SIDEBAR

Community Health Worker Prevention Services: COVID-19 and Beyond

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Community health workers (CHWs) are frontline public health workers with "an unusually close understanding of the community served" [1]. This allows CHWs to connect community members with needed services and improve cultural competence of those services. According to the American Public Health Association, CHWs also build "individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy" [1].

To individuals who do not operate in the discipline of public health, the work of CHWs in North Carolina may seem to be a new phenomenon; however, a pandemic and funding merely activated and compensated community-based organizations (CBOs) and the CHW workforce that was already poised to be called to action. Members of the North Carolina Department of Health and Human Services (NCDHHS) Community Health Worker Initiative began meeting regularly in December 2015 and formed workgroups to determine key roles and responsibilities of CHWs, identify core competencies and recommend a training curriculum, and develop the requirements and process for the certification of CHWs [2]. The context of the historic work to bolster the gainful employment of CHWs in North Carolina is invaluable. It laid the foundation for the ability to deploy the workforce with agility under the pressures and complexities of a pandemic.

The Effectiveness of Community Health Workers in COVID-19 Response Support

Upon the onset of the COVID-19 pandemic, the CHW Initiative utilized its care resource coordination model, which includes 435 CHWs working with seven vendors in 55 counties, to promote safe quarantine and isolatioon practices among historically marginalized populations across the state. At the same time, the NCDHHS Support Services Program (SSP) delivered direct supports through four vendors in 29 of the 55 CHW counties. The technology platform used by CHWs to connect individuals to resources is NCCARE360. The top three service needs identified were: food assistance (34%), financial relief (29%), and housing and shelter (10%) [3]. By March 2021, the CHW program had served over 385,000 individuals and made 121,000 referrals to short- and long-term resource supports, and the SSP delivered over 171,000 services, including food assistance, PPE, cleaning supplies, and financial relief, to 38,000 households [3]. Of 236 SSP recipients surveyed by Partners in Health, 88% reported that they were able to fully quarantine and isolate [3].

Economic Ecosystem Impact

The funding of CHW initiatives has had a tremendous impact on the infrastructure of service delivery and on the personal economics of the growing CHW workforce and the communities its members serve. North Carolina's CHW COVID-19 program utilized $14.7 million in federal Coronavirus Aid, Relief, and Economic Security (CARES) Act funding from August through December 2020 to hire and manage workers in targeted counties (with an additional $16 million in state/ Centers for Disease Control and Prevention [CDC] funding allocated for January–June 2021) [3].

My organization, the Asheville Buncombe Institute of Parity Achievement (ABIPA), is a practical example of the

economic impact on CBOs and the CHWs they employ. ABIPA employed two contracted CHWs on a part-time basis prior to the pandemic. Grant funding to support COVID-19 relief efforts allowed us to bring CHWs we had employed since 2013 up to full-time employment at the rate of $20 per hour and hire an additional full-time CHW to expand our reach into Rutherford County. This infusion of resources into a small organization, which in turn employs community members to support the health of their neighbors while circulating their wages back into their community, is an economic ecosystem at work.

Emerging Support for Continued Funding

National support is being scaled up for CHWs who provide support to high-risk populations and communities hit hardest by COVID-19. On March 25, 2021, the CDC announced plans to provide $332 million to 75 organizations for CHW services to support COVID-19 prevention and control, training, technical assistance, and evaluation, using funding from the CARES Act [4]. The funding is meant to focus on disparities in access to COVID-19 testing, contact tracing, and vaccines among historically marginalized populations; address factors that increase risk of serious illness from COVID-19, such as social drivers of health like chronic disease; and meet community needs exacerbated by the pandemic, such as mental health care access and food insecurity [4].

On July 30, 2021, NCDHHS announced an expansion of its COVID-19 CHW program through eight vendors [5]. The initiative will run through at least June 2022, and will focus on vaccination efforts. CHWs in this program will receive tablets or laptops with mobile hotspots so they can use NCCARE360 to connect people across the state with non-medical services such as food and transportation. While this is encouraging, there is a concern within small CBOs that the CHW industry could be permanently commercialized by organizations with little to no community understanding.

Community Health Worker Preventive Services: COVID-19 and Beyond

The current health disparities illuminated by the pandemic have fast-tracked efforts to elevate the use of CHWs as a part of the community health care team. The impact of CHW deployment over the last year has strengthened connections between community members and the resources and health education they need. This experience has also strengthened the case for reimbursement of CHW services through Medicaid and private insurance.

Demonstrating positive return on investment (ROI) for chronic conditions has enormous implications for health care organizations because the most common health challenges are often the costliest [6]. CHW program ROI evaluation conducted by MHP Salud, a nonprofit that implements CHW programs in Latinx communities, contributes to a growing body of evidence that investments in these programs are both impactful and financially sustainable [7]. It is their stance that ROI results provide a great "snapshot of information to share with both stakeholders and the community, to demonstrate both social and fiscal responsibility" [7].

A cancer prevention program reviewed by MHP Salud demonstrated ROI of $3.16 for every $1 spent; a diabetes management program demonstrated ROI of $1.09 for every $1 spent [7]. A 2020 analysis of a randomized control trial of a CHW intervention, published in *Health Affairs*, reported an expected return of $2.47 to the average Medicaid payer for every dollar invested in the program within the fiscal year [8]. These outcomes demonstrate both positive ROI for the individuals experiencing better outcomes and cost savings for systems providing supportive services.

On January 1, 2014, the Centers for Medicare and Medicaid Services (CMS) created a new rule that allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner [9]. The new rule for the first time offered state Medicaid agencies the option to reimburse for more community-based preventive services, including those of CHWs [9].

This rule was pivotal in officially providing a new opportunity to recognize and advance the role of CHWs. Now, in the midst of a pandemic, the scope of work and value of the CHW are powerful tools for fostering success. As our state continues to recover from the pandemic and we look to the future, we must sustain the support of CHWs as a part of health care workforce development; it is vital that we solidify the systems supports that ensure financial and technical sustainability for CHWs. CBOs that have historically used the CHW model need to be afforded intentional infrastructure investments to house and bill for the work independently and ensure that the nuances of the work are not overshadowed by commercial expansion. CHWs have a gift of natural service and connection that is uniquely theirs and imbedded in their DNA. Many have, and would, do the work for free. These are the individuals who should be recruited, retained, and rewarded for their service with significant salaries, because the return on investment provided to and by CHWs is invaluable. NCMJ

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