The Intersection of Social Support and Clinical Healthcare: A CST-Informed Care Coordination Model

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Catholic Social Tradition Minor Capstone
April 21, 2023

Using a See - Judge - Act model for theological reflection and social action, this paper aims to convey the need for community-based intervention in healthcare settings serving underserved and/or vulnerable patient populations, and accordingly proposes a model for the utilization of community health workers. I begin with a reflection on my experiences working at a community health center and a literature review, followed by an application of CST principles and theological guidance on preferential options for the poor and vulnerable, and conclude with a proposal to fuse patient navigator and community health worker roles in order to best serve patients with complex social and physical health needs.

See

Watching "Michael" and his service dog (a dachshund) walk into the exam room, I knew we were in for a complex appointment. He was significantly overweight and experiencing difficulty walking and breathing without assistance, clutching his dog to his chest as the MA struggled to help him onto the scale. The Nurse Practitioner I was working with had been seeing Michael for years and filled in the details of his story. Despite a plethora of pre-existing conditions - diabetes, peripheral neuropathy, severe depression - Michael was an inconsistent patient, frequently canceling or no-showing appointments, presumably due to a lack of transportation or PTO. He was reliant on random gig work for his income due to his disability and education level, leaving him without a reliable schedule during the day or night, depriving him of sleep. Michael mentioned that he was constantly worried about affording groceries and fighting with his landlord, who placed significant restraints on his activity. He had been living without electricity or water for a while, so for this appointment, my job was to discuss healthy food options that didn't need to be cooked or refrigerated, a task that was admittedly difficult for me. Michael made it very clear, however, that the purpose of the visit was not to discuss his diet or weight: he was looking for more extensive psychiatric care. He was uncomfortable with a different doctor and health system for multiple reasons - one being cost without insurance - and eventually decided to keep working on lifestyle changes to hopefully better his mood without intervention beyond that of what the community health center could provide.

Terry Reilly Health Services (TRHS) mostly serves patients like Michael, whose social and/or economic status directly affects their ability to take care of themselves and seek out and receive medical care when needed. Whether they were immigrants fleeing traumatic experiences in their home countries, single mothers struggling to make ends meet, or veterans experiencing

homelessness, I felt like I was surrounded by patients who did not have the resources to prioritize their health daily. As a result, I was also surrounded by people who could not stay healthy or adequately recover from acute illnesses. I kept asking myself, day after day, what is going on in this community that is causing its members to be so unhealthy?

Due to the organization of our healthcare system, many Americans believe that health disparities can be eliminated by increasing access to clinical healthcare. There is some truth to this belief: individuals with insurance are more likely to seek out primary care generally and emergent care in circumstances of ambiguous severity [1], as shown by a study of the Oregon Medicaid lottery, which found that lottery winners received higher rates of detection of chronic diseases and lower rates of depression than their uninsured neighbors, two effects that have positive effects for overall health outcomes. [2] However, if healthcare access was the only variable affecting individuals outcomes, Michael should have been much healthier than he was when I met him. As an established Medicaid patient at TRHS, Michael had access to regular appointments with a primary care provider, an in-house pharmacy, referrals to specialists when needed, and potentially further payment assistance from the clinic. By all accounts, he had quality healthcare available to him; however, Michael experienced barriers to accessing this care, and furthermore, lacked the tools outside of the clinic to take advantage of the quality of care he was receiving inside.

Differences in access to care cannot account for all existing disparities, and social factors are at times more predictive of negative health outcomes. Social determinants of health (SDHs) are defined as the conditions in an individual's environment that affect their ability to function and control their quality of life, which typically refers to the health-related behaviors inherent to neighborhoods - like walkability, healthy food availability, and prevalence of outdoor recreation -

but should also expand to include fundamental causes, including economic stability, education access and quality, race and ethnicity, and social status. A study of mortality rates of British civil servants found higher mortality rates due to all causes for men of lower employment grades despite equal access to clinical healthcare through the National Health Service, exemplifying the strong connection between low social status and poor health. [3] This connection is presumed to be due to the psychological stress inherent to working in subordinate positions, a similar kind of chronic stress present in the lives of those experiencing persistent financial troubles, racial or ethnic bias, neighborhood or domestic violence, or proximity to substance abuse. [4] All of these factors disproportionately affect disadvantaged populations.

