Community Health Workers—Birth of a New Profession

By Manmeet Kaur

We are in the midst of a once-in-a-generation opportunity to improve healthcare and expand it beyond the walls of clinics and hospitals into the places where people live, work, play, and age. New roles are emerging for clinical and non-clinical care providers—particularly that of the Community Health Worker (CHW). To be effective, these new types of caregivers and care coordinators require extensive systems of ongoing support, contextual anchoring into the right type of care teams, clear role delineation, and robust systems of care.

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After the flood of public investments driven by the Affordable Care Act (ACA) dries out, promising workforce models will need to demonstrate concrete value to existing care teams, payers of health services, and patients to play a lasting role in the U.S. health system. By focusing on people, caregiving, and supportive systems, we can ensure that this moment in time results in transformative change—not merely slight improvements on a broken system.

Pressures Spurring Change

Providing effective care for vulnerable populations, especially older adults with complex care needs, has for years posed significant economic, demographic, and design challenges to the U.S. health system. Patients with complex needs typically have multiple specialists offering disparate care plans and prescriptions. This type of patient often makes trips to the emergency room that are not mentioned to their primary care doctor (if they have one) and no one is held accountable to ensure follow-up appointments are made. Healthcare spending on these high-need adults is economically unsustainable; and 5 percent of these Americans account for 50 percent of the nation’s healthcare spending (Schoenman, 2012).

►ABSTRACT We have a once-in-a-generation opportunity to improve healthcare and expand it beyond the walls of clinics and hospitals into places where people live, work, play, and age. New roles are emerging for clinical and non-clinical care providers—particularly that of the Community Health Worker. To be effective, these workers require extensive systems of ongoing support, contextual anchoring into the right type of care teams, clear role delineation, and robust systems of care. To ensure such roles are effective and lasting, promising workforce models must demonstrate concrete value to existing care teams, payors of health services, and patients. | key words: aging-in-community, care providers, healthcare teams, Community Health Worker
Three significant pressures are driving efforts to redesign how healthcare services are delivered and paid for in the United States. The first relates to a weak primary care infrastructure. Lack of continuous engagement with a primary care physician in the standard “episodic care model” is associated with high rates of emergency room use by older adults (Ionescu-Ittu et al., 2007). Common risk factors driving preventable emergency room use by older adults are age, functional impairment, recent hospitalization or emergency department use, living alone, and lack of social support (Aminzadeh and Dalziel, 2002).

Such care needs are managed optimally through primary care with community-based supports, yet primary care clinicians struggle to meet their patients’ needs during short visits, and half of patients leave the doctor’s office not understanding what they were told (Heisler, 2008). Further, there is an acutely high rate of primary care clinician vacancies in low-income communities where compensation levels are less competitive due to lower Medicaid payment rates (IHS, 2015).

The second significant pressure is the increasing recognition that socioeconomic and behavioral health needs must be addressed, along with the need for medical services, to deliver effective care. The diversity of skills, roles, and resources required to meet these blended needs cannot be encompassed within any one provider; thus, health systems increasingly are hiring non-clinical workers to address diverse care needs.

The third pressure driving change is the introduction of incentives through the ACA. Today, states across the country are investing unprecedented levels of public dollars to transform how healthcare is delivered and paid for in the United States. To usher in change, new care models are attempting to move traditional episodic, reactive models toward proactive approaches that enhance the capability of overburdened primary care clinics to manage patients. Lower cost, community-based workers increasingly are being recognized as a part of a promising approach to help patients with complex needs to manage their own care, make behavior changes, access the right care at the right time, close communication gaps with clinicians, and reduce fragmentation among providers. A 2014 survey of the primary care workforce projects that the demand for care coordinator workers will grow by 127 percent by October 2016 (Greater New York Hospital Association [GNYHA], 2015).

As this nascent workforce grows, it is essential to design care models that carefully define the function of such workers and the systems that need to be in place to ensure their success. Without strong workforce models, implementation of new care models are subject to the following risks.
First, due to the early nature of this emerging sector of workers, there is an extraordinary multiplicity of job titles, variation in training standards, and lack of clarity around work functions. To help clarify patterns, a 2015 survey of employees within New York Health Homes (which provide intensive care management, and behavioral and social service support to Medicaid patients with multiple chronic conditions) identified the following three categories of non-clinical workers:

1. **Patient outreach-engagement workers**
   Focus on conducting outreach to enroll patients in health home services, and on conducting reminder and follow-up calls. These jobs typically require a high school diploma and annual salaries fall between $31,000 and $35,000.

2. **Care management workers**
   Focus on creating care plans, coordinating with primary care providers, and serving as liaisons between clinics and patients. The position requires some familiarity with clinical work. Care manager jobs generally require a bachelor's degree and annual salaries fall between $41,000 and $45,000.

3. **Supervisory staff**
   Act primarily in administrative and leadership capacities: managing staff, conducting staff training, managing metrics, and ensuring policy and procedural compliance. This role typically requires a bachelor's degree (preferably, a master's degree), along with job experience. Annual salaries fall between $56,000 and $70,000.

