# A Cross-Cutting Workforce Solution for Implementing Community–Clinical Linkage Models

See also Dasgupta, p. S174.

Federal agencies have identified the need to foster integration between health care and social services to address the underlying role of social determinants of health and achieve health equity. Community–clinical linkage models are partnerships to help connect health care providers, community organizations, and public health agencies so that they can improve patients' access to preventive, chronic care, and social services. Models for linkage have proliferated to tackle the complexity of addressing social needs from health care settings. Examples include using electronic community referrals systems to facilitate connections between patients and organizations that offer social services, creating medical-legal partnerships, and employing community health workers (CHWs) to navigate complex health systems and facilitate access to community resources such as affordable housing and food banks.

Most community–clinic linkage approaches have been tested, implemented, and disseminated across large health systems, academic medical centers, or federally qualified health centers—largely to the exclusion of small, independently owned practices. As of 2016, approximately 40% of primary care physicians in the United States were working in practices with fewer than five physicians.[1] From a quality-of-care perspective, small, independently owned practices may offer certain advantages compared with hospital-owned primary care practices, including a greater level of personalization and responsiveness, higher-quality care, lower average cost per patient, and fewer preventable hospital admissions.[2] For small, independently owned practices whose focus is on serving low-income, underserved patients, community–clinical linkage programs that connect patients to resources addressing social and cultural issues may be particularly impactful. However, small, independently owned practices struggle with limited staff, financial resources, and technological expertise to implement system changes, and they are often organizationally isolated, which impedes their ability to network with community organizations and identify resources.

On recognizing these barriers, numerous federal initiatives (e.g., EvidenceNOW, Million Hearts) have supported a renewed focus on small, independently owned practices to enhance their role in effectively improving health outcomes in the communities they serve. These initiatives emphasize the role of practice facilitation, a process led by a trained facilitator that focuses on fostering collaborative team-based problem solving, building effective communication, establishing and sharing common goals between members of the health care team, and helping practices integrate tools that leverage health information technology and promote data-driven improvement in patient outcomes. Also known as quality improvement coaching,[3] practice facilitation is a strategy for building capacity among small, independently owned practices to adopt and implement evidence-based systems and care processes—like the integration of CHWs into primary care to facilitate community–clinical linkages—for improving patient care. CHWs, a US Department of Labor–recognized workforce, are frontline public health professionals who are trusted members of the communities they serve. CHWs represent a cost-effective strategy to improve patients' self-management, adherence to treatment of chronic disease, and connections to community resources.[4,5] However, information is lacking on how to integrate CHWs successfully into small, independently owned practice settings, which tend to lack the infrastructure and resources to integrate a new workforce.

Drawing from different streams of literature on (1) the effectiveness of CHWs in addressing patients' social needs and (2) the effectiveness of practice facilitation in building practice capacity to integrate evidence-based strategies to improve care, we propose that small, independently owned practices strategically employ practice facilitators, who are specially trained quality improvement coaches, to integrate CHWs into their primary care teams to support the effective implementation of community–clinical linkage models. We argue that the role of practice facilitators is well aligned with the goal of implementing innovative team care models that link patients to community services through the addition of CHWs to the primary care team, representing a cross-cutting workforce solution for small, independently owned

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TABLE 1—Strategies Used by Practice Facilitators to Enhance Integration of Community Health Workers (CHWs) Into Small, Independently Owned Practices (SIPs)

| SIP Challenges | Role of CHW in Addressing Unique SIP Challenges | Strategies Used by Practice Facilitator to Enhance Integration of CHWs Into SIP Settings |
|---|---|---|
| Many SIPs in urban and rural areas serve patient populations that face health disparities but have limited staff to engage patients in health coaching efforts. In addition, many SIPs are organizationally isolated. | CHWs can provide culturally and linguistically tailored health coaching. | Practice facilitation can help support strategic identification and hiring of CHWs that are culturally congruent with patients through information sharing and connection to external hiring agencies. |
| SIPs lack resources and knowledge of community resources to address social determinant challenges faced by patients. | CHWs have knowledge of local community resources related to housing, food insecurity, employment, and other social issues and have facilitated improvements in social and family support and food insecurity for patients. | Practice facilitators can support SIPs in integrating health information technology–based referral systems and mechanisms to facilitate linkages and information sharing between CHWs, patients, and providers. |
| SIPs that provide care for underserved and uninsured patients face challenges with patient health literacy and adherence. | CHWs can improve patient adherence, health literacy, and health outcomes across a range of conditions through culturally and linguistically tailored health education. | Practice facilitators can support SIPs to embed health coaching and referral materials, including CHW curriculum and culturally tailored materials, into the electronic health record. |
| SIPs serving patients in urban and rural areas have a high volume of walk-in patients. | CHWs can provide support to SIPs to enhance regular scheduling of patients for routine care and follow-up visits by making reminder calls to patients and emphasizing the importance of preventive and routine care, particularly for individuals with chronic conditions. | Practice facilitators can provide health information technology support and on-site coaching to train practice staff, including CHWs, in developing patient registries and creating follow-up protocols with patients. |
| SIPs implement fewer patient-centered medical home processes, including care coordination services. | CHWs can support care coordination efforts at a lower cost and higher value for improving patient outcomes compared with case managers. | Practice facilitators can provide coaching to implement system changes related to practice workflow, communication, and shared decision-making between CHWs and other practice staff supported by health information technology efforts. For example, facilitators can work with SIPs to integrate templates that CHWs can upload into the electronic health record (including counseling documents or progress notes that document goal attainment) and feedback loops that integrate this information into electronic health record–driven decision support and performance reports. These system changes ensure that (1) clinicians are up-to-date on contextual issues that patients are facing and how CHWs are mitigating these factors and (2) CHWs are able to effectively and efficiently complement physicians' treatment recommendations with health coaching and referral efforts. |

