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Reverse Innovation from the Least of Our Neighbors: Community Health Workers and U.S. Health Care

M Therese Lysaught
Loyola University Chicago, mlysaught@luc.edu

Reverse Innovation from the Least of Our Neighbors

BY M. THERESE LYSAUGHT, Ph.D.

In a recent *New York Times* article, Pauline Chen, MD, asks: "What We Can Learn from Third-World Health Care?"[1] Chen rattles our assumption that the vector of aid and insight travels in one direction — from the U.S., with all our resources, knowledge and technology, to less fortunate places that need our help. Could the arrow point in the opposite direction? Could we who have everything learn from the widow and her mite?

Increasingly, clinicians who work in urban and rural health care say yes. Decades of experience providing high-quality health care in resource-poor areas both abroad and in the U.S. are giving new ways to envision how we structure and deliver health care. Central to these new models are players long present but largely invisible on the American scene: community health workers.

Delivery models incorporating community health workers should be of particular interest to Catholic health systems. Evidence suggests that integrating community health workers into system structures improves health outcomes and reduces expensive inefficiencies. Such delivery models also align particularly well with the accountable care organization (ACO) quality measures that the Affordable Care Act (ACA) mandates. Most importantly, these models concretely embody Catholic social thought far better than current health care delivery practices. Beyond simply the preferential option for the poor, they richly incarnate a real practice of solidarity, an authentic vision of subsidiarity and a genuine opportunity for participation that enhances the dignity of patients and providers alike while advancing the common good.

REALIGNING HEALTH WITH CARE

Chen highlights a recent and important article entitled "Realigning Health with Care," by Rebecca Onie, director of the Health Leads community service nonprofit headquartered in Boston; Paul Farmer, founder of the Boston-based international nonprofit, Partners In Health; and Heidi Behfourouz, who leads the Prevention and Access to Care and Treatment Project, a community-based health care initiative in Boston.[2] These authors draw on experience from developing countries to fundamentally challenge how we think about three key concepts in health care: *product, place* and *provider*.

What, they ask, is the product of health care? Often, our product is identified as medicines, diagnostic tests and access to a physician and clinic/hospital. But are these the most important things for promoting health or addressing illness? Over the past 20 years, focus has shifted to what are now referred to as the social determinants of health. Scholars and practitioners in public health have begun identifying various structural, nonclinical factors and quantifying their effects on health outcomes. Acknowledging such factors — illiteracy, culture-based power differentials between physicians and patients, access to reliable transportation, social isolation and more — will require health systems to think differently about what needs to be provided to improve patient and population health.

It also requires us to rethink the place of health care — where care is best delivered. Most social determinants of health are not located in hospitals, clinics and physician offices but in patients' homes and communities. A more effective and cost-effective vision disburses key aspects of health care to places such as retail clinics where patients are more able and likely to access them. The vision also fits with long-standing realities: Most caregiving and tending of the sick occurs in

the home, where patients would rather be when they're ill.

Here some might blanch. Centralization, we are told, is more efficient. Demographics, counter-productive reimbursement structures and the ACA already are creating serious shortages of primary care professionals — physicians, nurses, social workers and case managers. But rather than seeking to enlarge the scope of overtaxed health professionals, Onie and her colleagues challenge us to think more expansively about who counts as a legitimate health care "provider." Their experience, abroad and in the U.S., has convinced them nontraditional medical workers, particularly community health workers, play a critical role.

Community health workers may be one answer to the now-constant question, how do we continue to carry on the mission of our founding sisters in this new and complex health care environment?

Usually drawn from the communities they serve, community health workers possess firsthand understanding of patient culture, community, experience and language, and they are more often aware of the nonmedical barriers to accessing health care and maintaining health, as well as of local resources for improving patient care. Consequently, they "can help health systems overcome shortages of human and financial resources by providing high-quality, low-cost services to community members in their homes and by diagnosing diseases in their early stages, before they become more dangerous and expensive to treat."[3]

REALIGNMENT IN ACTION

But would this work in the U.S.? Aren't community health workers simply stop-gap measures, insufficiently skilled for mainstream U.S. health care? Chen and Onie offer specifics on three successful programs in the U.S. that have achieved significant health outcomes while reducing costs.

