



## FORUM SESSION

# Coaching, Connecting, Collaborating: The Community Health Worker's Role in Primary Care

JULY 31, 2015

---

Team delivery of health care services generally draws praise for both quality and efficiency, and this approach to medical practice is increasingly seen as “the way it should be,” with each team professional carrying out the duties for which he or she has been trained and working to the top of their license. Primary care practice team members often include nurses, nurse practitioners, physicians’ assistants, health coaches and educators, social workers, and medical assistants. In some places, the team may also include professionals whose job is to bridge a perceived gap between the health care system and the community in order to teach, encourage, and reassure those who are wary of medical treatment. Specific objectives might include getting people to sign up for insurance, start getting some exercise, or seek needed treatment (outside the emergency department).

Though they have many titles, these “bridgers” are most commonly known as community health workers (CHW), and their defining characteristic is that they come from the same community as the patients being served. The Bureau of Labor Statistics (BLS), which created an occupational category for CHWs in 2010, defines their work: “Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.”<sup>1</sup>

The BLS estimated that nearly 48,000 CHWs were working in 2014, with a mean annual wage of just over \$38,000. It should be noted that the BLS separates CHWs from health educators for purposes of classification; it may be that the full range of functions sometimes carried out by CHWs would produce numbers more in line with the Health Resources and Services Administration's (HRSA's) 2005 estimate of 120,000 CHWs in the United States.<sup>2</sup> About one-third of the HRSA estimate were unpaid volunteers, rather than the paid positions tallied by BLS. A subset of CHWs continues to serve in a volunteer capacity.

CHWs who are employed work for a variety of organizations, including local health departments, community health centers, provider organizations, and health plans. A CHW network may contract to provide services to multiple organizations, as is the case with the District of Columbia's Capital Clinical Integrated Network. Whoever the actual employer, the essence of this work is that CHWs will interact with a clinical care team as well as with patients.

As *Health Affairs* editor Alan Weil noted in a 2014 blog entry, there are two visions of where the CHW profession is (or should be) heading.<sup>3</sup> The first entails standardized training, certification, and full integration into the clinical team. Proponents of this path cite enhanced professionalism, career growth, and perhaps greater earning capacity. The second vision slots the CHW firmly in the community, as opposed to a professional office, and measures performance in terms of community health and engagement, stressing that what makes CHWs effective is the life experience they share with others in the community. Too-close identification with the medical establishment risks making them no longer "one of us." Both visions may have to be accommodated. In many situations, the CHW profession needs to make a business case to potential employers, but also counts its practitioners' community relationships as a unique strength.

CHWs' specific duties vary by organization, sometimes dictated by funding, such as a grant to address a particular health problem or situation. For example, the Sisters Together & Reaching (STAR) program in Baltimore employs CHWs to reach out to HIV-infected and at-risk African American women. CHWs in southeastern Kentucky have been charged with overcoming the resistance of many Appalachian women to cervical cancer screening. Managed care plan Molina hired CHWs to identify people eligible for but not enrolled in health insurance, and to persuade and help them to make appointments to receive care.

### National Health Policy Forum

2131 K Street, NW  
Suite 500  
Washington, DC 20037

**T** 202/872-1390  
**F** 202/862-9837  
**E** [nhpf@gwu.edu](mailto:nhpf@gwu.edu)  
[www.nhpf.org](http://www.nhpf.org)

Judith Miller Jones, MA  
*Director*

Sally Coberly, PhD  
*Deputy Director*

Monique Martineau, MA  
*Director, Publications and  
Online Communications*

### Forum Session Manager

Lisa Sprague, MBA  
*Principal Policy Analyst*

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at [www.nhpf.org](http://www.nhpf.org).

Certain themes of education, persuasion, and empathy are common across projects, and there is some evidence of agreement between CHWs and their hiring organizations on what is important. A 2012 survey of CHWs and their employers in New York state found that the two groups agreed on the five most critical roles for a CHW:

- outreach and community organizing,
- case management and care coordination,
- home visits,
- health education and coaching, and
- system navigation.<sup>4</sup>

Qualifications to serve as a CHW tend to include a high school diploma, a history of community involvement, and a caring personality. A handful of states have laws or regulations governing the training and certification of CHWs, and (as noted above) there is much discussion of standardized training, but today most employers provide the training and define the expectations.<sup>5</sup> Training may include education on diseases and disease management, nutrition and exercise, health information technology, and interpersonal techniques, such as motivational interviewing.

Shreya Kangovi and colleagues, writing this year in the *New England Journal of Medicine*, suggest that the outlook for CHWs has less to do with their skills and personalities than with implementation barriers in the health system around them.<sup>6</sup> Among these are insufficient integration with clinicians and a lack of well-developed work protocols (supervision, documentation, evaluation). Advocates for CHWs are quick to point out that medical team members need to be educated with respect to CHWs' capabilities and assignments, which often go beyond medical care to encompass social services. However, introduction of CHWs into team practice may stir more of the turf concerns already at stake among health professionals.

