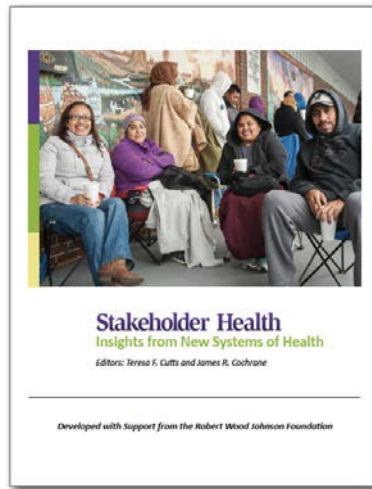


# Stakeholder Health

## Chapter 5 Navigating for Health



From

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# Navigating for Health

*Nancy Combs, Kimberlydawn Wisdom, Dominica Rehbein, Catherine Potter and Joan Cleary, with Loel Solomon, Nada Dickinson, Teresa Cutts, Ameldia Brown, and Monica Lowell*

*"Serving as a community health worker is being a resource to help ease some of the stressors in people's lives. We are a bridge of support that brings our clients to the road of their success."*

*- Nada Dickinson,  
Community Health Worker, Detroit*



## A DAY IN THE LIFE OF A COMMUNITY HEALTH WORKER

Nada Dickinson, a community health worker (CHW) since 2011, is on a team with four other CHWs, all of whom have key roles within the Women-Inspired Neighborhood Network: Detroit. The WIN Network is a collaboration among four Detroit health systems, public health agencies, universities and more than 40 community partners to reduce Detroit's high infant mortality rate. Nada also serves as a health insurance navigator at Henry Ford Health Medical Center-Hamtramck, in a culturally diverse, largely underserved neighborhood north of downtown Detroit. Throughout this narrative, you will see the CLOCK icon to mark a moment in Nada's average day—although she assures us that no day is "average" in the life of a CHW!

## Navigation is More than a Compass

We'll begin by asking this key question: "Why is navigation important in health care today?" In today's complex health environment many people struggle to find the health care services they need. Even highly educated people with comprehensive insurance may struggle to understand and successfully negotiate our fragmented system when facing a health crisis or needing other services. People from marginalized communities or those in poverty may be even less able to find or access the care they need. As a result, many organizations have recognized the need for navigation to improve health care access and to connect patients with the social services necessary to truly optimize health.

Navigators of many types may be hired to support strategies in the name of "population health," a real challenge in light of aging demographics, an epidemic of chronic disease and disparate health outcomes among subgroups. This broadly used term is built into the Institute for Healthcare Improvement's Triple Aim (Berwick, Nolan, & Whittington, 2008), which we have repeatedly expanded to the Quadruple Aim or Triple Aim+ (HSLG, 2013). To help achieve Quadruple Aim goals, we can provide navigation services that are particularly critical to patients facing barriers related to poverty, culture, language, literacy, isolation, mistrust, disability, geography and other such factors.

Due to their experience and training, many navigators are equipped to work across a variety of health-related sectors. In the population health environment, navigators can assist with insurance enrollment,



**8 A.M.** Coffee in hand, Nada arrives at her office and sits down to check email. Over the weekend, she's received contact info for 73 community members who have reached out to the CHWs for help getting enrolled in Michigan's expanded Medicaid program. "Many of these callbacks will be brief," Nada says, "but you never know when someone will have more complex health needs that will require a longer conversation. My team members and I will divide up the calls to address everyone's concerns." Collecting the information, she heads off to her weekly CHW Team huddle.

connecting people with health care services, locating and connecting clients with social supports, interpreting treatment plans, making follow-up appointments and contributing to research projects. Many worker types include navigation as one of their core competencies, and some exclusively serve in a navigator capacity.

The following describes some of the many types of navigators, with examples of the settings where they may be found, and one example of their work duties.



Title	Examples of Settings	Examples of Navigation (specific to worker type)
Care Coordinator	Hospital, Health System, or Care Delivery Setting	A nurse or social worker helping a cancer patient understand her treatment plan and make optimum use of health system resources
Health Navigator	Community-Based Organization	A worker in a social service setting who helps community members with insurance enrollment
Community Health Worker	Community Based Organization or Health System	A lay person, with unique skills and community connections, who helps community members find and connect with needed services
Promotora	Community Clinic	A lay person who does outreach and education on behalf of a clinical team, including home visits, to Spanish-speaking patients (often considered one of the major titles under the broad "CHW umbrella")
Faith Community Nurse	Church or other Faith Community	A nurse (often a volunteer) who helps congregation members find needed services and maintain their health
Peer Support Specialist	Community Mental Health Agency	Lay person with personal experience in the mental health system, helping someone else in the early stages of recovery, to find housing and meet other basic needs
Navigator	Primary Care Team	A bachelor's level worker who works in a team-based care setting, helping patients address social needs and connect with community resources
Doula	Home	A lay person, with special training in childbirth and postpartum care, who helps a new mom find supplies needed to care for an infant

## AMERICAN PUBLIC HEALTH ASSOCIATION & COMMUNITY HEALTH WORKERS

According to the American Public Health Association (APHA), a community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (APHA, n.d.).

CHWs do not typically hold a license in a health vocation such as nursing or social work. While the CHW role is considered an “emerging health profession,” it has deep roots in many urban and rural communities across the U.S. and is now more fully entering mainstream health and public health settings.

Navigation is rarely enough for people with complex health needs or those struggling with weighty basic issues of food, housing, and violence. Ongoing support and the ability to address larger issues—not only with a compass, but with trust and companionship for the journey that comes from shared culture or shared life experience—are often needed.

Community health workers (CHWs) are particularly well suited to play this more comprehensive role. As members of the communities they serve, they are intimately familiar with the barriers and challenges facing people with complex medical and sociocultural needs. Through them, we will see what frontline health workers can accomplish, as navigators but also as clinical team members, neighborhood-based mentors or guides, and powerful agents of measurable community and systems change. We will find it easier to envision a

health care system, where the term “population health” is understood and embraced by all—even for the most challenged, vulnerable communities.

Below, we will further examine the work of CHWs to show the impact and potential for addressing population health, and we will also highlight other navigation models—all best practices in their own right—in sidebars. Look for the Best Practice icon to learn more.

In summary, in today’s complex health system, navigators of various types are needed to help individuals connect with resources to help them live healthier lives, but in our current environment, simple navigation is often not enough. Community health workers go “beyond the compass” through their relationships with patients and clients over time, evidence-based outcomes, and connectedness to clinical and community settings, illustrating the highest potential for frontline navigators working for population health.

### *How Community Health Workers contribute to the Triple Aim+*

#### **Reduced per capita costs**

- Improved utilization of preventive services
- Reduced use of ED
- Improved birth outcomes

#### **Improved quality and the patient experience**

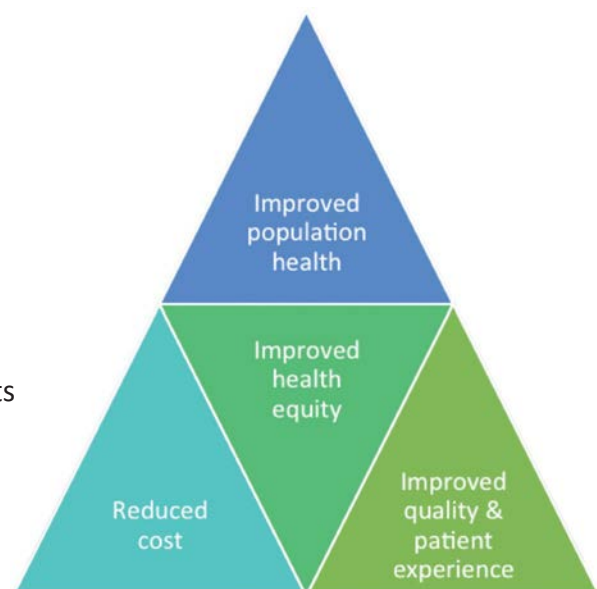
- Improved utilization of preventive services
- Improved care transitions
- Improved patient activation

