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A Unique Model of the Community Health Worker

The MGH Chelsea Community Health Improvement Team

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With current trends in legislation around the delivery of patient care, the role of a community health worker (CHW) is gaining growing and much deserved attention. However, a system needs to be built for any CHW program to be successful and sustainable. This article describes a unique approach to community health work at the Massachusetts General Hospital Chelsea HealthCare Center where a well-integrated CHW model provides support for everyone involved in patient care: patients, providers, the community at large, and the internal CHW staff.
Key words: *community health worker, continuum of care, health disparities, patient navigation, vulnerable populations*

DESPITE continuing advances in health care in the United States over the past decade, the system still struggles to bring these benefits to its most vulnerable populations. Recognizing inequities in health care, the United States has implemented laws that protect the patients' rights (The American's with Disabilities Act, Executive Order 13166),[1] yet multiple studies[2] have shown that disparities are still far too common in the delivery of patient care.

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This article was inspired by the great work that the community health workers do at MGH Chelsea. Their work touches and improves the daily lives of our patients. The center relies on their support and is grateful for their commitment and professionalism.

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The Institute of Medicine[2] committee report *Unequal Treatment* had multiple recommendations on how health care institutions can improve the quality of care as well as access for underserved patients. One key recommendation is addressing health care disparities through community involvement, specifically the involvement of community health workers (CHWs).[2]

Community health workers are unique to the programs and the population they serve, fulfilling various roles and performing unique tasks depending on the community's needs. Since the work of CHWs can vary greatly, it is difficult to evaluate what specific functions and roles produce the greatest benefit when CHWs are used. However, review of outcomes of programs involving CHWs in various capacities indicates that success is more likely when they have a close connection to the community that they serve and are used to offer more comprehensive services to a smaller target population rather than less comprehensive services to a larger group.[3]

In particular, studies on the effectiveness of CHWs have demonstrated the following:

- CHW patient navigation helps reduce health care disparities.[4]
- CHW intervention, prevention work, and health promotion lead to improved health outcomes.[5]
- CHWs can be effective in chronic disease management.[6]
- CHWs play an important role in efforts based on behavioral change theories.[7]
- Delivering culturally competent care and health education through CHWs leads to accurate diagnoses, effective disease prevention and management, and greater patient satisfaction.[8]

However, CHWs are unlikely to be effective without partnership between a health care organization and the communities it serves.

This article discusses an approach to community health work in Chelsea, Massachusetts, where a unique model of CHWs naturally evolved, given the community's resources and challenges and a partnership between the community, the Massachusetts General Hospital (MGH) Chelsea HealthCare Center, and the MGH Center for Community Health Improvement (CCHI).

THE COMMUNITY

Located 2 miles north of Boston, Chelsea is a city of 3 square miles and just over 35 000 residents.[9] Chelsea has been a gateway for refugees and immigrants entering the United States since the Industrial Revolution. In the past decade, Chelsea has become home to refugees fleeing areas devastated by war and poverty including Bosnia, Chechnya, Somalia, Afghanistan, Iraq, Bhutan, Northern and Western Africa, and countries in Central America. Often these individuals have experienced trauma, witnessed violence, been born and/or lived in refugee camps with limited resources, and had very limited health care access and educational support. In the last 5 years, 496 refugees/asylees have resettled in Chelsea. In 2010, Latinos comprised 62.1% of Chelsea's population, up from 48.4% in 2000. English is the language spoken at home by 41.6% of residents, and 30.8% speak Spanish.[9] A total of 81.3% of Chelsea public school students are Latino and 84% of students speak English as a second language, the highest percentage in Massachusetts.[10]

Chelsea residents face significant economic, educational, and health challenges. More than 23% of residents live below 100% of the Federal Poverty Level, the fourth highest rate in Massachusetts.[11] More than 27% of Chelsea households survive on one of the lowest per capita incomes ($14 628) in the state, ranking Chelsea 349th for income of all 351 Massachusetts municipalities.[11] Education levels are low: the high school graduation rate in 2007 was 53.3% for Chelsea versus 82.1% for the state, and only 15.3% of Chelsea residents have an associates or bachelor's degree compared with 27.5% statewide.[12]

