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Developing a Health Care Workforce That Supports Team-Based Care Models That Integrate Health and Social Services

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DEVELOPING A HEALTH CARE WORKFORCE THAT SUPPORTS TEAM-BASED CARE MODELS THAT INTEGRATE HEALTH AND SOCIAL SERVICES

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ABSTRACT

Across the country, health care professionals are joining forces to improve the health care of populations with complex social, financial, and behavioral health needs. One promising approach relies on community-based integrated health teams (CIHTs), or interprofessional teams that integrate a broad range of medical, behavioral health, and social services, offer intensive case management, and link patients to available community resources. Yet whether CIHTs fulfill their potential depends in part on policymakers enacting policies that support CIHTs delivering comprehensive, high-value care to their patients. Drawing on the insights of CIHT professionals shared with the authors, this Article highlights several factors that contribute to CIHTs' success, namely utilizing community health workers (CHWs) to provide patients with high-touch care, including behavioral health experts on the care team, and increasing coordination between CIHTs and patients' primary care providers. The Article

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then calls for federal and state policies that would promote expansion of the CHW and behavioral health workforce, provide more flexible and sustainable financing to CIHTs, and support primary care providers acquiring the financial resources, data capabilities, and personnel needed to either embedding CIHTs within their practices or coordinate with outside CIHTs.

I. INTRODUCTION

President Biden's appointment of the first-ever presidential advisor focused solely on health disparities, Dr. Marcella Nunez-Smith,[1] signals the administration's commitment to improving the health of racial and ethnic minorities and other groups that have been economically and socially marginalized. These health disparities stem not only from existing inequities in access to health care, but also unequal social, economic, and environmental conditions.[2] Growing appreciation of the interconnectedness between health and unmet social, economic, and behavioral health needs has led to enormous interest in innovative care delivery models that take a holistic view of patients' health. In particular, emerging evidence suggests that team-based approaches that integrate a broad range of medical, behavioral health, and social services and offer intensive case management can improve the health of patients with chronic conditions complicated by complex social, financial, and behavioral health needs.[3] We refer to this care model as community-based integrated health teams (CIHTs).[4]

Although CIHTs vary in their structure and operations, they share a holistic approach to health that goes beyond the traditional focus on medical needs.[5]

1. Maria Aspan, *Biden's Health Equity Adviser on Her Approach to Addressing the Politicization of COVID and Misinformation*, FORTUNE (Jan. 9, 2021, 2:00PM), https://fortune.com/2021/01/09/dr-marcella-nunez-smith-biden-covid-task-force-health-equity-advisor-vaccine/.

2. *See* COMM. ON INTEGRATING SOC. NEEDS CARE INTO THE DELIVERY OF HEALTH CARE TO IMPROVE THE NATION'S HEALTH, THE NAT'L ACADS. OF SCIS., ENG'G, MED., INTEGRATING SOCIAL CARE INTO THE DELIVERY OF HEALTH CARE: MOVING UPSTREAM TO IMPROVE THE NATION'S HEALTH 20 (2019).

3. *See, e.g.*, Brian W. Powers et al., *Impact of Complex Care Management on Spending And Utilization for High-Need, High-Cost Medicaid Patients*, 26 AM. J. MANAGED CARE e57, e57, e60 (2020) (reporting that Medicaid patients randomized to complex care management had lower total medical expenditures, inpatient admissions and days, and fewer specialist visits than patients randomized to usual care); COMM. ON ACCT. FOR SOCIOECONOMIC STATUS IN MEDICARE PAYMENT PROGRAMS, THE NAT'L ACADS. OF SCIS., ENG'G, MED., SYSTEMS PRACTICES FOR THE CARE OF SOCIALLY AT-RISK POPULATIONS 44–47 (2016) (summarizing studies showing that collaborative partnerships can improve patient outcomes).

4. The literature uses terms that capture specific types of CIHTs, such as "community health teams" that support primary care providers who provide patient-centered care and "super utilizer programs" that provide intensive care management to high-need, high-cost patients. In addition, some articles use similar terminology when referring to interdisciplinary care teams based in the primary care setting that integrate medical and behavioral health care, some (but not all) of which also address patients' social needs. We use the term CIHT to broadly capture any interdisciplinary care team that provides intensive care management to specific or non-specific patient populations with the goal of addressing their physical, behavioral, and social needs, including care teams that are embedded in or support primary care practices, care teams operated by a hospital, health care system, or local or state public health department, and teams operated by community-based organizations that may or may not support specific types of providers (e.g., primary care practices).

5. *See generally* MARY TAKACH & JASON BUXBAUM, THE COMMONWEALTH FUND, CARE MANAGEMENT FOR MEDICAID ENROLLEES THROUGH COMMUNITY HEALTH TEAMS 7 (2013),

Specifically, they address the full spectrum of patients' health-related needs, coordinating care across the health care, public health, and social services sectors, and linking patients to community resources.[6] This approach relies on multidisciplinary care teams that may include clinicians, behavioral health specialists, social workers, community health workers (CHWs), [7] and other health-related professionals.[8]

Whether CIHTs can advance health equity goals, however, depends in part on the adoption of federal and state policies that promote their success. The experiences of frontline professionals participating in CIHTs can offer instructive insights into the factors that support their mission of improving the health of groups that are economically and socially marginalized, as well as the challenges that hinder their success. Drawing on qualitative interviews conducted with CIHT professionals, this Article highlights several factors that contribute to CIHT success. These insights offer instructive lessons to policymakers as they develop a national health equity agenda. In particular, the Article focuses on how the emerging agenda could support the CIHT model by ensuring that the future health care workforce is skilled in providing comprehensive, integrated care.

https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2013_may_1690_takach_care_mgmt_medicaid_enrollees_community_hlt_teams_520.pdf (identifying as a core program feature for profiled community health teams "whole-person care of patients identified as high-risk, high-need, or high-cost"); CTR. FOR HEALTH CARE STRATEGIES & STATE HEALTH ACCESS DATA ASSISTANCE CTR., COMMUNITY CARE TEAMS: AN OVERVIEW OF STATE APPROACHES 2 (Mar. 2016).

6. TAKACH & BUXBAUM, *supra* note 5, at 7, 11 (describing the activities of community health teams); CTR. FOR HEALTH CARE STRATEGIES & STATE HEALTH ACCESS DATA ASSISTANCE CTR., *supra* note 5, at 2; Stephanie L. Barker et al., *Values-Based Interventions in Patient Engagement for Those with Complex Needs*, 23 POPULATION HEALTH MGMT. 140, 140–45 (2020) (describing the use of an integrated records system to support coordinated activities across agencies).

7. The literature has not yet settled on a consistent definition of the term "CHW," but this Article uses the terms as follows: "A [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 worker 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." *Community Health Workers*, AM. PUB. HEALTH ASS'N, https://www.apha.org/apha-communities/member-sections/community-health-workers (last visited Mar. 7, 2022).

8. TAKACH & BUXBAUM, *supra* note 5, at 7; CTR. FOR HEALTH CARE STRATEGIES & STATE HEALTH ACCESS DATA ASSISTANCE CTR., *supra* note 5, at 2, 8.

II. THE RESEARCH STUDY[9]

Between the spring and fall of 2021, we conducted virtual interviews with twenty-nine professionals who were members of CIHTs.[10] These professionals included physicians, registered nurses, nurse practitioners, pharmacists, behavioral health specialists, social workers, CHWs, housing coordinators, and program administrators. Interviewees represented a diverse group of CIHTs from multiple regions of the United States. The CIHTs operated in large cities as well as in rural communities, and primarily served populations that are economically and socially marginalized. Some CIHTs focused on seniors, others focused primarily on the homeless, and some others focused on low-income or uninsured individuals. Some CIHTs had flexibility in choosing their target populations, while others were limited to specific populations. Most, however, targeted patients who frequent emergency departments and inpatient facilities and/or suffer from multiple chronic conditions.

Given the wide range of CIHTs included in the study, there were several differences among them. Some CIHTs followed a more transitional approach in which they provided services to patients for a limited period of time (e.g., six months), while others had no time limit and provided services to patients on an as-needed, long-term basis. Additionally, some CIHTs were embedded in primary care practices, hospitals, health care systems, or local public health departments, which we refer to as provider-based CIHTs. Other CIHTs were unaffiliated with a health care provider and were operated by independent community-based organizations (CBOs), which we refer to as CBO CIHTs. CIHTs also varied in how they financed their operations. Many CIHTs relied in whole or in part on grant funding, and some CIHTs received funding from the state. Provider-based CIHTs often were financed in whole or in part by their organization's general operating budget, while some CBO CIHTs had contracts with local hospitals or health care systems. Some CIHTs also had contracts with managed care organizations. Given the variation in CIHTs' structure and financing, there also were differences in the types of services they provided to patients. Some CIHTs offered behavioral health and primary care services to patients, while others referred patients to outside resources for those services.

Regardless of these differences, all CIHTs conducted some type of screening for social determinants of health and helped enroll patients in public assistance programs, connected patients with community resources, or assisted patients in other ways with their unmet social needs. All CIHTs also provided care coordination, helped patients navigate the health care system, and coached patients on healthy behaviors.

9. This research was done with approval from the University of Houston Institutional Review Board.

10. Jessica Mantel et al., Interviews with Members of Community-Based Integrated Health Teams (2021) (unpublished manuscript) (on file with authors).

Our interviews explored multiple aspects of CIHT activities. Interviewees were asked to describe their patient populations and the process for selecting individual patients, their care models, and their processes for screening for social determinants of health. We also asked interviewees to describe the different roles performed by the members of their care teams and the services they provide to patients, including any referral or liaison services. The discussion regarding referrals or liaison services also encompassed a CIHT's relationship with other organizations in their respective communities. Further, we asked the interviewees about the data they used in their operations and how that data guided the CIHT's operations. Finally, we asked interviewees to discuss how their CIHT came into being and how they finance their operations.

One limitation to our analysis is sample size. Because CIHTs were, and still are, occupied with COVID response efforts, our sample size is small. Thus, it may not be representative of the full range of CIHTs currently operating in the United States. Despite this limitation, some common themes emerged, as discussed below.

III. USING COMMUNITY HEALTH WORKERS TO PROVIDE HIGH-TOUCH CARE

As the health care system moves toward team-based care delivery models that address the full range of patients' health needs, policymakers must ensure that the health care workforce includes a sufficient number of professionals with the training and skills that CIHTs need to be successful. As described below, our research suggests that CHWs are essential members of CIHTs. This Part describes the benefits CHWs bring to CIHT care teams and discusses policy changes at both the federal and state level that will support expanding the CHW workforce.

A. High-Touch Care and Community Health Workers

All organizations participating in the study provide "high-touch care," or frequent encounters between patients and care team members who check-in with patients, monitor their progress, and address health-related needs as they arise.[11]

11. Describing her organization's high-touch care, one interviewee stated:

> As an organization, we also assess regularly for social determinants of health as well. That is done as a standard part of work, every six months. Our social worker talks with the patient to do an assessment, at least one time when they're admitted, and then our navigators are constantly assessing when they see the patient.

Id. (interview with program administrator). Similarly, another interviewee highlighted the high-tough case management services her CIHT provides to patients with chronic needs or frequent emergency room visits, stating:

> We also have a case management division of [organization's name] where if we enroll anybody who has a chronic health or mental health disease and has had a couple of emergency room visits in the last year or a hospital admission in the last year, we connect those individuals to a case manager, and that case manager then works closely with that

Although empirical studies on high-touch care have found mixed results on whether it leads to better health outcomes and cost-savings for high-needs patients,[12] our interviewees emphasized the value of giving patients high-touch care management:

> I still advocate for case management services . . . And like I said, the impact that case management can make in helping people learn to use the tools that are available for them in the community and navigate the health care system has been the most impactful way for us to improve health outcomes.[13]

Several interviewees not only emphasized the importance of patients having frequent encounters with the full care team, but also the benefits of designating a *specific* care team member as a patient's primary contact.[14] Organizations gave these team members different titles—case managers, care coordinators, navigators, outreach workers—but all are tasked with regularly engaging with their assigned patients.[15] Many patients come to trust their primary contact and

person one-on-one to make sure that they understand how to utilize the health system and the medical system and also get connected to the resources that they need to help maintain their chronic diseases, to help keep them out of the ER, and to help them shift from a crisis care mode to a preventative care.