#### **Improved population health**

- Improved chronic disease management
- Better connections with social services and supports
- Culturally appropriate health education

#### **Improved health equity**

- Reduced infant mortality
- Improved asthma control
- Better language access
- Increased knowledge of local community needs







## Minnesota Community Health Worker Alliance

*Used with permission from the Minnesota Community Health Worker Alliance*

*“As Henry Ford continually addresses the Triple Aim of improving population health, enhancing patient experience and outcomes, and reducing per capita cost of care, we see community health workers as playing a pivotal role. We invest in CHWs because we know they help us make a difference where our patients live their lives and make their daily health choices. And as the Triple Aim+ embraces Equity as its fourth component, our CHWs are already there—at the key juncture where clinical and community work converges to reduce health disparities. At Henry Ford we like to say we are ‘All For You’—our patients and community. There is no better personification of this than the community health worker.”*

*- Nancy Schlichting, CEO, Henry Ford Health System, Detroit*

### Advancing the Triple Aim+ or “Quadruple” Aim

We first ask how CHWs can help our organizations work toward achieving the “Quadruple Aim” or “Triple Aim+,” adding the critical dimension of equity to the Triple Aim (Achieving the Triple Aim, 2015). In working to simultaneously improve the quality and experience of care, improve population health, and reduce the per capita cost of health care, health systems are finding that CHWs play an important role in achieving all these goals. CHWs’ history and trusted connections with underserved communities uniquely equip them to reduce health disparities, while their deep community understanding (language and culture) allows them to serve as effective brokers between their communities and the broader healthcare setting. Here we highlight key evidence of how CHWs contribute to achieving the Triple Aim+.



**9:40 A.M.** Nada is gathering up materials for the group prenatal care class she will help lead later this morning when the phone rings. It's a fellow CHW who's active in the Michigan Community Health Worker Alliance, (MiCHWA), the statewide CHW advocacy organization. Next week, Nada will join her colleague and other CHWs from across the state, along with health plan and health system decision makers and representatives of the Michigan Department of Health & Human Services. This ad hoc group is working to develop a payment model so that CHWs can be funded through Medicaid. Nada and her colleague check in on details for the summit, then Nada heads to the clinic classroom to set up for the prenatal group visit.



## Reducing Per Capita Costs

As the healthcare system continues to take on increasing responsibility for the costs and outcomes of their patients, healthcare providers, health plans and purchasers are seeking care delivery improvements that lower costs and offer a positive return on investment. The Institute for Clinical and Economic Review (ICER) completed a rigorous review of the evidence on value of CHWs and found that, compared to usual care, CHW programs resulted in significantly improved outcomes and reduced healthcare costs, in part due to their ability to fill an important gap in services (ICER, 2013). Healthcare professionals are directed to provide care “at the top of their license.” This creates space in the care team for CHWs to address some of the patient’s basic needs such as scheduling healthcare appointments, connecting with available community resources and applying a health care provider’s recommendations in daily life. Integrating CHWs into care teams as experts in addressing these needs is a cost-effective way to ensure these needs are met (Felix, Mays, Stewart, Cottoms, & Olson, 2011).

Cost savings can be realized in various ways, including improved utilization of preventive health care services, reduced waste such as missed appointments, decreased overall costs for group visits, and avoided high-cost services. For example, CHWs working through the Arkansas Community Connector Program (ACCP) assisted individuals in setting up home and community-based services that could meet their needs instead of their moving to a costly long-term care facility. This reduced per-participant Medicaid spending by 23.8 percent on average, and generated \$2.619 million in savings over a three-year period (Felix, et al., 2011).

For a health care organization, savings may come in the form of fewer emergency room visits, pre-term births or admissions/readmissions. In Baltimore, home visits by CHWs to low-income patients with diabetes and hypertension reduced their visits to the emergency department by 40 percent. The Children’s Hospital of Boston Community Asthma Initiative reduced emergency visits by 65 percent and hospitalizations by 81 percent, and the success of this initiative led to the inclusion of CHWs on the team of providers in a bundled payment arrangement with the state’s Medicaid plan (CHWA, 2013).

In a matched cohort study of enrollees in Molina Health, a Medicaid managed care plan in New Mexico, an assessment of the economic impact of a CHW intervention on high-risk patients found a sustained ROI of at least 3:1 (Johnson, Saavedra, Sun, Stageman, Grovet, Alfero, Kaufman, 2011). Molina’s corporate office thus expanded this model from New Mexico to all states where it has a Medicaid contract. Using frequent ED visits to identify high-risk patients, CHWs provided home visits for needs assessments, appointment support and reminders, health literacy support and education, advocacy, equipment and supplies. Using claims data to evaluate the program, the team found that costs

decreased from the pre-program period in both groups. Compared to a similar group that received no CHW services, there were significantly greater reductions in ED use, hospitalization, and both narcotic and nonnarcotic prescriptions, with an annual cost reduction of \$3,003 per patient (Johnson, 2011).

Return on investment for CHWs can also be measured from the societal perspective. Improving health outcomes for groups of patients increases their economic productivity in a community. This includes wages earned, taxes paid and reduced urgent care use. A 2012 study conducted by the St. Paul-based Wilder Foundation found that for every dollar invested in CHW cancer outreach, society receives \$2.30 in benefits, a return greater than 200% (Hardeman & Gerrard, 2011).



**10 A.M.** Twelve women at similar stages in their pregnancies have arrived for this group prenatal care session with a certified nurse midwife, medical assistant and Nada. The women receive their prenatal care together and learn about important practices for their prenatal health. Nada, who is making home visits to each participant, co-facilitates the session, and shares resources. “I really enjoy spending time with these women,” says Nada. “We have some common experience, and I can guide them toward services near where they live. It’s also great to work in partnership with the clinical team,” she adds. Having this connection to a trained health professional who is familiar with their circumstances puts the group members at ease.



## Improving Quality and the Patient Experience

As patient-centered medical homes and behavioral health home models are established across the country, team-based, patient-centered approaches for organizing care and services are receiving greater emphasis. These models focus on care coordination, patient goal-setting and activation, coaching, and community-clinical linkages in order to help achieve the Quadruple Aim.

Integrating CHWs as part of these teams improves the effectiveness of the models and accessibility to community members. An increasing number of studies demonstrate the dramatic impact they can have on health care quality (as measured by the National Committee for Quality Assurance or NCQA, and the HealthCare Effectiveness Data and Information Set, HEDIS). For example, statistically significant increases in breast cancer screening rates have been noted when CHWs working in primary care practices reached out to women via phone, mail, or home visits. They offer support and education, meet women at the screening sites, provide needs assessments and address financial, coverage and transportation barriers. Women accessing these CHW services were three times as likely to receive mammograms as those not engaged with CHWs (Achieving the Triple Aim, 2015).

CHWs can also be deployed within clinical teams to improve care transitions and reduce hospital readmission rates with considerable potential value to providers especially in light of payment models that assign penalties for high readmission rates. The IMPaCT (Individualized Management for Patient Centered Targets) community health worker model developed by the University of Pennsylvania Health System is a good example. IMPaCT is a standardized, scalable CHW model that includes clear guidelines for hiring, supervision, integration into care teams, and work planning for CHWs. In this model, CHWs began working with patients early on during their hospital stay to set patient-identified goals for recovery. Through regular ongoing contact and follow-up post-discharge, patients receiving the CHW intervention showed improved rates of timely follow-up care, increased rates of patient activation and reduced rates of multiple readmissions (Kangovi, Mitra, Grande, White, McCollum, Sellman, Shannon & Long, 2014).





