

Catherine Oakar
MPHP 439
26 April 2007

Community Health Workers: Bridging the Gap between Patients and the Health Care System

Outline

- I. Introduction
- II. Community Health Workers/Lay Health Advisors:
 Who they are and what they do
- III. Barriers to healthcare
- IV. History of Lay Helping Programs
- V. Effective Community Health Worker Studies, Interventions, and/or Programs
- VI. Recruitment and Training of CHWs
- VII. Workforce Issues and Barrier to recruitment of CHWs
- VIII. Implementing a Community Health Program
- IX. Conclusion
- X. Additional resources
- XI. References

I. Introduction

The complex healthcare system in the United States seems to be increasingly difficult to navigate, especially for those who are poor, underinsured and uninsured, and/or minorities.

Several intervention programs have evolved that train indigenous community members to serve as links between their communities and their professional health care system (Eng and Young, 1992; University of Arizona, 1998). These lay people, who work in community health, are identified by approximately 35 different titles, making it difficult to delineate the field (Keane et al., 2004). Community health worker (CHW) and lay health advisor (LHA) may be the current terms of choice in the United States; however, countless terms are utilized, including community health advisors, community health aides, peer counselors, lay volunteers (CDC, 1998), natural helpers, paraprofessionals, patient navigators, promotores (primarily used in Latino communities), and outreach workers (Eng, 1997).

CHW/LHA interventions may be useful for a myriad of reasons. Ethnic and racial minority communities have been historically marginalized from the health care system. Lay health advisors have gained recognition as those capable of gaining entry into such communities to promote health. (Brownstein et al.,1992). Because LHAs share the priority population's language, ethnicity, religious beliefs, and social characteristics, the assumption is that they can promote preventive behaviors more effectively than health professionals alone can (Eng & Young, 1992). In addition, LHAs can develop a connection between the health care system and their own community (Eng & Smith, 1995). When agencies recognize the value of lay helping, relations between formal (professional) and informal (community) helping systems can be strengthened. LHA interventions may also be more appropriate than professional-driven approaches for affirming and strengthening a community's own assets to improve health (Bishop et al., 2002). In essence, from their unique position in the community, lay health advisors can: 1) increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages to traditionally underserved populations; 2) reduce costs to both providers and patients by providing preventive services, health education, screening, and early detection of disease and basic emergency care; and 3) improve quality of care by aiding patient-provider communication, facilitating continuity of care (by providing follow-up), and by acting as a patient navigator and advocate within the health care system (Keane, 2004).

II. Community Health Workers/ Lay Health Advisors: Who they are and what they do

No single accepted definition of the lay health advisor exists so there is a broad spectrum of LHA descriptions. Essentially, however, a community health worker is a health professional who applies his or her unique understanding of the experience, language, and/or culture of the populations he or she serves in order to bridge individuals, communities, and health and human services, provide culturally appropriate health education and information, assure people receive the services they need, provide direct services such as informal counseling and social support, and advocate for individual and community needs (MDPH). In terms of whom they target and what their goals are, LHAs can be socially and community focused or they can be more clinically focused. They can integrate both health and social services or concentrate purely on health issues. They may be responsible solely to the community or they may be employed in a health care setting. LHAs may also act purely as volunteers or they may collect a salary (Keane, 2004).

In addition, lay health advisors may be trained formally or may be taught the necessary skills in an informal setting. At the formal end of the continuum is the paraprofessional LHA intervention strategy. These LHAs are extensions of the health service delivery system and perform tasks typically carried out by practitioners, such as translation, transportation, and explanation of procedures and insurance. They are often paid by an agency, and while the paraprofessional LHA has an opportunity for employment and career advancement, the community may suffer as the talents and accountability of the paraprofessional LHA are shifted to the service delivery system (Eng et al., 1997).