Michael's case can be used as a domestic example of the overwhelming effects of SDHs on health outcomes. Despite access to quality clinical healthcare, Michael's health was deteriorating. His living and employment situations kept him from implementing the lifestyle changes necessary to manage his diabetes, and constant stress at home prevented him from implementing the coping strategies presented by his psychiatrist and accordingly prevented self-management of his mental health. Michael's social status significantly affected both his mental and physical health in a way that clinical healthcare could not overcome, but that could have been theoretically overcome with proper social support. After meeting Michael, and several other patients in similar situations, I quickly learned that in order to properly care for vulnerable populations, healthcare cannot only consider the patient's clinical needs, but must also extend to address their social needs.

Community health workers (CHWs) are popular choices for bridges between the community and the clinic, especially in resource-limited settings outside the United States. These

workers assume a wide variety of job titles and responsibilities, reflected in the broad definition of CHW from the NIH:

> Community health workers (CHWs) are lay members of the community who work either for pay or as volunteers in association with the local health care system in both urban and rural environments. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles, such as community health advisors, lay health advocates, *promotoras*, outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, help people get the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening. [5]

When utilized in any of these capacities, CHWs have been shown to improve access and use of healthcare, decrease utilization of emergency services, and increase adherence to recommendations and treatment plans. [6] When integrated into the primary care space, CHWs have shown promise in preventing and controlling chronic cardiovascular conditions. [7] At the same time as providing these benefits for health outcomes, CHW programs have been shown to decrease healthcare costs significantly, at times providing a return on investment of up to 316%. [8] The kind of support CHWs provide is invaluable, both from a humanistic perspective and from a financial one, and could have drastic effects on the healthcare system in the US if widely utilized.

Non-governmental organizations in the world of global health have already acknowledged the positive role of community support in treatment plans. Partners in Health (PIH) specifically built their healthcare model on the backs of community health workers, relying heavily on local residents to provide accompaniment and community-driven intervention in the lives of the sick and suffering. Their CHWs provide mental and physical health services, such as basic psychological intervention or medication assistance, in addition to making sure patients have the social support they need to stay healthy, all in a “linguistically and culturally relevant way.” [9] PIH has implemented their accompaniment model across the globe and found extreme success in clinical outcomes as a result. [10] Other global organizations have followed suit, making community health workers a substantial workforce in under-resourced settings around the world.

There is not a singular solution for the provision of social support for underserved or impoverished communities. The needs of any given community depend on demographics, social capital of the community, and geographic location, among other factors that are highly variable between communities, indicating the need for personalization of programming. The solution TRHS utilized provides every patient access to a patient navigator. Patient navigators (PN) have a job description that is similar to that of a community health worker, keep their own patient list, and see patients individually or alongside the patient’s primary care provider (PCP). They are able to assist with a wide variety of services, such as Medicare education and enrollment; arranging transportation; locating food pantries and other private assistance programs; housing, legal, employment, and safety resources; applying for Medicaid, SNAP, and other state programs; and any other unique needs a patient may bring to the table. [11] Working alongside these patient navigators, it was impossible to ignore the impact they made on patients. New

patients would typically come into the office agitated or exhausted, with difficulty following the conversation or answering questions, obvious signs of the immense amount of stress they were under. When the PN would offer help, a brief moment of confusion would ensue, followed by a visible wave of comfort when they realized there were real options for their next steps. I was able to see a few patients regularly over the course of the summer whose demeanor drastically changed from their first appointment, visibly gaining confidence and serenity. The providers were almost as grateful as the patients for the intervention of the PNs, because they experienced the positive effects of alleviating some extra-clinical stress on adherence to treatment plans and general health decisions. My experiences, coupled with the literature, show that social support in the healthcare setting has large positive implications for patients, providers, and business models.

