Community Health Workers as Extenders of the Behavioral Health Workforce in Certified Community Behavioral Health

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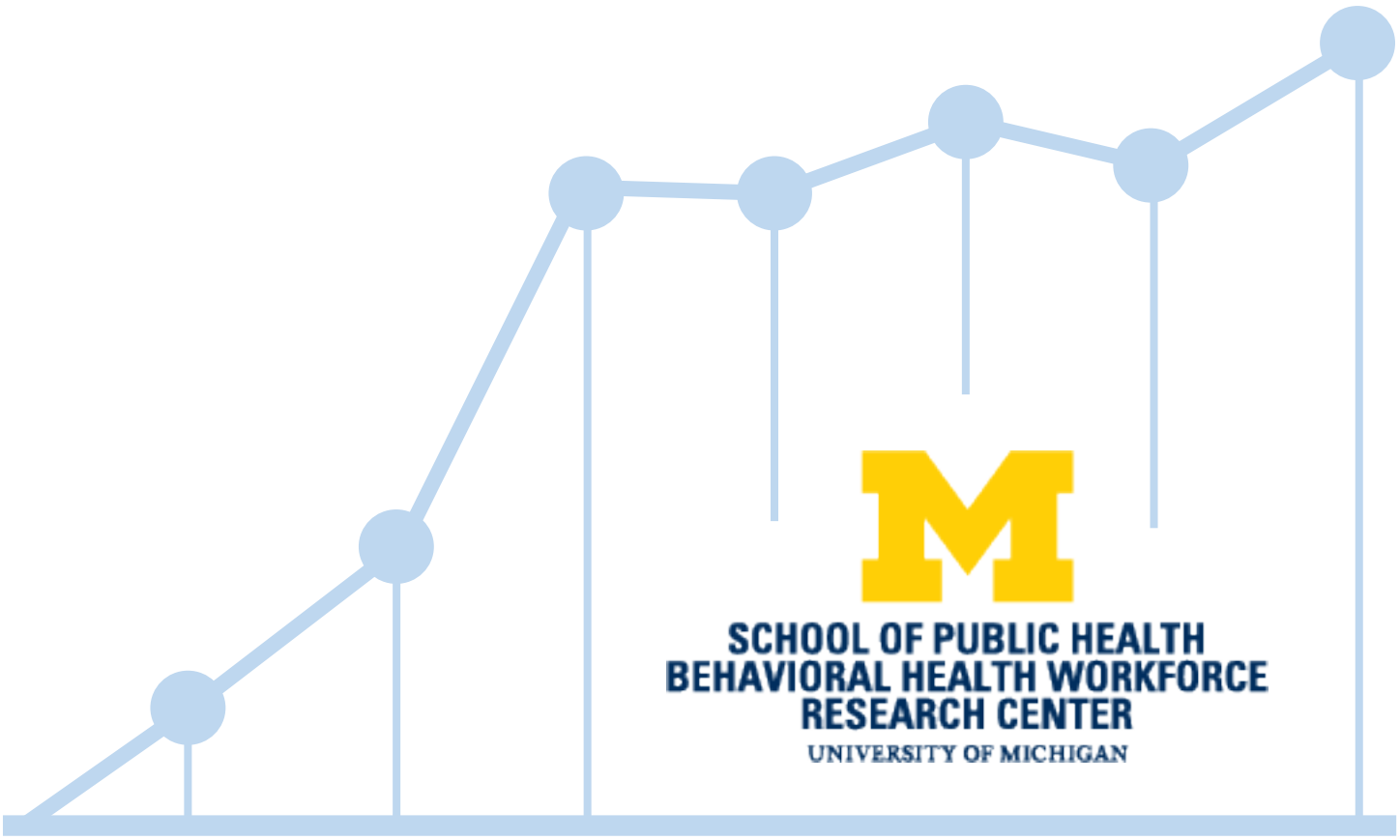

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Introduction

Community health workers (CHWs) are trusted frontline health workers who often live in or come from the communities they serve.[1] These community connections allow CHWs to provide support for hard-to-engage populations by liaising between patients and providers, in addition to advocating for patients' social needs. Prior studies emphasize the importance of this workforce in improving physical health outcomes and lowering healthcare costs for their patients, yet there is limited research on the roles CHWs fill in behavioral health care.[2,3] The increasing investment and implementation of the Certified Community Behavioral Health Clinic (CCBHC) model across the country presents opportunities to utilize CHWs to broaden behavioral health service availability. The aim of this qualitative study was to evaluate the extent to which CHWs are currently employed in the CCBHC setting, and the opportunities that exist to integrate CHWs into the CCBHC model.