Id. (interview with program administrator).

12. *See* Reyan Ghany et al., *High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population*, 24 AM. J. MANAGED CARE e300, e301–02 (2018) (finding that high-intensity primary care models that involve frequent direct person-to-person interaction between patients their health care providers hade lower health care costs and fewer hospitalizations than a matched group of patients receiving standard primary care); Martha Hostetter et al., *CareMore: Improving Outcomes and Controlling Health Care Spending for High-Needs Patients*, COMMONWEALTH FUND (Mar. 28, 2017), https://www.commonwealthfund.org/publications/case-study/2017/mar/caremore-improving-outcomes-and-controlling-health-care-spending-0 (describing CareMore's high-touch approach to caring for high-risk patients and stating that this approach generated savings through a twenty percent reduction in hospital admissions, twenty-three percent fewer bed days, and a four percent shorter length-of-stay relative to beneficiaries covered under fee-for-service Medicare).

13. Mantel et al., s*upra* note 10 (interview with program administrator).

14. *See id.* (interview with program administrator, explaining that they assign high needs patients a case manager who works closely the patient "one-on-one" and helps the patient navigate the health care system, connect with available resources, and better manage their chronic conditions so that they focus on preventive care stay out of the emergency room); *id.* (interview with a community health worker (CHW), who commented that she personally does "a ton of outreach" to individual patients); *see also infra* note 15 and accompanying text.

15. Mantel et al., *supra* note 10 (interview with outreach worker, stating that "I have a caseload of patients that I check-in with on a weekly, monthly, or bimonthly basis."); *id.* (interview with primary care physician, stating that "essentially we don't want to lose anyone in the follow-up. Roughly, we want the navigators to be touching base every two weeks."); *id.* (interview with program administrator, noting that the patient navigators see patients at least once per month if not more frequently).

in time will openly share their personal challenges.[16] This in turn supports the CIHT developing a more effective action plan that addresses a patient's unique health-related needs. The director of a rural-based CIHT explained the importance of ongoing interactions between a patient and their primary as follows:

> [S]o that has been the most effective piece to improving our outcomes at [organization name]. I think having that one-on-one support person, having that person that actually goes with you to the doctor's office, and it's also a person that you develop a trusting relationship with. So they're able to get more than just maybe surface level information from patients. When they come into [organization name] for the first time, . . . they're probably not going to tell you everything that's going on in their life that has gotten them where they are right now. But as they develop a relationship with their case manager, they start to build trust. And then they begin to tell a little bit more of their story, which helps us to better understand how we can help that person. So I think that's been the biggest and most impactful resource that we have here.[17]

We therefore recommend that CIHTs include on their care team one or more individuals who serve as patients' primary contact and provide them with one-on-one, high-touch care.

Although some of the organizations participating in our study employ nurses or social workers in this capacity,[18] CHWs are a more cost-effective alternative.[19] As explained by one organization's director, "[o]ur model has shifted a little bit where we have found that it's more effective and more cost-effective to not use nurses and social workers as case managers, but to use our

16. *See id.*; *see also* SHARON K. LONG & LEA BART, URB. INST. HEALTH POL'Y CTR., HEALTH REFORM MONITORING SURVEY: DO PATIENTS TRUST THEIR PROVIDERS? 3, 5 (2017), https://www.urban.org/sites/default/files/publication/105146/hrms_trust_providers_final.pdf (noting that while most adults trust health care providers, adults with a chronic condition or disability who had more frequent interactions with providers, including more frequent contact that included bad news, were more likely to have the highest trust in their providers and were more willing to tell providers the truth about their health).

17. *See* Mantel et al., *supra* note 10 (interview with program administrator).

18. *See id*. (interview with social worker, commenting that the intervention team consists of social workers, who are the part of the team with direct contact with clients).

19. The U.S. Bureau of Labor Statistics reports that CHWs on average make less than registered nurses (RNs) and health care social workers, who typically receive additional years of education and training. *See Occupational Employment Wages*, *May 2020: 21-1094 Community Health Workers*, U.S. BUREAU LAB. STAT., https://www.bls.gov/oes/current/oes211094.htm (last modified Mar. 31, 2021) (noting a national mean annual wage of $46,000); *Occupational Employment Wages*, *May 2020: 29-1141 Registered Nurses*, U.S. BUREAU LAB. STAT., https://www.bls.gov/oes/current/oes291141.htm (last modified Mar. 31, 2021) (noting a national mean average wage of $80,010); *Occupational Employment Wages*, *May 2020: 21-1022 Healthcare Social Workers*, U.S. BUREAU LAB. STAT., https://www.bls.gov/oes/current/oes211022.htm (last modified Mar. 31, 2021) (noting a national mean annual wage of $60,470).

CHWs."[20] Moreover, some interviewees commented that using less costly CHWs for patient outreach allows other team members, such as nurses and social workers, to dedicate more time to other important activities, such as clinical care coordination, building relationships with community social services providers, and assessing patients' mental health.[21]

CHWs not only offer a less costly strategy for providing high-touch care, but bring a unique capacity to build strong connections with the populations aided by CIHTs. Because CHWs usually are members of the communities they serve, they share lived experiences with their patients and have a deep understanding of their communities' strengths and challenges.[22] Experts contend that this understanding allows CHWs to respond to patients' needs in culturally responsive ways.[23] In addition, they often gain patients' trust more quickly and effectively than other team members representing more traditional health professions.[24] Recent empirical studies document that the skills and insights CHWs bring to patient care teams both improve health outcomes and generate savings to payors from reduced inpatient costs.[25]

20. *See* Mantel et al., *supra* note 10 (interview with program administrator).

21. For example, one interviewee explained that the CHWs focus on helping patients navigate the health care system, but that nurses assist the patients with "more serious problems" such as management of their chronic conditions or understanding their medications, and the social workers intervene on mental health issues. *See id.* (interview with referral specialist).

22. *See* JIM LLOYD ET AL., CTR. FOR HEALTH CARE STRATEGIES, INC., TRAINING AND SUPPORTING COMMUNITY HEALTH WORKERS AND PROMOTORES: LESSONS FOR CALIFORNIA AND OTHER STATES 9 (2020), https://www.chcs.org/media/Training-and-Supporting-CHW-Report_082120.pdf ("Because they are often members of the communities they serve, [CHWs] typically have a deep understanding of the factors that impact residents' health, what makes their communities resilient, and the challenges they face.").

23. *See id.* (commenting that CHWs deep understanding of their communities "makes them uniquely capable to address issues in a culturally responsive way, and to establish trusting relationships with community members").

24. *See id.* (discussing how CHWs' cultural understanding can help establish trusting relationships); *see also* MARTINA BRESCIANI, CMTY. CATALYST, TRUSTED VOICES: THE ROLE OF COMMUNITY HEALTH WORKERS IN HEALTH SYSTEM TRANSFORMATION 1 (2015), https://www.communitycatalyst.org/resources/publications/document/Community-Catalyst-CHW-Issue-Brief-1.pdf (noting CHWs' effectiveness is facilitated by the close relationships they often have as members of the communities in which they serve); Talya Meyers, *Community Health Workers Are on the Rise. Here's Why They're Indispensable*, DIRECT RELIEF (Nov. 8, 2021, 12:52 PM), https://www.directrelief.org/2021/11/community-health-workers-are-on-the-rise-heres-why-theyre-indispensable/ (noting how CHWs are often well-known and trusted members of the communities in which they serve).

25. *See* Shreya Kangovi et al., *Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment*, 39 HEALTH AFFS. 207, 211 (2020) (finding that although outpatient utilization was higher for Medicaid patients receiving a standardized CHW intervention relative to a control group receiving standard care, savings from reduced inpatient days would generate an estimated return-on-investment of $2.47 for every dollar spent on the intervention for an average Medicaid payer within the fiscal year); Aditi

Several interviewees similarly commented on the benefits from including CHWs on their care teams, describing them as "invaluable,"[26] "the most important part,"[27] and playing a "critical role" by filling gaps in the team's understanding of patients' needs.[28] As explained by one interviewee,

> A CHW that works with us, ideally, they come from within the community that they are serving. So, they also have a component of that kind of peer support. And I've been in that position, or I'm very familiar with the community in which you come from, kind of the social norms of that community, the resources of that community, the other members of that particular community, so that peer connection is often of great value to the client.[29]

One interviewee, who worked closely with the state of California in developing the MediCal Whole Person Care Pilot Program, noted that in interviews with pilot sites, "CHWs and peers kept coming up as a theme of [sic] really critical to the model."[30]

Our research reinforces other studies establishing the valuable contribution CHWs make in improving the health of populations that are economically and socially marginalized and reducing health inequities.[31] Specifically, CHWs

Vasan et al., *Effects of a Standardized Community Health Worker Intervention on Hospitalization Among Disadvantaged Patients with Multiple Chronic Conditions: A Pooled Analysis of Three Clinical Trials*, 55 HEALTH SERVS. RSCH. 894, 898 (2020) (finding that patients living in high-poverty regions around Philadelphia who received tailored social support, health behavior coaching, and help navigating the health care system and connecting with resources from CHWs had reduced total "hospital days per patient" as compared to a control group); Shreya Kangovi et al., *Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities*, 178 JAMA INTERNAL MED. 1635, 1640 (2018) (finding that among uninsured or publicly insured patients living in high-poverty zip codes with two or more chronic conditions, those receiving tailored support from CHWs "spent fewer total days in the hospital" both six months and nine months after program enrollment relative to a controlled group receiving standard care).

26. *See* Mantel et al., *supra* note 10 (interview with medical director discussing the role of community outreach workers on the CIHT care team and commenting "that role has been invaluable").

27. *See id.* (interview with licensed clinical social worker (LCSW), stating that "CHWs – they're the most important part. They're the people who actually engage with the patient ongoing.").

28. *See id.* (interview with medical director). The interviewee stated:

> I think [CHWs] play a critical role in just being more ingrained. There's what I see, again, as a primary care doctors, there's what I see in the walls of my office, right? But a lot of times we are often blinded to what's happening in the home or just in that person's day to day, and I think that's the gap the CHWs help fill.

Id.

29. *See id.* (interview with a RN).

30. *See id.* (interview with Amanda Clark, Director of Programs, California Healthcare Safety Net Institute).

31. *See* Miya L. Barnett et al., *Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved Populations: A Systematic Review*, 45 ADMIN. & POL'Y

bring to care teams a much needed, in-depth understanding of their communities and can connect with patients in a culturally sensitive manner.[32] CIHTs therefore should endeavor to include CHWs on their care team.

B. Policy Considerations

As more and more organizations adopt the CIHT model, integrating additional CHWs into CIHTs will require expanding the CHW workforce. According to the United States Bureau of Labor Statistics, employment of CHWs is projected to grow much faster than other occupations, with projected growth of seventeen percent from 2020 to 2030.[33] Fortunately, policymakers at both the federal and state levels increasingly recognize the value of CHWs' services and the need for policies or grant programs that support CHW training and employment.[34] Despite these efforts, challenges remain. In particular, employers of CHWs have struggled to identify sustainable funding streams that support further integration of CHWs into their organizations.[35] In addition, the availability of robust, low-cost CHW training and certification programs vary greatly across states.[36] This Section identifies promising policies that would support expansion of the CHW workforce.

MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 195, 206 (2018) (noting the effectiveness of CHWs in reducing disparities in mental health outcomes).

32. *See* Andrea Cherrington et al., *Recognizing the Diverse Roles of Community Health Workers in the Elimination of Health Disparities: From Paid Staff to Volunteers*, 20 ETHNICITY & DISEASE 189, 189 (2010) (noting one of the CHW model's strengths is providing culturally competent care).

