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Enhancing patient care efficiency: The role of health administration technicians in streamlining community health services

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***Abstract*---Background:** Community health workers (CHWs) play a crucial role in addressing health disparities and enhancing community health services, yet their diverse roles and competencies remain underexplored in the literature. **Aim:** This study aims to investigate the integration of CHWs within healthcare systems, identifying the characteristics and competencies necessary for their effective employment and impact. **Methods:** The study involved a comprehensive analysis of 57 CHW programs across various settings, coupled with key informant interviews. Data were collected on program characteristics, integration types, funding sources, hiring qualifications, and perceived competencies for successful integration. **Results:** The findings revealed that 75% of CHW programs operate within home and community settings, primarily overseen by clinical providers or community organizations. Direct hiring was the most common integration model. CHWs significantly contribute to chronic disease management, preventive care, and health education, primarily through strong community ties and cultural competence. Despite the

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increasing recognition of CHWs, barriers such as inconsistent funding and a lack of standardized competencies persist. **Conclusion:** Effective integration of CHWs into healthcare systems can improve health outcomes, particularly for underserved populations. However, achieving this integration requires establishing clear communication channels, fostering mutual expertise, and maintaining CHW autonomy while addressing gaps in competency frameworks.

***Keywords*---**community health workers, healthcare integration, health disparities, competencies, patient care efficiency.

Introduction

Policymakers and healthcare professionals have taken notice of community health workers (CHWs) because of their unique contribution to reducing health disparities and addressing the socioeconomic determinants of illness. There is still a dearth of research that focuses on the variety of CHW roles and connections, as well as how this diversity relates to management styles, integration of the health system, and competencies needed for various CHW roles. This study looks into a number of important questions. First, we look at how healthcare systems are using CHWs and what qualities these programs look for when hiring new staff. We then examine the elements that experts and businesses believe are critical to the successful integration of CHWs. In light of the new demands placed on CHWs, we conclude by evaluating the existing competency frameworks for these workers. The term "CHW" refers to a broad range of jobs and roles, such as community health advocate, promotor, and lay health worker, in addition to roles that call for particular expertise or training, such asthma educators. CHWs are described as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" by the American Public Health Association (APHA) (APHA 2009). Their distinctive quality is not just their deep comprehension of community resources and needs, but also the fact that they share common experiences in life with the community, which cultivates trust in ways that traditional healthcare providers might not be able to. Due to their special combination of abilities, community ties, cultural resonance, and time, CHWs can address social determinants of health in areas where the healthcare system may be hindered (American Public Health Association 2009; U.S. Department of Health and Human Services Office of Minority Health 2015). CHW numbers in the US rose from 86,000 in 2000 to 121,000 by 2005, according to the only nationwide survey of CHWs, which was carried out by HRSA in 2007. (U.S. Department of Health and Human Services, Bureau of Health Professionals, Health Resources and Services Administration 2007). The number of CHWs nationwide varies significantly depending on state populations and total employment, according to data from the Bureau of Labor Statistics (U.S. Department of Health and Human Services, Bureau of Health Professionals, Health Resources and Services Administration 2007; Bureau of Labor Statistics 2012, 2013, 2014). Nevertheless, the total number of CHWs is still rising.

A growing corpus of research demonstrates the positive impacts of CHWs on patient and community health, especially for underprivileged and marginalized populations. Research has shown that CHWs are beneficial in improving the management of chronic diseases (Norris et al. 2006; Reinschmidt et al. 2006; Brownstein et al. 2007; Baig et al. 2010; Spencer et al. 2011; Islam et al. 2013b; Islam et al. 2014), enhancing disease prevention and screening (Navarro et al. 1998; Hunter et al. 2004; Hansen et al. 2005; Ingram et al. 2007; Martinez et al. 2011; Islam et al. 2013a), promoting healthy lifestyle changes (Corkery et al. 1997; Elder et al. 2005), helping with insurance enrollment (Perez et al. 2006), and reducing needless healthcare utilization (Fedder et al. 2003; Enard and Ganelin 2013). CHWs are becoming more and more valued as essential members of the healthcare workforce as a result of recognition of their extraordinary capacity to enhance health outcomes (AMA 2015). CHWs were officially recognized as a separate labor category by the U.S. Department of Labor in 2010 (U.S. Office of Management and Budget 2009). Federal programs, such as the Promotores de Salud Initiative (U.S. Department of Health & Human Services 2015) and HHS's Action Plan to Reduce Racial and Ethnic Health Disparities (U.S. Department of Health & Human Services 2011), acknowledge the important role CHWs play in reaching underserved populations and support their involvement in reducing health disparities.