Methods

A literature review (Appendix A) was conducted to summarize existing literature on CHWs in the CCBHC setting. The literature was very limited, so an annotated bibliography (Appendix B) of sources was created to supplement the literature review.

A semi-structured interview protocol (Appendix C) was created with variations for participants, depending on whether they were affiliated with a CCBHC, CHW, or state health department such as a Medicaid office. In addition to clinical directors and CCBHC staff, the pool of potential interviewees was expanded to include Medicaid and state offices, health policy organizations, as well as CHWs that work in other behavioral health settings. This expansion was necessary as we discovered that most interviewees from CCBHCs were unfamiliar with the roles of CHWs or were not currently employing any CHWs. The interview protocol was also modified to include additional questions about CCBHC staffing when we learned that CHWs generally are not currently being employed in this setting.

Data collection methods were varied, as interviews were conducted through Zoom video conferencing, phone calls, and asynchronous question-and-answer formats via e-mail. Participants were recruited largely through contacts in state offices, CHW organizations, and CCBHC websites and through "snowballing" to identify other participants through referrals from those interviewed. In addition to 12 interviews, one group discussion was conducted with representatives from four CCBHCs in one state who were interested in sharing feedback collectively.

The majority of interviews were audio recorded with permission from participants, and detailed notes were analyzed using inductive reasoning and thematic analysis to identify common ideas shared during interviews. Interviews were not transcribed verbatim, but notes were organized into specific thematic categories to demonstrate commonalities, as well as highlight unique challenges faced by individual states and CCBHCs. Additional research was also conducted into the health policies governing Medicaid reimbursement and CHW certification in each state.

This study (HUM00211132) was deemed "not regulated" by the University of Michigan IRBMED.

Findings

Prevalence of CHWs in CCBHCs

Through interviews with stakeholders in eight of the ten CCBHC demonstration states, the key finding from this study is that CHWs are not currently commonly employed in the CCBHC setting. In several interviews, CCBHC staff were unfamiliar with the term CHW, and were unclear about the roles and qualifications of this workforce. All CCBHC staff interviewed noted that the role of peer support workers, and at times, case managers or care coordinators, may serve some similar or overlapping functions to the

kinds of support CHWs would provide, but that none of their staff were certified CHWs. One CCBHC in Michigan reported that they did have one staff member with a CHW certification, but that individual was not employed as a CHW, or working in that capacity in their role at the CCBHC.

Broad Staffing Challenges in CCBHCs

Another main finding was that staffing shortages continue to be a challenge in CCBHCs. These shortages are not just for behavioral healthcare workers, but for all positions across the board, including environmental services and administrative or support staff. The coronavirus disease 2019 (COVID-19) pandemic exacerbated staffing shortages, and many CCBHC staff noted that they lost staff members for a number of reasons throughout the pandemic, including inability to offer competitive pay in the high-demand field, and many behavioral health providers leaving for jobs in the virtual or telehealth environment. Some noted that since their clinic became a CCBHC, they were able to offer more competitive pay to staff, but with the overall workforce shortages, they are still often unable to compete with the private sector or other more lucrative job opportunities for behavioral health service providers.

Additionally, the acceleration toward telehealth and virtual care delivery in behavioral health during the pandemic created new remote job opportunities for direct care staff, and some individuals opted to stay remote or find positions that would allow them more remote work flexibility. CCBHC staff acknowledged that working in the CCBHC environment can be particularly challenging. Interviewees from a Nevada CCBHC stated that they have lost staff to other industries. In particular, with the large number of hospitality jobs available locally in Las Vegas, individuals can choose their work environment with more flexibility, and oftentimes those jobs offer comparable pay and may be less demanding.