33. *Occupational Outlook Handbook: Health Education Specialists and Community Health Workers*, U.S. BUREAU LAB. STAT., https://www.bls.gov/ooh/community-and-social-service/health-educators.htm (last updated Apr. 18, 2022). The Bureau of Labor Statistics combined CHWs and health education specialists, with CHWs defined as workers who promote wellness by helping people adopt health behaviors and health education specialists defined as workers who develop programs that teach people about conditions affecting well-being. *Id.*

34. *See, e.g.*, ELINOR HIGGINS ET AL., LESSONS FOR ADVANCING AND SUSTAINING STATE COMMUNITY HEALTH WORKER PARTNERSHIPS 2 (2021), https://www.nashp.org/wp-content/uploads/2021/12/community-healthworker-brief.pdf (commenting that building the CHW workforce is central to many states' strategies to advance health equity and improve health); CARL RUSH, NAT'L ASS'N OF CMTY. HEALTH WORKERS, SUSTAINABLE FINANCING OF COMMUNITY HEALTH WORKER EMPLOYMENT 1 (2020), https://nachw.org/wp-content/uploads/2020/10/SustainableFinancingReportOctober2020.pdf (summarizing federal grants that supported CHW pilot programs and infrastructure development).

35. *See* OR. CMTY. HEALTH WORKERS ASS'N, COMMUNITY HEALTH WORKER PAYMENT MODEL GUIDE 9 (2020), https://www.orchwa.org/resources/Documents/ORCHWA%20Payment%20Model%20Guide%202020.pdf (noting the lack of payment models that can sustain CHWs in the workforce).

36. LLOYD ET AL., *supra* note 22, at 4.

1. Sustainable Financing for CHWs

The lack of sustainable financing for CHWs has been a significant barrier to expanding the CHW workforce.[37] Organizations employing CHWs generally rely on grant funding or their operating budgets to cover CHWs' salaries.[38] Most of the CIHTs in our study similarly reported that their operations, including staff salaries, are largely funded through grants and/or their organization's general operating budgets.[39] These sources of funding, however, are frequently unstable or unpredictable and can lead to CHWs being laid-off when funding is terminated or reduced.[40] Organizations such as government agencies and health care providers/systems often have tight budgets and face competing demands for their limited operating or administrative funds,[41] while grant funding commonly is time-limited.[42] Not surprisingly, then, several interviewees in our study reported that their CIHTs face ongoing challenges in securing sufficient funding for staffing, including their care teams' CHWs.[43]

37. *See* OR. CMTY. HEALTH WORKER ASS'N, *supra* note 35, at 28.

38. *See id.* at 13 (explaining that grants are the most common mechanism for funding CHWs); Emmett Ruff et al., *Building Capacity for Community Health Worker Integration: Three Key Steps State Policymakers Should Take During the Covid-19 Crisis And Beyond*, FAMS. USA (July 21, 2020), https://familiesusa.org/resources/building-capacity-for-community-health-worker-integration-three-key-steps-state-policymakers-should-take-during-the-covid-19-crisis-and-beyond/ ("[M]ost CHW programs that have been run by community health centers and community-based organizations have historically relied on either their own operating budgets or specific grants to fund CHW programs."); LLOYD ET AL., *supra* note 22, at 14 (stating that hospitals employing CHWs may rely on general operations or administrative budgets, but community health centers and CBOs employing CHWs generally fund them in part with grants, and community centers often use grant dollars of administrative funds).

39. *See* Mantel et al., *supra* note 10 (interview with program administrators and medical directors, describing how their CIHTs are financed).

40. *See* RUSH, *supra* note 34, at 2.

41. *See* Ellen Albritton, *How States Can Fund Community Health Workers Through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities*, FAMS. USA 5 (July 2016) https://familiesusa.org/resources/how-states-can-fund-community-health-workers-through-medicaid-to-improve-peoples-health-decrease-costs-and-reduce-disparities/ (reporting that funding includes organizations' own operating budgets can be "unpredictable . . . and generally insufficient to sustain the full breadth of services and supports that CHWs can provide").

42. *See* OR. CMTY. HEALTH WORKERS ASS'N, *supra* note 35, at 13 ("[G]rants are often time limited and can be considered an unstable source of funding resulting in starts and stops in programs and services as grants end.").

43. As one interviewee explained:

> I think what hinders our work right now is that, frankly, figuring out the balance of how do we make sure we're funded to do the work that we want to be doing . . . We are super innovative, tons of ideas, but finding someone to pay for it becomes a little more challenging. As so, that hinders that, and that hinders staff, and that ultimately can hinder patients.

Mantel et al., *supra* note 10 (interview with program administrator). *See also id.* (interview with program administrator, commenting that "it comes down to funding. Everybody's working hard

Because CHWs are effective in improving the health of groups that have been economically and socially marginalized, CHW advocates have identified Medicaid as a promising source of sustainable financing of CHW services.[44] Some policymakers similarly appreciate that covering CHW services potentially can generate net savings for Medicaid payors by reducing spending on expensive urgent care.[45] In response, several state Medicaid programs now provide direct, fee-for-service reimbursement[46] to CHWs or their employers for some CHW services.[47] Other state Medicaid programs, such as Alaska, Louisiana, and New Mexico, require the managed care organizations under contract with the state to pay for CHW services provided to certain patient populations, while some managed care plans in other states have voluntarily elected to do so.[48] However, these state Medicaid payors do not cover the full range of CHW services, including many of the services provided by CIHTs.[49] For example, Indiana's state Medicaid program only covers face-to-face self-management education and training provided by CHWs, and does not cover other services typically provided by a CIHT's CHWs, including assistance navigating the health care system, case management/care coordination, and linking patients to social services programs.[50] Advocates have therefore called for broader coverage of CHW services under Medicaid, and have encouraged the Centers for Medicare

and doing all they can. There's not enough people doing it and there's not enough people doing it because it's not a priority.").

44. *See* RUSH, *supra* note 34, at 2 ("Conversations among policymakers and CHW advocates in most states about financing CHWs focus heavily on Medicaid, since CHWs have historically been most effective at meeting the needs of low-income minority populations.").

45. *See* Kangovi et al., *supra* note 25, at 211.

46. "Fee-for-Service" refers to paying health care providers for each separate service performed. *See Fee for Service*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/fee-for-service/ (last visited Mar. 10, 2022) (defining "fee for service").

47. *See, e.g.*, *IHCP Adds Coverage of Community Health Worker Services*, IND. HEALTH COVERAGE PROGRAMS (May 21, 2018), http://provider.indianamedicaid.com/ihcp/Bulletins/BT201826.pdf (discussing Medicaid coverage of CHW services by the Indiana Health Coverage Programs); MINN. STAT. § 256B.0625(49) (2021) (providing for Medicaid coverage of care coordination and patient education services provide by a CHW). Other states that provide direct, fee-for-service reimbursement for CHW services include Oregon, Rhode Island, and South Dakota. *See State Community Health Worker Models*, NAT'L ACAD. FOR STATE HEALTH POL'Y, https://www.nashp.org/state-community-health-worker-models/#tab-id-2 (last updated Dec. 10, 2021) (summarizing state Medicaid reimbursement of CHW services).

48. *See id.*

49. *See generally* Ruff et al., *supra* note 38, at 8 ("In several states, CHW programs have not gotten traction because of narrow services definitions . . . This narrow role does not fit the interdisciplinary and community-based nature of CHWs, which is precisely what makes them so effective."); OR. CMTY. HEALTH WORKERS ASS'N, *supra* note 35, at 18 (identifying cons of fee-for-service reimbursement for CHW services, including "[r]eimbursement limited to approved service codes only and might discourage holistic services").

50. *See IHCP Adds Coverage of Community Health Worker Services*, *supra* note 47, at 2 (explaining covered and noncovered CHW services under the Indiana Health Coverage Programs).

and Medicaid Services (CMS) to signal to states that they can cover CHW services by amending their state Medicaid plans or requesting a Section 1115 waiver.[51] In addition, federal legislation that both adds CHW services as an optional Medicaid benefit and increases the federal government's share for spending on these services would give states strong financial incentives to cover CHW services.[52]

While fee-for-service reimbursement for CHW services would promote the growth of the CHW workforce, the payment model has several drawbacks. Employers who receive fee-for-service reimbursement for CHW services under Medicaid report that these reimbursements are too low to cover the costs of hiring a CHW on a full-time basis.[53] Inconsistent coverage of CHW services across payors contributes to this funding challenge. For example, Medicare does not cover CHW services.[54] Moreover, it would be difficult for CIHTs operated by CBOs to take advantage of fee-for-service reimbursement of CHW services. Fee-for-service payment requires that the organization employing a CHW have in place the necessary billing infrastructure to track, code, and submit claims for payment,[55] something that CBO CHITs typically lack.[56] In addition, because CHWs are unlicensed health care professionals, many states likely would limit coverage to CHW services provided under the supervision of licensed providers eligible to bill Medicaid, such as physicians, hospitals, and community health clinics.[57] Because CBO CIHTs operate independently from providers, they would have difficulty meeting these supervisory requirements.

To support the growth of the CHW workforce and, more specifically, the employment of CHWs as part of a CIHT care team, Medicaid payors should pursue alternatives to fee-for-service reimbursement for CHW services.

51. *Our Letters Below Prioritize the Importance of CHWs in the COVID-19 Crisis Response and Public Health Recovery*, IMPACT, https://chw.upenn.edu/2020/04/17/callstoaction/ (last visited Mar. 13, 2022).

52. *Id.*

53. *See* Ruff et al., *supra* note 38, at 6 (stating that some Minnesota employers of CHWs reported that Medicaid reimbursement alone could not support full-time CHW employment).

54. CMTY. HEALTH WORKERS FIN. SUSTAINABILITY WORK GRP., HEALTHY CMTYS. TASK FORCE, INFORMATION AND RESOURCES FOR COMMUNITY HEALTH WORKERS: SERVICES, BILLING AND CARE MODELS 5 (2018).

55. *See* OR. CMTY. HEALTH WORKERS ASS'N, *supra* note 35, at 17.

56. *See* Laura Beerman, *How Payers Are Linking Community-Based and Value-Based Care to Strengthen Outcomes and Equity*, HEALTHLEADERS MEDIA (Jan. 6, 2022), https://www.healthleadersmedia.com/payer/how-payers-are-linking-community-based-and-value-based-care-strengthen-outcomes-and-equity.

57. For example, Minnesota's Medicaid program requires that covered CHW services be done under the supervision of eligible billing providers. *See* RUSH, *supra* note 34, at 6; s*ee also* OR. CMTY. HEALTH WORKERS ASS'N, *supra* note 35, at 17 (explaining that Oregon's Medicaid program will pay fee-for-service reimbursement for CHW services only if the CHW is under the supervision of a licensed health care provider and the billing provider is a clinic or supervising medical provider).

Alternative payment models can give organizations the flexibility to provide a broad range of CHW services consistent with patients' individual needs.[58] One promising approach is paying organizations such as CIHTs a monthly amount for each patient assigned to them, or a per-member-per-month (PMPM) payment, which the organizations can then use to defray the cost of employing CHWs.[59] For example, Maine's Medicaid Community Care Teams receive a PMPM payment that many teams use to cover CHW positions.[60] In New Mexico, some Medicaid managed care organizations refer high-risk patients to organizations paid on a PMPM basis for providing CHW services.[61] Value-based payment models such as partial or full capitation payments[62] and pay-for-

58. *See generally* Hannah L. Crook et al., *How Are Payment Reforms Addressing Social Determinants of Health? Policy Implications and Next Steps*, MILBANK MEM'L FUND 2 (Feb. 2021), https://healthpolicy.duke.edu/sites/default/files/2021-02/How%20Are%20Payment%20Reforms%20Addressing%20Social%20Determinants%20of%20Health.pdf (explaining that value-based payment models give providers greater financial flexibility, which may allow them to fund coordinators).

59. *See generally* OR. CMTY. HEALTH WORKERS ASS'N, *supra* note 35, at 21 (noting that primary care homes that receive a PMPM payment can use these funds to cover the cost of supplemental patient programs, including CHW services); Ruff et al., *supra* note 38, at 10 (suggesting that Oregon Medicaid program adopted a PMPM payment that "could allow CHWs to provide all services within their capabilities").

