this workforce by Ohio health care providers.**

Our review showed that financially, the return on investment for CHWs is considerable when used in the treatment of chronic diseases, and CHWs have been shown to decrease the total cost for primary care practices. For example, several studies have found that CHWs are cost effective—sometimes dramatically so. One randomized controlled trial for pediatric asthma cases found that the return on investment for the CHW intervention was $1.90 for every $1 invested.[13] Compared to the standard asthma treatment control group, the CHW intervention saved the hospital $1,340.92 per patient.[14] Another study found that by shifting urgent and inpatient care to primary care using CHWs, the return on investment was $2.28 for every $1 invested.[15] In this program, the CHW program resulted in a monthly savings of $14,224 and an estimated savings of $96,000 annually.[16] Other return on investment studies found as much as $8 for every $1 invested for case management and reinforced education from CHWs.[17] [18]

The University of New Mexico conducted research on the savings of their Integrated Primary Care and Community Support (I-PaCS) Model, a model using CHWs to work in primary care practices to address individuals' medical and social needs. These I-PaCS showed substantial cost savings for primary care settings that use CHWs. They anticipate that practices using their model save more than 3% in the first year, as compared to less than 1% for PCMHs in the first year, and more than 7% to 1% by the third year.[19]

Researchers at the University of New Mexico also investigated the impact of CHWs providing community-based support services to high consumers of health resources in a Medicaid managed care system.[20] A sample of 448 enrollees were assigned to field-based CHWs in 11 counties. Across the board, there were significant reductions in the number of claims and payments after the CHWs had engaged the patients.

**The difference in cost from six months before to six months after the CHWs had engaged the patients was considerable:**

| | |
|---|---|
| Emergency Department | $425,551 |
| Inpatient | $872,694 |
| Non-narcotics prescriptions | $699,129 |
| Narcotics prescriptions | $42,091 |
| **TOTAL:** | $2,039,465 |

**THE RESULT: $2,039,465 less following intervention by a CHW.**

**“Educating providers on return on investment is critical in gaining broader acceptance of this workforce by Ohio health care providers.”**

The effectiveness of improved health outcomes is noteworthy as well. CHWs have demonstrated significant improvements in key patient outcomes in treating diabetes, cardiovascular disease, asthma, and premature births. First, a randomized controlled trial for a CHW diabetes management intervention in Latino populations found A1C levels significantly decreased by 0.42% at 3 months, 0.47% at 6 months, and 0.57% at 12 months.[21] Similarly, another study found that A1C levels dropped from 10.3 to 7.2 after 3 months after increasing access to diabetes supplies through CHW efforts.[22] CHW interventions have also shown positive results with cardiovascular disease outcomes. In 2015, the Community Preventive Services Task Force found “strong evidence of effectiveness for interventions that engage CHWs in a team-based care model to improve blood pressure and cholesterol in patients at increased risk for CVD.”[23] Studies have also found that CHW intervention resulted in significant decreases in blood pressure among African-Americans,[24] in 53.2% lower mortality rates from hypertension,[25] and to significant increases in appointment-keeping for hypertension care.[26] Finally, a study on asthma management with CHW intervention found significant increases in asthma trigger reduction behaviors (when resources were available), significant decreases in asthma symptoms, significant decreases in caregiver depressive symptoms, and significant decreases in urgent care and ER utilization.

## Positive results such as these can help drive provider investment in CHWs.

# TRAINING FOR COMMUNITY HEALTH WORKERS

**Community health worker training and certification is key to successful integration of CHWs in the health care team and is linked to financing for them. Fifteen states, including Ohio, have instituted training and certification programs for CHWs, according to the National Academy for State Health Policy.**

States that have standardized training and credentialing for CHWs coupled with training for providers and standardized reimbursement methods report increased utilization of CHWs.

## Certified Community Health Worker Training Programs In Ohio:

In Ohio, certified community health workers hold a certification from the Ohio Board of Nursing (OBN). Sections A, C, D, and E of 4723-26-13 of the Ohio Revised Code outline the competencies for standard minimum certified CHW curriculum:

*Curriculums must include a minimum of one hundred hours of didactic classroom instruction and one hundred thirty hours of clinical experience. Relevant laboratory experiences may be integrated into the curriculum and include course content and expected outcomes, relative to the defined role of the CHW in the following major areas: 1) Healthcare including expected competences in the following areas: physical, mental, emotional and spiritual impacts on health, basic anatomy and physiology of major body systems; substance use and effects on health; signs indicating change in a client's health status; obtaining accurate vital signs; basic cardiopulmonary resuscitation skills; medical terminology; documentation methods and utilization of local health and referral systems; 2) Community resources; 3) Communication skills; 4) Individual and community advocacy; 5) Health education; 6) Service skills and responsibilities. Students participating in a clinical practicum in a community setting shall be supervised by qualified instructional personnel employed by, or under contract with, the CHW training program. CHWs must complete 15 clock hours every two years to maintain their certification.*[27]

In order to be certified through the OBN, a person must be a high school graduate or equivalent and complete a training program from one of the twelve OBN-approved, certified CHW training programs around the state.[28] These certified CHW training programs are based on the above core competency requirements and are primarily located in academic institutions, community colleges, and universities.