Telehealth

The CCBHC staff acknowledged that the rise in the delivery of services through telehealth has created new remote job opportunities for behavioral health providers, making some view the in-person or hybrid clinic setting of CCBHCs less appealing. However, many highlighted positive aspects of the increased use of telehealth as well. Many CCBHCs reported that telehealth has given them opportunities to connect in new ways with patients. In addition, one CCBHC in Kentucky reported much lower numbers of missed appointments/“no shows” (as low as 8%) than they typically would experience, and they considered the fast pivot to telehealth a win in this regard. A CCBHC in New York noted that telehealth helped them expand their reach, especially for populations like mothers with young children who would otherwise require childcare to attend in-person visits. This CCBHC noted they have seen more patients who identify as women since opening up to more telehealth services, and they plan to keep this option available for individuals with childcare or transportation challenges.

Additionally, as CCBHCs deliver more telehealth services, interviewees noted that Internet connectivity is a challenge for many people living in rural environments. They also shared that some CCBHCs have found creative solutions to remedy this issue. One CCBHC in Kentucky, predominantly serving a rural population, put free WIFI in their parking lot so community members who had transportation and devices but poor Internet connectivity could come to the clinic parking lot and work on their laptops/tablets or utilize telehealth from their vehicles.

Underemployment or Role Dissatisfaction of CHWs in Behavioral Health Settings

Although our data do not show that CHWs are being employed in CCBHCs, one CHW who is employed in a behavioral health home in Minnesota not designated as a CCBHC was interviewed to provide insight on CHW roles within behavioral health more broadly. Their primary role as a CHW in a behavioral health home is to assist patients with managing their chronic illnesses, and to help patients at their medical appointments understand the right questions to ask and identify ways to advocate for their needs. This CHW noted that because they work in a state with direct reimbursement of CHW services through Medicaid,

they can be reimbursed for services such as health education or care coordination, so long as those services are ordered by an overseeing healthcare provider.

This CHW reported that they do not have any colleagues working in the CCBHC setting, but that they would expect that the role of a CHW would likely be similar in that setting to one in a behavioral health home. This CHW noted that patients with behavioral health diagnoses often have their physical health needs overlooked or downplayed vis-a-vis managing their behavioral health needs, and CHWs can assist patients in finding a balance to manage their health more holistically.

This CHW noted that while they have personally found satisfaction in their work in the behavioral health home setting, this is not always the case for many CHWs. CHWs are often "underemployed" or underutilized and are not allowed to work at the top of their scope of practice. This is often the result of a lack of understanding on the part of administrators and other providers about what CHWs are trained to do and what roles they are qualified to perform. CHWs are often asked to perform administrative tasks, such as calling patients for appointment reminders, rather than being utilized to their full capacity, such as delivering health education or working to connect clients with resources in the community resources or assisting individuals with adhering to their care plans. The CHW role is extremely varied, and owing to the general lack of familiarity with their role, education, and potential for improving health outcomes, CHWs often find that they need to educate providers about their capabilities so that they can work to their greatest potential. This CHW noted that many individuals in this profession have high burnout rates, and the lack of education about their role leads to lower job satisfaction when they find themselves underutilized.

CCBHC Staffing Requirements and the CHW Role

Interviewees from CCBHCs shared concerns about whether CHWs would fit into current CCBHC staffing requirements, and whether CHWs would be recognized as eligible providers. Although there are staffing shortages, and most CCBHCs would be happy to have a larger pool of eligible candidates for filling open positions at their clinics, CCBHCs have minimum education requirements for staffing and CHW certifications are not specifically mentioned in those requirements. Many CHW certification programs require a bachelor's degree in a health-related field,[4] which is the minimum educational prerequisite for most CCBHC positions, but CHW certification is not necessarily a staffing requirement. CCBHCs are required to place a focus on hiring peer support workers with lived experience, but the staffing provisions do not currently mention or encourage the hiring of CHWs specifically, and the important factors in hiring are currently that individuals meet these other educational and experience-based criteria. As CHWs are not a specified role within the CCBHC workflow, having staff members with a CHW certification may be a "bonus," but not a requirement of a CCBHC at this time. Interviewees reported that CCBHCs have large administrative burdens as well as data and reporting requirements, so CHWs would need to fit into current workflows and job descriptions to fit the specific services that CCBHCs are required to provide.

