Integrating and Paying for Traditional Health Workers in Primary Care

The Oregon Primary Care Payment Reform Collaborative (PCPRC) developed this document to recommend incentivizing the integration of Traditional Health Workers (THWs) in primary care through payment strategies, including value-based payment (VBP). In addition to payment, successful integration of THWs requires provider and staff education about their role and how to best utilize them to address patient needs. The practice may also require infrastructure and workflow changes, including administrative support and data collection to measure quality and impact. The THW workforce will also need to grow to meet the expanded need with training and development of new THWs. These issues, while important, are out of scope for this document which is focused on payment.

The last section of this document provides background information on THWs and evidence of their impact on the quality and of cost care.

Recommendation: The PCPRC recommends improving health equity by incentivizing the integration of THWs into primary care through targeted and sustainable payment strategies, including VBP models.

The PCPRC recommends improving health equity by incentivizing the integration of THWs[i] into primary care through payment strategies, including VBP models. Given the variations in types of THWs, there is no one-size-fits-all payment model to support THWs. Implementation of THW programs and payment models will vary and should build upon the strengths and respond to the needs of the community.

Principles for Developing and Implementing Payment Strategies for THWs

The Oregon Health Authority (OHA) Traditional Health Worker Commission has outlined the following core principles for payments for THWs:[ii]

1. Sustainable (i.e., continuous, not time-limited grants or pilots)
   - Funding needs to account for the initial start-up costs of setting up and administering a new program
   - Rates that sustain services including administrative costs, living wage and benefits for THWs, ancillary program costs (e.g., supervision, training & education, data collection & evaluation), and a career ladder/lattice for THWs.
   - THWs are part of members' continuum of care and wellbeing across care settings.

2. Support THWs practicing at the top of their certification
   - THW roles and position descriptions should be based on the THW Commission-approved THW scope of practice.[iii]

Oregon Health Authority

- Enable and support THWs to enact their full range of core roles, including individual-level (health-related social needs) and upstream community and policy-level (social determinants of health) interventions and activities.
- Alternative payment methods such as per-member-per-month (PMPM), capitated payments and population-based payments are likely to better support the full THW scope of practice compared to fee-for-service.

3. Community and equity-driven
   - Health systems are encouraged to partner with and leverage the expertise of community-based organizations and other health systems that currently employ or contract with THWs.
   - Options for integrating THWs include hiring directly or contracting with community-based organizations.
   - Consult the THW Commission for referrals to appropriate community-based organizations (CBOs), THW-run organizations, and/or THW-recommended best and promising practices for THW integration.

4. Not solely contingent upon short-term outcomes
   - THWs are an important component of strategies moving toward health equity and addressing the social determinants of health, not short-term return on investment or particular health outcomes, though those may well be some results of integrating THWs.
   - THWs improve the overall quality and value of healthcare by providing person-centered care and increasing the timeliness, efficiency, equitability, safety and effectiveness of care.
   - It is recommended that THWs and participants of THW programs are involved in planning and implementing qualitative and quantitative THW evaluation.

Building on these principles for payment, the following design principles are recommended for VBP for THWs:[iv]

- Co-design: Any specific approach to VBP, as well as implementation and evaluation, should be co-designed by THWs, providers, and payers, as well as representatives of patients and communities served.
- Equity: Local and regional community needs assessments that identify disparities and gaps in access and utilization should drive VBP that intentionally includes THWs as an evidence-based strategy to reduce those disparities and close those gaps.
- Capacity: VBP should leverage existing availability, experiences, strengths, skills, and network/organizational capacities of local THWs, or intentionally increase such availability and build such capacities.
- Sustainability: Any VBP model should build long-term sustainability, including documentation of outcomes and impacts.

Various payment models can be used to support THWs.[v]

As in all of healthcare, a payment model can impact the type of care that is available. THW payment models must fund the development of programs and sustainably support the unique value THWs provide to patient care. The evidence of THW impact on cost and quality is robust as demonstrated in the studies listed starting on page six. These programs were supported by fee-for-service and / or grants. There is limited evidence of the impact of other payment models.

