Community Health Workers:

A Critical Link for Improving Health Outcomes and Promoting Cost-effective Care in the Era of Health Reform

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Improving the state of New York's health

Community Health Workers

The future success of the Patient Protection and Affordable Care Act (PPACA) hinges on two critical questions:

1

Will this landmark attempt at health care reform yield improved outcomes in people's lives?

2

Will the nation be able to curb the costs of care enough to sustain the progress of health care reform?

The provisions and demonstrations authorized by PPACA wisely promote strategies to improve health outcomes and contain the costs of care. Two crosscutting themes among myriad strategies are prevention and care coordination, particularly for chronic diseases, a chief driver of increased costs of health care.

The Problem: The United States has been plagued by a disturbing, paradoxical trend: health care spending—surpassing $2.3 trillion in 2008, an average of $7,680 per resident—is among the highest of all industrialized countries, and yet the nation lags behind other wealthy nations in health measures, such as infant mortality and life expectancy. With a life expectancy rate ranked 38th in the world, the United States is behind most other industrialized nations, falling below countries such as Cuba (35th) and Chile (37th). In 2010, the Commonwealth Fund ranked the United States last in the quality of health care among similar countries. Yet, the rate of increased health care costs has only worsened with time—more than three times the $714 billion spent in 1990, and more than eight times the $253 billion spent in 1980.

New York State serves as a prime example of this health care conundrum. Despite leading the nation in health care spending—$180 billion annually—New York's rate of deaths as a result of chronic disease is the highest in the country. In addition, the prevalence of chronic conditions is high across all age groups: nearly one in 12 children in New York suffers from asthma, and almost one in four from obesity.

Two key issues driving the cost of care are poor quality and inefficient care, and the increasing burden of chronic diseases, such as diabetes and cardiovascular disease. The latter has been exacerbated by a fragmented system of care and a lack of focus on preventing associated risk factors (e.g., obesity, smoking, diet, etc.). There is clear evidence that chronic conditions can be better managed by health care teams with a range of skills, such as teams comprising physicians, nurse practitioners, and dieticians. An emerging member of effective care management team is the community health worker (CHW). Community health workers have been shown to play a critical role in addressing the drivers of health care costs and improving quality of care.

WHO ARE COMMUNITY HEALTH WORKERS? WHAT IS THEIR ROLE IN THE SOLUTION?

Known by a wide range of titles—outreach workers, community health representatives, patient navigators, peer educators, health advocates—community health workers are trusted members of the communities in which they live, sharing common racial and ethnic backgrounds, cultures, languages, and life experiences with the people they serve. In 2009, the Department of Labor created a Standard Occupation Classification (SOC) that defined CHWs as frontline, public health workers who function as liaisons between individuals and health and social services delivery systems. The SOC states that CHWs are able to build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, health counseling, social support, community education, and advocacy.

Historically, CHWs have been well positioned to break down barriers to help people receive the care they need when they need it. Employed by health care delivery organizations, as well as community-based agencies, CHWs enable people to access and navigate the health care system and better manage their health conditions, coordinate services for people with multiple chronic conditions, and lead communitywide efforts to identify and address underlying causes of poor health. CHWs' ability to facilitate access to timely primary and preventive care while improving the quality and cultural competence of medical care has been shown to reduce the need for high-cost medical services.

> CHWs provide a range of services and play a number of roles. They assist individuals and communities in adopting healthy lifestyle behaviors. They conduct outreach within marginalized communities to implement programs that promote, maintain, and improve individual and community health. Specifically, CHWs provide information on available resources, offer social support and informal counseling, and help coordinate care across the health and social service sectors. In addition, CHWs often play a lead role in community-based participatory research, serving as "natural researchers." The trust CHWs share with members of their communities enable them to collect accurate information that can inform public health policies and programming.