The health of Chelsea residents is also poor. One hundred percent of the Chelsea census tracts are designated as Health Professional Shortage Areas. Overall and disease-specific mortality rates in Chelsea are higher than those for the state. Rates for infant mortality (4.9 vs 2.9 per 1000), low birth weight (2.4 vs 1.4 per 1000), and teen births (97 vs 21.1 per 1000) for Chelsea residents are among the highest in Massachusetts, respectively. Safety and security are a substantial concern for Chelsea residents: Chelsea's violent crime rate is 1732.2 per 100 000, the highest rate in Massachusetts.[11]

THE PARTNERS AND PROGRAMS

Since 1996, the MGH CCHI has collaborated with community partners in Chelsea to design and implement numerous CHW programs.

Most of the community-based health care in Chelsea is delivered through the MGH Chelsea HealthCare Center (MGH Chelsea), which in 2010 provided comprehensive primary and specialty health care services to more than 32 000 individuals in more than 140 000 ambulatory visits. Begun in 1971, MGH Chelsea is the largest community health center in the MGH system.

The MGH, the CCHI, and MGH Chelsea have a strong and public commitment to the communities they serve. In 2008, the

MGH made a highly significant decision, based largely on the success of the CCHI programs, to rewrite its mission to incorporate a commitment to its surrounding communities:

> Guided by the needs of our patients and their families, we deliver the very best health care in a safe, compassionate environment, we advance that care through innovative research and education, and we improve the health and well-being of the diverse communities we serve.

The CCHI mission is to implement the community component of the MGH mission, guided by values that foster collaboration, data-driven and community-based approaches, long-term system change, and improved access to care for underserved populations. Focus on prevention and timely public health promotion, empowerment, data gathering, full inclusion of communities in health promotion, respect for diversity, community collaboration, and policy change are reflected throughout the CCHI programs.

In summary, at MGH Chelsea, 33 staff members work as CHWs, known as the Community Health Improvement team. They have many different working titles. These include patient navigator, coach, CHW, advocate, visiting mom, and program coordinator. Collectively these staff provide health education, emotional support, motivation promoting behavior change, connection to concrete resources, accompaniment to appointments, help with rescheduling and overcoming barriers that prevent patients from attending appointments (eg, child care, transportation, language), follow-up on the recommendations of providers (ie, calls the day after appointments to make sure the patient has received his or her medication and is taking it properly), home visits, and help with cultural brokering when advocating for patient's needs (Table 1).

THE APPROACH

The MGH Chelsea Community Health Improvement team implements the following strategies in its work:

- Identifying key health issues through periodic community-based needs assessments. Data are compiled from several state and local databases as well as through community stakeholder, provider and patient interviews, and focus groups. Health is defined broadly and is inclusive of socioeconomic and environmental factors that impact well-being.
- Developing and implementing programs and strategies to improve health outcomes through prevention, early intervention, and environmental strategies based on best practices and evidence-based models used in similar communities throughout the country. All of this program and strategy development work is done with the input of our CHWs.
- Creating policies and procedures to successfully and safely run the various components of the programs (eg, implementing procedures for maintaining safety during home visits, clarifying boundaries around what issues staff should work on, and what needs to be referred elsewhere, ensuring appropriate documentation into the electronic medical record)
- Building partnerships with various community entities to implement programs together in order to successfully reach our target populations.
- Hiring bilingual and bicultural staff from many different backgrounds and providing those qualified individuals, who may have been professionally trained in their countries of origin but who do not have the same professional qualifications here in the United States, a chance to redevelop as professionals in the health care field and to contribute in important and meaningful ways.
- Empowering and continually supporting the work of CHWs through regular supervision, ongoing trainings, participation in case reviews, shadowing of encounters to provide coaching and feedback, and peer mentoring.
- Advocating for cultural competency in all aspects of a patient's interaction with the

