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Strengthening the Effectiveness of State-Level Community Health Worker Initiatives Through Ambulatory Care Partnerships

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Abstract

The transformation of the US health care system and the recognition of the effectiveness of community health workers (CHWs) have accelerated national, state, and local efforts to engage CHWs in the support of vulnerable populations. Much can be learned about how to successfully integrate CHWs into health care teams, how to maximize their impact on chronic disease self-management, and how to strengthen their role as emissaries between clinical services and community resources; we share examples of effective strategies. Ambulatory care staff members are key partners in statewide initiatives to build and sustain the CHW workforce and reduce health disparities.

Keywords

chronic disease; community-clinical linkages; community health worker; state health department

The transformation of the health care system in the United States and the recognition of the effectiveness of community health workers (CHWs) in facilitating the care of persons with chronic diseases have accelerated state and local efforts to engage CHWs in the delivery of culturally appropriate support for members of vulnerable populations. As frontline public health workers, CHWs strengthen the connections between communities, health care, and human service systems. Community health workers deliver culturally appropriate services and interventions, assist at-risk or disadvantaged populations with managing chronic conditions, foster healthier lifestyles, improve maternal and child health, increase rates of preventive screenings, and improve access to and use of clinical and social services through outreach, enrollment, and patient education (Balcazar et al., 2011; Centers for Disease Control and Prevention, 2013; Rosenthal et al., 2011).

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Community health workers are typically community members who assist in addressing local social and health issues. Because they are part of the community, CHWs are able to gain a high level of trust from other community members, often leading to improved health behaviors and health outcomes (Brownstein et al., 2011). They are particularly effective because of their ability to connect with the community and their experience working in the community (Gilkey et al., 2011). In 2009, the American Public Health Association (APHA) defined a CHW as:

> . . . a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds 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)

While health care practices are evolving rapidly, there is much to be learned about how to successfully integrate CHWs into health care teams, how to maximize their expertise in the self-management of chronic disease, and how to strengthen their role as key emissaries between clinical services and community resources. Growing evidence supports the inclusion of CHWs into care teams (Bodenheimer et al., 2009; Brownstein et al., 2011; Herman, 2011), as CHWs are effective in addressing chronic diseases (Allen et al., 2011; Brownstein et al., 2011) such as diabetes (Cummings et al., 2013; Prezio et al., 2013; Trief et al., 2013; Walton et al., 2012) and conditions such as hypertension (Balcazar et al., 2010; Brownstein et al., 2005, 2007; Cooper et al., 2011; Griffin-Koniak et al., 2014; Institute of Medicine, 2010). Community health workers are well suited to assist in providing self-management programs and offering ongoing support for people with diabetes (Cummings et al., 2013; Norris et al., 2006; Walton et al., 2012). Similarly, CHWs play a critical role in disease prevention, early detection, and wellness, as they are able to provide screening, education, and care coordination leading to lower blood pressure, healthier weight, and improvement in diet among individuals with uncontrolled risk factors for coronary heart disease (Hayashi et al., 2010; Krantz et al., 2012). Such evidence has sparked interest in the integration of CHWs into health care teams where they can build capacity in individuals and communities and can act as facilitators between patients and community resources. Providers and managers of ambulatory care practices are key stakeholders and potential partners in these efforts. This article provides examples and illustrations of vital areas for partnership and engagement among CHWs, ambulatory care settings, and state health departments.

STATE HEALTH DEPARTMENT PROGRAMS AND CHWs

The Centers for Disease Control and Prevention’s 5-year cooperative agreement, State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health, includes evidence-based strategies for including CHWs in 2 of the 4 health promotion domains of the National Center for Chronic

Disease Prevention and Health Promotion: health system interventions and community-clinical linkages (Centers for Disease Control and Prevention, 2012). Strategies in the cooperative agreement recognize the strengths CHWs bring to care teams and include increasing the use of team-based care through employing nonphysician team members, increasing the role of CHWs in providing high blood pressure and diabetes self-management programs and support, and tapping CHWs to promote cooperation between health care systems and community resources that serve adults with high blood pressure and diabetes.

Health departments that receive funding through this cooperative agreement use a variety of CHW strategies, such as offering training to CHWs to increase the skills needed for coaching patients on chronic disease self-management, giving CHWs access to electronic health record (EHR) systems to facilitate follow-up with patients, communicating with providers on the care team, and referring patients to community resources. Additional strategies include exploring financing mechanisms to support them, assisting with development of core competencies, and developing training and certification programs for CHWs.

