Community Health Workers Can Be a Public Health Force for Change in the United States: Three Actions for a New Paradigm

Community health workers (CHWs) have gained increased visibility in the United States. We discuss how to strengthen the roles of CHWs to enable them to become collaborative leaders in dramatically changing health care from ''sickness care'' systems to systems that provide comprehensive care for individuals and families and support community and tribal wellness.

We recommend drawing on the full spectrum of CHWs' roles so that they can make optimal contributions to health systems and the building of community capacity for health and wellness.

We also urge that CHWs be integrated into ''community health teams'' as part of ''medical homes'' and that evaluation frameworks be improved to better measure community wellness and systems change. (*Am J Public Health*. 2011;101:2199–2203. doi:10.2105/AJPH.2011.300386)

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THE UNITED STATES IS CURRently embarking on a new era of social change to improve the well-being of its residents. Improvements are needed to remediate a health care system whose costs have spiraled out of control[1] while still leaving about 50 million citizens without health care coverage,[2] a system that has lagged behind its counterparts in other industrialized nations in terms of health outcomes and the efficient delivery of quality health care services.[3,4] A new era of ethics, efficiency, and effectiveness is needed to make health care systems more accessible, affordable, and accountable for all Americans.[4,5] Unfortunately, current relationships in the United States between its people, their communities, and the health care system can often be described as disconnected, and the care rendered is often episodic. If true changes in health care systems are to come about, and if people are going to become more engaged in these systems and in improving their own health, then these relationships must become more trusting and more continuous, and they should be mutually respectful.

For more than 60 years, community health workers (CHWs) have been working to improve engagement between communities and the US health care system, but mainly on short-term, grant-funded projects and in grassroots volunteer community initiatives.[6] Increasing awareness of the contributions of CHWs, combined with changes in health care systems, however, should increase their involvement with health care providers and community and tribal members in the years to come. CHWs are recognized as important members of the public health and primary health care workforce.[5,7] In 2009, the American Public Health Association defined CHWs as

> frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison . . . between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also 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.[7]

To date, CHWs have shown their effectiveness in high-priority health care issues such as managing chronic diseases, improving birth outcomes, and maintaining child wellness.[7–18] CHWs can play multiple roles, including improving access and continuity of health insurance coverage, enhancing provider–patient communication, monitoring of health status, monitoring adherence to treatment, and linking to health and human services.[7–18] Broader recognition of the CHW as a distinct occupation will no doubt help these workers expand their contributions, and thus the inclusion of CHW as a Standard Occupational Category (SOC) in 2009 was an important step. In 2010, CHWs were recognized by the Department of Labor with their own SOC (#21–1094).[19] Also in the recent past, Texas, Massachusetts, Ohio, and Minnesota have taken actions that give official recognition to the job category of CHW. More broadly, a growing consensus, which includes the Institute of Medicine,[20,21] has called for greater roles for CHWs in improving access to care, controlling costs, and helping to eliminate persistent health inequities among vulnerable populations, as well as including CHWs within multidisciplinary care teams.

With the fundamental changes currently seen in public health and the financing and delivery of health care services, we now have an opportunity to work toward shifting current health care systems to ones with a patient-centered perspective and a preventive approach in which CHWs, as members of community health teams, can help to create systems that are actually seen as more appropriate and accessible by community members and society at large.

In this Commentary, we reflect on the philosophy in public health prevention of viewing the well-being of populations as an ethical issue, a philosophy that prioritizes benefits to the community. We propose 3 action steps involving CHWs to further drive this philosophy[7]:

1. Promote the awareness and appreciation of the uniqueness of CHWs and support their roles in bringing community

perspectives and priorities into the process of improving health care systems;
2. Promote the integration of CHWs in the full range of health care delivery and population health programs; and
3. Implement a national agenda for CHW evaluation research and develop comprehensive polices to enhance the sustainability of the CHW workforce, with CHW leadership in guiding policy recommendations.