Table 1. Community Health Improvement Programs at MGH Chelsea

Program	Patients Served in Fiscal Year 2010	Staff Title	Staff	Program Goals
Avon Breast Health	188	Breast Health navigator	1	Avon Breast Health navigator links with patients who have abnormal breast findings to ensure that patients get the follow-up treatment they need. The navigator helps patients to overcome concrete barriers that prevent them from attending further diagnostic appointments including providing emotional support and even accompanying patients as needed.
Bridging the Gap	44	Program coordinator	1	Bridging the Gap program seeks to improve the cultural competence of future physicians. The program pairs Harvard Medical School students with immigrant/refugee families. Students support families as advocates, educators, mentors, and friends, while learning firsthand the cultural issues that pose challenges to refugee families.
Cervical Health	570	Cervical Health navigator	1	The Cervical Health navigator links with patients who have abnormal Papanicolaou tests to ensure that patients get the follow-up treatment they need. The navigator helps patients to overcome concrete barriers that prevent them from attending further diagnostic appointments including providing emotional support and even accompanying patients as needed.
Colon Cancer Screening	156	Colon health navigator	2	The colon health navigators work with male and female patients to ensure that they will get screened for colon cancer. The navigators help patients to overcome concrete barriers that prevent them from getting colonoscopies, including providing education to help patients properly prepare for the procedure and accompanying patients as needed.
Diabetes Coach	97	Diabetes coach	1	The diabetes coach provides individual coaching, one on one visits and group support for adult patients who have poorly controlled type II diabetes (patients with hemoglobin A_{1c} level >8. The coach assists patients to overcome social, financial, language, and other barriers that prevent them from managing their disease.

(*continues*)

Table 1. Community Health Improvement Programs at MGH Chelsea (*Continued*)

Program	Patients Served in Fiscal Year 2010	Staff Title	Staff	Program Goals
Food for Families	793	Community health worker	1	The Food for Families CHW uses routine screening to identify patients in the pediatric, adult medicine, and obstetrics units who are experiencing food insecurity. The CHW connects patients with food resources such as food pantries and government food assistance.
HAVEN	538	HAVEN advocate	2	The HAVEN advocates provides domestic violence advocacy services to people who have been affected by intimate partner abuse. The advocates offer safety planning, education, connection to concrete services, support groups, and accompaniment to relevant community agencies and courthouses.
Healthy Living	35	Healthy Living coach	1	The Healthy Living coach provides individual coaching to overweight children and their families to help them manage their weight and be physically active. Through home visits and health center appointments, the coach addresses the social, cultural, financial, and environmental barriers that prevent children from eating healthy and being physically active.
Medical Interpreter and Community Health Worker Services	8256	Medical interpreter/ community health worker	13	The medical interpreter/CHWs provide linguistic and community health services to all patients who have LEP, to reduce language and cultural barriers to health care. The goals include providing equal access to health care for all patients, helping LEP patients navigate unfamiliar systems, and building trusting relationship with existing and potential patients.
Prenatal Outreach	360	Community Health Worker	1	The Prenatal Outreach CHW is a certified medical interpreter and provides medical interpreting and concrete services and support to at-risk mothers to promote optimal pregnancy. The CHW helps pregnant women receive necessary medical and social services, health education, and other concrete support related to pregnancy.