60. Pay-for-performance refers to various arrangements between payors and providers that reward providers for meeting certain performance measures, such as reducing hospital readmissions, lowering diabetic patients' A1C levels, or giving aspirin to heart attack patients within a specified time after their arrival in the emergency room. *See* Julia James, *Health Policy Brief: Pay-for-Performance*, HEALTH AFFS. 1–2 (Oct. 11, 2012), https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/full/healthpolicybrief_78.pdf.; BRENDA C. SPILLMAN ET AL., U.S. DEP'T HEALTH & HUM. SERVS., MEDICAID HEALTH HOMES IN MAINE: REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT 2, 8 (2013); KERRY KERNAN, DOUGLAS CNTY. HEALTH DEP'T, NEBRASKA COMMUNITY HEALTH WORKERS: FINANCING AND SUSTAINABILITY MODELS, REPORT OF A CROSS-SECTOR WORKGROUP, SEPTEMBER 2019 TO APRIL 2020, at 23 (2020).

61. *See* Ruff et al., *supra* note 38, at 10 (discussing New Mexico's requirement that Medicaid managed care organizations fund CHW services).

62. Capitation payments are fixed amounts paid to a provider by a payor on a per-patient basis for the delivery of health care services to the payor's members. The fixed amount depends on the number of patients cared for by the provider, the period of time covered, and the range of services covered by the fixed payment. For example, a managed care organization may pay a primary care practice a fixed monthly amount for each patient enrolled in the managed care organization's plan who is cared by the primary care practice, with the fixed payment covering all services the primary care practice provides to its patients. *See* Patrick C. Alguire, *Understanding Capitation*, AM. COLL. PHYSICIANS, https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/understanding-capitation (last visited Feb. 25, 2022).

performance bonus payments[63] similarly could cover health care providers' costs of employing CHWs as members of their interdisciplinary care teams.[64] Moreover, although value-based payments are only available to providers, providers can use these payments to contract with CBO CIHTs assisting the providers' high-needs patients.[65]

Managed care organizations and providers are more likely to utilize alternative payment models to fund CHW positions if they have confidence that doing so will generate a positive return on investment.[66] Additional empirical research demonstrating the value of financing CHWs through specific payment mechanisms could promote more managed care organizations and providers doing so.[67] Federal agencies can support this research through various grants.[68]

2. CHW Training and Certification

Historically, CHWs have received training from either the organizations that employ them or local public health agencies.[69] These training programs typically offered CHWs only one-off training sessions on narrow topics.[70] Most experts, however, support standardizing the curriculum for training CHWs and

63. "Pay-for-performance" payment models financially reward health care providers for meeting performance targets on quality or efficiency metrics. *See* TIM MATHES ET AL., COCHRANE DATABASE SYSTEMATIC REVS., PAY FOR PERFORMANCE FOR HOSPITALS 2 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6611555/pdf/CD011156.pdf.; James, *supra* note 60, at 1.

64. For example, the University of New Mexico's Health Sciences Center used its monthly capitation payment from Molina Healthcare of New Mexico to cover its costs of employing CHWs who functioned as field case managers. *See* NAT'L CMTY. VOICES INITIATIVE AT THE CTR. FOR PRIMARY CARE AT MOREHOUSE SCH. OF MED. & THE NORTHERN MANHATTAN CMTY. VOICES AT THE COLUM. UNIV. CTR. FOR CMTY. HEALTH P'SHIPS, FINANCING CHWS: WHY AND HOW 11 (2007); *see* Ruff et al., *supra* note 38, at 11 (commenting that payment models such as capitation payments to primary care providers can support the comprehensive scope of services provided by CHWs).

65. Contractual arrangements between providers and CBO CIHTs may be increasingly common, as several of the CBO CIHTs participating in our study reported having contracts with local hospitals and health care systems. Mantel et al., *supra* note 10 (interview with a program administrator, commenting that some of their patient referrals come from insurance companies that they have contracted with); *id.* (explaining that her CIHT has contracts with different managed care organizations).

66. RUSH, *supra* note 34, at 8.

67. Ruff et al., *supra* note 38, at 8 ("Demonstrating the value of CHWs in terms of the return on investment they generate for MCOs is one way to facilitate the development of a CHW program at scale.").

68. *See id.*

69. *See* Theresa H. Mason et al., *Statewide Training Approaches for Community Health Workers*, NAT'L ASS'N OF CMTY HEALTH WORKERS 2 (Aug. 2021), https://nachw.org/wp-content/uploads/2021/09/8.25.21StatewideTraining.pdf?mc_cid=2df483658a&mc_eid=16dae5e526 (describing the training options historically available to CHWs).

70. *See id.*

establishing a state certification process for these programs or individuals who successfully complete standardized CHW training.[71] As detailed in a 2014 report published by the Centers for Disease Control and Prevention (CDC), there is strong evidence that a standardized CHW curriculum and certification process promotes "a common base of professional knowledge among CHWs" and establishes "professional standards in the field."[72] This in turn promotes employment of CHWs by ensuring that CHWs are prepared for their work with interdisciplinary health teams like CIHTs, as well as by signaling to employers that an individual possesses the core competencies necessary for the CHW role.[73] Importantly, a standardized CHW curriculum and certification helps legitimize CHWs in the eyes of other health care professionals who themselves are formally trained and licensed.[74] CHW certification also would promote Medicaid payors covering CHW services, as certification typically is a prerequisite for direct fee-for-services reimbursement or inclusion in managed care organizations' provider networks.[75]

The benefits of CHW training programs and certification, however, will be lost if their cost and time commitments create barriers for individuals from low-income communities. As explained previously, because CHWs typically are members of the communities they serve, they bring to the health care system a deep understanding of their communities' needs and can provide culturally sensitive care while building patients' trust.[76] But the value CHWs add to care teams cannot be realized if potential CHW candidates are deterred by high training and certification fees or time-consuming training for which they are not compensated.[77] Advocates of formal CHW training and certification therefore

71. *See, e.g.*, LLOYD ET AL., *supra* note 22, at 4; Mason et al., *supra* note 69, at 5; Ruff et al., *supra* note 38, at 2.

72. CTRS. FOR DISEASE CONTROL & PREVENTION, POLICY EVIDENCE ASSESSMENT REPORT: COMMUNITY HEALTH WORKERS POLICY COMPONENTS 4, 9 (2014).

73. *See* LLOYD ET AL., *supra* note 22, at 23 (suggesting that health care organizations may be more likely to engage with CHWs if there is a state-recognized framework for their formal training and certification); CTR. FOR HEALTH CARE STRATEGIES & STATE HEALTH ACCESS DATA ASSISTANCE CTR, *supra* note 5, at 8 (explaining that formal training and certification of CHWs promotes "a common understanding of whether an individual is qualified" and prepares CHWs for their roles and potentially improves the quality of care delivery).

74. *See* Mason, *supra* note 69, at 4 ("Common arguments in favor of certification [of CHWs] are that it will aid in legitimizing practitioners in the eyes of other health care professionals"); LLOYD ET AL., *supra* note 22, at 23 (noting that the health care system has licensure requirements for other health care professionals, and that "organizations may be less likely to engage with [CHWs] in the absence of a recognition framework.")

75. *See* LLOYD ET AL., *supra* note 22, at 25; Ruff et al., *supra* note 38, at 2.

76. *See Community Health Workers*, *supra* note 7.

77. *See* LLOYD ET AL., *supra* note 22, at 21 ("Any training programs should ideally ensure that members of the community are not excluded through excessively high fees or time commitments."); Ruff et al., *supra* note 38, at 4 ("[The CHW] certification process should facilitate CHW employment, not impeded it. Therefore, it should be affordable and not overly complex or

propose that states, employers, public health agencies, or other organizations cover these programs' costs and that CHW candidates receive compensation for their training.[78]

Growing recognition of the need to build the CHW workforce has led some states to adopt policies related to CHW certification and training programs.[79] Sixteen states either require or offer voluntary certification of individual CHWs, with a handful of states in the process of creating certification programs.[80] As an alternative to certifying individual CHWs, five states have elected to establish standards for CHW training programs.[81] Approximately half of all states, however, neither certify individual CHWs or oversee CHW training programs.[82] For some of these states, financing CHW certification programs is a challenge given that certification programs typically are financed with applicant fees, but as explained above, many CHW candidates cannot afford these fees.[83]

time-consuming."); Mason et al., *supra* note 69, at 2 (commenting that training programs need to be accessible to CHWs, which is determined in part by their cost); *Program Financing and Administration*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 28, 2019), https://www.cdc.gov/dhdsp/pubs/toolkits/chw-ta-financing.htm (noting that applicant fees for certification "might be especially burdensome" for CHWs given that many come from low-income communities).

78. Ruff et al., *supra* note 38, at 4 ("CHWs should not be held responsible for the cost of certification . . . Financial assistance should be readily available."); LLOYD ET AL., *supra* note 22, at 21 (noting that individuals interviewed by the authors "emphasized that the training [for CHWs] should be compensated financially"); *Program Financing and Administration*, *supra* note 77 (suggesting that stakeholders consider offering CHW certification at no cost and cover other expenses that CHWs incur when completing certification requirements).

79. Tammie M. Jones et al., *Evaluating the Association of State Regulation of Community Health Workers on Adoption of Standard Roles, Skills, and Qualities by Employers in Select States: A Mixed Method Study*, 19 HUM. RES. FOR HEALTH 1, 3 (2021).

80. *See State Community Health Worker Models*, NAT'L ACAD. FOR ST. HEALTH POL'Y (Dec. 10, 2021), https://www.nashp.org/state-community-health-worker-models/#tab-id-7 (listing state certification and training programs). Twelve states offer voluntary certification (CO, FL, KY, IN, MA, MD, MN, MO, NV, OR, RI, and SC), with four states requiring that CHWs be certified (AK, CT, OH, and TX). Four additional states are in the process of creating certification programs (AZ, IL, NH, and MS). *Id.*

81. *State Community Health Worker Models*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Dec. 21, 2021), https://www.nashp.org/state-community-health-worker-models/#tab-id-7 (listing state certification and training programs).

82. States that currently recognize or certify CHW training programs include Arkansas, New Jersey, and New Mexico, with Louisiana and Utah in the process of developing standardized criteria and a review process for CHW training. *Id.*

83. *See Program Financing and Administration*, *supra* note 77, stating:

> Although it is common for certification programs to be financed with applicant fees, it is important to remember that CHWs often come from lower-income communities, so fees and other expenses might be especially burdensome. It will be important to identify ways and means to sustain a statewide CHW certification program over the long term.

Ruff et al., *supra* note 38, at 3 (noting in some states, certification costs have been a barrier to CHW program development).

With costs posing a significant barrier to expansion of the CHW workforce, the federal government can help finance CHW training and certification.[84] Several federal agencies currently support CHW training through grants to states and the public and private organizations that train CHWs.[85] However, some grants or grantees narrowly focus on training CHWs to address specific disease states or public health conditions.[86] For example, recently announced grants from the support training and deploying CHWs specifically for COVID-19 response efforts.[87] Grants from the National Heart, Lung, and Blood Institute provided funding to organizations implementing CHW heart health programs targeting specific ethnic groups.[88] CIHTs employing CHWs, however, often treat patients with a range of health conditions and address a broad array of health-related needs. Moreover, these federal grants are time-limited and do not provide sustainable financing for CHW training and certification programs; nor do they offer financing to states to help defray their costs of administering state certification programs.[89]

84. Organizations that train CHWs include CHW organizations and associations, state and local public health agencies, community-based organizations, and universities and community colleges. *See Training for Community Health Workers*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/toolkits/community-health-workers/4/training (last visited Feb. 20, 2022) ("After recruitment and hiring, programs may provide hands-on training for CHWs."); JULIE ANN ST. JOHN ET AL., PROMOTING THE HEALTH OF THE COMMUNITY: COMMUNITY HEALTH WORKERS DESCRIBING THEIR ROLES, COMPETENCIES, AND PRACTICE 48 (Springer 2021) (reporting that most of the survey participants who self-identified as a CHW instructor or trainer worked at a university or community-based organizations with nonprofit status).

85. *See Community-Based Workforce for COVID-19 Vaccine Outreach Awards*, HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/coronavirus/community-based-workforce (last visited Feb. 20, 2022); *see also Communities in Action*, NAT'L HEART, LUNG, AND BLOOD INST., https://www.nhlbi.nih.gov/health/educational/healthdisp/communities-in-action.htm (last visited Feb. 20, 2022) (describing the CHW Health Disparities Initiatives).

