

# Bringing Community Health Workers into the Mainstream of U.S. Health Care

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*\*The authors are participants in the activities of the  
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# Bringing Community Health Workers into the Mainstream of U.S. Health Care

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We have an innovation that is showing tremendous gains in improving health, especially among vulnerable populations. It has produced a return on investment of 4:1 when applied to children with asthma and a return on investment of 3:1 for Medicaid enrollees with unmet long-term care needs (Felix et al., 2011). Among participating patients with HIV, 60 percent achieve undetectable viral loads (Behforouz, 2014). In fact, examples keep emerging from around the country about its effectiveness in improving health outcomes and reducing emergency room visits and hospitalizations (CHWA, 2013; CDC, 2011; ICER, 2013).

If these were the results of a clinical trial for a drug, we would likely see pressure for fast tracking through the FDA; if it was a medical device or a new technology, there would be intense jockeying from a range of start-ups to bring it to market.

Instead, despite the promise this innovation has shown for years—and recognition from the Institute of Medicine (IOM, 2010), the Affordable Care Act, and the Department of Labor—it still has not been widely replicated or brought into the mainstream of U.S. health care delivery. It is still not supported by most health care financing mechanisms, which causes some organizations that successfully deploy the innovation—and show better health outcomes—to *actually lose money* (Paquette, 2014).

The innovation is the use of community health workers (CHWs), and, more specifically, their integration into team-based primary care. Scaling up the use of CHWs presents a unique set of obstacles, but it is also possible to chart a roadmap forward. The potential to improve care for vulnerable populations, help achieve the Triple Aim of better care, better health and lower costs, and advance population health is too promising to be deterred.

## BACKGROUND

For the purpose of this article, we use the American Public Health Association's definition of a CHW: “[A community health worker is] a person who is a trusted member of and/or who has an unusually close understanding of the community served in the delivery of health-related services through either working directly with providers or their partner organizations. This trusting relationship with the community enables community health workers to serve as a liaison between health and social services and the community to facilitate members' access to services and improve the quality and cultural competence of services delivered. Community health workers 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” (APHA, 2014).

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What does this look like in the real world? The following list shows just a handful of the hundreds, if not thousands, of efforts across the country that utilize CHWs in a variety of capacities:

- The federal Center for Medicare and Medicaid Innovation (CMMI) has funded multiple demonstration projects across the country that involve CHWs providing health education and coaching, assisting with case and medication management, and linking patients to social services such as housing, disability and insurance benefits, food, and transportation (CMS, 2013).
- In the Transitions Clinic Program, CHWs who have been incarcerated themselves help those recently released from prison to navigate the health system and access housing, transportation, and substance abuse services (Transitions Clinic, 2015).
- Provided with continuous education and support by the Regional Asthma Management and Prevention program at the Public Health Institute, CHWs with the Asthma Start program in the San Francisco Bay Area visit the homes of children with asthma (PHI, 2009; ACPHD, 2013). In collaboration with social workers, they educate families about asthma, including how to reduce in-home asthma triggers, and provide referrals to such services as smoking cessation, legal aid, and insurance enrollment.
- St John’s Well Child and Family Centers engage CHWs in a variety of capacities related to health education, insurance enrollment, and community-led organizing and advocacy around such issues as substandard housing and funding for local services (CHWA, 2013).
- CHWs in the CA4Health program, funded by the federal Community Transformation Grant program, teach the evidence-based Chronic Disease Self-Management Program developed by Stanford University to hard-to-reach rural residents with such conditions as diabetes and high blood pressure (CA4Health, 2015).

### **CHWS AND THE ENHANCEMENT OF TEAM-BASED CARE**

CHWs have been providing the services we described above, and many other services, for years. But when they provide them in the context of being a fully integrated member of the primary care team—alongside medical assistants, nurses, and doctors—their impact can be magnified in new and important ways. As the Affordable Care Act and other pressures push the health care system to move beyond the traditional provider-centric model to one that also addresses the broader social and environmental determinants of health, engaging CHWs as critically important members of the primary care team is one of the most important strategies available to us.