(*continues*)

Table 1. Community Health Improvement Programs at MGH Chelsea (*Continued*)

Program	Patients Served in Fiscal Year 2010	Staff Title	Staff	Program Goals
Pediatric Asthma	294	Community Health Worker	1	The Pediatric Asthma CHW strives to improve the management of asthma symptoms and disease in order to reduce emergency department visits and to attain better health outcomes over time. The CHW reinforces the patient's understanding of their illness by providing education about asthma including triggers, symptoms, and medications. The CHW reviews an individualized action plan with each patient and conducts home visits to identify potential environmental hazards in the home.
Visiting Moms	48	Visiting mom	3	The Visiting Moms aim to prevent child abuse and neglect of children by providing encouragement to new mothers who have multiple risk factors to help them nurture and care for their babies. Visiting moms support new mothers to care for their children within their traditional cultural context. They also offer patients connections to concrete resources with the goal of reducing parental stress.
Refugee School	165	Program coordinator	1	The Refugee School Program coordinator is a multilingual resource to the Chelsea public school system to work with school staff to help refugee students make a smooth transition into their new academic environment. The coordinator helps students and their parents to understand various requirements and processes of school. The coordinator works with students to help alleviate behavior challenges, to avoid risk-taking behaviors, and to achieve academic success.
Refugee Health Assessment	79	Program coordinator	1	The Refugee Health Assessment program coordinator organizes the refugee health assessment examinations required in the refugee resettlement process. The program receives referrals of refugees from resettlement agencies and connects patients to primary care providers. The coordinator makes home visits to assess concrete needs and to provide critical health education. The coordinator helps patients navigate specialty care and/or other social services as well.

(*continues*)

Table 1. Community Health Improvement Programs at MGH Chelsea (*Continued*)

Program	Patients Served in Fiscal Year 2010	Staff Title	Staff	Program Goals
Refugee Women's Health Access	120	Program coordinator	1	The Refugee Women's Health Access program coordinator ensures that refugee women stay connected to primary care providers and receive recommended screening and preventive care. The program was created to address refugee women's unique health care needs resulting from their experience with war, cultural and religious beliefs, illiteracy, poverty, and the stress of resettlement. The program coordinator assesses the patient's level of access to care and identifies barriers and gaps in access. The coordinator also connects patients to key aspects of care and facilitates communication between providers, patients, and other professionals.
Refugee Cancer	117	Patient navigator	2	Refugee Cancer patient navigators work to decrease the disparities that exist in breast cancer screening rates among women refugees from former Yugoslavia, Somalia, Swahili-speaking countries, and Arabic-speaking countries. The navigators work to teach patients about the importance of routine breast cancer screening and help to minimize any barriers that patients may have to patients receiving yearly mammograms, including accompanying patients as needed.

Abbreviations: CHW, community health worker; LEP, limited English proficiency.

health care system. Community health workers become cultural brokers helping staff throughout the health center and hospital to understand important cultural nuances and strive for the most effective means of bringing a patient to full understanding and action.

- Tracking daily work and routinely reporting on program progress to ensure that goals and measures outlined in program logic models are being met.
- Reinforcing the value of community health work and the buy-in for this work from the hospital and health center's senior management by providing opportunities for recognition and gratitude for CHWs and the work they do.

This approach to community health work at MGH Chelsea can be further understood by looking at the results of a recent survey taken by all the community health work staff members (Table 2). One direct quote by a

staff member taken from the comments section states the following:

I love the positive atmosphere at the health center towards both employees and patients. I feel valued as an employee and care a lot about my co-workers and managers. Continuing education is highly valued and encouraged when possible. This place is filled with a lot of heart and soul ... not to mention people who are skilled and capable and act each day with integrity on the job.

WHAT MAKES THE "CHELSEA APPROACH" UNIQUE?

As health care institutions across the country learn more about the benefits of involving CHWs in their efforts to serve increasingly diverse populations, the number of CHWs grows and the field gains steady recognition. What is unique about the CHWs at MGH Chelsea is how well they are integrated within the care teams at the health center, the CCHI, and the hospital itself (Figure 1).