**11:30 A.M.** Nada arrives at Kayla's address in Detroit's Osborn neighborhood, on a street where half the houses are boarded up. Kayla, 26 and in her first trimester, has recently signed up for group prenatal care. She and her energetic toddler are currently staying with Kayla's older sister until they can afford their own place. "We call this situation 'couch-homeless,'" Nada says quietly as we wait for Kayla to answer the door. It's the first time Nada has met with Kayla so she walks through the standard first-visit protocol. "Kayla, it's so great to meet you,

and I look forward to our getting to know each other better," Nada says. "What are your major concerns today?"

"I'm really worried about how we can pay the heating bill," Kayla responds. "What if we get a shutoff notice?" Right there, Nada dials United Way 2-1-1 and puts Kayla on the phone to talk to one of their trained counselors who assures her they can work out a payment plan.

Immediate crisis averted, Nada reminds Kayla about her group prenatal care visit coming up next week. She then arranges for free transportation through Kayla's Medicaid health plan. She shares helpful tools: a brightly illustrated book on having a healthy pregnancy, a directory of community resources, and last but not least, links to the WIN Network: Detroit website and Facebook page, replete with resources and upcoming events. Together they look at opportunities to connect with other WIN Network: Detroit members. Nada hands Kayla her cell number and contact info for the WIN Network. Lastly, they work out action steps that Kayla agrees to accomplish in the next week, and set a time for Nada's next check-in.

"Developing a trusting relationship with Kayla is first and foremost," says Nada upon leaving. "My assistance to her is guided by her priorities for her and her family. Kayla also is worried about getting her own place. We'll work on affordable housing options next."

## Improving Population Health

Community health workers are significant assets to a community for the prevention and management of chronic diseases, as well as tireless advocates for community development. They are thus also allies and key partners in addressing the socioeconomic and behavioral risk factors of patients.

For example, in the prevention and early identification of chronic disease, Access El Dorado (ACCEL) includes public and private agencies that work with vulnerable populations to connect community members with existing local services, particularly health insurance (AHRQ, 2011). CHWs from participating agencies help participants navigate the array of services. Besides a more coordinated experience for families, the participation of a variety of organizations, including social services and health care, allows for outcomes data from all sectors to be collected and analyzed together (CHWA, 2013). This approach also allows stakeholders to see the link between health education or connection with a medical home, and averted emergency visits or other costs due to prevention.

A survey of community health centers in Massachusetts found that the task of assisting with chronic disease management is another primary focus of many CHWs (Achieving the Triple Aim, 2015). As trusted resources, CHWs may be the first to learn about symptoms a patient with a chronic disease is experiencing and can enable them to access primary care at the appropriate time. Further, CHWs have more opportunities to understand the unique challenges a patient is experiencing in managing their chronic disease and can assist them in problem-solving (CHWA, 2013).

At the most upstream level, CHWs can impact social determinants such as employment, food insecurity or homelessness (CHWA, 2013). This occurs both through direct referrals to needed resources for individual clients and through policy change. Through building relationships with community organizations, CHWs keep up with services available and how to access them. Through community "asset mapping," a participatory endeavor, community members identify what they view as assets in



their neighborhoods and, as members of the neighborhoods, CHWs contribute to this process and can use information about strengths and gaps in resources to advocate for policy change (City of Healthy Neighborhoods & Buildings, n.d.).

## Improving Health Equity

Factors such as culture, language, literacy, income, disability, and geographic location often create barriers to achieving ideal health status in our increasingly diverse U.S. population. We are challenged to confront and eliminate these health inequities, which shorten life expectancy, impair health and well-being, and reduce the ability of many Americans to lead productive lives (Disparities, n.d.). In the context of such inequities, which are unjust and costly for individuals, communities and society, the American Public Health Association, the Centers for Disease Control and Prevention, the Institute of Medicine and other leading health authorities all endorse and recognize the key contributions that CHWs can make to reducing health disparities (Smedley, Stith, & Nelson, 2003).

First, CHW programs designed for chronic disease management will more frequently work with

communities negatively impacted by poverty and other social determinants where people are more likely to develop chronic diseases (Achieving the Triple Aim, 2015). Second, as members of those communities, CHWs tend to have a deep and thorough understanding of the communities they serve that helps them better communicate issues, promote healthy options and problem-solve with patients, resulting in more acceptable recommendations.

Here we highlight three projects that illustrate how CHWs are reducing health disparities:

- There is no more glaring or troubling health disparity than infant mortality, a sentinel health indicator or barometer of a community's health. In Detroit between 13 and 15 babies per thousand live births do not survive until their first birthday—among the highest rates in the U.S. (Infant Mortality, 2016) and almost three times that of the state's non-Hispanic white babies (Infant Mortality by Race, 2016). A game-changing public-private partnership in Detroit—which includes competing health systems—is making promising headway in addressing this crisis.

The WIN Network: Detroit, a program of the Detroit Regional Infant Mortality Reduction Task Force facilitated by Henry Ford Health System, employs CHWs to support women at high risk for preterm, low-birth weight infants. In the three neighborhoods where



### FAITH COMMUNITY NURSING AND HEALTH MINISTRY ADVANCING POPULATION HEALTH AND CHRONIC DISEASE MANAGEMENT

Partnering with Faith Community Nursing (FCN) and Health Ministry is a key community benefit strategy for Henry Ford Health System (HFHS) as it addresses chronic disease management, population health, and lifestyle improvement. Aligning mutual goals has allowed Henry Ford Macomb Hospital, one of five HFHS hospitals, to achieve many positive health outcomes.

In one transitions-of-care project targeting heart failure patients, unpaid FCNs were able to achieve decreases in physician, ED and hospital visits by 70%, 50% and 29% respectively over a 24-month period. Similarly, successful results were documented in a clinic for low-income uninsured and newly insured clients with diabetes management. In 2014, the average A1C change was a decrease of 5.7% (N = 38) and in 2015 the average A1C was decreased by 5.9% (N=29).

FCNs and their teams have been instrumental in the planning and rollout of the systematic approach to advance care planning for end-of-life. They account for 25% of the documented outcomes of HFHS advance care planning efforts (classes, conversations initiated, advance directives completed). Faith Community Nursing also is leading the implementation of the health system's Diabetes Prevention Recognition Center activities. In seven months, 17 coaches were trained and 6 classes implemented.

The commitment and quality of the FCNs and health ministers is what allows such rapid deployment of this complex program. HFHS also communicates on behalf of the national network using the documentation system. Over three years, FCNs and Health Ministers from 23 different networks in 25 states have documented 78,086 individual interactions, 1,587,070 group participant contacts for education, screenings and support groups, and \$4,818,454 group cost savings and cost avoidances.

its CHWs have been working since 2012, there have been no infant deaths among more than 364 mothers enrolled in the program. WIN Network also has enrolled 1,518 non-pregnant women who are connected with and learn about resources that focus on healthy living, family planning, stress management, budgeting, nutrition and physical activity. WIN has also trained more than 438 local health providers on the health equity framework and social determinants of health. It is expanding its model to introduce group prenatal care for obstetric patients at Henry Ford, and beginning in spring 2016, CHWs are co-facilitating the sessions with groups of 12-15 patients and Henry Ford nurse midwives.

