ARIZONA LICENSED PROVIDER PERSPECTIVES ON THE IMPACT OF COMMUNITY HEALTH WORKERS IN PRIMARY CARE

Results of the 2015 Community Health Worker Utilization and Impact in the Primary Care Setting Survey

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Presentation Flow

• CHW Policy Opportunities and Windows 101
• 2015 Arizona Provider Survey
  • Methods
  • Results
• Evidence on CHW integration in primary care
• Arizona CHW Workforce Coalition Recommendations
• Group Think on How to Move Forward in Arizona
CHWs and the Patient Protection and Affordable Care Act of 2010

- Law cites CHWs as:
  - An effective way of improving health outcomes as part of a health care team while containing costs \(^1\)
  - A member of the health care workforce and a health professional \(^2\)

- Law authorizes the Centers for Disease Control (CDC) to:
  - Fund agencies who train health care team members, including CHWs \(^3\)
  - Direct intervention grants “to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.” \(^3\)

\(^1\) Patient Protection and Affordable Care Act, 42 USCA §18001 (2010).
\(^2\) Patient Protection and Affordable Care Act, 42 USCA §294q (2010).
\(^3\) Patient Protection and Affordable Care Act, 42 USCA §280g-11 (2010).
CHWs Role in Primary Care

CHW promotes health in the following ways:

A. by serving as a liaison between communities and healthcare agencies;
B. by providing guidance and social assistance to community residents;
C. by enhancing community residents’ ability to effectively communicate with healthcare providers;
D. by providing culturally and linguistically appropriate health or nutrition education;
E. by advocating for individual and community health;
F. by providing referral and follow-up services or otherwise coordinating care; and
G. by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.³

³ Patient Protection and Affordable Care Act, 42 USCA §280g-11 (2010).
The CDC “awards grants to eligible entities that promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers” in the following areas:

1. Prevalent health problems in medically underserved communities, particularly racial and ethnic minority populations;
2. Promotion of health behaviors and discouragement of risky health behaviors;
3. Enrollment in health insurance;
4. Identify and referring individuals to healthcare agencies and social services to increase access and eliminate duplicative care; and
5. Provide home visitation services for maternal health and prenatal care.
ACA §5403 - Interdisciplinary, Community-based Linkages

Authorizes Area Health Education Centers to:

“Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.”
CHWs and the Children’s Health Insurance Program (CHIP) Reauthorization Act of 2009

• Makes explicit that CHIP outreach funds can be used for activities conducted by community health workers.
CHWs and the States

- CA 916
- CN 2011 SB 913-PA
- FL SB 866 2011 Intro
- HB02244I
- HB3650.1
- MA Bill H00339
- MA Bill H00598
- MA Bill H01220
- MA Bill H01518
- MA Bill S01087
- MN HF0262
- MN S.F. 1467
- New Mexico-2011-HB35
- New Mexico-2011-SJM12-Introduced
- Ohio 129 HB 16 9 1 Y
- Ohio H0169-i-129
- Oklahoma SB882 Introduced
- PA HB 342
- Rhode Island 2011 H5633 (Draft)
- Rhode Island 2011 S0481 (Draft)
- Texas HB 2610
- Texas HB02244I
Most Important - Centers for Medicaid and Medicare (CMS)

In June of 2014, the Centers for Medicaid and Medicare (CMS) issued new guidance that allows for reimbursement of preventive services offered by unlicensed professionals such as CHWs.
A Profile of CHWs in Arizona

The following are findings from the 152 self-identified CHWs in Arizona who completed the 2014 National Community Health Worker Advocacy Survey.

- Predominantly female: 95%
- Average years worked as CHW: 8.4 years
- Most CHWs have completed some college or higher: 81%
- Most “agree” to “strongly agree” with the APHA’s definition of a CHW: 94%
- 62% Hispanic/Latino(a)
- 29% American Indian/Alaska Native
- 7% White
- 3% Black/African American
- Average weekly hours for paid CHWs: 37.6 hours
- Average weekly hours for non-paid CHWs: 8.6 hours
- Most CHWs work at a Community-Based Organization, Federally Qualified Community Health Center or Tribal Health Department: 79%
- Average annual income for over half of CHWs: $10,000-$35,000

Survey Purpose

• Assess Arizona licensed health care providers general perspectives on the impact, integration and barriers to integration of CHWs within primary care
  • Providers were defined as licensed health professionals:
    • Physicians
    • Physician assistants
    • Nurse practitioners
    • Psychologists or behavioral health specialists
    • Pharmacists

• Survey development – MEZCOPH researchers, AzCHOW, CHW Coalition, colleagues in MA, TX, WI
Methods

• Cross-sectional, anonymous, on-line survey
  • In some cases face to face data collection through existing clinical staff meetings

• Conducted with 364 Arizona providers
  • 245 (67%) involved with CHWs
  • 119 (33%) NOT involved with CHWs

• Represents diverse clinical settings including
  • Federal qualified community health centers (FQCHC)
  • Indian Health Service
  • Tribal 638 Clinics
  • Solo, group, managed behavioral care settings
Participant Recruitment

• Partnered with the Arizona CHW Workforce Coalition
  • Broad-based CHW stakeholder group representing: ADHS, Arizona Alliance for Community Health Centers, AHECs, health plans, AHCCCS, community colleges, professional networks (nursing, CHWs, etc), tribal CHR programs

• 136 contacts were verified representing:
  • FQCHCs, hospitals, Indian Health Service, 638 Tribal Health Clinics, behavioral health centers, provider local and state professional associations and networks, and health plan leadership.