At MGH Chelsea, there is a synergetic relationship between the CHWs and the direct providers of care (Figure 2). This begins with a foundation of respect and equality that is mirrored beginning with senior management and continuing throughout the health center. Community health workers are clear about their supporting role in the patient-physician encounter and their boundaries of not giving clinical advice. Providers value the cultural clues and nuances that CHWs provide to them. When working together with patients and providers, the CHWs strive to improve patient understanding and motivation around key behavioral changes that would benefit their health (eg, going for a cancer screening, cutting down on trigger foods). Together they brainstorm—the provider from the basis of the patient's clinical background

Table 2. Community Health Worker Job Satisfaction at MGH Chelsea (2011)

Statement	% Strongly Agree or Agree (N = 26)
I feel I have the skills necessary to do my job	100
I feel engaged by meaningful work	100
I am proud of what I do for patients	100
I feel my coworkers are committed to providing quality services for the patients	96
Overall, I am satisfied with my role as a CHW	96
I would recommend CHW services to a friend or a family member	92
I am satisfied with the team spirit in my work environment	88
Looking back, I would apply for my job again	88
I received the necessary basic training when I started	80

Abbreviations: CHW, community health worker.

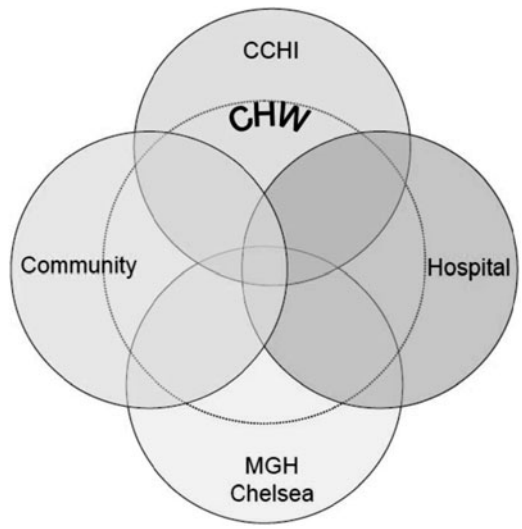

Figure 1. Transition of community health workers (CHWs) at the MGH Chelsea between departments at the main hospital, the Center for Community Health Improvement (CCHI), the community, and back again.