Despite their global success and large potential domestic impact, CHWs and PNs have been slow to enter into the clinical healthcare space in the US, primarily due to substantial perceived financial barriers. [12] The use of these professionals has historically been made possible by private grants, and consequently been limited by issues of availability. For example, health systems that serve larger geographic areas or patient populations tend to receive the majority of private donations, while smaller clinics or those serving specific patient populations are heavily reliant on state and federal funding. With recent changes in attitude and legislation, it is now possible to allocate state and federal funding sources to community health initiatives. Over half of states now allow for Medicaid reimbursement of community health services, and 11 states report plans to implement coverage of CHW services under state plan authority in the near future. [13] Because a large portion of patients served by CHWs are Medicaid recipients, Medicaid reimbursement would provide a level of financial self-sufficiency to CHW programs and as such potentially make them more desirable for investors in the future. Increased federal

funding for CHW programs has also recently become a reality, beginning with structural changes made by the Affordable Care Act, and continuing post-pandemic with a grant program from the Biden Administration that awarded $225 million for the purpose of training over 13,000 CHWs nationally. This was the largest one-time federal investment in the CHW workforce. [14] For the near future, the Consolidations Appropriations Act of 2023 authorized $50 million annually through 2027, also for the purpose of growing the CHW workforce. [15] Growth of social safety net programs in the clinical healthcare space is a step in the right direction and would open the door for making these programs and workforce improvements sustainable, which will hopefully be the focus of future grant allocations. Movement away from dependence on private funding will allow CHW programs to expand into federally qualified spaces and smaller health centers that do not have the luxury of a large donor base and ultimately support nationwide growth of the profession.

The community health worker program in St Joseph's county was made possible by one of these grants, although partisan stigma initially and continually affects the ease of the appropriation of funds. In 2021, St. Joseph and Elkhart counties were awarded federal grants that would fund additional full-time CHWs and help to support struggling health departments in their quest to meet the needs of their communities. Unfortunately, the respective County Councils voted to deny acceptance of the grants due to partisan controversy surrounding the actions of the CDC and other federal health policy makers throughout the COVID-19 pandemic. While an override vote in St. Joseph's County was able to procure the funds, Elkhart County was not as lucky, and therefore does not have the available funding to be able to employ CHWs through their health department. St. Joseph's County CHW program is thriving as of today, but questions persist as to the long-term barriers to appropriating county funds or applying for federal grants

for the purpose of community health work as long as the County Council is under Republican control.

This is one example of the many barriers to procuring funding for new community-based health initiatives. Community health work attempts to serve all, regardless of race, socioeconomic status, neighborhood, or political party, and as a result is not partisan, and erroneously viewing it as such undermines the common good, which should be the ultimate goal of all government officials. Turning the acceptance of federal grants for CHWs into a political conversation hurts vulnerable communities and prohibits holistic healthcare reform, and therefore should be admonished by party officials on both sides of the aisle. Love for our neighbors should always be above political influence.

Regardless of funding source, health officials of all political views should be able to support programs which decrease costs and improve quality of life in the communities they serve. As already shown, adequate social support leads to large return on investment and significantly decreases healthcare costs overall, creating a financial incentive in addition to the incentives related to patient well-being and quality of care. Therefore, the importance of social support in clinical healthcare settings is an interdisciplinary reality that should be addressed as healthcare reform is considered. In the remainder of this paper, I will explore the theological obligation to holistic healthcare and provide a proposal for the integration of social services into the clinic for primary care coordination.

Judge

Healthcare, especially the holistic kind of healthcare that I am advocating for, is deeply connected to many principles of Catholic social teaching. For the interest of brevity, I will focus on the principles named by the US Conference of Catholic Bishops:

> The nation's healthcare system needs to be rooted in values that respect human dignity, protect human life, respect the principle of subsidiarity, and meet the needs of the poor and uninsured, especially born and unborn children, pregnant women, immigrants, and other vulnerable populations. [17, no. 80]

Human dignity, subsidiarity, and the preferential option for the poor are helpful principles for guiding medical care decisions and structures, and similarly helpful (and necessary) for expanding existing healthcare structures to include social support.