86. *See generally* BETH A. BROOKS ET AL., BUILDING A CHW PROGRAM: THE KEY TO BETTER CARE, BETTER OUTCOMES, & LOWER COSTS 28 (2018) (commenting that state and locally administrated programs that receive grants from government agencies are often disease specific).

87. *See, e.g.*, *Community Health Workers for COVID Response and Resilient Communities*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/covid-community-health-workers/index.html (last visited Feb. 20, 2022) (providing financial support and technical assistant to sixty-nine states and organizations to support the training and deployment of CHWs to strengthen COVID-19 response efforts). Similarly, the Health Resources and Services Administration (HRSA) has awarded grants to mobilize CHWs to educate and assist individuals in getting the COVID-19 vaccination. *See Community-Based Workforce for COVID-19 Vaccine Outreach Awards*, *supra* note 85.

88. *See Communities in Action*, *supra* note 85; *see also Behavioral Health Workforce Education and Training (BHWET) Program for Professionals*, HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/grants/find-funding/hrsa-21-089 (last visited Feb. 20, 2022) (grants to organizations training behavioral health professionals, including CHWs receiving behavioral health training).

89. *See id.*

As part of a national strategy to improve health equity, the federal government and states should find sustainable means for financing CHW training and certification that go beyond targeted, time-limited grants. With CHWs potentially lowering Medicaid spending, Medicaid payors who support CHW training and certification may see a positive return on their investment. For example, states could impose an assessment fee on Medicaid managed care organizations that could fund the costs of CHW training and certification. Alternatively, Medicaid providers who receive value-based payments can use a portion of those payments to cover the cost of CHW training and certification. For example, the University of New Mexico's Health Sciences Center used its monthly capitation payment from a Medicaid managed care organization to cover its costs of recruiting, hiring, and training CHWs who functioned as case managers for Medicaid patients.[90]

IV. THE VALUE OF TEAM MEMBERS WITH BEHAVIORAL HEALTH EXPERTISE

The populations served by CIHTs commonly face a range of mental health challenges, which one program supervisor described as "a fairly significant burden."[91] Several interviewees further commented on the interrelationship between a patient's mental and physical health. For example, one interview stated that her CIHT had observed that "medical conditions are wrapped into emotional or psychosocial conditions,"[92] with others noting that patients' anxiety about their health can lead to medication nonadherence or frequent emergency department visits.[93] These observations are consistent with studies documenting the wide-ranging mental health needs among groups that are economically and socially marginalized and the adverse impact of poor mental health on physical health.[94]

90. *See* NAT'L CMTY. VOICES INITIATIVE AT THE CTR. FOR PRIMARY CARE AT MOREHOUSE SCH. OF MED. & THE NORTHERN MANHATTAN CMTY. VOICES AT THE COLUM. UNIV. CTR. FOR CMTY. HEALTH P'SHIPS, *supra* note 64, at 10–11.

91. Mantel et al., *supra* note 10 (interview with program manager).

92. *Id.* (interview with LCSW).

93. *See id.* (interview with LCSW, commenting that "[E]ven if we give somebody a medication for a condition, but we're not addressing their anxiety about taking the medication, or not taking the medication, then that person may not take their medication."); *id.* (interview with medical director). Another interviewee also commented:

> But those people, it seems like if they are using the ED quite a bit, usually the driver . . . So, if I use the example of the little lady that had been in the ED over 150 times in the past year, it was mostly anxiety and mostly mental health and mostly some social-determinants-of-health issues.

Id. (interview with medical director).

94. *See* Anna Macintyre et al., *What Has Economics Got to Do with It? The Impact of Socioeconomic Factors on Mental Health and the Case for Collective Action*, PALGRAVE COMMC'NS 2018, at 4 (summarizing evidence on the link between socioeconomic factors and mental health); Joseph Firth et al., *The Lancet Psychiatry Commission: A Blueprint for Protecting*

The CIHTs participating in our study primarily address patients' behavioral health needs by connecting them with mental health and substance abuse counselors.[95] Nevertheless, many interviewees commented CIHTs can better meet their patients' health-related needs when the care team includes a behavioral health expert.[96] As explained by one interviewee,

> [W]hen we are addressing one side of health, which is the physical part, and not addressing the psychosocial part, . . . our results are not going to be the progress that we expect or that we would like. So when we have a behavioral health specialist on site, there's that union of the whole, the system, the holistic approach.[97]

This statement was echoed by other interviewees who commented on the valuable expertise licensed clinical social workers (LCSWs)[98] and other behavioral health experts bring to the care team.[99]

This Part first describes the benefits of including behavioral experts on CIHT care teams. However, many CIHTs lack this expertise due to current behavioral health workforce shortages.[100] Expanding the behavioral health workforce, therefore, should be high on policymakers' health equity agenda. This Part concludes with suggestions on how to achieve this objective.

Physician Health in People with Mental Illness, LANCET PSYCHIATRY COMM'N, Aug. 2019, at 26 (summarizing evidence showing physical health disparities for people with mental illness).

95. See Mantel et al., *supra* note 10 (interview with program administrator, stating that, "[W]e don't have an internal behavioral health care provider. We do assess for behavioral health issues on every patient that we enroll. And then we work closely with our county's mental health center and our area's behavioral health center to be able to connect patients to services."); *id.* (interview with social worker, stating that "I think, at this point, we've been focused more on getting them linked with a community psychiatrist and a program and a therapist, as opposed to providing those services ourselves.").

96. *Id.*

97. *Id.* (interview with LCSW); *see also id.* (interview with program administrator, stating that, "[W]hen we are doing comprehensive services for people, it's important to have comprehensive viewpoints at the table. And behavioral health is no different. It's helpful").

98. LCSWs are licensed by the state to assess, diagnose, and treat mental illness, addiction, and other behavioral disturbances. *See Clinical Social Work*, NAT'L ASS'N SOC. WORKERS, https://www.socialworkers.org/Practice/Clinical-Social-Work (last visited Feb. 21, 2022).

99. *See, e.g.*, Mantel et al., *supra* note 10 (interview with CHW, stating that, "Just like having a primary care physician, having a behavioral health specialist or a psychiatrist or a social worker, or licensed clinical social worker that does therapy, is hugely impactful."); *id.* (interview with a RN, stating that it was "really important" to the success of the CIHT to have a care team member who is a behavioral health provider on staff); *id.* (interview with program director, who stated, "[I]t would great to have a mental health counselor as part of our team. We'd love it."); *id.* (interview with primary care physician, who stated, "I think the rapport part was really nice when we had someone physically locate in our office and as a part of our team process who could talk more in-depth about mental health from a counseling perspective. That was helpful."); *id.* (interview with a RN, commenting that behavioral health providers "phenomenally" impact patient care).

100. *Behavioral Health Workforce Faces Critical Challenges in Meeting Population Needs*, SCI. DAILY (May 17, 2018), https://www.sciencedaily.com/releases/2018/05/180517102343.htm.

A. The Benefits of Including Behavioral Health Experts on Care Teams

Interviewees identified four benefits of including behavioral health experts such as LCSWs on their care team. First, their expertise in conducting mental health assessments makes it more likely that the CIHT will correctly identify patients' mental health needs and that these patients will then receive appropriate treatment.[101] An anecdote shared by a primary care physician we interviewed illustrates this point:

> [Our LCSW] did more in-depth screening . . . I can remember vividly a patient that our LCSW came [sic] and she really uncovered some of the history talking to the patient's wife that made it pretty clear that bipolar disorder was the actual driver and helped us get the medication management right.[102]

After identifying a patient's mental health needs, a behavioral health expert can then help devise a plan of action that will address these needs, including connecting patients to mental health providers and other community resources.[103]

Second, LCSWs and other behavioral health experts can deliver direct mental health care to patients who are in crisis, face barriers to accessing providers for longer-term behavioral health treatment, or have less intensive mental health needs that do not require ongoing treatment.[104] As noted above, interviewees reported that their CIHTs generally do not provide direct services to patients requiring long-term, intensive mental health or substance abuse treatments but instead connect them with behavioral health providers.[105] However, a CIHT's behavioral health experts can provide support to patients experiencing a mental health crisis who are unable to timely access needed

101. *See The Behavioral Health Specialist*, IMPROVING PRIMARY CARE, http://improving primarycare.org/team/behavioral-health-specialist. (last visited Feb. 21, 2022).

102. Mantel et al., *supra* note 10 (interview with primary care physician). Another primary care physician who serves as the medical director of a CIHT echoed these comments:

> But a lot of times the licensed clinical social workers have helped us identify that [challenging personality types]. Or times when you're treating what you think is anxiety and panic attacks, but it's actually a particular version of bipolar disorder and being able to have a radar on to pick that up.

Id.

103. *Id.* (interview with LCSW). The interviewee described her role in helping to both assess patients' mental health and developing a treatment plan for meeting these needs as follows:

> [W]e are able to do a full psychosocial assessment . . . So, we can determine if there's a diagnosis, a condition that is a mental health related that should be diagnosed or substance abuse and add that to the diagnosis, but also we can determine what do we do next? How do we address the mental health need here? And then start to formulate a plan.

Id.

104. *See The Behavioral Health Specialist*, *supra* note 101.

105. Mantel et al., *supra* note 10.

care.[106] In addition, with many patients facing long wait times and other barriers to accessing behavioral health care,[107] CIHTs' behavioral health experts can fill the gap by providing temporary interventions. As explained by one interviewee:

> [Given barriers to treatment,] we continue to do those supportive calls and continue to follow-up on what we thought, the treatment, what we think the treatment should be. And also how do we continue to get them to, if they really need psychiatry, continue to support them until we get them there.[108]

CIHTs' behavioral health experts also can provide short-term treatment to patients needing low-intensity interventions, such as teaching patients coping mechanisms that can help them manage their anxiety over their health or the COVID pandemic.[109]

106. *See* Mantel et al., *supra* note 10 (interview with program supervisor, commenting that an LCSW who was previously part of the team "was able to do a lot of ad hoc care. Very in the moment, when the patients needed it, versus them having to schedule and wait for an appointment, especially when they were in crisis[.]"); *id.* (interview with LCSW, who stated, "We can provide those [behavioral health] services, and we have in crisis situations."); *id.* (interview with LCSW, commenting that in addition to managing treatment referrals for mental health and substance abuse treatments, her CIHT's LCSWs also do "crisis intervention[.]").

107. *See* COHEN VETERANS NETWORK & NAT'L COUNS. FOR BEHAV. HEALTH, AMERICA'S MENTAL HEALTH 2018, at 4 (2018), https://www.cohenveteransnetwork.org/wp-content/uploads/2018/10/Research-Summary-10-10-2018.pdf (summarizing barriers to getting mental health care reported by patients, including lack of waiting to get appointments, stigma, cost, transportation, lack of knowledge of where to access mental health care); Mantel et al., *supra* note 10 (interview with medical director). Several interviewees similarly commented on the challenges of finding long-term therapy for their patients. As explained by the medical director of one CIHT:

> The goal is to, if they need longer-term therapy, is to get them into it, therapist or psychiatrist, if they need one. The issues are often that those wait times are always long for our patients to get into therapy or psychiatry externally. And often we have other barriers in our population. They're seniors. Sometimes transportation is an issue in some of our communities. Language barrier is an issue as well to find a mental health provider that speaks the language.

Id.

108. Mantel et al., *supra* note 10 (interview with medical director); *see also id.* (interview with LCSW, stating that her CIHT conducts "maybe a weekly phone call until we get them into a therapist or psychiatrist.").

109. *Id.* (interview with medical director). As described by another interviewee:

> So, the behavioral health interventionists are helpful in that a weekly call, a weekly touch-in to just see how you're doing, and to be able to escalate to the clinical nurse as appropriate has been helpful for those folks that are anxious and their first reaction was to go to the emergency room because they don't feel good. By having a weekly touch-in from the psychologist, their anxiety level is decreased. The other thing is people do have a hard time coping and some difficulty complying with a diabetes diet or carb-control diet have difficulty stopping smoking and a lot of anxiety. Our psychologists are able to have touch-in visits and give them some coping mechanisms to help with the anxiety and to help them change their eating habits and talk through the benefits of making some small changes and celebrating small successes.

