

A Managed Care Organization's Call Center–Based Social Support Role

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ABSTRACT

OBJECTIVES: We described the social support provided by CommUnity Liaisons, a layperson role that addresses participants' unmet social needs with linkages to community resources. The call center–based role operates within HealthConnections, a managed care organization's program responsible for developing a nationwide network of local community-based social service organizations.

STUDY DESIGN: We utilized an explanatory case study approach to describe a new health layperson role.

METHODS: Multiple evidentiary sources, including in-depth interviews, training documents, and program data, enabled analysis of the application of the CommUnity Liaison role to social support theory within a logic model framework.

RESULTS: To alleviate the impacts of stress on participant health, the call center–based program created a social support layperson role. Consistent with social support theory, CommUnity Liaisons' experiences enabled them to match participants' unmet social needs with community resources not covered by their insurance benefits. Social service referrals most commonly included patient and family support, transportation, and housing assistance.

CONCLUSIONS: This study's results demonstrated the feasibility of managed care organizations to address social determinants of health using a social support layperson role. Future study should investigate whether this form of social support protects population health and reduces healthcare spending.

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The presence of stress is related to increased morbidity and mortality,^{1,2} whereas social support from a person's network, such as family, friends, and valued peers, may protect their health.³⁻⁶ A majority of physicians acknowledge that unmet social needs contribute to poor health outcomes, but most report a lack of time during the clinical appointment to address patients' social needs in addition to their medical needs.⁷ They also may be unwilling or unable to address patients' social determinants of health.^{8,9} Garg et al have suggested that when providers screen for issues, such as food insecurity, unemployment, and interpersonal violence, without the capacity to link to community resources, their effort becomes "ineffective and, arguably, unethical."¹⁰

To more effectively address unmet social needs, most physicians want social service coordination to be funded by payers, such as managed care organizations (MCOs).⁷ Alternative social support roles have been introduced by MCOs but have not been formally studied. Existing literature describes layperson roles that leverage the advantages of social support to improve the delivery of medical care.¹¹ These individuals, such as community health workers,^{12,13} care guides,^{14,15} and lay navigators,¹⁶ seek to achieve patient-specific clinical goals by improving access to social services, such as transportation, food, and housing.

This study describes the new social support role, CommUnity Liaisons, developed by WellCare Health Plans, an MCO based in Tampa, Florida, that serves Medicaid and Medicare beneficiaries nationwide.¹⁷ WellCare established HealthConnections to improve

plan members' health and reduce unnecessary healthcare services utilization. The program comprises multiple operational components, including CommUnity Liaisons who make referrals to social service organizations. Other program elements include a research team that identifies local community resources, a field-based community relations team, an outbound call team that confirms referral access, and an analytics team. According to Carman and McGladrey,¹⁸ HealthConnections acts as a public health facilitator by identifying gaps between needs and services in the community, encouraging collaboration among community health stakeholders, and expanding local public health and social services capacity.

Since September 2014, participants with unmet social needs have contacted a call center to obtain free referrals to a nationwide network of local community-based public assistance programs. The social services have been provided to participants outside of the health plan benefits package. The call center, called the CommUnity Assistance Line, is available through a toll-free number or video link on weekdays from 9 AM to 6 PM Eastern Standard Time. Participants learn of the referral program through numerous sources, including the MCO customer service and case management units, member materials (eg, provider directories), advertisements, and healthcare service providers. CommUnity Liaisons support all participants, including members, family, and other individuals unaffiliated with the MCO.

The present case study investigated the role of the CommUnity Liaison at a single MCO.¹⁹ Consistent with social support theory constructs, we posited that CommUnity Liaisons supported individuals who faced stressful circumstances and needed information about community resources.^{5,6} In addition, we expected that CommUnity Liaisons would provide informational and emotional support, both enabled by personal experiences with the social services system.²⁰