■ **PACT, the Prevention and Access to Care and Treatment program, launched in 1997 by Partners In Health.**[4] Serving "the sickest and most marginalized HIV-positive and chronically ill patients" in Boston, PACT combines comprehensive medical care with wraparound antipoverty services. PACT trains and pays community health workers to accompany patients to important visits, communicate regularly with licensed clinicians, visit patients' homes to provide directly observed therapy and survey patients' pantries to help them identify ways to make healthy, affordable meals. In doing so, they have realized impressive clinical and fiscal outcomes. "Seventy percent of its AIDS patients show significant clinical improvement, whether measured by viral load, CD4 count, incident opportunistic infections, or emergency room visits. Costs to Medicaid have dropped significantly, thanks to a 60 percent decrease in hospitalization rates among enrolled patients: One analysis of Medicaid claims from PACT patients showed 16 percent net savings. Similar gains are being made among patients with multiple chronic diseases and behavioral health comorbidities."[5]

■ **Health Leads, located in six East Coast cities.** Health Leads uses 1,000 volunteer college students "to connect patients and their families with the basic resources they need to be healthy."[6] Health Leads encourages and empowers physicians and nurses to ask questions about basic social needs impacting health, enabling them to "'prescribe' resources such as food, housing, and heating assistance — just as they do medication. Patients can take their prescriptions to the clinic waiting room, where volunteers help 'fill' them by connecting patients to community services." Among other outcomes, a recent study "found that Health Leads increased the clinic social worker's ability to provide reimbursable therapeutic services to children by 169 percent, improving the quality of care while generating additional revenue for the health center."[7]

■ **Special Care Center (SCC) in Atlantic City, N.J., which serves 14,000 union employees of Atlantic City's restaurants, hotels and casinos.** Created by Rushika Fernandopulle, MD, the center recruited health coaches from within the community to serve on teams with doctors, social workers and nurse practitioners who meet daily to review medical and nonmedical issues facing patients. They see patients at least once every two weeks and regularly communicate by phone and email. After 12 months, these impressive results were noted: "patients' emergency room visits and hospital admissions dropped by more than 40 percent and surgical procedures fell by 25 percent. Among 503 patients with high blood pressure, only two were in poor control of it at the end of the study. Patients with high cholesterol experi-

ROLE OF LAY HEALTH WORKERS IN U.S. IS LIMITED, BUT COULD HELP FILL GAPS IN CARE

Although lay health workers are a familiar presence in some developing countries — the World Health Organization estimates there are 1.3 million working worldwide — their role in U.S. health care has been far more limited. It is sure to increase, though, as health reform places greater emphasis on the strong part they can play in helping people access health care, manage chronic illnesses and lead healthier lives.

In fact, their success in nurturing positive health and improved outcomes at lower cost is recognized under terms of the Affordable Care Act (ACA), which provides for grants to encourage the employment of community health workers in underserved areas. There is growing evidence to support their impact on community health. For example, a policy brief by the National Center for Disease Prevention and Health Promotion (www.cdc.gov/dhdsp/docs/chw_brief.pdf) cites numerous studies documenting their successful efforts to help people manage chronic illnesses, thereby reducing emergency room visits and hospital stays.

Community health worker Rodrigo Cornejo knows from experience that, in underserved communities, physicians and nurses need extra hands when it comes to helping people improve their health. Cornejo, one of about 1,300 community health workers in Texas, is employed by CHRISTUS Santa Rosa Hospital in San Antonio in one of two CHRISTUS Health programs that work with clients to help them better access and navigate the health care system. The Care Partners program is for uninsured people with chronic illnesses. It follows them for a year or longer.

Maria Hernandez, one of Cornejo's clients in the Care Partners program, was clearing tables in the cafeteria at CHRISTUS Santa Rosa last year when she fell to the floor, sending dishes and glasses clattering.

"I passed out," she recalled. "I woke up inside the ER. It was bad. My sugar was way too high."

