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From Rhetoric to Reality — Community Health Workers in Post-Reform U.S. Health Care

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Many low-income countries, facing shortages of health care professionals, rely on community health workers (CHWs) — trusted community members who are uniquely positioned to bridge the gap between health care providers and patients, performing a range of health-related functions that don't require medical or nursing training. At least since the 1960s, CHWs in the United States have been xxxx. Many experts believe that CHWs will be instrumental members of U.S. health care teams in the future, as the Affordable Care Act (ACA) increases providers' accountability for outcomes that are influenced by factors outside the clinical setting.

Experts have called for a variety of policies to accelerate the adoption and growth of CHW programs in the health care system. The Center for Medicare and Medicaid Innovation is supporting several demonstrations of care models that include CHWs. Several states have heavily utilized CHWs to facilitate enrollment in ACA insurance programs, and states such as New York, Oregon, and Massachusetts are testing strategies for reimbursing CHWs through Medicaid waivers. Numerous health care providers and Medicaid payers have developed internal-financing strategies to support CHW-based interventions for high utilizers of care.

CHW programs are not new; they date back to the 1800s in Russia, and they grew in the 1920s with the creation of China's "barefoot-doctor" program. During the 1960s, the barefoot-doctor concept gained attention as it became clear that "modern" medical care was costly and inaccessible to poor populations. CHW programs soon emerged in many countries, including the United States. By 1975, the World Health Organization described CHWs as a "key to [health care's] success, not only on the grounds of cheapness but because [CHWs] are accepted and can deal with many of the local problems better than anyone." Criticism of the CHW model emerged in the 1980s, however, as a number of programs failed to meet expectations and were short-lived. Evidence regarding the efficacy

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of CHWs was mixed and outcomes were inconsistent, raising questions about what accounted for the "gap between rhetoric and reality."[1]

Thirty years later, that question is still highly relevant. The challenges faced by global CHW programs in the 1980s have fueled decades of comparative-effectiveness and implementation-science research. On the basis of a review of this literature, expert interviews, and our own experience, we believe CHW programs must address five key barriers in order 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.

CHW services are commonly delivered by community-based organizations that are not integrated with the health care system. Without such a linkage, CHW programs face many of the same limitations — and may produce the same disappointing results — as standalone disease-management programs. CHWs cannot work with clinicians to address potential health challenges in real time. Clinicians are unable to shift nonclinical tasks to the more cost-effective CHW workforce. In fact, clinicians often don't recognize the value of CHWs because they don't work with them. As a result, providers may be less willing to finance CHW programs, leaving the programs reliant on unsustainable grant funding. Although it's important for CHWs to maintain their community-based identity, they also need to be able to communicate with clinicians by means of telephone or electronic medical record and collaborate in person through multidisciplinary rounds.

Historically, CHW interventions in the United States have been funded by disease-specific grants. This approach has major limitations. First, Americans frequently have multiple coexisting conditions. Single-disease programs increase the fragmentation of care for these vulnerable patients. Second, health systems with limited resources must choose among disease-specific programs, rather than being able to invest in a single scalable model. Third, CHWs in these programs are often tasked with providing disease education or basic clinical care. Although this barefoot-doctor model may be necessary in some settings, CHWs may feel ill-prepared for clinical responsibilities and overburdened. Finally, the focus on disease-specific care misses the opportunity for CHWs to intervene in important upstream socioeconomic problems, such as trauma or food insecurity, which affect people with many different diseases. We recommend the use of patient-centered programs that can be adapted for various types of patients.[2,3]

CHW programs often lack clear protocols that define their operational details. 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. These oversights can lead to burnout and in some cases adverse patient outcomes. Although it makes sense for CHW programs to vary in their mission and scope, each program needs protocols that outline caseloads, supervision structures, workflow, and necessary documentation. Open-source examples are readily available for new programs.[2]

Turnover and the expense of training new people have been identified as reasons for higher-than-expected costs in CHW programs.[1] Programs have tried to address these workforce problems by further emphasizing training. Yet as organizational psychologists have known for decades, careful selection of employees is a better predictor of high performance than training is, especially for jobs that depend on inherent personality traits and interpersonal skills. A recent systematic review found that less than half of articles about CHW programs described the employee-selection process at all; only one article described a formal hiring process that included an application and interview.[4] CHW programs need clear and well-defined candidate-selection guidelines. Structured job interviews that include case scenarios to assess personality traits such as listening skills, empathy, and a nonjudgmental nature can provide insight into a candidate's likely future performance.

A 2010 systematic review concluded that many studies evaluating CHW programs have substantial methodologic limitations, including high rates of attrition and study designs that introduce the potential for bias.[5] This track record has led policymakers, on the basis of low-quality science, to either be dismissive of CHW programs or have unrealistic expectations for their success. But the situation seems to be improving. Since 2010, the number of articles on CHWs published annually (in journals indexed in PubMed) has nearly doubled. The quality of research has also improved; nearly 400 randomized controlled trials have been published in the past 5 years. This increase in high-quality evidence suggests that CHW interventions can — and should — be subjected to the same level of rigorous evaluation as a new drug or medical device.

The long history and rapidly expanding evidence base for CHW programs suggest that they have strong potential for improving health outcomes. Many policymakers believe that the key to realizing this potential lies in standardized training and certification of individual CHWs. Yet history reveals that unless we address program-level implementation barriers, standardization at the employee level is unlikely to be effective. Program accreditation based on evidence and on-site surveys — such as those conducted by the Joint Commission — may be a useful strategy for fostering the CHW programs that are most likely to succeed.

The current policy environment has created a historic opportunity to improve health care delivery in the United States through the effective use of CHWs. It will take hard work at the implementation level to maximize the likelihood of success.

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