Community Health Workers in the United States: Time to Expand a Critical Workforce

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See also Heisler et al., p. 766.

Community health workers (CHWs) have a long, rich global history of extending essential health services and helping address social determinants of health for underserved populations.[1] The 1978 Declaration of Alma-Ata, which called for the achievement of "health for all," explicitly defined a role for CHWs as an integral member of primary health care teams.[2] In the United States, CHWs have historically been patient health educators and advocates, particularly for patients who have limited health knowledge or whose first language is not English. The 2010 Affordable Care Act called for the integration of CHWs into primary care settings to help improve the provision of care to culturally diverse patients. Despite these efforts, the CHW workforce in the United States has been underrecognized and underutilized, and many have called for policy change to better integrate CHWs into the US health system.[3,4] CHWs have been largely neglected in health workforce planning, with existing programs often led by multiple actors without coordination, with fragmented or disease-specific foci, unclear links to the health system, and unclear identities because of wide-ranging job titles.[2] Small programs and demonstration projects have shown the efficacy and promise of CHWs to improve population health outcomes,[5,6] but monitoring and evaluation systems for large-scale CHW programs have been weak, and evidence of their real-world effectiveness and cost-effectiveness has been limited.

In this issue of *AJPH*, Heisler et al. (p. 766) describe an innovative multisector partnership between Medicaid health plans, a local health department, community-based organizations, and academia that implemented and evaluated a health plan–led CHW program in a low-income neighborhood in Detroit, Michigan. One year in, the study found that emergency department visits and costs were lower in the intervention group of Medicaid beneficiaries randomized to the CHW program compared to beneficiaries who received usual care. Outpatient ambulatory care costs were higher in the intervention group. Although total costs did not differ between the two groups, increases in ambulatory care use among low-income, medically underserved populations are a clear marker of success, and future longitudinal studies may demonstrate important implications for long-term savings and health outcomes.

The strengths of this study are numerous. Importantly, the evaluation of a real-world program revealed key implementation barriers that more controlled CHW efficacy trials do not typically face; yet, they can ultimately hamper translation of research to practice. Furthermore, this study provides a rigorous methodological template for other settings to replicate in evaluating their own CHW program effectiveness and cost-effectiveness. Although recent studies have shown that CHW programs can address health disparities and generate a positive return on investment (ROI),[7] a lack of available context-specific evidence on cost-effectiveness and ROI often inhibits interested organizations from implementing CHW programs, despite mounting evidence of their success.[5–7] This study and the future studies it will inspire are essential to achieve sustainable financing for CHW workforces in the United States. Reliance on short-term grants and cumbersome reimbursement mechanisms are well-documented challenges to CHW workforce expansion[8,9]; thus, health plan–implemented CHW programs such as the one described by Heisler et al. can serve as an innovative model for other contexts.

The next challenge is to replicate, extend, and scale up such programs. Evidence, innovation, and policy change are needed to ensure that CHWs become trusted members of the workforce and are reimbursed accordingly.[9] The COVID-19 pandemic has escalated the urgent need for CHW programs and has also created opportunities for the necessary policy changes.

LESSONS LEARNED DURING COVID-19

The COVID-19 pandemic has called attention not just to persistent health disparities in the United States but also to the severe underinvestment in community health workforces needed to address them. A national CHW workforce could and should have been in place at the start of the pandemic to address issues ranging from vaccine hesitancy, barriers to accessing testing, and low health literacy and misinformation to the broader social, economic, and behavioral health needs of vulnerable populations. Instead, an onslaught of federal funding through the 2020 Coronavirus Aid, Relief, and Economic Security Act and the 2021 American Rescue Plan meant that state and local governments scrambled to hire, train, and deploy CHWs amid the ongoing public health crisis. In March 2020, the US Department of Homeland Security included CHWs, for the first time, as part of the Essential Critical Infrastructure Workforce in their strategy to ensure community and national resilience in the COVID-19 response.

In many communities, CHWs have been instrumental in COVID-19 public health messaging and communication, contact tracing and monitoring in medically underserved communities, navigation to vaccine and testing appointments, and even in conducting rapid antigen testing with the proper training and personal protective equipment. They have leveraged their established relationships and trust of their communities to dispel myths, advocate against evictions, help clients access their stimulus checks, and promote mental and physical health and resilience.[4] CHWs have also expanded the capacity of social service organizations who have been on the front line throughout the pandemic, including homeless shelters, food pantries, and other agencies providing public assistance. The recent federal investments in CHWs, though overdue and time limited, should be leveraged to strengthen the workforce to address ongoing community health needs and prepare us for future public health crises.

A WINDOW OF OPPORTUNITY

The political commitment needed to expand and sustain a robust CHW workforce was largely lacking until recently. In January 2022, a new bill was introduced in the Senate, S.3479—Building a Sustainable Workforce for Healthy Communities Act—which calls for investment in the sustainability of the CHW workforce and expands funding opportunities beyond state and local governments to include community-based organizations. The success of this bill is yet to be determined, but, as with any policy, demonstrating success and positive ROI will be critical to its sustainability. Rigorous large-scale longitudinal evaluations of CHW programs with respect to health care use, health outcomes, and health system savings will become increasingly necessary. Heisler et al. provide an elegant blueprint for a health plan–implemented and potentially financially sustainable model whose evaluation can strengthen the evidence base for CHW effectiveness and cost-effectiveness.

Future studies should focus on longer-term impacts of CHW programs and should consider including patient-centered outcomes in their evaluation. A growing commitment to community engagement and patient-centeredness in public health research funding will also increase opportunities to engage CHWs as research partners,[10] creating further opportunities for workforce expansion. Leveraging this current momentum and unique window of opportunity to strengthen and expand this critical workforce will require evidence-based practices[8,11,12] for effective recruitment, training and certification, retention, evaluation, supervision, reimbursement, recognition, and remuneration of CHWs to ensure success and sustainability long beyond the COVID-19 pandemic. AJPH

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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