METHODS

Case study research enables descriptions of the characteristics, patterns, structures, or processes of individuals or complex systems.¹⁹ A case study protocol, including propositions related to social support theory, logic linking the evidence to the propositions, an analytical approach, and criteria for interpretation, was developed to guide this investigation. According to social support theory, interactions with similar and valued peers can be protective of individuals' health in times of stress.^{5,6} Four types of social support are distinguished in the literature: emotional, instrumental, informational, and appraisal.⁴ The 5 propositions related to social support theory advanced by Cohen and Wills,⁵ Hogan et al,³ Thoits,²⁰ and House et al²¹ were: 1) participants sought informational support from CommUnity Liaisons; 2) a CommUnity Liaison's main goal was to provide informational support through advice, suggestions, and information that participants could use to address their problems; 3) CommUnity Liaison

interventions provided emotional support conveyed through empathy, love, trust, and caring; 4) participants contacted the CommUnity Assistance Line because they experienced adversity; and 5) CommUnity Liaisons' life experiences enabled empathic understanding and delivery of tailored information.

In-depth interviews with CommUnity Liaisons and managers of the program were conducted by researchers using semi-structured interview instruments, provided in eAppendix 1 [eAppendices available at ajmc.com]. The questionnaires consisted of 26 questions for CommUnity Liaisons and 28 questions for program managers. The interviews were organized using a logic model that enabled systematic review of the CommUnity Liaison role.²² The Figure describes the logic model used for the evaluation. Using purposeful sampling, 9 study participants were selected by a HealthConnections administrative staff member from the total of 28 CommUnity Liaisons. Each of HealthConnections' 4 managers were interviewed. All interviews were conducted in December 2016 at the MCO headquarters. Additional information supplied by the MCO included number of referrals given, number of referrals accessed, call statistics, and training materials.

The analytic strategy of the interviews involved 3 key steps: 1) transcription, 2) analysis, and 3) interpretation. After the audio-recorded interviews were transcribed, responses were coded by multiple researchers. These coded responses then were categorized according to theoretical propositions, and patterns of responses were analyzed. We interpreted the explanatory evidence according to consistency with the 5 social support theory-based propositions.¹⁹

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Figure. Evaluation Logic Model

Inputs: Resources supporting the CommUnity Liaisons, including training, software, and promotional efforts.
Activities: How CommUnity Liaisons use resources to achieve intended program results, including the content of the calls.
Outputs: Direct products of CommUnity Liaison activities, including how referrals are delivered.
Outcomes: Specific changes in participants' behavior, knowledge, skills, and status in the short term, including types of social support provided to the participant.
Impact: The fundamental intended or unintended change occurring in the organization, communities, or healthcare delivery system as a result of program activities.

RESULTS

Interviews revealed that CommUnity Liaisons mostly worked part time in the call center and were recruited through a variety of sources, including the state vocational rehabilitation agency, recruitment

Table 1. Functions of CommUnity Liaisons and Other Layperson Roles

	CommUnity Liaisons	Community Health Workers ^{12,13}	Care Guides ^{14,15}	Lay Navigators ¹⁶
Coordinate medical care and improve communication with medical providers		X	X	X
Patient-specific clinical health goal orientation (eg, drug adherence)		X	X	X
Deliver health education, literacy, and coaching		X		X
Provide limited medical care (eg, screenings, first aid, in-home visits)		X		
Engaged only through a defined set of health services (eg, cancer treatment)				X
Peers offer social support derived from similar life experiences	X	X	X	
Build individual and community capacity to address social determinants of health	X	X		
Provide services in response to a broad array of stressful life circumstances	X			

firms specializing in employment for people with disabilities, and the MCO's employment website. Many CommUnity Liaisons had a variety of disabilities, including deafness and physical limitations. The ideal qualities of a CommUnity Liaison included being empathetic, engaging, and investigatory and having similar "lived experiences" as participants. Required skills included interpersonal communication, computer aptitude, and knowledge of social service programs. CommUnity Liaisons completed 2 weeks of training, including education on compliance, software, motivational interviewing, observational learning, and mock calls. **Table 1**¹²⁻¹⁶ identifies distinguishing functions of the CommUnity Liaison role and other layperson roles.