Within the required services, CCBHC staff shared that they did see a potential role for CHWs, particularly within the realms of health education and care coordination. Interviewees from CCBHCs in Kentucky mentioned that smoking cessation and weight management are two frequent health needs they address with patients in their clinics, and CHWs could have the perfect skillset to review health education modules with these individuals and may be able to conduct patient follow up services more frequently than other health providers working with those patients. Interviewees who were unfamiliar with CHWs expressed interest in the position, and after learning more about their qualifications, stated that this workforce could likely help with many integrated care components, particularly in warm handoffs to other care providers, following up with patients about their care plans, and connecting patients with complex care or social needs to services in the community, such as food banks, community centers, and other programs.

Additionally, interviewees raised questions about the specific training CHWs receive about behavioral health. CHW trainings differ from state to state, and although interviewees in Kentucky and Minnesota mentioned that a behavioral or mental health module is included in the training for a CHW, this

may not be the case in every CHW certification program.

Reimbursement

A major concern of interviewees from CCBHCs and state departments was whether CHWs on staff would be eligible for reimbursement. Not all of the demonstration states have enabling legislation in place allowing for the reimbursement of CHWs through Medicaid, and the process for integrating CHWs into the CCBHC setting would be different in each state. Of the ten demonstration states, Michigan, Minnesota, Oregon, and most recently, Kentucky, allow for the reimbursement of CHWs directly through Medicaid. Nevada, New Jersey, and Pennsylvania do not have a direct path to reimbursement for CHWs through Medicaid, but Managed Care Organizations reimburse for CHW services or hire CHWs directly. The remaining demonstration states—New York, Oklahoma, and Missouri—do not currently reimburse CHWs through Medicaid.

Without the ability for CHWs to bill services to Medicaid, interviewees from CCBHCs expressed concern about whether clinics would be able to employ CHWs, particularly as they noted that care coordination is a required but non-billable service generally covered by the enhanced Medicaid reimbursement rate they receive. They questioned if they were to hire CHWs, would they be providing billable services or would CHWs be eligible providers for reimbursement? If CHWs are not providing billable services, or if they are not considered eligible providers for reimbursement in their state, hiring them would become costly to a clinic.

Discussion

The evidence base is building that CHWs have a positive impact on health outcomes and are cost saving to healthcare systems. A study published in 2014 found that after adding CHWs to a patient-centered medical home in the South Bronx, New York, hospitalizations dropped by 12.6% among patients with diabetes and other chronic health conditions. The study found that adding CHWs to the care team also reduced costs, with the hospital saving $2.30 for every $1 it invested in a CHW.[5] A randomized clinical trial analyzing the IMPaCT intervention, a standardized CHW program that addresses socioeconomic and behavioral barriers to health in low-income populations, showed that patients who received CHW services using this approach had a 30% relative reduction in hospitalizations in the first year (versus the control group) and the Medicaid savings divided by the program expenses demonstrated a return of $2.47 for every dollar invested in this CHW program.[6]

Given that studies are demonstrating the value added by CHWs, our finding that CHWs are generally not currently employed in the CCBHC setting was somewhat surprising. As the CCBHC demonstration started in 2017, these clinics are a relatively new model for integrated care and despite their enhanced reimbursement rates, they experience staffing shortages like many other sectors of health care that deliver behavioral health services.

CHWs could be a relatively low cost and effective way to extend the behavioral health workforce, opening up a whole new pool of eligible candidates for employment in certain roles. However, there are several barriers to integrating this workforce into CCBHCs. The current barriers to hiring appear to be primarily focused on awareness of CHWs and their skills, specific staffing requirements regarding certain educational qualifications, and issues about whether clinics can be reimbursed for CHW services.

