Perspective

From Rhetoric to Reality — Community Health Workers in Post-Reform U.S. Health Care

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Community health workers (CHWs) are community members who are trained to bridge the gap between health care providers and patients. Many low-income countries, facing shortages of health care professionals, rely on CHWs to perform various public health and clinical functions, including vaccination. Since the 1960s, CHWs in the United States have helped patients navigate health and social service systems, helped address socioeconomic barriers such as homelessness, and promoted healthy behaviors, among other functions. Though most U.S. CHW programs have been grant-funded and relatively small, some policymakers believe that CHWs will become instrumental members of future U.S. health care teams, as the Affordable Care Act (ACA) increases providers' accountability for outcomes that are influenced by upstream factors.

Various policies and programs should accelerate the adoption and growth of U.S. CHW programs. The Center for Medicare and Medicaid Innovation is supporting several demonstrations of care models that include CHWs. Several states have used CHWs to facilitate enrollment in ACA insurance programs or provide core services for Medicaid Health Homes. The Centers for Medicare and Medicaid Services recently allowed states to file Medicaid Plan Amendments authorizing reimbursement for CHW-delivered preventive care services; states such as New York, Oregon, and Massachusetts are testing strategies for reimbursing CHWs through Med-

icaid waivers. Numerous health care providers and Medicaid payers have developed internal financing strategies to support CHW-based interventions for high utilizers of care.

CHW programs date back to the 1800s in Russia, and they grew in the 1920s with the creation of China's "barefoot doctor" program. During the 1960s, the barefoot-doctor concept gained attention as it became clear that modern medical care was inaccessible to poor populations. CHW programs soon emerged in many countries, including the United States. By 1975, the World Health Organization described CHWs as a "key to [health care's] success, not only on the grounds of cheapness but because [CHWs] are accepted and can deal with many of the local problems better than anyone." Criticism of the model emerged in the 1980s, however,

as some programs failed to meet expectations and were terminated. Evidence regarding efficacy was mixed and outcomes were inconsistent, raising questions about what accounted for the "gap between rhetoric and reality."[1]

That question remains relevant today. Political and financial factors contributed to the failures of some CHW programs in the 1980s, but decades of comparative effectiveness and implementation research have also revealed substantial implementation problems. On the basis of a review of the literature, expert interviews, and our own experience, we believe CHW programs must address five key implementation barriers in order to succeed in the post-ACA era: insufficient integration with formal health care providers, fragmented and disease-specific interventions, lack of clear work protocols, high turnover and variable performance of the workforce, and a history of low-quality evidence.

CHW services are commonly delivered by community-based organizations that are not integrated with the health care system — for example, church-based programs offering blood-pressure screening and education. Without formal linkages to clinical providers, these programs face many of the same limitations — and may produce the same disappointing results — as stand-alone disease-management programs. CHWs cannot work with clinicians to address potential health challenges in real time, and clinicians can't shift nonclinical tasks to more cost-effective CHWs. Indeed, clinicians often don't recognize the value of CHWs because they don't work with them. Providers may therefore be

less willing to finance CHW programs, which must rely on unsustainable grant funding. Although it's important for CHWs to maintain their community-based identity, they also need to be integrated into care teams. Such integration may require communication through telephone or electronic medical records, shared use of patient registries, participation in multidisciplinary rounds to develop holistic care plans, and co-location of CHWs with care teams.

CHWs in low-income countries, and to a lesser extent in the United States, may be tasked with providing disease education or basic clinical care, such as triaging of patients. Although this barefoot-doctor model may be necessary in some settings, it has important limitations. CHWs may feel ill-prepared for clinical responsibilities; health care organizations may have liability concerns about CHWs performing clinical tasks; the approach can exacerbate turf struggles with other clinicians such as nurse case managers; and programs focused on clinical care miss the opportunity for CHWs to intervene in upstream socioeconomic problems, such as trauma or food insecurity, which affect people with many different diseases. We recommend the use of holistic, patient-centered programs that can be adapted for various types of patients.[2] This approach can reduce fragmentation for patients with multiple coexisting conditions. It also allows health systems with limited resources to invest in a single scalable model, rather than choosing among disease-specific programs.