CommUnity Liaisons utilized an extensive software suite that allowed them to locate more than 160,000 community resources in a database, identify service gaps in the local social services network, and manage referrals. The liaisons entered referral information into a dedicated "social services electronic health record" accessible by the liaisons and other MCO employees, such as nurse case managers. CommUnity Liaisons delivered referrals in 10 languages, including American Sign Language. Participants were responsible for making contact with the community organization directly. **Table 2** indicates the most common types of social services that received referrals in 2016. The services were categorized consistent with the Nonprofit Program Classification System taxonomy developed for tax-exempt organizations by the National Center for Charitable Statistics.²³ **Table 3** shows the descriptive statistics of the CommUnity Assistance Line in 2016.

The following quotes were selected from the in-depth interviews as they related to the 5 social support theory propositions:

Table 2. Social Service Referral Categories

Social Service Type	Example	Proportion of Referrals
Patient and family support	Medical expense assistance or Area Agency on Aging services	25%
Transportation	Free or low-cost transportation to doctor	20%
Housing	Expense assistance for rent	18%
Personal goods and social services	Provision of clothes or hygiene products to an individual and/or their family	15%
Food	A food pantry that provides canned goods	13%
Patient care and healthcare delivery	Services that supply medical cost assistance and/or medical equipment to patient	6%
Other	Family violence prevention or general advocacy support	3%

Proposition 1. Participants sought informational support from CommUnity Liaisons. Each of the respondents confirmed that participants sought informational support:

"We exist as an informational resource for what [social services] they can access in their communities."

One respondent cited advice on social services as a reason participants called the CommUnity Assistance Line:

"[Participants] don't know how to navigate the social service arena to get help. So, they're looking for someone to guide them through that process."

Table 3. CommUnity Assistance Line 2016 Statistics

Description	Amount
Number of participants	11,768
Number of participant contacts	13,975
Mean (SD) contact duration in minutes	14:42 (8:42)
Mean (SD) referrals per participant	2.62 (1.92)
Total number of referrals distributed	34,178
Total number of social services accessed	10,367

Proposition 2. A CommUnity Liaison’s main goal was to provide informational support through advice, suggestions, and information that participants could use to address their problems. All interviews with CommUnity Liaisons and CommUnity Assistance Line management confirmed this proposition. A CommUnity Liaison stated that the CommUnity Assistance Line’s purpose was to:

“... share knowledge and to empower people to be able to find help and to let them know that there may be help out there and it just may not be common knowledge.”

The information could be used to support participants’ medical and social needs:

“I love sharing information. People that don’t realize that there are a lot of different types of assistance programs out there, they may think, ‘Oh, I didn’t think of getting help for my utility bill to be able to pay for this surgery I’m supposed to get ... or going to [a] food pantry and getting food, and then the money I would have spent on that food I can put toward this bill.’”

CommUnity Liaisons addressed more than 1 need:

“Even if they just call in for 1 issue, our [CommUnity Liaisons] are so good that they say, like, ‘Okay, is there anything else going on? Anything else we need to talk about? Okay, you need transportation to the grocery store or the pharmacy?’”

Proposition 3. CommUnity Liaison interventions provided emotional support conveyed through empathy, love, trust, and caring. We found inconsistent evidence regarding the CommUnity Liaisons’ delivery of emotional support. Only 7 of the 13 respondents described providing emotional support to participants. One of the 7 respondents acknowledged that emotional support was a precondition of delivering informational support:

“In the beginning of the call, they sound very disheartened ... and embarrassed for asking for assistance. And then by the end of the call, typically their attitude changes, their tone of voice changes. And it’s just providing the information for them to be able to help themselves. It’s tremendous! I think that’s better than just giving assistance.”

Again, although most respondents did not report providing emotional support, a CommUnity Liaison suggested that participants’ emotional needs must be met before providing informational support: *“Sometimes when they call, they’re emotional. So, on our end, we have to find out the proper cause, and to bring them emotionally down, and see how we can help them.”*

According to another CommUnity Liaison, healthcare providers often lacked the time to support participants’ unmet social needs:

“They call up, and they’ll give me a whole story about everything that’s gone wrong in their life. They only need 1 thing that I could probably give [to them] in 5 minutes and get them on their way, but they just want somebody who’ll listen to all that. Because doctors are limited in time, nurses are limited in time, social workers are limited in time.”