Payment mechanism	Strengths	Limitations

Fee-for-service	• Fee Schedule with billing codes for some THW services is available:
	  ○ For CHWs: https://www.oregon.gov/oha/HSD/OHP/Tools/CHW_Billing%20Guide.pdf
	  ○ For doulas: https://www.oregon.gov/oha/HSD/OHP/Tools/Billing%20for%20doula%20services.pdf
	  ○ For peer specialists: https://www.oregon.gov/oha/HSD/OHP/Tools/Enrollment%20and%20billing%20for%20peer-delivered%20services.pdf
	• Primary care providers who employ THWs can bill and receive reimbursement for approved services[vi]
	• Extensive tracking/billing for services can be used for calculating ROI of THW services
		• Requires a diagnosis and adherence to a medical model of care that limits community and population health roles of THWs, many of whom operate outside health care settings[vii]
		• Reimbursement limited to approved service codes only and might discourage holistic services
		• Billing codes not available for all THW types, i.e., patient navigators
		• Reimbursable services can sometimes cover the salary for a CHW, but not other provider types
		• If services are strictly clinical, incentive to “upcode” by using other higher-paid providers
		• Requires billing infrastructure
		• No connection to quality of service or outcomes

Performance-based payment	• Can be designed for panels of patients and longitudinal care rather than tying payment to individual billed encounters • Primary care clinics could employ THWs as part of clinic costs in a performance-based contract • Rewards quality, not quantity	• Payment relies upon meeting performance standards so there is some risk of not meeting standards and therefore, not receiving full payment • Pay for performance models that tie payment to outcomes are generally limited to short-term outcomes that are easily

Payment mechanism	Strengths	Limitations
	• Can be an “on-ramp” to more advanced VBPs and can be coupled with more advanced VBP models.	documented versus longer term outcomes addressing social determinants of health and equity
PMPM payments / global payments / case rate payments	• Provides flexibility for the employing entity to use the funds consistent with the needs of their patient population • Can include foundational payments to pay for HIT and data exchange capabilities to document and increase impact • Could be structured with partial prospective payments to provide working capital/funding to hire THWs (with reconciliation of payments after a performance period) • Payments are more stable over time allowing programs to and sustain investments	• Funds may not be earmarked for THWs and may be used for other purposes. • Payments may not be sufficient to fund community based THW services • Payments may exclude THW services provided in the community or with specialist physicians and other providers serving patients with chronic conditions such as diabetes or substance use disorders • PMPMs may not be sufficient to fully support and sustain the program • A provider or organization needs a large, assigned population in order to support the overall costs of program development and on-going support • Few shared savings or downside risk models have included THWs
Grant or contract	• Organization receiving the grants/contracts and hiring THWs has certainty about revenue available and what THW services can be provided • THWs may be funded by multiple payers and/or braided funding streams • Can leverage/braid federal and foundation funding for THWs • Builds organizational/community capacity that supports THWs (and THW ownership/control)	• Grants will end and contracts may not be renewed • Grants and contracts often do not cover true overhead/administrative (or constant grant writing/reporting and contracting) expenses • Commonly tied to a specific program, e.g. diabetes, cancer, etc. which may limit scope of THW services available and tailoring to patient and community needs

Payment mechanism	Strengths	Limitations
	• Flexibility in program design to meet patient and/or community identified needs	• Integration can be a challenge if the primary care provider is not directly hiring or supervising the THWs

There are different models to integrate and sustain the THW workforce.[viii]

One successful model of THW implementation is employment by a primary care clinic combined with extensive work in the community. The close connection with the clinic facilitates integration with the primary care team and availability for warm handoffs. Work in the community allows a THW to meet patients in the community where they live and / or work and maintain connections with organizations working in the community.

THWs can also work solely in the community or a clinic. Clinic-based approaches can be easier and more comfortable for health and hospital systems to implement with easy integration into the care team, warm handoffs and increased trust among some patients. With a clinic-based approach, THWs spend their time in a clinical setting and may be unable to fully connect with community members. The strengths of THWs to work in the community is not leveraged when patients must come to the clinic for care and services, including those provided by the THWs; this is additionally pronounced for underserved communities that have faced decades of discrimination and disparate treatment from and often mistrust healthcare and government institutions.

THWs working exclusively out of a CBO can benefit from the relationship CBOs have with target populations. CBOs are often known and trusted, making it easier to connect with the population and be more knowledgeable about the resources available in a community. However, there can be challenges incorporating community based THWs into systems of care, including sharing of health records and the ability to do warm handoffs. There is also often a lack of capacity of CBOs to contract with health systems due to underinvestment in CBOs. Culturally specific CBOs may especially lack the infrastructure to contract with health systems and government entities. Additional investments from healthcare funding dollars would be beneficial to bridge this gap.

Key Definitions, Background and Evidence

THWs are trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members. THWs have historically provided person- and community-centered care by bridging communities and the health systems that serve them, increasing the appropriate use of care by connecting people with health systems, advocating for patients, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health.