SUPPORT CHWS IN IMPROVING HEALTH CARE SYSTEMS

When addressing inequities in population health, the World Health Organization has noted that social determinants of health are best addressed by a public health model in which communities are engaged in resolving their own health problems; this is a key strategy for bringing about changes to a variety of systems in the health care continuum (e.g., primary care, secondary care, and tertiary care).[22] Through their direct involvement in community-based prevention and primary care and in community-based participatory research (CBPR),[23–25] CHWs actively engage community members in both their individual health and in community and individual efforts to improve health generally. Through their various roles,[26] CHWs can make significant contributions to strengthening and building community systems of care both as members of clinical care teams and as part of community-based prevention efforts.

A potential barrier to realizing the full potential of CHWs is a general lack of understanding of the CHW's expertise. Other health professionals, health care administrators, and policymakers must come to understand that the strength of CHWs lies not solely in their understanding of clinical care and health systems but in their ability to relate to community members or patients because of the commonalities of shared life experiences. This "experience-based expertise"[27] allows CHWs to establish a level of trust and rapport that can elicit candid responses from patients about their symptoms and their actual comprehension of communications from providers. It also helps CHWs consider cultural factors in the patient's care and issues of adherence to a medical regimen or healthy lifestyle recommendations. In brief, this expertise allows CHWs to develop approaches to wellness and community empowerment based on their particular and direct personal understanding of the community's culture, beliefs, norms, and behaviors. It is a strength that differentiates CHWs from their colleagues in related professions such as nursing or social work; thus, CHWs should be encouraged to cultivate these strengths rather than being treated as "extenders" or assistants who can be delegated nursing or social work tasks just to save money on salaries and benefits. Definitions of the CHW commonly specify that they be members of or have an unusually close understanding of the community they serve. Still, we must resist the temptation to judge CHWs by the same values we use for clinical disciplines or to use the common classifications of clinical versus administrative personnel when utilizing their skills.

INTEGRATE CHWS IN HEALTH CARE DELIVERY AND PROGRAMS

Current efforts to restructure the delivery of primary care include proposals for a patient-centered medical home (PCMH) in which the health care system focuses on providing "accessible, comprehensive, family-centered, coordinated, compassionate and culturally effective care."[28] This model differs from conventional health care by placing the family and patient rather than the care provider at the center of the system. Rosenthal et al. suggest that including CHWs in the community health teams operating in the PCMH is essential for the success of this model because CHWs have close ties to the community, foster cultural awareness and sensitivity, and facilitate communication between providers and patients,[29] thus enabling the PCMH to become more culturally and linguistically appropriate to the populations they are to serve. Clearly, the essence of the PCMH is in improved openness and continuity of patient–provider communication. However, even in the PCMH there will still be countervailing pressures for greater productivity from clinical personnel (not to mention near-term shortages of such personnel). This will require effective ways to strengthen that communication—a natural role for CHWs, who bring patience, persistence, empathy, and respect to their relationships with the patient.[26] In the absence of CHWs, however, the PCMH model is likely to be viewed by the community as just a realignment of the same old players; it seems unlikely that they will view it as either patient centered or a medical home.

Integrating CHWs into the delivery of health care means allowing CHWs to go beyond patient recruitment and undertake the full range of roles and responsibilities of which they are capable.[5,7,24] In this context, the potential rules of engagement—the various ways in which CHWs engage the health care system and the client or community—need to be more widely understood. Also, stakeholders must recognize the common job definitions and scope of practice for CHWs, as defined to date at the state government and local program levels; a national scope of practice has not been defined. Most stakeholders recognize CHWs' proactive role in case finding and referrals, but health care providers should be aware that CHWs also carry out health education; provide support, coaching, and follow-up[26]; and increasingly play a role in patient navigation, particularly in the management of chronic conditions.[16] They have had widespread success in assisting users of emergency departments in finding more appropriate sources of routine care. We suggest they could also play a role in following community members who have been hospitalized for heart attack, stroke, heart failure, complications of diabetes, and other such common but serious conditions as a part of postdischarge planning, with an eye toward reducing readmissions.

A key strategy for system changes involves further development of the roles played by CHWs outside the health care system and, thus, strengthening their role in improving population health. CHWs have been integrated within many other settings that address health, such as schools, faith-based organizations, housing developments, parks and recreation, and community-based nonprofits such as the YMCA/YWCA, programs in early childhood education and parenting, and community preparedness and disaster response. In these settings they are part of community-based approaches to wellness and capacity building. Their efforts here are important for

addressing the social determinants of health and combating, through social support (e.g., helping people problem solve), the social isolation brought about by the social stigma and discrimination that can exacerbate existing disease and mental illness and make new cases harder to find or prevent.