Proposition 4. Participants contacted the CommUnity Assistance Line because they experienced adversity. All respondents reported that adverse circumstances in the participants’ lives caused them to contact the CommUnity Assistance Line:

“It’s any number of life circumstances—they’ve lost their job, their hours were cut at their job, their lease ended and their landlord is increasing their rent by 25%, they’re going through a divorce, or they got into a car accident.”

Financial needs often caused individuals to contact the CommUnity Assistance Line:

“When I say crisis, I mean emergency help. Most likely it’s financial assistance. They need help with their rent and utility and water bills.”

A CommUnity Liaison articulated the impact of stressful events on participants’ health behaviors:

“They’re more worried about putting food on the table and keeping the electric on than they are going to a doctor’s office.”

Proposition 5. CommUnity Liaisons’ life experiences enabled empathic understanding and delivery of tailored information.

The evidence supporting this proposition was mixed. In all cases, CommUnity Liaisons had involvement with social services through either previous training or personal experience. Most CommUnity Liaisons who were hired at the beginning of the CommUnity Assistance Line’s operation were recruited from vocational rehabilitation services or other recruitment firms specializing in supporting nontraditional workers:

“Actually, I’m disabled. I went to vocational rehab to find information on how to help myself with my financial need and with my medical need and stuff like that. They gave me a job coach, and from the job coach ... that’s how I learned about [the CommUnity Assistance Line].”

Specific experiences with certain services led some CommUnity Liaisons to recommend those services:

“For example, if you have transportation [benefits], it’s limited; some people have 12 rides for the year, some people have 24. It depends on their benefits. So after they access all of their rides, they will come to us for assistance. Then we check personally. If I don’t like something, I don’t give it to no one. So I usually use the paratransit door-to-door services that I use, and I know they provide good services.”

In one instance, a CommUnity Liaison could offer social support based on a disease-specific experience and the government benefits related to that illness:

“I learned of [this job] through vocational rehab, because I had a [serious illness]. Then [when I became a CommUnity Liaison], I talked to somebody who has had [the same serious illness], but they lost their job because they couldn’t do it anymore. Then they had no income... It took me like 2-and-a-half years to get Social Security income coming in.”

However, as the program evolved, the CommUnity Assistance Line management started an alternative recruiting approach to rapidly expand the call center. As of 2016, fewer recently hired CommUnity Liaisons had received social services. Individuals seeking part-time and flexible employment, such as students, caregivers, or veterans, joined the staff as CommUnity Liaisons. Although not exclusively disabled, these employees demonstrated familiarity with the social service system and the ability to empathize with the participants. Some of these CommUnity Liaisons used early life experiences to deliver tailored informational support:

“I have an 86-year-old mother, so I just picture everyone calling is that range or siblings in their 60s. Those are people in need. I grew up in Chicago, and I know poor sections and I know what they need, so I’m just trying to assist them.”

Other CommUnity Liaisons used earlier experiences in their families to provide informational support:

“I never really had to worry about these things, you know, but [I try] to relate to the members, especially people that are cancer patients. I think of people in my family who have had cancer. So it hits at home where you can do this important thing we’re doing.”

DISCUSSION

Clinical care providers may lack the incentive to invest in addressing unmet social needs, especially in the short term,²³ and most seek compensation for any effort associated with connecting patients to needed community programs.⁷ In contrast, MCOs accept financial risk and therefore retain the incentive to build community capacity to address social determinants of health, under the assumption that

social support protects population health³⁻⁶ and reduces health-care spending.¹¹ The HealthConnections initiative, including the CommUnity Assistance Line and CommUnity Liaisons, demonstrated the feasibility of MCOs instituting programs to address social determinants of health.