- Across the U.S., asthma disparities challenge many low-income communities where costly and preventable suffering continues as a result of substandard housing with patients often landing in busy hospital emergency rooms. Effective use of trained CHWs as home visitors can substantially improve asthma outcomes and reduce costs, as Krieger, Takaro, Song, Beaudet and Edwards (2009) show. They document the work of the Seattle-King County Healthy Homes II Project, which serves low-income, multi-ethnic communities, and conclude that CHW home visits coordinated with support from asthma nurses in the clinic increased symptom-free days and improved caregiver quality of life.
- CHWs also help health systems implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards of the U.S. Office of Minority Health while improving outcomes for diabetes and other chronic diseases (Office of Minority Health, n.d.). As one of multiple examples, a culturally competent pilot study known as the Promotora-Led Diabetes Prevention Program (PL-DPP) used promotoras as intervention facilitators for a group of 20 Latina women in Chicago who were at risk for diabetes. The participants—socioeconomically challenged with limited access to health care services—engaged in a 12-month lifestyle intervention by a Spanish-speaking promotora. Eighteen of them attended at least half of 24 sessions. After a year, a mean loss of almost 11 pounds or 5.6% of initial body



## A HEALTHCARE HERO IN MEMPHIS

Joy Crawford Sharp is an exceptional Community Health Network navigator, the first place-based population health navigator in the Methodist Le Bonheur Healthcare (MLH) system in Memphis, Tenn. She was born and lived her early years in zip code 38109, the poorest in Memphis, where MLH first identified in 2010 that they had high levels of charity care, anticipating the Affordable Care Act.

Joy, hired early in 2013, literally “hit the ground running,” establishing alliances with trusted locals like “Big Dog” who gave her explicit instructions on staying safe in the neighborhood, as well as local pastors, and neighborhood youth, many of whom were unemployed. To date, her most important job has been serving as the point person for the Cigna-funded “Wellness without Walls” initiative, which spun out of what the community said they needed: better access to healthcare.

MLH leadership, seeking a more innovative approach than building brick and mortar clinics, in 2013 began offering a “Shall Not be Called Health Fair” held regularly at the local community center. Joy personally followed up with every person who had needs or outlying values on screenings at those events, which grew to reach more than 1,700 people. She found herself engaging in tasks as diverse as locating hearing aids, finding adoption agencies for pregnant teenagers, or counseling a 16-year-old girl frequently hospitalized for intractable gastrointestinal disease who just wanted to graduate from high school.

Joy’s efforts led to early overall reductions in charity care (reported in the 2013 Health Systems Learning group monograph). Although charity care had increased 35% from 2010-2011, overall charity care costs dropped 6.9% from 2011-2012, with costs in zip code 38109 dropping an astounding 8.9%. Of course, the most important “metric” is that persons who stay out of the hospital have much improved quality of life. Joy and the team continued in 2014 to focus on frequent utilizers in 38109—97 people, most of whom had at least 3 co-morbid conditions (Congestive Heart Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Renal Disease). By November, charges for those persons had dropped by 43% (Nelson, Rafalski, Bailey & Marinescu, 2014).

She sees her job as a ministry and feels blessed to be able to provide such hands-on care to so many, addressing the social determinants of health that truly drive avoidable health care costs and readmissions. Her efforts have been so important on the ground that the Memphis Business Journal acknowledged Joy with the 2015 “Healthcare Hero” award.

weight was reported, along with pre-post reductions in blood pressure, LDL cholesterol and insulin levels. Participants also reported high program satisfaction (O'Brien, Perez, Alos, Whitaker, Ciolino, Mohr & Ackermann, 2015).

In sum, CHWs can “stand in the gap” to link clinical and community resources for their clients and, as members of clinical teams, provide a culturally competent, intrinsically trustworthy bridge while also helping clinicians increase patient engagement in a treatment plan. Because time with the doctor can be very brief, CHWs help by following up with the patient to assess for health literacy and understanding of a plan, listen for core concerns that could impede self-management, and offer ongoing support that can favorably impact health outcomes.

By bridging important gaps in services, helping manage chronic diseases among patients, improving preventive screening rates, reducing readmissions and improving patient satisfaction—all aspects in achieving the original Triple Aim—CHW programs generate savings for providers, payers and society as a whole. Lastly, community health workers’ knowledge about and connection with the neighborhoods they serve make them powerful advocates for policy change and key players in improving health equity, the critical fourth or Quadruple Aim.



**1:30 P.M.** Nada arrives back at the office with a sandwich she’s grabbed in route. She ensures Kayla’s pregnancy info file is up to date. Additionally, she sets an alert for the day she will follow up with Kayla to see how she is progressing. “Planning and organization are key in a job like mine,” she reflects.

Now, Nada will start working on a phone call queue of community members who have recently connected with the WIN Network. Among these contacts is a young woman who is interested in joining the Co-Captains Club. The Co-Captains Club is a way to expand the WIN Network and empower the young women who have worked with the program in the past. Co-Captains are trained in groups by WIN Network CHWs to host informational meetings where they talk to their friends and family about physical and mental health, family planning and other issues impacting the community. This training empowers the Co-Captain to be a resource for her network of friends and family and supports her along the way. Nada enrolls the new caller in the upcoming Co-Captains training the following week.

The next message is from Tara. Nada explains that Tara has gestational diabetes and was having trouble affording the foods that will help keep her blood sugar in check. “We connected with Detroit’s Food Assistance Program which, so far, has helped Tara stay out of the ED,” Nada said. But today, Tara was calling because her local grocery doesn’t consistently stock the foods approved by the assistance program. Nada helps Tara find the name and contact information for the grocery store manager to ask about the inconsistent food stock. “Please call me back after you talk with him,” Nada says. “We’ll figure this out.”

## Standardized Training: Benefits and Challenges

Health systems need to know how to find trained CHWs in their community. They also need to know what steps to take if they wish to send persons for CHW training and what the key considerations are for starting a CHW program in their own organizations. As CHWs continue to gain recognition for their role in impacting the Quadruple Aim, full integration into health systems they are helping to transform is likely to require more formalization and standardization of this workforce.

CHWs and other lay frontline navigators historically have been trained on the job, with emphasis on learning about local resources, understanding practices and guidelines of their employers, and occasional continuing education opportunities, often narrowly focused in response to specific funding

*“Health systems are just now realizing the value of community health workers and navigators in empowering patients and connecting them to community services that aren't part of the traditional medical treatment plan. Their efficacy lies in their credibility and authenticity for whom they provide services. As expectations and regulatory considerations mount to professionalize this new member of the health care team, along with the inevitable requirements for standards and certification, we need to hold on to this unique asset. We will risk losing what we value most if we focus on standards versus pathways for success.”*

*- Winston F. Wong, M.D., M.S., FAAFP, Medical Director, Community Benefit and Director, Disparities Improvement and Quality Initiatives Kaiser Permanente National Program Office*

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opportunities. Now regional training programs in several cities and states put greater emphasis on teaching for core competencies using effective and proven adult education methodologies. Community-based organizations, public health departments, or CHW associations have led the movement toward standardized training and in some states, community colleges or universities have taken on the task of creating more formal training curricula.

The benefits of more defined and structured training for CHWs are substantial. Credentialing or certification becomes possible, with greater opportunities for career advancement and portability of skills. Through credit-based foundational programs in post-secondary schools, such as Minnesota's model statewide curriculum, CHWs gain an educational pathway towards an associate or bachelor's degree and matriculation in other health professions. The Minnesota CHW Alliance has found that CHWs are often the first in their families to pursue higher education. In successfully completing the certificate program, they provide the inspiration and know-how for relatives and members of their communities to access education beyond high school and experience employment opportunities and health co-benefits associated with education and better income.

Improving the consistency of training programs also facilitates evaluation and research, which in turn builds the evidence for and credibility of the workforce, while standardized training supplies an important prerequisite for sustainable funding given that payers want to know that the workforce is competent to provide covered services.

This also raises some important issues. CHWs are trusted members of the communities they serve and are recruited for their lived experience, communication skills and local knowledge, but many have less formal education than other health care professionals, while those from marginalized communities may confront barriers to completing training programs. Registration requirements that inadvertently leave out certain groups including immigrants may be an issue. So too, training costs can be a barrier—though scholarships, employer tuition payment benefits, and school financial aid can be used to address potential financial barriers to CHWs achieving higher education.

