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What Doctors Can't Do

By Tina Rosenberg

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Fixes looks at solutions to social problems and why they work.

Mary White makes house calls. She's a senior community health worker in Philadelphia in the IMPaCT program at the Penn Center for Community Health Workers. She has 25 of the University of Pennsylvania Health System's toughest patients. It's her job to help them set health goals and, step by step, carry them out.

One of her patients is Grover Wilson, an engaging man of 56 who weighs 515 pounds. Wilson had long been athletic and sociable, the organizer of a long-running community volleyball game. But depression and an injury led him to gain weight. Now he lives in a tiny basement apartment packed floor to ceiling with boxes of his possessions, and is trapped and isolated by his weight.

White has been visiting Wilson for three months. He's lost 15 pounds during that time, with the help of a group class at the Penn Center and her visits. "How are you doing on your goal to cut down on sugary drinks?" she asks. What about your snacks? "I've finished all my hummus and pretzels," he says. "I'm going to get some baby carrots, and more hummus, and pita chips."

“That’s good, that’s good,” White says. “They’re having a sale on hummus.”

They talk about his exercise goal: walking up and down his hallway. “As usual, I’m not doing a great job on my own,” he said. “It’s very easy when you’re alone and obese and have sleep apnea and other problems to say, ‘I just want to give up.’ Depression comes and goes. But today’s a good day.” He means because White is visiting.

“You’ll do it. I took half a person off me,” White says — she accompanies another patient to the gym, and she’s lost 50 pounds so far. “My knees are feeling better. You’ll do it. Be around positive people.”

They talk about his other problems. He’s on a payment plan with the power company, worried about his next payment. “But then I got my S.S.I. rebate,” he says. “Now I can pay my bills.”

“I’m so happy!” White beams: “Why didn’t you tell me?”

Wilson squeezes her hand. “You don’t get half, you know,” he says, smiling.

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In 2010, researchers from Penn began interviewing patients who lived in high-poverty neighborhoods about what they saw as barriers that kept them from getting health care, and kept them sick. Those responses — from long interviews with 115 patients — became the basis of the Penn Center and IMPaCT, which stands for “individualized management for patient-centered targets.”

The center’s community health workers, or C.H.W.s — seven now, but there will be 30 next year — visit some of Penn Medicine’s poorest and sickest patients: people who live in high-poverty neighborhoods, are hospitalized or have two chronic diseases, and either have Medicaid or no

insurance at all. Since they began seeing patients in 2011, they've treated 1,800 of them. They expect to work with that number every year starting in 2015.

Many poor countries use C.H.W.s on an enormous scale — in rural areas, where doctors and nurses are scarce, a C.H.W. often serves as the doctor. In the United States, their role is different. White and her colleagues have no medical training. (Before this, she was a family health worker with the Supportive Child Adult Network.) They're chosen for their ability to listen, support and encourage, without judgment. They are people from the same communities as their patients, and often with the same struggles. They help patients with the many factors keeping them sick that aren't typical doctor problems.

This is a crucial role in a country where vast numbers of people are sick with chronic lifestyle-related diseases. Doctors can't help patients change their behavior in the 15 minutes they spend with each patient. But community health workers can.

Yet C.H.W.s are few in the United States. Some "promotora" programs employ them in Native American and Latino communities, especially with migrant workers. A few states make them a part of health care — and Obamacare will increase that number.

"Every so often you see a foundation sink a lot of money into community health worker programs," said Prabhjot Singh, a Columbia professor and doctor in East Harlem who is co-chair of the One Million Community Health Workers Campaign. "The DNA of a lot of these programs comes from an activist, almost anti-bottom-line perspective. They are grant funded, and there's a lot of academic interest but there is not a way to systematically invest in C.H.W.s." So even though many studies — this is a good compilation (pdf) — show they improve health and save money, these programs rarely last very long or grow.

The Penn Center was founded by Shreya Kangovi, an internist and pediatrician who is an assistant professor of medicine at the University of Pennsylvania Perelman School. Before she and her colleagues designed the IMPaCT program, they reviewed other C.H.W. programs to see why they didn't last.

They found several common problems. Most important, C.H.W.s were rarely integrated into a health care system's processes or its financing. "They were often all by themselves, in a church basement," Kangovi said. "If they were doing great work, no one knew about it and no one paid for it." Many programs vanished when their grant money disappeared.

There were also staffing problems — lots of turnover, lots of workers who weren't right for the job. Organizations didn't understand what kinds of skills they needed and how to identify the people who had them. Many C.H.W. programs were disease-specific — but a lot of patients have multiple serious illnesses. And the work wasn't standardized: Few programs had manuals, for example. Each new worker was re-inventing the job.