There are twelve OBN-approved training programs (see **appendix II** for list) ranging from 10 weeks to 6 months in length, including anywhere from 75 hours to 251 hours of didactic training, and 130-180 hours of practicum/clinical training hours, and ranging in cost from free to over $800.00. All of the OBN-certified programs offer a combination of class and practicum/clinical experience in

health or community-based settings. There is great variation on how Ohio's CHW training programs address the core competencies set forth by the OBN. However, an examination of nine of eleven programs revealed some trends in training topics. Most programs include anatomy, information on community resources and how to link clients to appropriate resources, client advocacy and support, cultural diversity/sensitivity, medical terminology, CPR and basic life support, interviewing, and data collection.

For example, the Cincinnati State Technical and Community College CHW Program focuses on interviewing, data collection, obtaining vital signs, mentoring, client advocacy, referrals to community resources, promoting basic health, working with culturally diverse clients, and community organization. Mercy College of Ohio in Toledo's key focus areas include medical terminology, cultural diversity, basic life support and first aid, academic success strategies, community health-specific topics such as advocacy, referral processes, documentation, and skills to complete home visits, as well as practical experiences in area community health settings. The Ohio State University's program includes nineteen different key focus areas including the impact of culture and socioeconomic status on individuals' health, communication, barriers to obtaining health care services, community resources, the relationship between culture and individual health, community health models documentation, health disparities, and navigation of clients' social and health care systems.

## Highlighted Ohio Programs:

Care Coordination Systems (CCS) was the first OBN-approved program. They offer both credit and noncredit programs. They have a noncredit program through CCS and a credit program housed at North Central State College. CCS was founded by Mark and Sarah Redding. Originally called Community Health Access Partnership (CHAP), the Reddings' program was instrumental in establishing CHW credentialing in Ohio and across the country. The OBN competencies are based on their model. Today CCS uses the Pathways HUB training model developed by the Reddings. This outcomes-based intervention approach is nationally recognized and an Agency for Health Research and Quality (AHRQ)-approved strategy based on community-wide accountability and payment for outcomes. The Pathways model trains CHWs to deliver a certain set of interventions designed to improve outcomes around specific health conditions. For example, there are a set of interventions designed to improve full-term delivery and Pathway interventions to address diabetes. Through this model CHWs are placed in HUBs, community-based programs that coordinate care for a specific geographic area and contract with health systems and providers in that geographic region. These CHWs use the Pathways model to work on health issues specific to the populations and communities in that particular region. Over the past 2 years, CCS has trained over 250 individuals.

Based on this model Ohio now has 6 Pathways HUBs operating in different parts of the state. For a list see **Appendix III.**[29]

Wright State University is focusing both on CHW training and provider training. The Center for Healthy Communities at Wright State works closely with the Ohio Association of Community Colleges to encourage more schools to offer OBN-approved CHW curricula. For every CHW training program, there are multiple provider sites that serve as field placements, and by housing a CHW student during their field training experience, the provider learns about the resource that is the CHW. Additionally, the Center for Healthy Communities places CHWs as employees on inter-professional teams in primary care sites to assist patients beyond the walls of the physician's office. Using a CHW Script, providers refer patients to the CHWs, who in turn follow up with patients to address issues identified in the CHW Script. CHWs are working with family medicine, geriatric, and pediatric practices as well as hospital-based asthma clinics, Federally Qualified Health Centers, homeless clinics, and HIV/AIDS training provider staff on how to use CHWs to improve clinical and quality outcomes and reduce cost of care.

Finally, Northeast Ohio Medical University (NEOMED) is currently piloting a novel CHW curriculum and continuing education courses in Ohio for CHWs to broaden their scope of practice and act as care extenders for a variety of health professionals, such as physical therapists, occupational therapists, and speech therapists. As a start, NEOMED is piloting curricula for CHWs on how to work with people with disabilities and how to decrease health disparities observed in this population in Ohio. Furthermore, NEOMED is creating an "e-Commons" online learning community for CHWs, providers, and employers that will act as a collaborative space for CHWs and their partners, providing virtual networks for all partners and stakeholders. The e-Commons will provide access to additional resources, create a virtual structure for open-sourced learning communities, and promote external dissemination of curriculum and continuing education courses.

**Non-Certified Community Health Worker Training Programs in Ohio:**

The CHW role was created from models like promotoras (a model for training community lay health educators to work in Hispanic communities) and peer educators ( a model that trains lay people to facilitate health screenings and provide health promotion activities). As a result, many CHWs across the country do not receive formal academic training. Instead, their training may come from their employer and is based on the roles they play. In Ohio, there are a number of CHWs with various titles trained by the organizations they work for or other organizations that train certain groups of CHWs for roles specific to their patients/clients. For example, promotoras are trained by the Ohio Hispanic Coalition, and peer educators are trained by Asian American Community Services and ASIA Inc. These CHWs are trained to do certain health screenings and provide health promotion activities and referral information for health and other social service resources. Other examples include peer volunteers trained by the American Cancer Society to work with newly diagnosed cancer patients. These volunteers are trained on basic counseling skills and armed with community resources. The Office on Minority Health and

the Ohio Department of Aging (ODA) have lay leaders to assist with diabetes management. ODA uses the evidence-based Stanford University Chronic Disease Self-Management Program (CDSMP) to train these lay leaders. Numerous peer-reviewed studies from Stanford University demonstrate the efficacy of training lay leaders to host community-based chronic disease self-management courses on positive clinical outcomes.

