Community Health Workers and Behavioral Health Care

Richard C. Boldt

Eleanor T. Chung

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RICHARD C. BOLDT[*] & ELEANOR T. CHUNG[**]

INTRODUCTION

Community health workers are community members trained to facilitate interactions between the health care system, individual patients, and the communities in which they are situated.[1] The health care system is comprised of many components, including primary care professionals, clinical specialists, emergency departments, hospitals and other inpatient facilities, outpatient clinics, administrators, ancillary care providers and others, whose efforts collectively help to determine the health of individuals and of the population as a whole.[2] In the case of low-income communities and communities that include a significant number of persons from marginalized groups, frequently there are inadequate health care resources, including behavioral health care services, available to meet the needs of individuals and their families.[3] In addition, various elements of the health care system are not effectively linked to the patients in these communities who most need their services.[4] The community health worker model is designed to ameliorate the problem of limited resources and inadequate service provider penetration by building a matrix of productive relationships.[5]

1. *See* Shreya Kangovi et al., *From Rhetoric to Reality – Community Health Workers in Post-Reform U.S. Health Care*, 372 NEW ENG. J. MED. 2277 (2015) (discussing the role community health workers play in bridging the gap between health care providers and patients).

2. *See Community Health Worker Toolkit*, BEHAVIORAL HEALTH LEADERSHIP INST. 1, 4–5 (2016), https://health.maryland.gov/mchrc/Documents/ONE-Toolkit-from-Behavioral-Health-Leadership-Institute.pdf (explaining the various components and roles at play within the healthcare system).

3. *Achieving Health Equity in the United States,* AM. PUB. HEALTH ASS'N (Nov. 13, 2018), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/achieving-health-equity.

4. *Id.*

5. *See* E. Lee Rosenthal et al., *Community Health Workers: Part of the Solution*, 29 HEALTH AFF. 1338, 1338 (2010) (providing an account of how CHWs build a bridge between health care providers and patients).

When the model is most effective, the community health worker ("CHW") attends to the relationships between herself and the patients with whom she works, between herself and members of the clinical teams assigned to provide health care to those patients, and between herself and other service providers whose efforts can impact health outcomes for individual patients and the community.[6] CHWs are especially well suited to working with patients who have behavioral health needs because the integrated care that CHWs encourage is an effective way to tackle the co-occurring psychiatric and physical problems many patients experience.[7] CHWs are also optimally situated to address a number of the social determinants of illness that patients with serious mental illness confront, and to ameliorate some of the ethnic and racial disparities that impact the quality of care they receive.[8]

CHW practice is, essentially, an "umbrella" concept.[9] The universe of CHWs is made up of a variety of individuals who share important characteristics with the patients they serve and who bridge the space between those patients and the health care system.[10] Some within this broader universe are referred to as patient navigators or peer support workers, while others may be termed *promotores* or *promotoras*, community health representatives (CHRs), or lay outreach workers.[11] In one form or another, CHWs have been serving patients

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6. *See* BEHAVIORAL HEALTH LEADERSHIP INST., *supra* note 2, at 4 (emphasizing the importance of strong relationships between the CHW and the health care provider as well as the CHW and the patient).

7. *See* Patrick W. Corrigan et al., *Peer Navigation and Integrated Care to Address Ethnic Health Disparities of People with Serious Mental Illness*, 29 SOC. WORK PUB. HEALTH 581, 587–89 (2014) (explaining how CHWs help patients with serious mental illness navigate the health care framework to access services).

8. *See id.* at 587–88 (describing how CHWs are in the position to help remove some of the burdens that patients with mental illness face when navigating the health care system).

9. *See* Rosenthal et al., *supra* note 5, at 1338 (noting the wide range of professions encompassed under the label of community health worker).

10. *See* Addie Weaver & Adrienne Lapidos, *Mental Health Interventions with Community Health Workers in the United States: A Systematic Review*, 29 J. HEALTH CARE POOR & UNDERSERVED 159, 161 (2018) (explaining that a widely accepted definition of "community health workers" provided by the American Public Health Association identifies these actors as "frontline public health workers who are trusted members of and/or have a markedly close understanding of the community serviced.").

11. *See* Rosenthal et al., *supra* note 5, at 1338 (explaining how patient navigators, peer support workers, and promotor(es/as) all fall under the umbrella term community health worker). Some observers understand "community health representatives" as fulfilling a slightly different, more communitarian function than others within the CHW umbrella, who may be more focused on advocating for or improving the health of individuals within the community. According to this more dichotomous view, "community health representatives" function primarily as advocates for the community's health needs, while peer support workers, *promotoras*, and other CHWs target individual patient needs. This dichotomous view has sparked concerns, in the United States and elsewhere, that a focus on "task shifting" for some within the CHW umbrella may "challenge th[e] ability [of all community health workers] to promote health equity and social change within the communities to which they belong." Weaver & Lapidos, *supra* note 10, at 175. In addition, one published study offering a systematic review of community health workers engaged in mental health interventions categorized peer support specialists as distinct from other community health workers because of "their location in behavioral health specialty care, and their lived

in the United States at least since the middle of the twentieth century.[12] Today, there are well over 120,000 community health workers providing services in the United States, and many more world-wide, operating particularly in developing countries and in regions where the health care delivery system is stretched thin.[13]

When the number of CHWs operating throughout the world swelled in the 1960s and 1970s, the World Health Organization endorsed their use, both to extend the reach of the health care system and to ensure that providers are responsive to the needs of local communities.[14] In 2009, a policy committee of the United States Department of Labor recommended the creation of a standard occupational classification for CHWs.[15] The Affordable Care Act, enacted the next year, contains several provisions that support the use of CHWs to improve health outcomes and service delivery.[16] The Children's Health Insurance Program (CHIP) also recognizes a role for CHWs.[17] The statutory roles identified for CHWs are varied, and include improving the cultural competence of health care services, improving access to care, and encouraging prevention and health screening functions in the community.[18]

For the most part CHWs offer peer-to-peer relationships of trust rather than clinical expertise.[19] Their goal is to improve access to health care services and healthy outcomes by facilitating interactions between health care professionals and patients, and by teaching patients about the importance of preventative care and attending to the social determinants that often affect the health of community members.[20] There are important questions about where CHWs should focus their

experience of mental illness . . ." *Id.* at 161. Notwithstanding these internal distinctions, which track to some degree the different functions that subgroups of CHWs perform on the ground, this Article will consider the potential of the whole universe of CHWs to advance the wellbeing of persons with behavioral health needs. *Id.* at 161.

12. *See* Kangovi et al., *supra* note 1, at 2277.

13. Rosenthal et al., *supra* note 5, at 1338; Kangovi et al., supra note 1, at 2277. A version of the model dates back to the end of the nineteenth century in Russia. *See* Kangovi et al., *supra* note 1, at 2277. Community-based advocates and liaisons who served the function of community health workers, known as "barefoot doctors," were an important feature of the health-care system in China in the 1920s. *Id.*

14. *See* Kangovi et al., *supra* note 1, at 2277.

15. *Id.*

16. *Id.*

17. *See id.* (noting that the Children's Health Insurance Program views community health workers as providers of outreach, education, and enrollment in primary care).

18. *See id.* (noting that CHIP describes community health workers as liaisons facilitating relationships between the community and health care systems).

19. *Id.*; *see also* Weaver & Lapidos, *supra* note 10, at 160 (noting CHWs' essential role as "culturally-embedded and community-oriented;" however, also pointing out that that "CHWs could play both medically and socially oriented roles").

20. *See* BEHAVIORAL HEALTH LEADERSHIP INST., *supra* note 2, at 5 (highlighting how CHWs are instrumental in building successful relationships between the patient and health care provider). "As defined by the World Health Organization (WHO), "social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels." *What Are the Social Determinants of*

attention. They must consider the trade-offs between emphasizing prevention and upstream issues versus primary care and other health-care interventions, as well as between improving the communication and responsiveness of clinicians on the care-giving team of individual patients versus advocating for the health needs of the whole community.[21] It is likely that individuals within each of the subcategories that together comprise the broader universe of CHWs tend to resolve these tensions according to norms or conventions established within their cohort.

Patient navigators, for example, generally focus on guiding patients with serious or chronic conditions through complex health care delivery systems and insurance entitlement requirements that might otherwise overwhelm individuals lacking specialized training or experience in the area.[22] Originally recruited from relevant professional groups, including social workers and nursing professionals, patient navigators more recently have been drawn from patients in recovery who have lived experience dealing with the diseases and the treatment systems that their clients are confronting.[23] These peer navigators have been deployed most often to support patients undergoing treatment for cancer.[24]

Peer navigators working with cancer patients perform a wide range of tasks. They assist in the coordination of health care services, help patients access care, notify potentially eligible individuals of clinical trials, run interference with health insurers, and participate in community outreach efforts.[25] Peer navigators in the oncology arena also enhance the cultural competence of available treatment services.[26] "Patients of color report emotional support, 'being there,' and feeling heard as essential elements of successful navigators, qualities often perceived as absent in traditional clinics."[27] Some researchers have also found that peer navigators are perceived to be "more sensitive to family issues that may be pronounced in some minority cultural groups," and that patients from ethnic

Health?, WORLD HEALTH ORG., http://www.who.int/social_determinants/sdh_definition/en/ (last visited Feb. 23, 2020).

21. *See* Kangovi et al., *supra* note 1, at 2278 (explaining how being a CHW requires balancing the needs of the individual patient and the needs of the patient community).

22. *See* Corrigan, *supra* note 7, at 583 (explaining that patient navigators are a good resource for patients dealing with chronic illnesses).

23. *See id.* at 585 (explaining that patient navigators who have had experience with illness can help patients complete prolonged treatment regimens with fewer disruptions).

24. *Id.* at 584–85 (explaining that because of the great success patient navigators have had in helping patients with long term illness, patient navigators have naturally turned to helping cancer patients as well).

25. *See* Corrigan, *supra* note 7, at 584 (listing the specific tasks for navigators created by the Patient Navigator Outreach and Disease Prevention Act).

26. *Id.* at 585.

27. *Id.* (first quoting Carroll et al., *Patients' Experiences With Navigation For Cancer Care*, 80 PATIENT EDUC. & COUNS. 241, 244 (2010); then quoting Natale-Pereira et al., *The Role of Patient Navigators in Eliminating Health Disparities*, 117 CANCER 3543, 3549 (2011)).

minorities "had fewer disruptions in care and greater likelihood of completing prolonged treatment regimens as a result of patient navigators."[28]

In light of these promising experiences, some have suggested that peer support services can be effective as well in improving access to behavioral health care and in increasing the effectiveness of the treatment that individuals receive for mental illness, substance use disorders, and other mental disabilities.[29] This article explores the promise of CHW involvement in the delivery of behavioral health services. Part I provides a brief look at preliminary research on the work of peer navigators and other CHWs whose efforts are focused on clients with behavioral health needs, paying particular attention to the distinct characteristics of this service population. Part I also examines the variety of implementation barriers that have confronted those advocating for the greater use of CHWs in other settings and that are especially pronounced in the context of behavioral health, including issues related to stable funding.

Part II then provides a series of detailed profiles of five states that have made significant efforts to expand the use of CHWs for behavioral health care. The profiled states are ordered from the least to the most formal, in terms of the regulatory, statutory, and funding infrastructure present in each state supporting the use of CHWs. This ordering permits a consideration of whether top-down public health reform in this area is effective in stimulating grassroots efforts or whether such reform necessarily takes place only after grassroots work prepares the ground for new approaches.

The profile of each state illustrates many interconnected sources of law and funding, and depicts how differently the CHW movement grows in different funding substrates. New Mexico and Michigan have very strong grassroots CHW traditions: they both have a long history of CHWs used to reach distinct, marginal populations in culturally sensitive ways, and have long used CHWs to expand limited healthcare resources in underserved communities.[30] Texas and Minnesota have strong grassroots traditions, as well as substantial state infrastructure. In these four states, CHWs engage in behavioral health care in very distinctive ways.[31]

In contrast, Oregon has a rich history of state policy initiatives and fewer informal sources of funding. By state law and regulation Oregon has regularized the role of CHWs, as reflected in its training programs, certification, and

28. *Id.* at 584.

29. *See e.g.* Mara Laderman et al., *Community-Based Behavioral Health Integration: A Focus on Community Health Workers to Support Individuals with Behavioral Health and Medical Needs*, INST. FOR HEALTHCARE IMPROVEMENT (2015) (explaining the value of peer support in the success of CHW programs as a reinforcement that recovery is possible and as a liaison between patients and medical providers).

30. See discussion *infra* Sections II.A., II.B. (for further details on CHWs in Michigan and New Mexico, respectively).

31. See discussion *infra* Sections II.A.–II.D. (for details on CHWs in all four states).

reimbursement paradigms. Notably, Oregon is also the state under study with the least evidence of CHWs engaged in behavioral health care.[32]

The research methodology for this project began with a survey of websites (state agencies, nonprofits, CHW associations, and health care providers). From this public information, we selected the five states surveyed below, based on our assessment that these states were broadly representative and had demonstrated significant activity involving CHWs in behavioral health.

The websites helped us to identify those who play leading roles in each of our targeted states in promoting and developing CHW certification and CHW integration into behavioral health care. They included officials from state health departments, program coordinators and directors of health care institutions, and leaders of nonprofit organizations, whom we interviewed via telephone or email. The interviews provided us with a more nuanced understanding of the laws and regulatory initiatives we had identified as operating in each jurisdiction, as well as a deeper set of insights into the ways top-down initiatives play out on the ground.

We also conducted more traditional legal research bearing on the use of CHWs in behavioral health care. We reviewed the legislative histories of the laws identified in interviews and the workgroup materials that led state committees to develop relevant regulations. In order to gain a deeper understanding of state support for CHWs over time, we consulted articles in professional journals in law, social work, and public health. Lastly, we took score of the provisions of the ACA that affect informal caregivers and reviewed the scholarship on such provisions. The result is a detailed summary of CHWs engaged in behavioral health in a set of selected jurisdictions.

The goal of this analysis is to show the impact of state and federal legislation and regulation on CHWs on the ground and to facilitate judgments about how meaningful public behavioral health reform is accomplished. This Article also sheds light on whether some funding mechanisms are superior to others, whether CHWs should receive formal training, whether CHW certification is important, and what the role of the CHW should be.

PART I. AN OVERVIEW OF COMMUNITY HEALTH WORKERS

A. Preliminary Research on the Work of Peer Navigators and other Community Health Workers with Persons with Behavioral Health Problems

In a series of promising studies summarized in the journal *Social Work in Public Health*, Patrick Corrigan and his colleagues report that peer navigation can be as effective as, and in some cases more effective than, the services provided by mental health professionals. In several of these studies, people who

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32. See discussion *infra* Section II.E. (for further details on CHWs in Oregon).

received psychiatric case management services from peer navigators "demonstrated the same level of functional and symptom stability as those provided by professional or paraprofessional staff."[33] In one randomized clinical study, participants who were assigned to "peer mentors" had "significantly fewer rehospitalizations and inpatient days" during the study period than the control group that had received "aftercare as usual."[34]

Similarly promising results have been reported by Yaminette Diaz-Linhart and colleagues in the context of a pilot study using peer navigators for mothers with depression who had children in Head Start programs.[35] These peer navigators were Head Start workers and other lay providers who received a two-day training and then were supervised by professional social workers. Their training was in the "fundamentals of community health work, health disparities, and social determinants of health, cultural competency; professional organizations; and advocacy."[36] The navigators also received instruction in managing mental health emergencies, understanding mandated child abuse disclosure rules, and "engagement interview training."[37] The outcome measure of the study was the respective engagement with mental health services of the two study groups, one of which received peer navigation services and the other of which did not.[38] At the early stages of the study there were no statistically significant differences between the two groups; however, by the six-month mark significantly more of the mothers who had received peer navigation support reported having engaged with a psychologist, therapist, or social worker. By the end of the study period, 80% of the mothers in the "navigation arm" reported that they had a "depression care provider" compared with only 41% of the participants in the "non-navigation arm."[39]

Among the most compelling studies of CHWs in the behavioral health context are investigations of a model in which peer navigation is employed to assist patients with serious mental illness manage their physical health needs by accessing primary care services. In one study, navigators were employed to assist patients following a psychiatric crisis by helping them identify and obtain primary medical care.[40] The patients in this study had not had a primary care doctor for six months or more. The group assigned patient navigators received education about fees and services, facilitation to primary care providers, and

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33. Corrigan, *supra* note 7, at 585.

34. *Id.* at 585–87.

35. Yaminette Diaz-Linhart et al., *Patient Navigation for Mothers with Depression Who Have Children in Head Start: A Pilot Study*, 31 SOC. WORK PUB. HEALTH 504, 504 (2016)

36. *Id.*

37. *Id.*

38. *Id.* at 505-06.

39. *Id.* at 509.

40. Kim S. Griswold et al., *Connections to Primary Medical Care After Psychiatric Crisis*, 18 J. AM. BOARD FAM. PRAC. 166, 167 (2005).

ongoing "follow-up, including in-home visits and mobile outreach."[41]   After three months, 57% of the patients who received support from patient navigators were successfully linked to primary medical care, compared to only 16% of the control group that had not received navigation support.[42] In another, somewhat different, study, researchers assigned one group of patients with serious mental illness to receive a six-session modified "chronic disease self-management program," led by peers.[43] The sessions covered information about "symptoms, disease management techniques, regular action planning, and problem solving."[44] At the six-months mark, the group that had received this peer-led instruction had "significantly more primary care visits," and "better physical activity, medication adherence, and physical health related qualify of life," than the control group that had not received these specialized services.[45]

B. The Needs of Persons with Significant Behavioral Health Problems

While the research on peer support for patients with behavioral health needs is promising, both with respect to improving the care these individuals receive for their mental illness and in accessing primary medical services,[46] more work should be done to explore whether sustained efforts by peer navigators and other community health workers might yield additional benefits for the most vulnerable members of this patient population.[47]

People with serious mental illnesses have disproportionately high levels of co-occurring physical disorders that often interact with their psychiatric disabilities to compound the severity of both.[48] Data collected on patients with bipolar disease and schizophrenia show a high incidence of cardiovascular, respiratory, and gastrointestinal disease.[49] People with serious mental illness are hospitalized for physical health conditions at much higher rates than the

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41. *Id.*

42. *Id.* at 169.

43. Corrigan, *supra* note 7, at 587.

44. *Id.*

45. *Id.*

46. *See* M. Chinman et al., *Peer Support Services for Individuals with Serious Mental Illnesses: Assessing the Evidence*, 65 PSYCHIATRIC SERVS. 429 (2014) (discussing an expansion of the continuum of care due to peer support services); *See also* Julie Repper & Tim Carter, *A Review of the Literature on Peer Support in Mental Health Services*, 20 J. MENTAL HEALTH 392, 392 (2011) (highlighting the role peer support can play in facilitating recovery).

47. *See* Kangovi et al., *supra* note 1 (considering the value of CHWs in low-income countries); *see also* Weaver & Lapidos, *supra* note 10, at 175 (noting the benefits CHWs provide underserved populations and their potential future value).

48. *See* Marc De Hert et al., *Physical Illness in Patients with Severe Mental Disorders: Prevalence, Impact of Medications and Disparities in Health Care*, 10 WORLD PSYCHIATRY 52, (2011) (noting that individuals with serious mental illness are significantly more likely to face morbidity and mortality).

49. Corrigan, *supra* note 7, at 582.

population average and have significantly shorter life expectancies.[50] In some cases this heightened morbidity and mortality of patients with serious mental illnesses may be due to genetic predisposition.[51] In other instances it may result from the long-term use of psychotropic medications, which can produce both metabolic and cardiovascular side-effects.[52] In addition, psychiatric symptoms can drive lifestyle choices such as smoking and other substance misuse and can result in behaviors and circumstances that increase physical health risks.[53]

Social determinants that impact the wellbeing of individuals with serious mental illnesses include homelessness, poverty, unemployment, and excessive involvement in the criminal legal system, as well as an increased risk of criminal victimization.[54] Adults with serious mental illnesses have substantially lower rates of workforce involvement than similarly situated adults without SMI and are much more likely to be in a family living in poverty.[55] The increased incidence of homelessness associated with this population is a special risk factor for a variety of physical health problems, and enmeshment in the criminal legal system is associated with health problems for a number of reasons, not the least of which is limited access to health care.[56]

Individuals with serious mental illness who are members of minority racial or ethnic groups have even more physical health problems than their white counterparts.[57] In part, these disparities are due to the higher incidence of poverty, homelessness and criminal legal system involvement experienced by people of color. In addition, these groups generally have access to fewer health care services and tend to be less successful in establishing ongoing relationships with primary care providers.[58] Finally, to the extent that the health care system available to patients of color lacks cultural competence, the impact of culture on mental health stigma and cultural misunderstandings about psychiatric symptoms can have the effect of driving patients away from care both for their behavioral health needs and for other physical medical conditions.[59]

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50. *Id.*

51. *Id.*

52. *See*, e.g., Lars Vedel Kessing, *Treatment with Antipsychotics and the Risk of Diabetes in Clinical Practice*, 197 BRITISH J. PSYCHIATRY 266, 269 (2010) (noting that an increased risk of developing diabetes is associated with the use of some antipsychotic drugs).