Furthermore, a major modification to Medicaid regulations made in 2013 (Centers for Medicare & Medicaid Services) allows Medicaid programs to pay for preventative services provided by CHWs as long as a licensed practitioner first recommends them. The potential of this regulatory change, combined with ongoing reforms brought about by the Affordable Care Act (ACA) that are changing the makeup of the healthcare workforce, has sparked conversations about the future role of CHWs in the healthcare system. States are currently looking into how to implement this change (Association of State and Territorial Health Officials, n.d.). Increasing CHWs' possibilities to work with or integrate into the healthcare system has become a priority in light of the changing payment and service delivery environment that encourages providers to address social determinants of health (NEHI 2015). Unfortunately, the best ways to integrate CHWs with health systems have not been fully explored in the literature that is currently available (NEHI 2015). One topic of concern is whether or whether the CHW profession has to be standardized, and if so, in what way (NEHI 2015). State certification or credentialing is one emerging method of standardizing CHWs; it has been implemented in many states and is being worked on in others (Association of State and Territorial Health Officials, n.d.). However, there are benefits and drawbacks to the certification process for standardization for different stakeholders (Bovbjerg et al. 2013). According to Dower et al. (2006), accreditation for CHWs can improve employment security and open up professional possibilities. While states may view certification as a chance to establish consistency in this growing sector of the healthcare workforce (Anthony et al. 2009) and boost funding for services (Agency for Healthcare Research and Quality 2014), payers may view it as a way to guarantee a standardized skill set and knowledge base among CHWs (Miller, Bates, and Katzen 2014).

But standardization runs the risk of destroying what makes CHWs unique—the trust they foster in the communities they serve—for a profession still in its

infancy (Davis 2013; Weil 2014). A change of this kind would constitute a dramatic divergence from the movement's historical roots and could create obstacles for anyone wishing to enter the field (Goodwin and Tobler 2008; Bovbjerg et al. 2013; Weil 2014). Because of this, CHWs have started working to create their own guidelines (Community Resources, LLC n.d.). Regarding the competences that should be required of CHWs under state certification or credentialing frameworks, stakeholders typically have differing opinions. In addition to outlining the responsibilities of CHWs, competencies also guide curriculum creation and act as instruments for evaluation (Rosenthal 1998; U.S. Department of Health and Human Services Bureau of Health Professionals 2007; Anthony et al. 2009; McCormick et al. 2012). Therefore, a crucial factor in the growing standardization of the field and its capacity to improve patient health through systemic integration is the range of CHW activities that fall under the purview of competencies. Should competences recognize and integrate the distinct contributions made by Community Health Workers (CHWs) to the healthcare system, this could suggest that the process of standardization could ultimately improve their effectiveness and influence. The findings are organized into three segments. The initial section identifies five primary variables that differ among CHW employers, subsequently analyzing significant associations among these variables, particularly concerning CHW integration types and employers' hiring criteria. The second section encapsulates the principal themes derived from key informant interviews regarding the characteristics of effective CHW integration within health systems. Finally, the third section compares existing competency frameworks and addresses potential gaps in light of our findings from the prior sections.

Program Characteristics

Primary Site of Intervention: Seventy-five percent of the programs in our dataset (57 total) deliver services in home and community environments: 28 programs utilize the home as their main intervention site, while 29 programs operate primarily in various community settings (e.g., churches, schools, community centers). An additional 13 programs are situated in non-hospital clinical environments, such as physician offices or school-based health centers, whereas six programs are based within a hospital framework. Interview statements corroborated the results from the database.