• Online survey was distributed in three waves
  • April, May and June of 2015
  • Each time, a week later, an AzPRC researcher followed up with a phone call or an email to:
    • (1) explain in more detail the study and answer questions and
    • (2) learn the ways in which to better target dissemination of the survey to eligible licensed staff.
  • In each follow up, approximately 63% (83) contacts were spoken with directly.
## Survey Participants by License

### Table 1. Selected Characteristics of Licensed Arizona Provider Survey Participants

<table>
<thead>
<tr>
<th>Provider Credential</th>
<th>Providers Involved with CHWs (N=245)</th>
<th>Providers NOT Involved with CHWs (N=119)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>106/245 (43.3)</td>
<td>61/119 (51.3)</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>37/245 (15.1)</td>
<td>25/119 (21.0)</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>17/245 (6.9)</td>
<td>13/119 (10.9)</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>27/245 (11.0)</td>
<td>4/119 (3.4)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>6/245 (2.4)</td>
<td>4/119 (3.4)</td>
</tr>
<tr>
<td>Behavioral Health Provider</td>
<td>20/245 (8.2)</td>
<td>5/119 (4.2)</td>
</tr>
<tr>
<td>Other</td>
<td>32/245 (13.1)</td>
<td>7/119 (5.9)</td>
</tr>
</tbody>
</table>
## Type of Practice

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQCHC</td>
<td>88</td>
<td>39%</td>
</tr>
<tr>
<td>Indian Heath Service /638 Tribal Clinic</td>
<td>66</td>
<td>29%</td>
</tr>
<tr>
<td>Other (group, solo practices, manages care, hospital based practice)</td>
<td>74</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>228</td>
<td>100</td>
</tr>
</tbody>
</table>

56% (125) were part of Patient Centered Medical Home
Provider Perspectives on CHW Impact

In my experience CHWs have contributed to:

- Have good birth outcomes
- Better manage their chronic disease
- Maintain regular care
- Show up for scheduled appointments
- Follow my recommendations

The chart shows the percentage of providers who have observed these contributions from CHWs, broken down by different settings such as IHS, FQHC, and Total.
In my experience, CHWs have contributed to:

- Reduction in the cost of care
- Improved health outcomes
- Prevention of high risk or high cost health conditions
Provider Perspectives on CHW Impact on Provider Time

In my experience, CHWs have saved me time:

- Arranging clinical referrals and follow-up for patients: 65%
- Arranging social-service referrals for patients: 69%
- Educating patients on disease management: 70%
- Educating patients on health promotion (i.e., nutrition and physical activity): 77%
- Educating patients on healthy childbirth: 51%
CHW Integration

- CHWs are integrated in the following ways:
  
  - 68% (155/228) Regularly receive patient referrals or assignments from primary care staff (for needed education sessions or home visits)
  - 44% (100/228) Meet regularly with primary staff
  - 51% (116/226) Provide interpreting services
Providers Perspectives on CHW Integration

• Providers suggested more CHW integration with primary care, including having more CHWs available to meet patient needs in the clinic

“Greater integration of CHW services with provider teams including efforts on child health and chronic disease management. More CHWs to provide optimal patient to CHW ratio”

Physician, Indian Health Service/638

 “[We need] more CHWs available in clinic to work with a greater percent of patients”

Physician, Federally Qualified Community Health Center

“A CHW is part of our interdisciplinary team managing a sub-population of high acuity adult patients within our family practice. She is a great asset to the team, and I would like to see CHW services available to our whole population.”

Nurse Practitioner, Group Practice
## Barriers to CHW Integration Within Primary Care

### Barriers in CHW integration

<table>
<thead>
<tr>
<th></th>
<th>Providers Involved with CHWs (N=245)</th>
<th>Providers NOT Involved with CHWs (N=119)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of ability to bill insurer</td>
<td>117/245 (47.8)</td>
<td>40/119 (33.6)</td>
</tr>
<tr>
<td>Lack of clarity about the value</td>
<td>64/245 (26.1)</td>
<td>44/119 (37.0)</td>
</tr>
<tr>
<td>Lack of clarity about the function</td>
<td>95/245 (38.8)</td>
<td>46/119 (38.7)</td>
</tr>
<tr>
<td>Lack of CHW training</td>
<td>59/245 (24.1)</td>
<td>30/119 (25.2)</td>
</tr>
</tbody>
</table>
Barriers to Integration of CHWs

- 75% of providers would be more likely to utilize CHWs as part of the health care team if:
  - CHWs service were reimbursable by the Center for Medicare and Medicaid Services (CMS) (or AHCCCS in Arizona) or third-party payers.