Steady funding has long been an issue for CHW programs, many of which were inaugurated with short-term grants or public health dollars. The Patient Protection and Affordable Care Act of 2010 (ACA) offered the possibility of grants to states from the Centers for Disease Control and Prevention for the purpose of improving health in underserved areas through the use of CHWs. Funding for such grants was not appropriated. However, as part of the regulations implementing the ACA, the Centers for Medicare &

Medicaid Services made a change in Medicaid policy permitting preventive services *recommended* by a physician or other licensed practitioner to be reimbursed even if provided by a non-licensed person (such as a CHW).<sup>7</sup> Previous policy had been that such services were only reimbursable if *provided* by the licensed practitioner. States must specify what preventive services will be covered, who will provide them, and the provider qualifications the state will require. Also post-ACA, grants from the Center for Medicare & Medicaid Innovation have supported some projects involving CHWs.

Kangovi *et al.* observe that evidence on the effectiveness of CHW programs has had “substantial methodologic limitations.” However, they go on to note that the number of articles on CHWs published in academic journals and the number of randomized, controlled trials conducted have increased substantially in the past five years, suggesting that rigorous evaluation is possible. Some CHW programs have been able to document both clinical success and monetary savings.<sup>8</sup>

The use of CHWs is not the only strategy that has been tried to close the gap between a medical organization and the hard-to-reach members of its patient population. Health Leads is a model that embeds trained college students in hospitals, health centers, and medical practices. These advocates help patients identify, track down, and connect with resources they may need beyond medication, such as food, transportation, or heat, that clearly affect their health. The Medical-Legal Partnership model, which combines public health and legal professionals, similarly identifies and addresses what its creators call “patients’ health-harming social and legal needs.” While it is difficult to predict the progress toward better integration of physical, social, and behavioral needs—and to agree on how such integration will be paid for—it is evident that many organizations are willing to try new methods to reach out to underserved populations.

## SESSION

This Forum session considered the development of the CHW profession, the objectives and experience of organizations that have adopted a CHW program, and the prospects for and barriers to expansion of such programs. **Mary-Beth Malcarney, JD, MPH**, assistant research professor in the Department of Health Policy and Management at the George Washington University, summarized

her research into how CHWs are recruited, trained, employed, and evaluated. Following Ms. Malcarney's presentation was a facilitated discussion featuring representatives of three organizations with CHW programs. They are **Frances Feltner, DNP, MSN, RN**, director of the University of Kentucky's Center of Excellence in Rural Health; **Gina Pistulka, PhD, MPH, RN, APRN**, chief nursing officer of Capital Clinical Integrated Network in Washington, DC; and **Michelle Martin, JD**, director of policy for Molina Healthcare of California. **Michelle M. Washko, PhD**, deputy director of the National Center for Health Workforce Analysis in the Health Resources and Services Administration, will speak briefly to federal efforts to foster the CHW model.

## KEY QUESTIONS

- What are the advantages and disadvantages of in-house versus academic training of CHWs? Would standardization of training limit the range of functions CHWs may perform?
- Are some CHW functions more associated with cost savings than others?
- Should CHW licensure or certification become the norm?
- What training or interventions can facilitate care team acceptance of CHWs?
- To what extent are CHWs able to bring community knowledge and resources to medical practice, as well as reach out from the practice to the community?
- How will reimbursement for CHW services evolve? Will such services be included in bundled payments?

## ENDNOTES

1. Bureau of Labor Statistics, Occupational Employment and Wages, "21-1094 Community Health Workers," May 2014, [www.bls.gov/oes/current/oes211094.htm](http://www.bls.gov/oes/current/oes211094.htm).
2. Health Resources and Services Administration, *Community Health Workers National Workforce Study*, Executive Summary, May 2007, p. x, <http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf>.
3. Alan Weil, "What is the Future for Community Health Workers?" *Health Affairs Blog*, November 25, 2014, <http://healthaffairs.org/blog/2014/11/25/what-is-the-future-for-community-health-workers>.

4. Sally Findley, "New Survey of Community Health Workers and Employers Shows Emerging Consensus on Standards Defining the Profession," Columbia University Mailman School of Public Health, August 21, 2012, [www.mailman.columbia.edu/news/new-survey-community-health-workers-and-employers-shows-emerging-consensus-standards-defining-p](http://www.mailman.columbia.edu/news/new-survey-community-health-workers-and-employers-shows-emerging-consensus-standards-defining-p).
5. For a map showing state activity, visit [www.astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards](http://www.astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards).
6. Shreya Kangovi, David Grande, and Chau Trinh-Shevrin, "From Rhetoric to Reality – Community Health Workers in Post-Reform U.S. Health Care," *New England Journal of Medicine*, 372 (June 11, 2015): pp. 2277-2279, [www.nejm.org/doi/full/10.1056/NEJMp1502569](http://www.nejm.org/doi/full/10.1056/NEJMp1502569).
7. Centers for Medicare & Medicaid Services, "Update on Preventive Services Initiatives," CMCS Informational Bulletin, November 27, 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>.
8. For examples, see Lisa Sprague, "Community Health Workers: A Front Line for Primary Care?" National Health Policy Forum, Issue Brief No. 846, September 17, 2012, [www.nhpf.org/library/details.cfm/2907](http://www.nhpf.org/library/details.cfm/2907).