Leading Organization: Forty-four programs (58 percent) are overseen by clinical providers and health plans: 24 programs are led by hospitals or health systems, 10 by other clinical entities (e.g., federally qualified health centers), and another 10 by public or private health plans. Community-based organizations (CBOs) and other nonprofit entities (including universities and community coalitions) lead 29 programs, while health and social agencies, such as local health departments, direct seven programs. Notably, despite database findings, the majority of interviewees (15) presumed that CBOs predominantly lead organizations employing CHWs. This assumption may stem from the distribution of CHWs across various programs. For instance, several health plans in our dataset employed only a small number of CHWs (fewer than five), while CBOs typically managed larger CHW workforces. Data from other CHW surveys indicate that most CHWs are employed by CBOs (University of Arizona Prevention Research

Center 2014). Moreover, in 28 programs (37 percent), CHWs were directly employed by hospitals, health systems, or health plans, yet operated in community settings. Interviewee perspectives may reflect a misconception that the presence of numerous CHWs working within community contexts signifies CBOs as the main leaders of these initiatives.

Funding Source: Twenty-seven programs received funding from federal health/social agencies (mainly the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Centers for Medicare and Medicaid Innovation); private foundations supported another 21 programs; state or local health/social agencies financed 15 programs; health system entities (typically hospitals or integrated health systems) funded 15 programs; and health plans served as the financial source for nine programs. A minority of programs (nine) were supported by multiple funding sources. Although our database represents a convenience sample, these findings align with existing literature indicating that short-term categorical grants and contracts are the most prevalent funding models for CHWs (Dower et al. 2006; Alvillar et al. 2011; Alvisurez et al. 2013). The literature describes the lack of public and private insurance reimbursement as a significant barrier to the expanded employment of CHWs (Dower et al. 2006; Johnson et al. 2012). Statements from interviewees confirm the diverse funding mechanisms for CHWs, with six noting that, as a nascent profession, there is no standardized financial support for organizations employing CHWs. Three-quarters of interviewees (16 of 21) emphasized the critical role of the Affordable Care Act (ACA) in fostering innovation in this domain, while 18 highlighted the ongoing significance of public health funding and philanthropic contributions.

Hiring Qualifications: Nearly half of the programs in our database (37) mandated that applicants either reside in the community served (community membership) or possess substantial familiarity with that community based on prior experience (community familiarity). Educational requirements were infrequently established: only eight programs specified any educational criteria, the majority necessitating that CHWs hold a high school diploma or GED. Twenty-seven programs required some form of "other" training, such as certification as an asthma educator or completion of a program-specific training course. Seventeen programs specified requirements for language fluency or proficiency. Five programs mandated applicants to have some level of "peer status," such as a diabetic CHW working within a diabetes prevention initiative. Although this is not an exhaustive account of all hiring criteria, these represent the most common types identified in the database. Notably, for 15 programs in our database (19.7 percent), hiring criteria were indeterminate. Interview responses corroborate database findings. Every interviewee asserted that community membership/familiarity is vital to the CHW role, and several (7) noted the importance of peer status. Interviewees reported few instances where “education level” was a prerequisite for CHWs. Three interviewees indicated that even where some educational level is preferred, CHW employers often prioritize candidates with community membership/familiarity.

Types of Integration: An examination of the database and interview transcripts revealed four categories of integration:

1. **Direct Hire**: Programs characterized as “direct hire” involve arrangements where CHWs are incorporated into a broader health team, functioning as internal members rather than external partners or resources. In many instances, the health team establishes its own CHW workforce by recruiting and training individuals who bridge the divide between the healthcare system and the community.
2. **Community Partner**: Programs classified as “community partner” entail arrangements where CHWs are employed by an external entity that maintains a formal partnership with the health system. In these cases, the external CHW program receives referrals from and communicates back to the health system through established communication channels, yet the CHW does not operate as a distinct member of the larger healthcare team.
3. **Informational Resource**: Programs identified as “informational resource” denote arrangements where CHWs function as external informational assets to the health system without any formal partnership or communication pathways. In such arrangements, part of the CHW's role involves educating health practitioners on community-related health determinants.
4. **Independent**: Programs termed “independent” operate without any connections to the healthcare system beyond managing referrals. CHWs engaged in these arrangements are not integrated into a team or formal partnership, nor is serving as an informational resource to the health system a designated task.