Third, LCSWs and other behavioral health experts can advance other team members' skills in working with patients who have mental health or substance abuse issues. Specifically, team members with behavioral health expertise can educate other team members about mental health conditions and treatments.[110] In addition, behavioral health experts can further other team members' understanding of a particular patient's behavioral health challenges and give guidance on how to interact with and support the patient. As explained by one interviewee,

> I think it's really important [to have an LCSW on the team] because a lot of times it helps us to. . . She'll frame it in a way of what's best or how to best manage working with someone who's been in the hospital or whether it's suicidal ideations or frequent bouts of depression or anxiety . . . And it's valuable because not everybody on the team is a licensed professional to get that scope of what it looks like, and to hear it coming from our [licensed clinical] social worker, it really helps.[111]

Finally, having available someone with behavioral health expertise can reduce stress among other care team members.[112] Describing this benefit, one interviewee stated:

> [Having a team member with expertise in behavioral health is] helpful not just at the patient intervention level, but really at staff intervention, too. Just knowing that when staff are working with people who have severe behavioral health issues or needs, that there is someone else on the team who is more fully trained and capable to support them, the patient and the staff, . . . it takes off some of the anxiety and the stress from the frontline staff knowing that there is someone else who can help. I think that that alone is a huge intervention.[113]

Id. (interview with pharmacist). Another interviewee similarly commented on how the CIHT's behavioral health experts addressed patients COVID-related anxiety and depression:

> A lot of our patients were stuck at home, weren't seeing anyone; couldn't see their grandchildren, couldn't see other people just because they were so high-risk and that took a huge toll on their mental health. The behavioral health team helped out in a huge way with the patients that were willing in helping them find resources or other ways that they can help improve their moods and their outlook on everything.

Id.; *see also id.* (interview with primary care physician, stating that during COVID, "we've seen a lot of rise in anxiety and depression throughout the country. And so it's been a blessing to have their [(LCSWs')] support in helping patients get through this challenging and confusing time.").

110. *Id.* (interview with program administrator, commenting that LCWS do "staff trainings to staff around mental health 101.").

111. *Id.* (interview with a RN); *id.* (interview with program administrator, stating that, "Well, I think it always helps when someone is within the confines, easier access, stronger communication, building expertise because they can spend more time with the team members to help build their capacity in handling mental health and behavioral issues.").

112. *Id.*

113. Mantel et al., s*upra* note 10 (interview with program administrator); *id.* (interview with medical director, stating that, "There's times when in doing this work, there's certain personality

Having a care team member who can reduce staff stress is particularly important given the very real problem of burnout among health care professionals working with patient populations with complex medical, financial, and social needs.[114]

Given the tremendous value professionals with behavioral health bring to CIHT care teams, we recommend that every CIHT include at least one behavioral health expert on their care team. Many interviewees, however, reported that their CIHTs lack this expertise.[115] In particular, some interviewees commented that behavioral health workforce shortages hinder their hiring LCSWs or other behavioral health professionals:

> [I]t's a bottomless pit of people that could benefit from community health teams and it's not a bottomless pit of providers, right . . .[I]t's hard recruiting to fill positions. Counselor positions, MSW positions, that's a challenge is [sic] workforce shortages."[116]

The relevant literature similarly flags a shortage of behavioral health experts as a primary cause of unmet behavioral health needs among groups that are economically and socially marginalized.[117] Accordingly, supporting the CIHT model, and in particular CIHT activities that address patients' behavioral health needs, requires expanding the behavioral health workforce.

types where boundaries setting is even more critical. Right? And identifying that early on helps the team not overly extend or exhaust themselves. Right? And that's key, that's key.").

114. *Id.* (interview with primary care physician). Several interviewees flagged staff burnout as a problem for their CIHT, with one interviewee commenting that having others on the team that can help others process their emotions can help with this challenge:

> I think that a lot of teams, and this is not me speaking only for my own team, but seeing other programs around the country or around this region, burnout is a real issue. How to maintain compassion for patients and engagement with really challenging situations day-in, day-out . . . And we can kind of help each other in that. Sometimes, someone else on the team will be able to help kind of refocus, recenter, or step in and say, then they may be in a better place to interact . . . I think having forums for people to process the emotional aspects of this type of care is really important.

Id.

115. *Id.* Among the eight CIHTs participating in our study, five reported that the did not have a LCSW or other behavioral health professionals on their care team.

116. *Id.* (interview with program administrator).

117. *See* BENJAMIN F. MILLER & ANITA BURGOS, ENHANCING THE CAPACITY OF THE MENTAL HEALTH AND ADDICTION WORKFORCE: A FRAMEWORK 6 (2021) (discussing the challenge of finding mental health care and noting that barriers to care "are often more significant in communities of color, particularly the Black community, and often result in more severe mental health concerns due to unmet needs"); BENJAMIN F. MILLER ET AL., HEALING THE NATION: ADVANCING MENTAL HEALTH AND ADDICTION POLICY 28 (2020) (stating that there are too few mental health providers to meet the public's mental health needs, with "[seventy-seven percent] of people with mental health conditions report[ing] unmet mental health needs due to lack of clinicians").

B. Policy Considerations

Experts have advocated for various policies that would increase the number of licensed behavioral health clinicians.[118] Noting that low salaries and reimbursement rates deter medical and graduate students from entering the behavioral health field, mental health advocates have called on payors such as Medicare and Medicaid to increase their payments for behavioral health services.[119] Advocates also argue that expanding fellowships and loan forgiveness programs for students who enter the behavioral health professions and serve disadvantaged populations will encourage more students to do so.[120] Relatedly, strengthening funding programs for behavioral health education and training programs such as the Behavioral Health Workforce Education and Training Program (BHWET) for Professionals[121] also supports the pipeline for behavioral health clinicians.[122]

Policy initiatives designed to expand the supply of licensed behavioral health clinicians, however, take time and will not allow CIHTs to address their communities' current need for mental health interventions.[123] Some experts therefore have proposed incorporating into the behavioral workforce lay or

118. *See* AM. HOSP. ASS'N, THE STATE OF THE BEHAVIORAL HEALTH WORKFORCE: A LITERATURE REVIEW 9 (2016) (explaining that medical and PhD students are avoiding behavioral health due to low reimbursement rates, and that an increase in these rates is needed to increase the number of individuals entering the behavioral health workforce).

119. *Id.* at 6–7, 15; MILLER & BURGOS, *supra* note 117, at 7 (noting that inadequate compensation limits incentives to enter the mental health profession).

120. *See* MILLER ET AL., *supra* note 117, at 28, 66 ("The federal government should expand programs that provide direct incentives for individuals to enter the mental health workforce, such as the National Health Services Corps or the Minority Fellowship Program."); EMMA GILCHRIST & STEPHANIE KIRCHNER, COLORADO BEHAVIORAL HEALTH TASK FORCE: SUBCOMMITTEE'S PROCEEDINGS AND RECOMMENDATIONS 30 (2020) (recommending that the state of Colorado strengthen the Colorado Health Service Corps loan repayment program so that it adequately covers the cost of completing internships and supervised hours required for licensure in the behavioral health fields); COUNCIL ON SOC. WORK EDUC. ET AL., SOCIAL WORK EDUCATION POLICY PRINCIPLES 2020: A CALL FOR EQUITY AND JUSTICE 4 (2020) (advocating for improved implementation of the Public Service Loan Forgiveness Program).

121. The BHWET "aims to increase the suppl of behavioral health professionals" by providing grants to institutions of higher education and accredited professional training programs that educate or train individuals for the behavioral health professions. *Behavioral Health Workforce Education and Training (BHWET) Program for Professionals*, *supra* note 88.

122. *See* COUNCIL ON SOC. WORK EDUC. ET AL, *supra* note 120, at 8 ("Federal policies should support federal education and training programs to ensure an adequate pipeline of mental health and substance use providers.").

123. MILLER & BURGOS, *supra* note 117, at 8 (explaining that relying on the licensed behavioral health workforce "will not allow our communities to get ahead of the problem and more proactively address mental health needs").

community workers trained to deliver behavioral health interventions, including unlicensed social workers, CHWs, peer specialists, and clergy.[124]

Behavioral health services fall along a continuum, and emerging evidence suggests that some interventions can be done effectively by CHWs.[125] In particular, experts have identified many of the behavioral health-related interventions done by CIHTs (described above) as appropriate for trained CHWs.[126] These include screening for behavioral health conditions, providing lower levels of care to patients with less intensive mental health needs, promoting self-management of health conditions through patient education, and teaching patients coping mechanisms.[127] In addition, utilizing CHWs who reflect the demographics of their community partly alleviates concerns about the lack of diversity in the behavioral health workforce and can promote more culturally sensitive care.[128]

124. *See id.* at 5, 7–8 (advocating to broaden the behavioral health workforce beyond licensed clinicians); Theresa J. Hoeft et al., *Task-Sharing Approaches to Improve Mental Health Care in Rural and Other Low-Resource Settings: A Systematic Review*, 34 J. RURAL HEALTH 48, 49 (2017) (summarizing the evidentiary support for task shifting, or including less highly trained individuals on teams that care for individuals with behavioral health needs); Francesca Mongelli et al., *Challenges and Opportunities to Meet the Mental Health Needs of Underserved and Disenfranchised Populations in the United States*, 18 FOCUS 16, 20 (2020) (advocating for a task-sharing approach where many mental health interventions are done lay health workers); Miya L. Barnett et al., *Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved Populations: A Systematic Review*, 45 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 195, 196 (2019) (stating that mental health interventions by CHWs "can increase the availability of care, given substantial workforce challenges to meet service needs").

125. *See* MILLER & BURGOS, *supra* note 117, at 8, 13–14 ("[M]ental health services, as well as need exist on a continuum," and "[i]n many cases, community workers may be effective in meeting the need for support," with evidence also showing that peer support services are beneficial); Barnett et al., *supra* note 124, at 196, 206 (explaining that CHWs "can provide lower levels of care to patients with less intensive needs," and that studies of mental health interventions provided by CHWs can be effective in producing positive mental health outcomes for underserved communities); AM. HOSP. ASS'N, *supra* note 118, at 9 (noting that research has shown peer support services to be highly effective).

126. MILLER & BURGOS, *supra* note 117, at 13; Hoeft et al., *supra* note 124, at 50; AM. HOSP. ASS'N, *supra* note 118, at 12.

127. *See* MILLER & BURGOS, *supra* note 117, at 11 (describing the components of team-based care that includes community workers); Barnett et al., *supra* note 124, at 196 (noting that existing models for incorporating CHWs in mental health interventions includes CHWs providing lower levels of care to patients with mental health needs); AM. HOSP. ASS'N, *supra* note 118, at 12 (reporting that CHWs can help patients develop coping mechanisms).

128. *See* MILLER & BURGOS, *supra* note 117, at 7, 13 (noting concerns about the diversity of the behavioral health workforce, and that "increasing the number of providers who reflect the demographics of the community they are serving is key to addressing gaps in linguistically and culturally competent care").

Preparing community workers to deliver effective behavioral health services requires that these professionals receive adequate training in basic mental health. In addition, certifying community workers who have successfully completed mental health training would communicate to employers, behavioral health clinicians, and patients that an individual possesses the necessary knowledge and expertise to provide basic mental health care. Accordingly, federal and state regulators can support the incorporation of community workers into the behavioral health workforce by developing and financing standard training curriculum and certification procedures.[129]

Although training community workers in behavioral health presents a promising solution for broadening the behavioral health workforce, ensuring their competence also requires ongoing support and supervision from licensed behavioral health clinicians.[130] CIHTs based in hospitals or health care systems that employ licensed behavioral health clinicians can provide this oversight.[131] PC CIHTs and CBO CIHTs, however, generally do not have licensed behavioral health clinicians on staff, and therefore must contract with professionals outside their organization to perform this supervisory role.[132] But with many of these organizations facing significant budget constraints,[133] financing these outside supervisors may prove difficult. Policymakers can lessen this challenge for CIHTs by offering loan forgiveness or other financial incentives to licensed behavioral health clinicians who agree to supervise community workers free of

129. *See* Hoeft et al., *supra* note 124, at 58 (calling for an assessment of how to scale-up programs for ensuring minimum standards of competency of CHWs and other non-specialist workers providing behavioral health care); GILCHRIST & KIRCHNER, *supra* note 120, at 45 (calling on the state of Colorado to create training and certification structures to support peers and non-traditional CHWs with behavioral health expertise).