THWs diversify the health care workforce, provide high-quality and culturally competent care to Oregon's increasingly diverse populations and ultimately promote health equity.[ix] OHA

defines health equity as “when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

There are multiple types of THWs recognized and certified by OHA:

- **Doula** is a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.
- **Peer Support Specialist** is any range of individuals who provide supportive services to a current or former consumer of mental health or addiction treatment.
- **Peer Wellness Specialist** is an individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being.
- **Family Support Specialist** is an individual with experience parenting a child or youth who has experience with substance use or mental health treatment who supports other parents with children or youth experiencing substance use or mental health treatment.
- **Youth Support Specialist** is an individual with lived experience with substance use or mental health treatment who also had difficulty accessing education, health or wellness services who wants to strictly provide support services to people under the age of 30.
- **Personal Health Navigator** is an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions.
- **Community Health Worker** is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.
- **Tribal Traditional Health Worker** is an individual who has expertise or experience in public health and works in a tribal community or an urban Indian community.

Multiple program evaluations show strong evidence of improved quality and decreased costs resulting from the integration of THWs across provider types.

Doulas – findings from three studies	A randomized control trial of continuous support in labor to low-income women by a lay doula at a women’s ambulatory care center at a tertiary perinatal care hospital in New Jersey found that doula-supported mothers had significantly shorter lengths of labor, more cervical dilation and higher infant Apgar scores at one- and five-minutes post birth.[x] A retrospective program evaluation of a hospital-based doula program in an urban, multicultural setting through the first seven years of the

	program found that women with doula support had significantly higher rates of breastfeeding initiation and lower rates of cesarean deliveries.[xi] The YWCA community-based Healthy Beginnings Doula Program launched in 2008 in Greensboro, North Carolina focuses on reducing adverse birth outcomes for women at risk because of racial disparity (particularly African American and Hispanic), homelessness, interpersonal violence, unhealthy housing, poverty or young age. A study of the program found doula-assisted mothers were four times less likely to have a low-birth-weight baby, two times less likely to experience a birth complication involving themselves or their baby and significantly more likely to initiate breastfeeding.[xii] Women who received doula support had lower preterm and cesarean birth rates than Medicaid beneficiaries regionally (4.7% vs. 6.3%, and 20.4% vs. 34.2%). After adjustment for covariates, women with doula care had 22% lower odds of preterm birth (AOR=0.77, 95% CI [0.61–0.96]). Cost-effectiveness analyses indicate potential savings associated with doula support reimbursed at an average of $986, (ranging from $929 to $1,047 across states). [In comparison group, doulas worked at CBO, and were funded by Medicaid managed care plans to provide childbirth-related education, but were not funded to provide support during labor and delivery][xiii]
Personal health navigators / patient navigators – findings from one study	A study of the Cancer Disparity Research Partnership, a community-based program in South Dakota for Native Americans developed by the National Cancer Institute, found that navigated patients undergoing radiotherapy had fewer treatment breaks compared with non-navigated patients. This outcome may result in higher cure rates for some tumor types as a result of this intervention. The success of the program resulted in fewer referrals out for treatment, thereby significantly increasing health care dollars available for cancer treatment.[xiv]
Peer support specialist – findings from five studies	In 2006 the Georgia Department of Behavioral Health & Developmental Disabilities compared consumers using certified peer specialists as a part of their treatment verses consumers who received the normal services in day treatment. The study found that consumers using certified peer specialists cost the state $997 per year on average verses an average cost of $6,491 in day treatment, providing an average cost savings of $5,494 per person per year.[xv] A New York Association of Psychiatric Rehabilitation Services program matches peers who are managing their recovery and completed training with patients just beginning treatment. An evaluation of the program found that 71% of the people the Peer Bridgers worked with were able to stay out of the hospital in 2009 and 54% have not been re-hospitalized.[xvi]