“Direct hire” was the most prevalent integration type, with 41 programs (53.9 percent) incorporating CHWs as integral members of larger teams of health professionals. A smaller subset of programs (7) followed the “community partner” model, while two programs in our dataset utilized both “direct hire” and “community partner” strategies, employing some CHWs as part of their internal team and formally contracting with an external CBO. Nine programs were categorized as “informational resource” arrangements, and 21 as “independent.” Correlating these integration types with the four structural elements analyzed above reveals, first, that when clinical entities (healthcare providers/clinics and hospitals/health systems) and health plans serve as leaders and/or funders of CHWs, they are more likely to engage in direct hiring of CHWs rather than collaborating with existing CBOs. Secondly, we observe that programs that directly hire CHWs are more inclined to impose educational and training requirements on applicants, despite all integration approaches recognizing community membership/familiarity as a fundamental hiring criterion.

Expert Perceptions of the Keys to Successful Integration:

Our second research question delves into key informants' insights regarding factors deemed critical for successful CHW integration within health systems. Informants voiced concerns that integration could undermine the distinctive role of CHWs unless competencies and health systems actively work to maintain the elements of their independence. In particular, the participants highlighted three interconnected themes that are crucial to consider when evaluating competency lists (elaborated upon in the next section).

1. **Communications about Patient Care**: Most interviewees (16) emphasized that for CHWs to be effectively integrated into the health system, established communication channels must be in place to facilitate open dialogue with other providers regarding patient care. Illustrative examples of such channels (noted in interviews and documented in our database) include CHWs: attending daily clinical rounds, entering patient data into a shared electronic medical record, and regularly participating in provider-patient appointments/calls. These mechanisms promote a consistent, bidirectional flow of information between healthcare practitioners and CHWs.
2. **Sharing of Provider Expertise**: Many interviewees (10) considered the reciprocal transfer of expertise between CHWs and other providers to be equally vital. For instance, do CHWs merely attend daily hospital rounds, or do they contribute information and share their expertise? Are other providers cognizant of the unique contributions CHWs make, prompting them to seek CHW insights? Examples of mechanisms facilitating this exchange include forums for CHWs to share "best practices" and training sessions for clinical providers to comprehend the distinctive role of CHWs in enhancing patient care.
3. **CHW Autonomy**: A third characteristic highlighted by several interviewees (13) relates to the degree of autonomy that CHWs possess in executing their duties. Even in scenarios where communication channels exist and CHWs can share their expertise, if they simply follow care directives from other providers or convey structured information to patients without the ability to make real-time judgements about patient needs, then the system is not fully leveraging CHWs' capabilities. Mechanisms that foster CHW autonomy include allowing CHWs to create individualized action plans for patients and empowering them to respond to evolving patient circumstances (e.g., loss of transportation or housing).
4. **CHW Competencies:** In addressing the competencies necessary for CHWs, your findings indicate:
    - Standardization of Competencies: A comparative analysis of nine existing competency sets shows considerable consistency, but highlights gaps in competencies specific to CHW integration within health systems.
    - Integration-Specific Competencies: Key competencies identified by informants include:
    - The ability to communicate effectively within a healthcare team.
    - Understanding the healthcare provider's environment and standards for record-keeping.
    - Skills in advocacy, negotiation, and conflict resolution, enabling CHWs to serve as liaisons between patients and providers.