Hernandez, 52, suffers from diabetes. Since 2011, when Cornejo began working with her, Hernandez has attended diabetes education classes, enrolled in a diabetes clinic, gotten her illness under control and returned to work. Their successful partnership exemplifies how community health workers can empower people to take control of their health care.

CHRISTUS also has a patient navigator program that focuses on patients facing non-emergency conditions and works with them for a shorter time.

A primary goal in both the Care Partner and patient navigator programs is to connect patients with a consistent source of heath care and to build a relationship with their providers.

"Our entire model is built around helping the patient find a medical home," said Andrea Guajardo, director, community benefit at CHRISTUS Santa Rosa. "You can imagine the benefits of always going to the same doctor rather than going to the emergency room or some random clinic for incidental treatment."

Requirements for community health workers vary by state. Texas and Ohio are among those that have established certification programs.

Other community health programs, with similar goals of helping people find providers, benefits and social services and navigate the health care system, are offered at St. Joseph Health Santa Rosa Memorial Hospital in Petaluma Valley, Calf., and at Mercy Regional Medical Center in Lorain, Ohio.

St. Joseph's *Promotores de Salud* are a group of four community health workers and one manager who serve as a bridge to the community. They help connect community members with health and social services resources, and they assist families in enrolling in food stamp and insurance programs and other public benefits.

At Mercy Regional Health Center, the Resource Mothers program provides assistance to at-risk, underserved and vulnerable pregnant and parenting women and families from the prenatal period though the infant's first year of life. The resource mothers become teachers, advocates and friends with their clients, said Beth Finnegan, director of health ministry, parish nursing and the Resource Mothers program.

Community health worker Zuleidy Lopez became familiar with the resource mothers when she was a young mother and a health worker visited her home once a month. The worker provided information and emotional support and dispelled some misinformation: Lopez had heard that she shouldn't try breastfeeding and that Lamaze classes were not worth the effort.

"I thought I was getting good advice," she recalled. "But I didn't know."

As she gained knowledge and confidence, Lopez, now the mother of five grown children, realized that she wanted to help other mothers. She decided to apply for a community health worker job, a position that in Ohio requires training and state certification.

Requirements for community health workers vary by state. Texas and Ohio are among those that have established certification programs or are moving in that direction. Minnesota developed a statewide standardized curriculum for community health workers in 2008; workers who complete the curriculum and receive a certificate can provide services supervised by a physician, advanced practice nurse, dentist or public health nurse. California does not require state certification, but St. Joseph's *Promotores de Salud* program provides health workers with orientation and ongoing training.

Dory Escobar, director of community benefit at St. Joseph, said the duties of

a health worker vary by a community's particular needs.

"There is no agreement yet on the scope of a community health worker," Escobar said. "That's not necessarily a bad thing. It [the work] is on the ground level. It's a very local thing. It needs to be tailored to the needs of the community."

In addition to helping patients with practical matters in navigating the health system, community health workers at St. Joseph help patients increase their health knowledge and self-sufficiency through a variety of functions, including education, informal counseling, social support and advocacy.

It's not uncommon for workers in these programs to be on hand as patients make calls to schedule appointments, connect with a social service agency or get test results. The health workers may offer patients advice or emotional support, but the patients make the calls themselves.

St. Joseph's health workers also support community-based programs and grassroots efforts that promote health in other ways — from addressing zoning issues that might prevent a community garden from being planted to developing healthy nutrition programs or promoting children walking to school.

The workers train residents in making positive changes that can affect the entire community. One such effort brought about more healthful menu choices throughout a local school district. It started with a handful of mothers who met in the preschool parking lot after they dropped their children off. Their conversation often turned to the quality of food served in the school.

"They felt unhappy, but not powerful enough to make a change," Escobar said. The community health worker met with them and offered advice about how to approach the school district to ask for a change.

"They learned how to have a constructive conversation," said Escobar. "And they were able to change the food for their kids and thousands of others."

Mercy's resource mothers program also has helped people make healthy changes in their lives. Finnegan said that one of the program's goals is to see that no baby's birth weight is below 5.5 lbs. In 2011, only one baby of 63 in the program was born under that weight. In addition, 100 percent of the infants were enrolled in Medicaid prior to their first birthday,

The health workers may offer patients advice or emotional support, but the patients make the calls themselves.

and 98 percent of them received all necessary immunizations before their first birthday, as well.

