Mounting Evidence of the Effectiveness and Versatility of Community Health Workers

In December 2011, the *American Journal of Public Health* dedicated a theme issue to community health workers (CHWs) when studies of the effectiveness of CHWs in health improvement were just beginning to appear in peer-reviewed journals. The related "Editor's Choice" stressed that proper evidence and cost-effectiveness assessment was needed to gain reimbursable institutional support for these services.[1] We take the opportunity of two articles dedicated to CHW in this issue of *AJPH*[2,3] to review the situation four intervening years later.

CHWs, also referred to as health workers, health navigators, *promotores,* and various other titles, play a variety of roles within both research and patient-centered care teams including fostering linkages with local communities, data collection, outreach and case management, counseling and education, and health system navigation. Community-based research can benefit from the insights of CHWs regarding acceptability, validity and feasibility, and potential barriers to implementation. As a member of a research team, a CHW also provides a unique perspective in interpretation of findings.

Of note, CHWs are increasingly involved in public health interventions that identify and address barriers to prevention, care, and treatment. As members of their local communities, CHWs can help programs create culturally responsive public health interventions, as well as community-based research studies that are informed by and responsive to local priorities and concerns.

An indubitable recognition of the success of CHW is that more states each year have been developing laws, regulations, or both addressing issues of training, credentialing, and reimbursement of CHWs. The objective is ensuring the effectiveness of this component of the workforce and retaining CHWs in the field through support of sustainable financing mechanisms.[4]

However, the ongoing struggle in the United States to reign in health care costs has placed CHWs in a critical but uncertain position. Are they exceptionally cost-effective team members who can improve outcomes at a low cost? Or are they yet another layer of staffing in an already bloated system characterized by inefficiencies, redundancies and misaligned incentives? With a stretched and stressed healthcare work force and an impetus to add workers who are reflective of the communities they serve, there is substantial support for the first view.

EFFECTIVENESS

The good news is the increased evidence of the effectiveness of the CHWs. The two articles in this issue add to the evidence in the areas of chronic disease management and care among vulnerable populations, and in CHW involvement in research.

With 67 peer-reviewed articles meeting the criteria needed to generate the systematic review, Kim et al. found that CHWs support "trends toward improvement" in cancer prevention and cardiovascular risk reduction. In addition, eight studies documented cost-effectiveness of CHW intervention. However, research was limited in terms of documenting best practices for hiring, training, supervision, and intervention fidelity required to demonstrate effectiveness and develop scalable, evidence-based models.[2]

As the need for CHWs continues to rise, it will also be important to understand the desired attributes of CHW applicants. Further study is needed to determine whether particular attributes are correlated with intervention efficacy, to inform training and credentialing, as well as reimbursement structures.

About CHWs and research, Hohl et al. studied 18 community intervention research sites and report that the most highly valued attributes of CHWs included knowledge of host community, communication skills, and personality.[3] For a subset of projects, there was also great value placed on CHWs being bilingual or bicultural, or having experience with administrative tasks such as report writing.[4]

VERSATILITY

The potential range of the impact of CHWs across public health and health care is impressive. We use here as example the uses of CHWs to enroll in health insurance people living with HIV and in LGBT health. While CHWs are commonly used to support interventions for the prevention and treatment of chronic disease, much work done in both HIV and Lesbian, gay, bisexual, and transgender (LGBT) health has strongly benefited from their use.

People Living With HIV

Case managers and peer counselors have long been key members of the HIV service systems in both prevention and care. Now, under the Patient Protection and Affordable Care Act (ACA; Pub L No. 111–148), enrollment assisters (including Navigators and Certified Application Counselors) play a crucial role in helping people get engaged and enrolled in health coverage options. The ACA provides standards, training, and funding to provide one-on-one assistance with enrollment.