RESEARCH AND POLICY AGENDA AND WORKFORCE SUSTAINABILITY

Current research methods based on narrowly focused clinical interventions, including the gold standard randomized controlled trial, are limited in their capacity to fully capture complex systems and community changes. According to Smyth and Schorr,

> Experimental methods are an especially poor fit with the efforts that could help the most vulnerable populations. . . . Our evaluation methods must be modified to embrace this complexity, not simply to control for it as nuisance variables.[30(p2)]

Health is experienced in a highly complex personal and community context. Given the range of roles played by CHWs and the broad range of settings and health issues in which they work, a single-minded focus on something like the cost-effectiveness of a narrowly defined CHW intervention will not provide usable and sufficient evidence to help shape policy and program planning. Certainly it cannot capture the intangible impact of building individual and community capacity, which encompasses opportunities for strengthening social support, building relationships to support self-help, increasing access to resources, developing social capital, and producing changes in power relationships. Thus, we will need greater reliance on qualitative and ecological approaches to research on community health and on CHWs. We propose adding social justice and equality as a new theme for examining the contributions from a vibrant CHW workforce. Furthermore, we will need to incorporate CHWs' own viewpoints to inform what we evaluate and how we best gather that evidence, as we would in studying the impact of any other profession.[31]

In January 2007, a national conference was held to begin drafting a national research agenda for the CHW field.[25] This conference generated a set of general recommendations that are pertinent to the current dialogue,[23–26] finding in part that:

1. CBPR holds promise as an approach to empowerment;
2. a range of methods, both qualitative and quantitative and interdisciplinary, need to be incorporated;
3. research findings must be translated into practice to meet the needs of policymakers and advocates;
4. cost-effectiveness studies are needed, but equal weight should be given to assessing and building community capacity; and, most importantly,
5. standard methods and metrics should be developed for CHW research and practice.

To accomplish changes in how the CHW workforce serves its communities, state-level government, in consultation with CHW leaders, will need to implement a range of interrelated, comprehensive policies, including (1) workforce development strategies for CHWs, including on-the-job training and career development; (2) occupational regulation, such as establishing standards for training and certification at the state and potentially national level; (3) the development of sustainable financing models for employment of CHWs; and (4) the creation of guidelines for common measures that can be used in research and evaluation.[29] Policies around financing are particularly important because to date as many as 70% to 80% of paid CHW positions are financed with "soft money" (i.e., funding coming from grants, contracts, gifts as opposed to a mandated, consistent funding stream).[6] However, one example that is utilizing an existing mainstream financing mechanism is Minnesota's Medicaid policy for the reimbursement of CHW services for health education and the coordination of care.[32] Other sustainable mechanisms need to be developed to pay for CHW services, including both public and private payers and private corporate financing. Health care organizations and private self-insured employers must be made aware that the cost savings and revenue enhancements available from employing CHWs, even within the current budgets of these organizations, can be dramatic.[6]

SUPPORT CONTRIBUTIONS TO HEALTH CARE SYSTEM CHANGES

We recognize that, for many years, health care in the United States has not been considered a fundamental human right and, instead, has been guided by a set of economic principles in a market economy where health care is

Call to Action for Community Health Workers' (CHWs') Full Participation in Patient-Centered Primary Care and the Promotion of Community Wellness

To advance the contributions of both paid and volunteer CHWs known by various names, including outreach workers, peer educators, Community Health Representatives, and *promotores de salud,* we urge the following:

1. *Advocate for Inclusion of CHW Perspectives*
   Promote the awareness and appreciation of the uniqueness of CHWs and support their roles in bringing community perspectives and priorities into the process of improving health care systems
2. *Promote the CHWs' Integration Into Systems of Care*
   Promote the integration of CHWs in the full range of health care delivery and population health programs
3. *Promote CHW-focused Research and Policy*
   Implement a national agenda for CHW evaluation research and develop comprehensive polices to enhance the sustainability of the CHW workforce with CHW leadership in guiding policy recommendations

considered a commodity whose consumption is guided by complex elements of demand and supply. In such a market economy, not everyone wins, which is evident for many vulnerable populations, including those left outside the health care system, often called the "hard to reach." To realize the greatest potential benefit of increased roles for CHWs, high-level leadership will be needed, most likely from state government (primarily in its role as an insurer of care for disadvantaged groups, but also in its legislative and executive roles) and other third-party payers, including those in the private, nonprofit, and business sectors.