The patient outreach-engagement worker category included thirty-three job titles; the care management category included thirty-six titles; and the supervisory staff category included eighteen titles (Silverman, Schaub, and Lowenstein, 2015). A more recent survey of 109 hospitals and health systems in New York State found that the majority of respondents required a bachelor’s degree for emerging care coordination jobs (Healthcare Association of New York State, GNYHA, and Center for Health Workforce Studies, 2015). CHWs, one of the main emerging sub-categories of non-clinical workers, perform roles that fall under the first two categories.

Many of these new hires are being supported through short-term investments related to the ACA. However, without clarity on how to define the core functions of such roles, it will be impossible for health systems to assess their value and ensure long-term payment for these services. We face a critical short-term window to demonstrate value and to ensure that health systems and health plans pay for new care models and roles.

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A related second risk is further care fragmentation. Amid the heightened activity among ACOs, primary care clinics, managed care organizations, senior homes, and other providers, there is a proliferation of health workers hired by distinct entities that are contacting patients to help coordinate and manage care (Span, 2015). Because these roles generally are created in isolation from other entities, it is increasingly common for patients to receive calls from multiple staff persons attempting to play a coordinator role. To avoid further fragmentation, duplication of services, and confusion for patients, new care models and new roles should be defined in close coordination with other providers of clinical, mental health, social service, and care management services.

Building a skilled workforce is a third challenge to the success of new care models. The GNYHA conducted a recent survey of the primary care workforce in New York and found that more than half of ambulatory care clinic employers cited lack of work experience as a challenge to the recruitment of clinical and non-clinical personnel. While clinicians are
struggling to adapt to new responsibilities related to care coordination and population health management, the lack of work experience among non-clinical workers speaks in part to the nascent nature of the new care delivery models, as well as a lack of clarity regarding job functions, titles, and training standards.

CHWs Can Close Care Gaps, Reduce Disparities

In the United States, CHWs have been involved in efforts to improve access to and quality of care for vulnerable populations for more than fifty years. Most recently, because of the ACA, there is increased interest in the potential of CHWs to help close gaps in care and reduce health disparities, particularly for patients with complex needs, such as elders. With a long history of CHWs in the health system, it is useful to examine this subcategory of non-clinical workers to assess the degree to which they could become a lasting feature of the health system.

Clarifying the CHW role

CHWs have for a long time played a prominent role in developing countries facing severe clinical workforce shortages; they deliver life-saving services to reduce mortality from preventable and treatable diseases such as malaria, diarrhea, and HIV/AIDS. The United States has a rich history of CHWs addressing health disparities, particularly in extending access to care to the urban poor and to migrant or undocumented populations in rural areas. In the current climate of health reform, converting CHWs’ potential into meaningful and sustainable value will require careful design of where and how these workers optimally enhance clinicians’ capabilities within the implementation of new care models.

Because primary care clinicians are pressured to see large volumes of patients during brief visits, CHWs commonly are used to augment medical personnel’s ability to empower individuals and communities to adopt healthy behaviors, secure resource access, obtain social support, and enable timely access to care (U.S. Bureau of Labor Statistics [BLS], 2014). The BLS estimates that in 2014 only 48,000 CHWs were working, earning a mean annual wage of just over $38,000. A significant number of CHWs also serve as volunteers. Spurred by health reform, the 2014 GNYHA survey of ambulatory care providers in New York projected a 2,800 percent increase in CHW hiring by October 2016 (GNYHA, 2015). Reaching this ambitious expectation of demand will depend upon the ability of health systems to attribute improvements in health and savings to the CHW role.

Numerous studies have shown that CHWs in the United States can play a major role in improving health outcomes, reducing mortality, and reducing costs, especially for patients with complex medical and social needs (Foundation for Healthy Generations, 2013). Yet most CHW programs have been piloted in small-scale academic settings, and thus outcome data have limited applicability to the larger health system. Despite the longtime prevalence of CHWs in the United States, there are scant examples of CHW programs that have become integrated into health systems and have demonstrated effectiveness at scale.

Not only does the optimal role of CHWs need to be clarified, but approaches to using these workers must address common implementation barriers, including insufficient integration of CHWs with formal healthcare providers, fragmented and disease-specific interventions, lack of clear work protocols, high turnover, and variable performance of the workforce—plus a history of low-quality evidence (Kangovi, Grande, and Trinh-Shevrin, 2015).

Financing, reimbursement, and certification challenges

The foregoing barriers coexist with long-standing financing challenges, as traditional sources of funding have been limited to short-term grants or public health department–supported projects.
Today, there is heightened optimism about potential payment options for CHW services. As a result of the ACA legislation, public investments in creating new care models offer a window of opportunity to demonstrate the value of CHWs, because ACOs and PCMH programs can allocate their care coordination dollars to include the hiring of non-clinical workers. Also, a recent regulatory change allows Medicaid reimbursement for preventive services delivered by CHWs—if they have been recommended by a physician or other licensed practitioner (Center for Medicaid and CHIP Services, 2013). However, this regulatory change has yet to be adopted widely at the state level.