CHWs become the critical extenders of care beyond clinic walls and between doctor visits that are so needed for patients with medically complex conditions. CHWs also serve as the intermediaries that link clinical services to practical actions in the community to address the social determinants of health. The information they glean about patients’ health status and their unique understanding of patients’ social and cultural barriers to health can be shared with the team, vastly improving care. One such example was the Prevention and Access to Care and Treatment project in Boston. In a recent *Health Affairs* article, Dr. Heidi Behforouz described working on that project with a CHW named Geoffrey to care for Maxine, a Haitian patient who was HIV positive: “They [CHWs] also teach me how to be a better doctor, to understand a patient’s whole context before constructing and communicating a care plan, and to work as a

member of a team whose impact extends well beyond my clinic walls and expertise. . . . Had Geoffrey not taught me about Haitian culture and the stigma surrounding HIV, or told me about the suitcase of medications in Maxine’s closet and her struggle with the church, I would not have understood her illness experience or given her the kind of recommendations that both were effective and made sense to her” (Behforouz, 2014).

Geoffrey also went with Maxine to doctors’ appointments, made sure she was taking her medications, advised her on diet and nutrition, gave her rides to church, and more.

CHWs are well positioned—often better positioned than others on the care team—to gather data on patients’ social needs and to identify the social and cultural dynamics that may impede the adoption of healthy behaviors. If we can build systems that integrate that data with clinical data, in particular in the electronic health record, then we have a powerful new tool in helping health care systems better understand and address the social determinants of health. This is a key element in moving a comprehensive population health agenda forward.

In addition, CHW positions create a health career pathway entry point for groups typically underrepresented in the industry, contributing to economic and workforce development in local communities where health inequities are often most concentrated.

## **OBSTACLES TO USING COMMUNITY HEALTH WORKERS**

Having CHWs on the health care team would seem to help in solving some of the problems facing health care. So why hasn’t the use of CHWs been scaled up in the U.S. health care workforce?

The California Health Workforce Alliance (CHWA), also a project at the Public Health Institute, conducted a statewide assessment, followed by regional consultation meetings with clinical and administrative leaders and frontline staff, to answer this question as it relates to the California safety net (CHWA, 2013;-CHWA, 2015). However, the obstacles identified are applicable to both mainstream health care institutions and many other states:

- **Limited professional recognition.** In general, CHWs have been an “extremely diverse and poorly defined part of the health workforce” (CHWA, 2013). The term “CHW” is also often used interchangeably with other titles, such as promotora, navigator, and health outreach worker. This diversity in titles is often driven by the many sources of categorical funding used to support CHWs.

There is a lack of specificity as to the distinct roles of CHWs versus other members of the care team, such as medical assistants, who can have overlapping functions. Providers voiced concerns about ensuring quality of care and avoiding duplication of services. The absence of standardized training and credentialing (in such states as California) contributes to this lack of recognition.

- **Lack of data to make the business case.** Individual clinics do not have the analytic capacity, or routine access to cost-of-care data from hospitals or insurers, to evaluate the impact of CHW services on key cost drivers such as emergency room visits or hospital admissions.

- **Sustainability.** Currently, CHW positions are primarily supported through grants, which are time limited and often are not sustained. Due in large part to the two barriers mentioned above, limited mechanisms exist for reimbursement from private or public payors.
- **Lack of knowledge of best practices.** As best practices and strategies emerge, there is no “go to” resource to track and disseminate them. Some key questions include the following: How should CHWs engage with patients vis-à-vis other members of the care team? How will they be incorporated into routine care processes? How should they be evaluated and supervised? What are the key elements of organizational readiness (from office space to equipment to training and supervisory resources) to integrate CHWs? What level of patient data should they be allowed to access, and what data should they contribute to the medical record?

## **RECOMMENDATIONS FOR THE FUTURE**

As a follow-up to their statewide assessment, the CHWA recently released a second report focused on how to take the engagement of CHWs to scale in California (CHWA, 2015). Below is a summary of some of the key recommendations made by the CHWA in both their first and second reports. Although developed for California, these recommendations are relevant to many states (CHWA, 2013; CHWA, 2015).

### **1. Implement statewide infrastructure for CHW scope of practice, training, and certification that covers the role of CHWs in providing team-based primary care.**

*Outline a scope of practice for CHWs that accommodates alternative team-based care models and delineates roles with other team members.* The distinct professional and practical skills of all members of the primary care team need to be assessed and clearly defined (which will require addressing concerns from groups including unions). The ultimate goal should be to establish a framework by which every member operates at the top of his or her licensure and skills in a way that is most cost-effective and maximizes quality and outcomes.