53. Corrigan, *supra* note 7, at 582.

54. Jeffrey Draine et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illness*, 53 PSYCHIATRIC SERVS. 565, 565–67 (2003).

55. *Id.*; Corrigan, *supra* note 7.

56. Corrigan, *supra* note 7, at 582.

57. *See id.* at 583.

58. *Id.*

59. *See id.* (describing a number of ways in which a lack of cultural competence can negatively impact the quality of care).

While the considerable experience of peer navigators and other CHWs in the oncology context provides a foundation for building similar resources into the behavioral health care system, the analogy between cancer treatment and mental health treatment is imperfect. More pilot programs and associated research are needed, particularly with respect to the role that CHWs can play in improving the physical health of patients with serious mental illnesses and the ways in which better primary health care engagement might improve psychiatric health.[60] In addition, more must be learned about how the particular challenges presented by patients with serious mental illness might interact with the CHW model or models that have been developed in other health care settings.[61] More experience will be essential in determining how well peers in supportive roles can manage the cognitive and affective symptoms that are characteristic of serious mental illnesses, and how effectively they can deal with the stigma that inevitably attaches to this population.[62] Finally, research must further refine our understanding of the impact of race and ethnicity on the efforts of peer navigators and other community health workers.[63]

C. Implementation Barriers

There is good evidence that peer navigators, peer support workers, and other CHWs can play an effective role in improving the health care that targeted communities receive, but the evidence drawn from work with cancer patients and others is not universally positive.[64] These mixed results are due to several significant implementation barriers that advocates of the CHW model must confront if this approach is to succeed in the future, and especially if the goal is to extend the model to patients with mental illness and other behavioral health needs.[65]

1. Insufficient Integration

First, because CHWs are most often recruited, trained, and supervised in the context of community-based organizations, they frequently are not well integrated with professional clinicians in the health care system.[66] This problem

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60. *See* Weaver & Lapidos *supra* note 10 (discussing empirical studies on CHWs that assess their effectiveness).

61. *Id.* at 160.

62. *See* Corrigan, *supra* note 7, at 588 (explaining the unique challenges posed by those with severe mental illness in the provision of quality and effective health care services).

63. *See id.* (discussing the potential for community-based participatory research).

64. *See* Kangovi et al., *supra* note 1, at 2278 (listing five key implementation barriers CHW programs must overcome to succeed in the post-ACA era: "insufficient integration with formal health care providers; fragmented and disease specific interventions; lack of clear work protocols; high turnover and variable performance of the workforce; and a history of low-quality evidence").

65. *Id.*

66. *Id.*

of insufficient integration has a number of consequences. Other health care professionals may not have day-to-day exposure to CHWs or understand the valuable contributions they can make to the care of their patients; "[c]linicians often don't recognize the value of CHWs because they don't work with them. Providers may therefore be less willing to finance CHW programs, which must rely on unsustainable grant funding."[67] In addition, this segregation of CHWs can exacerbate turf struggles with nurses and other professionals, as well as foster liability concerns that CHWs are inappropriately undertaking clinical tasks rather than addressing upstream problems or engaging in ancillary advocacy and support activities.[68]

2. Fragmentation

The problem of insufficient integration is compounded in many instances by a second implementation barrier, the highly fragmented nature of much CHW practice. Because peer navigation and a number of other community health worker initiatives in the United States have evolved in the context of specific diseases, the interventions that CHWs pursue frequently are cabined by the specific treatments those diseases require and the specialized institutional structures within which they are delivered.[69] Fragmented disease-specific work, in turn, often is inimical to a holistic patient-centered approach capable of addressing the multiple co-occurring health problems that many behavioral health patients experience.[70]

3. Misallocated Human Resources and Other Workforce Issues

Two additional implementation barriers combine with the concerns regarding segregation and fragmentation to limit the potential effectiveness of much CHW work. Peer support programs and other CHW programs sometimes operate without well-developed written guidelines, which are necessary to organize and rationalize the work of individual workers.[71] "When protocols exist, they often describe the discrete tasks to be performed by CHWs, and underemphasize program-level issues. Without clear guidelines, CHWs may perform tasks for which they are ill-suited or lack adequate supervision, or they may carry caseloads that are too large for their role and catchment area."[72] These

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67. *Id.*

68. *See id.* (noting challenges that CHW programs face in integrating with others in the health care system); *see also* Weaver & Lapidos, *supra* note 10, at 175 (noting that CHWs may "hold marginalized positions that challenge their ability to promote health equity and social change within the communities to which they belong.").

69. *See* Kangovi et al., *supra* note 1, at 2278 (noting that fragmentation of CHW practice may encourage stand-alone disease intervention and management programs).

70. *See id.* (explaining the value of holistic, patient-centered programs).

71. *See id.* (noting that many CHW programs lack settled protocols and operating procedures).

72. *Id.*

problems of misallocated or overloaded human resources, in turn, implicate the final implementation barrier, recruiting and maintaining an effective CHW workforce.[73] Many peer support programs and other CHW initiatives experience high levels of turnover and individual burnout, which can be attributed, at least in part, to the lack of well-defined selection criteria, inadequate training, and insufficient supervision.[74] These problems can impact the quality of the work that individual CHWs engage in, but they also may lead to higher operating costs that raise essential funding issues.[75]

4. Funding

The question of stable funding for CHWs is central to the long-term sustainability of this model. To date, many CHW programs have relied on grant funding, which can be episodic and ultimately unreliable.[76] One alternative funding strategy is to become a part of integrated care-giving teams that receive hard money funding or have arranged to receive fees for services.[77] In the recent past, the federal government has made demonstration grants available to support health care delivery models that include CHWs.[78] Perhaps the most important source of stable funding is Medicaid. Every state provides for mental health treatment services in their state plans.[79] Many also include "a wide variety of supportive services, including counseling, recovery supports, and skills training," although some state plans are more limited and only cover "medication management and short-term psychiatric inpatient hospitalization, rather than a broader array of wraparound services. . ."[80] For the many states that do include supportive services, the expansion of Medicaid under the Affordable Care Act offers a promising route to significant support for peer navigation and other CHW services.[81]

When the ACA was first promulgated, the federal officials responsible for planning and evaluation estimated that as many at 5.4 million individuals with

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73. *Id.*

74. *See id.* at 2278–79 (describing the importance of a more structured employment system to improve employee performance).

75. *Id.* at 2278 (emphasizing that these factors can lead to adverse patient outcomes while pushing costs significantly higher than expected).

76. *See id.* at 2277–78 (noting CHW programs' reliance on unsustainable grant funding).

77. *See* Rosenthal et al., *supra* note 5, at 1339–40 (highlighting Massachusetts and Minnesota as having developed programs that increase third-party payments to finance CHWs and provide a sustainable source of funding to support CHWs).

78. *See* Kangovi et al., *supra* note 1, at 2277.

79. 42 USC § 1396u-7(b)(2)(A)(v); *Health Insurance and Mental Health Services*, DEP'T OF HEALTH AND HUMAN SERVS., https://www.mentalhealth.gov/get-help/health-insurance; Laysha Ostrow et al., *Medicaid Reimbursement of Mental Health Peer-Run Organizations: Results of a National Survey*, 44 ADMIN. & POL'Y MENTAL HEALTH 501, 502 (2017).

80. Ostrow et al., *supra* note 79, at 502.

81. See *id.* at 509–10 (discussing funding implications of the Medicaid expansion).

behavioral health problems would gain insurance coverage through Medicaid expansion.[82] Even the partial implementation of Medicaid expansion so far has yielded insurance coverage for several million individuals with mental illness and/or substance use disorders.[83] Within this population of patients with behavioral health care needs who have obtained insurance through state expansion, the opportunities for CHWs supported by Medicaid dollars are significant. The Centers for Medicare and Medicaid Services (CMS) has encouraged the integration of peer support and patient navigation services in state waivers, and many state Medicaid plans expressly cover peer support, which "includes assistance in learning and overcoming challenges in health/wellness and self-monitoring."[84] A number of states now have certification processes for peer support workers and these certified peer support specialists "are now Medicaid reimbursable in 31 states and the District of Columbia."[85]

A major point of departure for CHW funding is the choice to tie reimbursement to a managed care contract with a Medicaid managed care organization instead of providing funding through a fee-for-service model.[86] The former approach may prove to be more successful, in part because "many of the goals of managed care are those of peer support: increasing wellness and recovery, and reducing hospitalization."[87] In addition, the fee-for-services approach can prove challenging for nonprofessional providers, including CHWs and peer navigators, precisely because these peer support workers are not oriented toward medical diagnoses or medical necessity but instead prefer "focusing on strengths, not documenting impairments."[88] The tendency of many CHW programs to "reject conceptualizations of life problems as medical illnesses" is, however, a double-edged sword.[89] On the one hand, resistance to a medicalized model of service makes it more difficult for CHWs and those with whom they work to meet traditional billing requirements centered on documenting diagnoses and functional deficits in clients and demonstrating the medical necessity of services.[90] On the other hand, the core values held by many CHWs, including a commitment to "promoting empowerment and self-direction

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82. *Id.*; *See also* Rachel L. Garfield, et al., *Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services*, 61 PSYCHIATRY SERVS. 1081, 1082 (2010) (noting the number of individuals impacted by the coverage expansions).

83. Louise Norris, *How Obamacare Improved Mental Health Coverage*, HEALTHCARE.GOV (July 5, 2018) https://www.healthinsurance.org/obamacare/how-obamacare-improved-mental-health-coverage/.

84. Ostrow et al., *supra* note 79, at 502.

85. *Id.* at 502–03.

86. *See id.* at 503 (discussing the potential benefits CHW programs could realize by joining a Medicaid managed care network).

87. *Id.*

88. *Id.*

89. *Id.* at 509.

90. *Id.*

thorough non-hierarchical relationships" and to promoting healthy outcomes through prevention and advocacy directed to upstream determinants such as poverty, environmental risks, and racism, hold the potential to "broaden opportunities for recovery-oriented services within the managed care network and other network providers."[91]

5. Future Developments

In practice, the tensions faced by CHW organizations are likely to be resolved based on local and state circumstances, including available funding schemes and the training and certification regimes that are in place in a given jurisdiction.[92] Some CHWs will continue to maintain a community-based identity even though that may prevent their greater integration into clinical care delivery teams.[93] Some programs will continue to train their focus on upstream socioeconomic factors that drive health outcomes for low-income communities and communities of color, rather than on disease management tasks and clinical interventions with individual patients.[94] All of these decisions will require careful thought and will benefit from the experience of pilot projects and well-designed research efforts. In the end, a diversity of approaches to building peer support into the health care system is probably the best outcome so long as the overall number of CHWs working with vulnerable patients and their communities continues to expand.

PART II. REVIEW OF SELECTED STATES

The sources of CHW funding are quite varied and quite interconnected. While CHWs have existed in the United States since the mid-20th century, reliable sources of funding came much later.[95] The first major source of reliable funding was the Section 1115 Medicaid Waiver, which provided states with flexibility in funding health care delivery.[96] The most recent sources of reliable

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91. *Id.*

92. *See* Rosenthal et al., *supra* note 5, at 1349–40 (highlighting several policy recommendations that can encourage development of community health worker programs).

93. *See* Kangovi et al., *supra* note 1 (discussing the implementation and integration barriers CHW programs face). In other settings, the concern is the reverse, that CHWs will "favor medically oriented roles over socially oriented roles promoting justice and equity within communities." Weaver & Lapidos, *supra* note 10, at 175.

94. *See* Kangovi et al., *supra* note 1, at 2278 (discussing the issues CHW programs face when integrating with clinical providers, noting that if CHWs focus too closely on clinical care, they may miss opportunities to intervene in upstream socioeconomic problems); *see also* Anna Stapleton, et al., *How to Build Sustainable Community Health Programs in the United States*, HEALTH AFFAIRS (December 20, 2016), https://www.healthaffairs.org/do/10.1377/hblog20161220.057871/full/ (explaining that CHW programs can serve a valuable role in addressing disparities among marginalized groups).

95. *See* Kangovi et al., *supra* note 1, at 2277-78 (describing CHW programs' challenging history).

96. *About Section 1115 Demonstrations*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Feb. 23,

funding, and perhaps the most influential, stem from the Affordable Care Act. Interspersed between these federal milestones is state legislative activity, which, in addition to creating sources of funding, shaped the CHW role by developing certification and education programs. The effects of federal and state legislation vary greatly among the states.

Professionalization of the CHW is closely tied to the Section 1115 Waiver. Two states profiled here have used the Section 1115 Waiver to fund CHW engagement in behavioral health care (Oregon, Texas). More generally, as Waivers became widespread, state legislatures became interested in CHWs, establishing committees to formalize the CHW role and scope of work (Minnesota, Texas). Other state legislatures became interested in CHWs very recently, with legislative action to professionalize CHWs for the purpose of acknowledging work well done (New Mexico), or to further statewide integrated health care initiatives (Oregon).

The Affordable Care Act includes several major provisions that support the use of CHW engagement in behavioral health care.[97] It defines the CHW's many roles in language borrowed from the Department of Labor's Standard Occupational Classification, describing a CHW as

> [A]n individual who promotes health or nutrition within the community in which the individual resides—
> by serving as a liaison between communities and healthcare agencies;
> by providing guidance and social assistance to community residents;

2020). The Section 1115 Waiver is a provision of the Social Security Act, which allows the Secretary of Health and Human Services to approve experimental projects that promote the objectives of Medicaid or Children's Health Insurance Programs (CHIP). Introduced by the Kennedy Administration in 1962 as part of the Public Welfare Amendments to the Social Security Act, Pub. L. No. 87-543, Section 1115 projects are budget-neutral; expenses are not greater than federal spending would have been without the project. Generally, each project is approved for a five-year term with an option for extension. *Id.; see also* The Public Welfare Amendments of 1962, Pub. L. No. 87-543, 76 Stat. 172 (1962). States did not make great use of the provision until 1982, when Arizona reduced health care spending with its innovative Arizona Health Cost Containment System (AHCCCS). *See* ARIZONA DEMONSTRATION FACT SHEET (2018), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/az/az-hccc-fs.pdf; *see also* Richard E. Chard, *The State of Health: Innovations in Health Policy*, *in* INNOVATION AND ENTREPRENEURSHIP IN STATE AND LOCAL GOVERNMENT 61, 76 (Michael Harris & Rhonda Kinney eds., 2003) (noting that Arizona's success, coupled with the Clinton Administration's willingness to grant waivers, resulted in a succession of state waiver programs, akin to "ripples created by dropping a stone in the pond.").

97. *See* AMY KATZEN & MAGGIE MORGAN, AFFORDABLE CARE ACT OPPORTUNITIES FOR COMMUNITY HEALTH WORKERS, 2 (2014) https://www.chlpi.org/wp-content/uploads/2013/12/ACA-Opportunities-for-CHWsFINAL-8-12.pdf (highlighting three ways that the ACA has opened doors for CHWs to better serve the community). One provision, authorizing the Centers for Disease Control and Prevention to issue grants to

organizations that utilize CHWs in underserved areas, was a nonstarter because Congress did not appropriate funding; *see also id.* (noting that while funding has never been appropriated, the ACA has still generated changes to increase the role of CHWs in the health system); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5313, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

> by enhancing community residents' ability to effectively communicate with healthcare providers;
> by providing culturally and linguistically appropriate health or nutrition education;
> by advocating for individual and community health;
> by providing referral and follow-up services or otherwise coordinating care; and
> by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.[98]

The Act allows state Medicaid plans to utilize non-licensed providers, including CHWs, to provide preventative health services.[99] It also authorizes funding for state Medicaid programs to create "health care homes" for patients with chronic illnesses, including those with serious mental illnesses or substance use disorders.[100] Lastly, the ACA creates further funding for CMS Innovation Awards, which allow states to implement unique health care plans toward the goal of improving health and quality outcomes while reducing cost.[101]

While all states surveyed here utilize Medicaid funding for CHW reimbursement, there is great variety in how the provisions of the ACA have affected CHW engagement in behavioral health care. Some CMS Innovation Award-winners have allowed CHWs' services to be reimbursed by bundling payments for health care teams (Michigan's MI Care Teams, Texas's Center for Health Care Services). Others have funded CHWs through the use of accountable care organizations (Minnesota's Hennepin Health) or federally qualified health centers (New Mexico's Ben Archer Health Center). Still others

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98. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5313, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

99. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4106, 124 Stat 119 (2010) (amending 42 U.S.C. § 1396d(a)(13)(c) to expand medical assistance payments to cover costs of any medical or remedial services provided by a non-licensed practitioner that was recommended by a licensed practitioner or physician). *See also* DEP'T OF HEALTH & HUMAN SERVS., CMCS INFORMATION BULLETIN, UPDATE ON PREVENTATIVE SERVICES INITIATIVES (Nov. 27, 2013), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf (discussing a final rule published by CMS allowing non-licensed practitioners to provide services recommended by a licensed practitioner or physician to be consistent with the ACA).

100. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 2703, 124 Stat. 119 (2010)**;** *See also* CTR. FOR MEDICARE & MEDICAID INNOVATION, STATE INNOVATION MODELS: FUNDING FOR MODEL DESIGN AND TESTING ASSISTANCE 1, 60–61 (2012), https://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf (describing the ACA's requirement to test innovative health care delivery methods, including health homes).

101. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 3021, 124 Stat. 119 (2010); Protection & Affordable Care Act, Pub. L. No. 111-148, § 3302, 124 Stat. 119 (2010); *see also Health Care Innovation Awards, Round 2 Frequently Asked Questions*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/faq-round-2.html (last visited Mar. 6, 2020).

have created behavioral health care homes that utilize CHWs (Minnesota and Oregon).

The overall effect of the ACA on CHW usage was no doubt shaped by the state systems in place before its passage. Several states already had formal statutory authorization, policy initiatives, and funding sources for CHWs engaged in behavioral health care. Other jurisdictions utilized CHWs in a far more informal fashion. Of those surveyed for this project, Michigan and New Mexico had perhaps the strongest grassroots traditions, while Oregon had the longest history of a more formal, top-down type of organization.

The states profiled below are ordered from those that had the least formal systems in place prior to the passage of the ACA to those with the most formal statutory and regulatory supports for CHW engagement. This order permits a consideration of how top-down, federal legislation influences a state's indigenous grassroots tradition. Reading in this order facilitates contemplation of how top-down activity may augment the effects of state law governing CHW certification and practice: more specifically, the reader may contemplate how federal legislation impacts a state's indigenous Section 1115 Waiver projects and grassroots activity. Naturally, the order is imperfect, as our assessment of formal and informal systems is somewhat subjective, and because each state exhibits some features of both top-down and bottom-up public health reform.

We begin with New Mexico because it has a very strong grassroots tradition and relatively less, and more recent, state legislative activity. We end with Oregon, a state with relatively little grassroots activity, but with a rich history of Section 1115 Waiver use. In between, Michigan, Minnesota, and Texas exhibit gradations of grassroots and state legislative activity.

A. New Mexico

New Mexico has one of the oldest and strongest CHW traditions in the United States. There, CHWs engage in inter-program collaboration, attend trainings in neighboring counties, conduct home visits in very remote locations, and help patients with every aspect of health and daily life. Behavioral health care is embedded into CHW services. The state also offers behavioral health care programing. Funding for CHWs stems from capitated Medicaid payments, a CMS Innovation Award, and federally funded programming. Recent state legislation created a voluntary certification, allowing CHWs the option of formal recognition for their work. Certification is not a prerequisite for Medicaid reimbursement.

