and advocating for our patients' basic needs, health professionals can confront stigma and support the expansion of harm-reduction approaches in several ways.

At the local level, clinicians can partner with people who inject drugs, listen to their experiences, and engage stakeholders — including mayors, police, and faith leaders — to offer education about harm reduction and address concerns. At the state level, they can advocate for laws that authorize comprehensive syringe-exchange programs, decriminalize possession of syringes and residual substances, and guarantee access to over-the-counter syringes without a prescription. At the national level, clinicians can encourage their elected representatives to support harm reduction as a core component of the country's public health strategy. Just as Surgeon General Jerome Adams called for more people to carry naloxone, he could call on state leaders to ensure that syringe-exchange programs and opioid-substitution therapy are available in all counties nationwide.

Finally, once these programs are authorized, clinicians can establish direct connections between syringe-exchange programs and health systems to ensure that people with addiction receive the care they need and are treated with dignity.

Four years after the United States received a wake-up call about the importance of harm reduction, the most vulnerable areas of the country remain asleep. Despite the federal government's goal of ending the HIV epidemic in the United States, it's not clear that it will do what is necessary to address the spread of HIV and HCV in rural America. Health professionals can advocate for legal changes that authorize syringe-exchange programs and other lifesaving interventions.

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Realizing the Value of Community Health Workers — New Opportunities for Sustainable Financing

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Community health workers (CHWs) can play an important role in improving the quality and value of health care. As trained frontline health workers who are trusted members of — or closely connected to — the population they serve, CHWs generally share a culture, language, and community with their clients. They help address underlying inequities in health care access and quality by participating in culturally congruent interventions, including outreach, advocacy, education, counseling, and linkages to social services. Until recently, CHW programs had largely been funded by time-limited grants. In the past few years, however, new public policies and an increasing recognition of the role of social determinants of health have led to innovative reimbursement strategies that could help realize the value of CHWs and sustain their work.

CHW-led interventions have been shown to be both effective and cost-effective for managing certain chronic health conditions among vulnerable populations.[1] According to a 2014 report from the Centers for Disease Control and Prevention, many components of CHW programs are supported by strong evidence (see box).[2] Although not all programs have been successful, a growing body of evidence points to the elements that are necessary for such programs to improve health care utilization and outcomes. These elements include careful recruitment of CHWs, training based

on core competencies and follow-up training in evidence-based approaches targeted to the population served, ongoing supervision and support, clear definition of CHWs' roles, integration of CHWs into health care teams, balancing of support for CHWs' autonomy with fidelity to an evidence-based model of care, and sustained outreach to patients and community members outside clinical settings. Perhaps the most crucial components of CHW interventions are the shared experiences of CHWs and their clients, which help reduce social distance and generate trust. Decades of scholarship have emphasized the need to preserve CHWs' role in building community capacity and maintaining deep connections to the people they serve.[3]

One barrier to sustainably financing CHW programs has been the absence of billing codes to support the work of CHWs in a predominantly fee-for-service environment. This gap has been attributed to the lack of sufficient evidence regarding the effectiveness and cost-effectiveness of CHW programs under a broad enough range of conditions. Despite the compelling evidence from grant-funded studies that CHW programs are effective, establishing the ongoing training and supervision necessary to sustain such programs requires planning, flexibility, and creativity — as well as time and money. Without sustainable financing, many organizations don't consider it feasible to invest in such initiatives. Given the stronger incentive to develop and test evidence-based CHW interventions when long-term funding is available,[4] sustainable financing of such programs could accelerate the pace of innovation without compromising quality by laying a foundation for rigorously evaluated demonstration projects. As the U.S. health care system moves toward payment structures that feature risk sharing, value-based purchasing, and models such as accountable care organizations, several new opportunities for financing CHW programs have emerged that could facilitate integration of such programs and support research to determine the circumstances under which they are most effective.