In addition, there are several other models that Ohio programs use to train CHWs that offer different certifications. For example, the Harold P. Freeman Patient Navigation Institute model offers a patient navigation certification. This certification involves a two-day training that covers 10 modules focused on eliminating barriers to care for patients with chronic disease such as cancer.[30] CareSource managed care plan uses this model to train its CHWs and care coordinators.

## Provider Training in Ohio:

Provider training on CHWs could help Ohio providers move towards increased integration of CHWs. Provider training is important to creating a supportive environment for integrating CHWs in the health care team. Working in multidisciplinary teams is a new skill for both clinical and non-clinical providers, and training for licensed professionals on how to work on teams with non-licensed professionals is needed. In our review we talked to representatives from CHW credentialing programs in other states with standardized training and certification programs and some that have standard payment mechanisms in place. All agree that provider education is critical. In fact, a key recommendation for fostering an environment supportive of CHW integration from the Center for Disease Control's report ***Addressing Chronic Disease Through Community Health Workers; A Policy and Systems Level Approach*** is to "educate groups of health care providers (privately and publicly funded) on the roles that CHWs can play, how CHWs fit into the Medical Home Model, and how to engage community-based organizations that employ CHW."[31] A study pairing nursing students with CHWs to address population health reported increased understanding and acceptance of CHWs.[32] Another study evaluating a community health worker cultural mentoring project also demonstrated increased understanding of the need for CHWs and the roles they play in bridging cultural gaps.[33]

**Currently in Ohio there is not a coordinated approach to training providers on the benefits of CHWs.** However, there are a couple of places that have instituted provider training for medical students. **Wright State University Boonshoft School of Medicine** has begun training future providers to be CHWs. In a new required course, Boonshoft medical students complete a three-week, classroom-based course in the fall of their first year of medical school, and then complete a six-month field

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experience assisting patients referred from local primary care practices. Physicians complete a CHW Script for the patients and connect the patients to the students, then medical students assist in addressing social determinants of health identified on the CHW Script. In this way, medical students understand from the beginning of their professional careers the value of the CHW on the primary health care team.

***Pathways to Health: Transforming Care Coordination and Medical Education in an Outpatient Setting*** is a new collaborative project between Health Care Access Now (HCAN) and Tri-Health in Cincinnati. One of its goals is to improve graduate medical education by training medical residents to practice in primary care settings aligned with the principles of a PCMH. The program will be implemented with 480 patients at Good Samaritan Hospital’s Faculty Medical Center (FMC) and 40 residents in Good Samaritan’s Internal Medicine Residency Program. HCAN’s evidence-based Chronic Care Coordination Pathway Program using community care coordinators will be integrated into the FMC’s clinical care process. Residents will have an opportunity to work with this model and will be trained in competencies relevant to primary care transformation including team-based care delivery, social determinants of health, chronic disease management, and population health improvement.

Ohio’s emerging CPC model is an excellent place to begin to educate licensed providers on the role of CHWs in the health care team and expand their use. Ohio’s CPC model does include a plan to convene a learning community for providers that participate in the model. This could be an excellent place to begin offering provider training on the roles CHWs can play on the health care team, their benefits, current reimbursement codes, and other strategies for paying for them. Ohio’s Pathways HUBs are another place that training for licensed providers could be easily implemented. These HUBs work with a number of provider organizations. HUBs already using CHWs could offer training on how to use CHWs to their surrounding provider community.

# Other State Models:

We would like to highlight other states that have standardized their training and certification processes for CHWs, offer provider training, and include some of the key elements we think would address the training and certification needs of Ohio's CHWs and assist providers in expanding their use of CHWs.

**Specific elements include:**

**A grandfathering clause which would help non-certified CHWs already working in the field gain credit for life experience and work experience.**

**A tiered system that allows for different levels of training with a core set of competencies and tracks for advanced learning in certain areas like chronic disease, community mobilization, etc.**

**Training that creates pathways for CHWs to move into other health professions.**

**A certification process that addresses barriers like immigration status, criminal backgrounds, and credit history issues that sometimes prevent qualified members of the community from being trained as CHWs.**

**Training for providers and supervisors to increase understanding and acceptance of CHWs as a key part of the health care team.**

# Oregon

**In Oregon the Office of Health Equity and Inclusion houses the certification program for CHWs. Their tiered certification defines and recognizes scope of practice for 5 different traditional health worker types, defined below:**

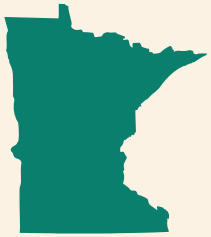
- **Community health workers (CHW):** Assist community members in receiving the health care they need.
- **Peer support specialists (PSS):** Provide support, encouragement, and assistance to addictions and mental health consumers.
- **Peer wellness specialists (PWS):** Provide support, encouragement, and assistance to address physical and mental health needs.
- **Personal health navigators (NAV):** Provide care coordination for members from within the health system.
- **Birth doulas:** Provide companionship and personal, nonmedical support to women and families throughout the childbirth and postpartum experience.