At a more informal end of the LHA continuum, natural helper LHAs differ from other types of LHAs in how they carry out their activities. Natural helpers “provide informal spontaneous assistance, which is so much a part of everyday life that its value is often not

recognized” (Israel, 1985). Natural helper interventions intend to tap into a reservoir of natural assistance, spreading health information through normal interactions with friends, family members, and acquaintances. In addition, natural helpers may participate in the same sorts of structured outreach efforts as do other LHAs; however, the assumption is that they will have access to a larger network of existing contacts within the community in conducting their outreach mission. Natural helping LHAs provide a community-based system of care and social support that complements the more specialized functions of health professionals. However, not everyone can be natural helper LHAs. It requires a unique individual who has an already established rapport with the community and a reputation for good judgment, sound advice, and being compassionate and honest (Eng et al., 1997).

In fact, natural helpers are the ideal candidate for the lay health advisor because they may already exemplify some aspects of the LHA role. The lay health advisor concept rests on the premise that such people exist in the community and if trained, they could serve as important providers of health information. This is what is referred to as the *true* lay advisor, a person who is identified by other community people as one who offers help and embodies the culture of the target community (Jackson & Parks, 1997). Overall, however, the lack of definition and recognition of who lay health advisors are has been identified as one barrier to the use of LHAs by the health care delivery system (Witmer et al., 1995). This obstacle is certainly one that needs to be addressed if lay health advisors are to be at all effective in improving access to health care, especially for those who are medically underserved.

III. Barriers to Healthcare

Poverty, limited English skills, lack of health insurance, unemployment, immigration and refugee status, homelessness, and an inability to access transportation are among the main obstacles keeping some individuals and families from receiving the health care and services they need. In addition, however, according to the Institute of Medicine's report, *Unequal Treatment: What Healthcare Providers Need to Know about Racial and Ethnic Disparities in Healthcare*, racial and ethnic minorities receive lower quality healthcare than whites, even when they are insured to the same degree and when other healthcare access-related factors (such as ability to pay for care), are the same. Patients vary in help-seeking behavior and some racial and ethnic minorities may be more likely than whites to avoid or delay seeking care, perhaps because of a general mistrust of health care providers, negative experiences in the clinical encounter, or a perception that their doctor is not invested in their care. Cultural competence may be lacking in the health care field, as cross-cultural education is increasingly being implemented to promote cultural sensitivity, knowledge, and skills to improve health professionals' awareness of how cultural and social factor influence healthcare. The combination of these socioeconomic, cultural, clinical, and systemic barriers leaves a large gap between patients and the healthcare system and the need for a bridge between the two.

IV. History of Lay Helping Programs

The concept of community members as active health advocates and healers is a familiar one around the world. Numerous cultures worldwide have different types of a lay health care system that is comprised of natural health aides- community members to whom neighbors consult for health advice (Centers for Disease Control, 2004). The first systematic use of community health workers arose in China. After the Chinese Revolution of 1949, Mao Tse Tung

established the Barefoot Doctor Program, a program where workers brought basic health care to rural populations and addressed issues such as nutrition, vaccinations, and sanitation (Love & Gardner, 1992).

The oldest and largest community health worker program in the United States is the Community Health Representative Program, established in 1968 to address the needs of American Indian tribes. The role of the CHW was reemphasized internationally during the Alma Ata conference in 1978. The conference, which called for “health for all by the year 2000,” emphasized the role of CHWs as “one of the cornerstones of comprehensive health care.” (Bhattacharyya et al., 2001; Keane, 2004).

Lay health advisor programs in the United States, like the CHRP program, prior to the 1970s, were based on the concept of community health worker, health aide, or outreach worker. They focused mainly on health care access, services, and delivery. Lay health advisor programs initiated in the 1970s followed the “natural helper” perspective in their use of community members (Salber, 1979; Hatch, 1980). One of the first fully documented LHA programs in the United States was the Community Health Education Program (CHEP), initiated by the Department of Community and Family Medicine at the Duke University Medical Center in 1973. Implemented in two predominantly African American communities, the CHEP model provided one of the original frameworks for recruitment and training in U.S. LHA programs. Presently, many programs still employ CHEP methods of recruitment and training community health advisors.