Within the field of behavioral health, it will be important to educate and build awareness among clinic directors and other providers about the CHW workforce as a whole, and about their particular qualifications that could benefit those served by CCBHCs. Integrated care clinics and CCBHCs in particular have seen a significant increase in investment in recent years, potentially offering real opportunities to increase the employment of CHWs in integrated care.

Although interviewees raised pertinent questions about the level of specific behavioral health training

CHWs typically receive, the variation across CHW training programs can be considered a strength, as this variety may allow individuals to be trained in ways that are culturally responsive and best suited to their respective communities. Clinics seeking standardization of training may take advantage of the Health Resources and Services Administration's recent (April 2022) announcement of a new training program for eligible applicants in all states.[7] This may serve to be a path to standardized training if staffing requirements for the federal demonstration require consistency in CHW certification.

Consideration of the role for CHWs in CCBHCs is a timely issue with current policy implications: many states are currently considering (or have recently passed) state-regulated CHW certifications or legislation to allow for the reimbursement of CHW services through Medicaid. Kentucky passed enabling legislation just 2 months prior to our interview in 2022 and may be further along than most states in considering what settings are most appropriate for CHWs. Our interviewees from Kentucky said that the question posed by this research about whether CHWs are providing services in CCBHCs provided them an opportunity to jointly consider the best approaches to utilizing CHWs along with their state Medicaid office, as well as their Department for Behavioral Health, Developmental and Intellectual Disabilities. Our questions elicited a discussion that allowed them to share experiences between clinics and to communicate about the roles CHWs may be able to fill in integrated care settings. This may also allow the Kentucky Medicaid office to work more collaboratively with the service providers about reimbursement options. Increasing communication and sharing information more broadly about the potential roles of CHWs in CCBHCs may help to fill gaps in the behavioral health workforce.

Conclusion

Although CHWs are generally not currently being employed in CCBHCs, expanding funding structures and assessing CCBHC staffing requirements, including education levels, could create a path toward expanding the eligible workforce and help provide required CCBHC services. Expanding awareness about CHWs and their capabilities will also be important as systems focus on reimbursement and education requirements. Integrating CHWs into CCBHC workflows would not be a uniform process across all CCBHC demonstration states given differing Medicaid policies and CHW certification processes but could have a significant positive impact given staffing shortages in behavioral health.

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Additional Resources

Medicaid Coverage of Community Health Worker Services. https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf.

State Certification Programs - RHIhub Community Health Workers Toolkit. www.ruralhealthinfo.org. https://www.ruralhealthinfo.org/toolkits/community-health-workers/4/training/certification.

State Community Health Worker Models – The National Academy for State Health Policy. https://www.nashp.org/state-community-health-worker-models/.

Health Resources and Services Administration. HRSA. https://www.hrsa.gov/grants/find-funding/HRSA-22-124?A+Session+about+the+Community+Health+Worker+Training+Pr=&utm_campaign=TODAY%3A+Q&utm_medium=email&utm_source=govdelivery.

Appendix A

Community health workers (CHWs) are professionals who work closely with their community to increase access to healthcare services, provide health education, and improve cultural competency of care, among other functions.[1] They are typically lay members of the community in which they serve, and they act as links between healthcare services and community members.[2]

CHWs have had success in helping patients manage chronic diseases while reducing hospitalizations and emergency room visits.[3] Interventions in which CHWs provide support to low-income populations in the U.S. have been effective in controlling hypertension and reducing cardiovascular disease risk.4 CHWs are also effective in helping community members manage diabetes, adhere to medications such as antiretroviral therapy, and receive recommended cancer screenings.[4]

CHWs can play a variety of roles in behavioral health, though research in this area is limited.[5]

In a systematic review, mental health interventions performed by CHWs were found to be effective, feasible, and acceptable to clients.[5] Another review identified 18 effective mental health interventions involving CHWs, though evidence-based treatments for mental health involving CHWs were more common in low- and middle-income countries than in the U.S.[6] In general, behavioral health interventions involving CHWs have been more commonly tested in low- and middle-income countries.[6,7]