1. Overview: CHWs in New Mexico

The Southwest is the land of the "*promotores de salud*" and is one of the birthplaces of the American CHW movement. In no other state is the notion of CHWs practice as an "umbrella" concept more apparent.. "*Promotores de salud*"

are colloquially known as "*promotoras*" because they are almost always women. CHWs in this region who work exclusively with Native American Communities may also be referred to Community Health Representatives, or CHRs.[102]

The Community Health Representative Program was first funded by Indian Health Services in 1968 and provides services distinct from those of CHWs and *promotoras*.[103] CHRs conduct tribal health outreach and are in many ways the predecessor to CHWs nationwide.[104] A CHR is "a tribal or Native community-based, well-trained, medically guided, health care provider, who may include traditional Native concepts in his/her work and is funded with IHS-CHR appropriations."[105] The concept of culturally suitable health care delivery is inherent to CHR work.[106]

2. State Funding & Voluntary Certification in New Mexico

a. CHW Services Embedded in Capitated Medicaid Rates

State Medicaid reimburses CHW services as medical expenditures for care coordination services.[107] This means that no provider-patient encounter data—information regarding the particular patient, or a diagnosis code—is required in order to seek Medicaid reimbursement.[108]

As care-coordinators, CHWs are directly contacted by patients. CHWs can be salaried, or independently contracted as a group or individually.[109] The state prescribes the ratio for CHWs to patients.[110] Native American patients may request assignment to a Native American Care Coordinator; if none is available, a CHW or CHR must be present in all in-person meetings between the assigned care coordinator and the patient.[111]

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102. *Office of Community Health Workers*, N.M. DEP'T OF HEALTH, https://nmhealth.org/about/phd/pchb/ochw/ (last visited Mar. 14, 2020). *Community Health Representative*, INDIAN HEALTH SERV., https://www.ihs.gov/chr/ (last visited Mar. 14, 2020).

103. INDIAN HEALTH SERV., INDIAN HEALTH MANUAL, https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c16#316.3Chttps://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c16#3-16.3C (last visited Mar. 6, 2020).

104. *Id.*

105. *Id.*

106. *Id.*

107. N.M. DEP'T OF HEALTH, MANAGED CARE POLICY MANUAL 36–37 (rev. 2015), http://www.hsd.state.nm.us/uploads/files/Managed%20Care%20Policy%20Manual%204_17(1).pdf.

108. *Id.*

109. *Id.* at 35.

110. *Id.* at 35–36. The ratio is generally lower for members residing in a nursing facility. *Id.*

111. *Id.* at 36.

b. Voluntary Certification

The predecessor to the Office of Community Health Workers was the Office of Health Workers, which was established in 2006.[112] It was known as the "virtual office" because it employed only three people and did not receive state funding.[113] The New Mexico Department of Health (NMDH) established an Office of Community Health Workers (OCHW) in 2008, which developed a standardized, state-wide curriculum for CHWs.[114]

The modern office still employs only three people: a Northern liaison, who works primarily with tribal populations and where the CHWs are called "CHRs", a Southern liaison, who works with a primarily Latinx population and where the CHWs are called "*promotoras*," and an Albuquerque liaison.[115] In 2014, the New Mexico legislature passed Senate Bill 58, the Community Health Workers Act, which enabled the OCHW to certify CHWs.[116] The Act mandates that at least three CHWs must sit on the certification board.[117] It also explicitly states:

> F. "community health worker" means a public health worker who applies an understanding of the experience, language and culture of the populations that the individual serves and who provides direct services aimed at optimizing individual and family health outcomes, including:
> (1) informal and motivational counseling and education;
> (2) interventions to maximize social supports;
> (3) care coordination;
> (4) facilitation of access to health care and social services;
> (5) health screenings; and
> (6) other services that the secretary defines by rule[118]

The act also allows for "grandfathering" of experienced CHWs practicing before the passage of the Act.[119] The CHW must have at least 2,000 hours of work or volunteer experience within two years prior to his or her application, or have worked or volunteered at least half-time within five years prior to his or her

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112. Telephone Interview with Claudia Macias, Southern Liason, Office of Cmty. Health Workers, N.M. Dep't of Health (Aug. 26, 2016).

113. *Id.*

114. *Office of Community Health Workers*, N.M. DEP'T OF HEALTH, https://nmhealth.org/about/phd/pchb/ochw/ (last visited Mar. 14, 2020)).

115. Interview with Claudia Macias, *supra* note 112.

116. S. 58, 2014 Leg., Reg. Sess. (N.M. 2014).

117. *Id.*

118. *Id.*

119. *Id.* (allowing the board of certification of community health workers to advise the secretary on the qualifications needed for certification, including experience); *see also Frequently Asked Questions about CHW Certification*, N.M. DEP'T OF HEALTH, https://nmhealth.org/publication/view/help/1764/ (last visited Nov. 28, 2019) (explaining the process by which experienced CHW professionals may obtain certification based upon previous training or experience).

application.[120]   Neither U.S. citizenship nor state residency is required for certification.[121]

New Mexico is unique in that its certification process is not intended to bar entry into the CHW field, but rather to lend legitimacy to and recognition of practicing CHWs.[122] After passage of the Act in 2014, the University of New Mexico created the Community Health Worker Initiatives Unit (CHWIU) to "design, implement and evaluate projects that utilize Community Health Workers as a strategy to increase New Mexicans' well-being, promote health equity, and minimize the negative impacts associated with the social determinants of health."[123] The Southern New Mexico Promotora Committee (SNMPC) helped to develop the language of core competency standards.[124] The SNMPC is also working to develop four additional specialty competencies: diabetes management, asthma management, mental health or mental health first aid, and health-coaching.[125] The training is offered by the Department of Health at no cost to the CHW, although there is a $45 certification fee and additional competencies cost $10.[126]

A CHW can also elect to become certified as a Clinical Support specialist.[127] The NMDH teaches ten competencies as part of its curriculum and is currently considering the addition of other specialty competencies, including those for diabetes management, asthma, mental health, and health-coaching.[128]

The state also has a number of CHW groups, including the New Mexico Community Health Worker Association,[129] and a number of groups associated with the Office of Border Health, including the Paso Del Norte Red De Promotora Network, New Mexico Community Health Worker Association, and the Southern New Mexico Promotora Committee.[130] Each organization is

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120. *Id.*

121. *Id.*

122. Interview with Claudia Macias, *supra* note 112.

123. Health Sci. Cent., *Community Health Worker Initiatives*, UNIV. OF N.M., http://hsc.unm.edu/community/chwi/ (last visited Mar. 6, 2020).

124. Interview with Claudia Macias, *supra* note 112.

125. *Id.*

126. *Id.*

127. *See Office of Community Health Workers*, N.M. DEP'T OF HEALTH https://nmhealth.org/about/phd/pchb/ochw/ (last visited Mar. 6, 2020) (noting the availability of specialist certification and providing a link to the specialty certification application); *Frequently Asked Questions about CHW Certification*, N.M. DEP'T OF HEALTH, https://nmhealth.org/publication/view/help/1764/ (last visited Mar. 6, 2020).

128. Interview with Claudia Macias, *supra* note 112.

129. *See New Mexico Community Health Worker Association*, CTR. FOR NONPROFIT EXCELLENCE, https://www.centerfornonprofitexcellence.org/nonprofit-directory/nonprofit/3132 (last visited Mar. 6, 2020) (providing information about the New Mexico Community Health Worker Association).

130. *Office of Border Health*, N.M. DEP'T OF HEALTH, https://nmhealth.org/about/asd/ohe/obh/#chw (last visited Mar. 6, 2020).

invested in CHW integration into the health care delivery process, advocacy for the community, and advocacy for the profession.[131]

3. Federal Funding

New Mexico funds CHWs engaging in behavioral health care through CMS Innovation Awards, a funding type that allows "Medicare and Medicaid programs to test models that improve care, lower costs, and better align payment systems to support patient-centered practices."[132] New Mexico's Ben Archer Health Center is a federally qualified health center, a type of outpatient clinic qualifying for special Medicare and Medicaid reimbursements under Section 330 of the Public Health Services Act.[133] Although Ben Archer's goals were to reduce spending while improving patients' diabetes and cholesterol markers, behavioral health care was nevertheless woven into the tapestry of the Ben Archer program through CHW training programs.

a. A CMS Innovation Award in New Mexico

Ben Archer Health Center has just under a dozen New Mexico locations.[134] In 2013, it received a CMS Innovation Award of $1.2 million for its program entitled "A Home Visitation Program for Rural Populations in Northern Dona Ana County, New Mexico."[135] The program was expected to save $6.3 million over three years.[136] Ben Archer employs nurse health educators (NHEs) and CHWs to "bridge the gap between patients and medical providers, aid patient navigation of the health care system, and offer services including case management, medication management, chronic disease management, preventive care, home safety assessments, and health education, thereby preventing the onset and progression of diseases and reducing complications."[137]

The very specific, measurable goals of the program were to reduce total health care spending in Dona Ana county by 10%, to lower patient HbA1c (a diabetes marker) levels, to reduce patient LDL-C (a cholesterol marker) levels,

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131. *Id.*

132. *About the CMS Innovation Center*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/About/index.html (last visited Mar. 6, 2020).

133. 42 U.S.C. § 254b (2018) (codifying Public Health Services Act, Pub. L. No. 78–10 § 330 58 Stat. 682 and laying the framework for health centers to receive federal funding); *see also Federally Qualified Health Centers*, RURAL HEALTH INFO. HUB,
https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers (last visited Mar. 6, 2020) (highlighting the value of federally qualified health centers).

134. *About Us*, BEN ARCHER HEALTH CTR., https://bahcnm.org/site/about.php (last visited Mar. 6, 2020).

135. *Health Care Innovation Awards: New Mexico*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/New-Mexico.html (last visited Mar. 6, 2020).

136. *Id.*

137. *Id.*

and to control patient hypertension values.[138] The program also had the broader goal of improving patient care through health education and through fostering healthier lifestyles,[139] which would ideally result in a greater number of primary care and intensive case management visits and fewer emergency department visits.[140] To those ends, CHWs and NHEs hosted community events and in-home health education sessions; patients with complicated medical conditions received further home visits.[141] CHWs were trained in dealing with conditions like diabetes and asthma, and how to teach healthy behaviors.[142]

The 2017 CMS innovation award evaluation report indicated that Ben Archer's program significantly reduced emergency department admissions.[143] During the first CMS Innovation Award site visit, however, the CHWs expressed a need for further behavioral health training because behavioral health issues were a "significant challenge in the target population."[144] Although CHWs did attend two training programs with a behavioral health component, "Stepping Up" and "Your Heart of Hope," provided by the Southern New Mexico Promotora Committee,[145] the Innovation Award evaluation revealed that additional mental health training was desired.[146] The evaluation also noted that the program is not sustainable because it cannot continue the community and home-based visits without additional funding.[147]

The "Stepping Up" initiative does seek to provide "comprehensive behavioral health crisis response" training.[148] Elements "baked in" to the curriculum are:

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138. Julianne Payne et al., RESEARCH TRIANGLE INST., *Awardee-Level Findings: Ben Archer Health Center- in* EVALUATION OF THE HEALTH CARE INNOVATION AWARDS: COMMUNITY RESOURCE PLANNING, PREVENTION AND MONITORING, 3RD ANNUAL REPORT 2-2, 2-3 (2017), https://downloads.cms.gov/files/cmmi/hcia-communityrppm-thirdannualrpt.pdf.

139. *Id.*

140. *Id.* at 2-5.

141. *Id.* at 2-7.

142. *Id.* at 2-50.; The CHW and NHE pairs "emphasized the unique contributions of staff in different roles;" the NHEs provided "clinical expertise and communicated clinical information to physicians," and the CHWs helped Ben Archer to connect with far-flung, rural patients, and to connect those patients to other community resources. *Id.* at 59. The CHWs enabled trust among community members and clinical care staff. *Id.* Patients were better able to manage their chronic conditions, and over time, patients displayed improvements in diabetes health outcomes. *Id.* at 42–44; *see also* LUCIA ROJAS SMITH ET AL., RESEARCH TRIANGLE INST., *Executive Summary- in* EVALUATION OF THE HEALTH CARE INNOVATION AWARDS: COMMUNITY RESOURCE PLANNING, PREVENTION AND MONITORING, 3RD ANNUAL REPORT ES-1, ES-11(2017), https://downloads.cms.gov/files/cmmi/hcia-communityrppm-thirdannualrpt.pdf.

143. LUCIA ROJAS SMITH ET AL., *supra* note 142.

144. Julianne Payne et al., RESEARCH TRIANGLE INST., *supra* note 138, at 2-51.

145. N.M. DEP'T OF HEALTH, MANAGED CARE POLICY MANUAL 36–37 (rev. 2015), http://www.hsd.state.nm.us/uploads/files/Managed%20Care%20Policy%20Manual%204_17(1).pdf.

146. *Id.* at 36-37, 50.

147. *Id.* at 4.

148. *Amended Notice of Work Session*, DOÑA ANA CTY. 1 (Oct. 31, 2017), https://www.donaanacounty.org/sites/default/files/agendas/BOCC_work_session_10-31-2017.pdf.

- Embracing recovery
- Significant roles for peers
- Trauma-informed care
- Suicide safer care
- Safety/security for staff and consumers
- Crisis response partnerships with law enforcement.[149]

A major goal of the programming is to reduce criminal recidivism and divert community members from the criminal justice system.[150] The "Stepping Up" program is "a national initiative to reduce the number of people with mental illnesses in jails,"[151] and provides a tool kit for county leaders.[152]

The "Stepping Up" initiative in Dona Ana County included an introduction to the "Sequential Intercept Model" workshop, which "helps communities determine gaps in services and plan for community change."[153] The workshop noted that such goals are "best accomplished by a team of stakeholders that cross multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others."[154] The model defines five points of intercept for those with mental health conditions; workshop members identified numbers one and four as having the greatest significance[155]:

- Law enforcement/911 diversion
- Initial detention/first court appearance
- Jails/courts (specialty courts, jail, dispositional court)
- Reentry from jails and prisons to community
- Community corrections (parole, probation)[156]

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149. *Id.*

150. *Id.*

151. *Stepping Up: A National Initiative to Reduce the Number of People with Mental Illnesses in Jails*, THE STEPPING UP INITIATIVE, https://stepuptogether.org (last visited Mar. 6, 2020).

152. *Resources Toolkit*, THE STEPPING UP INITIATIVE, https://stepuptogether.org/toolkit (last visited Mar. 6, 2020).

153. DOÑA ANA CTY., *supra* note 148, at 2; *see e.g. Six Questions Case Studies,* THE STEPPING UP INITIATIVE (2018),
https://stepuptogether.org/wp-content/uploads/2018/03/Six-Questions-Case-Studies.pdf
(providing a reference to quick toolkits for counties seeking ways to better respond to people with mental illnesses).

154. DOÑA ANA CTY., *supra* note 148.

155. *Id.*; *see also Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model,* THE CTR. FOR MENTAL HEALTH SERVS. NAT'L GAINS CTR., https://www.criminaljustice.ny.gov/opca/pdfs/5-GAINS_Sequential_Intercept.pdf (last visited Mar. 6, 2020) (describing the five sequential points of intercept where providers, law enforcement officials, and other advocates and professionals can take action to improve overall outcomes for individuals with behavioral health issues); *see also Criminal and Juvenile Justice,* SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/criminal-juvenile-justice (last updated May 15, 2019) (discussing many of the barriers individuals with behavioral health issues encounter upon attempting to reenter the community after incarceration).

156. THE CTR. FOR MENTAL HEALTH SERVS. NAT'L GAINS CTR., *supra* note 155.

Workshop members noted that many individuals reentering the community have "co-occurring primary care needs, such as diabetes management, along with mental illness" management, and wanted to implement "crisis care services" as an alternative to involvement in the justice system or visits to the emergency room.[157] Workshop members recommended maximizing "the billing capacity of the core services agency"—in other words, billing Medicaid to reduce the burden on the county; developing quality measures; and expanding the advisory committee to include members of other agencies, especially law enforcement.[158] CHWs made for significant improvements in health outcomes for other innovation award-winners, as well. In fact, the "Cross-Awardee Findings" section of CMS's report noted that CHWs that were well-trained relieved overburdened clinicians.[159] Providers who employed CHWs spent 13% less time arranging referrals and follow-up visits, and 29% less time arranging social services referrals than did providers who did not employ CHWs.[160] However, unclear role-definition, insufficient training to care for the most difficult patient populations, and burnout were the most significant challenges to CHWs employed by award-winners.[161]

b. Federally Supported CHW Programming in New Mexico

Much of the programming conducted by Ben Archer CHWs is federally funded, including Healthy Start, Welcome Baby, Birth-Three, Partners for a Healthy Baby, Nurturing Parenting, Strengthening Families, 24-7 Dad, and other programs which include training in breastfeeding, healthy lifestyles, nutrition, and healthy environments.[162] Some of these programs involve home and school visitation.[163] Behavioral health is embedded into all of this programing.[164] CHWs are trained in "reflective practice," which means that parents will reflect what the CHW does and the children will reflect what the parents do.[165] The CHW training has also been described as "parallel process," in which a family is encouraged to parallel the healthy behaviors of the CHW.[166]

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157. DOÑA ANA CTY., *supra* note 148, at 33.

158. DOÑA ANA CTY., *supra* note 148, at 4.

159. *See e.g.* LUCIA ROJAS SMITH ET AL., RESEARCH TRIANGLE INST., *Cross-Awardee Findings- in* EVALUATION OF THE HEALTH CARE INNOVATION AWARDS: COMMUNITY RESOURCE PLANNING, PREVENTION AND MONITORING, 3RD ANNUAL REPORT 3-1, 3-30, 3-35 (2017), https://downloads.cms.gov/files/cmmi/hcia-communityrppm-thirdannualrpt.pdf.

160. *Id.* at 3-35.

161. *See id.* at 3-30 (describing the essential role training plays in implementing CHW programming).

162. Telephone Interview with Juana Carreon, Program Coordinator, Ben Archer Health Ctr. (Aug. 19, 2016).

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.*

Because Ben Archer is located in Las Cruces, which is near four neighboring counties, the CHWs from each county's federally qualified health center share trainings and attend each others' trainings.[167]   At trainings, community presenters teach behavioral health assessment,   such as how to identify spousal abuse, child abuse and neglect, and fetal alcohol syndrome, as well as pedagogical topics, such as how to teach community members to make the most of their Electronic Benefits Transfer (EBT) food supplement cards.[168]

B. Michigan

Michigan features a great variety of funding for CHWs engaged in behavioral health. One of the most stable sources of support for CHWs comes from a national nonprofit headquartered in Michigan: MHP Salud. The unique advantage of Michigan's nonprofit funding is the interstate coordination of programming, which allows programming to follow the seasonal movement of migrant-worker patients, from Michigan in summer to Florida in the winter.

Medicaid funding for CHWs is in near constant flux because of the managed care rebid system, by which companies compete to serve a certain region's Medicaid population for five-year increments. So far, CHW services have been reimbursed as "care coordination." A CMS Innovation Award helps to fund the program Strong Beginnings, which has made tremendous improvements in maternal and infant health—reducing African American infant mortality by 50%—attributed, to a large extent, to the use of CHWs in behavioral health care delivery.[169]

1. Overview: CHWs in Michigan

There are several funding mechanisms for CHWs in Michigan, and CHWs play an important part in connecting patients to behavioral health services. While there is no CHW certification, licensure, or credentialing program in Michigan, the Michigan Community Health Worker Alliance (MiCHWA) has created a pilot training program that may become the basis for credentialing.[170] The pilot

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167. *Id.*

168. *Id.*

169. *See* Strong Beginnings Uses Holistic Approach to Reduce Infant Mortality Among Communities of Color in Kent County, Michigan, W.K. KELLOGG FOUNDATION, https://www.wkkf.org/what-we-do/featured-work/strong-beginnings-uses-holistic-approach-toreduce-infant-mortality-among-communities-of-color (noting that the Strong Beginnings program succeeded in maintaining its infant mortality rate of African-American participants at half of the rate for all African-American women living in Grand Rapids).

170. *See* Press release, Mich. Cmty. Health Worker All., First Standardized Cmty Health Worker Training Launches in Mich. (Feb. 2015), http://www.michwa.org/wp-content/uploads/MiCHWA_PressRelease_Feb2015.pdf (discussing the creation of curriculum and training standards for CHWs).

is taught at two colleges and is hosted by the University of Michigan School of Social Work.[171]

The state's great utility of CHWs in behavioral health care can be attributed in part to MiCHWA's strong presence. The Alliance has a web page dedicated to "Mental Health" which features studies reflecting the positive effects of CHWs' work on behavioral health. One study, conducted in Michigan, observed a reduction in symptoms of depression for Latina mothers who utilized CHW services.[172] Additionally, the site also regularly profiles member CHW programs, such as Strong Beginnings.[173]

Strong Beginnings, discussed herein, is a tremendously successful collaboration among Spectrum Health, Arbor Circle, Cherry Street Health Services, Grand Rapids African American Health Institute (GRAAHI) Spectrum, Kent County Health Department, Spectrum MOMS, and the Salvation Army, and is focused on improving the lives of impoverished African American mothers.[174] The program has two mental health therapists on staff, and CHWs that help to connect mothers to additional mental health services.[175]

Funding in Michigan for CHW services is unique. On the state level, Medicaid managed care rebids are very influential, and on the federal level, a CMS Innovation Award may impact the way that medicine is practiced throughout the state. The innovation award report to DHHS noted that the use of CHWs in Michigan has been linked to decreased symptoms of depression, as well as myriad other improved health outcomes.[176]

Additionally, a national nonprofit based in Michigan is disseminating immensely popular CHW behavioral health programing, which influences the way that CHWs practice behavioral health care across the country.