Recently, the concept of patient navigation has become the latest approach endorsed by the National Cancer Institute (NCI) to engage underserved populations in more timely cancer treatment. As defined in the Patient Navigator Outreach and Chronic Disease Prevention Act

signed into law in June 2005, patient navigation refers to using lay members of the community or other health professionals to guide and support the medically underserved with obtaining screening, information about treatment options and preventive behaviors, and timely medical care for chronic diseases. It offers assistance to healthcare consumers (patients, survivors, families, and caregivers) in charting a course through the healthcare system and therefore gaining access to quality care. Harold Freeman, MD, director of NCI's Center to Reduce Cancer Health Disparities (CRCHD) and medical director/founder of the Ralph Lauren Center for Cancer Care and Prevention in Harlem, New York, pioneered the concept of patient navigation while he was director of surgery at Harlem Hospital in New York City (Lieberman et. al., 2002; Freeman et. al., 1995). According to NCI's definition, navigation spans the period from an abnormal finding through necessary diagnostic tests to completion of cancer treatment. This is referred to as clinical navigation (NCI press release 4/18/05), a concept that emerged at the Lauren Center. Clinical navigation is part of a Breast Health Patient Navigator Resource Kit© launched in 2002 as a demonstration project by the Healthcare Association of New York State to assist hospitals with starting navigator programs.

While the navigator model has focused on cancer, previous studies have illustrated that lay health advisors effectively deliver an individualized health intervention that serves a role in many types of cancer, but also in HIV/AIDS interventions, control of hypertension, heart disease and stroke (Brownstein et al., 2005), lead poisoning (Kegler et al., 2004), reducing farmworker pesticide exposure (Arcury 2005). LHAs also provide navigation through the health care system, offer social support and social networking for patients, (Brownstein et. al., 1992), and serve as a link between community members and the medical care system through outreach, education, information dissemination, and in some cases, system navigation (Love et. al., 1997).

V. Effective Community Health Worker Studies, Interventions, and/or Programs

Asthma

As part of their community action plan, Allies Againsts Asthma coalitions employ community health worker (CHW) programs. The programs utilize CHWs to provide community-based education and/or outreach to community members, utilizing face-toface interventions. Coalitions utilize one-on-one, home-based interactions between a CHW and a family whose child(ren) has asthma and/or provide one-on-one guidance and education in community settings, such as schools and health fairs. Often CHWs identify and recruit families of children, conducting door-to-door surveys of residents or independent interviews to identify potential participants. However, families are also referred from external sources, such as clinicians, schools, emergency departments, and managed care organizations. They may also be identified by use of clinical records such as billing data, chart review, provider reports, and/or registries that indicate children with poorly controlled asthma, persistent asthma, and/or no asthma education.

CHWs focus not only on recruitment, but education, environmental trigger reduction, care coordination, building relationships, and family empowerment. They act as an extension of the clinician, providing education in a family-friendly setting, context, and place. CHWs ensure that the meeting location is convenient for the families, and offer the time and support that physicians and nurses often cannot. Families learn about basic asthma self-management education, rationale for daily medication use, recognition of signs and symptoms, appropriate use of equipment such as inhalers and spacers, and recognition and avoidance of asthma triggers. CHWs provide resources to families to reduce environmental triggers such as pillow and

mattress covers, asthma-friendly cleaning kids, and low-emission vacuum cleaners. Because many families live in rented homes, Allies CHWs often must address environmental issues through property owners and/or landlords.

To coordinate care, the CHW often facilitates doctor's appointments and refer families to external services and resources. The CHWs utilize role playing of common scenarios to improve families' communication with their health care providers. They teach them how to prepare for physician visits, ask questions, and advocate for their child's needs. In addition, the Allies CHW emphasize building a relationship with the families with whom they work. They spend significant time simply visiting with and listening to family stories and concerns. Sending birthday cards and/or holiday baskets and keeping track of current events in the families' lives are small, yet effective measures that CHWs employ to earn the trust and rapport of family members. Consequently, CHWs seek to also empower families to improve their children's health and advocate for their needs. They help them understand what constitutes good asthma management and thus develop a sense of control over the disease. Certainly, this is utilized at an individual level, but it is also noted at a community level. In Long Beach, CHWs successfully engaged families in efforts to oppose a proposed freeway expansion route that threatened to increase pollution in their neighborhood.