THE EVIDENCE: THE ROLE OF COMMUNITY HEALTH WORKERS IN IMPROVING HEALTH OUTCOMES AND MAXIMIZING COST EFFICIENCY

Although the field would benefit from more evidence, several studies have documented the impact of community health workers on health outcomes and costs of care. As members of the care delivery team, CHWs have been shown to play a critical role in the following three areas: **1)** securing access to health care; **2)** coordinating timely access to primary care, behavioral health, and preventive services; and **3)** helping individuals manage chronic conditions. Below is a summary of findings from studies that have documented the impact of CHWs in improving health outcomes and reducing the use of costly health care services.

Securing Access to Health Care. Access to health insurance is known to improve health outcomes: however, to achieve those outcomes, the uninsured must be successfully enrolled. Strong policies to ensure health insurance coverage do not guarantee that people will attain

health insurance. Lessons from Massachusetts—and from New York's expansion of its Child Health Insurance Program—demonstrate that laws to expand coverage must be supported by initiatives to facilitate enrollment in health insurance programs.

In several studies, CHWs have been shown to effectively connect and enroll people in health insurance. In New York City, for example, one community-based organization implemented a CHW initiative to increase enrollment in health insurance among eligible residents.[1] Between 2000 and 2005, CHWs enrolled nearly 30,000 previously uninsured people and helped facilitate access to primary care for the newly insured. Similarly, CHWs in El Paso, Texas enrolled 7,000 individuals in Medicaid and other state-funded health plans in a period of three years.[2] Another study aimed at increasing the number of insured Latino children in Boston found that children in a CHW intervention group were significantly more likely to be insured and stay insured as compared to children in the control group.[3]

The success of these programs is attributed to the "inside" knowledge CHWs have of the communities where they work and the trust they develop with the people they serve. CHWs know their neighborhoods and the distinct cultural aspects of their communities. Knowing where and when people congregate and how to connect with neighbors, and being known as "trusted sources of information" by their peers are all qualities that underscore CHWs' value. They share the life experiences of the people they serve and therefore can form meaningful and trusting relationships with their clients. It is these relationships—more than their clinical expertise—that make CHWs successful at assisting people in accessing health care.

The CHW-client relationship is key to breaking down the barriers (e.g., issues of mistrust of the health care system, health literacy, language, and other cultural barriers) to accessing care. Yet, the work of CHWs does not end there. Once a person has an insurance card, navigating the maze of health and social services can be a challenging task—especially for people who have been historically disenfranchised or marginalized from the health care system. CHWs have been shown to coordinate access to health and social services, particularly for primary and preventive care.

Coordinating Timely Access to Primary Care, Behavioral Health, and Preventive Services. As frontline workers, CHWs often represent the first point of contact for people who have not had access to the health care system. Several studies have shown that CHW programs produce improvements in patients' use of preventive services, such as mammography and cervical cancer screenings among low-income and immigrant women.[4–7] A Denver study of CHW interventions among underserved men found that interventions by CHWs shifted care from costly inpatient and urgent services to primary care and prevention. This shift resulted in a return on investment of $2.28 per $1 spent on the community-based intervention, for a total savings of $95,941 per year.[8] Other studies have shown that CHWs can increase healthy food choices and physical activity among patients with diabetes,[9–12] leading to improved clinical outcomes for diabetes, such as decreased A1C levels.[13]

Helping Individuals Manage Chronic Conditions. CHWs work with clients to develop long-term strategies for addressing chronic health issues. CHWs partner with individuals to help them use advice from their medical providers to develop daily lifestyle strategies that prioritize prevention. CHWs provide the necessary support to help people adopt positive behavioral changes and adhere

to complex treatment regimens necessary for multiple chronic conditions. By contributing to improved health outcomes associated with diabetes and other chronic diseases (e.g., asthma, cancer, and HIV/AIDS), CHWs can help reduce the costs of emergency care and preventable hospitalization,[14–28] particularly in communities burdened with high rates of chronic illness.[29–32]

A 2003 study of CHWs working with Medicaid patients with diabetes in West Baltimore found that CHWs generated a savings of $2,200 per patient per year, a 40% reduction in emergency room visits, and a 33% drop in hospital admissions. Patients who participated in the study also reported an improvement in overall quality of life. [33]