To better understand the issues that clinics, hospitals, health departments, and other organizations working with CHWs face, we conducted semistructured phone interviews with individuals from 9 organizations (eg, nonprofits, federally qualified health centers, training networks, academic partners) to gain insight into effective strategies and policies to integrate CHWs into care teams and health systems. Interviewees were selected on the basis of their experience with CHWs. Information gathered from these interviews was compiled and synthesized to provide recommendations for ways health departments and health care system can best integrate CHWs into their systems. While CHWs work in a variety of settings outside of the health care system, this article focuses on integrating CHWs into ambulatory care setting.

SUMMARY OF FINDINGS

On the basis of comments from interviewees, increasing the use of team-based care in health systems by adding CHWs to teams requires state health departments to focus on the following: (1) integrating CHWs into organizations and care teams; (2) improving occupational regulations (including a defined scope of practice) and workforce development; (3) identifying viable funding mechanisms for sustaining the CHW workforce; (4) building statewide support; and (5) engaging CHWs in community-clinical linkages. Findings from interviews included ways that health departments could work with partners—such as ambulatory care managers—to include CHWs in efforts related to the health care systems and community-clinical linkages.

Integrating CHWs into organizations and care teams

Interviewees noted that integrating CHWs into team-based care is not without challenges; however, they provided examples of important integration techniques that led to successful implementation in their programs. While the amount of time it took for an organization to integrate CHWs into their programs varied, it was especially important for organizations to prepare by educating health care staff, administrators, and payers about CHWs and their

roles to establish acceptance of CHWs and their unique contributions to the health care team. Communicating early and often throughout the implementation process was especially important because it led to continued success throughout the life of an intervention and facilitated full integration of CHWs into organizational culture. Interviewees described the importance of forming relationships, building trust, and having a program champion during the integration process. A program champion with executive power was a key to preserving the role of CHWs and allowing their perspectives on the health care setting to be heard. For example:

> Having a program champion is a key element to successful CHW implementation. The medical director began focusing on CHWs, and it was with his leadership and the buy-in from other upper-level management that CHWs were successfully integrated into the hospital system.

In addition to preparing staff members and planning logistics for the integration of CHWs, it is important to build institutional practices within the health care system or organization that last through the program's lifetime. Interviewees noted that organizations working toward a team-based CHW model need the involvement of CHWs, providers, and other stakeholders to sustain and continue institutional support and integration of the new team members.

One interviewee described integrating CHWs into the patient-centered medical home team, which actively collected data early in the implementation process. Data included information on changes in use of the emergency department, reasons for hospitalization, and outcomes for hypertension. Community health workers were given responsibility for care management, which included connecting clients to services with community partners, facilitating appointments through telephone outreach, follow-up, and home visits. According to one of our interviewees, collecting data allowed this organization to demonstrate cost savings and increased support from managed care partners and hospital leadership.

In addition, having access to EHRs allows CHWs to be more fully integrated into the care team by facilitating communication. The CHW's access to EHRs can be accomplished in a variety of ways, such as granting access to the CHWs' supervisors, providing CHWs with access to EHR auto-generated templates, and allowing CHWs to use structured questionnaires for various conditions (eg, asthma, HIV, diabetes). Community health workers should also be trained about confidentially concerning EHRs. Granting CHWs access to EHRs may also help ambulatory care providers understand and appreciate CHWs' capabilities and potential contributions.

Improving occupational regulations and workforce development

Although CHWs are an important part of the health care system, often they are not recognized to the same degree as other team members, in part, because their unique roles, skill sets, and rich knowledge of the community are not understood (Rosenthal et al., 2010). However, as noted by one interviewee, with continual education of ambulatory care staff, CHW appreciation increases:

> CHWs have been a vital part of the health team; they are valued by all. In the beginning, there was a fear from agencies that we would lose funding, but now they know we do not duplicate services—instead we partner!

There are many models for CHW work-force development. Interviewees described the importance of providing workforce development for CHWs, as it allows for the sustainability of CHWs and legitimizes their role. Examples of workforce development for CHWs include building a career ladder with various positions, titles, and pay increases; creating additional supervisor responsibilities for CHWs; and providing training and opportunities for CHWs to become specialists (eg, breast-feeding counselors). Regardless of the type of CHW workforce development an organization pursues, it is important to have providers and managers of ambulatory care and CHWs work together to help establish expectations for nonlicensed team members. Expectations and qualifications may vary by organization or program needs; however, it is important to recognize that CHWs are part of the community—neither clinicians nor office staff. They have their own occupational identify and should be supervised and evaluated accordingly. Together, CHWs, ambulatory care managers, and other practitioners can play critical roles in advancing CHWs as members of care teams by identifying opportunities for the CHWs and by creating infrastructures in their practices to provide for their development, continuing education, and disease-specific training.