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171. *Id.*

172. *Mental Health*, MICH. CMTY. HEALTH WORKER ALL., http://www.michwa.org/mental-health/ (last visited Mar. 6, 2020).

173. *CHW Program Profile – Strong Beginnings*, MICH. CMTY. HEALTH WORKER ALL., http://www.michwa.org/wp-content/uploads/CHW-Program-Profile_Strong-Beginnings.pdf (last visited Mar. 6, 2020).

174. *Id.*

175. *Id.*

176. STATE OF MICH. EXEC. OFFICE: GOVERNOR RICK SNYDER, REINVENTING MICHIGAN'S HEALTH CARE SYSTEM: BLUEPRINT FOR HEALTH INNOVATION 1, 129 (Jan. 24, 2014), https://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_REMOVED_454499 _7.pdf ("In Michigan, the use of community health workers in a variety of programs and initiatives has been tied to increased access to primary care and specialty services, improvements in prenatal care and birth outcomes, improved adherence to blood glucose testing and decreased blood glucose levels, and decreased depressive symptoms."). *Id.*

2. Nonprofit

MHP Salud[177] is a nonprofit organization that helps to form the infrastructure for community health work in Michigan and nationally,[178] especially in the field of behavioral health.[179] MHP Salud was formed in Michigan in the 1980s as a collaboration among the National Migrant Worker Council, Inc., an association of Catholic Sisters and volunteers.[180] As the nonprofit expanded to other states with migrant workers, including Texas, Florida, Ohio, Washington, and Oregon, its programming diversified.[181] CHWs noticed that behavioral health issues such as depression and social isolation were particularly prevalent in migrant communities due to poverty, separation from family, lack of beneficial exercise, and the frequent uprooting endemic to migrant lifestyle.[182]

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177. *See History of MHP Salud*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/about-mhp-salud/history/ (last visited Mar. 6, 2020) (explaining the history and development of MHP Salud's impact, and that "MHP" stands for "Migrant Health Promotion.").

178. *See Community Health Worker Program Models*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/programs/community-health-worker-models/#CHWsComSupport (last visited Mar. 6, 2020) (stating that MHP Salud has used CHW programs to address a variety of issues, including mental health). *See Community Health Worker Program Models*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/programs/community-health-worker-models/#CHWsComSupport (last visited Mar. 6, 2020) (stating that MHP Salud has used CHW programs to address ongoing issues such as mental health). MHP Salud's mission is to "empower underserved Latino communities and promote[] the CHW model nationally as a culturally appropriate strategy to improve health." *See About MHP Salud,* MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/about-mhp-salud/mission/ (last visited Mar. 6, 2020). Its work is particularly focused on areas where the Latino population is transitory and engaged in migrant agriculture. *History of MHP Salud*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/about-mhp-salud/history/ (last visited Mar. 6, 2020). The nonprofit offers training and support outside of Michigan, collaborating with national health care providers and groups with a state-wide or regional reach, including those in Michigan, Ohio, Texas, Florida, and the Pacific Northwest. *See Who We Proudly Serve*, MIGRANT HEALTH PROMOTION SALUD,
https://mhpsalud.org/who-we-serve/ (last visited Mar. 6, 2020).

179. MHP Salud's mission is to "empower underserved Latino communities and promote[] the CHW model nationally as a culturally appropriate strategy to improve health." *See About MHP Salud,* MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/about-mhp-salud/mission/ (last visited Mar. 6, 2020). Its work is particularly focused on areas where the Latinx population is transitory and engaged in migrant agriculture. *History of MHP Salud*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/about-mhp-salud/history/ (last visited Mar. 6, 2020). The nonprofit offers training and support outside of Michigan, collaborating with national health care providers and groups with a state-wide or regional reach, including those in Michigan, Ohio, Texas, Florida, and the Pacific Northwest. *See Who We Proudly Serve*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/who-we-serve/ (last visited Mar. 6, 2020).

180. *History of MHP Salud*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/about-mhp-salud/history/ (last visited Mar. 6, 2020).

181. *See id.* (explaining that "MHP Salud has developed several adaptations of the original Camp Health Aide Program model to build on community strengths and meet complex health needs").

182. Telephone Interview with Anne Lee, Program Director, MIGRANT HEALTH PROMOTION Salud, (Jan. 12, 2017).

In the year 2000, MHP Salud in Michigan developed the Salud Para Todos program manual to educate CHWs about behavioral health.[183] The manual describes mental health challenges and solutions for CHWs themselves, such as burnout and self-care, and describes how to care for community members' behavioral health. For instance, it describes how a CHW can identify negative coping behaviors and teach tools for positive coping.[184]

The manual has since been disseminated to CHW groups across the country.[185] The original Michigan version of the program focused on referrals to services, but the manual is regularly adapted and expanded to meet the particular needs and facilities of diverse communities.[186] The Salud Para Todos program in Texas, for example, was modified to allow for further CHW involvement,[187] which included a training on how CHWs could make appointments and follow up with patients.

Additionally, once the program has taken root in a particular geographic location, it is easily adopted nearby and revived per communities' needs. In Texas, for example, it spread like wildfire. There, a version of Salud Para Todos, called Nuevas Avenidas, was taught in 2006, when the Migrant Health Promotion Promotores(as), Hope Medical Clinic, and the Tropical Texas Center for Mental Health & Retardation collaborated to integrate primary and behavioral health care for the insured and uninsured.[188] Then, in 2015, Salud Para Todos was revived and taught in Hidalgo County, Texas.[189] It then expanded into Star County, Texas, in 2016.[190]

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183. *History of MHP Salud*, *supra* note 180.

184. *Salud Para Todos Program Manual*, MIGRANT HEALTH PROMOTION SALUD 8, 18–40, https://mhpsalud.org/portfolio/premium-content-salud-para-todos-program-manual-english/ (last visited Mar. 6, 2020).

185. *See Salud Para Todos Program Manual (English)*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/portfolio/salud-para-todos-program-manual-english/ (last visited Mar. 6, 2020) (making the manual available for download online). The manual is 71 pages and "is designed to walk Community Health Workers or *Promotores(as) de salud* through strengthening knowledge about mental health issues and coping mechanisms and utilizing resources to help those suffering from mental health issues access the services available to them in their community." *Id.* Six chapters guide the CHW reader through potential challenges to mental well-being, the role of the CHW as an advocate and impetus for positive change within a community, techniques for spotting negative coping behaviors, methods for positive coping, and development of community resource lists and referrals. *Id.*

186. Telephone Interview with Brynna Burguard, Chief Allocation and Res. Officer, Migrant Health Promotion Salud (Jan. 12, 2017).

187. Interview with Anne Lee, *supra* note 182.

188. MIGRANT HEALTH PROMOTION SALUD, PROMOVIENDO VIDAS SALUDABLES BIENNAL REPORT 2005-2006 (2012), http://mhpsalud.org/wp-content/uploads/2012/10/AnnualReport2005-2006.pdf.

189. Interview with Anne Lee, *supra* note 182.

190. *Id.*

Because the Salud Para Todos manual is available for free online,[191] it is impossible to know exactly many CHW programs have borrowed from or implemented the program. However, CHW programs do occasionally request further implementation training from MHP Salud, which the nonprofit provides for free to Federally Qualified Health Centers, because the Health Resources and Services Administration will reimburse its costs.[192]

MHP Salud supports itself from the support of a number of permanent and impermanent funding sources: community foundations, nonprofits, religious groups, and federal and state sources.[193] For example, MHP Salud has an endowment from the Ann Arbor Area Community Foundation.[194]

The national reach of MHP Salud allows for a coordinated CHW effort. Programing follows the path of the migrant workers: it begins in Michigan during the warmer months, and continues in Florida during the second half of the year.[195] The CHWs are peers of the patient population and home visits are the crux of their work.[196] CHWs are from the same geographic location as those they serve, and often hold a leadership role in a church or a community center before becoming CHWs.[197] Applicants for CHW positions must have "experience in community work, education, health care," have "knowledge and/or part of [the] community served," and be fluent in Spanish.[198] While workforce stability and portability have been cited as problems generally afflicting the CHW profession,[199] there is scant evidence of it in Michigan.

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191. *See Salud Para Todos Program Manual (English)*, MIGRANT HEALTH PROMOTION SALUD, https://mhpsalud.org/portfolio/salud-para-todos-program-manual-english/ (last visited Mar. 6, 2020) (reflecting that the manual may be downloaded free of charge).

192. Interview with Brynna Burguard, *supra* note 186.

193. *Current and Recent Funding Partners*, MIGRANT HEALTH PROMOTION SALUD, https://web.archive.org/web/20161029162032/http://mhpsalud.org/about-mhp-salud/funding-partners/ (last visited Nov. 28, 2019).

194. *MHP Salud Endowment Fund*, ANN ARBOR AREA CMTY. FOUND., https://www.iphiview.com/aaacf/AccountInformation/tabid/495/dispatch/accountselection_id$10470_ha sh$4070730425826f93e33966bdc1df80bb8fa6c56b/Default.aspx (last visited Mar. 6, 2020).

195. Interview with Brynna Burguard, *supra* note 186.

196*. Id.*

197*. Id. See also Community Health Worker Job Description*, MIGRANT HEALTH PROMOTION SALUD, http://mhpsalud.org/wp-content/uploads/2012/10/Job-Description-CHW_DPM.pdf (last visited Mar. 6, 2020) (describing the functions, desired qualities, and skills needed of a community health worker applicant).

198*. Id*.; interview with Brynna Burguard, *supra* note 186.

199. JOHN E. SNYDER, OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, ASPE ISSUE BRIEF: COMMUNITY HEALTH WORKERS: ROLES AND OPPORTUNITIES IN HEALTH CARE DELIVERY SYSTEM REFORM, 5, 14, 18 (2016), https://aspe.hhs.gov/system/files/pdf/168956/CHWPolicy.pdf. (describing efforts taken to remediate these issues)

3. Michigan State Funding

Funding for CHWs in Michigan is tied to its Medicaid managed care rebid system. Essentially, insurance companies bid to provide legislature-defined health coverage for a designated region.[200] Medicaid rebid occurs every five years.[201] The 2015 bidding cycle instituted a number of requirements for bidders, including a primary care provider to patient ratio of 1:750,[202] mandatory coverage of all counties in governor-defined "prosperity regions," mandatory carved-out pharmacy benefits, value rather than fee-for-service reimbursement, and a greater emphasis on care integration.[203] The Michigan CHW community has perceived the latter two requirements as good first steps toward the establishment of a stable source of funding for CHWs.[204] Under this paradigm, CHW work is reimbursed as "community outreach."[205]

Another way CHW work is funded in Michigan is through MI Care Teams, a type of primary care health home that began in 2016 as a result of the Affordable Care Act.[206] A CHW is a required member of the care team.[207] MI Care Teams receive reimbursement for federally mandated core services including "comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, and referral to community and support centers."[208] The MI Care Team plans are not fee-for-service; instead, payment for the program involves two rates: (1) a once-per-lifetime beneficiary for a "Health Action Plan," which is paid only the first month of the patient's participation, and (2) an "Ongoing Health Coordination" rate.[209] The latter rate is reassessed yearly.[210]

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200. Interview with Brynna Burguard, *supra* note 186; *see also Training and FAQs*, BUY4MICHIGAN, https://web.archive.org/web/20180102125749/https://www.buy4michigan.com/bso/ (last visited Mar. 6, 2020) (reflecting Michigan's e-procurement site).

201. Steve Fitton & Farah Hanley, *Medical Services Administration Fiscal Year 2016*, MICH. DEP'T OF CMTY HEALTH, 21, 5 (Mar. 2015), https://www.michigan.gov/documents/mdch/MSA_Budget_Final_3-2-15_482908_7.pdf.

202. *Medicaid Rebid Pushed Back*, LEADING AGE MICH., (Feb. 6, 2015), http://www.leadingagemi.org/page/MCDRebidPushedBack/Medicaid-Rebid-Pushed-Back.htm

203. Fitton & Hanley, *supra* note 201, at 22.

204. Interview with Brynna Burguard, *supra* note 186.

205. *Id.*

206. *MI Care Team*, MICH. DEP'T HEALTH & HUM. SERVS., (July 30, 2019), http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_75161—-,00.html.

207. *MI Care Team: Frequently Asked Questions and Answers*, MICH. DEP'T HEALTH & HUM. SERVS.,. 1 (June 2016), https://www.michigan.gov/documents/mdhhs/MI_Care_Team_Q_and_A_for_Providers_528108_7.pdf.

208. MICH. DEP'T HEALTH & HUM. SERVS., *supra* note 206.

209. *MI Care Team Handbook, Version 2.6,* MEDICAL SERVS. ADMIN., MICH. DEP'T HEALTH & HUM. SERVS., 17 (Aug. 2017), https://www.michigan.gov/documents/mdhhs/MI_Care_Team_Handbook_528104_7.pdf.

210. *Id.*

"Ongoing Health Coordination" may include behavioral health as showcased in three ICD-10 diagnosis codes for this service, including one for "Persons with potential health hazards related to socioeconomic and psychosocial circumstances."[211] CHWs participate in the delivery of a wide range of services, including behavioral healthcare services, such as coordinating access to individual, family, and community resources; meeting daily with the care team to plan care, discuss cases, and exchange information; identifying community resources (i.e. social services, workshops, etc.); providing referral tracking; coordinating and providing access to chronic disease management, including self-management support; implementing wellness and prevention initiatives; facilitating health education groups; and providing education on health conditions and strategies to implement care plan goals, including both clinical and non-clinical needs.[212] In this regard, MI Care Teams are unique in the broad latitude practitioners and CHWs have for behavioral health service and reimbursement.

a. Hybrid State, Federal, and Private Funding in Michigan

A final way that Michigan pays for CHW work is through its innovative partnership with the Pay for Success program. Pay for Success launched in the UK in 2010, quickly expanding and developing dozens of projects in the United States, including the creation of a technical assistance program through the Harvard Kennedy School of Government Performance Lab.[213] The Harvard Kennedy School of Government Performance Lab grew out of the school's Social Impact Bond Technical Assistance Lab, formed in 2011 with funding from the Rockefeller Foundation.[214] The goal of the lab is to research the way governments can improve "core government spending without using social impact bond financing."[215] There have been three national competitions for

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211. *Id.* at 19.

212. *Id.* at 8.

213. *See What Is Pay for Success?*, NONPROFIT FINANCE FUND: PAY FOR SUCCESS, http://www.payforsuccess.org/learn/basics/ (last visited Mar. 6, 2020) (describing the development of the Pay for Success model in the US); *see also The Government Performance Lab*, HARVARD UNIV., https://web.archive.org/web/20190121031016/https://govlab.hks.harvard.edu/gov-lab (last visited Mar. 7, 2020) (describing the homepage of the Harvard Kennedy School Government Performance Lab, a program that provides on-the-ground technical assistance to state and local governments to test a cohort-based model of Pay for Success).

214. *The Government Performance Lab*, HARVARD UNIV., https://web.archive.org/web/20190121031016/https://govlab.hks.harvard.edu/gov-lab (last visited Mar. 7, 2020); *Harvard Kennedy School Social Impact Bond Lab Helping Governments Explore Innovative Social-Service Funding Models,* CORP. FOR NAT'L & CMTY. SERV., https://www.nationalservice.gov/programs/social-innovation-fund/knowledge-initiative/blog/2015/dec/harvard-kennedy-sib-exploring-new-funding-models (last visited Mar. 7, 2020).

215. *Id.*

selection of government partners since 2011; Michigan's Strong Beginnings program was one of the first winners.[216]

In the Pay for Success program, private investors purchase Social Impact Bonds from service providers attempting to achieve a particular goal.[217] If the goal is achieved, the government repays the private investors with interest.[218] If the goal is not achieved, the government pays nothing.[219] Strong Beginnings began to receive Pay for Success funding on August 1st, 2016, in the amount of $1 million per year.[220] The program's annual budget is $1.4 million, sustained through Healthy Start federal funding and grants from the W.K. Kellogg Foundation.[221]

Strong Beginnings is focused on improving maternal, infant, and child health for high-risk African American and Latinx families.[222] The overarching goal of the program is to address the association between maternal depression, infant health, and negative parenting, through culturally sensitive treatment.[223] It accomplishes this goal with its novel approach to therapy, for which CHWs

216. *Michigan Strong Beginnings Pay for Success*, HARVARD UNIV., https://govlab.hks.harvard.edu/michigan-strong-beginnings-pay-success-project-3 (last visited Mar. 7, 2020); *see also* Damian Thorman, *Social Innovation Fund Launches New Pay for Success Grant Program*, THE WHITE HOUSE (Dec. 11, 2015, 1:40 PM), https://obamawhitehouse.archives.gov/blog/2015/12/11/social-innovation-fund-launches-new-pay-success-grant-program (announcing the 2016 Pay for Success competition); *see also* HARVARD UNIV., *supra* note 214. The second round was related to behavioral health: "In 2014 we again held a national competition and awarded technical assistance to twelve governments including a cohort of three governments receiving behavioral health-related technical assistance: Arkansas, Baltimore, California, DC Water, Louisville, Nevada, *Olmstead* Cohort (New Mexico, New York, Washington), Pennsylvania, San Francisco, and Vermont." HARVARD UNIV., *supra* note 214.

217. HARVARD UNIV., *supra* note 214.

218. *Id.*; Noelle S. Baldini, *Pay for Success: Financing Research-Informed Practice*, 89 CASCADE, Fall 2015, https://www.philadelphiafed.org/-/media/community-development/publications/cascade/89/pdfs/pay-for-success.pdf.

219. HARVARD UNIV., *supra* note 214.

220. *Gov. Snyder: New pay-for-success pilot program launches today, aims to improve birth and health outcomes for high-risk women in West Michigan*, MICHIGAN.GOV (Sep. 21, 2016), https://www.michigan.gov/formergovernors/0,4584,7-212-90815_57657-393691—,00.html; Charlsie Dewey, *Strong Beginnings to Pilot Pay for Success Model*, GRAND RAPIDS BUS. J. (Oct. 7, 2016), http://www.grbj.com/articles/86316-strong-beginnings-to-pilot-pay-for-success-model.

221. Dewey, *supra* note 220; *Strong Beginnings Uses Holistic Approach to Reduce Infant Mortality Among Communities of Color in Kent County, Michigan*, W.K. KELLOGG FOUND., https://www.wkkf.org/what-we-do/featured-work/strong-beginnings-uses-holistic-approach-to-reduce-infant-mortality-among-communities-of-color (last visited Mar. 6, 2020).

222. Dewey, *supra* note 220; Marguerite Morgan, *Strong Beginnings: A Holistic Approach to Improve Birth Outcomes Among African American Infants* (Feb. 12, 2015), https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/131/attachments/original/142362 8704/MORGANMIHPConference_Presentation_2015-3.pdf?1423628704.

223. Dewey, *supra* note 220; Marguerite Morgan, *Strong Beginnings: A Holistic Approach to Improve Birth Outcomes Among African American Infants* (Feb. 12, 2015), https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/131/attachments/original/142362 8704/MORGANMIHPConference_Presentation_2015-3.pdf?1423628704.

play an important part.[224] CHWs are part of a therapy team; they attend the first mental health session, and from there, "manage the community resources, so the therapists can focus on clinical issues."[225] More generally, they help to normalize behavioral health care by assisting patients in overcoming embarrassment and stigma so that they can meaningfully engage in treatment.[226]

In the past 11 years, the program has succeeded in reducing African American infant mortality by 50 percent, through education facilitated by home visitation, health care coordination, and community programming,[227] including that on infant health[228] and fatherhood.[229] All programming is for families with children under the age of two.[230]

The dramatic success of the program in reducing infant mortality is attributed by program leadership to its incorporation of behavioral health services.[231] Kenneth Fawcett, M.D., vice president of Spectrum Health Healthier Communities of GRAAHI, a partner and key source of funding for Strong Beginnings, has stated that CHWs engaging in behavioral health are a cornerstone of the program:

> The community health workers are from the communities. Many are individuals who have benefitted from the program and want to give back, and they have a cultural sensitivity and can establish trust relatively easily with their clients. We've also embedded behavioral health resources into the program. We can deliver the mental health services right in the construct of our program, and that is a differentiator and something that allows us to be so successful.[232]

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224. Marguerite Morgan, *Strong Beginnings: A Holistic Approach to Improve Birth Outcomes Among African American Infants* (Feb. 12, 2015), https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/131/attachments/original/142362 8704/MORGANMIHPConference_Presentation_2015-3.pdf?1423628704.