Certified Community Behavioral Health Clinics (CCBHCs) were established through Section 223 of the Protecting Access to Medicare Act of 2014 with the goal of increasing access to quality behavioral health services.[8] Eight states were selected in 2016 to participate in the demonstration program.[8] In 2020, the demonstration was expanded through provisions made by the Coronavirus Aid, Relief, and Economic Security (CARES) Act to include two more states, Kentucky and Michigan.[8] These demonstration clinics are required to provide coordinated care and nine types of services, including crisis behavioral health services and outpatient mental health or substance use disorder services.[9] CCBHCs can also work with Designated Collaborating Organizations in order to provide these services.[9] These clinics utilize a prospective payment system.[9] This model allows CCBHCs to receive reimbursement based on their anticipated costs of providing services.[9]

Little is known about how CCBHCs use CHWs to provide their services. CCBHCs are required to offer peer support services, but not CHW services, though both types of workers are considered paraprofessionals in behavioral health.[9] Before CCBHC certification, 27% of CCBHCs employed CHWs.[9] In March 2018, the first year of the demonstration, 40% of CCBHCs employed CHWs.[9] As of March 2019, 35% of CCBHCs employed CHWs.[9]

In a 2019 survey of CCBHCs, 72% reported employing outreach workers to work with populations such as those who are homeless or those at risk for suicide who have dropped out of services.[10] Ninety-seven percent of CCBHCs reported serving homeless populations.[10] Based on this data, CHWs may be able to play a key role in CCBHCs by helping to retain patients in need of behavioral health services.

As CHWs have been effective in increasing access to primary care, they could act in an outreach capacity to increase awareness of available mental health services at CCBHCs and decrease stigma related to receiving these services.[11] In substance use disorder services, CHWs could potentially work alongside peer support workers to help retain clients who are in treatment.

The role of CHWs is compatible with the goals of CCBHCs to improve coordination of care and reach vulnerable populations.[12] The prospective payment model used in the CCBHC program allows CCBHCs to perform more community outreach and engagement services, which could be accomplished through hiring more CHWs.[13] Because CHWs are often effective in working with low-income populations, they could be well suited to the populations served by CCBHCs.[14] However, further research is still needed to determine the effectiveness of CHWs in behavioral health in the U.S.

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Appendix B

1. **Boldt RC, Chung ET. Community health workers and behavioral health care. *J Health Care Law Policy*. 2020;23(1):1-65. https://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1387&context=jhclp.**

This article discusses the role of CHWs in behavioral health care and how five states have implemented them into the behavioral health workforce. The authors first provide an overview of CHWs in behavioral health, including implementation issues and other barriers.

The second part of this article contains profiles of five different states (New Mexico, Michigan, Minnesota, Texas, and Oregon) that are trying to expand the role of CHWs into behavioral health care. The profiles give an overview of regulations, funding, training, and certifying bodies related to CHWs in each state. Of particular interest is the profile of Oregon, which is a CCBHC demonstration state. In 2016, the Oregon Health Authority created the Behavioral Health Collaborative, which called for increased utilization of CHWs. Despite this, although there are 15 CCBHCs in Oregon, only one of these, Cascadia Behavioral Health, is known to employ CHWs. None of the other state profiles discuss CCBHCs and CHWs. The authors conclude that in order to involve CHWs in behavioral health care, there needs to be funding, training, certification, education, and community engagement at all three levels of government.

2. **Mathematica Policy Research, RAND Corporation. *Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2019.* Office of the Assistant Secretary for Planning and Evaluation; 2020. https://aspe.hhs.gov/reports/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2019-0.**

This report summarizes the activities and costs of CCBHCs in 2019 using survey data and qualitative data from interviews at the state level. The authors describe the CCBHC demonstration and its goals. Eight states were selected by the U.S. Department of Health and Human Services in 2016 to participate in the CCBHC demonstration. CCBHCs within each demonstration state are required to provide coordinated care as well as collect and report on a wide variety of data.

Main findings of the report include that most CCBHCs hired more staff as part of the certification process and most have expanded the scope of their services, including by adding evidence-based practices. The CCBHCs did show sustained delivery of the nine core CCBHC services.