Training programs are tailored to each of the different roles, and all five can become certified as a traditional health worker. For example, CHW training program participants must complete 50 hours online and 30 classroom hours, or 25 hours if they possess an associate degree. Birth doulas must complete 29 hours, and both doulas and CHWs can be certified as a “Traditional Health Worker.” There are a variety of types of organizations that offer training for the five types of traditional health workers. Oregon also offers grandfathering for those that completed training in one of the now-approved programs prior to 2014. Oregon instituted provider training and training for CHW supervisors and has developed a supervisor training manual. Finally, Oregon’s Patient-Centered Primary Care Homes (PCPCH) model explicitly includes CHWs in the description of providers for four of the six core Health Home services, and certified CHWs are reimbursed.[34]

# New Mexico

New Mexico's CHW certification program is voluntary. They are in the process of creating a standardized curriculum. Their core competencies include The CHW Profession, Effective Communication, Interpersonal Skills, Health Coaching, Service Coordination, Advocacy, Technical Teaching, Community Health Outreach, Community of Knowledge, and Assessment. Clinical Support Skills is optional for those who desire to enhance their skills or whose jobs require it. Their model recognizes promotoras, and they have grandfathering for experienced CHWs. The University of New Mexico has developed strategies for training licensed providers on CHWs. The University has developed a manual for training primary care providers on how to integrate CHWs into their care teams. They also provide on-going support to the primary care practices they work with and continued supervision of the CHWs placed in their practices.[35]

In addition, they are implementing a new learning community model, Project ECHO, that creates a community of providers that includes CHWs and allows for group education on interventions for certain groups of patients.[35]



# Minnesota

The Minnesota Community Health Worker Alliance is a professional trade group comprised of CHWs, hospitals, Federally Qualified Health Centers, physicians, nurses, and others who have an interest in using CHWs to address health equity. This group has helped to raise awareness of CHWs and developed an 11-credit-hour CHW certification program. The statewide training curriculum is taught at five higher education sites across Minnesota. A key component of the program is that CHWs can apply the credits from the program to other health occupations, allowing CHWs to move to a different health career. The Minnesota Community Health Worker Alliance offers supervisor training and helps supervisors to provide training to other staff prior to bringing CHWs on staff. They facilitate trainings for hospitals and Federally Qualified Health Centers to educate providers on how to integrate CHWs into their work. They have also developed a webinar to educate providers on how to bill for Medicaid reimbursement of CHWs.

# Payment Models:

## Ohio

In Ohio, like most states, CHW's are paid for primarily out of grant funds. MEDTAPP grants have been used to add CHWs to Federally Qualified Health Centers and other social service settings and there are a few programs across the state that have secured Health Resource Service Administration (HRSA) grants or Center for Disease dollars to add CHWs in rural health and hospital settings.

Ohio also has some non-grant-funded programs that utilize capitated rates (per-member-per-month fees) by a few managed care plans and Pathways Health HUBs. The 2016-2017 Ohio state budget increases funding for Pathways HUBs. The Ohio Office on Minority Health was funded to work with existing HUBs and provide grant funding to start up at least two new HUBs. Funding was also increased for managed care plans to utilize CHWs who live in the most high-risk neighborhoods to assist with the outreach and identification of parenting and pregnant women. The goal of this effort is to connect women with health care and community resources to support infant mortality reduction efforts. This budget allocation comes at a cost of $13.4 million in fiscal years 2016 and 2017, with $5 million of that coming out of the state's coffers.[36] In addition, there are a few codes that could be used to reimburse for CHW services related to hospital discharge and preventable hospital readmissions. However, few providers know how to use the codes to reimburse for CHW services. Educating providers on these existing codes and adding other codes could facilitate providers in thinking about how to use CHWs and pay for them.

In 2014, Ohio received a State Innovation Model (SIM) grant award. Ohio is using this grant to tailor CPC+ (formally Patient Centered Medical Home, a team-based approach to primary care with care coordination as the focus) and episode-based payments design to transform care for Ohio's most vulnerable populations. The Governor's Office of Health Transformation, in redesigning the CPC+ model, is moving Ohio away from a fee-for-service model and toward a model that will concentrate on paying for value. The goal of the new model is to promote high-quality, individualized, continuous, and comprehensive care. The model's vision is to excel in patient experience, patient engagement, potential community connectivity activities, behavioral health collaboration, provider interaction, transparency, patient outreach, access, assessment, diagnosis and care plan, care management, and provider operating model.[37] The model further envisions CHWs being involved throughout.

The CPC model allows participating health care practices to access two payment streams. The first is a CPC Operational Activities Payment stream to compensate practices for activities that improve care and are currently under-compensated. The second is a Quality and Financial Outcomes-Based Payment for achieving total cost of care savings and meeting predetermined quality targets.[38] The CPC Operational Activities payment stream would be a risk-adjusted, per-member, per-month (capitation) payment based on performance on standard processes, activities, clinical quality, and efficiency.[39] The Quality and Financial Outcomes-Based Payment would be an annual shared savings payment based on performance on total cost of care and clinical quality, along with the presence of fundamental standard processes.[40]

Currently, the model does not clearly outline strategies for using these payments to hire and reimburse for CHWs. The model could be enhanced by including reimbursement codes for CHWs and perhaps incentivizing CPC providers to hire CHWs to address population health and achieve certain health outcomes. For example, CHWs could be standardized as a preferred strategy for specific chronic conditions among specific populations, and training on how to use CHWs could be offered to practices in the model. Or Ohio's Department of Medicaid could adapt a model like the University of New Mexico's I-PaCS described in the return on investment section. All would facilitate CPCs in hiring and paying for CHWs.