The foremost principle of Catholic Social Teaching (CST) is the dignity of the human person, which "anchors the Catholic commitment to defend human life, from conception until natural death, in the fundamental moral obligation to respect the dignity of every person as a child of God." [17] Access to quality healthcare is integral to any conversation of life issues, and as such, provision of adequate healthcare to all has been included in conversations of human dignity since the beginning of CST. Pope Leo XIII advocated for the protection of the health of workers, setting a foundation expanded upon by Pope Pius XI when he called health a sacred right stemming from every person's inherent dignity. [RN 40, QA 28] The connections made in these sources are based on the necessity of health for participation: a sick person is unable to work, worship, or support their family, all of which are imperative to maintaining dignity. Such a

view of health prioritizes health maintenance and primary care in order to prevent disease and its accompanying debilitation.

In *Pacem in Terris,* Pope John XXIII explicitly connected the right to healthcare to social needs, stating that every person "has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, *medical care*, rest, and, finally, *the necessary social services*." [PT 11, italics mine] This connection emphasizes the interdependence of health and social status in the protection of dignity: while both adequate healthcare and social support are necessary, neither are solely sufficient. Here, CST begins to take a more holistic view of human health, which is reflected in larger society as well. The World Health Organization currently defines health as "a state of complete physical, mental and social well-being and not just the absence of unhealth." [17] Accepting healthcare as a human right and as a necessary step to promote the dignity of all requires integration of holistic definitions like these into healthcare structures, and extend the importance of eliminating social structures which outside of the clinical healthcare realm that undermine human dignity in addressing the root causes of health inequality.

The second principle mentioned by the USCCB is subsidiarity, a principle which broadly calls for responsibility to be left in the hands of the individual or community to the greatest extent possible. [QA 79-80] Agency and governance are best performed by the smallest possible spheres of influence because "those nearest to a given problem or conflict are most familiar with it and also are most apt and able to respond," traditionally referring to those living or working within a certain community, who undoubtedly have both experience with the problem(s) at hand and a vested interest in finding solutions. [18] The benefit to promoting and allowing for local participation is two-fold: not only does it give more individuals a seat at the table, effectively

promoting the realization of dignity of all members of a community, especially those traditionally marginalized or forgotten at higher levels of order, but also creates more effective solutions.

Subsidiarity is traditionally expressed in medicine when states assume control of nationwide health initiatives, such as Medicaid, or when patients are given agency in their treatment decisions; with the physician shortage of recent years, however, there is the need for much greater realization of subsidiarity in the healthcare space, in which CHWs can play a large role. County and state public health efforts have begun to reflect this need, taking nationwide programs and enacting them on a smaller scale in response to the unique needs of their community. One local example would be the Lead Safe South Bend initiative, which is run by CHWs and addresses the particularly high percentage of homes within certain South Bend census tracts with improper lead paint remediation. The initiative, which is run by CHWs, works in partnership with many community organizations to educate the community, test children and homes for lead, and make necessary home repairs at no cost to affected families. The huge positive implications of preventing pediatric lead exposure illustrates the role of CHWs and community-driven public health in the protection of long term health and wellbeing. There are many other examples of such initiatives in communities throughout the US, emphasizing the positive role of subsidiarity in healthcare reform.

Subsidiarity is closely connected to a third principle of CST, solidarity, which prioritizes relationships in the search for the common good, and "challenges everyone to recognize all the ways that people are linked together and to strengthen the bonds that promote the good of all." [19] A state that successfully promotes subsidiarity "combines spontaneity with closeness to those in need," and is capable of "guaranteeing the very thing which the suffering person - every

person - needs; namely, loving personal concern." [DCE 28] Personal encounter and relationship are central to our existence as a human family, and acknowledgement of the necessity of relationships in solidarity manifests itself as accompaniment.