Cancer

Mammography is underutilized, particularly in poor and minority women. A lay health advisor intervention was developed in Robeson County, North Carolina, a rural, low-income, triracial (white, Native American, African American) population. The goal of the educational intervention was to increase awareness of the benefits of early detection of breast cancer and to

encourage women to reduce their own risk of breast cancer death. It sought to identify and reduce important barriers to obtaining mammography screening and provide basic knowledge and education about the breast, breast abnormalities, and breast cancer screening. Two Native American women (a former nurse and a social worker) and one African American woman (a research study interviewer) who lived in the community were hired as LHAs. They received extensive training on breast development, breast abnormalities, breast cancer screening, diagnosis, treatment, and risk factors.

The intervention consisted of an intensive, face-to-face interactive educational program over 9-14 months. At the first home visit, the LHA described the project, provided educational materials about cancer risk, discussed what mammography, breast cancer, and breast self-examination are, and explained methods of overcoming barriers to receiving a mammogram. These barriers included transportation, lack of respect or encouragement to receive a mammogram from healthcare professionals, cost and lack of insurance, misconceptions about mammograms (that it is painful or causes cancer), and the false impression that if a woman feels well, she does not need to bother receiving a mammogram. The second home visit taught and reinforced breast self-examination and the need for setting up mammogram appointments, which the LHA offered assistance in scheduling. Phone calls were utilized in months 2 and 6 to assist participants in making mammography appointments, discuss any remaining barriers to obtaining a mammogram, provide information on other important health topics, determine stage of readiness to change, and encourage women to discuss their mammogram experiences. Mailings and postcard reminders were sent during months 4 and 8. Near month 10, the LHA made a final home visit, inquired about screening received and the participant's ability to do breast self-

examination, and reiterating the importance of good breast care. Small gifts (such as cups and calendars) were given to participants in appreciation of their time and cooperation.

This study effectively impacted these women through a personalized intervention, navigation through the health care system, social networking, and social support. The LHA successfully delivered messages about breast cancer health to this underserved population. This was illustrated through the study data because women assigned to the LHA intervention had higher mammography rates (42.5% versus 27.3%), more accurate beliefs and improve knowledge about mammography, and reduced barriers to obtaining this screening.

Cardiovascular Disease

Obesity, poor diet, lack of exercise, and exposure to tobacco smoke are undoubtedly identified as behavioral risk factors associated with cardiovascular disease (CVD). Coronary heart disease continues to be the leading cause of death and disability-adjusted life years for both men and women in Los Angeles County (LAC). The impact of CVD is especially noted in Latinos, as it is their primary cause of death in California and nationwide (County of Los Angeles, 1999). More than half (54%) of Latino adults are considered overweight and obesity is on the rise, afflicting about 1 of 4 Latino adults (Fawcett SB, Francisco VT, 200). Eating habits, such as consuming fewer fruits and vegetables and choosing fast food when eating out of the home, are major contributing factors to this situation. Compared to any other ethnic group in LAC, Latinos have the highest rates of a sedentary lifestyle (46%) and report exposure to tobacco smoke, at home and at work.

A lay health advisor program was implemented to reach Latino residents and provide content tailored to be linguistically and culturally relevant to Latinos. The initial community

needs assessment indicated that many Latinos could not recall a doctor or nurse ever talking to them about exercising (37.5%), their weight (42.2%), what they ate (35.9%), or smoking (50%). Yet, other themes emerged regarding awareness and motivation issues, incorporating and maintaining specific practices in daily life, and cooperation or resistance of family members. For example, families were already attempting to eliminate some unhealthy foods from their diet, incorporate healthier ways of food preparation, exercise more, and smoking less. However, the challenges consisted of maintaining family interest and cooperation for eating healthier and exercising, adolescent children's continued interest in fast foods, and sustaining a smoke-free environment when many extended family members smoke.