225. *Id.*

226. *Id.* For example, CHWs help to disabuse patients of the idea that they are "too blessed to be stressed." *Id.; see also* Dewey, *supra* note 220.

227. *Strong Beginnings*, GRAND RAPIDS AFRICAN AM. HEALTH INST., https://web.archive.org/web/20180528123111/http://www.graahi.org/Advocacy/Strong-Beginnings (last visited Mar. 7, 2020).

228. *Id.*

229. *Strong Fathers*, GRAND RAPIDS AFRICAN AM. HEALTH INST, https://graahi.com/join-a-program/strong-fathers// (last visited Mar. 7, 2020).

230. *Id.; Strong Beginnings*, *supra* note 227.

231. Dewey, *supra* note 220; *see also* W.K. KELLOGG FOUND., *supra* note 221 (explaining the holistic approach taken to improve patients' health, including providing mental health services); *see also* Bennett Rylah, *Strong Beginnings*, RAPID GROWTH (Apr. 12, 2012), http://www.rapidgrowthmedia.com/features/04122012strong.aspx (pointing out that in the mental health program there are two full-time therapists to work with high risk women and efforts are taken to reach out to fathers who may be struggling with their mental health).

232. Dewey, *supra* note 220.

An important piece of the program's mental health infrastructure is provided by Arbor Circle,[233] a partner of Strong Beginnings and a private nonprofit with a presence in Michigan since 1945.[234] Two Arbor Circle licensed therapists work exclusively with the Strong Beginnings women identified as highest risk.[235] CHWs provide social support, referrals, and education for women who are pregnant and the parents of children aged 0-24 months.[236] Services include transportation assistance; assistance getting food and baby supplies, and medical care; education regarding infant health; treatment for mothers exhibiting symptoms of depression; and parenting skills.[237]

4. Federal Funding and Certification in Michigan

The Michigan Department of Health and Human Services (MDHHS) was awarded a Model Design Grant from the Center for Medicare and Medicaid Innovation.[238] MDHHS used the grant to develop its Blueprint for Health Innovation (hereafter "Blueprint"), which was created in collaboration with a wide variety of health care stakeholders, including representatives of health systems, physicians, payers, business, safety net providers, community service providers, and consumers.[239] The plan was awarded an implementation grant, which provided technical and financial support to test and evaluate the program.[240]

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233. Telephone Interview with Connie Noel, Admin. Program Coordinator, Spectrum Health (Aug. 2, 2017).

234. *Early Childhood,* ARBOR CIRCLE, https://arborcircle.org/services/early-childhood/ (last visited Mar. 7, 2020); *FAQ*, ARBOR CIRCLE, https://arborcircle.org/faq/ (last
 visited Mar. 7, 2020)

235. Rylah, *supra* note 231.

236. *Referral Form*, STRONG BEGINNINGS,
https://www.strongbeginningskent.org/Portals/0/SB%20Referral%20Form.pdf (last visited Mar. 7, 2020).

237. *Client Services,* STRONG BEGINNINGS, https://www.strongbeginningskent.org/What-We-Do/Client-Services (last visited Mar. 7, 2020).

238. *State Innovation Models Initiative: Model Design Awards Round One*, CMS.GOV: CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/State-Innovations-Model-Design/ (last visited Mar. 7, 2020).

239. Rachel Burton, et al., *Michigan, in* STATE INNOVATION MODELS (SIM) INITIATIVE EVALUATION 15-1 (prepared by Research Triangle International, 2014), https://downloads.cms.gov/files/cmmi/SIM-Round1-ModelDesign-PreTest-EvaluationRpt_5_6_15.pdf.

240. *State Innovation Models Initiative: Model Test Awards Round Two*, CMS.GOV: CENTERS FOR MEDICARE & MEDICAID SERVICES, https://innovation.cms.gov/initiatives/state-innovations-model-testing-round-two/ (last visited Mar. 7, 2020) (depicting an interactive map featuring state-level innovation).

One of the hallmarks of the plan is its emphasis on health care teams,[241] of which CHWs are an important component.[242] Under this plan, Michigan will move away from the fee-for-service model, which, according to Michigan leaders, does not facilitate team-based care,[243] and move toward a "Payment for Value" model, which includes Accountable Systems of Care (ASC) based on Medicare's Accountable Care Organizations (ACOs).[244] ASCs have the risk and profit-sharing features of ACOs,[245] but will emphasize "prevention, primary care, and effective case management."[246]

The Blueprint notes the use of CHWs is associated with decreased symptoms of depression.[247] However, the Blueprint also makes clear that standardization, including a core curriculum and a certification of competency, is needed in Michigan.[248] Important competencies for CHWs identified by the Blueprint include advocacy, teaching, ethics, care coordination, care documentation, communication, and hands-on training.[249] There is a consensus among Michigan's CHWs and MDHHS that standardization is desired. MiCHWA[250] has endorsed use of Minnesota's Community Health Worker curriculum as the standard for its certification competency.[251] The Blueprint noted that if a national CHW certification were established, Michigan could

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241. STATE OF MICH. EXEC. OFFICE *supra* note 176, at 125.

242. *Id.* at 128.

243. *Id.* at 77.

244. *Id.* at 83–85. Accountable Care Organizations (ACO) are a type of Shared Savings Program under the ACA. Press Release, Affordable Care Act to Improve Quality of Care for People with Medicare, Dep't of Health & Human Servs. (Mar. 31, 2011), http://wayback.archive-it.org/3926/20140108162229/http://www.hhs.gov/news/press/2011pres/03/20110331a.html. Groups of health care providers and hospitals link reimbursement to quality metrics, rather than fee-for-service, and are sometimes referred to as "partial capitation." If spending is kept below a certain amount, the difference is divided between CMS and the ACO, who keeps it as profit. Taylor Burke, *Accountable Care Organizations*, 126 PUB. HEALTH REP. 875, 876 (2011).

245. *See* STATE OF MICH. EXEC. OFFICE, *supra* note 176, at 83–84 (describing features of ACOs and ASCs). The Medicare Shared Savings Program was established by section 3302 of the ACA, and allows eligible providers to create or participate in an ACO. *Program Statutes & Regulations*, CMS.GOV: CENTERS FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-statutes-and-regulations (last visited Mar. 7, 2020). ACOs use a complex formula for determining health care quality, improvement, and cost; providers are "accountable" because they share in cost savings. *Accountable Care Organization 2017: Quality Measure Narrative Specifications*, RESEARCH TRIANGLE INT'L, at 1 (Jan. 5, 2017), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2017-Reporting-Year-Narrative-Specifications.pdf.

246. STATE OF MICH. EXEC. OFFICE, *supra* note 176, at 96.

247. *Id.* at 129.

248. *Id.*

249. *Id.* at 126–27, 129.

250. "Michigan Community Health Worker Alliance." *Our Mission*, MICH. CMTY. HEALTH WORKER ALL., http://www.michwa.org (last visited Mar. 7, 2020).

251. STATE OF MICH. EXEC. OFFICE, *supra* note 176, at 130.

"leverage" the certification to create a registry of all certified CHWs.[252] Ideally, CHWs could be analogous to respiratory therapists, for example, who are neither regulated nor certified in Michigan, but are instead certified by a national organization.[253]

One of the reasons that MiCHWA would like a CHW certification program is to facilitate billing for CHW services.[254] But, as the Blueprint makes clear, the trend in Michigan is to move away from a fee-for-service model.

C. Minnesota

Minnesota has been very successful in treating the "whole" patient through care coordination, which in many cases is task charged to a CHW. Minnesota professionalized CHWs very early, and is the only state with a statewide standardized, competency-based CHW curriculum based in higher education.[255] Certified CHWs may be directly reimbursed through Medicaid for a broad range of services, characterized as "self-management and training."[256]

Minnesota also created behavioral health care homes, which are funded through a risk-tiering system; health care homes are paid per patient and per month, based on the severity of the patient's illness.[257] The teams that take care of these patients must include a qualified home specialist, who may be a CHW.[258] The practice of integrated health care can also be found in a CMS Innovation award-winner, which improved patients' depression, hypertension, and diabetes through care coordination.

1. Overview: Minnesota CHWs

Minnesota makes great use of CHWs in behavioral health care. This may be due to CHWs' long and accomplished history within the state. The emergence of CHWs as a profession was born out of the Healthcare Education-Industry Partnership (HEIP, now HealthForce Minnesota), which was funded by the Minnesota Legislature in 1998 to reduce health disparities among Minnesota's

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252. *Id.*

253. *Id.*

254. *CHW Training FAQ*, MICH. CMTY. HEALTH WORKER ALL., http://www.michwa.org/chw-training-faq-2/ (last visited Mar. 7, 2020).

255. *Scope of Practice for Minnesota Community Health Workers*, MINN. CMTY. HEALTH WORKERS ALL., http://mnchwalliance.org/wp-content/uploads/2013/05/ScopeOfPracticeCurriculum-.pdf (last visited Mar. 7, 2020).

256. MINN. DEP'T OF HEALTH, CHW TOOLKIT: SUMMARY OF REGULATORY AND PAYMENT PROCESSES 12 (2016), https://www.health.state.mn.us/facilities/ruralhealth/emerging/docs/chwreg2016c.pdf (last visited Mar. 7, 2020).

257. *Id.* at 13.

258. *Id.*

diverse population.[259] HEIP, through the Minnesota Community Health Worker Project (MCHWP), brought together twenty-one health care organizations to develop a state CHW program, which led to several advances in the profession.[260] After formally defining a scope of practice in 2003, in 2005, Minnesota became the first state to standardize a CHW certification curriculum through its post-secondary institutions.[261] The scope of practice broadly described the CHW role as advocate ("be a spokesperson for clients"), navigator ("increase access to primary care"), and provider of direct services ("conduct health-related screenings").[262] The curriculum defined six core competencies requiring a total of nine credit hours; seven health promotion competencies, including mental health, requiring a total of seven credit hours; and a practice competency, requiring two credit hours.[263]

The objective of the Mental Health course is to introduce CHWs to mental health studies, to strengthen the role of CHWs in promoting mental health, and to decrease the stigma associated with mental illness.[264] Students are taught the indicators of good mental health; the symptoms of poor mental health; the causes of mental illness; how to demonstrate empathy for those suffering from mental illness; the legal and ethical aspects of mental health work; and how to promote mental health in the CHW, clients, families, and in the community as a whole.[265] They are also informed of local mental health resources and how to overcome barriers to care.[266]

One of the most notable advancements in CHW engagement in behavioral health occurred in 2009, when state law was amended to allow supervision of

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259. MINN. DEP'T OF HEALTH, CHW TOOLKIT: A GUIDE FOR EMPLOYERS 14 (2016), https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/docs/2016chwtool.pdf (last visited Mar. 7, 2020). About 11% of the state of Minnesota lives below the poverty level. *American FactFinder: Community Facts,* U.S. CENSUS BUREAU, https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml (last visited Mar. 7, 2020). According to census statistics, Minnesota is populated by over four million whites, over three-hundred thousand African Americans, over three-hundred thousand Asian Americans, and over fifty-thousand Native Americans. *American FactFinder: Community Facts,* U.S. CENSUS BUREAU, https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml (last visited Mar. 7, 2020) (click "Poverty," then click "Poverty Status in the Past 12 Months Age, Sex, Race, Education, Employment. . .).

260. CHW TOOLKIT: A GUIDE FOR EMPLOYERS, *supra* note 259, at 14.

261. *Id.*; *see also* MINN. CMTY. HEALTH WORKERS ALL., *supra* note 255 (explaining the scope of practice).

262. MINN. CMTY. HEALTH WORKERS ALL., *supra* note 255.

263. *Id.*

264. MINN. CMTY. HEALTH WORKER ALL., MINNESOTA CHW CURRICULUM (Feb. 2015), http://mnchwalliance.org/wp-content/uploads/2012/12/Minnesota-CHW-Curriculum-Outline-Updated-Feb-2015.pdf.

265. *Id.*

266. *Id.*

CHWs by mental health professionals.[267] Minnesota defines "mental health professional" very broadly, such that a supervising professional could include a registered psychiatric nurse, a registered nurse practitioner, a clinical social worker, a licensed family therapist, or person with a master's degree and at least 4,000 hours of supervised experience in a field entailing clinical delivery of mental health services.[268]

2. State Funding and Certification in Minnesota

In 2007, the Minnesota legislature approved direct Medicaid reimbursement for CHW services, thus marking another significant advancement in the state's utilization of CHWs.[269] The statute requires CHWs to have earned a certificate through the Minnesota State Colleges and University System or have at least five years of CHW experience under a licensed health professional.[270] Qualifying licensed professionals are physicians, registered nurses, and advanced practice registered nurses.[271] Furthermore, the statute required CHWs whose experience "grandfathered" their qualification for Medicaid reimbursement to pass an exam by the beginning of 2010.[272] All CHWs practicing in Minnesota who earn a certificate through the university system qualify for reimbursement by Medicaid. Additionally, to qualify for Medicaid reimbursement, CHWs must work under the supervision of a physician, registered nurse, or advanced practice registered nurse.[273] The supervising clinician must be a Minnesota Health Care Programs (MHCP)-enrolled provider.[274] MHCPs are programs for low-income Minnesotans, including those

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267. MINN. STAT. § 256b.0625(49)(2)(b).

268. MINN. STAT. § 245.462(18).

269. CHW TOOLKIT: SUMMARY OF REGULATORY AND PAYMENT PROCESSES, *supra* note 256, at 4; *see also* MINN. STAT. § 256b.0625; *see also* KATE BLACKMAN & SAMANTHA SCOTTI, NAT'L' CONF. OF STATE LEGISLATURES, INCORPORATING COMMUNITY HEALTH WORKERS INTO STATE HEALTH CARE SYSTEMS: OPTIONS FOR POLICYMAKERS 6 (Aug. 2015), http://www.ncsl.org/Portals/1/Documents/Health/CHWbrief2015.pdf, for a comparison of Minnesota law with that of other states.

270. MINN. STAT. § 256b.0625(49)(a).

271. *Id.* § (49)(a)(2).

272. *Id.; see also* CHW TOOLKIT: A GUIDE FOR EMPLOYERS, *supra* note 259, at 42–43 (providing a description of CHW qualifications for reimbursement).

273. MINN. STAT. § 256b.0625(49).

274. CHW TOOLKIT: A GUIDE FOR EMPLOYERS, *supra* note 259, at 43; *see also Health Care Programs and Services Overview*, MINN. DEP'T OF HUM. SERVS. (May 16, 2018), http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelec tionMethod=LatestReleased&dDocName=id_008922 (providing an overview of Minnesota Health Care Programs (MHCP) insurance coverage of low-income Minnesotans).

with disabilities and those who need assistance paying costs not covered by Medicare.[275]

a. Minnesota Health Care Homes

The Minnesota Department of Health certifies two types of health care homes: Health Care Homes and Behavioral Health Care Homes.[276] CHWs participating in a MHCP-enrolled patient's care team can provide services, which are reimbursable by MHCP on a per patient and per month basis.[277] These services must be provided in person and include delivery of health care to an individual or a group of no more than eight persons.[278] CHW case management, advocacy, and enrollment assistance services are not approved for reimbursement.[279] MHCP reimburses through a level system, which assigns a patient a "Tier" number depending upon the severity and number of health conditions.[280] That is, care for a healthy, Tier 0 patient, who has no chronic conditions, is reimbursed at the lowest amount, whereas care for a Tier 4 patient is reimbursed at the highest amount.[281]

Behavioral Health Home services became reimbursable through Medical Assistance on July 1, 2016, as a result of the home health model of the Affordable Care Act.[282] To be eligible for behavioral health home services, a patient must have a "serious mental illness" or "emotional disturbance," as defined by Minnesota statute.[283] This multi-disciplinary approach involves care teams composed of (1) a team leader, who may be a clinic manager, medical director, or other management-level professional; (2) an integration specialist, who in

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275. *Minnesota Health Care Programs Overview*, MINN. DEP'T OF HUM. SERVS., https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/overview.jsp (last visited Mar. 7, 2020).

276. CHW TOOLKIT: A GUIDE FOR EMPLOYERS, *supra* note 259, at 44.

277. *Id.*

278. CHW TOOLKIT: SUMMARY OF REGULATORY AND PAYMENT PROCESSES, *supra* note 256, at 10.

279. *Id.*

280. MINN. DEP'T OF HEALTH, CARE COORDINATION TIER ASSIGNMENT TOOL, VERSION 1.0 HEALTH CARE HOME INITIATIVE 1, http://www.health.state.mn.us/healthreform/homes/payment/training/complexteirtool.pdf (last visited Mar. 7, 2020).

281. Health Reform Minn., *HCH I Health Care Homes*, MINN. DEP'T OF HEALTH (Oct. 1, 2014), http://www.health.state.mn.us/healthreform/homes/payment/training/teiringslides.pdf (discussing the potential composition of a population using the tier system); *see also* MINN. DEP'T OF HUM. SERVS. MINN. DEP'T OF HEALTH, HEALTH CARE HOME PAYMENT METHODOLOGY: STRUCTURE AND DESIGN 6–7 (January 2010), https://www.health.state.mn.us/facilities/hchomes/payment/background/pymtmethstructure.pdf (explaining the tier system structure and the increased payment rate at each tier to reflect patient complexity).

282. *Behavioral Health Home Services Overview,* MINN. DEP'T OF HUM. SERVS., 1 (2018), https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6307-ENG.

283. *Id.* at 2; *see also* MINN. STAT. § 245.462(20)(a) (defining serious mental illness); *see also* MINN. STAT. § 245.4871(15) (defining emotional disturbance).

behavioral health settings, must be a registered nurse; (3) a systems navigator, who can be either a "case manager" as defined by Minnesota statute or a "mental health practitioner" as defined by Minnesota statute; and (4) a qualified home specialist.[284]

The qualified home specialist role may be filled by a number of practitioners whose roles are defined by Minnesota statute: community health worker, peer support specialist, family peer support specialist, case management associate, mental health rehabilitation worker, community paramedic, or a certified health education specialist.[285]

b. Accountable Care Organizations in Minnesota

The Affordable Care Act incentivizes care coordination through savings agreements conditioned on meeting certain quality thresholds.[286] In Minnesota, Accountable Care Organizations (ACOs) share in cost savings beginning the first year, and share in losses beginning the second year.[287] ACOs can utilize CHWs as part of their care teams in order to maximize efficiency.

i. Medicaid ACOs

Minnesota Medicaid created Integrated Health Partnerships (IHPs), which use an ACO model that allows health care deliverers to share in savings.[288] Twenty-five major hospitals and health care networks now participate in the IHP program, including the Mayo Clinic and Children's Hospitals and Clinics of Minnesota.[289] The Mayo Clinic utilizes CHWs as part of its integrated care teams.[290]

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284. *Behavioral Health Home Services Overview, supra* note 282, at 1; *see also* MINN. STAT. § 245.4871(4)(b-m) (defining case manager); *see also* MINN. STAT. § 245.462(4)(b-j) (describing a case manager's duties); *see also* MINN. STAT. § 245.4871(26) (defining mental health practitioner); *see also* MINN. STAT. § 245.462(17) (defining mental health practitioner).

285. MINN. STAT. § 256B.0625(49) (defining community health worker); MINN. STAT. § 256B.0615 (defining peer support specialist); MINN. STAT. § 256B.0616 (defining family peer support specialist); MINN. STAT. § 245.462(4)(g) or § 245.4871(4)(j) (defining mental health rehabilitation worker); (defining community paramedic); *see also Behavioral Health Home Services Overview, supra* note 282 (enumerating BHH service team members).

286. CHW TOOLKIT: SUMMARY OF REGULATORY AND PAYMENT PROCESSES, *supra* note 256, at 13. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 3021, 124 Stat. 119 (2010); Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 3302, 124 Stat. 119 (2010).

287. CHW TOOLKIT: SUMMARY OF REGULATORY AND PAYMENT PROCESSES, *supra* note 256, at 13.

288. *Integrated Health Partnerships*, MINN. DEP'T OF HUM. SERVS., http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelec tionMethod=LatestReleased&dDocName=dhs16_161441 (last visited Mar. 7, 2020).

289. *Id.*

290. Sarah Klein & Martha Hostetter, *In Focus: Integrating Community Health Workers into Care Teams*, THE COMMONWEALTH FUND (Dec. 17, 2015), http://www.commonwealthfund.org/publications/newsletters/transforming-care/2015/december/in-focus.

