

The Importance of Community Health Workers for CVD Prevention and Treatment

Guidance to AHA Staff

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Summary AHA position

The American Heart Association (AHA) supports the appropriate use of Community Health Workers (CHWs) as part of a team approach to preventing and treating cardiovascular disease. With an unparalleled ability to reach and support individuals in their homes and communities, CHWs play a vital role in supporting patient care, particularly in many underserved communities. Additionally, with the critical need to create seamless clinic to community linkages, CHWs will continue to serve an increasingly important role in the healthcare workforce.

Background

Cardiovascular disease (CVD) remains the number one killer of American men and women.¹ With an aging population, the prevalence and cost of care associated with CVD and conditions like heart failure and stroke will increase markedly over the next several decades.^{2,3} By the year 2035, nearly half of the U.S. population is projected to have CVD, generating \$1.2 trillion annually in direct and indirect medical costs.^{4,5} Because of the growing national burden and persistent disparities in the rates of CVD, AHA is committed to improving the cardiovascular health of all Americans while simultaneously reducing deaths from CVD.⁶ This is especially true for children and adolescents who are increasingly exhibiting pre-diabetes, hypertension, and other risk factors for CVD and stroke at an earlier age.^{7,8}

In addition to the growing burden of CVD, too few health care providers exist where they are needed to prevent and treat chronic diseases. Significant numbers of medical students are subspecializing, rather than pursuing primary care, and decades-long nursing shortages show no indication of correcting.⁹ Under likely scenarios, the U.S. will face a physician shortage between 40,800 and 104,900 by 2030, and up to 96,800 even if physicians were equitably distributed throughout the nation.¹⁰ While the CHW workforce cannot replace physicians or other licensed providers, CHWs play a critical role in supporting care and addressing many of the social determinants of health that significantly impact patient outcomes.

Community Health Workers

The American Public Health Association (APHA) defines a CHW as “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 worker to serve as a liaison between health/social services and the

Policy Research: Linking scientists, clinicians and policymakers to help improve cardiovascular health and decrease heart disease and stroke mortality.

community to facilitate access to services and improve the quality and cultural competence of service delivery... [and] 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. ”¹¹

A CHW may be a lay health worker, community health advocate, patient navigator, *promotor de salud*, or another care provider, and may be trained and certified in a particular area, such as chronic disease management education. The World Health Organization has provided global case studies on integrating CHWs into national health systems to deliver care in countries across the world, including in Southeast Asia, sub-Saharan Africa, and Latin America.¹²

CHWs play a particularly important role in health care because they are able to gain a level of trust that may be unattainable by traditional health care workers. This attribute enables CHWs to strengthen connections among community networks, improve the cultural competency of service delivery, and improve individual and community capacity to prevent and manage disease.

According to the Centers for Disease Control and Prevention (CDC), the core roles of CHWs include:

- Bridging the divide between communities and the health care system.
- Providing culturally competent health education and information.
- Providing direct services and preventive health screenings.
- Ensuring adequate service delivery and follow-through.¹³
- Providing counseling and social support.
- Advocating for individuals and communities.
- Building individual and community capacity to address health and well-being.

Additionally, CHWs may support chronic disease prevention and management as part of multidisciplinary teams by:

- Reaching out to individuals in a community and creating clinic-community linkages.
- Measuring and monitoring risk factors.
- Educating patients and their families about healthy behaviors and medication adherence.
- Helping patients navigate health care systems.
- Leading, supporting, and/or assessing individualized goal-setting or self-management programs.
- Providing cultural competency training to the other members of a health care team.¹⁴

While these definitions guide a general understanding of the work that CHWs perform and the role they may play as part of a health care team, professional identities vary by state. As of 2016, only fifteen states defined a CHW scope of practice or specified their roles, responsibilities, and functions.¹⁵

CHW education and certification

There is no single national or industry-established CHW education and/or certification policy. As of August 2017, twelve states do not recognize any CHW training programs or curricula in their state; four are in the process of developing standards for such programs; seven recognize but do not approve training programs in their state; and 26 have certified curricula and/or training program standards. Thirteen states certify CHWs, though most of these certifications are voluntary, and 11 are discussing or developing certification programs.¹⁶

The National Academy of State Health Policy (NASHP), maintains a list of current state certification policies informed by an annual survey.¹⁷ While some states require strict curricula and training programs for CHWs, others support an approach more focused on maintaining CHWs' close community ties. States may develop their own CHW curricula and certification standards or adopt another state or private institution's curricula and certification, such as:

- Certification Guidelines: Credential Standards and Requirements Table – Certified Community Health Worker (CCHW) – *Florida Certification Board*¹⁸
- Community Health Worker (CHW) – *MN Department of Health*¹⁹

States that utilize CHWs

According to the NASHP, CHWs are active in all states except Alabama, Tennessee, and Wyoming. Their competencies, scopes of practice, titles, and disease areas of focus vary among states. For example, a CHW in Arizona may provide the full breadth of preventive services recommended by the American Public Health Association,²⁰ including chronic disease management and health education, while a CHW in another state may be limited to providing care related to the home environment, such as asthma trigger remediation or falls prevention.²¹ Rules regarding CHW education, certification, and financing are similarly varied.