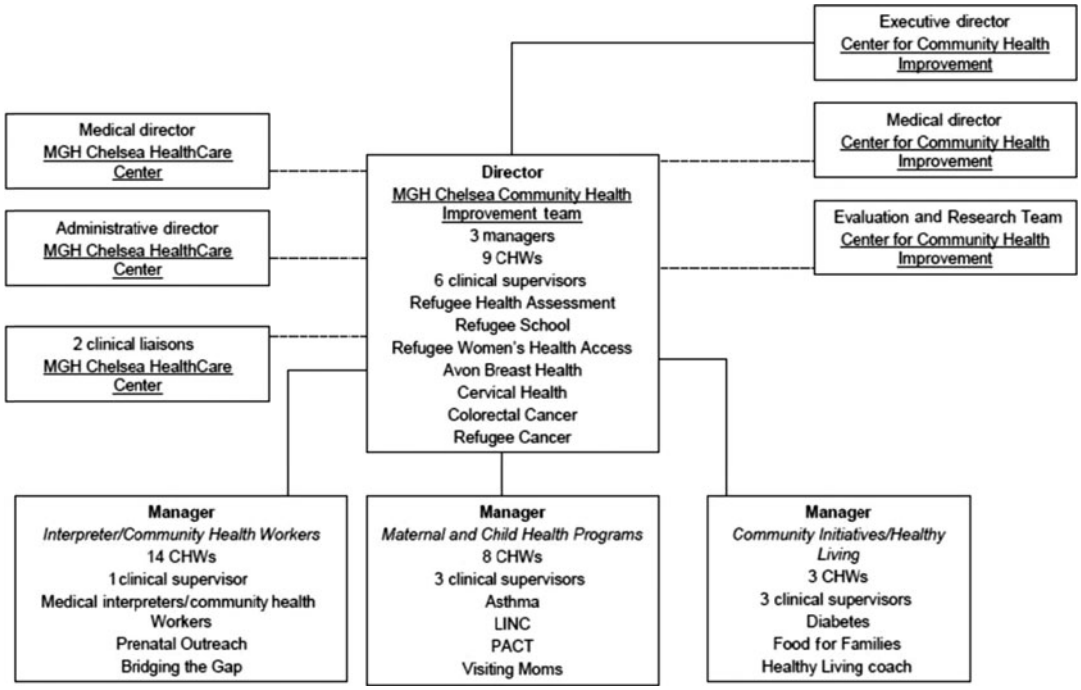

Figure 2. Organizational chart of MGH Chelsea Community Health Improvement team. CHW indicates community health worker.

and the CHW from the basis of the patient's cultural background, often with additional knowledge about the patient's living environment—about how to get a patient to the empowered place where he or she can make positive changes or take positive steps. CHWs follow up for providers on all of the issues that providers do not have time to take care of, given their busy clinic schedules. If a family's central heating system has been turned off or if they have run out of food that may be a patient's primary concern when they arrive at a medical appointment. Providers often cannot take the time to help patients with all these barriers to healthier living and yet medical care is often ignored if these environmental stressors are not addressed. At MGH Chelsea, the division of labor is transparent: CHWs do these tasks while staying in close communication with providers, through the conversations, consults, and the electronic medical record about the progress they are making. At case reviews around challenging patients, the voice of both the provider and the CHW at MGH Chelsea carries equal importance and each understands that they cannot be successful in their work without the other.

Another key to the success of CHWs is that each program has a clinical supervisor from the clinical departments who has particular expertise, who is clearly vested in the issue, and who has set aside paid time to be able to provide clinical supervision to the CHW staff. These providers play a key guidance role to the CHWs and are also able to interface and advocate directly with other providers in their departments if the communication lines break down as the CHWs are doing their work for patients.

Another unique aspect of the Chelsea approach is the idea of being able to "give back" to patients with multiple complex needs, which provides much satisfaction to CHW staff at MGH Chelsea. At times, the work with patients can cause increased stress and a

feeling of being overwhelmed if the staff member relates personally to the situation with which the patient is dealing. If there are parts of a patient's story that are familiar, the staff member is able to step back and take a helping role. When they are in that helping role, they come from a real place of empathy, familiarity, and knowledge. This fosters a great deal of satisfaction in doing their work.

EVALUATING THE MODEL

Evaluating the effect of the work CHWs perform at MGH Chelsea and the hospital is important in terms of quality improvement, accountability, and long-term sustainability. The CCHI employs a team of 5 internal evaluators for this purpose. To assess whether programs are making a difference, meeting the needs of communities, and efficiently and effectively carrying out goals and objectives, the CCHI Evaluation and Research team evaluates direct programming and community-wide initiatives.

Evaluation and research methods are guided by principles of community-based participatory research and evaluation. These principles are founded on the belief that the people who live in communities have the right to participate in the process of defining community problems, designing and implementing interventions and solutions, and evaluating outcomes. This truly defines CCHI's approach to addressing public health issues in the communities the MGH serves. Key principles include building on a community's strengths and resources, collaborating and creating partnerships, ensuring all partners benefit mutually, co-learning, community empowerment, and dissemination of research and outcomes to all involved.

Each MGH Chelsea Community Health Improvement program is assigned an evaluator as part of its team. The evaluator works with the CHWs, managers, and clinicians to assess the needs of the patients and define appropriate, evidence-based programming. In addition, the evaluator will identify data to collect, to ensure programs are reaching goals and objectives as intended. On the basis of the work of the team, a logic model and evaluation plan is created, implemented, and revised annually.

Evaluating CHW work can be challenging. Because of the nature of the team approach, there is not always a direct correlation between the CHW and better health outcomes for the patient. Recognizing this, the team creates an evaluation plan that takes this into account and collects data on process (Did an activity occur?), impact (Was the situation resolved?), and outcome (What is the patient's health status?). It is imperative that data collected is evidence based and truly reflects the aims of the program. It is also important that CHWs are part of the team that identifies the data to be collected. Not only does this create buy-in to collecting the data but also CHWs can provide valuable insight into what information is appropriate to collect, how a patient might react to a particular question being asked, and what measured data points might ultimately improve patient outcomes.

