COMMUNITY HEALTH WORKERS:

A KEY ROLE ON THE COLLABORATIVE CARE TEAM

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There is relentless change happening today across the full continuum of healthcare; new models of healthcare delivery and reimbursement are evolving rapidly. Affected practice settings include accountable care organizations (ACOs), integrated health delivery systems and population health management models of coordinated care with value-based (outcomes-driven) reimbursement, and they all rely on effective identification, engagement and care coordination of patients at risk for adverse outcomes, both to achieve improvements in clinical outcomes and reduced cost of care.

However, there are additional factors that need to be considered in these models when they serve vulnerable populations such as the economically disadvantaged, racial and ethnic minorities, the uninsured or underinsured, low-income children, the frail elderly, the chronic mentally ill and the homeless. For these populations, it's absolutely critical to incorporate a community-based focus to effectively address the many social determinants of health that are key drivers of health inequities and disparities in care.

Community health workers are the ideal members of the collaborative care team to help achieve this critical need in vulnerable populations and underserved communities. Case managers and other members of the collaborative care team need to understand the role and functions of the community health worker (CHW) to fully appreciate the value CHWs bring to the team and to the patients they work with.

WHO ARE COMMUNITY HEALTH WORKERS?

Healthcare professionals are often surprised to learn that community health workers have been around for many years! In fact, CHWs have a "long and proud history of accomplished service" in reaching underserved populations within communities that typically have both complex medical and social needs (Phalen & Paradis, 2015).

CHWs are non-clinicians and do not provide clinical care. They are not physician or nurse extenders, but rather have a unique specialized role that is best described by the American Public Health Association's policy statement on CHWs (APHA, 2009):

- CHWs are front-line 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/link/intermediary between health/social services and the community.
- CHWs seek 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.

CHW ROLES AND FUNCTIONS

CHWs work in a wide variety of settings along the care continuum, including public health organizations, healthcare clinics, medical offices, hospitals, managed care organizations, schools and community centers. CHWs most commonly focus on helping patients manage chronic diseases, encouraging preventive healthcare and ensuring healthcare access.

Since CHWs generally live in the communities where they work, they are highly tuned into the social context of the community. Thus, they are uniquely qualified to be connectors to the community and link patients to resources and networks (Brownstein & Hirsch, 2011).

The roles and activities of CHWs are focused on meeting the unique needs of patients within their communities and the goals of the organizations within which they work. Generally, these include:

- Creating connections between vulnerable populations and healthcare systems;
- Ensuring cultural competence among healthcare professionals serving vulnerable populations;
- Providing culturally appropriate health education on topics related to chronic disease prevention, physical activity and nutrition; and
- Advocating for underserved individuals and communities.

The CHW serves as an integral member of the healthcare team by supporting the team's patient-centered goals and interventions. For example, CHWs:

- Support individualized goal-setting, implementation of self-management plans and long-term self-management support;
- Help patients navigate healthcare systems (for example, by providing assistance with

enrollment, appointments, referrals, transportation to and from appointments, and interpreter services at appointments);
- Provide social support by listening to the concerns of patients and their family members and helping them find solutions; and
- Create community-clinical linkages to help create a team-based approach through supporting and enhancing the work of the healthcare team (CDC, 2015).

CHW PRACTICE IS EVIDENCE-BASED

An abundant body of evidence supports the impact of the CHW on reducing costs and improving health outcomes, which has significant implications as CHWs become increasingly incorporated in healthcare teams. Some noteworthy research findings include:

- CHW programs have been shown to help improve disease outcomes for patients with asthma, hypertension, diabetes, cancer, tuberculosis, HIV/AIDS, and depression (Kim et al, 2016).
- Documented savings in CHW programs have been attributed to reduced ED use, reduced hospitalizations, fewer readmissions and reduced long-term care placements in numerous studies (Commonwealth Fund, 2015).
- There is also strong evidence that CHW interventions within multidisciplinary healthcare teams improve health-related outcomes such as chronic disease understanding and self-care management for many groups experiencing health disparities, such as low income, uninsured, African-American, Filipino and Hispanic populations (CDC, 2014).