Across the country, work has been under way for several years to define, create, and standardize various aspects of the CHW role, including training, certification, scope of practice and payment models. The National Academy for State Health Policy (NASHP) maintains a comprehensive listing of certification programs ([www.nashp.org/state-community-health-worker-models](http://www.nashp.org/state-community-health-worker-models)). Some states, including Florida and Ohio, have created certification programs linked to other credentialing boards, such as nursing or behavioral health professionals. Massachusetts, Oregon and Rhode Island have built independent bodies to guide and approve the certification process for CHWs. Certification typically involves completion of an approved training program, criminal background check, a written application and professional references as well as a fee. Recertification often requires proof of continuing education among other provisions.



Though the process may vary from state to state, establishing a set of core competencies is one important prerequisite. These were first documented in the National Community Health Advisor Study published in 1998. Seven roles were identified: cultural mediation, health education, building individual and community capacity, connecting people with services, informal counseling and social support, advocacy, and direct service (e.g., taking blood pressure or administering other screening exams with sufficient training and supervision). Currently, a multi-state effort is underway to expand the list of core competencies and update the list to reflect new and emerging roles related to health reform, such as participating in community health needs assessments.

While the body of evidence supporting the effectiveness of CHWs continues to grow, work also is under way to develop a set of common metrics and indicators of success. Measures such as return on investment and reduced utilization of high-cost services may be effectively applied to CHW programs, but these programs also provide opportunities to measure more nuanced outcomes such as increased health knowledge, levels of empowerment, or quality of life of program participants. Such measures, though not yet common, may be exactly the indicators necessary for guiding responses to health disparities and the social determinants of health.

As meaningful standards continue to develop at the national, state or local level, CHWs themselves need to be part of the process. State CHW associations or networks are growing and deserve support and recognition. Likewise, their members need support to continue to bring their knowledge and energy to the work ahead, including training programs, curriculum development, and inclusion as faculty. This practice recognizes CHW expertise while creating career advancement opportunities for experienced CHWs. As the popular CHW slogan says, “Nothing about us without us!”

*To find out if your state has a CHW alliance or association and to get involved at the state or national level, visit the webpage for the American Public Health Association (APHA) CHW Section at: [www.apha.org/apha-communities/member-sections/community-health-workers](http://www.apha.org/apha-communities/member-sections/community-health-workers).*



**2:37 P.M.** Nada makes it through most of her planned phone calls for the day when the clinic’s front desk rings her. A patient who had just walked into the clinic needs to talk about health insurance enrollment as they do not have a health plan in place. Nada grabs her laptop and goes to meet with the patient in the office conference room. She confirms with the patient that he does not already have an application for Medicaid filed with the state and then proceeds to help complete his application. After informing him what to expect next in the application process, Nada learns the patient has not activated his online patient health portal, or MyChart, account. Nada helps the patient activate his account and learn how to utilize it.

## Stakeholders and Partners

CHW stakeholders are richly diverse—from health plans to federally qualified health centers, from private health systems to federal, state and local public health; from banks to blight fighters; from accountable care organizations to foundations and faith-based partners. Their aims and the community context shape a variety of models through which CHWs are employed, deployed and funded. For example, CHW teams may be hired by an insurance organization to address needs of high-utilizer patients, or they may become part of an accountable-care strategy to fill gaps in services provided. The table opposite matches nationally embraced CHW core competencies with stakeholders who have the potential to benefit from engaging them.

Community health workers not only are touch points for population health in a hospital's ability to build and engage in meaningful community partnerships but help support the triennial IRS requirement for non-profit hospitals and health systems to perform Community Health Needs Assessments (CHNAs) and post their actionable and measurable CHNA Impact Plans. From stakeholder surveys to community-based partnerships that address assessed health needs, CHWs can help build the relationships that make programs effective and sustainable.



## HEALTH LEADS AT KAISER PERMANENTE

As one key element of its work to address the social needs of its members and the communities it serves, Kaiser Permanente (KP) has developed a strategic partnership with Health Leads, a pioneering nonprofit that connects patients with community resources through a variety of interventions including on-site help desks staffed by volunteer students using highly reliable, constantly refreshed local resource directories. Initially piloted in a KP pediatrics practice and a public safety net hospital in Northern California, Health Leads is now being deployed in multiple KP medical centers in its Southern California region. In that region, a variety of different models are being tested that integrate KP and Health Leads operations in order to screen, refer and close social need gaps. The goal is to reach approximately 5,000 patients in the first phase, with a focus on patients expected to be high utilizers of healthcare based on predictive analytics. This is one of more than 30 social needs programs and pilots being implemented across Kaiser Permanente's service areas as part of its broader Total Health strategy—a strategy that focuses on addressing the drivers of health beyond the walls of its hospitals and medical office buildings.

As of January 15, 2016, the KP/Health Leads Community Resource Hub had proactively called 412 predicted high utilizer members, 181 picked up, and 117 participated in screening. Of 117 screened, 81% (95) reported at least one social need! This preliminary data shows a much higher prevalence of social needs in health care settings than prior reports indicated. It further illustrates the importance of the coordinated effort for KP Southern California members. A systematic approach to screening and resource navigation could lead to decreased utilization, decreased total costs of care, improved self-management of chronic conditions, increased patient satisfaction and greater member retention.

*“Effective engagement of individuals most at risk for poor health outcomes calls for a collaborative approach among multiple stakeholders—and it’s often CHWs and other frontline workers who supply the connective tissue.”*  
*- Kevin Barnett, DrPH, MCP, Public Health Institute, Oakland, California*

CHW Core Competencies (from C3 Project)	Stakeholders
Cultural Mediation among Individuals, Communities, and Health and Social Service Systems	Payers, health systems and other providers, Accountable Care Organizations, social service agencies, government agencies such as public health, human services, education and housing; Federally Qualified Health Centers, State Innovation Models; health policy/health service researchers; policymakers; professional associations and trade associations; community/neighborhood organizations; faith-based organizations; K-12 schools; community colleges and other post-secondary schools; foundations, community/economic development, employers/business community and more.
Providing Culturally Appropriate Health Education and Information	
Care Coordination, Case Management, and System Navigation	
Providing Coaching and Social Support	
Advocating for Individuals and Communities	
Building Individual and Community Capacity	
Providing Direct Service	
Implementing Individual and Community Assessments	
Conducting Outreach	
Participating in Evaluation and Research	

*From The Community Health Worker Common Core Project (C3)*



**4 P.M.** Nada updates the office records for each of the phone calls she has made and starts a teleconference with a community agency, Matrix Human Services, to learn more about their youth programs. “It’s important that we CHWs develop and maintain good working relationships with the organizations that serve members of our community,” she explains. “When an organization offers a new service or a new director is hired, I call to connect and to be sure they are providing the most up-to-date information about WIN Network, as well.”

## Toward Sustainability

As the clear value that CHWs bring to the healthcare team becomes increasingly evident, opportunities for programs and health care organizations to identify more sustainable funding are being explored across the country. Most CHW programs have depended on grant and contract funding in the past. Narrow categorical guidelines, coupled with discontinuous support, have led to unstable CHW jobs and unpredictable, sporadic access to CHW services. While philanthropic dollars will continue to be vital for start-up costs, research and evaluation, and infrastructure development, more sustainable funding sources for CHW services are needed. A variety of existing and potential funding sources outlined by the National Fund for Medical Education at the University of California San Francisco Center for the Health Professions (now Healthforce Center) at University of California, San Francisco includes grants and contracts, government support, health plan/insurance payment, companies with a diverse workforce and consumer self-pay (Dower, Knox, Lindler, & O’Neil, 2006).

Healthcare reform has also created a variety of CHW payment methods such as federal innovation funds and Medicaid dollars. CHWs show the greatest value in serving low-income populations that are Medicaid-eligible. Additionally, around the U.S., Medicaid expansion has extended access to thousands of previously uninsured persons who are now able to obtain coverage. Medicaid policies can drive interest by private payers and a greater number of providers (Rush & Mason, 2015).