practices to address upstream factors affecting the health of their patients.

## STRATEGIES FOR IMPLEMENTATION

Small, independently owned practices are eager to integrate CHWs into their practices. However, effective partnerships between practices and CHWs require a "population health management" infrastructure, for which practice facilitators are trained to offer support. Specifically, practice facilitators build practices' capacity to integrate evidence-based interventions into organizational workflow by offering coaching, training, and assistance in planning and performing a range of specific tasks, such as electronic health record template management or report building and supporting more complex change processes (such as team building or workflow redesign).[3] With the support of a facilitator, primary care practices are almost three times more likely than usual care practices to implement recommended evidence-based interventions for preventive services, and research suggests that the effects of practice facilitation are sustained one year postintervention.[3] Small, independently owned practices, in particular, value the facilitator's role in connecting them to the external health care environment

to overcome organizational isolation. This can include teaching the practice through information sharing, promoting networking with other practices, and linking practices to resources and opportunities to enhance quality and reimbursement.[6]

Thus, practice facilitators can provide the skills and a process for integrating CHWs into the care team as a central resource for addressing social determinants of health. Table 1 outlines several ways that practice facilitation can help small, independently owned practices mitigate their unique challenges and successfully integrate CHWs to foster the bidirectional nature of community–clinical linkages.

## SUSTAINING THIS CROSS-CUTTING WORKFORCE

Some emerging public models and regional solutions focus on creating a sustainable workforce of practice facilitators and CHWs. In New York City, the local health department supports a practice facilitation program, providing services for more than 1000 small, independently owned practices to promote high-quality primary care and advance population health and prevention. States like Washington, Texas, and New York also have leveraged Delivery System Reform Incentive Payment waivers to create regional networks of providers, with resources and mechanisms to sustain CHW services through value-based payment models. Several new laws and Centers for Medicare and Medicaid Services rules, as well as managed care organization rules designed to engage enrollees in care, provide sustainable mechanisms to support CHWs in primary care practice settings.

Payer organizations, in collaboration with independent practice associations and Accountable Care Organizations, also can play a role in supporting practice facilitation and CHW services. Payment models can include payers directly hiring practice coaches and CHWs as staff and deploying them to member practices. Alternatively, payers may directly reimburse practice facilitation or CHW efforts through independent practice association or other hub models, whereby groups of practices with a natural affiliation pay into shared services, a strategy that has been successfully used in Oregon and California.

The Affordable Care Act authorized—but did not fund—the creation of a Primary Care Extension Program, which policy researchers have cited as a way to "accelerate changes in primary care, integrate primary care with public health, and translate research into practice to improve health outcomes, health care, and costs."[7(p176)] New Mexico's Health Extension Rural Offices program was built on the Primary Care Extension Program model. Health Extension Rural Offices agents have roles that include components of practice facilitators and CHWs, suggesting a hybrid workforce model that may be more cost-effective.

## CONCLUSIONS

Strong evidence that CHWs are effective, coupled with evidence that practice facilitation can optimize implementation of evidence-based models of care, should inform decisions about future funding of practice facilitation to support CHW integration in small, independently owned practices. However, research is necessary to examine strategies to optimize the implementation of this community–clinical linkage model in small, independently owned practices through the use of practice facilitation and the cost and return on investment of these strategies. Such evidence can provide much-needed support for the role of small, independently owned practices in addressing the social determinants of health and affirm their relevance in a rapidly changing health care context.[2] AJPH

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### CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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