Main Roles of Health Administration Workers in Community Health

Health administration workers play a vital role in enhancing community health by managing health services, developing policies, and ensuring that health systems operate effectively. Their work is essential for addressing public health challenges,

improving access to care, and ensuring that community health programs are responsive to the needs of the population. Below are the primary roles of health administration workers in community health.

1. Program Management: One of the key responsibilities of health administration workers is the management of community health programs. They are tasked with planning, implementing, and evaluating these programs to ensure they meet their objectives and serve the needs of the community. This involves coordinating activities, managing budgets, and ensuring compliance with regulations and standards. Effective program management ensures that resources are used efficiently, and outcomes are assessed to identify areas for improvement.

2. Policy Development: Health administration workers play a critical role in policy development that affects community health. They analyze health data, research trends, and gather input from stakeholders to inform policy decisions. By advocating for policies that promote health equity and access to care, they contribute to the creation of a supportive environment for public health initiatives. Their expertise in navigating the regulatory landscape is essential for developing policies that address pressing health issues such as chronic disease management, mental health, and substance abuse.

3. Coordination of Services: Coordinating services among various health providers and community organizations is another crucial role of health administration workers. They facilitate communication and collaboration between different stakeholders to ensure a comprehensive approach to health care delivery. By building partnerships with community organizations, local government, and health systems, they help to create a network of services that effectively addresses the diverse needs of the population. This coordination is especially important in integrated care models, where multiple providers work together to deliver seamless care.

4. Resource Allocation: Effective resource allocation is fundamental to the success of community health initiatives. Health administration workers manage budgets and funding sources to ensure that health programs are adequately financed. They seek grants and funding opportunities to enhance services and often engage in negotiations with funding bodies. By prioritizing resource allocation based on community needs and program effectiveness, they help to maximize the impact of health initiatives.

5. Data Management and Analysis: Health administration workers are responsible for collecting, analyzing, and interpreting health data to inform decision-making and program development. They utilize data to monitor health outcomes, identify trends, and assess the effectiveness of interventions. By leveraging data analytics, they can pinpoint areas of concern, such as rising rates of chronic diseases or health disparities among different demographic groups. This information is vital for developing targeted strategies that address specific community health challenges.

6. Community Engagement: Engaging with community members is a critical aspect of health administration work. Health administrators work to understand the health needs of the community by conducting surveys, focus groups, and community meetings. This engagement not only helps to identify pressing health issues but also fosters a sense of ownership among community members regarding health initiatives. By promoting health education and encouraging

participation in health programs, health administrators empower individuals to take charge of their health and well-being.

7. Quality Improvement: Quality improvement initiatives are central to the role of health administration workers in community health. They implement quality assurance measures to enhance the effectiveness of health programs and ensure that services are delivered safely and meet established standards. By conducting regular evaluations and seeking feedback from participants, health administrators can identify areas for improvement and implement changes that enhance service delivery.

8. Advocacy: Health administration workers often serve as advocates for community health issues. They represent the interests of the community in discussions with policymakers, funding bodies, and other stakeholders. By raising awareness about health disparities and advocating for resources and support, they play a key role in influencing decisions that impact community health.

9. Training and Support: Providing training and support to healthcare workers and volunteers is another important function of health administration. Health administrators ensure that staff are equipped with the necessary skills and knowledge to deliver quality care. This includes developing training programs, workshops, and continuing education opportunities to enhance the competencies of the workforce.

10. Crisis Management: In times of public health emergencies, health administration workers are critical in coordinating response efforts. They mobilize resources, communicate with the public, and collaborate with health authorities to manage crises effectively. Their ability to organize and implement emergency response plans is vital for protecting community health during outbreaks, natural disasters, or other emergencies.