Evidence Supporting Various Components of CHW Programs.*

Policy components with "best" quality evidence
Provision of services for chronic disease care
Inclusion in team-based care models
Certification based on core competencies
Supervision by health care professionals
Standardization of core curriculum
Reimbursement for services by Medicaid
Certification to establish standards for specialty areas
Inclusion of CHWs in development of certification requirements

Policy components with "promising" (P) or "emerging" (E) evidence
Standardization of specialty-area curriculum (P)
Defined scope of practice (P)
Inclusion of CHWs in development of curriculum (P)
Coverage and reimbursement for services by private insurers (E)
Educational campaign about CHW services (E)
Availability of grants or incentives to support CHW workforce (E)

* CHW denotes community health workers. Adapted from the Centers for Disease Control and Prevention.[2]

First, the 2018 CHRONIC (Creating High-Quality Results and Outcomes Necessary to Improve Chronic) Care Act allows Medicare Advantage plans to offer nonmedical benefits that could improve the well-being of chronically ill enrollees. This law provides new opportunities for plans to cover CHW services aimed at addressing the social determinants of health and serving as a bridge to medical teams.

Second, some states have introduced requirements that Medicaid managed care organizations (MCOs) deploy CHWs to help engage certain enrollees in care. For example, under Michigan's Medicaid contract, Medicaid MCOs are required to provide or arrange for CHW services for enrollees with behavioral health problems and complex coexisting physical conditions. New Mexico's Medicaid program has leveraged contracts with Medicaid MCOs to support the work of CHWs who serve enrollees. CHW salaries and training and service costs are embedded in capitated rates paid to Medicaid MCOs in that state.

Third, in 2016, the Centers for Medicare and Medicaid Services (CMS) updated its Medicaid managed care rules to facilitate access to high-value nonmedical interventions. The updated rules designate such interventions as covered services for the purposes of calculating capitated rates, which therefore provides an incentive for Medicaid MCOs to pay for services aimed at addressing social determinants of health such as transportation options and access to food. When integrated into health care teams, CHWs are a natural addition to the capitated or bundled-payment structures that are being implemented in many Medicaid programs throughout the country,

under which team-based care is especially important. Since Medicare and Medicaid account for nearly 40% of U.S. health care spending, establishing mechanisms for CHW financing in these programs is a key starting point.

Although value-based payment systems better support CHW financing and integration, fee-for-service payment is still a dominant force in U.S. health care and will probably remain so for some time. It will therefore be essential to establish billing codes for financing the work of CHWs in fee-for-service environments and allow all payers to reimburse CHW activities as they do other extender services that are "incident to" physician services. However, several important concerns regarding reimbursement of CHWs under fee-for-service structures would have to be addressed.

Fee-for-service reimbursement for CHW activities would be flawed in the same way it is flawed for all health care services: it would reward volume over value. Oversight, monitoring, and clear benchmarks for evaluating effectiveness would be essential to ensuring that CHW-led interventions follow best practices and contribute to desired outcomes. Reimbursement rates for CHW activities would also have to be high enough to cover the costs associated with work in the community, such as travel expenses for home visits and the cost of time spent developing trust and providing ongoing social support. Finally, many states are working toward a model in which CHWs can bill for their time only if they have completed licensure or certification programs. Such programs are excellent ways of ensuring quality and providing a career path for CHWs, but we believe that certification programs should not have rigid educational prerequisites for participation, since such requirements could exclude workers who are most likely to establish strong, trusting relationships in the community.

It is not unprecedented for lay health workers to transition from the margins of the health care system to more integrated positions backed by sustainable financing. For example, services delivered by peer-support specialists — people who have been diagnosed with a mental illness or substance use disorder and are trained to support others with similar conditions — expanded rapidly throughout the United States after CMS published Medicaid-reimbursement guidelines supporting their work. Several states were prepared for that transition with established certification programs. Today, more than 40 state Medicaid programs provide direct reimbursement for peer services in community mental health settings. Buoyed by the assurance of a sustainably financed peer workforce, peer-led interventions have taken root in diverse areas, with research indicating their effectiveness in reducing the use of inpatient services and improving recovery outcomes.[5] A similar model could be applied to sustain CHW services.

CHWs are an underused resource in a system that is actively seeking effective strategies for increasing the value of health care. Their potential lies in their ability to remedy inequities in health care access and quality by means of culturally congruent interventions and advocacy in their communities. New opportunities to sustainably finance CHW activities within current and future payment structures can help realize this potential. Stable funding of CHW programs could improve access to high-value care for people facing barriers to engaging in such care and accelerate research to determine the most effective CHW practice models.

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