"The national average for immunizations is about 77 percent, so that's a really good statistic," Finnegan said.

Programs staffed by community health workers around the country are reporting success as well. In New York City, patient navigators at 18 hospitals share information about colon cancer with patients and encourage them to undergo colonoscopies. Hospitals reported a 45 percent decrease in the patient no-show rate for the screening. In addition, the number of screened adults soared by 24 percent between 2003 and 2009.

Massachusetts has 3,000 community health workers, and a state department of public health report credits them with improving access to health care and the quality of care. The report also contained 34 recommendations for further integrating the workers into health care and public health services.

In Texas, a research study found that using lay health workers led to more screenings for breast and cervical cancer among low-income Hispanic women. Completion of screening was higher among women in the intervention group — 40.8 percent for mammography — than among the control group, which was at 29.9 percent. For Pap testing, screenings were 39.5 percent for the intervention group and 23.6 percent for the control group.

Jerry Rodriguez, vice president and administrator, CHRISTUS Santa Rosa Hospital — Medical Center, said the Care Partners and patient navigators programs have resulted in fewer visits to the emergency room and more follow-up appointments with primary care physicians. He attributes these improvements to the relationships the health workers build with their clients.

"They have that personal connection," he said. "They become part of who the client turns to as a resource."

Cornejo said that when he works with clients, he looks for all the other stresses in their lives that may be adversely impacting their health, such as a lack of housing or a job.

"I listen to them to know what's going on in their household, not just their medical condition," he said. "Some clients have more needs than others."

In the case of Hernandez, who had lost her apartment because her diabetes limited her ability to work, Cornejo said he was able to help her find a relatively low-cost apartment on Craigslist, the website of local classified ads. Her apartment is a short bus ride from the hospital where she has returned to work part time in the cafeteria.

Hernandez is doing well, Cornejo said.

"Maria is exceptional," he said. "She doesn't miss work. She has a doctor. She is able to manage her bills."

Guajardo said all that Hernandez has achieved reflects the program's mission to help clients become self-sufficient.

"We see that it's easy for the uninsured to be dismissed or considered less," she said. "But we absolutely disagree with that. We tell clients, 'We want you to take responsibility. We'll help you every step of the way.' That empowers and brings dignity to a person."

ANNEMARIE MANNION is a freelance writer in Chicago.

enced, on average, a 50-point drop in cholesterol level. And a remarkable 63 percent of smokers with heart and lung disease quit smoking ... Meanwhile, the cost of care for these patients rose by only 4 percent per year, compared to 25 percent before they began participating."[8]

Currently, about 86,000 community health workers practice in the United States.[9] Published literature suggests that they work predominantly with underserved, vulnerable, immigrant and ethnic communities — pregnant Latina women; African-Americans, both urban and rural; Appalachia and other rural communities; and Native American reservations. Interventions focus on breast and cervical cancer screening; HIV treatment adherence; asthma, especially in children; diabetes; hypertension; as well as many health promotion and disease prevention educational campaigns.

Recent policy initiatives have affirmed the important role community health workers should play. The Institute of Medicine's 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, recommended expanding, evaluating and replicating community health worker programs, especially for medically underserved and racial/ethnic minority populations.[10] In 2009, the Office of Management and Budget included a unique occupational classification for community health workers for the 2010 Standard Occupational Classifications (SOC 21-1094).[11]

The ACA recognizes community health workers as central to the health care work force.[12] The Office of Minority Health at the Department of Health and Human Services established a *Promotoras de Salud* initiative in 2011.[13] The Centers for Disease Control and Prevention strongly affirms this role in its 2011 evidenced-based policy brief on community health workers entitled *Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach*, which provides important information on established U.S.-based programs and their efficacy, particularly around certain chronic conditions (e.g., diabetes, hypertension). This is an important resource for systems interested in establishing programs.[14]

COMMUNITY HEALTH WORKERS AND ACOS

Thus, leaders in U.S. public health policy have increasingly recognized the critical role community health workers could and should play in our health care infrastructure. The ACO model is pushing health systems in a similar direction, paving the way for integrating community health workers into mainstream health care. In fact,

COMMUNITY HEALTH WORKERS: A BRIEF HISTORY

The vision of PACT, Health Leads and the Special Care Center draws on models of community health work in developing countries, such as China's "barefoot doctors" in the 1950s, medical professionals who lived among the rural people they treated and who also concentrated on prevention — such as better sanitation and nutrition — to help improve community health and control infectious disease.