TRAINING AND CREDENTIALING OF CHWS

CHW training initiatives come from local and regional efforts such as state and local health agencies, service provider professionals and organizations, community-based organizations, health advocacy groups and community-based academic coalitions (Rural Health Information Hub, 2016).

Currently, there are no national training or credentialing standards for CHWs. However, in recent years there has been a surge of activity and interest in promoting standard definitions of CHW practice as well as training, certification and credentialing programs.

An excellent resource to determine the status of CHW education and training, certification, scope of practice legislation and existing CHW organizations on a state-by-state basis is the National Academy for State Health Policy (NASHP), an independent academy of state health policymakers. The NASHP has an interactive CHW Model Map on its website, which readers are encouraged to reference for more details on state-specific information in these areas. The CHW Model Map can be found at **http://www.nashp.org/state-community-health-worker-models/.**

CHWs have proactively formed specialty associations in a number of states. Efforts are also underway to develop a national association to represent the interests of CHWs and advocate for a greater understanding of CHW practice in order to promote acceptance as a recognized occupation and highlight their contributions on multidisciplinary healthcare teams (Commonwealth Fund, 2015).

FINDING COMMON GROUND: HOW COMMUNITY HEALTH WORKERS BRING VALUE TO THE COLLABORATIVE CARE TEAM

PATIENT CENTERED CARE COORDINATOR

- Proactive communication and outreach with providers, patients, families
- Help identify patient's strengths, needs, and preference
- Promoting true patient-centered focus and care delivery

HEALTH PROMOTION

- Help reinforce clinical education efforts—increase patient's understanding of conditions and importance of treatment/medication adherence
- Help build personal skills and resources for self-management and wellness
- Focus on closing gaps in clinical effectiveness quality measures such as HEDIS and STARS

ADVOCACY & ACCESS

- Help ensure patients are connected to needed services and resources
- Enable access to services such as transportation, interpreters, and child care
- Linking patients, families, and their support system to meet basic human needs (housing, food, clothing, safety and security)

OUTREACH

- Serving patients "where they are," based on their preferences
- Assertive engagement efforts including home and provider visits
- Knowledge and experience with local community cultural norms and values

PROMOTING COLLABORATIVE TEAM-BASED CARE

One of the most important elements of successful care coordination is without a doubt collaboration. Collaboration is so fundamental, so necessary and so essential to effective case management practice that the very definition of professional case management is based on the premise of it being "a collaborative process" (CMSA, 2016).

Collaborative care has become critically important in optimizing patient-centered care and serves as a "safety net" for patients at risk for adverse health outcomes. In fact, team-based collaborative care is now widely recognized as an evidence-based best practice.

Therefore, it is essential that professional case managers and other members of the collaborative care team fully understand the complementary role the CHW plays. The team will be at its most effective when mutual trust and respect for the CHW role is clearly valued, communicated and demonstrated in everyday practice.

Research has consistently demonstrated highly functioning care teams include the following characteristics (Mitchell et al, 2012):

- All team members understand and are working toward the same shared goals.
- All team members have a solid and deep trust in each other and in the team's purpose.

- Team members are clear on how to work together and how to accomplish tasks.
- Team members believe that no individual members are more important than the team.
- Each team member respects the team processes and other members' roles.

It is essential that professional case managers pursue meeting these goals for high-functioning teams and model the required collaborative behaviors to promote understanding, trust and respect for the CHW role. In doing so, we help ensure that CHWs are seen as fully vetted members of the team who provide uniquely salient contributions to achieving improved outcomes for vulnerable patients at risk for adverse health outcomes.

As we move forward and continue the transition to new and evolving models of care, it's more important than ever to think about ways to promote collaborative, team-based care. By better understanding the role and functions of CHWs, professional case managers are able to embrace the unique strengths and value CHWs bring to the collaborative care team. ■

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