130. *See* Barnett et al., *supra* note 124, at 207 (commenting that CHWs who deliver evidence-based mental health interventions "are likely require a high level of support through ongoing supervision and consultation"); Hoeft et al., *supra* note 124, at 49 (describing task sharing as a team-based approach where mental health specialists provide training, supervision, and consultation to community workers). Moreover, because community workers are unlicensed health care professionals, payors such as Medicaid likely would cover their services only if provided under the supervision of licensed mental health professionals. For example, state Medicaid programs that cover peer support services for individuals with addiction and/or mental health disorders require that the services be provided under the supervision of a mental health professional. *See* OPEN MINDS, STATE MEDICAID REIMBURSEMENT FOR PEER SUPPORT SERVICES 2 (2016), https://static1.squarespace.com/static/56d5ca187da24ffed7378b40/t/5e4e2ecc21989a778bc3db5f/1582182093508/OMCircle_ReferenceGuide_PeerSupport.pdf.

131. Hoeft et al., *supra* note 124, at 49, 52, 54; Barnett et al., *supra* note 124, at 203; BETH A. BROOKS ET AL., AM. HOSP. ASS'N & NAT'L URB. LEAGUE, BUILDING A COMMUNITY HEALTH WORKER PROGRAM: THE KEY TO BETTER CARE, BETTER OUTCOMES, & LOWER COSTS 37 (2018), https://www.aha.org/system/files/2018-10/2018-chw-program-manual-toolkit.pdf.

132. *See* Mantel et al., *supra* note 10; *see also* BROOKS ET AL., *supra* note 131, at 29.

133. *See* Mantel et al., *supra* note 10.

charge.[134] Alternatively, Medicare and Medicaid could cover these supervisory services under fee-for-service Medicare or Medicaid, or organizations could use the flexibility afforded them under value-based payment models to compensate licensed behavioral health clinicians for their supervisory services.[135]

V. CARE COORDINATION BETWEEN CIHTS AND PRIMARY CARE PROVIDERS

Increased interest in primary care models that both deliver coordinated care and address patients' social, economic, and mental health needs has prompted many primary care providers to incorporate the CIHT model into their practices.[136] Most of the CIHTs participating in our study, however, operate separately from primary care practices.[137] Some operate as discrete departments within a hospital, health care system, or local public health department; others are operated by non-profit CBOs.[138] We refer to these CIHTs as non-primary care based CIHTs (non-PC CIHTs).

While some non-PC CIHTs have a primary care physician serving as the organization's medical director, these medical directors generally do not provide primary care services to the CIHTs' patients.[139] Patients instead see primary care providers who are not members of the non-PC CIHT care team.[140] Some interviewees reported open lines of communication between their CIHT and some patients' primary care providers, such as weekly calls to discuss their joint

134. *Cf.* GILCHRIST & KIRCHNER, *supra* note 120, at 30 (proposing that the state of Colorado support supervised training of LCSW candidates by identifying a pool of licensed behavioral health providers who offer supervision free-of-charge in exchange for loan repayment or other cost incentives).

135. OPEN MINDS, *supra* note 130, at 1; BROOKS ET AL., *supra* note 131, at 29.

136. AM. HOSP. ASS'N, *supra* note 118, at 10; *see* MILLER & BURGOS, *supra* note 117, at 11.

137. *See* Mantel et al., *supra* note 10.

138. *Id.*

139. *Id.*; *see also* CTR. FOR HEALTH CARE STRATEGIES & STATE HEALTH ACCESS DATA ASSISTANCE CTR., COMMUNITY CARE TEAMS: AN OVERVIEW OF STATE APPROACHES 2 (2016), https://www.chcs.org/media/Community-Care-Teams-An-Overview-of-State-Approaches-030316.pdf (explaining that CIHT medical staff *may* include primary care physicians, but that staffing models differ according to available resources).

140. *See, e.g.*, Mantel et al., *supra* note 10 (interview with a RN, who commented that her CIHT does not have a primary care physician on the care team, so clients needing primary care are instead referred to a primary care clinician).

patients.[141] More commonly, however, there exists little if any coordination between a non-PC CIHT and patients' primary care providers.[142]

This following two Sections describe the benefits of increasing coordination between non-PC CIHTs and patients' primary care providers and propose policies that would promote primary care providers engaging in this coordination process.

A. The Benefits of Coordination Between CIHTs and Primary Care Providers

We asked interviewees affiliated with non-PC CIHTs whether they consider coordination between the CIHT and patients' primary care providers advantageous, and all but one answered in the affirmative. In the words of one interviewee, "[w]e truly need a physician. Even if they're not going to be face-to-face on a team meeting, we need their guidance."[143] Other interviewees similarly commented that the involvement of a patient's primary care provider is "always helpful,"[144] "hugely impactful,"[145] "essential,"[146] and "really effective."[147]

141. *Id.* (interview with social worker). As described by the interviewee:

> We have different provider team meetings that we participate in with the primary care doctors. They have a lot of input. And there are some primary care doctors that are so excellent in care coordination with us that it's just wonderful that we say, "this person is what this patient needs."

Id. Another interviewee similarly commented:

> [S]o that's how we like to have it happen is with our physician you know, patient centered, but involvement. And we like to have family team meetings with the physician or patient team meeting . . . And then with myself working with the patient and the community, I can relay back to them what I'm seeing, what I'm hearing out at their residences, because that's important.

Id. (interview with community care coordinator)*; see also id.* (interview with housing coordinator, who stated, "We have a couple of providers in the area that do coordinate with our team[.]"); *id.* (interview with program administrator, noting that the CIHT care team often coordinates with the social workers at the federally qualified health clinics in the area).

142. *Id.* (interview with social worker, commenting that one of the primary care providers in their community regularly coordinates with the CIHT care team, but others do not); *see also id.* (interview with a CHW, commenting that some, but not all, primary care providers will coordinate with the CIHT).

143. *Id.* (interview with community care coordinator).

144. *Id.* (interview with program administrator, stating that, "[I]t's always helpful when the primary care docs are involved.").

145. Mantel et al., *supra* note 10 (interview with a CHW, stating that, "I think it's hugely impactful that they [the primary care providers] are involved.").

146. *Id.* (interview with program administrator, stating that, "They're a critical member of the team, whether they are from our practice or from another practice, having a primary care provider is essential, yeah.").

147. *Id.* (interview with program administrator, stating that, "It has helped quite a bit when we are able to collaborate with the FQHCs [federally qualified health centers] in the area . . . And with

Interviewees said that regular communication between the CIHT and a patients' primary care provider promotes both having accurate, comprehensive, and timely information about the patient.[148] Several interviewees noted that the information patients share with the CIHT and/or their primary care provider may be erroneous or incomplete, as the patient may be uncomfortable sharing certain information or simply confused.[149] Regular communication between the CIHT and a patient's primary care provider facilitates both having reliable information.[150] As explained by one interviewee, "it is definitely helpful to have the primary care [provider] as a part of the collaborative group, because clients always aren't the best historians. It's really nice to have that actual information so that we can best support them."[151] In addition, CIHTs and collaborating primary care providers can update one another or alert each other when a change in a patients' status may warrant intervention.[152] Collaboration also supports the

those organizations that we have regular meetings with to go over our shared clients, that's really very effective.").

148. *Id.*

149. *See, e.g.*, *id.* (interview with social worker, commenting that that patients may provide incorrect medical information because they are confused); *see also id.* (interview with community care coordinator, noting that patients may not disclose to their physician that the patient is not adhering to treatment or diet recommendations or that social or economic circumstances are adversely impacting their health).

150. *See, e.g.*, Mantel et al., *supra* note 10 (interview with social worker, stating that, "I think that [coordinating with the primary care provider] is really helpful for the patient in terms of sharing information, especially because the patients aren't always consistent in what they're saying."); *see also id.* (interview with community care coordinator, who explained that diabetic patients may not want their physician "to know they're struggling" or "eating poorly," but that the CHW will discover otherwise when they visit the patient at home and "see what is on the kitchen counter").

151. *Id.* (interview with housing coordinator); *see also id.* (interview with community care coordinator, stating that, "And we like to have family team meetings with the physician or patient team meeting[s] . . . So we're all hearing the same thing.").

152. *Id.* (interview with program administrator). In discussing the benefits of coordinating with a particular nurse practitioner who cared from some of the CIHT's patients, the program administrator explained:

> So she would call us and say, "Hey, I just saw so-and-so. Can you go out and check on them?" We were able to come back and say, "Hey, this is what we did. This is what we saw. You might want to follow up with them on this." So yeah, I definitely think it would be great if we had more formal relationships with primary care physicians.

Id. Another program administrator explained that one of the lessons learned from assessing patients for mental health needs was that many were not connected with the mental health system, but were connected with their primary care physician, and that it was therefore important for the CIHT to ensure that the physician was "up-to-date and aware of what's going on." *Id.* A CHW-interviewee also stated:

> It also helps when it comes to the medical aspect of the patient's care that [the primary care provider is] involved. If it's a change of a medication or they've got something different going on with the pharmacy and we . . . you know what I mean? It's usually impactful that we all work together.

Id.

CIHT and primary care provider jointly developing an action plan to address a patient's health-related needs.[153] As explained by one program administrator,

> Oh, it's critical to have a physician as part of the team so that you can recognize when [a] patient's status is deteriorating, and you can turn to that physician and say, "If we do this, could you consider a change in medications?" Whatever that would avoid a hospitalization or an [emergency department] admission. And so that we have somebody that we can turn to and say, "This is what we're seeing. What else should we or could we do to make this be better?" They're a critical member of the team, whether they are from our practice or from another practice, having a primary care provider is essential.[154]

Unfortunately, with few primary care providers coordinating with non-PC CIHTs,[155] these benefits are rarely realized.

B. Policy Considerations

Both CMS and state Medicaid programs have implemented various voluntary initiatives that encourage primary care practices to adopt the CIHT model.[156] At the federal level, CMS recently launched the Primary Care First payment model across twenty-six regions.[157] Primary care practices participating in Primary Care First receive a significant portion of their Medicare revenues through monthly capitated payments that can be used to fund extra staff and care management activities, including CIHTs.[158] Participating providers accept the monthly payment in lieu of fee-for-service reimbursement for evaluation and management visits and receive a fixed fifty dollar fee for each office visit.[159] Primary Care First also includes a performance-based incentive, with the monthly capitated payment increased if the participating primary care practice meets certain performance measures.[160]

153. *Id.* (interview with program administrator).

154. Mantel et al., *supra* note 10.

155. *Id.*

156. *See Primary Care First Model Options*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/innovation-models/primary-care-first (last visited Feb. 25, 2022) (noting that Primary Care First builds on prior CMS alternative payment initiatives, including the Comprehensive Primary Care Plus (CPC+) model that was phased-out by CMS at the end of 2021).

157. *Id.*; *see Changes to CMMI Primary Care Payment Models*, PRIMARY CARE COLLABORATIVE (Apr. 29, 2021), https://www.pcpcc.org/2021/04/29/changes-cmmi-primary-care-payment-models.

158. *See Medicare Alternative Payment Models for Primary Care*, AM. MED. ASS'N (2019), https://www.ama-assn.org/system/files/2019-09/alternative-payment-models-primary-care.pdf (describing the CPC+ and Primary Care Initiatives).

159. *See id.* (describing the Primary Care Initiatives payment model); *Primary Care First Model Options*, *supra* note 156.

160. *See Medicare Alternative Payment Models for Primary Care*, *supra* note 158.

