



# Building and Sustaining a Health Care Workforce: Community Health Workers

Community health workers (CHW) are community members who work in the community setting and serve as connectors between health care providers and consumers to promote health among groups that have traditionally been underserved. CHWs provide support and health education that is needed for individuals to successfully modify behaviors, increase engagement in their treatment plan development and increase the likelihood of improved health outcomes. Despite the many positive contributions CHWs bring to delivering high-quality care, they experience significant barriers to becoming integrated members of the clinical care team. This set of resources will help to guide institutions toward building a CHW program to strengthen and sustain their health care workforce.

## Overview of Community Health Worker Programs

### Critical Inputs for Successful Community Health Worker Programs: A White Paper

CHWs are essential to the COVID-19 response and long-term health equity for the communities they serve. This white paper identified important considerations needed for future efforts to develop standards for CHWs, including CHW and other stakeholder buy-in on the need for standards, the diversity of settings that employ CHWs, mechanisms for supporting less-resourced organizations like CBOs, and meaningful engagement of CHWs and other relevant stakeholders in developing and implementing standards.

### Successful CHW Programs are Complex and Require Meticulous Planning: The IMPaCT Model

The Penn Center for Community Health Workers is a national center of excellence with the mission to advance health equity through effective, sustainable community health worker programs. IMPaCT has been tested in three randomized controlled trials and improves chronic disease control, mental health and quality of care while reducing total hospital days by 65%. In the last three years, IMPaCT has become the most widely disseminated community health worker program in the United States; it is being replicated by organizations across 18 different states including Veterans Health Administration, state Medicaid programs and integrated health care organizations.

## Tools and Resources

### **AHA and NUL: Building a Community Health Worker Program**

As a part of the community health worker initiative, the AHA and the National Urban League (NUL) hosted the Community Health Worker Consortium in Chicago in 2018. Representatives from hospital and health system organizations, federal and state agencies, academic institutions and community-based organizations attended the consortium. The session focused on three main topics: defining of community health workers, credentialing of community health workers, and funding sources and strategies for sustainability. After the consortium, the AHA and the NUL, along with Community Health Works Inc. formed a strategic advisory group that worked together to apply findings from the consortium to the Building A Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs toolkit. In addition to the toolkit, several Members in Action case studies are also available.

### **Penn Medicine Center for Community Health Workers**

Since 2013, Penn Medicine's Center for Community Health Workers (PCCHW) has served as a national center of excellence for CHW research, patient care and dissemination. The Center designed IMPaCT, a standardized, scalable, evidence-based CHW model of care, to help health care organizations reach beyond their own walls to help low-income patients address the root causes of their poor health.

## Outcomes Research

### **Clinical Integration of Community Health Workers to Reduce Health Inequities in Overburdened and Under-Resourced Populations**

The COVID-19 pandemic has resulted in broader awareness of health inequities across the United States and their impact on overburdened and under-resourced communities. Investing in and more effectively integrating CHWs into health care delivery has been beneficial during this time of uncertainty. CHWs serve as liaisons and connectors between patients, communities and health/social care systems, providing culturally appropriate education and addressing complex social needs within the individual and community context. Sinai Urban Health details valuable lessons learned over its 20 years of experience developing, implementing, evaluating and scaling CHW interventions.

### **An Emerging Model for Community Health Worker-Based Chronic Care Management for Patients With High Health Care Costs in Rural Appalachia**

CHWs can improve patients' health by providing them with ongoing behavioral support during the health care experience while also decreasing health care costs. The authors developed a CHW-based care model with the aim of improving outcomes and lowering costs for high-risk diabetes patients in rural Appalachia. They experienced positive results with diabetes management for their patients, leading to greater enrollment in the program.

## **Can Community Health Workers Increase Palliative Care Use for African American Patients? A Pilot Study**

This 2021 pilot study performed by researchers at The John Hopkins Hospital shows how community health workers can increase access to palliative care and advance care planning for people in marginalized communities living with serious illness. The researchers were successful in addressing the patients' social determinants of health, which leads to sustained and improved patient care.

## **Case Studies**

### **Videos and Podcasts Spotlight the Efforts of the AHA and UnidosUS Alliance**

- Two videos spotlight innovative partnerships that promote action and collaboration between community and health care leaders to advance health equity. The first video spotlights community partnerships led by Lurie Children's Hospital of Chicago, and the second spotlights efforts led by Saint Anthony Hospital.
- Healthy Equitable and Resilient (H.E.R.) Communities Podcast Series – The H.E.R. communities initiative highlights AHA member hospitals and UnidosUS affiliates working together to respond to challenges of disparities, violence and trauma. The podcast series explores a community's efforts to bring together health care leaders and community leaders to address key health challenges collectively.

### **Northeastern Vermont Regional Hospital: Community Health Workers**

Northeastern Vermont Regional Hospital (NVRH), St. Johnsbury, VT and its Community Connections (CoCo) program was an early adopter of the CHW model. As early as 2002 and at the request of its physicians, NVRH engaged community members to assist in helping their patients manage food, transportation, housing and life skills to improve their health and well-being.

CoCo gained traction in 2007 as part of the Vermont Blueprint for Health. The CoCo model became the cornerstone program for the community health teams (CHTs) in the NVRH service area. This comprehensive program consists of CHWs who were intentionally integrated into a larger CHT that now includes physicians, nurses, behavioral health specialists, chronic care coordinators, dietitians and other health care professionals to meet the needs of the local community.

### **Promoting Safe Quarantine and Isolation for COVID-19 Marginalized Populations: Case Studies on Care Resource Coordination in COVID-19**

In North Carolina, resource coordination is done by the NC Community Health Worker Program and Support Services Program. This case study describes the programs' operations, then analyzes key factors to their success, as well as challenges and lessons learned. These programs are a model for jurisdictions seeking to support isolation and quarantine in partnership with community-based organizations (CBOs). North Carolina's resource coordination is unique in its use of multiple interrelated programs, direct financing of social supports, and support of COVID-19 cases and contacts without directly integrating with contact tracing systems.

## **Winona Health: The Winona Wellbeing Collaborative + Winona Community HUB**

The Winona Wellbeing Collaborative (WWC), established in 2016, is a group of partner organizations working to positively impact social determinants of health by removing barriers for residents experiencing health inequities.

After a year of research and analysis centered on the needs of the local community, the WWC focused its efforts on addressing the fragmentation and silos between agencies and providers via implementation of a community HUB model. The Pathways Community HUB emerged as the most advanced evidence-based framework for community-based care coordination, and the model for the Winona Community HUB.

## **Southwestern Vermont Medical Center: Transitional Care Program**

For some people, having a chronic disease means frequent trips to the hospital. Bouncing between home, the emergency room and an inpatient bed is disruptive at best and is an indication that the disease is not well controlled. In response to this issue, Southwestern Vermont Medical Center's clinical leaders looked for a way to prevent this cycle.

The resulting Transitional Care Program (TCP) builds upon an integrated care delivery system that empowers patients to actively manage their care, to set individualized goals, and to make informed decisions while improving the patient experience, improving the health of the population and decreasing cost. Upon referral the TCN will (1) conduct a comprehensive assessment of the patient's health status, health behaviors, level of social support and goals; (2) develop an individualized plan of care consistent with evidence-based guidelines, in collaboration with the patient and doctors; and (3) conduct periodic home visits and/or scheduled phone contacts with the patient based on a standard protocol. SVMC TCNs guide patients from one setting to another and identify any gaps in the coordination of care and coordinate resources to address these gaps.