Some states have formally established mechanisms through which CHWs may provide care that helps prevent and/or manage CVD and other chronic diseases.

- **Arizona** adapted the National Institute of Health (NIH) *Your Heart, Your Life* program for its *Steps Forward* curriculum, a resource to aid CHWs in working with Latino populations to develop the knowledge, skills, and motivation to prevent heart disease and other chronic diseases.²²
- **New Mexico** defined the CHW scope of practice in the “Community Health Workers Act” of 2014, and established its CHW Certification Board the year after. Under the law, CHWs may, among other services, provide health screenings, conduct motivational counselling and education, and measure and respond to vital signs.^{23,24}
- **Kentucky** created the Kentucky Homeplace initiative to reach rural Kentuckians with education about disease risk factors, prevention, and self-management.²⁵ The training for the CHWs who

provide this care specifically includes modules on health coaching for chronic conditions, and other skills to support patients in preventing and managing illness and disease.²⁶

In all states, inconsistent funding remains a significant barrier to expansion of the CHW workforce. CHWs are often funded through grants or community programs with limited funding. Currently, few states reimburse CHWs through Medicaid, private plan reimbursement, or public employee plans.; and none reimburse for CHWs' full scope of practice.

- **Missouri** implemented a State Plan Amendment (SPA) to include reimbursement for CHWs through Medicaid; specifically for the provision of asthma preventive education and in-home environmental assessments recommended by a licensed practitioner.¹ This change allows CHWs to bill Medicaid on a fee-for-service basis.
- **Oregon** reimburses CHWs as part of coordinated care organizations (CCOs), which were established through a Medicaid (Section 1115) waiver. Within CCOs, CHWs may provide and be reimbursed for condition-related self-management education. CHWs must be certified by the Oregon Health Authority to qualify for reimbursement, and a licensed provider must order any service they provide.²⁷ **Minnesota** reimburses under a similar model.²⁸
- A grant program established through a 2013 pay-for-success project in **South Carolina** allowed primary care practices to hire CHWs and bill Medicaid for their services. Those practices that hired a CHW received a \$6000 grant from the South Carolina Department of Health and Human Services to cover the CHW's training and administrative costs. Primary care practices were also authorized to bill Medicaid for the CHW's work on a fee-for-service basis.²⁹

Broadly speaking, though CHWs already contribute to the healthcare workforce in 47 states, their work is often unregulated. State-based efforts to develop and implement CHW training and certification requirements in chronic-disease care, to create governing bodies such as New Mexico's CHW Certification Board, and to finance the work of CHWs may help equip these workers with important skills and facilitate their incorporation into provider networks.

Summary of the Existing Evidence on CHWs and Cardiovascular Disease

Through the provision of services listed above, a growing body of research demonstrates CHWs' positive impact on chronic disease outcomes, particularly among low-income and minority populations. CHWs have been shown to improve chronic disease management,^{30,31,32,33,34} enhance disease prevention and screening,^{35,36,37,38,39,40} and promote positive lifestyle behavior changes.^{41,42,43,44}

These successes are due in part to CHWs' ability to provide culturally-competent, patient-centered care outside of and in addition to traditional healthcare settings. During visits held in homes and community settings, CHWs can help expand cardiovascular care outside of the traditional office setting, bringing care to where barriers are most insurmountable.^{45,46} For example, CHWs have been shown to help underserved patients reduce their risk of cardiovascular disease and improve hypertension control by motivating lifestyle changes and addressing barriers to medication adherence.^{47,48,49} In one study, CHWs' identification of patients' CVD risk was identical to registered nurses' assessments.⁵⁰ In addition,⁵¹

¹ MO State Plan Amendment 16-0004. 2016. At: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MO/MO-16-04.pdf>

studies have found that care delivered by CHWs can supplement primary care to help patients adopt healthy lifestyle changes more cost-effectively than clinical care alone.⁵²

A great deal of a CHW's impact derives from his or her ability to form meaningful relationships with a patient. Strong patient-provider relationships and attention to the patient's sociodemographic circumstances have been shown to improve medication adherence and blood pressure control among hypertensive patients.^{53,54} Some of the observed positive outcomes may be attributable CHWs' ability to provide more frequent, regular treatment.⁵⁵ Furthermore, by making the person feel "that he or she is cared for and loved, esteemed, and a member of a network of mutual obligations," and/or by providing for social connectedness that might otherwise be missing from a person's life, the social support a CHW provides may itself reduce that person's risk of cardiovascular disease and stroke.^{56,57,58}