Finally, it is important to create a communication and dissemination plan for each program. All programs are encouraged to present their work at workshops, conferences, and meetings and publish their results. The CCHI builds this capacity by supporting the CHWs to do these presentations and write ups themselves through ongoing consulting.

A PATIENT CASE

A case of a 52-year-old Somali male patient with type 2 diabetes in poor control is presented. In November 2010, a middle-aged male refugee from Somalia was referred to the diabetes coach by his primary care physician. The patient had a hemoglobin A_{1c} level of 13.8%. The normal value is less than 6.5%. The patient spoke little English and did not understand why he should take his oral medications for diabetes or why he should test his blood glucose level on a regular basis.

The diabetes coach, who works with patients from many cultural backgrounds, had

difficulty understanding the patient's barriers at first. The patient talked about his financial struggles but offered little explanation to help the diabetes coach understand why he could not follow the physician's instructions. When the diabetes coach involved a Somali-speaking CHW, the team quickly realized that there were many cultural barriers that prevented the patient from taking better care of his own health.

Through the Somali-speaking CHW, the patient was able to explain that he believed there was nothing he could do about his illness and that it was God's will that he had to suffer. The diabetes coach did not dismiss the patient's beliefs. With the help of the CHW, the diabetes coach was able to find a culturally sensitive approach to help this patient to understand the disease and through motivational interviewing convinced him to take better care of his own health in accordance with his beliefs. The patient committed to testing his blood glucose just for a week to see if that would help. The diabetes coach taught the patient how to use a glucometer and met back with him regularly. After this important cultural breakthrough, the patient started to take his illness seriously, including committing to test his blood glucose routinely. He asked for advice about nutrition and the types of foods that would be most appropriate for him to eat.

The team educated the patient on nutrition and healthy eating, suggesting culturally appropriate foods and recipes that would work for the patient. The patient tried to follow these suggestions and liked how he felt. He was happy about his blood glucose numbers and was determined to bring them down. As he saw the results of medication combined with exercise were lowering his blood glucose level, he became more and more motivated to make positive changes.

At one point the patient was confused with the medication dosages. He had 2 prescriptions for metformin (500 mg twice a day and 1000 mg once a day). He made a mistake and was taking 1000-mg pills twice a day for a while until the diabetes coach set up an appointment for him with his nurse practitioner to clarify his medication regimen.

As of today, the patient has made some important behavioral changes. With ongoing encouragement from the diabetes coach, he takes his medications on a regular basis, eats healthier foods, and exercises regularly. Thanks to the Somali-speaking CHW, who reminds the patient about his visits and reschedules if necessary, he has been able to keep all of his follow-up appointments with both his nurse practitioner and the physicians involved in his care. During these visits, his medical team was able to better adjust his medications, thanks to his consistent monitoring. His current hemoglobin A_{1c} level is 6.5% as of April 2011.

SUSTAINABILITY

Although further evaluation is needed to elucidate the utility and effectiveness of CHWs, existing studies indicate that CHWs can play a valuable role in many health care encounters. Community health workers have been found to be effective in increasing access to care among underserved populations. Programs using CHWs to promote the use of screening or to facilitate the process of linking those in need of care to appropriate resources, clinicians, and treatment have shown that CHWs are useful in these capacities.[13]

Working through CHWs, a health care organization can

- gain community trust in the organization and the medical system;
- gain champions in the system;
- improve public image;
- provide comprehensive care;
- build a cost-effective model;
- secure partnerships that lead to increased funding; and
- contribute to organizational accountability.