An outreach program was developed (using participatory research methods) to address the disproportionate cardiovascular health risk factors in the LAC Latino community. Latina lay health advisors (LHAs) from the community were recruited and trained to teach 3 classes on healthy nutrition, physical activity, and maintaining smoke-free environment. The LHAs were referred to as health promoters, or *Promotoras de Salud*, a more meaningful term in the Latino community. The classes were offered in Spanish to adult Latinos recruited through the LHAs social networks and were held in familiar sites to community members (such as school-based parent centers, community centers, homes of the LHAs or participants, a church, and a workplace site). The outreach program demonstrated overall improved lifestyle behaviors of the participants at the end of the 3 sessions. This outreach program illustrated not only that lay health advisors can be an effective tool in delivery cardiovascular health promotion, but it emphasized the importance of tailoring health promotion in a cultural context- a key component to why lay health advisors can be crucial parts of the healthcare delivery system. It was pivotal to

understand not only the language barrier, but the eating habits of Latinos- what oils they use, what family members are accustomed to eating, and what family pressures exist.

HIV Prevention

The Protegiendo Nuestra Comunidad (Protecting Our Community) was developed for Mexicans who had recently immigrated to North Carolina. It sought to provide LHAs with the knowledge and skills necessary to engage in supportive activities for HIV/AIDS prevention and to facilitate the development of their sense of efficacy, critical awareness, and control associated with their consequent ability to help their community prevent the spread of AIDS. It aimed to facilitate empowering processes and empowerment outcomes at an LHA individual level to program participants collectively. The program sought to focus on learners as active participants in a dialogue of equals rather than passive objects trying to absorb expert knowledge (Beeker et al.; Wallerstein & Weinger, 1992). Therefore, the programs for discussion were rooted in the community and embedded within a familiar socio-economic, cultural, and political context.

In order to assess community members' beliefs about STDs/HIV, project team members attended community events, conducted focus groups, and individual interviews. Based on what was observed in the community, the LHA curriculum was developed. LHAs were educated about the transmission and prevention of STDs and HIV, HIV testing and available resources, cultural values and roles, and how to bring up sensitive topics. They were also trained to focus on attitudinal change and the development of social action skills. The 7 sessions addressed the role of the LHA and the importance of group confidentiality, STDs, HIV, HIV testing and resources, protection options, cultural values and roles, and goal setting for the future.

The program utilized various techniques to educate participants, including games such as “Name that STD,” role play of how to discuss HIV, condom demonstrations, and discussion triggers to facilitate dialogue and focus on problem identification, analysis, and development of steps for action. For example, within an activity discussing modes of HIV transmission, facilitators provided written messages on a flipchart and elicited discussions by presenting participants with various objects that could or could not transmit HIV, such as a toilet seat, a syringe filled with red coloring, and utensils. Literacy concerns were also addressed by utilizing pictures and visual icons and keeping words and sentences simple. In some sessions, men and women participated separated before uniting for group discussions. One such session covered protective options such as barriers and facilitators to condom use, how to mention it in relationships, and practicing putting on a condom on a wooden model. Participants were given homework assignments asking them to practice what they were learning with a friend or family member and bring their experiences back to the group for discussion and problem solving. (McQuiston, Choi-Hevel, & Clawson, 2001).

