

Bridging the Health Divide

Community health workers are helping eliminate costly health inequalities.

BY LAURA TOBLER

Lourdes Fernandez, a promotora, helps the people of Douglas, Ariz., learn how to prevent and manage chronic diseases. As a community health worker in this U.S.-Mexico border city, she's a trusted caregiver who helps her clients understand the resources available to them.

On any given day, she teaches, translates, directs clients to appropriate services, monitors blood glucose levels, measures blood pressure, helps arrange transportation and provides emotional and social support. More important, Fernandez teaches her clients that "they can prevent and control chronic disease." This is an important first step, she says, in her mission to reduce or even eliminate the disparities in health among people of different racial and ethnic groups in Douglas.

Studies show that members of white communities usually receive more health care and are in better health than members of racial and ethnic minorities, even when they have similar incomes and insurance coverage. A variety of factors are involved, including how easy it is to get appropriate health care services in the community; underlying genetic, ethnic and familial factors; and the physical and social environments of a community that may increase health risks.

The Costs of Disparities

Disparities in care result in costly inefficiencies, especially when preventive or primary care is missing. Without such care, a mild sickness may progress into a complicated condition that requires a trip to the emergency room, with a much higher price tag. Preventive care for minority populations is often inadequate for a variety of reasons, including a lack of transportation, poor English skills or a shortage of affordable primary care doctors in their communities.

Eliminating disparities, which includes expanding preventive care for minorities, could have reduced direct expenditures for medical care by \$229.4 billion between 2003 and 2006, according to a 2009 study by the Joint Center for Political and Economic Studies, a think tank based in Washington, D.C.

Many state and federal policymakers, concerned about the high costs and widespread inequalities, are looking for answers. And research indicates community health workers may be part of the solution.

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New CLAS Standards Out

In April, the federal government released the new National Standards on Culturally and Linguistically Appropriate Services in Health and Health Care (the CLAS standards). First developed in 2000, the updates are meant to help eliminate health disparities by providing guidelines on how to deliver health care services in a culturally respectful way to meet the needs of all patients. The new standards reflect a broader definition of culture and move beyond specific health care practices to address the overall health of individuals, organizations and communities.

Several states have proposed or passed legislation pertaining to cultural competency training for one or more segments of their state's health professionals in the decade since the initial publication of the National CLAS Standards. Legislatures in California, Connecticut, Maryland, New Jersey, New Mexico and Washington have passed laws requiring or recommending cultural competence training.

—Melissa Hansen

Source: U.S. Office of Minority Health

Although they go by a number of names—promotoras, village health workers, health aides, community health promoters and lay health advisers—community health workers have one main job, and that is helping patients in underserved communities navigate an increasingly complex health care system. They often work for community health centers, hospitals or health departments. Nonprofit organizations and researchers often hire them on a short-term basis. Approximately one-third are volunteers, while the rest, if they have experience, earn an average of \$13 an hour—a modest amount compared to other health workers.

Although the profession has existed for decades, only recently has it become more mainstream. The U.S. National Uniform Claim Committee, a voluntary organization that works to standardize health care billing and data collection, added a classification for community health workers in 2007, and the U.S. Department of Labor classified the occupation in 2010.

A Role for Lawmakers

The profession suffers from a lack of standardization and funding, and that's where lawmakers play a role. A 2007 national study of community health workers reported the occupation "has not been viewed as a career, because community health workers have



positions that are often short-term, low paid, and lack recognition by other professionals.”

The educational requirements vary from some on-the-job training to a formal community-college degree. The result is that workers in the same profession have significantly different skills and capabilities. “Health care payers [such as state government or health insurers] want to know what they are buying,” says Carl Rush, from the Institute for Health Policy at the University of Texas. He explains that payers will not invest in community health workers if their skills and abilities are unclear.

Contributing to the variation in skills is the belief by many community workers that integrating into the huge health care industry could jeopardize the fundamental reason for their success—their strong, primary connection with the community. Others argue that training and standards would bring recognition and opportunities for better pay through state Medicaid programs and third-party insurers.

Texas lawmakers, in 1999, were first to require certification for all paid community health workers. Ohio followed with similar legislation in 2003. Alaska and Indiana have certification programs that authorize community workers to perform specific duties. Most states, according to Rush, are developing or considering various kinds of training and credentialing.

Sustainable funding for services provided by community health workers is a perennial chal-

lenge. Minnesota law allows trained community health workers serving under an authorized Medicaid provider, such as a doctor or advanced practice registered nurse, to receive Medicaid reimbursement for educating patients and coordinating their care. The law passed after a coalition of educational institutions, health care providers, government agencies, businesses, foundations and nonprofit groups created a statewide standardized training program and reported the cost benefits to the Legislature. As of 2009, more than 80 community health workers in Minnesota had enrolled as Medicaid providers.

The Kentucky General Assembly, 19 years ago, created and funded a community health worker program that links rural residents with medical, social and environmental services they otherwise might not have received. The Home Plate program, which received \$1.3 million from the state this year, trains community health workers from rural communities to help residents obtain appropriate services, with an emphasis on preventive care, education and self-management of chronic diseases.

The program employs about 26 community health workers and five coordinators who serve more than 8,100 individuals with incomes below the federal poverty level, or the “neediest of the needy” in rural Kentucky, according to Fran Feltner, director of the University of Kentucky’s Center of Excellence in Rural Health. Home-place workers help clients get eyeglasses, den-

tures, home heating assistance, food, diabetic supplies and medical care, “as well as serving as a bridge ... to health care providers in the community,” Feltner says.

And in a new program set to begin later this year, South Carolina also hopes to address shortages in the medical workforce by using community health workers to support Medicaid recipients.

A Wise Investment

Research shows that community health workers improve the quality of care patients receive and reduce disparities among population groups, especially among patients with heart disease or diabetes, two prevalent and expensive chronic diseases.

A study in New Mexico, for example, found that between 2007 and 2009, when community health workers provided support to Medicaid patients in a managed care program, their payments to and use of emergency rooms, prescription drugs and doctor services decreased.

In 2003, a Baltimore program that matched community health workers with diabetic patients in the Medicaid program reduced emergency room visits by 38 percent and hospitalizations by 30 percent, resulting in a savings of around \$80,000 a year per community worker.

Another study in Denver found that behavioral health care patients working with community workers increased their visits for primary and specialty care, but reduced their trips to urgent care and inpatient and outpatient facilities, decreasing total costs by \$14,000 month. That’s a savings of \$2.28 for every \$1 invested in the program.

In Arkansas, specially trained community health workers connected people at risk for entering nursing homes to Medicaid home- and community-based services instead, saving \$2.6 million between 2005 and 2008.

The research results don’t surprise Fernandez; she knows that community health workers play an integral part in building healthier communities by addressing social or environmental factors that affect health. “If I am educating someone with diabetes or high blood pressure to exercise regularly, it is my job to make sure they have a place to do that,” says Fernandez. She says it’s common for community health workers to lobby local governments to repair uneven sidewalks, illuminate dark trails, or expand a community center’s hours so more people can exercise. “You won’t exercise if you don’t feel safe,” she adds. ■