HealthConnections represents 2 innovations. First, the MCO built a large referral network of local community-based social services organizations, including food banks, housing programs, and transportation. These services, intended to address social determinants of health and reduce preventable healthcare spending, occurred outside of benefits packages and were provided at no cost to consumers and the government. Second, the MCO staffed the call center with laypeople. The creators of HealthConnections recognized that to effectively alleviate the health impacts of stressful life events, participants needed to identify with CommUnity Liaisons as peers.¹ This approach was comparable to social support roles in health services delivery settings, such as community health workers¹² and care guides.^{13,14}

In most circumstances, social support involves a combination of emotional, instrumental, informational, and appraisal support.³ According to the matching hypothesis of the social support theory, effective social support requires that supporters’ advice matches participants’ needs.^{5,19} Participants contacted the CommUnity Assistance Line for social service referrals, and CommUnity Liaisons provided this needed informational support. We found that CommUnity Liaisons inconsistently reported providing emotional support. In the majority of cases, however, respondents acknowledged that emotional support was complementary to informational support. Due to the nature of their stressful life circumstances, participants often needed to be given empathic understanding before accurate community resource information could be delivered.

CommUnity Liaisons did not provide instrumental support, which involves the provision of tangible aid, nor did we find that CommUnity Liaisons directly coordinated medical and social services within the healthcare provider team. Rather, CommUnity Liaisons connected participants to community organizations or internal professionals (ie, nurse case managers) who provided direct assistance. Whereas other layperson roles within clinical care provider systems focus on enabling patients to meet specific clinical health goals, CommUnity Liaisons responded to an array of stressful life circumstances with a variety of community resources. Additionally, CommUnity Liaisons neither delivered health education nor provided limited medical care, which are functions generally associated with the community health worker role.²⁵ CommUnity Liaisons also did not deliver appraisal support, which involves constructive feedback, affirmation, or social comparison.

Limitations

Our study had several limitations. Although the interviewers were independent evaluators of the program, their presence during

in-depth interviews may have affected the subjects' responses to the questions. Also, our case study served to describe a single program and, therefore, has limited generalizability to other social support programs. In addition, the unit analysis of study was limited to CommUnity Liaisons and, thus, the description of HealthConnections and its CommUnity Assistance Line was beyond the scope of this paper. HealthConnections includes other important functions not investigated in the present study, such as field-based CommUnity Advocacy described by Carman and McGladrey,¹⁷ data analytics, social service organization grant making, and outbound satisfaction assessment.

Evidence in the existing literature is mixed regarding the ability of social support interventions to improve primary outcomes, such as morbidity²³ and mortality,³ or secondary outcomes, such as preventable hospitalizations.^{11,25} Future research should evaluate the relationship between participants' access to social services and medical spending and health services utilization. Additional analysis is needed regarding the costs and composition of social services networks in local communities.

CONCLUSIONS

The MCO-based social service referral program represents an alternative approach for coordination of the health system's capacity to link patients to community resources. In implementing a program designed to address unmet social needs, a new social support role was created, the CommUnity Liaison. Similar to policies designed to increase funding opportunities for navigators²⁷ and community health workers,²⁸ future health policy could enhance the health workforce by promoting a role similar to the CommUnity Liaison.