Another study based in Maryland compared health service utilization rates between two groups of clients with similar socio-demographic backgrounds and who differed in their use of CHWs. Examining Maryland Medicaid Claims data for emergency department use, hospitalizations, and Medicaid cost, the study found that each client served by a CHW cost an average of $2,700 less per year than a client who was not served by CHW. The evaluators estimated a projected savings of $50,000 per year for each CHW employed, assuming that CHWs had a caseload of approximately 30 clients.[34]

Overall, the existing literature suggests that CHWs are effective in helping people prioritize ongoing health maintenance, and primary and preventive care. In doing so, CHWs promote more cost-efficient use of the medical delivery systems by helping forgo more resource-intensive services, like emergency and inpatient care. CHWs play a critical role in improving patients' health outcomes and quality of life, and in addressing the chronic conditions that drive health care costs.

WHY ACT NOW?

Seven years ago, the Institute for Medicine recommended that CHWs serve as members of health care teams to improve the health of underserved populations.[35] Today, the Federal health reform law both heightens the need for the role of CHWs and creates myriad opportunities for integrating them into the health care delivery system.

The success of Health Reform will not only depend on actualizing the goal of expanding coverage, but on improving health outcomes and containing the costs of care. CHWs can play a critical role in the following ways: **1)** helping to enroll people who are eligible for coverage; **2)** coordinating access to primary care and behavioral and preventive services, particularly for those who remain uninsured; and **3)** helping people manage chronic conditions, particularly underserved populations and people with complex treatment regimens. Not only have CHWs successfully carried out these responsibilities, CHW interventions have led to significant improvements in health outcomes and reductions in the costs of care.

The Health Reform law recognizes the role of CHWs in achieving the goal of improving health outcomes and containing costs. CHWs are explicitly cited in the law as an important part of the care team for delivery system reform. Specifically, the law authorizes funding through the Centers for Disease Control and Prevention for CHWs to help promote positive health behaviors and outcomes for populations in medically undeserved communities. The law also authorizes Area Health Education Centers to conduct interdisciplinary training for community

health workers as part of the professional development of health care workers. Finally, although they are not explicitly mentioned, CHWs can play a critical role in the community health teams to support the implementation of patient-centered medical homes. The evidence of their effectiveness in helping to coordinate services across the health, behavioral, and social sectors, as well as their ability to help people manage chronic conditions, qualifies CHWs to be part of a team in the delivery of patient-centered care.

A CALL TO ACTION

The value of CHWs has been well documented. The failure of the health system to deliver high-quality, coordinated care that improves the outcomes of people's lives reflects a pressing need for CHWs. Not only does Health Reform acknowledge the value of CHWs and call for them to play a more central role, it presents the opportunity to formalize their position as part of the health care delivery team. One key challenge remains: establishing a mechanism to reimburse for the services provided by CHWs. There are two critical steps towards achieving this goal: **1)** establishing a standard scope of practice for CHWs; and **2)** instituting standard core competencies for their training and certification. These are feasible action steps, and more than 10 other states have begun implementing them. In fact, some states have successfully established stable funding mechanisms to secure the role of CHWs as part of the health care team.

Working through a statewide stakeholder coalition, Minnesota passed legislation to reimburse CHW services under Medicaid in 2007. In 2008, the Centers for Medicare and Medicaid Services (CMS) approved a Medicaid State Plan Amendment authorizing payment for CHWs that worked under Medicaid-approved providers, including physicians, nurses, dentists, and mental health providers. Minnesota has been a leader in securing the role of CHWs as members of care coordination teams. With the second largest population of CHWs in the nation, a well organized workforce, and a supportive leadership in several large health delivery organizations, New York is uniquely positioned to follow Minnesota's example and advance the goal of securing a sustainable funding source for its CHW workforce.

Taking to scale the benefits CHWs offer can have an enormous impact on the State's ability to improve the health outcomes of all New Yorkers and help to contain the escalating cost of care.

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