Hennepin Health is an IHP with a focus on behavioral health and social services.[291] The Hennepin Health IHP is composed of four parts: the County Human Services and Public Health Department, the Level One Trauma Hospital, a federally qualified health center, and its Health Plans.[292]

One of Hennepin Health's most remarkable achievements is its electronic medical records system (EMR). Unlike most EMRs, which are reserved for licensed professionals, Hennepin Health's EMR permits CHWs on the ground to record entries directly into a patient chart—they annotate the social and economic determinants of a patient's health into the medical record.[293] Hennepin Health thus overcomes the information-sharing barriers and fragmentation troubling other health systems.

Risk-tiering is another important tool at Hennepin Health. Hennepin Health utilizes a risk-tiering tool to place patients on a sort of health care hierarchy.[294] The tool looks prospectively at the cost of care based on age, gender, and diagnosis.

That information is then used to assign the members of a patient's care team. Based on a patient's risk level, Hennepin will assign a nurse, social worker, and/or CHW to the patient's care team.[295] If a patient has been assigned a "high" or "extreme" risk tier, a CHW may be assigned as the patient's primary care coordinator.[296] However, the system is flexible; if a patient has a complex medical condition, a registered nurse will be assigned as the primary coordinator.[297] If a patient has a specific cultural background, a CHW may also be assigned as the primary coordinator.[298] Hennepin Health has also assigned a few specialty CHWs to its emergency rooms.[299] For example, a specialized ER CHW was trained to re-route patients suffering from extreme dental pain to same-day dental clinics.[300]

Hennepin Health has three different health plans, which it describes as "products that use an innovative approach to blend medical, behavioral health and social services in a patient-centered care model... [which] not only allows members to address their health issues, but also to receive assistance with any

291. *Hennepin-Health-PMAP*, HENNEPIN HEALTH, http://www.hennepinhealth.org (last visited Mar. 7, 2020).

292. Telephone Interview with Renee Levesque, Care Coordination Manager, Hennepin Cty. Human Servs. and Pub. Health Dep't, Hennepin Health (Aug. 10, 2017).

293. *Id.*

294. *Id.*

295. *Id.*

296. *Id.*

297. Telephone Interview with Renee Levesque, Care Coordination Manager, Hennepin County Human Serv. and Pub. Health Dep't, Hennepin Health (Aug. 10, 2017).

298. *Id.*

299. *Id.*

300. *Id.*

housing and/or social service needs they may have."[301]   Hennepin utilizes
community health workers in several contexts. CHWs work at Access Care
Mobile Clinics and also at NorthPoint, an open-house-type program where
patients are encouraged to drop in, without an appointment, to speak to members
of a care team.[302]

CHWs have a remarkably expanded role at the Hennepin County Medical
Center, a partner of Hennepin Health.[303] There, 26 CHWs are employed: 19 at
clinic locations, four in the community, two in the emergency department, and
one at an inpatient location.[304] CHW responsibilities are primarily related to
access and care coordination; they help with health care home enrollment, help
patients to overcome barriers to treatment (for example, housing crises), assist
with admission transitions (such as scheduling appointments), help with pre-visit
planning (for example, conveying to the provider important patient information),
and assist with patient compliance (which includes helping the patient attend
referral appointments).[305] Hennepin assigns 'Primary Coordinator' status to
health care team members in accordance with patient needs. If the patient has
stable chronic diseases, is a frequent user of the Emergency Department for
primary care, or has a cultural or linguistic barrier to health care navigation, then
a CHW will be assigned to be the patient's Primary Coordinator.[306]

ii. Commercial ACOs

Little information is available on commercial ACO engagement of
CHWs.[307]

Some commentary explores the idea that commercial ACOs are looking to
Medicaid ACOs for the exemplary cost-saving measure of care coordination with

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301. HENNEPIN HEALTH, ANNUAL REPORT 2017, at 3 (2017), https://www.hennepinhealth.org/-
/media/hh/about/2017-annual-
report.pdf?la=en&hash=30A543598DA4125E6F61E3220BAD05CD27041CBA; Interview with Renee
Levesque, *supra* note 297.

302. *Id.* at 4.

303. *Health Reform*, HENNEPIN HEALTH, http://www.hennepinhealth.org/about-us/health-reform (last
visited Mar. 7, 2020).

304. NYU-CUNY PREVENTION RESEARCH CTR., INTEGRATING CHWS INTO HEALTHCARE SYSTEMS:
HENNEPIN HEALTH/HENNEPIN COUNTY MEDICAL CENTER COMMUNITY HEALTH WORKER PROGRAM
(Oct. 1, 2015), https://med.nyu.edu/prevention-research/sites/default/files/prevention-research2/godfrey-
walters-hennepin-health-oct-2015.pdf.

305. *Id.*

306. *Id.*

307. Medica, the first provider of an ACO product in Minnesota, does not seem to utilize CHWs.
*See Medica Continues Expansion of ACO Offerings in Minnesota: Lakeview Clinic Added to Ridgeview
Connect with Medica ACO*, BUSINESS WIRE,
https://www.businesswire.com/news/home/20131114006159/en/Medica-Continues-Expansion-ACO-
Offerings-Minnesota (last visited Mar. 15, 2020).

a focus on behavioral health, in recognition that comorbid mental illnesses drastically exacerbate patient costs.[308]

c. Reimbursement

The state has also taken remarkable steps to streamline reimbursement. The Minnesota Department of Human Services (DHS) operates a web-based, HIPAA-compliant billing and administrative transaction system called MN-ITS, where CHW services are reimbursable under a very general service code classification.[309] Namely, the reimbursement "Purpose" is broadly titled as "Self-management education & training;" the reimbursement rate is greater, however, if the CHW worked with a single patient, and proportionately lower if the CHW worked with a greater number of patients.[310]

3. Federal Funding in Minnesota

Other organizations that do not employ MHCP providers can also engage the services of CHWs in Minnesota by seeking alternative methods of payment, such as a CMS Innovation award.[311]   The Institute for Clinical Systems

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308. *See* Jill Brown, *Commercial ACOs Could Look to Medicaid for Behavioral Health Models*, ATLANTIC INFO. SERVS. BLOGS (March 27, 2015), https://web.archive.org/web/20150407014535/https://aishealth.com/blog/health-plan-business/commercial-acos-could-look-medicaid-behavioral-health-models (discussing ACOs turning to strategies utilized in the Medicaid program to integrate behavioral health care into their system).

309. CHW TOOLKIT: SUMMARY OF REGULATORY AND PAYMENT PROCESSES, *supra* note 256, at 11-12.

310. *Id.* at 12. A "face-to-face" "self-management & training" appointment for one patient is reimbursable at the rate of $19.94,; for 2-4 patients, the rate is $9.59, per patient; and for 5-8 patients, the rate is $6.81 per patient. Medicaid limits CHW service reimbursement to four 30-minute sessions within a twenty-four 24-hour period, which adds up to a two-hour maximum. Further, a provider can bill no more than twenty-four 30-minute sessions per calendar month. *Id.* "Self-management education & training" is a broad descriptor for CHW duties, which the Minnesota Department of Health describes as: "Assisting individuals and communities to adopt healthy behaviors; Conducting outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health; Providing information on available resources; Providing social support and informal counseling; Advocating for individuals and community health needs; Providing services such as first aid and blood pressure screening; Collecting data to help identify community health needs." *Community Health Worker (CHW)*, MINN DEP'T HEALTH, https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/index.html (last visited Mar. 7, 2020). It is evident that some of these duties are reimbursable through MN-ITS ("Providing social support and informal counseling"), but others are not ("Collecting data to help identify community health needs"). *Community Health Worker (CHW)*, MINN DEP'T HEALTH, https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/index.html (last visited Mar. 7, 2020).

311. CHW TOOLKIT: SUMMARY OF REGULATORY AND PAYMENT PROCESSES, *supra* note 256, at 12–13; *see also State Innovation Models Initiative: General Information*, CMS.GOV: CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/state-innovations/ (last visited Mar. 7, 2020) (showing that these CMS innovation awards can provide successful innovative participants hundreds of millions of dollars in rewards).

Improvement of Bloomington, Minnesota received an award for its project entitled "Care management of mental and physical co-morbidities: a TripleAim bulls-eye."[312] The project aimed to improve "care delivery and outcomes for high-risk adult patients with Medicare or Medicaid coverage who have depression plus diabetes or cardiovascular disease."[313] The Institute relied on "care managers" and "health care teams," and partnered with the Mayo Clinic Health System and Advancing Integrated Mental Health Solutions (AIMS), among others.[314] AIMS is particularly geared toward behavioral health, approaching integrated mental health care through a practice called "Collaborative Care," which utilizes CHWs, along with family members and licensed professionals, to form a treatment team.[315]

The project achieved many successes. A CMS annual report showed that participants were hospitalized and visited the emergency room less often.[316] Social outcomes also improved; many patients returned to work, and many patients reported feeling less socially isolated.[317] Lab results for HbA1cb (a diabetes marker) also improved.[318] Patients also reported feeling significantly less depressed.[319]

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312. *Health Care Innovation Awards: Minnesota*, CENTERS FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Minnesota.html (last visited Mar. 7, 2020) (describing the Institute for Clinical Systems Improvement's project and award).

313. *Id.*

314. *Id.* (providing a description of the program and a comprehensive list of partners). Jürgen Unützer, Director of the AIMS Center, stated: "In my experience, it is less important to find the perfect mental health professional for an integrated care program than to make sure that the integrated care team is prepared to get essential tasks done in a reliable way. The ability to shift some of the essential tasks of Collaborative Care to family members, peers or community-based organizations has the potential to dramatically increase access to effective treatment and to effectively leverage mental health services provided in primary care and other health care settings." *Task Sharing in Collaborative Care*, ADVANCING INTEGRATED MENTAL HEALTH SOLUTIONS CTR., https://aims.uw.edu/task-sharing- collaborative-care (last updated Jan. 9, 2018).

315. ADVANCING INTEGRATED MENTAL HEALTH SOLUTIONS CTR., *supra* note 314.

316. Henry Ireys et al., MATHEMATICA POL'Y RES., EVALUATING THE HCIA—BEHAVIORAL HEALTH/SUBSTANCE ABUSE AWARDS: THIRD ANNUAL REP. 94–95 (Jan. 23, 2017), https://downloads.cms.gov/files/cmmi/hcia-bhsa-thirdannualrpt.pdf (reflecting that emergency department visits declined to 0.28 per person, which was significantly lower than the 0.79 baseline average). Patients also became more actively involved in their health care, and improving communication with their health care providers, even though most patient-provider communications occurred between the patient and a care manager: "[o]ne physician noted, '[t]hey've become more engaged with their primary [care providers], although most of the engagement has been with the care managers and the care managers let the primary [care providers] know what's going on. But [participants have] become more engaged and compliant with testing and laboratory work [and] with medication adherence.'" *Id.* at 104.
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317. *Id.* at 104–105.

318. *Id.* at 104. The rate of improvement for those with hypertension improved much more than diabetes. *Id.* at 111. However, the study noted that diabetes can be more difficult to treat. *Id.* at 102.

319. *Id.* at 105.

The Innovation Award workforce was also surveyed and reported improvements in treatment team communication,[320] as well as a sense of satisfaction for having improved patient life.[321] Senior leaders did note that funding for care management and behavioral health was nevertheless still difficult to procure, stating, "We need to figure out … a way to pay for care management and for the time of … a psychiatrist to participate. And this is not something that we're really rewarded for today. We still get paid mostly for … volume-based stuff."[322] While room for improvement was noted, the project was a significant achievement in integrated health care: by linking behavioral health with physiological health, it noted marked improvements in both.

D. Texas

Texas offers encouragement for CHW involvement in health care, but offers less in the way of structure. In contrast with Minnesota and New Mexico, Texas has a relatively expansive certification program but lacks a standardized curriculum. The state legislature has sought to encourage the use of CHWs, even requiring the state's health department to use CHWs, and has published a report describing all of the funding mechanisms available in Texas. The expansion of certification may have fostered the growth of other, non-certified paraprofessionals.

There are several other types of community support practitioners in Texas in addition to CHWs. Certified Peer Support Specialists (CPS) help those with substance abuse disorders; their work captures much of the behavioral health care that CHWs do in other states. Additionally, Community Guest Specialists (CGS) and Community Outreach Specialists (COS) are uncertified but do work typical of a CHW in other states, such as connecting patients to appropriate services and resources. A CMS innovation award has employed CPSs and CGSs in a project that aimed to provide integrated behavioral health care and health care. A report noted modest successes, attributed in part to difficulty in meeting patients' basic housing and food needs, suggesting that CGSs were not proficient in connecting patients to services.

1. Overview: CHWS in Texas

In Texas, behavioral health support services and community outreach are conducted by both CHWs and Certified Peer Support Specialists. There is some

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320. *Id.* at 111.

321. *Id.* at 106.

322. *Id.* at 110.

overlap in scope of work and patient community, although the funding mechanisms available to each profession differ in important ways. [323]

2. State Funding and Certification of Paraprofessionals in Texas

a. Community Health Workers

The Texas legislature has taken a deliberate approach to incorporating CHWs and *promotoras* into state health services. In 1999, it directed the Texas Department of Health to establish a committee to study the issues and effects of community outreach and education programs.[324] The committee was composed of 15 members, and included two CHWs/*promotoras,* representatives from academic health centers, health department officials, and educators.[325] The committee was instructed to contemplate several issues, including funding mechanisms (such as a Medicaid waiver), the appropriateness of a certification program, a potential curriculum, methods for gauging program success, and an explanation of barriers to services.[326] The committee was also instructed to develop pilot projects to demonstrate the feasibility and benefits of employing CHWs in managed care organizations and CHIP programs.[327]

The committee's findings led the legislature to pass two important pieces of legislation in 2001. First, the legislature passed a bill requiring the state's Department of Health to mandate the use of certified *promotoras* "to the extent possible" in health education and outreach programs.[328] Second, the legislature passed a bill requiring the Texas Department of State Health Services to develop a CHW and *promotora* training and certification program, which mandated that all CHWs and *promotoras* who are paid for their services must be certified.[329] Since then, the Texas Department of State Health Services has authorized over 40 regional training sites, as well as three distance learning sites sponsored by academic institutions, although there is no standardized curriculum.[330]

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323. *See generally* Allen S. Daniels et al., *Defining Peer Roles and Status Among Community Health Workers and Peer Support Specialists in Integrated Systems of Care*, 68 PSYCHIATRIC SERVS. 1296 (2017) (describing the characteristics of CHWs as compared to Peer Support Specialists).

324. H.R. 1864, 76th Legis. Assemb., Reg. Sess. (Tex. 1999).

325. *Id.* §1.03(b).

326. *Id.* §1.03.

327. *Id.* §1.05.

328. *See CHW Program: Legislation*, TEX. DEP'T HEALTH & HUM. SERVS., https://www.dshs.texas.gov/mch/chw/legislation/ (last updated Sept. 13, 2019) (highlighting key legislation); S. 751, 76th Gen. Assemb., Reg. Sess. (Tex. 2001).

329. S. 1051, 77th Reg. Sess. (Tex. 2001).

330. *Community Health Workers Training Information*, TEX. HEALTH & HUM. SERVS., https://web.archive.org/web/20180305202514/https://www.dshs.texas.gov/mch/chw/Community-Health-Workers—-Training-Information/ (last updated Feb. 22, 2018); SIM CHW ADVISORY COMMITTEE, CHW CERTIFICATION INFORMATION 12 (2017), http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/chw/chw_certification_findings_20171227_u

Certification requires the potential CHW to have completed a 160-hour training program or have had at least 1000 hours of CHW experience within the last three years.[331] Certification is free of charge, but trainings can be expensive, ranging from $750 to $1000, depending upon the training site.[332] CHW instructor training ranges from $1200 to $1500, also depending upon the training site.[333]

In 2011, the legislature directed the Department of Health to continue to study funding and reimbursement mechanisms, to develop recommendations to "maximize the employment of and access to *promotoras* and CHWs," and to discover ways to expand the types of services provided by CHWs.[334] The ensuing report defined CHWs as "trusted community members" and noted that grant funding sustained most CHW employment.[335] The report's recommendations included CHW funding through a Section 1115 Waiver project and incorporating CHWs into managed care-type structures.[336]

The committee has submitted annual reports to the legislature every year since 2013;[337] the 2017 report noted a decrease in those seeking certification and cited incentivizing training as an important goal.[338] It tabulated 4,033 certified CHWs in Texas,[339] the majority of whom are female and Latinx.[340]

The lack of a standardized curriculum makes it difficult to assess whether CHWs are systematically trained in behavioral health issues. However, a number of CHW continuing education courses do deal with mental health; for example,

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pdated.pdf; *see also CHW & Instructor Training Sites,* TEX. HEALTH & HUM. SERVS., https://www.dshs.texas.gov/mch/chw/chw-Instructor-Training-Sites.aspx. (last updated May 23, 2019) (discussing the various curricula in Texas that may be approved).

331. *CHW Certification Requirements*, TEX. DEP'T OF HEALTH & HUM. SERVS., http://www.dshs.texas.gov/mch/chw/chwdocs.aspx (last updated Sept. 12, 2019).

332. *Welcome to CCHD's National CHW Training Center*, NAT'L CMTY. HEALTH WORKER TRAINING Ctr., https://nchwtc.tamhsc.edu/ (last visited Mar. 7, 2020); *see also Community Health Worker (CHW) and Community Health Worker Instructor (CHWI) Training Requirements,* TEX. AHEC EAST, http://www.cahectx.org/pdf/CHWApp1.pdf (last visited Mar. 7, 2020); *Community Health Worker Certification Training* (2013), UNIV. TEX. SCH. PUB. HEALTH, https://sph.uth.edu/content/uploads/2013/07/CHW-Cert-Flyer-Fall-2013.pdf (last visited Mar. 7, 2020).

333. *Training Offered*, NAT'L CMTY. HEALTH WORKER TRAINING CTR., https://nchwtc.tamhsc.edu/training-offered/ (last visited Mar. 7, 2020); TEX. AHEC EAST, *supra* note 332.

334. H.R. 2610, 82d Leg., Reg. Sess. (Tex. 2011).

335. TEX. DEP'T STATE HEALTH & HUMAN SERVS., TEXAS COMMUNITY HEALTH WORKER STUDY: REPORT TO THE TEXAS LEGISLATURE, 82D LEG., 2–3 (2012), http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589973810.

336. *Id.* at 4.

337. *DSHS Reports to the 83d Tex. Leg.*, TEX. DEP'T STATE HEALTH SERVS., https://www.dshs.texas.gov/mch/chw/announcementsreports.aspx (last visited Mar. 7, 2020).

338. PROMOTOR(A) OR CMTY. HEALTH WORKER (CHW) TRAINING AND CERTIFICATION ADVISORY COMMITTEE, TEX. DEP'T OF HEALTH & HUM. SERVS., 2017 ANNUAL REPORT 2 (Apr. 2018).

339. *Id.* at 10.

340. *Id.* at 16. 88% of certified CHWs are women, and 65% are Hispanic. *Id.*

one training site offers instruction on "Mental Health and Disasters,"[341] and another offers an "Overview of Mental Wellness."[342]

b. Certified Peer Support Specialists

The certified peer specialist role is geared toward helping a very specific patient population: those with substance use problems and those in recovery. The role was nationally formalized in 2007, when CMS issued a letter to state Medicaid officials providing the "option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system."[343] The letter suggested three mechanisms for billing Medicaid under the Social Security Act: Section 1905(a)13; 1915(b) Waiver Authority; and 1915(c) Waiver Authority.[344]

While their services are reimbursable through Medicaid, in Texas, 65% of the cost of peer support specialist training is born by applicants themselves.[345] The remainder is provided by the Department of State Health Services and The Hogg Foundation for Mental Health.[346] Training is 43 hours spread over six days and is divided into 21 modules.[347] Modules include "The Language of Recovery," "Healing in Relationships," "Modeling Peer Recovery," "Listening and the Art of Asking Questions," and other topics related to the peer/patient relationship.[348] Other modules address ethical issues ("Power, Conflict, and Integrity" and "CPS Ethics and Boundaries"), and at least one module is a substantive introduction to behavioral health systems ("Federal and State Mental Health Systems").[349] A certification exam follows the weekend after the

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341. *Community Health Workers – Continuing Education: DSHS-Certified Continuing Education Courses (CEUs) for Community Health Workers: What is a DSHS Certified CEU?*. TEX. DEP'T HEALTH & HUM. SERVS., https://www.dshs.texas.gov/mch/chw/Continuing-Education.aspx (last visited Mar. 7, 2020).