Kangovi and her colleagues tried to attack these problems systematically. They decided that C.H.W.s wouldn't limit their scope, but help patients with any health goal. They made hiring decisions and designed a manual and formal training based on the barriers to care cited by the patients. They aimed to have a plug-and-play model that other hospitals could use.

It is still early, but there are some good signs. Staff turnover has been zero. The researchers tracked the impact of having a C.H.W. visit patients at hospital discharge and for two weeks after. Patients who got the visits saw a doctor sooner, had better mental health and were less likely to later have multiple readmissions than patients in a control group. (The program had no effect on patients' physical health or medication adherence — not unexpected given such a brief intervention,) The long-term home visits the

C.H.W.s do now are aimed at improving patients' chronic diseases. The center is halfway through a long study looking at that.

The Penn Center is one of several new models hospitals are trying to make C.H.W. programs sustainable. (There's a whole other way of doing this, too — programs run by community organizations, paid for largely by cities or states.) Another is Grand-Aides. Unlike the Penn C.H.W.s, Grand-Aides don't help with social or logistical issues. They are nurse extenders who get hundreds of hours of medical training. Each patient visit is supervised in real time by phone by a nurse, who makes all the decisions. A pilot at two pediatric Medicaid sites in Texas showed that the program cut readmissions by at least two-thirds.

Arthur Garson Jr., who directs the Health Policy Institute of the Texas Medical Center in Houston and founded Grand-Aides, believes that C.H.W. programs have stayed small because most don't certify their workers. His program requires each Grand-Aide to pass a test for certification every year. It's a way of standardizing the work and building confidence with hospitals. "Hospitals want to know they are competent and tested yearly," he said. Currently 14 hospitals in the United States use Grand-Aides — Garson says the program will be in 40 hospitals by spring 2015.

Do hospitals make money from C.H.W. programs? Some believe they do. Garry L. Scheib, the chief operating officer of the University of Pennsylvania Health System, said that Penn had a financial as well as a medical interest in putting the C.H.W. program in its budget and tripling its size.

"The real economic benefit for us is the open beds it creates," he said. "I usually have a waiting list for inpatient beds." Hospitals profit most by filling those beds with patients who need complex, specialty surgeries and care — especially when they carry private insurance. IMPaCT patients, by contrast, often need routine care, or non-medical help. They carry Medicaid

(which brings in little revenue) or are uninsured (a total loss). Hospitals must accept these patients, so keeping them as healthy as possible — preferably outside the hospital — is good.

Scheib said IMPaCT also saves Penn money because its staffers are a low-wage way (their pay starts at $14 an hour) to stretch and complement doctors and nurses who are paid a lot more.

But Singh warns that only a minority of hospitals are solvent enough to see things the way Penn does. “Most have huge reservations about bringing on yet another work force, along with care managers and care coordinators. And providers don’t really have great incentives to reach out to Medicare and Medicaid patients that are hard to reach. If these patients don’t come to an appointment, well, that’s just how it goes. Maybe the hospital’s internal quality indicators go down a little — but it doesn’t warrant pounding the pavement to find these people.”

Given the rarity of C.H.W. programs, this is obviously how many hospitals think. The emergency room is still a profit center for many hospitals, as long as patients have some insurance.

Hospitals are also resistant because C.H.W. programs lie outside their core competency. “If it’s community health workers or nurses, they’ll always go with nurses. It’s easier — even if there’s a sizeable population nurses are unable to reach,” said Heidi Behforouz, an associate physician in the global health equity division at Brigham and Women’s Hospital in Boston. (She ran Partners In Health’s PACT program, perhaps the most renowned C.H.W. program in the United States. Even that program didn’t survive the loss of charitable funding – it was transferred to another organization, in much diminished form.) “Not a lot of places have glommed on to ‘Yes, we need the community health worker model.’ ”

Obamacare is changing this calculus. Medicare now bases a small part of its reimbursement to hospitals on measures of quality, including

readmissions — which gives hospitals an incentive to help patients stay healthy. In a major shift for C.H.W.s, the federal government this year permitted state Medicaid funds to pay for their work, as long as it was initially recommended by a doctor or other licensed practitioner.

But the biggest change initiated by the Affordable Care Act is a gradual shift away from fee-for-service medicine to rewarding quality, not quantity. With that shift, hospitals and payers will be looking for what Singh calls "the lightweight infrastructure that takes care of people outside of the hospital."

"If fee-for-service disappears, there is more emphasis on prevention, wellness and quality of life in the long term," said Behforouz, "Then everybody would be pushing for community-based models that kept people at home."

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