In another aspect of the program, LHAs provided supportive activities for STD/HIV prevention to family members, friends, and coworkers in a myriad of settings. They spoke to community members at community events, the Laundromat, and the local Hispanic Center. They served as brokers of information by clarifying questions about casual transmission (mosquitoes, kissing, or bathrooms), biomedical modes of transmission (sexual intercourse or shared needles), and prevention (such as care of syringes, condom use, and screening). The LHAs also provided direct assistance by offering to make clinic appointments, distributing condoms, and making referrals to the local health department for HIV testing. (McQuiston & Flaskerud, 2003)

VI. Recruitment and Training of LHAs

The original CHEP model anticipated at least three to six months to identify and recruit true lay advisors. The primary criterion for selecting indigenous natural helpers was the identification of people who embody the combination of social, cultural, ethnic, environmental, and communication values, norms, and beliefs of the target population (Jackson, 1997). This criterion contrasts the view that community health workers are paid or serve as voluntary community members who serve solely as connectors between health care consumers and providers (Beam & Tessaro, 1994). Staff members publicized the recommended health program in the community in an effort to gain support for it and to solicit names of potential LHA roles. They utilized a myriad of resources to identify potential LHAs. They tapped key organizations, such as local agencies and churches, and considered people in key occupations, such as ministers, teachers, storekeepers, barbers, and beauticians, who already knew the community and its members well. In addition, they explored services with outreach workers already in the area and utilized a community survey to ask residents who they thought were good people to ask for health or medical advice.

VI. Workforce Issues and Barriers to Recruitment and Retention of Community Health (as noted by the Massachusetts Department of Public Health)

According to the Massachusetts Department of Public Health (MDPH), there are a myriad of workforce issues and barriers in the recruitment and retention of community health workers. In a survey analysis of community health workers in Massachusetts, the MDPH notes a multitude of contributing factors. First, no formal career ladder exists for community health workers. In the MDPH report, CHWs stated that their only opportunities for advancement

consisted more so of building skills and increasing levels of responsibility within their current position, rather than a change in role or increase in salary. Subsequently, CHW wages can be relatively low (the MDPH reported the mean salary for their CHWs was \$23,000 per year) and salary levels for CHWs tend not to increase with educational level, experience, or years in the position. CHWs with college degrees earn approximately \$13,000 less than other individuals with college degrees in the general population. Many CHWs do not even receive health insurance through their jobs and therefore, pose an ironic problem. CHWs teach fellow community members how to use the system and then they themselves cannot even afford health insurance or pay the bills because of their poor pay.

Secondly, job security is impacted by unpredictable funding. Because funding for public programs in Massachusetts is appropriated on an annual basis, every year community-based agencies are uncertain of their program and operations budget. It is not surprising that consequently, CHW turnover is high with longevity averaging at 4 to 5 years in the CHW field, slightly longer (5 to 7 years) for supervisory roles. Finally, survey respondents indicated that they would like additional training. Thus, with a lack of opportunities for promotion, poor compensation, lack of benefits, questionable job security, and high turnover, community health workers can face a compromising work conditions, although there is a growing need for them. In addition, the lack of a standard CHW definition and the lack of understanding among providers about CHW services contribute to the challenges they face. It is therefore essential to develop a set of core competencies and guidelines for CHWs, offer them ongoing training and supervision to ensure they meet the community's evolving health care needs, and propose a career ladder for CHWs. In addition, it is crucial to identify stable funding sources that promote long-term program planning and sustainability of CHW services and establish recommendations for fair

and equitable pay for CHWs. Finally, it is pivotal to educate health providers and policy makers about the potential of CHWs and their contributions to the health care system.

VII. Implementing a Community Health Worker Program

Programs have proliferated throughout the United States that train indigenous community members to serve as links between their communities and the professional health care system. Naturally, a health problem, disparity, or need should be identified in a particular community. “Implementing a Natural Helper Lay Health Advisor Program: Lessons Learned from Unplanned Events” provides a guide to program plan implementation. LHAs are to be identified by community members and subsequently invited to a training to become an LHA (volunteer or salaried). Local advisory committee and focus groups may be helpful in generating lists of people in the community who are considered natural helpers. Outreach specialists invited referred women to attend the training. In the attempt to establish the North Carolina Breast Cancer Screening Program, uninvited women came to the training, brought by invited women or on their own initiative. This may have occurred partly because uninvited women heard about the training through an announcement made during a church service as a reminder to invited women. Women also seemed to feel left out because of the exclusive nature of the recruitment process.

Conclusioin

Additional Information Resources

References