A notable strategy for integrating CHWs and paying for them is Ohio's Pathways HUB model. The managed care organizations fund Pathways HUBs through their capitated rates. [41] [42] [43] Pathways HUBs are designed to work across organizations within a community to reach at-risk individuals and connect them to health and social services. Pathways HUBs incentivize outcome by providing outcome-based enhanced payments to their CHWs.[44] There are currently six Pathways HUBs throughout the state. All contract with providers in their area to provide care coordination, all use CHWs, and all are able to pay for CHWs out of capitation rates. This model, in addition to focusing on results rather than quantity of services, seeks to blend previously separate funding streams. The blend includes charitable foundations, Temporary Assistance for Needy Families, Medicaid managed care, state-run maternal and child health programs, and state grants. The result is effective financially, saving between $3 for every $1 invested and $6 for every $1 invested from the model's first year of operation to its second through fourth years of operation.[45]

## Other State Models

# New Mexico

The state of New Mexico, which in 2008 established an Office of Community Health Workers, is a national leader in its integration of CHWs into the health care system. The vision of the office is to reduce health inequalities for diverse communities through the increased access to high-quality, cost-effective, and integrated health care and social services CHWs help make possible.

There are nearly 900 CHWs working in New Mexico. They work for public funded health care providers, including health clinics, hospitals, public health departments, tribal health programs, and community-based organizations. CHWs are currently addressing population health and acting as supplements to primary care, and the state has linked them to managed care organization fulfillment of care coordination and delivery system improvement requirements.[46]

Through a Medicaid 1115 Waiver, New Mexico's department of Medicaid—called "Centennial Care"—has leveraged contacts with Medicaid managed care organizations (MCO) to support the use of CHWs in serving Medicaid enrollees. The cost of salaries, training, and service are borne by MCO administrative costs and embedded in capitated rates paid to MCOs. Centennial Care contracts with seven managed care provider organizations in New Mexico. For example, Molina Healthcare of New Mexico, one of the contracted MCOs, negotiated with the state's Medical Assistance Division to establish a billing code to provide reimbursement of CHW services. The code specifically identifies CHW reimbursement and tracks utilization in each of the state's counties.[47]

The University of New Mexico (UNM) has a CHW program funded through New Mexico hospitals. UNM has four programs that use CHWs. One of the University of New Mexico programs hires and places CHWs in eight community clinics in New Mexico. The CHWs used in this program are reimbursed by MCOs. There are also CHWs placed in clinics hired by the hospitals. These CHWs are also paid for through capitation rates the clinics receive from MCOs. The UNM program staff developed a new payment model to create a more sustainable funding mechanism for CHW reimbursement and are in the process of gaining support for their proposed model from New Mexico legislators. The new model would place the reimbursement for CHWs on MCOs and would have each MCO contribute to the hiring of CHWs at each clinic according to the percent of their clients seen by the clinic. For example, if a clinic had 30% of its clients from Paramount, 50% from Molina, and 20% from Aetna, the MCO's contributions to the salary and benefits of the clinic's CHWs would be 30% from Paramount, 50% from Molina, and 20% from Aetna. This payment stream would allow for CHWs to be in all primary care clinics and could be expanded to other settings like hospitals.[48]

New Mexico is also one of four states participating in the federal Primary Care Extension Program (PCEP). PCEP is charged with assisting primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services through use of community-based Health Extension Agents.[49] Participating Medicaid MCOs fund Medicaid medical home models, provide payments to practices, and pay capitated monthly payments for CHWs to provide care coordination for high utilizing/high need members. Funding has come from various sources, ranging from university funds, project-specific grants, and partnerships with community organizations.[50] The cost savings from this program are $4 per every $1 invested in CHWs.[51] The agents are located in regional hubs throughout the state.[52]

# Oregon

**Oregon is also a national leader in its integration of CHWs into the health care system, having begun efforts to integrate CHWs in 2008.**

Presently, several models in the state integrate CHWs. First, Oregon established Patient-Centered Primary Care Homes (PCPCHs) as a part of its State Plan Amendment, including certified CHWs as providers for four of its six core Health Home services (Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Support Services). The PCPCHs only permit reimbursement to certified CHWs,[53] and a health professional must supervise a CHW in order for Medicaid to reimburse for services provided.[54] Recognized PCPCH members receive capitated payments for health home enrollees, provided that the health home provides a core health home service for that enrollee at least once per quarter. Payment amounts vary based on PCPCH tier.[55]

Second, in 2011, Oregon's legislature established community-care organizations to deliver care through alternative payment methods, patient centered medical homes.[56] As a State Innovation Model state grantee, Oregon has expanded its Community Care Organization (CCO) Model[57] within Medicaid. There are currently 16 CCOs in Oregon.[58] CCOs are locally-based organizations that serve Oregon Health Plan (Medicaid) enrollees in the state. CCOs are responsible for providing and coordinating enrollee care across a variety of settings, including primary and acute care, behavioral health, and dental services. The Oregon Medicaid program identifies CHWs, peer wellness specialists, and personal health navigators as non-clinicians who might provide these supports. CCOs are required to use "non-traditional health care workers" such as CHWs, who must be certified and supervised.[59]

Oregon's SIM narrative states that CHWs, peer specialists, and patient navigators are an "integral part" of the CCO team, and that CCOs are required to incorporate such non-traditional health care workers into their teams.[60] Payment options include via PCPCH payment, CCO-ICM (integrated care management) Capitation, or as a CCO subcontracted entity.[61] The state's 1115 waiver request narrative provides the payment mechanism for CCOs to receive a fixed global budget from the state, which includes a PMPM payment for services provided to enrollees and a transformation incentive payment to support quality and cost reporting and improvement.[62] CCOs must ensure that members receive support navigating the health care system, accessing culturally and linguistically appropriate care, and connecting with social and community services.