As one example, the Michigan Community Health Worker Alliance (MiCHWA) has led efforts to convene payers, providers and state administrators in a series of highly effective stakeholder forums that include CHWs in promoting standardized training, and developing implementation and payment models in tandem with the state’s new requirement that Medicaid managed care hire or arrange for CHWs. Henry Ford Health System, Spectrum Health, St. John Providence and other Michigan health systems are also deeply involved in these efforts. Other examples include (Rush & Mason, 2015):

- **State Plan Amendments.** Minnesota has CMS authority through a State Plan Amendment (SPA) to provide Medicaid coverage for CHW services specific to diagnostic-related patient education, both individual and group.

*“Community health workers in the U.S. and in countries around the world, such as Brazil, India, Kenya, Liberia and South Africa play a growing role on the frontline in addressing the world-wide epidemic of chronic disease which disproportionately affects underserved communities experiencing health barriers related to income, literacy, access and other issues. Strategic philanthropic investments hold potential to broaden the adoption of high impact, sustainable CHW models—particularly when in partnership across key stakeholders such as governments and nonprofits. As a field, moving from time-limited grant support to proactive partnerships that elevate well-integrated CHW approaches is an important marker of success and key to empowering communities for better health.”*

*- Paurvi Bhatt, MPH, Senior Director, Global Access, Medtronic Foundation*

- **Medicaid Managed Care Organizations.** Several states have taken steps to ensure that Medicaid managed care plans include CHWs in contracting arrangements. As noted, beginning in 2016 in Michigan, the state Medicaid agency requires that all managed care plans maintain a ratio of at least one CHW for every 20,000 enrollees. In New Mexico, CHW services are included in the list of Medicaid benefits, and Medicaid contracts must encourage CHW care coordination.
- **Preventive Services Rule.** In July 2013, CMS published a rule change in the Federal Register which allows state Medicaid programs to pay for qualified non-licensed providers such as CHWs to deliver approved preventive services that are recommended by a physician or other licensed practitioner. Some view the Preventive Services SPA as a way for states to sustain CHW initiatives that are initiated with federal and state demonstration funds.
- **Medicaid Waivers and Reform Initiatives.** Most state strategies for covering CHW services are through waivers such as 1115a demonstration programs. Exciting health reform initiatives underway in many states through the CMS State Innovation Model (SIM) awards include policy and financial support for CHW models such as Oregon's Coordinated Care Organizations and Minnesota's Accountable Communities for Health. Patient-centered medical homes and healthcare homes in many states incorporate CHWs as members of patient-centered teams, some with per member per month funding that can help cover CHW care coordination services.

To date, Medicare does not yet regard CHW services as a covered benefit. However, Massachusetts' One Care Program for beneficiaries that qualify for both Medicare and Medicaid ("dually-eligible") include specific services that can be provided by CHWs (Communication, MA Dept. of Public Health). In some states, community benefit funds from charitable hospitals underwrite CHW programs. Hospitals can use the results of their required community health needs assessments to identify gaps that CHWs can effectively address. And while opportunities for CHW employment are burgeoning in the healthcare sector, CHWs also work in community-based settings such as schools, affordable family and senior housing, and other settings where there is potential to tap different funding streams.

The outlook for CHW financing is favorable in the context of new payment reform models, including bundled payment and global financing. Already, we are seeing volume-based payment for healthcare services replaced by value-based purchasing arrangements. State and private payers will continue to invest in programs such as these as they simultaneously manage costs and provide



### CHWS: KEY TO OUTCOMES AND ROI IN EVIDENCE-BASED CARE COORDINATION MODEL

Recognized by the federal Agency for Health Research and Quality (AHRQ), the Pathways Community HUB model is designed to identify the most at-risk individuals within a community, connect them to evidence-based interventions, and measure the results. This "Find-Treat-Measure" approach emphasizes the importance of tracking health and social service interventions at the individual, agency and regional level using common metrics. Each "Pathway" begins with a frequent need of the at-risk population, identifies appropriate interventions to address the issue and, upon completion of the interventions, measures the outcome. Payment is based on completing the Pathway.

The Pathways model originated with the Community Health Access Project (CHAP) in Richland County, Ohio. Co-founders of CHAP, Drs. Mark and Sarah Redding, developed the HUB with an initial focus on preventing low birth weight babies. Pathways identified for this at-risk group included: education, depression, prenatal care and housing. A Pathway is complete when an identified problem is addressed, and a patient may pursue several Pathways, based on their situation. Key to the model's success is the trusted and trained CHW who navigates the patient along the Pathway.

Since this model began 14 years ago, CHAP has designed, tested and implemented 20 core pathways and created the community HUB infrastructure. With endorsement and replication of this model by AHRQ and support from The Kresge Foundation, a certification process for community HUBs now is in place. Programs have expanded to new states and have also been adapted to address other high-risk populations, such as individuals with chronic disease. Evaluation of this model has found return on investment to be \$5.59 for every dollar spent on the program. Tools and technology in support of the HUB model are available through Care Coordination Systems, Inc., headed up by Dr. Sarah Redding.



the best outcomes for patients. If effectively focused and operated, CHW programs hold promise to help providers, organized as ACOs or in other risk arrangements, to help achieve key metrics on which the new value-based financing methods are based. At a fall 2015 meeting of policymakers convened by the National Academy for State Health Policy, a federal official observed that “incorporating CHWs into team-based models of care has the potential to augment CHWs’ role in emerging value-based and bundled payment models and minimize the reliance on grant funding to support CHW initiatives” (Clary, 2015).

More than ever, greater diversity of CHW funding is beginning to replace dependence on limited grant and contract funds that has impeded the growth of the CHW work force. Under health reform, states are funding CHWs through State Innovation Model (SIM) Initiatives, 1115 waivers, Accountable Care Organizations and advanced primary care initiatives. Looking to the future, innovative payment policies and mechanisms that reward value and equity hold promise for stronger CHW integration and financing.

*For a national map summarizing CHW financing policies and developments by state, see: [www.nashp.org/state-community-health-worker-models](http://www.nashp.org/state-community-health-worker-models).*

## Why the Time is Now

For so many compelling reasons, health navigators have a crucial and evolving role in health care today. Indeed, navigators improve health by addressing the cascade of non-medical factors that get in its way. Exemplifying the most robust of navigator roles, community health workers provide more than a compass—they extend important population health-management efforts beyond clinic walls into neighborhoods where health happens, where people “live, learn, work and play” (Hecht, 2010). CHWs stand in the gap, connecting the dots between clinic and community to support the Quadruple Aim goals of population health, improving quality and the patient experience, reducing cost, and achieving health equity.

Interest in CHWs and other types of health

navigators has grown exponentially in response to health reform and new complexities in the health care system. This includes powerful demographic shifts that will continue to shape healthcare delivery and finance, such as a rapidly growing 65+ year-old cohort and an increasingly diverse younger population with cultural, linguistic, socioeconomic and other challenges to good health. More and more, health systems, public health agencies, payers and other stakeholders are recognizing the key contributions that CHWs can make in addressing these social determinants. As enthusiasm and evidence for CHWs grow, initiatives to standardize their training also are burgeoning across states—improving opportunities for certification, inclusion on clinical teams, and benchmarking for outcomes and effectiveness. CHWs can also produce a manifold return on investment—with an ROI of up to and exceeding fivefold for each dollar spent. Built into government payment models and commercial coverage, CHW programs will become sustainable over time, no longer grant-dependent.