*Conduct an independent assessment of the wide range of employer-based, independent and academic CHW training programs* to develop a comprehensive strategy to strengthen existing training and ensure regional access to training. Ideally, a hybrid, competency-based model of CHW training and education would take into account the needs of mainstream health care providers and leverage contributions of these existing programs at regional training centers and community and state colleges.

This assessment would lay the groundwork to develop *competency-based certification standards* for new and existing training programs that validate the important contributions of CHWs and create a clear path for career advancement. Finally, research funding should be made available to refine that training and certification model over time as practice evolves in the context of national health reform.

There are ongoing concerns that the integration of CHWs in health care delivery will cause the role to lose its true spirit of service, connection to the community, and efficacy. These issues should be attended to, and the input of CHWs themselves should be prominent throughout the process

**2. Build the analytic capacity of safety net providers to document the value realized from CHWs.**

Broadly speaking, we should continue to invest in data capacity at safety net institutions and data sharing and interoperability at the local and state levels.

National, state, and local funders could prioritize CHW demonstration projects that require collaborative agreements among safety net providers, hospitals, and insurers to collectively share data and track outcomes. The CMMI grants (mentioned above) require detailed cost savings and return-on-investment analysis. Aggregated, this CMMI outcomes data can contribute to the evidence base at the national level, but we need many more demonstration projects.

*Piloting the establishment of local centralized data repositories* that integrate community data (such as social or supportive services) with patient and care management data could speed the process. This would allow safety net providers and mainstream health care institutions to better track and coordinate patient care at the community level and to document and allocate cost savings.

Community health centers will need technical assistance and better evaluation tools to monitor outcomes associated with CHWs. Standard metrics to measure how CHW services and activities contribute to the Triple Aim and address the social determinants of health would greatly strengthen evaluation efforts.

**3. Promote sustainable financing mechanisms**

The first two recommendations are key to advancing new reimbursement models, which should be designed to appropriately compensate CHWs, support the sustainable integration of CHWs into team-based care, and promote the broad engagement of CHWs by mainstream health care providers.

An immediate opportunity is the Centers for Medicare and Medicaid Services' Preventive Services Rule, which paves the way for state Medicaid programs to reimburse for community-based preventive services provided by personnel other than physicians or licensed practitioners.

Some states, such as Minnesota and Alaska, already reimburse for CHW services through their Medicaid programs. Even where CHWs are not formally reimbursed by the state, some public health plans have moved forward on their own. Alameda Alliance for Health in the San Francisco Bay Area, as well as CareOregon, pays for CHW services. Inland Empire Health Plan in Southern California employs an in-house team of full-time CHWs. In the absence of major state policy shifts on CHWs, which will take time, states can still

encourage further local action on CHW financing by providing guidance and approval to local plans on engaging CHWs.

In the long run, development of capitated financing mechanisms to transition the system from fee-for-service to global payment is perhaps the most important financing strategy to advance CHW integration into team-based.

Funding should be dedicated to researching innovative funding models as they emerge and evolve.

**4. Establish an information clearinghouse to document, disseminate, and replicate innovations in the engagement of CHWs at scale.**

Innovations in CHW practice are occurring within each state and across the country, but they are often fragmented and uncoordinated. A central clearinghouse could track and collect examples that address professional, financing, and technical barriers. A clearinghouse could focus on a specific state or be national in scope. The Public Health Institute is in the process of developing an innovation lab to help accelerate and disseminate advancements in population health, such as evolving CHW practices and more.

There is much to learn from states that are ahead of the curve, such as Massachusetts and Minnesota (Rosenthal, 2010). In fact, numerous states and the District of Columbia have enacted statutes, legislation, and regulations to address CHW infrastructure, professional identity, workforce development, and financing. How can their experience benefit states who want to move forward? This clearinghouse would serve as a valuable resource for communities, research organizations, providers, payers, and health systems.

## **CONCLUSION**

The Prevention and Access to Care and Treatment program mentioned earlier proved extremely successful in using CHWs to help care for chronically ill patients in Boston. It saved lives and money. And in June 2013, it closed its doors when charitable donations dried up. The CA4Health program faced a similar demise when Congress cut funding for the Community Transformation Grant program.

Today we face so many challenges providing care to patients with complex illnesses, lowering health care costs, and advancing a population health framework. An innovation such as CHWs in team-based care, which can help address all three issues, is too valuable to let flounder at the margins. It is time for our health care practice, financing, and training to catch up. It is time to bring CHW practice into the mainstream of U.S. health care.

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