Enrollment assisters walk people through the complicated application and enrollment process and help to determine and

ABOUT THE AUTHORS

Stewart Landers is an AJPH *Editor and a Senior Consultant and Director of US Health Services, Boston Office for John Snow, Inc. Mira Levinson is a Senior Consultant at John Snow, Inc.*

Correspondence should be sent to Stewart Landers, JSI, 44 Farnsworth Street, Boston, MA 02210 (e-mail: landers@jsi.com). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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document eligibility for coverage and subsidies, compare and select health plans, and complete and submit the application. The importance of one-on-one assistance, particularly for underserved communities, is a best practice for successful outreach and enrollment.[5]

Whether they provide direct enrollment assistance services, HIV service provider organizations are trusted community providers. The central role of case management in Ryan White HIV/AIDS Program model of service delivery means that case managers are able to build long-term, trusting relationships with clients. Many effective organizations are training case managers to talk with clients about the benefits of health coverage, as well as allaying clients' fears and concerns about getting covered. Clients may be distrustful of the health care system, or may not feel they need to enroll, particularly because these individuals may have limited past experience with health insurance. Case managers can also provide a warm handoff to an enrollment assister where needed and work with clients on an ongoing basis to ensure that they are retained in health coverage, that their coverage is affordable, and that there are no gaps in access to critical HIV medications.

Lesbian, Gay, Bisexual, and Transgender Health

Another example of the versatility of CHWs includes their role as LGBT community guides who help to identify hard to reach members for both research and intervention purposes. Transgender individuals were recruited to help conduct some of the first focus groups on the health care needs of transgender persons.[6] The transgender guides were trained in focus group facilitation, helped recruit focus group participants and cofacilitated the focus groups that identify health needs, as well as health care access barriers and facilitators. The transgender community supported the activity because members of their own community helped to develop and implement the qualitative study.

In North Carolina, Rhodes et al., developed an intervention to promote sexual health for Latino men who have sex with men. The intervention includes four modules to train Latino men who have sex with men to serve as lay health advisors known as *Navegantes*. The modules blend behavioral theory, lived experiences and cultural values of immigrant Latino MSM to maximize positive outcomes.[7]

MOUNTING EVIDENCE

The evidence is slowly but steadily mounting demonstrating the effectiveness of CHWs in improving both public health research and intervention by ensuring that both are more closely aligned with the values and practices of the communities in which these activities occur. The range of public health areas where CHWs can make a difference is likely as diverse as public health itself. AJPH

Stewart Landers, JD, MCP
Mira Levinson, MPH

CONTRIBUTORS

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A Public Health of Consequence: Review of the April 2016 Issue of AJPH

This month we start coupling this column with an editorial invited to complement the articles about which we are commenting. We intend the invited editorials to cover particular areas of concern around thinking of a public health of consequence, engaging around areas that we observe emerging from articles submitted to *AJPH* that aspire to inform our scholarship around a public health of consequence. This month's opinion editorial in the section Public Health of Consequence[1] introduces the notion of population health science as a discipline, arguing that such a discipline draws from a range of existing disciplines—from the social sciences to the natural sciences. The goal of population health science, as suggested in the editorial, would be

> the study of the conditions that shape distributions of health within and across populations, and of the mechanisms through which these conditions manifest as the health of individuals.[1(pXX)]

This then sets up the discipline well to be a foundational discipline that aspires to a public health of consequence—the subject of this series of editorials. In particular, Keyes and Galea[1] suggest that some of the principles of such a discipline

ABOUT THE AUTHORS

Sandro Galea is Dean and Professor, School of Public Health, Boston University, Boston, MA. Roger Vaughan is an AJPH editor, and is also the Vice Dean and Professor of Biostatistics, Mailman School of Public Health, Columbia University, New York, NY.

Correspondence should be sent to Roger Vaughan, Vice Dean and Professor of Biostatistics, Mailman School of Public Health, Columbia University, 722 West 168th Street, New York, NY 10032 (e-mail: roger.vaughan@columbia.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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