342. *CHW Continuing Education Courses*, TEX. DEP'T HEALTH & HUM. SERVS., https://www.dshs.texas.gov/mch/chw/Continuing-Education.aspx (last visited Mar. 7, 2020).

343. Letter from Dennis G. Smith, Dir., CMS, to State Medicaid Directors (Aug. 15, 2007), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf.

344. *Id.* States had already billed under those authorities; Georgia is widely recognized as the first state to do so, beginning in 2001; U.S. GOV'T ACCOUNTABILITY OFFICE, MENTAL HEALTH LEADING PRACTICES FOR STATE PROGRAMS TO CERTIFY PEER SUPPORT SPECIALISTS 9 (2018).

345. LAURA KAUFMAN ET AL., TEX. INST. FOR EXCELLENCE IN MENTAL HEALTH PEER SPECIALIST TRAINING & CERTIFICATION PROGRAMS: NATIONAL OVERVIEW 2016, 109, http://sites.utexas.edu/mental-health-institute/files/2017/01/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2016-Update-1.5.17.pdf (last updated Jan. 2017).

346. *Id.*

347. VIA HOPE: TEX. MENTAL HEALTH RES., TEXAS CERTIFIED PEER SPECIALIST PROGRAM POLICY AND PROCEDURE MANUAL (Mar. 1, 2016), https://www.viahope.org/wp-content/uploads/2017/08/CPS-Policy-Procedure-Manual-120716_1.pdf.

348. *Id.*

349. *Id.*

course.[350] Certification lasts 24 months.[351] A nominal recertification fee is paid for by the peer specialist's employer.[352] Texas allows for peer specialist certification reciprocity, as long as the certification is recognized by a state Medicaid agency in the state where the certification was granted.[353]

Forty-one states currently have peer support specialist certification programs, and many of those states allow their services to be billed to Medicaid Managed Care.[354] Like many state certification programs,[355] Texas certified peer support specialists must abide by a code of ethics, which emphasizes the importance of sharing recovery stories and maintaining one's recovery while supporting the patient. The peer specialist role is to be an advocate "for the full integration of individuals into the communities of their choice" and to "promote the inherent value of these individuals to those communities," because "all individuals have the right to live in the least restrictive and least intrusive environment."[356]

3. Federal Funding in Texas: CMS Innovation Award

The Center for Health Care Services (CHCS) won an innovation award of $4.5 million for its project entitled "A recovery-orientated approach to integrated behavioral and physical health care for a high-risk population."[357] The project aimed to coordinate behavioral, primary, and tertiary health care by utilizing two health navigators, ten community guest specialists (CGS), six certified peer support specialists, in addition to other health care professionals.[358] Community guest specialists have not been certified, nor have they undergone state-sanctioned training, although specialists at CHCS did undergo a new employee orientation, which covered basic information necessary for the work (HIPAA, relevant Texas regulations, etc.).[359]

The patient population was approximately 260 homeless adults in San Antonio with severe mental illness or co-occurring mental illness and substance use disorders, who were at risk for or had already developed a chronic physical

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350. *Id.*

351. *Id.*

352. *Id.*

353. *Id.*

354. KAUFMAN *supra* note 345, at 1.

355. *Id.*

356. VIA HOPE: TEX. MENTAL HEALTH RESOURCE, *supra* note 347.

357. *Health Care Innovation Awards: Project Profile—Center for Healthcare Services*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/Participant/Health-Care-Innovation-Awards/Center-For-Health-Care-Services.html (last visited Mar. 7, 2020).

358. *Id.*

359. Email Interview with Allison Greer, Vice President/External Relations, Ctr. for Health Care Servs. (June 29, 2016).

disease; most were Medicaid-eligible.[360] While certified peer specialists could be the preferred method of outreach when a high percentage of the patient population suffers from substance use disorders, peer support specialists' services are directly reimbursable through Medicaid.

CHCS successfully enrolled 520 homeless adults, its target number of patients.[361] It randomly assigned half of the adults to the innovation project and another half to a control group, which received standard care from community guest specialists.[362] To implement the behavioral integrated care program, CHCS hired a physician with "an appreciation of the recovery-oriented model and expertise in working with homeless individuals who have complex physical and mental health needs;" changed electronic health records to a platform more amenable to integrated health; and changed their peer referral service to comport with principles the peers learned as part of their certification training.[363] For example, the referral service was modified to allow for greater flexibility for peers to match with patients, as peers were taught that care is "most effective and person-centered when participants are compatible with a peer and the peer is able to offer empathy on issues that are important" to the patient.[364] Thus the innovation award programming is an excellent example of top-down change: federal funding and certification led to improvements on the ground.

The program was challenging in several ways. A few peers suffered relapses, and their caseloads were taken up by other peers and community guest specialists, who struggled under the increased workload.[365] While the small sample size made it difficult to assess the success of the program, information from key informants indicated improvements in health (improved HbA1c values), as well as mental health improvements.[366] The staff reported that "for many participants, satisfying basic needs such as those for housing or food is a higher priority than improving their health behaviors."[367] Such feedback suggests that the program would benefit by employing CHWs, in addition to peer support specialists. Another unexpected setback was the fact that many patients were not Medicaid-eligible, because Texas did not expand Medicaid under the Affordable Care Act.[368] Because the majority of the participants remained

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360. *Health Care Innovation Awards: Project Profile—Center for Healthcare Services*, *supra* note 357.

361. HENRY IREYS ET AL., MATHEMATICA POL'Y RESEARCH, EVALUATING THE HCIA—BEHAVIOR HEALTH/SUBSTANCE ABUSE AWARDS: SECOND ANNUAL REPORT 31 (2016), https://innovation.cms.gov/Files/reports/hcia-bhsa-secondevalrpt.pdf.

362. *Id.*

363. *Id.* at 33.

364. *Id.*

365. *Id.* at 34.

366. *Id.* at 37. For example, one homeless alcohol abuse patient greatly reduced his drinking. *Id.*

367. *Id.*

368. *Id.* at 39.

uninsured, CHCS could not afford to purchase specialty care for the patient cohort's specialty medical care needs.[369] This made it more difficult to determine whether the increased behavioral health outreach had an effect on patient health.

The Texas innovation award illustrates that funding mechanisms are of great import to patient care; funding mechanisms determine the type of professionals available to the patient, as well as the repertoire of available treatments and interventions.

E. Oregon

Oregon has tremendous infrastructure in support of CHWs, but less evidence of CHW "boots on the ground" than other states surveyed in this Article. State and federal legislation, including the Oregon health plans, state and federal mental health parity acts, the Employee Retirement Income Security Act, and the Affordable Care Act, have defined in granular detail the patient population, funding models, and the CHW role.[370] This sort of top-down infrastructure, while celebrating the value of CHWs, has not resulted in CHWs engaged in behavioral health care in numbers observed in other states. The relatively low number of practicing CHWs could be due, in part, to an overlap in the work of CHWs and the other professionals, or the state's emphasis on technological solutions for behavioral health care, such as the Behavioral Health Mapping Tool.

1. Overview: CHWs in Oregon

Oregon is a prolific user of the Section 1115 Waiver. Oregon's first Section 1115 waiver was the Oregon Health Plan of 1994.[371] The plan attempted to provide universal access to a basic level of care,[372] referred to as "prioritization

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369. *Id.*

370. *See e.g.,* Mental Health Parity Act of 1996, Pub. L. No. 104–204, 110 Stat. 2874, 2944; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. No. 110–343, 122 Stat. 3881 (MHPAEA) (2008); Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829; Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the Internal Revenue Code and 42 U.S.C.), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

371. *Waiver Amendments*, OR. HEALTH AUTHORITY, https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Waiver-Amendments.aspx (last visited Mar. 7, 2020); *see also* Philip A. Perry & Timothy Hotze, *Oregon's Experiment with Prioritizing Public Health Care Services*, 13 AM. MED. ASS'N J. ETHICS 241 (2011) (describing the history of Oregon's health services plan).

372. OR. DEP'T HUM. SERVS., OREGON HEALTH PLAN: AN HISTORICAL OVERVIEW 2 (2006), http://library.state.or.us/repository/2011/201104141026024/index.pdf.

of health care services."[373] The plan's universal access to a basic level of care[374] was to be defined through public process.[375] Establishing a "basic level of care" necessitated the "prioritization of health care services," a type of ranking system for health conditions and treatments based on clinical and cost effectiveness.[376] State legislators continually redefined what services would be covered and uncovered—due to budget constraints, especially during the economic downturn of the early 2000s, and also because of recommendations from the Health Services Commission.[377]

Despite the legislature's best efforts, many Oregonians were still without health insurance. In order to meet the costs of its broad enrollment goal, the health plan was amended to cover even fewer services than initially contemplated.[378] In 2003, the Section 1115 waiver attempted to cut costs by dividing the plan in two: OHP Plus for those who were Medicaid-eligible, and OHP Standard for expansion populations, who were given the option of purchasing a plan.[379] Only those at or near the federal poverty line were covered.[380] Enrollment plummeted as low-income families declined to purchase OHP Standard plans; legislators failed to realize that families would elect to go without, rather than purchase low-cost insurance.[381] By 2007, the Oregon Health Plan had lost 75% of its total enrollment.[382]

Oregon's health expenditures were also affected by both state and federal mental health parity laws. In 2007, the state legislature enacted the Oregon Parity Law, which required health insurance coverage for all mental health and substance abuse diagnoses, subject to few exceptions.[383] The protections afforded by the state act were very broad,[384] but were greatly limited in

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373. OR. HEALTH SERVS. COMM'N, PRIORITIZATION HEALTH SERVS.: A REP. TO THE GOVERNOR AND THE 733RD OREGON LEGISLATIVE ASSEMBLY (2005), https://www.oregonlegislature.gov/citizen_engagement/Reports/2005_Health%20Plan%20Policy_Priori tization%20of%20health%20services%20-%20a%20report%20to%20the%20Governor.pdf; Philip A. Perry & Timothy Hotze, *supra* note 371, at 242.

374. OFFICE OF MED. ASSISTANCE PROGRAMS, OR. DEP'T OF HUM. SERVS., OREGON HEALTH PLAN: AN HISTORICAL OVERVIEW 2 (2006), http://library.state.or.us/repository/2011/201104141026024/index.pdf.

375. Philip A. Perry & Timothy Hotze, *supra* note 371 at 242.

376. Laura D. Hermer, *On the Expansion of "Welfare" and "Health" Under Medicaid*, 9 ST. LOUIS U.J. HEALTH L. & POL'Y 235, 258 (2016); OR. HEALTH SERV. COMM'N, *supra* note 373.

377. Perry & Hotze, *supra* note 371, at 243-44.

378. *Id.* at 244.

379. *Id.*

380. *Id.*

381. *Id.*

382. *Id.*

383. John McConnell et al., *Behavioral Health Insurance Parity: Does Oregon's Experience Presage the National Experience with the Mental Health Parity and Addiction Equity Act?*, 169 AM. J. PSYCHIATRY 31, 32 (2012).

384. *See id.* (stating that the protections of the state act were broader than those of the federal act).

application by the Employee and Retirement Income Security Act of 1974, which exempts self-funded employer-sponsored health plans from state insurance laws.[385] Thus, in addition to the much-reduced Medicaid-enrolled population, only about half of Oregon's workforce was affected by the state parity law.[386]

In 2009, the federal parity act came into effect, which captured the remaining Oregonians not subject to the state parity law.[387] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act required that limits on lifetime mental health expenditures be no less than those for other medical benefits.[388] At least one study suggested a negligible impact of federal mental health parity on total health care spending in Oregon, as behavioral health accounted for relatively insignificant health care expenditures.[389] Nevertheless, in 2012, OHP cost $860 million more than what could be covered by state revenues.[390] The 2012 Section 1115 waiver attempted to remedy the deficit by switching from procedure-based to performance-based reimbursement under the Health System Transformation.[391] The idea was to create coordinated care teams of doctors, nurses, dentists, and other providers, focused on prevention and primary care,[392] for which providers would be reimbursed on the basis of health outcome and quality measures.[393]

The population of those eligible for mental health services grew even further in 2013, when the ACA health exchanges went live. Oregon's Medicaid enrollment grew by 72%.[394] In 2014, those with OHP Standard were converted to OHP Plus plans.[395] A 2016 study found that, despite the enormous expansion of coverage, the Health System Transformation saved $240 million over its first

385. *Id.*

386. *Id.*; *see also* Rich Daly, *Oregonians Gain Benefit of Parity MH Coverage*, PSYCHIATRIC NEWS (Oct. 7, 2005), https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.40.19.00400012.

387. *See* Daly, *supra* note 386, at 31 (describing the strength of the new federal law).

388. Daly, *supra* note 386.

389. Daly, *supra* note 386, at 36.

390. Bill Graves, *Oregon House Passes Health Care Transformation Bill to Reduce Costs*, THE OREGONIAN (June 27, 2011),
http://www.oregonlive.com/health/index.ssf/2011/06/oregon_house_passes_health_tra.html

391. *Oregon's 1115 Waiver with the Centers for Medicare and Medicaid Services*, OR. HEALTH AUTH., https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Basics-FAQs.pdf.

392. *Id.*

393. H.RR. 3650, 76th Legis. Assemb., Reg. Sess., § 5(a) (Or. 2011).

394. *See* Louise Norris, *Oregon and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Sept. 20, 2018), https://www.healthinsurance.org/oregon-medicaid/ (reporting that Oregon is tied with Colorado for the third greatest increase in Medicaid enrollment); Nick Budnick, *As Cover Oregon marks the one-year anniversary of 'go-live,' health exchange's struggles continue*, THE OREGONIAN (last updated Jan. 10, 2019), https://www.oregonlive.com/health/2014/09/as_cover_oregon_marks_the_one-.html.

395. *Information for Clients: OHP "Standard" Benefits Changing to "Plus*,*"* OR. HEALTH AUTH. (2014),
https://static1.squarespace.com/static/554bd5a0e4b06ed592559a39/t/55a7d8dae4b0f31be5a3d864/1437063386490/OHP+Standard+to+Plus+Fact+Sheet+2014.pdf.

three years and resulted in $120 less per Oregonian in health care expenditures.[396] In the span of a decade, the team delivery model had resulted in sizable cost-savings, expanded health care coverage, and greater access to behavioral health services.[397]

2. State Funding and Certification in Oregon

The change from procedure-rationing to coordinated care with greatly expanded Medicaid coverage fortified the CHW movement in Oregon. HB 3650, which established the Health System Transformation, mandated that the Oregon Health Authority establish coordinated care organizations.[398] These organizations feature "care teams" that must provide "integrated, person-centered care" to patients.[399] The law mandates that certified CHWs or Patient Navigators assist patients "in navigating the health care delivery system"[400]; it also requires consumer access to advocates—including CHWs—so that consumers may be guided to services in a culturally and linguistically appropriate manner.[401] The law instructs the Oregon Health Authority to work with health professional regulatory boards and advocacy groups to establish education and training requirements for CHWs, personal health navigators, and peer wellness specialists.[402] The Oregon Health Authority was also ordered to develop methodologies for the Medicare and Medicaid reimbursement of "nontraditional personnel," such as CHWs, personal health navigators and peer wellness specialists.[403]

a. The Traditional Health Workers Commission

In 2013, HB 3650 was buttressed by HB 3407, which established the Traditional Health Workers Commission within the Oregon Health Authority.[404] The bill instructed the Director of the Oregon Health Authority to appoint 19 members to serve on the commission.[405] Of the 19 members, there must be at

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396. Shaun McGillis, *Evaluating Oregon's Health System Transformation*, RES. & STRATEGIC PARTNERSHIP 11 (2016), found in Portland State University, Working to Improve Community Health in Oregon, Res. and Strategic Partnerships Q. Rev., III, 3, Fall 2016, at 11 https://www.pdx.edu/research/sites/www.pdx.edu.research/files/Research%20%26%20Strategic%20Part nerships%20Quarterly%20Review%20Fall%202016.pdf.

397. *Id.*

398. H.R. 3650, 76th Legis. Assemb., Reg. Sess. (Or. 2011).

399. *Id.* at § 4(1)(a).

400. *Id.* at § 4(1)(e).

401. *Id.* at § 8(1)(c).

402. *Id.* at § 11(1).

403. *Id.* at § 17(c).

404. H.R. 3407, 77th Legis. Assemb., Reg. Sess. (Or. 2013) (codified at OR. REV. STAT. § 414.665 (2017).

405. *Id.* at § 2(2).

least one CHW, personal health navigator, peer wellness specialist, and doula.[406] Six of the 19 members must be appointed by the Oregon Community Health Workers Association.[407] There must also be a member who represents a CHW labor organization, as well as a member who supervises CHWs at a community-based organization, health department, or agency.[408] The statute further instructs the Traditional Health Workers Commission to develop the education and training requirements for CHWs, personal health navigators, peer wellness specialists, doulas, and other unlicensed health care workers.[409]

Subsequently, the Traditional Health Worker Commission defined the work of each paraprofession and created five types of traditional health worker:

- DOULA: A (Birth) Doula is a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.
- PSS: A Peer Support Specialist is any [range of] individuals who provide supportive services to a current or former consumer of mental health or addiction treatment.
- PWS: A Peer Wellness Specialist is an individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being.
- PHN: A Personal Health Navigator is an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions.
- CHW: A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.[410]

To become a CHW in Oregon, one must complete an Oregon Health Authority-approved training program.[411] If a non-certified CHW can provide documentation that he or she volunteered as a traditional health worker for at least 3,000 hours in Oregon between January of 2004 and June of 2014, the CHW can earn a "grandfathered" certification.[412] Of the 35 approved certification and training programs, only seven are for CHWs; most training programs are for Peer Support Specialists.[413]

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406. *Id.* § 2(2)(a).

407. *Id.*

408. *Id.* § 2(2)(g-h).

409. *Id.* § 4(1).

410. OR. ADMIN. R. 410-180-0300 (2018).

411. OR. ADMIN. R. 410-180-0310 (2018).

412. *Id.*

413. *OHA-Approved Traditional Health Worker (THW) Training and Continuing Education*, OR. HEALTH   AUTH.,

CHWs have a number of different roles in Oregon, which include work in a number of facilities: primary care teams, federally qualified health centers, Head Start programs, and public and private social service organizations.[414] They also conduct home visits, facilitate access to community resources, assist care teams in supporting a patient's goals, and help patients manage chronic diseases.[415] CHWs have worked with the Latinx population, which makes up 12% of the state,[416] for over 25 years. The Columbia Gorge area offers one example, where agricultural workers who tend to the orchards are served by the Columbia Gorge Coordinated Care Organization (CGCCO).[417] In the GCCO, CHWs serve in management, leadership, and community-outreach roles.[418] A Community Advisory Council affiliated with the CGCCO solicits feedback from CHWs and other community members, and helps, along with other healthcare professionals, to set the CGCCO's top ten goals.[419] The role of the CHW in Oregon is thus population, employer, and region-specific.[420]

b. The Behavioral Health Collaborative

In 2016, the Oregon Health Authority brought together almost 50 members from across the state to "represent every part of the behavioral health system."[421] The Behavioral Health Collaborative spent six months developing recommendations to improve behavioral health care in Oregon.[422] The collaborative split into work groups for the purpose of developing a "21st

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https://web.archive.org/web/20180523040315/http://www.oregon.gov/OHA/OEI/Pages/THW-Approved.aspx (last visited Mar. 7, 2020).

414. *Community Health Needs Assessment Executive Summary*, PROVIDENCE HOOD RIVER MEM'L HOSP. (Dec. 16, 2016), https://communitybenefit.providence.org/~/media/files/cbr/chnas/2017/or/2016%20chna%20and%20chip%20%20providence%20hood%20river%20memorial%20hospital.pdf%20at%204; *see also Community Health Worker Job Details*, MOSAIC MED. (June 2018), https://recruiting.ultipro.com/MOS1005/JobBoard/8a5166bf-4cd3-6e94-af44-9cdd29bad37e/OpportunityDetail?opportunityId=17e2cc35-21ec-48b1-968e-87d8aa01dbfb (advertising an open CHW position which functions as an essential component of a holistic primary care practice).

415. *See, e.g., Community Health Worker Job Details* , *supra* note 414.

416. *Latinos in the 2016 Election: Oregon*, PEW RESEARCH CTR. (Jan. 19, 2016), http://www.pewhispanic.org/fact-sheet/latinos-in-the-2016-election-oregon/.

417. *Columbia Gorge Region, Oregon and Washington: 2016 RWJF culture of Health Prize Winner*, ROBERT WOOD JOHNSON FOUND. (Sept. 14, 2016), https://www.rwjf.org/en/library/features/culture-of-health-prize/2016-winner-oregon-washington.html.