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REFERENCES

1. Thoits PA. Stress, coping, and social support processes: where are we? what's next? *J Health Soc Behav.* 1995;(spec):53-79.
2. Marmot M. Social determinants of health inequalities. *Lancet.* 2005;365(9464):1099-1104. doi: 10.1016/S0140-6736(05)71146-6.
3. Hogan BE, Linden W, Najarian B. Social support interventions: do they work? *Clin Psychol Rev.* 2002;22(3):381-440.
4. House JS. *Work Stress and Social Support.* Reading, MA: Addison-Wesley; 1981.
5. Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. *Psychol Bull.* 1985;98(2):310-357.
6. House JS, Landis KR, Umberson D. Social relationships and health. *Science.* 1988;241(4865):540-545.
7. Fenton M. Health care's blind side: the overlooked connection between social needs and good health. Robert Wood Johnson Foundation website. www.rwjf.org/en/library/research/2011/12/health-care-s-blind-side.html. Published December 2011. Accessed November 16, 2016.
8. Bachrach D, Pfister H, Wallis K, Lipson M. Addressing patients' social needs: an emerging business case for provider investment. The Commonwealth Fund website. commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs. Published May 29, 2014. Accessed January 10, 2017.
9. Community health centers leveraging the social determinants of health. Institute for Alternative Futures website. altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf. Published March 2012. Accessed January 10, 2017.
10. Garg A, Boynton-Jarrett R, Dworkin PH. Avoiding the unintended consequences of screening for social determinants of health. *JAMA.* 2016;316(8):813-814. doi: 10.1001/jama.2016.9282.
11. Shier G, Ginsburg M, Howell J, Volland P, Golden R. Strong social support services, such as transportation and help for caregivers, can lead to lower health care use and costs. *Health Aff (Millwood).* 2013;32(3):544-551. doi: 10.1377/hlthaff.2012.0170.
12. Katigbak C, Van Devanter N, Islam N, Trinh-Shevrin C. Partners in health: a conceptual framework for the role of community health workers in facilitating patients' adoption of healthy behaviors. *Am J Public Health.* 2015;105(5):872-880. doi: 10.2105/AJPH.2014.302411.
13. Cosgrove S, Moore-Monroy M, Jenkins C, et al. Community health workers as an integral strategy in the REACH U.S. program to eliminate health inequities. *Health Promot Pract.* 2014;15(6):795-802. doi: 10.1177/1524839914541442.
14. Wholey DR, White KM, Adair R, Christianson JB, Lee S, Elumba D. Care guides: an examination of occupational conflict and role relationships in primary care. *Health Care Manage Rev.* 2013;38(4):272-283. doi: 10.1097/HMR.0b013e31825f3df9.
15. Adair R, Wholey DR, Christianson J, White KM, Britt H, Lee S. Improving chronic disease care by adding

- laypersons to the primary care team: a parallel randomized trial. *Ann Intern Med.* 2013;159(3):176-184. doi: 10.7326/0003-4819-159-3-201308060-00007.
16. Meade CD, Wells KJ, Arevalo M, et al. Lay navigator model for impacting cancer health disparities. *J Cancer Educ.* 2014;29(3):449-457. doi: 10.1007/s13187-014-0640-z.
17. About us. WellCare Health Plans, Inc, website. wellcare.com/en/Corporate/About-Us. Updated 2017. Accessed January 10, 2017.
18. Carman AL, McGladrey M. Facilitating community health improvement capacity through nongovernmental public health partners. *J Public Health Manag Pract.* 2017;23(5):496-498. doi: 10.1097/PHH.0000000000000480.
19. Yin RK. *Case Study Research: Design and Methods*. 3rd ed. Thousand Oaks, CA: Sage Publications; 2013.
20. Thoits PA. Mechanisms linking social ties and support to physical and mental health. *J Health Soc Behav.* 2011;52(2):145-161. doi: 10.1177/0022146510395592.
21. House JS, Kahn RL, McLeod JD, Williams D. Measures and concepts of social support. In: Cohen S, Syme SL, eds. *Social Support and Health*. New York, NY: Academic Press; 1985:83-108.
22. Anderson LM, Petticrew M, Rehfuess E, et al. Using logic models to capture complexity in systematic reviews. *Res Synth Methods.* 2011;2(1):33-42. doi: 10.1002/jrsm.32.
23. Nonprofit Program Classification (NPC). National Center for Charitable Statistics website. nccs.urban.org/classification/nonprofit-program-classification-npc. Published 2016. Accessed January 30, 2017.
24. Hollenbeak CS, Weiner MG, Turner BJ. Cost-effectiveness of a peer and practice staff support intervention. *Am J Manag Care.* 2014;20(3):253-260.
25. Support for community health workers to increase health access and to reduce health inequities. American Public Health Association website. apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities. Published November 10, 2009. Accessed January 21, 2017.
26. Lewin S, Munabi-Babigumira S, Glenton C, et al. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database Syst Rev.* 2010;(3):CD004015. doi: 10.1002/14651858.CD004015.pub3.
27. Patient Navigator Outreach and Chronic Disease Prevention Act of 2005, HR 1812, 109th Cong, 1st Sess (2005).
28. Patient Protection and Affordable Care Act, HR 3590, 111th Cong, 2nd Sess (2010).