	A peer support program in Pierce County Washington reduced involuntary hospitalizations by 32% leading to savings of $1.99M in one year. The Optum Pierce Peer Bridger program used peer coaches to serve 125 people; 100% of participating consumers had been hospitalized prior to having a peer coach, but only 3.4% were hospitalized after getting a coach; there was an estimated $550,215 in savings due to the 79.2% reduction in hospital admissions year over year.[xvii] A Federally Qualified Health Center in Denver (FQHC) that used peer support had an ROI of $2.28 for every $1 spent.
Family support specialist – findings from one study of three programs	Early research studies of three programs suggests that parent peer support offers parents and other caregivers 1) increased sense of collaboration, 2) decreased internalized blame, 3) increased sense of self-efficacy, 4) recognition of the importance of self-care, 5) decreased family isolation, 6) increased empowerment to take action and 7) increased acceptance and appreciation of child's challenges and increase ability to work with both formal and informal supports.[xviii]
Community health workers – findings from five studies of 10 programs	An Asthma CHW project among Medicaid covered children living in disadvantaged Chicago neighborhoods found an ROI of 5.58:1.[xix] A study in Nevada found a 1.81:1 ROI for a CHW-led program that worked with patients for 30-60 days.[xx] A Maryland CHW outreach program for African American Medicaid patients with diabetes resulted in a decline of 40% in ED visits, 33% in admissions and 27% in Medicaid reimbursements. These quality improvements resulted in average savings of $2,245 per patient per year.[xxi] Eastern Kentucky's rural health information hub staffed by CHWs targeting low-income residents saved $11.34 for every $1 invested in CHW staff and services.[xxii] A Denver CHW outreach program increased primary and specialty care visits and decreased urgent care, inpatient, and outpatient behavioral health care utilization, resulting in a ROI of 2.28:1.[xxiii] The Individualized Management for Patient-Centered Targets (IMPaCT), a Medicaid standardized community health worker intervention implemented across the country that addresses unmet social needs for disadvantaged people, resulted in a ROI of 2.47:1.[xxiv] A study of multisector interventions conducted by the Oregon Health Authority Health Evidence Review Commission found that the preponderance of evidence supports that CHWs serving as a part of an integrated care team appear to improve outcomes in:

	• Children with asthma with preventable emergency department visits • Adults with uncontrolled diabetes or uncontrolled hypertension This evidence includes an emphasis on minority and low-income populations.[xxv] Beginning in 2005, a New Mexico Medicaid managed care plan contracted to pay University of New Mexico Department of Family and Community Medicine $256 per member per month for CHW services (increased to $306 in 2007, and to $321 in 2009); 5 CHWs were employed by the UNM, and one by a partner federally qualified health center; ROI of 3:1.[xxvi] The Buckeye Health Plan in Ohio partnered with a community hub to provide CHW services, documenting an ROI of 2.36:1 from over 3,700 deliveries from 2013-2017, with greatest per member per month cost savings for newborns born to mothers with high risk ($403 PMPM).[xxvii] Pooled data (n=1,340) from three randomized clinical trials from 2011-2016, with CHWs employed by health systems, academic medical centers, Veterans Affairs medical centers, and Federally Qualified Health Centers, providing tailored social support, health behavior coaching, connection with resources, and health system navigation showed total number of hospital days per patient in the intervention group was 66% of the total in the control group, with fewer hospitalizations per patient and shorter mean length of stay.[xxviii] A randomized clinical trial of CHW intervention at an academic medical center among patients with ACO insurance showed reduced hospital readmissions, reduced missed clinic appointments, and reduced readmissions to rehabilitation for patients discharged to rehabilitation.[xxix]

[i] McCollum R, Gomez W, Theobald S, Taegtmeyer M. How equitable are community health worker programmes and which programme features influence equity of community health worker services? A systematic review. BMC Public Health. 2016;16:419 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4875684/pdf/12889_2016_Article_3043.pdf

[ii] https://www.oregon.gov/oha/OEI/THW%20Documents/FINAL-Payment-Models-Grid-by-Worker-Type-with-Disclaimer-9.25.19.pdf

[iii] Traditional Health Worker Toolkit https://www.oregon.gov/oha/OEI/THW%20Documents/Traditional-Health-Worker-Toolkit-2019-Final.pdf

[iv] Oregon Community Health Worker Association, Community Health Worker Payment Model Guide, 2020, https://www.orchwa.org/resources/Documents/ORCHWA%20Payment%20Model%20Guide%202020.pdf

[v] Ibid.

[vi] Eastern Oregon CCO Community Health Worker Policy. https://www.eocco.com/-/media/EOCCO/PDFs/chw_policy.pdf

[vii] Ibe CA, Hickman D, Cooper LA. To advance health equity during COVID-19 and beyond, elevate and support community health workers. JAMA Health Forum. 2021;2(7):e212724 https://jamanetwork.com/journals/jama-health-forum/fullarticle/2782746