Numerous recommendations include preparing CHWs for direct care roles with national training standards.^{59,60} The Community Preventive Services Task Force specifically recommends interventions engaging CHWs to prevent CVD, citing improvements in cholesterol and blood pressure.⁶¹ The World Health Organization and AHA also support BP measurement by CHWs for patients with hypertension, specifically "due to the increased access to digital blood pressure measuring devices."⁶²

However, a lack of clear definitions for roles and standard training requirements remains a barrier to bringing CHWs' work to scale. States rarely consider disease-specific training for CHWs a core competency.⁶³ Though research has found that CHWs may be taught and relied upon to conduct risk factor screenings and take basic vital signs, "training alone is not enough and...close supervision [is] critical to the effectiveness of CHWs."⁶⁴ As such, CHWs virtually never work alone. Numerous studies demonstrate that trained CHWs working alongside nurses, physician assistant, and/or as part of larger teams create an effective model of care for cardiovascular and other chronic diseases.^{65,66,67} The CDC notes "very strong" evidence in support of CHWs providing chronic disease care (e.g. blood pressure measurement, self-management, and education) under the supervision of a licensed provider and as part of a multidisciplinary care team^{68,69} and offers a CHW training manual to that end. This resource is designed to help individuals "prevent or manage heart disease, stroke, high blood pressure and cholesterol, diabetes, depression and stress, and other lifestyle risk factors."⁷⁰ To the extent that CHWs are providing disease-related care to patients with or at risk of CVD, they should be appropriately trained and their roles as members of larger care teams clearly defined.

What the AHA Supports

- Integration of CHWs into the health care team to foster clinic-community linkages and social support.
- State-based efforts to develop and implement CHW training and certification requirements in chronic-disease care and management, to create governing bodies, and equip these workers with important skills and facilitate their incorporation into provider networks.^{71,72,73}
- Payment for CHW services through Medicaid, private plan reimbursement, or public employee plans. There are several ways that states can fund CHWs through Medicaid -- State Plan Amendments (SPAs) for Reimbursing Preventive Services, defined reimbursement through Section 1115 Waivers, state legislation and State Plan Amendments (SPAs) for broader Medicaid

reimbursement, reimbursement through Managed Care Contracts, and funding through other health system transformation efforts.⁷⁴

Appendix –

National CHW Associations

American Association of Community Health Workers -Durrell Fox, Co-Chair, dfoxnehec@aol.com

APHA CHW Section www.apha.org/member_groups/sections/aphasections/chw - Wandy Hernandez, Chair, (312) 878-7018 wandyhdz@healthconnectone.org

National Association of Community Health Representatives - www.nachr.net Ramona Dillard, CHR/CHWD, (505) 552-6652 rdillard@lagunatribe.org

National Día de la Mujer Latina Promotores Network www.diadelamujerlatina.org - Venus Ginés, (713) 798-5715, or toll-free, (877) 518-8889

Most states have their own CHW Associations

The Preventive Services Rule Change

CHWs are an important part of the health care workforce in the vast majority of states, yet only seven state Medicaid programs reimburse even a portion of this work.⁷⁵ As such, the CHW work force remains burdened by unpredictable and often insufficient financial support. Though no states have yet implemented a recent regulatory rule change, CMS changes its regulations in 2014 to allow Medicaid to reimburse CHWs for preventive care.⁷⁶ By changing the definition of preventive services, the “preventive services rule change” gave states the option to provide Medicaid reimbursement for a preventive service provided by a non-licensed practitioner, including CHWs, as long as the service is recommended by a licensed practitioner.

To implement the preventive services rule change, states must use a mechanism called a Medicaid State Plan Amendment (SPA). States use SPAs to notify or seek permission from CMS for any change to eligibility, coverage, or reimbursement. By submitting a Medicaid SPA to include CHWs and other non-licensed practitioners as eligible providers of preventive services, states can bolster their healthcare workforce where needed.

Patients with or at risk of CVD would benefit from a state adopting the preventive services rule change. The CDC endorses training for CHWs in the prevention and management of heart disease, stroke, high blood pressure and cholesterol, diabetes, depression and stress, and other lifestyle risk factors. CHWs may use motivational interviewing to help identify and address lifestyle factors related to ones’ risk of CVD or stroke, screen for CVD risk, and provide other preventive services to underserved patients.

Minnesota was the foremost state to implement a SPA allowing for CHWs to be reimbursed for health education related to a patient’s specific health condition; a relevant but more narrow change. In 2017, California attempted to submit a preventive services rule change SPA to reimburse CHWs, but the directing legislation was vetoed by the governor.

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