Identifying viable funding mechanisms

One of the major barriers to the sustainability of the CHW workforce is the lack of consistent financial support for these workers. Many CHW programs are financed through short-term, disease-focused grants and lack a constant funding stream (Brownstein et al., 2005). Long-term funding is important because it sustains the employment of CHWs and improves the health care system. In addition, the APHA supports long-term funding, noting that it encourages CHWs to stay in the field, reduces turnover, and increases job security and employer commitment (APHA, 2009). There are a variety of opportunities for CHWs' reimbursement, for example, through Medicaid ruling, the Children's Health Insurance Program, Medicaid section 1115 waivers, and bundled payments (Martinez et al., 2011; Rosenthal et al., 2010; Zahn et al., 2012). One funding opportunity recently became available through the Centers for Medicaid & Medicare Services (CMS). Effective January 2014, the CMS has created a final rule (CMS-2334-F), titled "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligible Notices, Fair Hearings and Appeal Process, and Premiums and Cost Sharing, Exchange: Eligibility and Enrollment," which opens up payment opportunities for preventive services by nonlicensed individuals. This rule changes earlier language to state that "services must be *recommended* by physicians or other licensed practitioners of the healing arts within the scope of their practice under State law." The new ruling helps improve access to preventive services, facilitates partnerships between health care providers and promotes the engagement of CHWs, increases access to CHWs, broadens the scope of providers as an approach to reducing program expenditures, and carries the potential for having CHWs be reimbursed under Medicaid. This new provision requires state Medicaid plan amendments to provide comprehensive written statements describing the nature and scope of the state's Medicaid

program, including which covered preventive services will be provided by nonlicensed providers. States are required to include a summary of the qualifications of practitioners for those who are not physicians or other licensed practitioners. The summary should include required training, education, experience, and credentialing or registration (US Department of Health and Human Services, 2013).

Similarly, state Medicaid programs that are interested in working with CHWs may consider flexible funding methods such as demonstrations, waivers, and Medicaid state plan amendments, which may assist in creating long-term funding for CHWs (Witgert et al., 2014). For example, one interviewee functions under a section 1115 demonstration project through Medicaid. Demonstration projects provide flexibility in design and the opportunity to create pilot projects that promote the objectives of the Medicaid and Children's Health Insurance Program programs (Medicaid.gov, 2012). The organization received section 1115 waiver from the state health department and was required to send quality metrics to the state in exchange for CHW funding. The interviewee noted that the organization has continued to deliver successful CHW demonstration projects, thus providing support for expansion of CHW programs and integration into other locations.

Pilot projects and demonstration projects also have been useful for providing evidence about the effectiveness of CHWs and the cost savings, improved outcomes, and return on investment associated with employing them (Mirambeau et al., 2013; Whitley et al., 2006). Often, such demonstration projects display evaluation methods to assess the effectiveness of CHWs in helping community members manage chronic conditions and use appropriate health services to improve secondary and tertiary care, encourage organizational and managerial commitment to regular monitoring of the cost and outcomes of CHW programs, and model using results to support expansion and continued funding of CHW programs.

Building statewide support

Building state-level structures and organizations can encourage the integration of CHWs, help build support for this frontline workforce, and increase the sustainability of CHWs in programs that deliver health services. State-level CHW associations play an important role in promoting systems changes that affect the CHW workforce and are critical advocates for CHW issues. Furthermore, partnerships among CHW associations, public health agencies, and private organizations allow organizations to improve outcomes, leverage resources, and facilitate the sharing of ideas. Whether through formal alliances or informal partnerships, ambulatory care managers offer an important voice and perspective on building relationships and collaborating at the state level.