Only one finding in this report mentioned CHWs. Before CCBHC certification, 27% of CCBHCs employed CHWs. In March 2018 (demonstration year 1), 40% of CCBHCs employed CHWs. In March 2019 (demonstration year 2), this proportion dropped to 35%. The authors did not consider this a significant difference. They discussed how staffing changes over the years may be due to CCBHCs trying to use staff most efficiently.

3. **Michigan Department of Health and Human Services. *Michigan Certified Community Behavioral Health Center Project Narrative.* Michigan Department of Health and Human Services; 2015.https://www.michigan.gov/documents/mdch/MI-CCBHC_Project_Narrative__8-4-15_499119_7.pdf.**

This document is a project narrative from the Michigan Department of Health and Human Services (MDHHS) describing the planning process of CCBHCs in Michigan. The authors describe how behavioral health care is currently organized in Michigan and how CCBHCs will be able to meet behavioral health care needs.

In a section titled “Workforce Diversity,” the report mentions how MDHHS supports using CHWs in managed health plans. The authors do not specifically discuss utilizing CHWs as a part of CCHBCs.

Appendix C: Draft Interview Guides

Draft Interview Guide for CCBHCs

1. Has staffing been a challenge over the last 3 years at your CCBHC?
    a. What types of qualified staff have been a challenge to find/hire? (BH specialists, peer supports, MSWs, psychologists, other BH professionals/what credentials)?
2. Does [CCBHC] currently employ certified community health workers (CHWs)?

    If so:

    a. Approximately what percent of clients work with CHWs?
    b. Which client populations primarily work with CHWs? (Individuals with SMI, with mild/moderate behavioral health issues, with SUD, other?)
    c. Which services do CHWs provide?

    If not:

    a. Have you considered hiring CHWs? What were the barriers to hiring?
    b. Do you see opportunities for employing CHWs?
    c. Which populations might benefit most if CHWs were employed?
3. Are CHW services reimbursed by Medicaid in your state? Suggestion: (Now that enabling legislation has been passed to reimburse CHWs for services through Medicaid in KY, how do you think CHWs could be integrated into the behavioral health setting? What kinds of roles could CHWs play in CCBHCs?
4. If CHWs are not employed at CCBHCs in your state, do you have a support worker that provides similar support services to clients? (ex: peer support, workers who share the same background as your clients, or workers who go to clients' homes, or help them connect with resources for their social needs).
5. If you were able to hire CHWs, what might the overall impact be on CCBHCs? (e.g., what populations would benefit, reduced demand on behavioral health specialists, ability to increase caseloads for BH specialists, greater reach, ability to serve a greater number of clients, higher quality care, improved health outcomes)
6. Describe a "success" as a CCBHC. (any particular program, staff, or community impact?)
7. Is there anything we have discussed today that you would like to expand on/anything else you would like to add?

Draft Interview Guide for CHWs

1. What types of settings do CHWs primarily work in in your state?
    a. What populations do they primarily serve?
2. Do CHWs in your state work in the behavioral health setting? (mental health, substance use disorder support, within CMHs, or CCBHCs)

    If yes,

    a. What roles and services do they perform?
    b. What populations do they primarily work with?

If no,

   a. What has been the barrier to working in this space?
   b. Have CHWs tried to work in these settings (to your knowledge)?
   c. Have CHWs previously worked in behavioral health? In CCBHCs specifically?

3. Are CHW services currently reimbursed by Medicaid in your state?
4. Some behavioral health workers are unfamiliar with the roles and services that CHWs provide – why do you believe that is?
5. What impact do you believe employing CHWs would have on behavioral health clinics like CCBHCs? (e.g., what populations would benefit, reduced demand on behavioral health specialists, ability to increase caseloads for BH specialists, greater reach, ability to serve a greater number of clients, higher quality care, improved health outcomes)
6. What are some of the biggest challenges CHWs are currently facing in your state?
7. Describe a "success" in your organization.
8. Is there anything else I haven't mentioned during our conversation today that you'd like to include or expand on?