“Reimbursement for CHWs would allow us to increase the use of CHWs in the primary care setting”

Behavioral Health Provider, Federally Qualified Community Health Center

“Currently, because CHWs are paid through grants, we can only use them for specific sub-populations (e.g. refugee, under age 5, etc.). I would like to see them used in our whole practice to improve follow through in our mobile population that has difficulty navigating the health care system.”

- Physician, Hospital based practice
Growing Body of Evidence is Clear

• CHWs are increasingly recognized for their value in improving the **efficacy of care** and contributing to the provision of high quality and **coordinated care** (Brownstein et al., 2005; Brownstein et al., 2007; Felix, Mays, Stewart, Cottoms, & Olson, 2011; Tang et al., 2014).

• **Well functioning multidisciplinary care teams that include a CHW** have been identified as contributing to the efficacy of Patient-Centered Medical Homes (PCMH), Accountable Care Organizations (ACO), and Community Health Teams (Brownstein et al., 2011, Balcazar et al., 2011; Brownstein et al., 2005).

• **CHWs are well positioned to support coordinated care, both ACOs, PCMHs and** effectively meet health reform mandates for prevention, education and coordination of care (Brownstein et al., 2011).

• The **Affordable Care Act (ACA)** through expanding payment methods and focusing on value and quality of care may constitute a landmark in the movement to integrate Community Health Workers (CHWs) within the mainstream of health care, public health, and social services (ACA, 2010).
CHWs are Cost Effective

• CHW interventions have been shown to improve:
  • Clinical indicators (Allen et al., 2011; Culica, Walton, Harker, & Prezio, 2008; Esperat et al., 2012; Margellos-Anast, Gutierrez, & Whitman, 2012)
  • Lower risk factors in chronic disease and mental health (Krantz et al., 2013; Roman et al., 2007)
  • Increase medication adherence (Margellos-Anast et al., 2012; Roth et al., 2012).

• CHW interventions also contribute to:
  • Reduction in Emergency Department visits (Bielaszka-DuVernay, 2011a, 2011b; Findley et al., 2011; Gary et al., 2009; Johnson et al., 2012; Margellos-Anast et al., 2012; Peretz et al., 2012).

• CHW integration into the primary care team and beyond is associated with:
  • Reductions in cost (Bielaszka-DuVernay, 2011b; Brown et al., 2012; Esperat et al., 2012; Felix et al., 2011; Johnson et al., 2012; Krieger, Takaro, Song, & Weaver, 2005)
  • A return on investment (ROI) that ranges from $0.02 to $5.58 per dollar invested in CHW interventions (Bielaszka-DuVernay, 2011a; Esperat et al., 2012; Felix et al., 2011; Margellos-Anast et al., 2012).
In sum

- **90% of providers** reported that CHWs have had a positive impact on patient care.

- **No less than 70%** reported that as a result of working with CHWs their patients were more likely to follow their recommendations, maintain regular care, better manage their chronic disease and have access to care.

- **No less than half of all providers** reported that CHWs saved them time in arranging clinical and social referrals for patients, as well as educating patients on disease management, health promotion and healthy childbirth.
Recommendations

- Integrate and pay for this vital workforce

- Join the Arizona CHW Workforce Coalition to act on:
  - CHW identity campaign
    - Definition, Scope of practice
  - Voluntary certification process
  - Dynamic payment strategies (that do exist!)
  - Policy strategies to sustain the workforce outside of the clinical setting
## Sustainable Financing of CHW Activities: Three Broad Pathways

### A Conventional health care
- Emergency room diversion
  - “Hot-spotters” (high cost users)
- Prenatal/perinatal coaching
- Primary care based chronic disease management
- Care transitions
- Home/community-based long-term care

### B Population/community-based public health
- Specific condition-focused initiatives
- Community development approach (social determinants)

### C Patient-centered care systems (emerging hybrid structures)
- Patient Centered Medical Homes
- Accountable Care Organizations
- Health Homes

### 1 Promising program models
- Care coordination
- Self-management support for chronic conditions
- Referral and assistance with non-medical needs and barriers
- Medication management support
- Patient/family advocacy
- Support and extension of health education
- Patient navigation

### 2 Specific CHW roles in these models
- Fee for service
- Managed care organizations: admin/service dollars; duals
- Medicaid 1115 waivers
- Internal financing
- Prospective payment (FQHCs)

### 3 Payment mechanisms for these models
- Medicaid waivers
- Block grants
- Prevention trust fund (Mass. model)
- Pooled funds from third-party healthcare payers

### 4 Options for third-party payers
- CHWs directly employed by payer
- Health care provider contracts/add-ons to hire CHWs
- CBO contracts to employ CHWs
- CHWs as independent contractors

### Combined programs
- Combination of health care and population-based (as at left)

### Bundled/global/prospective payment
- Supplemental capitation payment for specific services
Acknowledgements

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References