418. *Id.*

419. *Id.*

420. *Community Health Worker Certification*, OR. DEP'T HUM. SERVS., https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/Pages/Community-Health-Worker.aspx (last visited Mar. 7, 2020).

421. OR. HEALTH AUTH., BEHAVIORAL HEALTH COLLABORATIVE REPORT 1 (2016), https://www.oregon.gov/oha/OEI/Documents/BHC-Recommendations.pdf.

422. *Id.*

Century Behavioral Health System."[423] Of note is the "Workforce Workgroup," which met to "assess the current behavioral workforce and identify gaps, develop standards…inclusive of licensed and unlicensed, certified, peer support specialists, and community health workers throughout the state."[424] Another work group, the "Peer Delivered Services Workgroup," was composed of members from the Traditional Health Workers Commission and other government and non-profit organizations, with the objective to identify core competencies for "peer supervision."[425] The Behavioral Health Collaborative published a report synthesizing the findings of all workgroups.[426] The report consisted of four findings, one of which was entitled "Workforce"[427] and stated that:

> Use of peer support specialists (PSSs), certified recovery mentors (CRMs) and community health workers (CHWs) are evidence-based and cost-effective strategies to reduce workforce shortages. These workers help improve outcomes for individuals and are an essential component of a primary care system able to address behavioral health issues.[428]

The report also recommended implementing a "learning collaborative" to educate Coordinated Care Organizations and other providers about hiring, retaining, and using CHWs and other traditional health workers in the most effective way.[429]

Another recommendation included the utilization of technology in ways that ranged from the specific, such as addressing youth suicide by launching a social media initiative, to the general, such as training providers and agencies on adoption of effective technologies.[430] One such technology unique to Oregon is

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423. *Id.* at 1,6.

424. *Behavioral Health Collaborative: Workforce Workgroup*, OR. HEALTH AUTHORITY, http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/BHC-Workforce-Workgroup.aspx (last visited Mar. 7, 2020).

425. *See Behavioral Health Collaborative: Peer Delivered Services Workgroup*, OR. HEALTH AUTH., http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/BHC-PDS-Workgroup.aspx (last visited Mar. 7, 2020) (providing an overview of the Peer Delivered Services Workgroup); *see also Behavioral Health Collaborative*, OR. HEALTH AUTH., https://www.oregon.gov/oha/hsd/bhp/Pages/Behavioral-Health-Collaborative.aspx (last visited Mar. 7, 2020) (stating that the objectives for the group also included "developing standards, expectations, and monitoring guidelines for PDS" and "recognizing a standardized training model").

426. OR. HEALTH AUTHORITY *supra* note 391.

427. *Id.* at 11.

428. *Id.*

429. *Id.* at 122.

430. *Id.*

the Behavioral Health Mapping Tool.[431] This tool can be used to identify gaps in the behavioral health care system. [432] The map displays five different types of data: (1) behavioral health county profiles, which identify the types of behavioral health needs in each county; (2) behavioral health service locations, which provide comprehensive information about the services provided at each center; (3) the population of Oregonians in a specific region with behavioral health needs, which also can simultaneously display behavioral health service locations; (4) behavioral health care funding in a specific region; and (5) access to behavioral health care, which shows the number "of Oregonians that are within a 30 minute drive of behavioral health services."[433]

3. Federal Funding and Certification

Oregon is an example of a broad federal funding structure implemented narrowly at the state level. A CMS Innovation Award and the state's Medicaid fund support CHW certification administrators, making certification free of charge to the CHW. During certification, CHWs can elect to "specialize" in mental health care by submitting certain items in a professional portfolio. A CMS Innovation Award also funds the Behavioral Health Centers; however, only one center utilizes CHWs.

a. CMS State Innovation Model Grant

A $45 million Innovation Award began in September 2012 and continued through September 2016.[434] The grant was to support Oregon's Health System Transformation, with a focus on three areas: (1) innovation and rapid learning, which include "promotion of health equity across sectors and payers including private payers, long-term care, community health, and education systems;" (2) delivery models, which include an "evaluation of methods for integrating and coordinating between primary, specialty, behavioral and oral health," as well as additional support for "community health through promotion and prevention activities;" and (3) payment models, which "focus on value, rather than volume, of services provided."[435] CHW work furthers all three goals.

The CHW certification supported by this federal funding has three parts: (1) a written exam composed of true/false and multiple choice questions; (2) a

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431. *Id.* at app. D. *See also Behavioral Health Mapping Tool Technical Advisory Committee*, OR. HEALTH AUTH., http://www.oregon.gov/oha/HSD/AMH/Pages/BH-Mapping.aspx (last visited Mar. 7, 2020) (providing the behavioral mapping tools and reports).

432. *Behavioral Health Mapping Tool Technical Advisory Committee*, OR. HEALTH AUTHORITY: ADDICTIONS AND MENTAL HEALTH SERVICES, http://www.oregon.gov/oha/HSD/AMH/Pages/BH-Mapping.aspx (last visited Mar. 7, 2020).

433. *Id.*

434. *State Innovation Model Grant (SIM)*, OR. HEALTH AUTH., https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SIM.aspx (last visited Mar. 7, 2020).

435. *Id.*

performance-based, role-play demonstration which tests the CHW's assessment of patient needs, counseling, and ability to refer to resources; and (3) submission of a professional portfolio.[436] The professional portfolio requires a response to two essay prompts, for which the CHW must give a personal definition for CHWs, describe his or her experience working in diverse communities, and opine on other similar topics.[437] The portfolio also requires that the CHW submit three items related to nine different subject areas.[438] For example, should the CHW choose to submit for the subject area "Mental Health Promotion," the items he or she must provide may include certificates of mental health training, such as a Mental Health First Aid certificate.[439] The required items reflect some overlap with the Peer Support Specialist profession, and should the CHW choose to submit for the subject area "Addiction and Recovery," certificates from Peer Support Specialist courses related to recovery from substance abuse disorders will suffice.[440] Finally, the CHW must submit academic transcripts, a resume, and a letter of recommendation from someone familiar with the CHW's work.[441]

There is no application fee for the CHW certification because the reviewing administrators are fully funded.[442] The Program Manager is paid through Oregon's general Medicaid fund, and the Administrative Specialist is funded through a CMS Innovation Award (referred to as a "SIM grant" in Oregon).[443]

b. Section 223 of the Protecting Access to Medicare Act: Certified Community Behavioral Health Centers

In March of 2014, Congress passed the Protecting Access to Medicare Act (H.R. 4302), which directed the Secretary of Health and Human Services to publish criteria for a state-certified community behavioral health clinic demonstration project.[444] The demonstration project concept was based on language from the Excellence in Behavioral Health Act, which has been introduced in the House of Representatives or the Senate in every Congress since 2009, but has yet to pass.[445] The Protecting Access to Medicare Act includes a

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436. *FAQ*, OR. CMTY. HEALTH WORKERS ASS'N, http://www.orchwa.org/resources/faq/ (last visited Mar. 7, 2020)

437. *Community Health Worker Professional Portfolio,* CMTY. CAPACITY CTR. (2014), http://www.orchwa.org/wp-content/uploads/2015/06/Assessment-Portfolio-FINAL.pdf.

438. *Id.*

439. *Id.*

440. *Id.*

441. *Id.*

442. *FAQ*, OR. CMTY. HEALTH WORKERS ASS'N *supra* note 436.

443. *Id.*

444. Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 223, 128 Stat. 1040, 1077-78.

445. Expand Excellence in Mental Health Act: S. 4038, 111th Cong. (2010); S. 2257, 112th Cong. (2012); H.R. 5989, 112th Cong. (2012); H.R. 1263, 113th Cong. (2013); S. 264, 113th Cong. (2013); H.R. 4569, 114th Cong. (2016); H.R. 4567, 114th Cong. (2016); S. 2525, 114th Cong. (2016).

mandate for "peer support and counselor services and family supports."[446] Implementation of the state-certified community behavioral health clinic demonstration project was a coordinated effort of several Department of Health and Human Services (HHS) agencies, including the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid Services, and the Office of the Assistant Secretary of Planning and Evaluation.[447] The objective of Section 223 is to "integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high-quality care."[448]

The demonstration project proceeded in two phases: in 2015, HHS awarded planning grants to 24 states and in December 2016 HHS selected eight of those states for the program, including Oregon.[449] The Oregon Health Authority interpreted the staffing requirement of Section 223[450] to be inclusive of CHWs, although various permutations of health care core staff were acceptable; a core staff could include a combination of licensed and certified professionals, including psychiatrists, social workers, licensed addiction counselors, and CHWs.[451] Training for core staff "must address cultural competence; person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care; and primary care/behavioral health integration."[452]

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446. Pub. L. No. 113–93, § 223, 128 Stat. 1077, 1079 (2014).

447. Press Release, U.S. Dep't Health & Human Servs., HHS Selects Eight States for New Demonstration Program to Improve Access to High Quality Behavioral Health Services (Dec. 21, 2016), (on file with author), https://wayback.archive-it.org/3926/20170128064335/https://www.hhs.gov/about/news/2016/12/21/hhs-selects-eight-states-new-demonstration-program-improve-access-high-quality-behavioral-health (Follow the link www.hhs.gov/about/news/2016/12/21/hhs-selects-eightstates-new-demonstration-program-improve-access-high-quality-behavioral-health and then from there, find the press release. Search "HHS Selects Eight States for New Demonstration Program to Improve Access to High Quality Behavioral Health Services" in the search bar on the webpage and the only result is the referenced press release. Follow the link. Once on this page, you must click on the second from the top January 27, 2017 which brings you to the release).

448. *About Section* 223, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/section-223/about (last visited Mar. 7, 2020); *see also* § 223, 128 Stat. at 1079 (stating "Care coordination.—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs.").

449. Press Release, *supra* note 447.

450. § 223, 128 Stat. at 1077-78 (stating "[s]taffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.").

451. OR. HEALTH AUTH., CRITERIA FOR THE DEMONSTRATION PROGRAM TO IMPROVE COMMUNITY MENTAL HEALTH CENTERS AND TO ESTABLISH CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS 12 (2015), https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

452. *Id.* at 13.

Altogether, there are fifteen organizations in Oregon that have become Certified Community Behavioral Health Centers (CCBHC).[453] Interestingly, even after the calls for increased CHW participation in integrated health care in the Behavioral Health Collaborative Report and the workforce provision of Section 223, only one of Oregon's CCBHC is reported by the Oregon Community Health Worker's Association to employ CHWs: Cascadia Behavioral Health in Portland.[454] A recent request for comment, however, suggests that CCBHCs, overall, were successful; the Oregon Health Authority is seeking to build upon the "more integrated and supportive behavioral health care" accomplished by CCBHCs during the demonstration period by submitting a State Plan Amendment to the Centers for Medicare & Medicaid Services.[455] If accepted, CCBHCs would become recognized Medicaid providers, and as such, would have a stable source of funding with which "to provide a comprehensive range of community-based mental health and substance use disorder services to vulnerable individuals."

CONCLUSION

The preceding set of state profiles was designed to identify ways in which the selected jurisdictions' decision-making in funding, training, certification, and support either reflect or ameliorate problems in behavioral health care delivery. More specifically, the profiles shed light on how such decisions, when augmented by federal and grass-roots forces, address the overall care coordination challenges endemic to our fragmented health care system,[456] as well as how such decisions addresses challenges unique to behavioral health care: namely, that poor mental health is exacerbated by poor physical health, poverty, and marginalization. In addition, stigma, cost, limited access to care, and the absence of culturally sensitive treatment are significant barriers to treatment.[457]

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453. *Map of Certified Community Behavioral Health Clinics Locations*, http://www.oregon.gov/oha/HPA/CSI-BHP/CCBHC%20Documents/CCBHC-Locations.pdf (last visited Mar. 7, 2020).

454. *Compare id.* (reflecting the CCBHC locations) *with CHW Programs in Oregon*, OR. CMTY. HEALTH WORKER ASS'N, http://www.orchwa.org/resources/chw-programs-in-oregon/ (last visited Mar. 7, 2020) (reflecting the organizations that employ or support CHWs in Oregon); *see also Community Support and Services*, Cascadia Whole Health Care, https://cascadiabhc.org/services/community-supports-services/
(last visited Mar. 7, 2020) (describing the services offered by Cascadia Behavioral Health in Portland).

455. *Public Notice*, Oregon Health Authority (2019),
https://www.oregon.gov/oha/HSD/OHP/Announcements/Request%20for%20comment%20-%20State%20Plan%20Amendment%20to%20add%20CCBHC%20Program.pdf.

456. THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 1, 3 (Einer Elhauge ed., 2010).

457. Kathleen Rowan, Donna D. McAlpine, & Lynn A. Blewett, *Access and Cost Barriers to Mental Health Care, by Insurance Status 1999-2010*, 32 HEALTH CARE 1723, 1724 (2013); David Mechanic, *Removing Barriers to Care Among Persons with Psychiatric Symptoms*, 21 HEALTH AFF. 137, 142 (2002);

The profiles demonstrate that behavioral health care coordination can, generally speaking, fall into one of three broad categories: top-down federal legislation and regulation, which incentivizes large-scale, comprehensive reforms (e.g., Section 1115 waiver programs, ACOs); top-down state legislation and other policy interventions, which tend to systematize and specialize through role-definition, often by developing certification programs and defining the scope of work; and bottom-up, grass-roots efforts, which tend to be more focused on the particular, immediate needs of individual patients and targeted communities.

We observed that the most successful states—those where CHWs have made great improvements in cost, quality, and access to behavioral health care— have followed one of two distinctive paths toward innovation. The first path involves a strong grassroots movement that has energized the health care community, prompting lawmakers to take notice and create new opportunities for federal, state, or nonprofit funding and support. The second route features the reverse,: top-down lawmaking that has laid a fertile substrate in which the CHW paraprofession grew.

Michigan is an example of the former path. The state has had a grassroots CHW presence at least since 1985, when the non-profit MHP Salud founded its Camp Health Aid Program to support migrant agricultural workers.[458] We hypothesize that the long history of CHW grassroots work in Michigan not only lent legitimacy to the field, but also placed CHWs at the ready to make use of innovative funding—such as the Pay for Success social impact bonds utilized by Strong Beginnings.[459] Strong Beginnings, where CHW participation in new mothers' behavioral health care has drastically reduced African American and Latinx infant mortality,[460] can be characterized as the result of positive feedback: CHWs become entrenched in the community, then began to coordinate with medical professionals, and then were poised to apply for and to make great use of new funding, which led to more CHWs on the ground engaging in behavioral health care.

A good example of the latter path is Minnesota's Hennepin Health Integrated Health Partnership.[461] The Minnesota legislature's creation of the Healthcare Education Industry Partnership in 1998 led to a cascade of accomplishments, beginning with the formation of the Minnesota Community Health Worker Project (MCHWP).[462] MCHWP united twenty-one health care

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Access to Care Ranking 2020, MENTAL HEALTH AM., https://www.mhanational.org/issues/mental-health-america-access-care-data (last visited Mar. 7, 2020).

458. *See The History of MHP Salud, supra* note 177.

459. *See supra* pp. 131-135.

460. *See supra* pp. 131135.

461. *See supra* pp. 141–143.

462. *See supra* pp. 141–143.

organizations to develop a state CHW program, which led to a defined scope of practice, followed by a standardized CHW certification curriculum in post-secondary institutions and the ability to reimburse CHW services through Medicaid.[463] Then, the passage of the Affordable Care Act incentivized the use of Accountable Care Organizations, leading to the creation of Hennepin Health—which, because of the strong CHW presence and tremendous CHW infrastructure already in place, incorporated CHWs into its health care delivery system to great success.[464] Among their many contributions, CHWs at Hennepin Health make notations in patients' electronic medical records, so that homelessness, poverty, unemployment, and excessive involvement in the criminal legal system are treated along with the patient's mental and physical ailments. This remarkable utilization of CHWs in behavioral health care can be traced to the positive-feedback-loop effects—funding, organization, training, and certification—spurred by the 1998 legislation.

In contrast, in Oregon we observed less CHW involvement in behavioral health care than we observed in sister states. This was surprising, because Oregon has a long legislative history, including the Oregon Health Plans and its state mental health parity act, which appeared to support CHW engagement in behavioral health care. We hypothesize four reasons for less CHW engagement. First, it is possible that key elements are missing from Oregon's health care ecosystem, or that existing elements are not balanced sufficiently to encourage the kind of innovation and engagement observed elsewhere. Second, it is also possible that less grassroots activity, coupled with an emphasis on state legislative solutions to the problems of health care cost, quality, and access, meant that the state was not as well equipped to make good use of the funding opportunities presented by the ACA. Third, the significant state legislative framework could have somehow stifled or disincentivized less formal means of encouraging the CHW paraprofession. Lastly, perhaps the state's legislation, while defining concisely the CHW role, has not sufficiently prescribed CHW integration into professional caregiving teams; in other words, paraprofessionals and professionals might understand the legislature's goal, but not know how to get there.

Looking Ahead

We are unable at this point to draw firm conclusions, but we are able to reject some hypotheses and identify some of the conditions that appear to encourage CHW engagement in behavioral health.

At the onset of this project we hypothesized that certification is a necessary condition for state Medicaid funding, and that reimbursement through Medicaid

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463. *See supra* pp. 141–143.

464. *See supra* pp. 141–143.

is a precondition of workforce stability. We also hypothesized that the attention of individual CHWs to upstream issues, such as community engagement and education, would be stifled, or at least diminished, as the CHW paraprofession became more "professionalized" through certification, uniform educational curriculums, and reliance on conventional, procedure-based funding mechanisms. Finally, we hypothesized that nonprofit funding, which we considered inherently unstable relative to federal and state funding, would be an indicator of operational instability. As the state profiles suggest, however, we found evidence in one or more of the jurisdictions that proved to be inconsistent with each of these hypotheses.

For example, CHWs in Minnesota are reimbursed through Medicaid for "self-management and training"; their services are billed and reimbursed as essentially fee-for-service procedures.[465] Nevertheless, we found abundant evidence of community engagement and education in Minnesota—and no evidence of stifling.[466] Additionally, New Mexico's strong *promotora* paraprofession flourished well before the development of a certification program.[467] In fact, CHWs need not be certified for Medicaid reimbursement of their services in New Mexico.[468] Our hypothesis regarding nonprofits was also proved wrong; Michigan's MHP Salud is a nonprofit with a vast history and broad reach.[469]

We instead conclude that funding, workforce, and operational stability come from interwoven applications of funding, training, certification, education, and community engagement at the federal, state, and local levels. Our overarching assessment is that CHWs are more successful and exist in greater numbers when many of these features are present. When some are missing, we find less CHW involvement in behavioral health care. These features for success include: the historical use of Section 1115 waivers; established ACOs, behavioral health homes and other innovative, indigenous health care institutions; interstate collaboration among CHWs; a historical grassroots tradition; federal grants such as the CMS Innovation Award; a strong nonprofit presence; many sources of funding—federal, state, academic, or nonprofit; state certification programs; a CHW educational curriculum; CHW services defined as procedures for billing purposes; a marked prioritization of integrative care, both in state law and in health care organizations; and strong CHW paraprofessional organizations. Further, we have found that when some of these factors are present, the ACA and other federal legislation is most impactful.

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465. *See supra* Section II.C.

466. *See supra* Section II.C.

467. *See supra* Section II.A.

468. *See supra* Section II.A.

469. *See supra* Section II.B.

While the best outcomes may require the presence of a critical mass of the conditions we have identified, some of these factors are worth replicating in virtually every state where CHW involvement in behavioral health care is a possibility, as they are likely to be successful in a wide variety of circumstances. For example, although our home state of Maryland lacks a CHW certification program, we are encouraged by New Mexico's development of a ready method for reimbursing CHW services through Medicaid sans state certification.

Further, some jurisdictions' approaches to behavioral health care are tremendously successful and may require little adaptation. For example, standout programming like Strong Beginnings, Hennepin Health Integrated Health Partnership, and Salud Para Todos could be replicated part-and-parcel in other jurisdictions.

Lastly, this research suggests a potentially broader application to other informal caregiving. Indeed, at the time of this writing, there is a marked need for a stable paraprofessional workforce in health care. Our hope is that other paraprofessionals—nursing assistants, home health aides, palliative care workers, and others—might enjoy greater operational stability through adoption of some of the features that have proved successful for CHWs. Thus it is also our hope that health care practitioner, paraprofessional, and lawmaker readers may find some utility in the above-detailed profiles. Instead of "remaking the wheel," successful practices from sister states may be borrowed and adapted to improve cost, quality, and access to paraprofessional care, in a great variety of circumstances.