CHW programs often lack clear protocols defining their operational details. When protocols

exist, they often describe the discrete tasks to be performed by CHWs and underemphasize program-level issues. Without clear guidelines, CHWs may perform tasks for which they are ill-suited or lack adequate supervision, or they may carry caseloads that are too large for their role and catchment area. These oversights can lead to burnout and adverse patient outcomes. Although it makes sense for CHW programs to vary in their mission and scope, each program needs protocols outlining caseloads, supervision structures, workflow, and necessary documentation. Such protocols will reinforce the need to invest in the program-level infrastructure that is crucial for CHW retention and success. Open-source protocol examples are readily available for new programs.[2]

Turnover and training expenses have led to higher-than-expected costs in CHW programs[1] — for instance, one third of CHW candidates dropped out during a 6-month training for the Harlem Regional Stroke CHW Program.[3] Programs have tried to address these workforce problems by further emphasizing training. Yet as organizational psychologists know, careful selection of employees is a better predictor of high performance than training is, especially for jobs that depend on inherent personality traits and interpersonal skills. A systematic review showed that less than half of articles about CHW programs described the employee-selection process at all; only one article described a formal hiring process that included an application and interview.[4] CHW programs need clear, well-defined candidate-selection guidelines. Structured job interviews that include case

scenarios assessing personality traits such as listening skills, empathy, and a nonjudgmental nature can help interviewers predict a candidate's likely future performance.

A 2010 systematic review concluded that many studies evaluating CHW programs have substantial methodologic limitations, including high attrition rates and designs that introduce the potential for bias.[5] This low-quality science has led policymakers to either dismiss CHW programs or have unrealistic expectations for their success. But since 2010, the number of articles on CHWs published annually (in journals indexed in PubMed) has nearly doubled, and the quality of research has improved; nearly 400 randomized, controlled trials have been published in the past 5 years — suggesting that CHW interventions can be subjected to the same level of rigorous evaluation as new drugs. As the evidence base for specific CHW interventions improves, future questions

will focus on the implementation and programmatic features required for success in a variety of settings.

Their long history and the expanding evidence base for CHW programs suggest that they have strong potential for improving health outcomes. Many policymakers believe that the key to realizing this potential lies in standardized training and certification of CHWs. But unless we address program-level implementation barriers, employee-level standardization is unlikely to be effective. Program accreditation based on evidence and on-site surveys — such as those conducted by the Joint Commission — might help to foster the CHW programs that are most likely to succeed.

The current policy and financing environment has created a historic opportunity to improve U.S. health care delivery through the effective use of CHWs. As we move beyond the financing, it will take hard work at the imple-

mentation level to maximize the likelihood of success.

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Post-9/11 Torture at CIA "Black Sites" — Physicians and Lawyers Working Together

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In December 2014, the U.S. Senate Intelligence Committee's report on torture was released to the public. The 600-page report (a redacted summary of the still-classified 6000-page report) documents in disturbing detail the use by the Central Intelligence Agency (CIA) of physicians, lawyers, and psychologists in its post-9/11 torture program at more than a dozen "black sites," or secret prisons, around the world.[1]

The United Nations High Commissioner for Human Rights, Zeid Ra'ad al-Hussein, has called the report "courageous and commendable," while condemning the torture program it details and noting that "torture cannot be amnestied" and should not be permitted to recur.[2] To begin to understand the torture, we believe it's necessary to understand how physicians and lawyers collaborated to overcome their professional inhibitions.

Medical professionals, primarily private contractors, filled four basic roles at the black sites: clearing terrorist suspects as "medically fit" for torture; monitoring torture to prevent death and treat injuries; developing novel torture methods; and actually torturing prisoners. All these actions were taken only after CIA and U.S. Department of Justice attorneys assured the medical professionals that they had im-