Creating a Hospital-Based Community Health Worker Program Using College Students: *Reducing Costs and Improving Quality*

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The current health care landscape is changing quickly. The Patient Protection and Affordable Care Act (ACA) (2010) has had significant impact on insurance coverage and the way in which health care is provided. The percentage of the population with no health insurance coverage declined by 2.9 percentage points between 2013 and 2014.[1] The 2.9% decline translates into 8.8 million more citizens with insurance coverage during this 1-year time period.[1] In addition, hospitals and health care systems are seeking programs and plans to decrease avoidable readmissions, unnecessary use of the emergency department, and improve the health and wellness of their communities. Our current system is stressed with shortages of many health care workers, including physicians, nurses, and dentists, as well as mental health and public health workers.[2] Estimates for the shortfall are varied, with physician shortages projected to increase to between 46,000 to 90,000 physicians by 2025.[3] Nursing is estimated to have a shortage of 500,000 by 2025.[2] These many coalescing factors create an environment where hospitals, health systems, and providers are receptive to implementing new methods of providing care and increasing access to care.

Although patients who have recently been hospitalized are recognized as at risk, there are many others individuals who are in a fragile state of health. They may be coping currently, but 1 acute illness, surgery, or the loss of their support system can send them into a downward spiral. These individuals may need support to pay for medications or prepare healthy meals. They may not be taking their medications as ordered due to costs or health literacy challenges and may not be following their prescribed diet because they do not understand their restrictions. Primary care providers can identify these at-risk patients in their practice: patients who need much more support than can be given in a 10-minute office visit.

How can we meet these varied and critical needs? Many options have been tried with limited success, and the providers at an Ohio hospital postulated that the missing link was having a more complete view of the patient, their environment, and their care needs. What happens within the walls of a patient's home is often unknown or poorly understood when not viewed from the perspective of the patient. Integrating community health workers (CHWs) into the population health efforts of hospitals and health systems is one way to extend the reach of the hospital and provider, and truly understand the needs and challenges of at-risk patients.

The CHW role is not new to the United States. Community health workers have been used since the 1960s as a mechanism for disease screening and health promotion in underserved communities.[4] Recently, there has been renewed interest in integrating these providers into the health care team, especially in programs where CHWs work collaboratively with nurses and other providers.[5] The United States Department of Labor defines the CHW role broadly: "Assist individuals and communities to adopt health behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs."[6]

PROGRAM DEVELOPMENT

Recognition of the many challenges faced by at-risk patients led a community hospital in Ohio to develop a hospital-based and -supported CHW program. The Wooster Community Care Network (WCCN) was conceived of a need to decrease fragmentation and improve health and patient outcomes while reducing costs. Hospital leaders recognized the lack of support for their at-risk, fragile patients upon discharge from the hospital. Although the local medical community was committed to seeing patients within a week of discharge, this intervention was not adequate to prevent all readmissions and ensure a smooth transition to home. In addition, the need for a bridge from hospital to home and for the chronically ill was recognized by nursing leadership, hospital leadership, and the nursing home care providers. Hospital leaders knew that they needed a way to support fragile individuals in the community.

Wooster Community Hospital's (WCH) chief executive officer heard a lecture from a Meadville, Pennsylvania, physician about a health coaching program he had developed in conjunction with Allegheny College and Meadville Medical Center. Shortly after, WCH leadership visited Meadville to see firsthand how the program worked. The hospital evaluated best practices from the literature and current CHW programs to develop the framework for WCCN. The hospital then approached the local college, College of Wooster, to determine whether there was an opportunity to partner, train, and engage selected students as CHWs in the program. From these discussions, WCCN was developed. The program commenced with training the first CHWs in the fall of 2013 and enrolled the first patient in January of 2014.

CARE NETWORK FUNCTIONING

Wooster's Community Care Network partners with patients with chronic medical conditions and assists them in setting health care goals that lead towards a healthier life style. This program uses a polyvalent CHW. Polyvalent CHWs are individuals who are "equipped with enough knowledge to deal with a variety of primary symptoms."[7] The patients enrolled in the WCCN are suffering from chronic illnesses such as hypertension, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. These patients often have 2 or more chronic illnesses and are at increased risk for hospitalization. Many have limited resources, as well as psychological and socioeconomic issues that may make it more difficult for them to access care and resources.

The WCCN provides a system of care coordination that improves a patient's health by coaching them on managing their health risk factors. This program is different from others because of 2 factors: the intervention plan is based upon the patient's goal(s), and the CHW provides "boots on the ground" observation and supervision. After patients are identified as possible candidates for the program, the program director meets with them and asks them what their primary goal for their health/chronic disease management is. The goals vary widely, from "I want to be able to breathe well enough to go fishing" to "I want to control my diabetes so that I don't have to have my toes amputated."

ROLE: CHW AS A HEALTH COACH

The WCCN is a collaborative program between Wooster Community Hospital and The College of Wooster. Students from the college function as CHWs, called health coaches, in the program. To be eligible to be a health coach, the student is typically a sophomore, junior, or senior and a science or public policy major. Students are selected for participation after completing a series of interviews with hospital and college staff. Successful applicants then complete a semester-long training program taught by hospital clinicians, leaders, and physicians. The training course incorporates didactic and experiential learning. Classroom topics include chronic diseases and their management, Health Insurance Portability and