Only two states provide direct Medicaid reimbursement for CHW services. Alaska’s Community Health Aide-Practitioners must pass a qualifying exam. Minnesota pays for CHW-delivered services through Medicaid for CHWs who are clinician-supervised and state-certified (Miller, Bates, and Katzen, 2014). Several states, including New York and Maine, list CHWs as optional members of care coordination models funded through the ACA, such as health homes and patient-centered medical homes. However, these are not guaranteed, long-term funding sources (Kahn-Troster and Sheedy, 2015).

Several states have tried to professionalize the role and thus improve recognition of their value by creating CHW certification programs. Ohio, Oregon, and Texas have highly developed regulatory regimes defining the profession, but none has demonstrated sizeable hiring levels. Massachusetts established a Board of Certification of Community Health Workers to develop statewide, standardized certification criteria, and is above the national average in terms of the number of paid CHWs (Miller, Bates, and Katzen, 2014). However, the majority of CHWs are employed through grant-funded programs. A concern of Massachusetts practitioners is that the state did not demonstrate the data required to rationalize payment of CHWs before establishing a certification board (Antonia McGuire, president and CEO, Edward M. Kennedy Community Health Center, interview with Manmeet Kaur, June 12, 2015).
Despite these efforts to develop and establish certification programs, there are two emerging concerns: over-professionalization and under-professionalization. Well-intentioned efforts to require credentials for CHW hiring without a clear payment mechanism are leading to increasing numbers of certified workers without opportunities for stable employment. Massachusetts is an important example of the risk of creating training and credentials without ensuring a financial case for the creation of such jobs by health systems. On the other hand, it won’t be possible to capitalize on the potential of non-clinical workers to play a meaningful role if employers and states do not carefully design workforce models that can achieve high performance and clear outcomes. To avoid under-professionalization, the following section provides recommendations for successfully integrating CHWs within evolving care models.

**Investing in People and Systems of Care**

The increasing number of recent efforts to redesign traditional care approaches and incorporate non-clinical workers reveal two common factors to success: investing in people and in well-designed care systems. A survey of eighteen complex-care management programs show that successful programs clearly define how interdisciplinary members of care teams relate to each other and to external providers; customize operations and service models within local contexts; and, invest in specialized care coordination to build this relatively new skill set among all care team members (Hong, Siegel, and Ferris, 2014).

In building City Health Works, a Harlem-based social venture, I collaborated with local health systems to develop a systems approach to integrating CHWs, with the aim of augmenting the reach of overburdened primary care clinics. Key recommendations for successful implementation include the following:

- **A local workforce model.** Locally hired CHWs have extensive local knowledge that supports a unique and powerful ability to build trusting relationships with patients. Successful implementation requires investing in careful selection of candidates and close, supportive clinical supervision.

- **Primary care integration and de-fragmentation.** Care team models must be co-designed at the outset in close collaboration with primary care providers, and must include investments in clinic infrastructure that enable team-based care, site-specific clarification of roles, and bi-directional communication.

- **Diversification of non-clinical roles into two primary categories.** To add greater clarity to the role CHWs play and to evaluate its impact, two categories of CHW roles are emerging and merit greater diversification. The first category serves as an extension of primary care, and specializes in skills that strengthen self-management of chronic illnesses among populations with multiple comorbidities. This type of CHW must work under close clinical supervision, and will soon receive recognition from the American Association of Diabetes Educators (AADE) as a Level 1 Diabetes Educator (AADE, 2015).

  The second category of CHW should be supervised by social workers and specialize in social work–oriented functions, such as navigating insurance issues, housing, employment, benefit enrollment, transportation, and mental health. Both of these types of workers should have strong familiarity with each other’s areas of expertise and serve as members of interdisciplinary care teams.

- **Continual investment in the workforce.** To address the common challenges of retention and variable quality of CHW programs—and capitalize on the natural talents of CHW candidates who may have only a high school education—employers must invest in rigorous systems to support continual skill development, supervision, and performance monitoring.

- **Continuous quality improvement and short-cycle testing.** Considering the quickly evolving nature of new care models, investing
in continuous quality improvement and short-cycle testing of operational strategies from the outset will enable programs to build a culture of improvement, high quality, and the ability to respond to evolving requirements of new care models in a more nimble manner.

• **Supportive technology and data systems.**

To support CHWs’ ability to carry out sessions and care activities with greater standardization, quality, and accountability, it is essential to invest in tailored technology and data solutions that can be updated regularly and enhanced to support evolving sets of activities, workflows, care processes, and roles.

To play a meaningful role in delivering care for older adults with complex care needs, CHW programs must first address common barriers to generate data on their ability to improve health outcomes, quality of care, and cost at scale. Achieving higher quality performance requires extensive systems of ongoing support, contextual anchoring into the right type of care teams, and clear role delineation.

**Conclusion**

The movement to value-based payment models offers great promise to the integration of non-clinical workers—such as CHWs—into care teams. However, the history of CHWs in the United States shows that the future of non-clinical roles might continue to be marked by lack of clarity and variable quality if these nascent jobs are not incorporated into well-designed workforce models and systems of care. To ensure non-clinical workers play an effective and lasting role in the healthcare system, new care models will need to demonstrate value to existing care teams, payers of health services, and patients.

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