# Massachusetts

The State of Massachusetts makes it abundantly clear how important CHWs are to its delivery of health care. In Massachusets, CHWs are viewed as a "vital component of the state and national public health and health care workforce," and the state defines CHWs broadly, and notes their efficacy in contributing to disease prevention, maternal health support, the rate of health insurance coverage for underserved populations, and improving access to primary health care at reduced costs.[63] [64]

**CHW services in Massachusetts, like most states, are primarily funded by grants. However, CHWs were included in Massachusetts' 2012 payment reform law[65] as follows:**

**Accountable Care Organizations (ACOs) are able to use CHWs in multidisciplinary care teams in a global fee structure.**

**The Prevention and Wellness Trust Fund (PWTF) established by the law supports CHWs in all nine of its projects across the state.**

**The Health Care Workforce Transformation Fund, designed to support the training of emerging health care workforces, is established.**

The PWTF is a unique state model which supports community-based partnerships to provide research-based interventions aimed at reducing costs and improving health outcomes. Funded through a $60 million, four-year commitment in 2012, the PWTF awards grants to partnerships.[66] Importantly, the PWTF integrates CHWs into clinical and community teams. Each partnership hires CHWs that are tasked with linking patients and health interventions.[67]

Additionally, Medicaid supports CHW services through a Medicaid 1115 waiver for high-risk pediatric asthma[68] and a demonstration project for dually eligible adults. The Pediatric Asthma Pilot Program provides comprehensive coverage for asthma-related care and was based on a Community Asthma Initiative that began at the Children's Hospital of Boston in 2005. The initiative saved $500,000 within five years through home visits that included environmental assessments and remediation.[69] The Massachusetts legislature approved a budget amendment in 2010 that directed the Medicaid program to develop the Pediatric Asthma Pilot Program, in which participating providers are responsible for the supervision and coordination of a medical team. The delivery of asthma-related services is paid for by per-member, per-month payments for each beneficiary enrolled.[70]

# New York

New York received a SIM grant and is using the funding to implement a multi-payer model of health system transformation. New York's plan supports population health goals, preventive services, and integrated behavioral primary care through an advanced primary care medical home model and through the SIM-funded public health consultants and practice transformation teams.[71]

New York has an approved Medicaid Health Home State Plan Amendment, which is another opportunity to integrate CHWs into whole-person care.[72] The state's Health Home program is available across the state and is available to beneficiaries with chronic conditions and those with serious mental illness. The state has designated eligible providers, including managed care plans, hospitals, mental and chemical dependency clinics, primary care practitioner practices, PCMHs, Federally Qualified Health Centers, and others. The State Plan Amendment says that "outreach workers including peer specialists" may be included as part of a health care team. This allows for the employment of CHWs as part of the multidisciplinary teams.[73] The current program serves communities with high rates of infant mortality, late or no prenatal care, teen pregnancies and births, and births to low-income women. Through the SPA, programs are designed that explicitly include or reference CHW employment or payment as a part of multidisciplinary teams through Health Home reimbursement.[74] Health homes are compensated on a per-member, per-month basis. There are two health home rate codes, outreach and engagement and active care management. The capitated payments make it possible for providers to hire CHWs to serve in care management teams and to provide services required by health homes.

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.[75]

The state's Delivery System Reform Incentive Payment (DSRIP) program also incorporates CHWs. DSRIP, which is the main mechanism by which New York is implementing its Medicaid Redesign Team Waiver Amendment, provides incentives for Medicaid providers to create and sustain an integrated, high-performing health care delivery system that can effectively and efficiently meet the needs of Medicaid-eligible populations and individuals by improving care, improving health, and reducing costs.The DSRIP Project Toolkit notes for perinatal care that one of the core components is implementing a CHW program.

**The above examples provide a range of options for paying for CHWs that could be implemented in Ohio, including:**

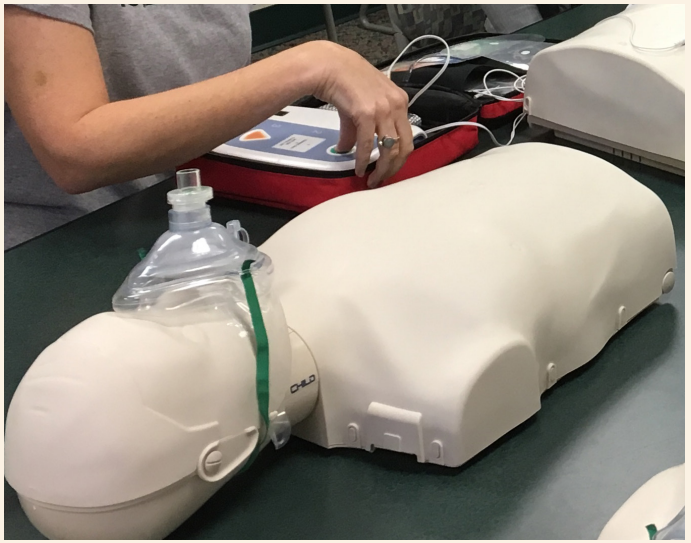
The New Mexico I-PaCS model and their new strategy of hiring CHWs for primary care clinics paid for by MCO's based on the percent of the MCO's clients seen at the clinic.