[viii] Oregon Community Health Worker Association, Community Health Worker Payment Model Guide, 2020, https://www.orchwa.org/resources/Documents/ORCHWA%20Payment%20Model%20Guide%202020.pdf; Traditional Health Worker Toolkit https://www.oregon.gov/oha/OEI/THW%20Documents/Traditional-Health-Worker-Toolkit-2019-Final.pdf
[ix] https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx
[x] Campbell DA, Lake MF, Falk M, Backstrand JR, J Obstet Gynecol Neonatal Nurs. 2006 Jul-Aug; 35(4):456-64.
[xi] Mottl-Santiago J, Walker C, Ewan J, Vragovic O, Winder S, Stubblefield P. A hospital-based doula program and childbirth outcomes in an urban, multicultural setting. Matern Child Health J. 2008 May;12(3):372-7. doi: 10.1007/s10995-007-0245-9. Epub 2007 Jul 3. PMID: 17610053. https://pubmed.ncbi.nlm.nih.gov/17610053/
[xii] Gruber J, Cupito S, Dobson C. Impact of Doulas on Healthy Birth Outcomes. J Perinat Educ. 2013 Winter; 22(1): 49-58. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/
[xiii] Kozhimannil KB, Hardeman RR, Alarid-Escudero F, Vogelsang CA, Blauer-Peterson C, Howell EA. Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. Birth. 2016;43(1):20-27. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5544530/pdf/nihms882297.pdf
[xiv] Petereit D, Molloy K, Reiner M, Helbig P, Cina K, Miner R, Spotted Tail C, Rost C, Conroy P, Roberts C. Establishing a Patient Navigator Program to Reduce Cancer Disparities in the American Indian Communities of Western South Dakota: Initial Observations and Results. Cancer Control. 2008 Jul; 15(3): 254–259. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2556124/
[xv] Bergeson, S. (2011). Cost Effectiveness of Using Peers as Providers. https://mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf
[xvi] Ibid.
[xvii] Ibid.
[xviii] Family, Parent and Caregiver Peer Support in Behavioral Health. Bringing Recovery Supports to Scale, Technical Assistance Center Strategy. SAMHSA. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf
[xix] Margellos-Anast H, Gutierrez MA, Whitman S. Improving asthma management among African-American children via a community health worker model: findings from a Chicago-based pilot intervention. J Asthma. 2012 May;49(4):380-9. doi: 10.3109/02770903.2012.660295. Epub 2012 Feb 21. PMID: 22348448. https://pubmed.ncbi.nlm.nih.gov/22348448/
[xx] Christiansen E and Morning K. 2017 May 31. Community Health Worker Return on Investment Study Final Report. https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/CHW/dta/Publications/CHW%20ROI%20Report%209-26-17.pdf
[xxi] Fedder DO, Chang RJ, Curry S, Nichols G. The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. Ethn Dis. 2003 Winter;13(1):22-7. PMID: 12723008. https://pubmed.ncbi.nlm.nih.gov/12723008/
[xxii] Kentucky Homeplace. https://www.ruralhealthinfo.org/project-examples/785
[xxiii] Whitley EM, Everhart RM, Wright RA. Measuring return on investment of outreach by community health workers. J Health Care Poor Underserved. 2006 Feb;17(1 Suppl):6-15. doi: 10.1353/hpu.2006.0015. PMID: 16520499. https://pubmed.ncbi.nlm.nih.gov/16520499/
[xxiv] Kangovi S, et al. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Affairs, Feb 2020 VOL. 39, NO. 2. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00981
[xxv] Oregon Health Authority Health Evidence Review Commission, Multisector Intervention Report: Community Health Workers for Patients with Chronic Disease, 2019. https://www.oregon.gov/oha/OEI/THWMtgDocs/CHW-Multisector-Report-Final.pdf
[xxvi] Johnson D, Saavedra P, Sun E, Stageman A, Grovet D, Alfero C, Maynes C, Skipper B, Powell W, Kaufman A. Community health workers and Medicaid managed care in New Mexico. J Community Health. 2012;37(3):563-571. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3343233/pdf/10900_2011_Article_9484.pdf
[xxvii] Lucas B, Detty A. Lower first year of life costs for health plan and community hub partnerships, Buckeye Health Plan, 2018 http://www.hcgc.org/uploads/1/0/2/7/102711164/buckeye_hcno_pathways_success--cost_savings.pdf

[xxviii] Vasan A, Morgan JW, Mitra N, Xu C, Long JA, Asch DA, Kangovi S. Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: A pooled analysis of three clinical trials. Health Serv Res. 2020;55(Suppl 2):894-901 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7518822/pdf/HESR-55-894.pdf

[xxix] Carter J, Hassan S, Walton A, Yu L, Donelan K, Thorndike AN. Effect of community health workers on 30-day hospital readmissions in an accountable care organization population: A randomized clinical trial. JAMA Netw Open. 2021;4(5):e2110936 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8138690/?report=printable