The use of CHWs supports both subsidiarity and solidarity as it returns a certain level of social support to the community and provides personal accompaniment. Educating and training community members so that they are able to provide social services and support to patients both inside and outside of the clinic environment provides those closest to poverty and marginalization a seat at the table and the space to speak up for their neighbors who may not be able to advocate for themselves. The relationships that are built through intimate advocacy is the realization of true accompaniment, where CHWs walk alongside patients to empower them to take control of their own health decisions and social needs. When the effects of accompaniment, and accordingly subsidiarity and solidarity, ripples out through the community, the power that was placed into the hands of CHWs ripples out as well, endowing vulnerable communities with more power on the whole.

Because of their far-reaching effect, CHWs are able to raise up the entire community, promoting the common good. The common good is described as "good that comes into existence in a community of solidarity among active, equal agents," [20] going beyond solidarity as individual accompaniment to include community development goals, a connection that Pope Francis emphasizes: "The more we strive to secure a common good corresponding to the real needs of our neighbors, the more effectively we love them." [CV 6/7] Solidarity becomes complete when we are working for the common good, as CHWs do when they raise up their communities. In connecting their neighbors to social welfare programs, accompanying them through the healthcare system, providing health education, and building relationships and

community identity, CHWs are capable of aiding the most vulnerable to the benefit of our entire society.

The final principle elucidated by the USCCB is the preferential option for the poor and vulnerable. Early CST documents alluded to the need for priority to be given to protecting the well-being of the poor and powerless, but more explicit language of such an obligation did not arise until after the Second Vatican Council. Reflecting on the social implications of the theme of a preferential option for the poor in the Gospels, *Justice for the World* (1971) developed a conception of justice as liberation from oppression and directed the Church's advocacy toward the poor and vulnerable. [no. 30] Liberation theologists in Latin America expanded this concept of injustice to acknowledge the social and economic structures - "structures of sin" - that oppress people living in poverty and perpetuate a cycle of marginalization that the Church should work to remedy. [CELAM 1968, CCC 1896] The option for the poor, which intends to end "structural sin that produces dehumanization of the poor," is preferential because it acknowledges the unequal experience of oppression at the hands of existing social structures. [21] The option for the poor has been since developed extensively by the USCCB, particularly in reference to the patterns of oppression experienced by groups within the United States, and culminated in their Catholic Campaign for Human Development. Today, America is plagued by social and economic inequality, and a preferential option for the poor can serve as a guiding principle for contemporary social justice efforts.

The large effect of social determinants on health outcomes is a prime example of the dangers of structures of sin. Environmental and social effects of living in poverty or other states of discrimination strongly predict negative lifetime health outcomes for an individual, directly affecting ability to fulfill the social roles required for social and economic success in our country.

Given the holistic nature of health, medicine is not exempt from participating in the promotion of social justice necessary for remediation. The initial development of large urban hospitals recognized this reality, as churches provided medical care to patients without familial caretakers, in a time when most medical care occurred at home and necessitated round-the-clock assistance from family members. Today, the commercialization of healthcare has caused the field to lose touch with its roots in social justice, and the poor are disproportionately deprived of access to preventative and emergent care. Therefore, healthcare reform that places equity at the forefront requires a preferential option for the poor and vulnerable.

CHWs programs are a step in the right direction, as they primarily serve medically underserved or otherwise vulnerable populations, whether that be low-income or predominantly minority neighborhoods, migrant or refugee communities, the unhoused, the impoverished, or other vulnerable demographics. CST teaches us that these communities not only deserve the best care possible - which they are not receiving, but that is an issue for another proposal - but also require further assistance than more privileged communities in order to fully realize their dignity, due to the structures of sin preventing them from full participation. The structures that are keeping the poor and vulnerable from economic success are the same structures that are preventing those communities from maintaining or bettering their health, giving the healthcare community the responsibility to intervene. CHWs are one possible intervention that specifically addresses the holistic needs of vulnerable communities.