Engaging CHWs in community-clinical linkages

Because CHWs are closely connected to the communities in which they serve and are effective relationship builders, they can be particularly successful in promoting community-clinical linkages. For example, it is important to ensure that CHWs continue to be active in their communities and to promote CHW support of community-clinical service linkages for patients. Community health workers have promoted community-clinical linkages in a variety of ways, such as facilitating referrals to self-management programs, food banks, churches,

and social workers; following up on referrals to ensure that appointments are kept and patients are receiving provider-recommended care; sharing linguistically appropriate health education materials with low-literacy adults; conducting motivational interviews to discover patient needs; and connecting patients with each other to provide ongoing personal support. For example:

> Many patients are alone and trying to deal with a complex health system. Having someone to point them in the direction of resources can really improve the quality of life for individuals who do not have that information. Having CHWs as part of the health care team means they can support health care providers and help patients become more engaged in their health and health care.

Having CHWs working in tandem with clinicians is mutually beneficial, as CHWs are able to address nonclinical and social service issues among populations most affected by inequities. This approach frees the ambulatory care manager and other practitioners to practice at the top of their skills.

FROM THE PERSPECTIVE OF A CHW

An underlying principle of the CHW field is that people most affected by inequalities are the experts about their own experience. This principle implies that CHWs themselves should be at the forefront of integration and development efforts in their field. Consistent with this principle, in the following section the fourth author (S.M.), himself a CHW, reflects on strengthening the effectiveness of CHW initiatives through ambulatory care partnerships.

Recent innovative health care practices emphasize preventive and wellness care through the use of community-based health teams, patient-centered medical homes, and health homes (Rosenthal et al., 2010). However, there is concern among CHW leaders and advocates about preserving the integrity of CHWs' work, as some seek to integrate CHWs into health care delivery teams. We must be especially careful when developing workforce standards to make them relevant to the full range of roles played by CHWs and to avoid redefining the CHW profession as being limited only to clinical work, in an effort to leverage emerging opportunities.

The literature documents factors that lead to success in enhancing CHW integration into health care delivery teams (Findley et al., 2012, 2014). Important elements include recruiting people with the qualities necessary to fill CHW positions (eg, relationship with the community, empathy), supervision of new CHWs by more experienced CHWs, providing initial training and ongoing development of core competencies and skills, appreciating the CHW scope of practice, and recognizing at the organizational level the unique contributions of CHWs to improving patient outcomes and lowering costs. In addition, successful CHW programs have found that including CHWs early in the planning process and having them participate in development and implementation can enhance the ability of the care team to meet the needs of the patient.

A new APHA policy statement supports the importance of CHWs having a voice in decisions about their workforce (APHA, 2014). This statement urges state governments and

other organizations to collaborate with local CHWs and CHW professional groups when deliberating about new policies for training standards and credentialing. In cases where CHWs and others jointly pursue policy development on these topics, the APHA statement calls for establishing a working group or governing board composed of at least 50% CHWs. These efforts can help minimize barriers to participation and ensure inclusion of CHW priorities, particularly related to language preference, disability status, volunteer versus paid status, past sources of training, and CHW roles. The APHA policy statement offers guidance on the importance of respecting CHW leadership in efforts to define or regulate the CHW workforce as CHWs are integrated into new systems of care, particularly ambulatory care.

CONCLUSIONS

Given the evidence that increased CHW engagement improves health outcomes and reduces costs, state health departments are working to enhance the integration of CHWs into local health care teams, expand the provision of self-management programs and ongoing support for adults with hypertension and diabetes, and engage CHWs in facilitating community-clinical linkages. Ambulatory care managers and other practitioners are important to advancing CHWs as members of care teams by identifying opportunities for CHWs to be integrated into their organizations, creating infrastructure to support CHWs within their practices, supporting professional development, and providing continuing education and training to CHWs and their supervisors. Ambulatory care providers and managers can collaborate with their state health departments and other statewide partners to support CHWs. Ambulatory care staff's practical experience with integrating CHWs can provide important insights into working with state health departments and other partners. Furthermore, such partnerships can inform issues of CHW workforce development, occupational regulation, and financing, thus creating a sustainable CHW workforce to reduce health disparities in vulnerable populations. Ambulatory care sites have much to contribute toward state health department efforts to increase the number of teams that include CHWs.

As is the case with qualitative methods generally, findings may be limited in generalizability to the broader population; however, the information collected from organizations for this work, combined with literature-based evidence, has important implications for other organizations working to integrate CHWs. In addition, it is important to remember that CHWs, as builders of organizational and community cooperation, should be engaged in all aspects of their practice as health care team members. With appropriate support and collaboration, it is possible for CHWs, state health departments, and ambulatory care partners to join in statewide alliances to implement interventions that include the important contributions of CHWs.

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