Payment codes for CHWs, making it easier to reimburse for CHW services (Ohio already has codes that are linked to preventing hospital readmissions that can be used to reimburse for CHW services, and others could be added).

Oregon's requirement that PCMHs incorporate non-traditional health care workers into their teams (Oregon's SIM narrative states that CHWs, peer specialists, and patient navigators are an "integral part" of the CCO team, and that CCOs are required to incorporate such non-traditional health care workers into their teams).

Using state plan amendments and 1115 waivers to explicitly include CHWs as part of health care teams.

A recent report from Families USA provides additional examples from states on payment models for CHWs and includes detail on how the above strategies could be implemented in Ohio.[76]



**Our review on CHWs in Ohio found four conditions critical to integrating CHWs on health care teams:**

- **Standardized scope of practice**
- **Training and certification for CHWs**
- **Training for licensed providers on how to use and pay for CHWs**
- **Sustainable financing**

## Recommendation 1

More definition and standardization of the roles and scope of work for certified and non-certified CHWs would help to increase understanding of this workforce here in Ohio.

**The Ohio Department of Health and the Ohio Board of Nursing could work with the Ohio Association of Community Health Workers (OCWHA), Pathways HUBs, Medicaid Technical Assistance and Policy Program (MEDTAPP) training centers, and The Ohio Colleges of Medicine Government Resource Center to further define and standardize the roles and scope of work for certified and non-certified CHWs.**

## Recommendation 2

Ohio's CHW training and certification process would be enhanced if a tiered process could be put in place that would allow for certification for the various roles CHWs play here in Ohio.

**The Ohio Board of Nursing could work with OCHWA, ASIA Inc., the Ohio Hispanic Coalition, MEDTAPP Training Centers, Pathways HUBS, and the Ohio Commission on Minority Health to implement a tiered process that would allow for certification for the various roles CHWs play in Ohio.**

## Recommendation 3

A grandfathering process for current certified and non-certified CHWs that gives credit for work and life experiences would help Ohio maintain its current CHW capacity as it works to implement the tiered process and expand the integration of CHWs on health care teams.

**The Ohio Board of Nursing could work with OCHWA, ASIA Inc., the Ohio Hispanic Coalition, MEDTAPP Training Centers, Pathways HUBS, and the Ohio Commission on Minority Health together to develop and adopt a grandfathering process for current certified and non-certified CHWs that gives credit for work and life experiences.**

## Recommendation 4

**Education and training to increase provider understanding of CHW roles, benefits, and return on investment would help licensed providers feel more comfortable in including them on health care teams.**

**The Ohio Department of Medicaid, managed care plans and Ohio's private insurers provide education and training to increase provider understanding on CHW roles, benefits, return on investment, and reimbursement methods. CHW training programs could develop supervisor training programs and make them available to those seeking to hire CHWs.**

## Recommendation 5

**Creating sustainable non-grant reimbursement for CHWs is key to expanding their use. Four things could be done in Ohio to make this easier. 1) Include language in the CPC model defining CHWs and outlining integration of CHWs in care teams and allowing for reimbursement of their services. 2) Continue and expand funding for HUBs. 3) Utilize billing codes for CHWs and train providers on how to use existing codes to reimburse for CHWs. 4) Adopt the Center for Medicare and Medicaid rule allowing for reimbursement of CHW services, as long as it is prescribed by a licensed professional.**

**The Ohio Department of Medicaid could include language in their CPC design recommending primary care providers in the program to include CHWs as part of their care teams and allow for CHW reimbursement. Funding increases for Pathways HUBs are included in the Ohio state budget, and reimbursement of CHWs is included in the Ohio Department of Medicaid SIM grant CPC design.**

## Recommendation 6

**Ohio could benefit from a statewide capacity assessment to provide a more accurate picture of how many certified and non-certified CHWs are in Ohio, how many are employed, what health care settings are using them and which ones are not, and what they are being paid.**

**The Ohio Department of Health works with the Ohio Colleges of Medicine, Government Resource Center to implement a statewide capacity assessment to provide a more accurate picture of how many certified and non-certified CHWs are in Ohio, how many are employed, how many remain unemployed, what health care settings are using them and which ones are not, and what and how they are being paid.**

# Conclusion

CHWs are a proven strategy in addressing population health. They are used across the country to address health disparities by bridging cultural gaps and addressing social and health needs that extend beyond the doctor's office. Through several key initiatives (State Innovation Grant, CPC design, Medicaid expansion, and the HUB model), Ohio is in the process of transforming its health care delivery system. CHWs will be critical to the success of this transformation. The above report and recommendations are intended to assist health care providers, provider organizations, policy makers, public health officials, and others in addressing the barriers to hiring and paying for CHWs.

Two priorities for Ohio in advancing the use of this workforce include increased understanding among health care providers of this workforce and sustainable payment sources. The report highlights promising strategies in both these areas used by other states, like I-PACS in New Mexico, Health HUBs in Ohio, including language and rules in state Innovation Models, State Plan Amendments, and Medicaid 1115 waivers that make hiring and paying for CHWs easier for providers. The authors did not do a statewide assessment of CHWs and therefore this report includes only a few examples of promising strategies being used in Ohio and not a complete list.  As a starting point, these two areas could be addressed in Ohio's State Innovation Model PCMH design. Additional research on where CHWs are would strengthen efforts to define this workforce in Ohio, establish provider training and sustainable reimbursement strategies, and create a stronger coalition to coordinate efforts to expand this workforce in Ohio.

