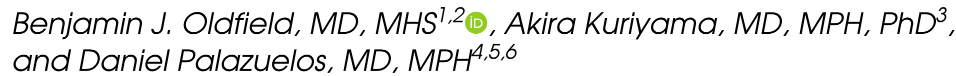
The Kitchen and the Cook: Context and Roles in Community Health Worker Programs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When health systems leaders and policy makers consider how to curb exorbitant health care costs, they appropriately home in on the most complex 5% of individuals who drive over 50% of healthcare spending.[1] These individuals tend to be both medically and socially complex, so efforts to improve upon their care and its cost have focused on coordination of services and addressing upstream socio-structural drivers of health. Community health workers (CHWs)—who understand health care systems and the local context of upstream drivers in their communities—represent one of the most promising interventions for individuals with complex health needs. CHW programs have garnered praise in the popular press[2] as well as funding and other resources from national organizations, such as the Centers for Disease Control and Prevention and the American Hospital Association. However, over the last decades, several CHW interventions have been reported upon with mixed findings, often with considerable heterogeneity in intervention and study design. There remains a need to identify "the special sauce" in CHW interventions that drives favorable outcomes in care, cost, and experience.

Previous systematic reviews seeking to identify unifying features of successful CHW programs have targeted cost-effectiveness[3] and overall health services utilization.[4] These analyses are now nearly a decade or more old. To help fill this gap, Loftis et al. report on a new systematic review and meta-analysis.[5] They focus specifically on 30-day hospital readmissions as their primary outcome to focus on a policy-relevant outcome. In a systematic search of two databases (PubMed and Embase), the authors retrieved 235 titles, of which 7 were included and whose text was analyzed for outcomes, quality, and bias. Their meta-analytic approach included pooled analyses, assessment of heterogeneity, and funnel plotting to assess publication bias.

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The key finding from the pooled analyses was that the analyzed CHW programs significantly improve 30-day readmissions; yet there was moderate heterogeneity in studies and their funnel plot did suggest some publication bias. A subgroup analysis of only the included randomized controlled trials (RCTs) did not demonstrate a significant reduction in 30-day readmissions, made more notable because the authors' assessment of risk-of-bias for the included RCTs was the lowest possible based on their chosen bias assessment tool. Strengths of the work include that the authors did not exclude non-English studies, given the international range of CHW programs (although all included studies were written in English); a focus on a specific, policy-relevant outcome; and a quantitative assessment of heterogeneity and publication bias.

A major limitation—germane to the comparative literature on CHW programs—lies in the heterogeneity of CHW roles, geographies, and patient populations targeted in the included studies. Age is just one variable of many to consider as an example here. Among the randomized-controlled trials, one conducted in Philadelphia, Pennsylvania had a patient cohort with a mean age of 42,[6] while one conducted in Boston, Massachusetts, had a patient cohort with a mean age of 70.[7] One can imagine that the support structures available for CHWs to engage are considerably different for a younger, poorer population compared to an older population largely insured by Medicare—and one may question the value of pooling such data. In addition to the heterogeneity in study design, there was also considerable variability in the quality of cohort studies, a variable the authors did not incorporate into their analyses nor discussion.

The work of Loftis, et al., helps us better understand the contours of and the quality of work available regarding CHWs and their impact on 30-day readmissions. But we are left with further questions about how health systems should partner with CHWs best and how these programs should be tailored to community, population, and system contexts. We suggest two approaches to build off Loftis' work and begin to answer these questions. When looking to find a special sauce that is central to programmatic efficacy, consider the kitchen context and look to learn from the cooks.

First, comparative studies (including future reviews) would benefit from methodologic approaches that

incorporate intervention-specific contexts. For example, realist synthesis—a review strategy that deviates from meta-analyses by seeking to answer what works, for whom, in what circumstances, and why—may better localize studies in their contexts and therefore help readers understand what strategies are best for their own contexts. Realist syntheses have been effective at comparing large-scale interventions that involve multiple professional types across different contexts, such as large-scale hospital quality improvement programs.[8]

Second, comparative studies of CHW programs would benefit from shared language and definitions for the tasks and methods of engagement employed by CHWs. The C3 Council, for example, offers a single set of CHW roles and competencies to increase cohesion in the CHW field and aid in the study of CHWs' impact.[9] These could be mapped onto specific interventional studies—and help plan future work—to allow for the study of which roles and competencies might most drive outcomes, where, and for whom. Attention can also be paid to the larger social support systems available in that region, as the strength of these will determine how much a community health program can instrumentally and materially supply for those in need.

Given how varied the CHW role can be, future work should also question who is agent of action; indeed, who is the cook of the special sauce? Too often, program architects, many with professional identities such as doctors, nurses, social workers, or public health specialists, are given the credit. In our opinion, greater engagement is needed of CHWs, who apply ingenuity to find individualized approaches for addressing the diverse medical, social and emotional needs of their clients. They often foster trust across great odds and against histories of untrustworthiness, bridging communities and healthcare systems. This enhances patients' sense of belonging and social connectedness, outcomes not fully captured by readmission metrics alone. However, CHWs often experience limited integration with other providers, which can render their contributions invisible. They commonly face constraints from scarce community resources that limit their capacity to address complex social needs. Given the complexity of their role, CHWs should be seen as more than mere employees, and instead can be positioned in such analyses as vital contributors that lend ideas "from the front lines," wisdom born from lived experience, and a deep knowledge of the local context.[10]

The interest in CHW programs is gaining momentum. Transitions in health care payment from fee-for-service to value-based mechanisms continue to unlock opportunities for enabling services providers to play key roles in care, particularly for the most complex individuals. At the same time, despite a boom in funding during the COVID-19 pandemic for CHW programs, the United States is experiencing an equally dramatic bust in its commitments to care for low income and chronically ill populations. In characterizing the current literature on the topic, focused on a specific, policy-relevant outcome, Loftis et al., have level-set for readers the current literature and its heterogeneity. Yet future work is needed to characterize the special sauce of CHW programs, examining the kitchens (intervention contexts and shared language) and engaging the cooks (our CHW colleagues themselves, not only the health system employers, managers, or policymakers).

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Declarations

Conflict of interest *The authors declare that they do not have a conflict of interest.*

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