The unique health needs of impoverished communities are reflected in the large negative effect of SDHs on long-term health. No matter how good or frequent a person's access to medical care is, poor social circumstances will prevent them from ever being truly healthy, in the same way that an undiagnosed chronic condition would wreak havoc despite the intervention of

well-meaning medical professionals. We provide endocrinologists to those suffering from diabetes, cardiologists to those with a history of heart attacks, and oncologists to those battling cancer, readily employing specialists to address the unique needs of each of these patient groups. In the same breath, surely we can provide social health specialists to the poor in their time of need.

Act

In order to respond to the call for a preferential option for the poor, and to more fully care for the health of our neighbors, healthcare must address all aspects of health, including social health. Community health workers have been used on the small scale in the United States to address the social and relational needs of patients, but despite their global success and large potential domestic impact, CHW programs have been slow to gain traction in the clinical healthcare space in the US. Therefore, first and foremost, I advocate for an increase in utilization of CHWs in clinics serving underserved or otherwise vulnerable communities. These personnel have been shown to have positive effects on patient outcomes and healthcare costs and therefore satisfy both humanistic and economic motives for healthcare reform, and can best provide for the complex needs of socially vulnerable patients both in and out of the clinic, providing a holistic preferential option for the poor in healthcare. The financial barriers that have historically prevented the growth of the CHW workforce are being broken down by increased Medicaid reimbursement and federal grant funding, meaning that the benefits of CHW programs can be provided to more communities across the country, if clinics and local health governing boards are willing to build them. Thus, informed by my personal experience and observations, I believe that wide availability and proper compensation of CHWs is the next step in ensuring proper care and accompaniment is provided to vulnerable and underserved communities.

After commitment to development of a CHW program, there is little to no guidance or industry standard regarding the logistics and organization of such a program. The range of CHW duties in existing domestic programs is wide and poorly defined, and it is a foreseeable struggle that healthcare systems would struggle to determine which model would be the best for their

community. Recognizing this struggle, the second and main part of my proposal concerns the specific model for introduction of CHWs into the clinic setting.

I advocate for the combination of the community health worker and patient navigator roles in order to promote accompaniment and place social support within a primary healthcare team. Patient navigators play a vital role in the clinic to begin to address social determinants of health, but generally lack the community trust, cultural competence, and potential for accompaniment intrinsic to community health workers. Conversely, community health workers are not given the training or space within primary care teams to make the same kind of impact as patient navigators. Expansion of the roles, responsibilities, and training of the CHW beyond health education and routine screenings, or a commitment to hire PNs from the community and reduce their patient load, are both courses of action that satisfy this proposal. For the rest of this paper, I will refer to this combined professional as a CHW in order to provide continuity with the literature and emphasize the importance of community identity in the proposed role.

In designing a professional role aimed at promoting effective care coordination, we can learn from the accompaniment approach taken by Partners in Health, which works best when:

1. CHWs are professional members of care delivery team
2. CHWs are positioned within the care team, not as islands
3. CHW program budgets make room for community work, not health work alone, and assign manageable patient ratios [22]

The first standard promotes a change in industry-wide standards for CHWs. While I have been emphasizing the importance of their identity as community members, it is vital that CHWs be given the professional respect, training, and pay to support a full-time position. As previously mentioned, private grant funding for full-time employees in these roles has been the more

popular form of funding among federally qualified community health centers (FQHCs) currently utilizing CHWs. Recent changes in Medicaid and Medicare reimbursement for social support services and federal grant funding, however, make proper funding a possibility for smaller health centers and communities. While cost will continue to be a significant hurdle, the great benefits CHW programs can provide to vulnerable communities go beyond any financial barriers. As CHW programs are established and become more integral to long-term clinic operations, the cost-cutting potential of these positions will become much more important as they will reduce costs of both operations and services.