In our high-tech age, on-the-ground relationships remain the indispensable key to sure and sustainable population health improvement. CHWs and other health navigators use the tools of technology—such as social media, real-time community resource databases, online reporting and measurement

*“As health policy, research and practice are becoming increasingly focused on improving the health of populations and addressing social determinants of health, Community Health Workers (CHWs) may be just what the doctor ordered.”*

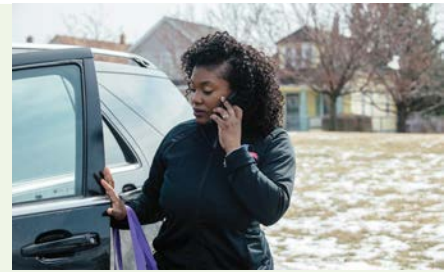
*- Health Affairs, January 16, 2015*

*“The policy and financial climate are ideal for expanded use of CHW programs. We must take advantage of this historic opportunity in order to create high-quality programs that measurably improve health in high-risk populations”*

*- Shreya Kangovi, MSHP, Assistant Professor Perelman School of Medicine at the University of Pennsylvania, Executive Director, Penn Center for Community Health Workers*



**4:45 P.M.** Nada adds to her team’s “asset map,” with its list and location of services and key contacts available to community members. “People sometimes think that poor communities only have needs,” Nada says, “but there are a lot of assets here, too. You just have to get to know the neighborhoods and the people in them.”



Nada ends her day sharing with her supervisor the progress she has made on the phone call queue. She responds to e-mails and checks her calendar for tomorrow. “Serving as a community health worker is being a resource to help ease some of the stressors in people’s lives. We are a bridge of support,” Nada says, “that brings our clients to the road of their success.”

platforms—as important supports. But these tools cannot replace the value of walking with someone on their journey. Hope never happens on the internet alone, or in a medical record. It happens at the intersections where people come together with the care that is right for them—accessible, patient-focused, health literate, culturally competent, high-quality, and equitable. And it’s eminently more likely to happen when people—especially but not exclusively in vulnerable populations—can see, embrace and embark on a clear road forward, connecting to other people and existing resources that empower them to achieve the healthiest, best life possible for themselves and their families.

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## REFERENCES

- Achieving the Triple Aim: Success with Community Health Workers. (2015, April/May). Retrieved February 05, 2016, from <http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/achieving-the-triple-aim.pdf>.
- Agency for Health Research and Quality (AHRQ). Innovation Profile: Program Uses “Pathways” to Confirm Those At-Risk Connect to Community Based Health and Social Services, Leading to Improved Outcomes. (2001). Retrieved February 05, 2016, from <https://innovations.ahrq.gov/profiles/program-uses-pathways-confirm-those-risk-connect-community-based-health-and-social-services>.
- American Public Health Association (APHA). Community Health Workers. (n.d.). Retrieved February 05, 2016, from <https://www.apha.org/apha-communities/member-sections/community-health-workers>.
- Berwick, D., Nolan, T., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. *Health Affairs*, 759-769.
- Centers for Disease Control and Prevention. Health Disparities and Inequality Report. MMWR 2011; 60(Suppl):1-109.
- California Health Workforce Alliance (CHWA). Taking Innovation to Scale. (2013, December). Retrieved February 05, 2016, from [http://www.chhs.ca.gov/PRI/\\_Taking Innovation to Scale—CHWs, Promotores and the Triple Aim—CHWA Report 12-22-13 \(1\).pdf](http://www.chhs.ca.gov/PRI/_Taking%20Innovation%20to%20Scale—CHWs,%20Promotores%20and%20the%20Triple%20Aim—CHWA%20Report%2012-22-13%20(1).pdf).
- City of Healthy Neighborhoods & Buildings. (n.d.). Retrieved February 05, 2016, from <http://www.sanantonio.gov/Health/HealthyLiving/HealthyNeighborhoods.aspx>.
- Clancy, C., Munier, W., Crosson, K., Moy, E., HoChaves, K., Freeman, W., & Bonnett, D. (2012, March). *National Health Care Quality Report 2011* [PDF]. Department of Health and Human Services.
- Clary, A. (2015, December 07). Community Health Workers in the Wake of Health Care Reform: Considerations for State and Federal Policymakers—NASHP. Retrieved February 05, 2016, from <http://nashp.org/community-health-workers-in-the-wake-of-health-care-reform-considerations-for-state-and-federal-policymakers/>.
- Davis, K., Stremikis, K., Squires, D., & Schoen, C. (2014, June). Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update. Retrieved February 05, 2016, from <http://www.commonwealthfund.org/publications/fund-reports/2010/jun/mirror-mirror-update>.
- Diaz, J. (2012, June). Social return on investment: Community Health Workers in Cancer Research. Retrieved February 05, 2016, from <http://www.wilder.org/Wilder-Research/Publications/Studies/Community%20Health%20Workers%20in%20the%20Midwest/Social%20Return%20on%20Investment%20-%20Community%20Health%20Workers%20in%20Cancer%20Outreach.pdf>.
- Disparities. (n.d.). Retrieved February 06, 2016, from <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>.
- Dower, C., Knox, M., Lindler, V., & O’Neil, E. (2006). Advancing Community Health Worker Practice and Utilization: The Focus on Financing. Retrieved February 05, 2016, from <http://healthforce.ucsf.edu/publications/advancing-community-health-worker-practice-and-utilization-focus-financing>.