Health care organizations need to remember that many of the activities involving CHWs in the clinical setting are not reimbursable. Moreover, many of these activities also require a long-term commitment to demonstrate

measurable change in a community's health indicators. The MGH CCHI assists the main hospital by

- conducting community needs assessments on a continuous basis;
- determining the value of CHW services to the community;
- researching and teaching about existing CHW models;
- developing a thorough approach to recruitment and selection of CHWs;
- ensuring the system-wide support for CHWs and programs;
- building an internal support system for CHWs through proper supervision and feedback;
- building community partnerships and staying actively connected to the community; and
- measuring outcomes.

CURRENT HEALTH LEGISLATION TRENDS AND INITIATIVES INVOLVING COMMUNITY HEALTH WORKERS

As members of care delivery teams, the CHW role is now being defined at both the state and national levels. For example, in Massachusetts, the formation of the Massachusetts Association of Community Health Workers not only defined their role but also reemphasized the importance of this role in improving patients' access to care and their health outcomes with the passage of the state's health care reform law in 2006. The Massachusetts Department of Public Health was directed by the legislature to complete an analysis of the role CHWs play in health care delivery, and the Massachusetts Association of Community Health Workers was granted a seat on the state's Public Health Council. Under the current Patient Protection and Affordable Care Act, this role will continue to expand.[14]

As Rosenthal et al[14] and other have stated, there are multiple health legislation policy trends that need to continue for the role of CHWs in our health care delivery system to evolve:

1. We need to find "sustainable financing" for reimbursing our CHWs for the many services they perform. Medicaid, Medicare, CHIP (Children's Health Insurance Program), and other payers need to understand the financial case for payment. For example, in 2008, Minnesota became the only state to approve an hourly rate for CHWs working under the supervision of a Medicaid-approved physician or nurse practitioner. Community health workers must complete the state's certification course to qualify for reimbursement and operate under a defined scope of practice.[14] Of note, the total budget for MGH Chelsea's Community Health Improvement work is just over 2 million annually. Of that 2 million, approximately half comes directly from various hospital sources including monies designated for community benefits and health center practices ongoing administration and operation dollars. The second half of the budget comes from a combination of federal, state, private foundation, and grateful patient dollars. One key to this work has been to use hospital resources to leverage outside dollars both by demonstrating true partnerships with outside agencies and by matching funding requests with in-kind contributions.
2. We need to provide resources for CHW workforce development and training. The Patient Protection and Affordable Care Act, the US Department of Health & Human Services' *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, and the National Partnership for Action to End Health Disparities' *National Stakeholder Strategy for Achieving Health Equity* all discuss this growing need.
3. We need to establish standards for the training and certification of CHWs. The US Department of Labor recommended

a standard occupational classification for CHWs as a first step in 2009.[14]

4. We need to establish guidelines for common outcome measures in CHW activities. Section 5313 (Grants to Promote the Community Health Workforce) of the Patient Protection and Affordable Care Act (HR 3590) authorizes the Director of the Centers for Disease Control and Prevention to award grants that promote positive health behaviors and outcomes in medically underserved communities through the use of CHWs.
5. Finally, we need to define what the integration of CHWs into any proposed new health care delivery models looks like. This includes patient-centered medical homes, accountable care organizations, and others. An example of this effort is the policy brief of Lyon et al[15] *The Affordable Care Act, Medical Homes and Childhood Asthma: A key Opportunity for Progress*.

CONCLUSION

Community health workers in the MGH Chelsea Community Health Improvement team work with vulnerable populations in the city of Chelsea to improve their health and well-being. They do this through a series of well-designed community programs. The basis of all these programs is a unique partnership between the community, the MGH Chelsea, the MGH CCHI, and the MGH itself. Community health workers can interact at any point in this care continuum and guide an individual from the community to the health center to the hospital and back again. Evaluation and sustainability are built around the process. They are part of the team that seeks a solution for any community member who might be experiencing a barrier to health care. It is now up to the larger health care system to continue to support this crucial function through sustained policy changes and health care reform.

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