During the 1960s and 1970s, many newly emerging countries implemented community health worker programs, a movement affirmed during the 1978 World Health Organization (WHO) and UNICEF international conference on primary health care held in Alma-Ata, then the capital of Kazakhstan. The conference fueled additional research and growth for a time; then community health worker programs saw a resurgence in the 1990s, primarily surrounding HIV/AIDS management.

Now community health workers are a staple member of the health care infrastructure in many resource-limited countries; WHO numbers them at approximately 1.3 million worldwide. Global scale-up of these programs is considered to be critical for achieving the United Nations' Millennium Development Goals for reducing poverty, hunger, disease and other conditions by 2015.

Community health workers have also been present in the U.S. since the 1960s, instituted primarily as a way to address health issues in underserved communities. The Federal Migrant Health Act (1962) and the Economic Opportunity Act (1964) mandated outreach to provide health services in migrant labor camps and impoverished urban neighborhoods. In 1968, the Indian Health Service established one of the largest programs of community health representatives, with some 1,500 currently serving 250 tribes in the continental U.S. and Alaska. Most recently, in 2006, Massachusetts included community health workers in its landmark health reform legislation.

models incorporating community health workers may be even more effective in enabling ACOs to achieve their quality measures.

Consider the ACO launched by Advocate Health Care/Chicago, highlighted in a 2012 *New York Times* story by health care writer Bruce Japsen, "Small-Picture Approach Flips Medical Economics."[15] Japsen details how Gwlie Lloyd, a registered nurse and care manager at Advocate, frequently calls to check on 69-year-old Fannie Cline, who suffers from badly managed diabetes and frequent hospitalizations. Lloyd "offers advice on diet and exercise, schedules appointments, orders meals for delivery and arranges for an appointment with a social worker." Like PACT and SCC, Advocate's ACO re-envisions product and place, attending not only to medications but also to social factors affecting Cline's home and

COMMUNITY HEALTH WORKERS EMBODY CATHOLIC SOCIAL PRINCIPLES

New health care delivery models shaped by broader visions of product, place, and provider make the case for themselves by achieving better health and patient outcomes, reducing costs and facilitating ACO quality measures. But for Catholic health care, a strong argument in their favor is how deeply community health workers embody Catholic social principles.

The Boston-based nonprofit Partners In Health is quite up-front about how its vision, practice and organization are rooted in Catholic social thought and informed by liberation theology; its motto is: "Providing a Preferential Option for the Poor in Health Care." But even secular community health worker programs resonate deeply with these Catholic principles:

The Principle of Solidarity — Recalling Pope John Paul II's robust vision in *Sollicitudo Rei Socialis*, solidarity "is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far [but rather] a firm and persevering determination to commit oneself to the common good; that is to say, to the good of all and of each individual, because we are all really responsible for all."

Via community health workers, health systems move into their communities in a new way. They literally reach out to, connect with and walk with persons and patients. Entering patient homes, working within communities, community health workers come face to face with practical realities experienced by patients, and they bring those realities back to health care teams.

The Principle of Subsidiarity — These models are premised upon the principle of subsidiarity, the conviction that, when possible, matters ought to be handled by the smallest, lowest or least centralized competent authority. Centralizing health care in a hospital or outpatient clinic, or asking health care providers to work at the bottom of their license, fails to recognize that in many cases, the proper level of care for health, especially for chronic illnesses requiring daily management, is the most local: the home. Community health workers can facilitate patients' ability to exercise authority over their own health, to the extent they can. They can link people to the most local and easily accessible resources and empower them with knowledge provided in culturally appropriate ways. They also help identify points at which patient capacity meets its limit, at which point the principle of subsidiarity affirms the crucial role of intervention from a higher level — in this case, the medical system.