My personal experience at TRHS addressed the second standard, emphasizing the added value to having CHWs located within the clinic. Not only does this central physical location inextricably connect clinical healthcare and social support, it legitimizes the role of CHWs as healthcare providers. Having an office, a patient list, and the privacy and autonomy typically afforded to providers gives the CHWs an adequate space on the care team, emphasizing their important role for skeptical doctors, nurses, or patients. The sheer proximity of community members will also increase the cultural competency of the entire care team through personal and professional encounters. As a legitimate healthcare provider and member of the care team, the CHW has the professional authority and personal relationship to educate their coworkers on the cultural and community needs of the patient population in a way that a patient cannot, effectively serving as a built-in patient advocate in addition to their other roles. Furthermore, the convenience of housing the whole primary care team under the same roof positively affects both patients and providers. Patients have the convenience of a centralized location for all of their primary care needs, especially helping those who struggle with reliable transportation, while care coordination among the team is greatly facilitated by the shared space. The physical location and

professional legitimacy of CHWs in the clinic allows primary care to be more effective and holistic, addressing both clinical and social health needs within the walls of a clinic.

The third standard concerns a problem with the distinction between the CHW and the PN. The PN's location in the clinic and their subsequent proximity to other healthcare services allow them to make an overwhelmingly positive impact on patients; however, the extent of their assistance is sometimes limited by an inability to venture outside of the clinic. At TRHS, familiarity with the PN led many patients to start requesting more from their providers, like calling personal numbers outside of office hours and asking for home visits. PNs that responded to these personal, relational requests were reprimanded by their superiors for doing so, not out of malicious intent for the patients, but in order to enforce respect for the PN's time and professional responsibilities. House calls, for example, are outside the scope of the role and take a significant amount of time out of a PN's day, preventing them from seeing their long list of other patients in the clinic. These professionals simply did not have the time to give their patients the support they needed.

CHWs, on the other hand, are better able to meet extra-clinical needs. They tend to have a smaller patient list, perform more home visits, and provide specific cultural and personal support easily due to their proximity to the community. That is not to say that the CHW role is perfect - their typical placement is reserved for distinct cultural neighborhoods or in places with few healthcare providers in close proximity, and they are typically responsible for providing health education or assisting with chronic disease management. As a result, CHWs are much more prevalent in rural areas than suburban or urban areas, and their potential for other supportive roles, like navigation services, is ignored.

Much of the difficulty in expanding the PN role comes from hiring professionals from outside the patient community and tasking them with too many patients, two issues that are not present in the traditional CHW model. Therefore, I propose a care coordination model built upon both roles, prioritizing individual accompaniment. Clinics should prioritize hiring CHWs from the community they serve, giving them adequate space on the clinical care team inside the walls of the clinic, and maintaining a workforce large enough to provide individualized support. A combined CHW/PN experiences the benefits of proximity to other primary care providers and has the training to provide a wide range of navigation services, while also providing the cultural and community competence and accompaniment that is central to the CHW role. In short, this model remedies the shortcomings of each individual role while preserving the benefits of both.

A CHW program that prioritizes accompaniment both in and out of the clinic is beneficial for any patient community, in any geographic location or serving any demographic, as long as the professional is themselves a member of the community being served. Iterations of such a proposal should be expected to vary slightly, but the importance of identity and personal accompaniment makes the model both general and specific, and gives it the potential to guide a wide variety of health centers in their journey toward the development of effective community support programs aligned with the clinic.

The costs of this model are large, and any manifestation of this plan that lessened quality of care as a result would be counterintuitive, especially since the intention of my proposal is to better quality of care and patient outcomes. In the short term, instigating new programs is an expensive and bold endeavor for clinics; however, doing so will significantly increase the social and physical health of the community in the long term while decreasing healthcare expenditures, as I’ve previously shown. Holistic accompaniment within the healthcare space also adheres to

CST principles of solidarity and human dignity, providing a preferential option for the poor by recognizing the extent of inequitable burdens. At this point in American healthcare reform, CHWs are in a unique position to better the lives of vulnerable patients by taking steps to remedy the social determinants of health present in their lives, and ensure a healthier future for the next generation of our country.

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