CHWs can play vital roles in implementing health care system changes. As members of community health teams, they form a crucial connection between the team and the community; they can also play a vital role in building community capacity and promoting patient empowerment. Well-being is achieved not just in the medical environment, which is concerned with making diagnoses and treating illness and injury. True prevention and real achievement of health and well-being can happen when CHWs work with individuals and families in both clinical settings and the community—empowering those whose lives they touch to reclaim health as defined holistically to include physical, mental, social, and spiritual health. In their multiple roles, CHWs can work along the entire spectrum of prevention levels,[33] which includes addressing primary, secondary, and tertiary prevention in all settings, areas currently in need of change. True health care reform offers a window of opportunity to create an environment in which CHWs can serve the medical community as well as the community at large in addressing health inequities and moving toward the goal of real population health and well-being (see box on the previous page). ■

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Public Health Research: Lost in Translation or Speaking the Wrong Language?

Public health leaders, like physicians, need to make decisions that impact health based on strong evidence. To generate useful evidence for public health leaders, research must focus on interventions that have potential to impact population-level health.

Often policy and environmental changes are the interventions with the greatest potential impact on population health, but studying these is difficult because of limitations in the methods typically used and emphasized in health research.

To create useful evidence for policy and environmental interventions, other research methods are needed, including observational studies, the use of surveillance data for evaluation, and predictive mathematical modeling. More emphasis is needed on these types of study designs by researchers, funding agencies, and scientific journals. (*Am J Public Health.* 2011;101:2203–2206. doi: 10.2105/AJPH.2011.300302)

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WHEREAS THE GOAL OF PURE scientific research is to increase knowledge, the goal of health research is more practically oriented to develop tools to combat human disease. Health research findings are often compiled into guidance that can be used by physicians to make evidence-based decisions. Undeniably, the translation of research into such guidance has led to more effective treatment of patients. But, whereas physicians have the utility of this evidence to guide their decisions, public health practitioners, who must also make decisions that impact health but usually on a much larger scale, often do not. Some see this as a failure of translation of research into action and have called for greater attention and funding for translational research as a means to improve health.[1,2] But the problem is less failure to translate research than it is to conduct research that is relevant to public health. Thus, the solution lies less in translation and more in the reorientation of our research questions and methods.

GAPS IN CURRENT RESEARCH

More than half of National Institutes of Health (NIH) research funding goes toward basic biomedical research.[3] This type of research has greatly increased our understanding of biological processes, from cellular mutations that cause various cancers to development of insulin resistance and diabetes. Clinical research, another significant portion of NIH-funded research,[4] complements this biological research by examining the occurrence of disease in individuals, including risk factors for disease and the impact of drugs or surgery on outcomes. Both types of research are essential. They facilitate the recognition of disease processes, identification of at-risk populations, and implementation of treatment. However, although this knowledge may be important for physicians treating ill patients, it does not give public health practitioners, such as those making decisions in local, state, or federal public health agencies, solutions for improving the health of entire populations.

For example, an NIH-funded study published in 2002 of 3000 patients demonstrated that a diet and physical activity program in prediabetic individuals decreased the incidence of diabetes.[5] It was a valuable study, but the program was intensive: it involved 150 minutes of physical activity per week; a healthy low-fat, low-calorie diet; and a minimum of 16 individual counseling sessions. Although the study is useful to physicians who can test individual patients and gauge motivation and access to the intervention components, to be useful to public health practitioners, research must identify interventions that can improve diet and physical activity across populations. Achieving this kind of behavior change in large numbers of people is an uphill battle when constrained by an unsupportive social and physical environment. According to the authors of this study, 10 million

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