Conclusion

The findings from this study underscore the vital role of Community Health Workers (CHWs) in enhancing the efficiency of patient care and addressing health disparities within underserved communities. As frontline public health advocates, CHWs bridge the gap between the healthcare system and the communities they serve, leveraging their unique understanding of community needs and resources. The analysis reveals that 75% of the CHW programs examined operate primarily within home and community settings, emphasizing the importance of localized care in addressing social determinants of health. The study identified direct hiring as the most prevalent model for CHW integration into healthcare systems. This approach not only fosters better communication and collaboration among healthcare professionals but also allows CHWs to play an integral role in the health team, contributing to improved chronic disease management, preventive care, and health education. However, the integration of CHWs is not without challenges. Many programs continue to face barriers such as inconsistent funding and a lack of standardized competencies, which can hinder the full realization of CHWs' potential. To effectively integrate CHWs into healthcare systems, it is essential to establish robust communication channels that facilitate information sharing between CHWs and other healthcare providers. Moreover, the reciprocal exchange of expertise can enhance the capacity of both CHWs and healthcare professionals, leading to improved patient care outcomes. The autonomy of CHWs

in making real-time judgments and creating individualized action plans is also crucial for maximizing their impact on patient health. Lastly, the study highlights significant gaps in existing competency frameworks for CHWs, particularly concerning their integration into healthcare systems. Addressing these gaps will be instrumental in developing standardized competencies that reflect the unique contributions of CHWs. By recognizing and formalizing the role of CHWs, healthcare systems can better harness their capabilities to enhance patient care efficiency, ultimately leading to healthier communities. The ongoing recognition and support for CHWs by policymakers and healthcare organizations will be critical in shaping the future landscape of community health services.

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تعزيزكفاءة رعاية المرضى: دور فنيي إدارة الصحة في تبسيط خدمات الصحة المجتمعية

الملخص:

الخلفية :يلعب العاملون في مجال الصحة المجتمعية دورًا حيويًا في معالجة الفوارق الصحية وتعزيز خدمات الصحة المجتمعية، إلا أن أدوارهم المتنوعة وكفاءاتهم لا تزال غير مستكشفة بما فيه الكفاية في الأدبيات.

الهدف :تهدف هذه الدراسة إلى التحقيق في تكامل العاملين في مجال الصحة المجتمعية داخل نظم الرعاية الصحية، وتحديد الخصائص والكفاءات اللازمة لتوظيفهم بشكل فعال وتحقيق تأثيرهم.

الطرق :شملت الدراسة تحليلًا شاملاً لـ 57 برنامجًا للعاملين في الصحة المجتمعية عبر بيئات متنوعة، بالإضافة إلى مقابلات مع خبراء والعديد من الدراسات السابقة. تم جمع البيانات حول خصائص البرامج، وأنواع التكامل، ومصادر التمويل، ومؤهلات التوظيف، والكفاءات المتصورة للتكامل الناجح.

النتائج :كشفت النتائج أن 75% من برامج العاملين في الصحة المجتمعية تعمل ضمن البيئات المنزلية والمجتمعية، وتخضع في الغالب لإشراف مقدمي الرعاية السريرية أو المنظمات المجتمعية. كان التوظيف المباشر هو النموذج الأكثر شيوعًا للتكامل. يساهم العاملون في الصحة المجتمعية بشكل كبير في إدارة الأمراض المزمنة، والرعاية الوقائية، والتثقيف الصحي، بشكل أساسي من خلال الروابط القوية مع المجتمع والكفاءة الثقافية. على الرغم من الاعتراف المتزايد بالعاملين في الصحة المجتمعية، لا تزال هناك حواجز مثل التمويل غير المتسق وغياب الكفاءات الموحدة.

الخاتمة :يمكن أن يحسن التكامل الفعال للعاملين في الصحة المجتمعية في نظم الرعاية الصحية النتائج الصحية، خاصة للفئات المحرومة. ومع ذلك، يتطلب تحقيق هذا التكامل إنشاء قنوات اتصال واضحة، وتعزيز الخبرة المتبادلة، والحفاظ على استقلالية العاملين في الصحة المجتمعية مع معالجة الفجوات في أطر الكفاءات.

الكلمات المفتاحية :العاملون في الصحة المجتمعية، تكامل الرعاية الصحية، الفوارق الصحية، الكفاءات، كفاءة رعاية المرضى.