Many state Medicaid programs also have in place initiatives that promote embedding CIHTs in the primary care practice setting.[161] For example, primary care practices participating in state Medicaid patient-centered medical homes programs typically receive a PMPM fee,[162] which can be used to support multidisciplinary teams that integrate and coordinate social services as well as primary and behavioral health care.[163] In addition, some states' Medicaid health homes programs[164] focus on primary care providers,[165] with participating providers required to both provide comprehensive care management and coordination of primary care, acute, behavioral health, and long-term services, and refer patients to community and social support services.[166] Most states pay participating health homes a PMPM payment, which providers can use to support multidisciplinary health teams.[167] Too often, however, PMPM fees under Medicaid are low and may not cover the providers' cost of creating and maintaining multidisciplinary health teams.[168] States should ensure that the

161. *See Defining the PCMH*, AGENCY FOR HEALTHCARE RSCH. & QUALITY, https://www.ahrq.gov/ncepcr/tools/pcmh/defining/index.html (last visited Feb. 25, 2022).

162. *See States That Reported Patient Centered Medical Homes in Place*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/states-that-reported-patient-centered-medical-homes-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Feb. 25, 2022) (noting that most states pay patient-centered medical homes on a PMPM basis).

163. Although the patient-centered medical home model emphasizes clinical care coordination and integration of primary and behavioral health services, the model also supports screening patients for social determinants of health and linking patients to community resources. *See Defining the PCMH*, *supra* note 161 (noting that some practices have a care team that links patients to services in their communities).

164. Health Homes are an optional benefit that states may provide to Medicaid beneficiaries. Health Homes integrate and coordinate all primary, acute, behavioral health, and long-term care services for Medicaid beneficiaries who have chronic conditions. *See Health Homes*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html (last visited Apr. 29, 2022).

165. *See* BRENDA C. SPILLMAN & EVA H. ALLEN, U.S. DEP'T HEALTH & HUM. SERVS., EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: EVALUATION OF OUTCOMES OF SELECTED HEALTH HOME PROGRAM, ANNUAL REPORT – YEAR FIVE 4 (2017), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//180166/HHOption5.pdf (identifying states with health home models that include primary care practices, federally qualified health centers (FQHC), rural health clinical (RHC), and community mental health centers).

166. *See Health Homes*, *supra* note 164 (describing the Health Homes benefit under Medicaid). For fiscal year 2019, twenty-two states reported that their Medicaid program includes health homes. *See States That Reported Health Homes In Place*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/states-that-reported-health-homes-inplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Feb. 25, 2022).

167. *See Health Homes*, *supra* note 164.

168. *See States That Reported Patient Centered Medical Home in Places*, *supra* note 162.

PMPM fees paid to providers new to the patient-centered medical care and health home models are sufficient to cover their initial costs, with providers eventually transitioning to financial models like Primary Care First where they receive a capitated payment in lieu of all or some of their fee-for-service reimbursements.

Although these initiatives encourage primary care practices to adopt the CIHT model, not all primary care practices are positioned to take advantage of these alternative payment mechanisms. Primary Care First, for example, requires participating practices to both deliver comprehensive care management as well as assume financial risk.[169] Some primary care practices, particularly small physician groups, may not have the necessary infrastructure or data analytics capabilities or feel comfortable assuming financial risk.[170] Similarly, some primary care practices may lack the resources and expertise to support their participation in the Medicaid patient-centered medical home and health home initiatives.[171]

For primary care providers unable to support a CIHT, partnering with a non-PC CIHT would give their patients access to team-based care that integrates clinical, behavioral health, and social services. However, our study indicates that many of these primary care providers do not coordinate with non-PC CIHTs operating in their communities.[172] According to several interviewees, one barrier

169. *See* Hanna Woldu, *Should Our Practice Participate in the New CMS Primary Care First Initiative?*, HEALTHCARE INNOVATION (Sept. 17, 2019), https://www.hcinnovationgroup.com/policy-value-based-care/article/21105968/should-our-practice-participate-in-the-new-cms-primary-care-first-initiative (noting that payment models that require health care provides to assume financial risk shift responsibility for paying for services from insurers to the providers); *see generally* Kevin Quinn, *The 8 Basic Payment Methods in Health Care*, 163 ANNALS INTERNAL MED. 300, 301 (2015) (discussing payment models that shift primary financial responsibility for cost from payors to providers).

170. *See* Woldu, *supra* note 169; *see also* Stephanie Quinn, *Here's What You Need to Know About Primary Care First*, AM. ACAD. FAM. PHYSICIANS (2019), https://www.aafp.org/news/blogs/inthetrenches/entry/20191112itt-PCF.html (stating that the Primary Care First model is better for physician practices with at least 300 Medicare fee-for-service beneficiaries and experience with value-based payment models offered by managed care organizations).

171. *See* Sarah Hudson Scholle et al., *Support and Strategies for Change Among Small Patient-Centered Medical Home Practices*, ANNALS FAM. MED., May/June 2013, at S6, S7, S8, S10 (reporting that small physician practices surveyed by the authors report time, resources, and information systems as barrier to implementing patient-centered medical homes); *Ensuring That Patient-Centered Medical Homes Effectively Serve Patients with Complex Health Needs*, AGENCY FOR HEALTHCARE RSCH. & QUALITY, 2 (2011) (commenting that small physician practices face barriers to providing patient-centered medical care, including that they "often lack time and resources to integrate medical and social services, and do not have practice team members with expertise in managing complex needs").

172. Mantel et al., *supra* note 10 (interview with housing coordinator, stating that although a "couple of providers" do coordinate with the CIHT team, others do not); *id.* (interview with social worker, stating that patients' primary care physicians are "not really involved").

to primary care providers coordinating with non-PC CIHTs is the absence of any financial benefit to those who do so.[173] As explained by one interviewee when asked about this lack of coordination,

> I think because there's no financial contract between us and the primary care physician. So there was communication and we certainly could call them and say, "Hey, this is what's going on with the patient. Can you go out and take a look at them?" Or the primary doc would call us and say, "Hey, they mentioned this?" But it wasn't formal, so it didn't always work that well . . . I definitely think it would be great if we had more formal relationships with primary care physicians. Yeah, absolutely. I think primary care physicians, though, it depends on the bandwidth of the primary care doc[tor], and I think it also depends on the return on investment.[174]

Accordingly, offering financial incentives to primary care providers who coordinate with CIHTs has the potential to increase the number who do so.

One promising approach for supporting greater coordination between primary care providers and non-PC CIHTs is the health home model that relies on care management networks or teams.[175] As an alternative to health homes fully embedded within a primary care practice, state Medicaid programs can designate as health homes any provider operating in coordination with an outside team of health care professionals, such as non-PC CIHTs.[176] Several states, including Maine and North Carolina, follow this model.[177] Under Maine's health homes program, participating primary care practices receive a PMPM payment and must partner with one of ten state-sponsored CIHTs located throughout the state.[178] Similarly, in North Carolina, primary care providers partner with Community Care of North Carolina (CCNC)[179] and its extensive network of care managers, with the state paying participating primary care providers a PMPM fee.[180] In addition, CCNC has built a comprehensive health information

173. *Id.*

174. *Id.* (interview with program administrator); *see also id.* (interview with primary administrator, stating that, "[U]ltimately, there's a return on investment so you would have to make the relationship in a way that's beneficial to both [the primary care provider and CIHT].").

175. *See also* SPILLMAN & ALLEN, *supra* note 165, at vi–viii.

176. *See* 42 U.S.C. § 1396w-4(h) (2018) (defining the terms "health home," "designated provider," and "team of health care professionals"); *see also* SPILLMAN & ALLEN, *supra* note 165, at 4, 17.

177. *See also* SPILLMAN & ALLEN, *supra* note 165, at vii, 4.

178. *See Health Homes*, STATE ME. DEP'T HEALTH & HUM. SERVS. (2021), https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/health-homes.

179. Originally operated by the North Carolina Department of Health and Human Services, CCNC is now a not-for-profit organization that works in partnership with the state. *See A History of CCNC*, CMTY. CARE N.C., https://www.communitycarenc.org/knowledge-center/history-of-ccnc (last visited Mar. 4, 2022).

180. *See Community Care of North Carolina/Carolina Access (CCNC/CA)*, N.C. MEDICAID DIV. HEALTH BENEFITS, https://medicaid.ncdhhs.gov/providers/programs-and-services/communi

infrastructure that allows primary care practices to communicate with and make referrals to care managers and other members of the patient care teams, access comprehensive assessments of their patients' needs, and view patients' care plans.[181] Expanding these supportive health home models to other states would give additional primary care providers the financial incentives and data infrastructure to support their coordinating with non-PC CIHTs.

VI. CONCLUSION

Across the country, health care professionals are joining forces to reduce health inequities by enhancing the care provided to populations who are socially and economically disadvantaged.[182] CIHTs that blend a broad range of medical, behavioral health, and social services while offering intensive case management have tremendous potential to improve the health of socioeconomically disadvantaged patients. Yet whether the CIHT model fulfills its potential depends in part on policymakers enacting policies that support CIHTs delivering comprehensive, high-value care to their patients. In particular, the CIHT professionals we interviewed highlighted the importance of federal and state policies that promote a health care workforce with a sufficient number of professionals skilled in providing integrated care.[183]

Our research underscores the valuable contribution CHWs and behavioral health experts bring to CIHT care teams. Unfortunately, the existing workforce includes too few CHWs and behavioral health providers. Reducing health inequities therefore requires expanding the CHW and behavioral health workforce. Specifically, federal and state policymakers should develop low-cost CHW training and certification programs across all fifty states and the District of Columbia, increase scholarships and loan forgiveness programs for graduate students entering the behavioral health field, and strengthen funding for behavioral health education and training programs. Of equal importance is incorporating into the behavioral health workforce CHWs who receive basic behavioral health training. Policymakers can encourage this by developing and

ty-care-north-carolinacarolina-access-ccncca (last visited Mar. 4, 2022); BRENDA C. SPILLMAN ET AL., U.S. DEP'T HEALTH & HUM. SERVS., MEDICAID HEALTH HOMES IN NORTH CAROLINA: REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT NC-2 (2013) (describing North Carolina's Medicaid Health Homes).

181. *Practice Perfect: Tools to Focus Your Effort Where It Matters Most*, CMTY. CARE PHYSICIAN NETWORK, https://www.communitycarephysiciannetwork.com/services/tools-success-amh-help/practice-perfect-tools (last visited Mar. 4, 2022) (describing VirtualHealth Provider Portal).

182. Anne Andermann, *Taking Action on the Social Determinants of Health in Clinical Practice: A Framework for Health Professionals*, 188 CANADIAN MED. ASS'N. J. E474, E474 (2016).

183. Mantel et al., *supra* note 10.

financing standard training and certification programs for community behavioral health workers.

Our research also found that a key challenge CIHTs face is securing sustainable financing that supports staffing care teams with professionals capable of meeting the full range of patients' health-related needs. Providing Medicare and Medicaid fee-for-service reimbursement for services provided by CIHT CHWs and behavioral health professionals, including community workers trained in behavioral health, could offer CIHTs a source of ongoing funding. However, the fee-for-service payment model presents several challenges for CIHTs, including narrow score of coverage rules and supervisory and billing infrastructure requirements that many CIHTs would have difficulty satisfying.[184] More promising are alternative payment models, such as full and partial capitation, that afford health care providers the financial flexibility to either employ CIHT staff or contract with CIHTs operated by other entities. Federal and state regulators should therefore intensify their efforts under Medicare and Medicaid to shift providers away from fee-for-service reimbursement to alternative payment models.

Lastly, our research suggests that the CIHT model works best when the care team either is embedded in the primary care setting or coordinates closely with patients' primary care providers. While alternative payment models under Medicare and Medicaid continue to nudge primary practices toward establishing their own CIHT care teams, this may not be a viable option for small and under-resourced primary care providers.[185] For these providers, state and federal regulators should offer financial incentives to coordinate with external CIHTs, as well as access to supportive health information infrastructure.

Although the CIHT model is a promising strategy for reducing health inequities, our research reveals various challenges confronting CIHTs that can check their success. This Article sets forth policy proposals for overcoming these challenges. Nevertheless, the issues raised by our research and their policy implications warrant further study and discussion to ensure that the CIHT model fulfills its potential to improve the health of patients with complex medical, behavioral health, and social needs.

184. OR. CMTY. HEALTH WORKER ASS'N, *supra* note 35, at 35.

185. Scholle et al., *supra* note 171, at S6.