**This report was made possible with funding from the Robert Wood Johnson Foundation Through the Value Advocacy project.**

Special thanks to Community Catalyst and Spitfire Strategies for their technical assistance in designing the report.

## Appendix 1

**I. (a.) CHW Job Titles** [77]

- Health Coach
- Community Health Advisor
- Family Advocate
- Community Health Educator
- Liaison
- Community Health Promoter
- Outreach Worker/Specialist
- Peer Counselor/Educator
- Patient Navigator
- Health Interpreter
- Public Health Aid
- Case Work Aide
- Community Care Coordinator
- Community Health Representative
- Consejera/Animadora (counselor/ organizer)
- Environmental Health Aide
- Family Service Worker
- Lactation Consultant/Specialist
- Lay Health Advisor
- Lead Abatement Education Specialist
- Maternal/Infant Health Outreach Specialist
- Neighborhood Health Advisor
- Patient Navigator
- Promotor(a) de Salud (health promoter)
- HIV Peer Counselor
- Community Health Worker

**(b.) CHW Roles and Functions** [78]

- Cultural Mediation between communities and health and human services system
- Culturally appropriate health education and information
- Ensuring people get the services they need
- Informal counseling and social support
- Advocating for individual, community needs
- Providing direct services, mainly in remote areas, and meeting basic needs
- Building individual and community capacity

**(c.) Tasks Performed by CHWs** [79]

- Conduct community outreach
- Connect people with medical services and programs
- Provide health education to groups
- Provide health education to individuals (one-on-one)
- Provide direct health services (e.g. take vital signs)
- Provide care navigation and coordination
- Assure that people get the coverage and services they need
- Provide interpreter services
- Transport people to appointments
- Connect people with non-medical services or programs
- Serve as a cultural link
- Educate professionals about the needs of cultural communities

## Appendix II

**II. Ohio Board of Nursing, Approved CHW Training Programs (as of July 2016)** [80]

**1. Care Coordination Systems' Community Health Worker Program**
75 Market Street
Akron, OH 44308
(419) 613-9263

**Administrator:** Anne Seifert
**Approval Expiration Date:** January 22, 2017

**2. Cincinnati State Technical and Community College Community Health Worker Program**
3520 Central Parkway
Cincinnati, OH 45223
(513) 569-1500

**Administrator:** Mary Kappesser
**Approval Expiration Date:** July 30, 2017

**3. Cleveland Institute of Community Health (CICH)**
291 East 222nd Street
Euclid, OH 44123
(216) 288-1404

**Administrator:** Monique Williams
**Approval Expiration Date:** September 19, 2016

**4. Evi-Base Community Health Worker Certification Program**
4807 Rockside Rd., Suite 740
Independence, OH 44131
(216) 215-2230

**Administrator:** Stacey Rokoff
**Approval Expiration Date:** May 18, 2018

**5. Chatfield College Community Health Worker Program**
20918 St. Rt. 251
St. Martin, OH 45118-9705
(513) 875-3344

**Administrator:** Janie Allen-Blue
**Approval Expiration Date:** March 16, 2018

**6. Cleveland State University School of Nursing Community Health Worker Program**
2121 Euclid Ave. JH 238
Cleveland, OH 44115
(216) 687-3598

**Administrator:** Vida Lock
**Approval Expiration Date:** September 17, 2017

**7. Cuyahoga Community College's Community Health Worker Program**
2145 Woodland Avenue
Cleveland, OH 44115
(216) 987-3038

**Administrator:** Resia Davis
**Approval Expiration Date:** January 22, 2017

**8. Lorain County Community College Community Health Worker Program**
1005 North Abbe Road
Elyria, OH 44035
(440) 366-7193

**Administrator:** Deborah Brown
**Approval Expiration Date:** May 18, 2018

**9. Mercy College of Ohio Community Health Worker Program**
2221 Madison Avenue
Toledo, OH 43604
(419) 251-1329

**Administrator:** Karen Keune
**Approval Expiration Date:** March 16, 2018

**10. The Northeast Ohio Medical University Community Health Worker Program**
4209 St. Rt. 44, P.O. Box 95
Rootstown, OH 44272
(330) 325-6787

**Administrator:** John Boltri
**Approval Expiration Date:** March 12, 2017

**11. North Central State College Community Health Worker Program**
2441 Kenwood Circle
PO Box 698
Mansfield, OH 44901
(419) 755-4823

**Administrator:** Melinda Roepke
**Approval Expiration Date:** March 16, 2018

**12. The Ohio State University College of Nursing Community Health Worker Program**
1585 Neil Avenue Newton Hall
Columbus, OH 43210
(6114) 292-4928

**Administrator:** Linda S. K. Daley
**Approval Expiration Date:** November 19, 2017

## Appendix III

III. Ohio Pathyways Health Hubs As of September 2016

1.Mahoning Health District, Youngstown
2.United Way of Central Ohio
3.Hospital Council Of Northwest Ohio, Toledo
4.Health Care Access Now Cincinnati
5.Akron-Summit Community Action Inc., Akron
6.Community Health Access Project, Mansfield

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