Community health worker programs are premised on the conviction that health care is a human right, and they seek to bring health care to persons who need it most.

Life and Dignity of the Human Person — Community health worker models enhance both patient and provider dignity. Their practice is predicated on seeing each patient as a person, in his or her complicated, organic context. By providing previously unavailable access to health care, they affirm and promote the sanctity of each person's life and enhance the dignity of the sick.

Simultaneously, these programs enhance the dignity of the community health workers by recognizing that local community members, even those without professional credentials, have important knowledge and skills crucial for building up their communities and by providing meaningful work in contexts where such opportunities can be scarce. They enhance the dignity of other health care professionals by reducing the demoralization of overtaxed doctors, nurses, social workers and others.

Rights, Responsibilities, Community and Participation — Community health worker programs are premised on the conviction that health care is a human right, and they seek to bring health care to persons who need it most, regardless of social location. By walking with patients disempowered by illness, age, poverty, bureaucracy, or the sheer complexity of the health care system, they enable patients to fulfill their own responsibilities.

Clearly, these alternative models build community in a variety of ways: by creating linkages between patients and health centers; by simply fostering relationships among persons; and by identifying and addressing community-based barriers to health care. Equally, they empower community members — patients, volunteer students, health coaches — to participate in the work of attending to health and reducing social factors negatively affecting health and community well-being overall.

does so at Cline's home, albeit via telephone. These simple interventions have improved Cline's health markedly and reduced her hospital admissions.

But is this the best use of the time and skills of a registered nurse? Onie and her colleagues raise concerns that Lloyd is "practicing at the bottom of her license." Community health worker models allow more highly trained health care professionals to "practice at the top of their license" — "to spend more time doing what they are trained to do, while leaving critical tasks like coaching patients and connecting them to community resources to other health care workers."[16] Community health workers, who share history and cultural backgrounds with local communities, may well be more effective than an RN — or nurse practitioner, physician assistant or even a social worker — in these tasks. Moreover, "practicing at the 'bottom' of one's license can be expensive for taxpayers, is draining (or demoralizing) for clinicians, and causes patients to wait longer to get timely and effective care. Task shifting — or task sharing, to be more precise — can reduce such inefficiencies."[17]

Broadening the concept of "provider" may also more effectively help achieve many of the 33 quality performance standards by which ACOs will be evaluated. They align remarkably well with community health workers' functions.[18]

"REVERSE INNOVATION"

Onie and colleagues describe the process of learning from our poorer neighbors as "reverse innovation." They also acknowledge an important insight from surgeon and journalist Atul Gawande, MD, who argues that "medical 'innovation' is less about discovering new interventions than it is about properly executing the ones we already have ... failure more often stems from ineptitude (not properly applying what we know works), rather than ignorance (not knowing what works)."[19]

Rethinking the place of health care as local — home and community — returns us to what we knew worked for most of human history. ACOs and related initiatives toward health care reform present a real opportunity for Catholic health systems to put this innovation — this knowledge of what we know works — into action.

We might ask: to what extent were the sisters who founded our health systems the original community health workers? While not always hailing from communities they served, they understood that reaching out to neglected populations — at pioneer outposts, in impoverished parts of cities, tending to persons with smallpox or cholera — was central to their ministry. They met their patients where they lived and tended to their social as well as their medical needs.

Community health workers may be one answer to the now-constant question, how do we continue to carry on the mission of our founding sisters in this new and complex health care environment? It might just be that the least among health care providers will be the ones who transform our ministry in the 21st century.

M. THERESE LYSAUGHT is associate professor, Department of Theology, Marquette University, Milwaukee, and a visiting scholar at the Catholic Health Association, St. Louis.

NOTES

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Beyond these policy documents, only two books have been published on community health workers in the U.S., both within the past three years: Josefina Lujan, *Community Health Worker: Diabetes Self-Management Intervention for Mexican Americans* (Saarbrucken, Germany: AV Akademikerverlag, 2012); and Berthold et al., *Foundations for Community Health Workers*, mentioned above.

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