- Felix, H. C., Mays, G. P., Stewart, M. K., Cottoms, N., & Olson, M. (2011). Medicaid Savings Resulted When Community Health Workers Matched Those With Needs To Home And Community Care. *Health Affairs*, 30(7), 1366-1374.
- Goodwin, K., & Tobler, L. (2008, April). Community health workers: Expanding the scope of the health care delivery system. Retrieved February 05, 2016, from <http://www.chwcentral.org/community-health-workers-expanding-scope-health-care-delivery-system>.
- Hardeman, R., Gerrard, M.D. (2011, June). Community Health Workers in the Midwest: Understanding and developing the workforce. Retrieved February 05, 2016, from <https://www.wilder.org/Wilder-Research/Publications/Studies/Community%20Health%20Workers%20in%20the%20Midwest/Community%20Health%20Workers%20in%20the%20Midwest%20-%20Understanding%20and%20Developing%20the%20Workforce,%20Full%20Report.pdf>.
- Hecht, B. (2010). Health Starts Where We Live. Robert Wood Johnson Foundation. Retrieved February 07, 2016, from <http://www.rwjf.org/en/library/research/2010/10/health-starts-where-we-live.html>.
- Infant Mortality. Kids Count Data Center. Michigan League for Public Policy. (2016). Retrieved February 08, 2016, from <http://datacenter.kidscount.org/data/tables/1637-infant-mortality?loc=24>.
- Infant Mortality by Race. Kids Count Data Center. Michigan League for Public Policy. (2016). Retrieved February 08, 2016, from <http://datacenter.kidscount.org/data/tables/21-infant-mortality-by-race?loc=1#detailed/2/24/fase/36,868,867,133,38/10,11,9,12,1,13/285,284>.
- Institute for Clinical and Economic Review (ICER). Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England. (2013). Retrieved February 05, 2016, from <http://cepac.icer-review.org/wp-content/uploads/2011/04/CHW-Draft-Report-05-24-13-MASTER1.pdf>.
- Institute of Medicine: U.S. Health in International Perspective Shorter Lives, Poorer Health. (2013, January). Retrieved February 05, 2016, from <http://iom.nationalacademies.org/Reports/2013/US-Health-in-International-Perspective-Shorter-Lives-Poorer-Health.aspx>.
- Johnson, D., Saavedra, P., Sun, E., Stageman, A., Grovet, D., Alfero, C., Kaufman, A. (2011). Community Health Workers and Medicaid Managed Care in New Mexico. *Journal of Community Health*, 37(3), 563-571. Retrieved February 5, 2016.
- Kangovi, S., Grande, D., & Trinh-Shevrin, C. (2015). From Rhetoric to Reality—Community Health Workers in Post-Reform U.S. Health Care. *New England Journal of Medicine*, 372(24), 2277-2279.
- Kangovi, S., Mitra, N., Grande, D., White, M. L., Mccollum, S., Sellman, J., Long, J. A. (2014). Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes. *JAMA Internal Medicine*, 174(4), 535.
- Krieger, J., Takaro, T. K., Song, L., Beaudet, N., & Edwards, K. (2009). A Randomized Controlled Trial of Asthma Self-management Support Comparing Clinic-Based Nurses and In-Home Community Health Workers. *Archives of Pediatrics & Adolescent Medicine*, 163(2), 141. Retrieved February 7, 2016.
- Massachusetts Dept. of Public Health. (n.d.) Communication, List of Covered Services for Members Enrolled in a One Care Plan. Retrieved from <http://www.mass.gov/eohhs/docs/masshealth/onecare/services-covered-by-one-care.pdf>
- Matos, S., Findlay, S., Hicks, A., Legendre, Y., & Do Canto, L. (2011). Paving a path to advance the community health worker workforce in New York State [Minnesota Community Health Worker Alliance]. Retrieved February 7, 2016, from <http://successwithchws.org/asthma/wp-content/uploads/sites/3/2015/02/CHWs-In-the-Community1.pdf>.
- National Academy for State Health Policy (NASHP). State Community Health Worker Models—NASHP. (2015). Retrieved February 07, 2016, from <http://www.nashp.org/state-community-health-worker-models/>.
- Nelson, K., Rafalski, E. Bailey, S. & Marinescu, R. (2015). Managing Rising-Risk Patients in a Value-Based World. 2015 Congress on Healthcare Leadership.
- O'Brien, M. J., Perez, A., Alos, V. A., Whitaker, R. C., Ciolino, J. D., Mohr, D. C., & Ackermann, R. T. (2015). The Feasibility, Acceptability, and Preliminary Effectiveness of a Promotora-Led Diabetes Prevention Program (PL-DPP) in Latinas: A Pilot Study. *The Diabetes Educator*, 41(4), 485-494.
- Office of Minority Health. U.S. Department of Health and Human Services. Think Cultural Health—CLAS & the CLAS Standards. (n.d.). Retrieved February 07, 2016, from <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>.
- Pathways: A system designed to produce positive outcomes and impact health disparities [PDF]. (n.d.).
- Phalen, J., & Paradis, R. (2015, January 16). How Community Health Workers Can Reinvent Health Care Delivery In The US [Web log post]. Retrieved February 5, 2016, from <http://healthaffairs.org/blog/2015/01/16/how-community-health-workers-can-reinvent-health-care-delivery-in-the-us/>.
- Redding, S., Conrey, E., Porter, K., Paulson, J., Hughes, K., & Redding, M. (2014). Pathways Community Care Coordination in Low Birth Weight Prevention. *Journal Maternal Child Health*, 19(3), 643-650.
- Rosenthal, E.L et al. (Nov 2, 2015). C3: The Journey towards a United Consensus. PPT presented at American Public Health Association 2015 Annual Meeting.
- Rush, C. (2015, October 15). Creating a Policy Infrastructure for Community Health Workers: Four Domains and Four Dilemmas. Lecture presented at National Academy for State Health Policy Convening.

Rush, C., & Mason, T. (2015, November 4). *Strategies for Integrating CHWs into Health Care Teams: Financing Options Under Medicaid*. Lecture presented at APHA Annual Conference, Chicago.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: National Academy Press.

Snapshots: Health Care Spending in the United States & Selected OECD Countries. (2012, April). Retrieved February 05, 2016, from <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/>.

## RESOURCES

The following is a select sample of the many resources, tool kits, publications and guides for planning, implementing and evaluating community health worker programs. Many of the resources listed here have more extensive resource lists included in their publications. This list is not intended to be inclusive and Stakeholder Health is not specifically endorsing these resources, but providing them as a starting place to learn more.

## CHW TOOL KITS

### Behavioral Health Leadership Institute CHW Tool Kit:

<http://bhli.org/communityhealthworkertoolkit.shtml>. This toolkit and reference is specifically designed for CHWs with a focus on mental health and substance use disorders within primary care settings.

### Best Practice Guidelines for Implementing and Evaluating CHW Programs in Health Care Settings:

<http://www.sinai.org/sites/default/files/SUHI%20Best%20Practice%20Guidelines%20for%20CHW%20Programs.pdf>.

This extensive report includes evidence-based guidelines on how to launch and evaluate a CHW programs in health care settings, from Sinai Urban Health Institute in Chicago, IL.

### Building a CHW Program: The Key to Better Care, Better Outcomes and Lower Costs:

[http://www.nursing.virginia.edu/media/2014-06-27\\_BCHWP.pdf](http://www.nursing.virginia.edu/media/2014-06-27_BCHWP.pdf). This publication is geared to the nurse executive in hospital and integrated health settings with accountabilities for starting and overseeing CHW initiatives.

### Centers for Disease Control (CDC) CHW Toolkit:

<http://www.cdc.gov/dhdsp/pubs/chw-toolkit.htm>. This compilation of evidence-based research supports the effectiveness of CHWs for use by state health departments and other organizations.

### Penn Center for CHWs Tool Kit:

<http://chw.upenn.edu/tools>. This tool kit provides extensive materials and guidelines for hiring, training, supervising and measuring CHWs in health care settings, using the IMPaCT model.

### Rural Health Information Hub CHW Tool Kit:

<https://www.ruralhealthinfo.org/community-health/community-health-workers>. This 8-module guide is designed to help rural health providers evaluate opportunities for developing a CHW program and provide resources and best practices developed by successful CHW programs.

### Success with CHWs for Asthma Care Providers:

[www.successwithchws.org/asthma](http://www.successwithchws.org/asthma). Web-based resource to help asthma care providers learn about and implement CHW strategies.

### Success with CHWs for Mental Health Providers:

[www.successwithchws.org/mental-health](http://www.successwithchws.org/mental-health). Web-based resource to help mental health providers learn about and implement CHW strategies.

## STATE COMMUNITY HEALTH WORKER ASSOCIATIONS

Many states, cities, counties and regions have developed CHW associations to promote the workforce, contribute to policy development, share resources, provide professional development opportunities, and advocate for CHWs in general.

**California Association of Community Health Workers:** <http://www.cachw.org/>.

**Community Health Worker Network of New York City:** <http://www.chwnetwork.org/>.

**Michigan Community Health Worker Alliance:** <http://michwa.org/>.

**Minnesota Community Health Worker Alliance:** <http://mnchwalliance.org/>.

**New Mexico Community Health Workers Association:** <http://nmchwa.com/>.

**Ohio Community Health Workers Association:** <http://www.med.wright.edu/chc/programs/ochwa>.

**Oregon Community Health Worker Association:** <http://orchwa.org>.



## ADDITIONAL RESOURCES

### Addressing Chronic Disease through Community Health Workers: A Policy and Systems Level Approach:

[http://www.cdc.gov/dhdsp/docs/chw\\_brief.pdf](http://www.cdc.gov/dhdsp/docs/chw_brief.pdf). A policy brief that includes recommendations for integrating CHWs into community-based chronic disease prevention efforts

### Care Coordination Systems:

<http://carecoordinationsystems.com/>. Website of the Community Pathways HUB model developer, Dr. Sarah Redding.

### Centers for Disease Control Policy and Systems Change to Expand Employment of CHWs: E-Learning Course:

[http://www.cdc.gov/dhdsp/pubs/chw\\_elearning.htm](http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm). Online self-paced course to acquaint stakeholders and others with the CHW field.

**CHW Central:** [www.chwcentral.org](http://www.chwcentral.org). An online resource for International CHW programs.

### Community Health Workers: Expanding the Scope of the Health Care Delivery System:

\Community Health Workers\Research & Data\Community Health Workers- Expanding the Scope of the Health Care Delivery System.pdf.  
A publication of the National Association of State Legislatures about state policy issues related to CHWs.

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