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Registered Nurses' Perceptions of Community Health Workers

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Abstract

Objective: The objective was to explore the experiences of Registered Nurses and Licensed

Social Workers who work directly with Community Health Workers (CHWs) in health care.

Design and Sample: A descriptive qualitative design was utilized. Six registered nurses

participated in semi-structured interviews. Interviews were audiotaped. Content analysis

consisted of identifying themes and patterns that emerged from the narratives.

Results: Three themes were identified, 1) the importance of role clarity, 2) relationship building,

and 3) filling in gaps in care.

Conclusions: Nurses consider CHWs to be vital members of the health car team. CHWs'

extensive knowledge of community resources and their ability to provide culturally sensitive care

has benefits for both patients and health professionals. The role of the CHW is evolving. Clear

delineation roles is an important factor in the implementation of new health professions

Key words: community health worker, multi-disciplinary teams, innovations in health care,

emerging health professions, registered nurses, role clarity, culturally appropriate care

Registered Nurses' Perceptions of Community Health Workers

In 2011 health care expenditures in the U.S. averaged $8,508 per capita (Davis, Stremikis, Squires, & Schoen, 2014, p. 7). National health spending is expected to rise from 17,4% of the gross domestic product in 2014 to 19.6% in 2024 (Keehan et al., 2015, p. 1407). Although the U.S. spends more on health care than any other nation, it continues to have the lowest overall health performance scores when compared to ten peer nations. Among the five categories of performance measures, the U.S. scored last or near last in the areas of access, efficiency, equity, and healthy lives (Davis et al, 2014, p. 7).

There is strong evidence that there is a higher incidence of illness, premature death, and disabilities among low-income and minority populations in the U.S. (Centers for Disease Control and Prevention [CDC], 2015; Smedley, Stith, & Nelson, 2003). Health disparities not only affect the quality of life for underserved populations but they are also costly. The economic burden of health inequities between 2003 and 2006 was estimated at 1.24 trillion dollars (LaViest, Gaskin, & Richard, 2009, p.1). Davis et al. (2014) suggest that there is a consistent relationship between low health equity scores and low performance on other health measures (p. 27).

Health equity is defined as a "state where all persons, regardless of race, income, creed, sexual orientation, gender identification, age or gender have the opportunity to be as healthy as they can-to reach their full 'health potential.' " (Minnesota Department of Health [MDH], 2014, p. 11). One of the primary strategies to reduce the cost of health care and increase health equity in the U.S. is the restructuring of health care delivery systems into multidisciplinary, team-based care delivery models such as medical homes.

Background: Community Health Workers

The addition of community health workers (CHWs) to health care teams has been growing over the past two decades. One of the most notable sources of support is found in the Patient Protection and Affordable Care Act of 2010 (PPACA). The PPACA recognizes the work of the CHW to improve access to care and the delivery of culturally and linguistically appropriate care among low-income, minority, and other vulnerable populations.

The American Public Health Association defines the role of the community health worker as

> A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (APHA, 2015, para. 3).

CHW services include outreach, health coaching and education, social support, and advocacy with the aim of increasing health knowledge and self-sufficiency among community members. Depending on the work setting, CHWs may also be known as promotores de salud, care guide, patient navigator, community health advisor, peer educator, and lay health worker.

Henderson, Kendall, and See (2011) found that there is positive evidence to support the use of bi-lingual CHWs in the delivery culturally and linguistically appropriate care. They concluded that interventions that utilized culturally competent bi-lingual CHWs may have the potential to impact health outcomes by improving, a) facilitating communication between providers and patients, b) providing culturally sensitive patient education on health services and health conditions c) promoting screenings and chronic disease self-management strategies, and

d) reaching out to patients for follow-up and appointment keeping (p. 247). However, the authors

recommended that more high-quality research is needed to draw firm conclusions.

There are currently no national standards for the training and scope of practice of CHWs.

Certification program requirements have been established in five states and seven additional

states have state-led training programs but no laws related to certification. (Association of State

and Territorial Health Officials, 2015, p. 1). Minnesota is the only state to have a curriculum

based in higher education (MDH, 2015).

Literature Review

A literature review was conducted to identify studies that focused on nurses' and social

workers' perceptions of the role of the CHW and implementation of CHW interventions in health

care settings. Only three studies could be found that were published between 2000 and 2015 that

included nurses. No studies were found that examined the perceptions of social workers. The

scope of the literature review was expanded to include studies that incorporated surveys, focus

groups, or interviews of providers or other health professionals involved in interventions that

include CHWs. An additional six studies were identified. The challenge in conducting the search

is that qualitative methods may be embedded in studies that utilize a mixed method approach and

may not be apparent in abstract summaries.

Nurses' perspectives on Community Health Workers. Nurses are the largest group of

health care workers and as such they play a pivotal role in the adoption of innovations in health

care. Literature suggests that nurses may feel threatened by the trend to shift tasks traditionally

performed by nurses to "lower cost" such as CHWs (Siemon, 2014; Wholey et al., 2012).

Doherty and Coetzee (2005) utilized interviews and focus groups to explore and describe

the relationship between CHWs and nurses working in resource-poor urban communities in

South Africa. The researchers identified three stages of relationship development. In the initiation phase, nurses did not understand the role of the CHWs and felt threatened by their presence. This lack of knowledge and suspicion was viewed as a major barrier to establishing relationships with CHW. In the second stage nurses and CHWs began to understand each other and conflicts decreased. Nurses started to see the CHWs as an extra pair of hands in the clinic. CHWs felt conflicted because their primary activities were community focused and yet they were also being asked to provide support to the clinic when there were staffing shortages. During the third stage, characterized as "uneasy cooperation" the nurses began to see the CHWs as links to the community however very few nurses reached the stage as seeing the CHWs as colleagues.

In another study, the perceptions of registered nurses on the effects of CHW certification on team climate were measured utilizing the Team Climate Inventory Short Form (Siemon, 2014). The results showed that overall team climate scores were not significantly different between nurses who worked in states that had certification standards and those that did not. However in one survey question, nurses in states with certification were significantly more likely to state that CHWs had a positive effect on the ability of the team to deliver quality care.

Whittemore, Rosenberg, Gilmore, Withey, and Breault (2013) conduced a study to describe the process of implementing a diabetes prevention program in public health housing. Two nurses and two CHWs were interviewed as part of the program review process. The nurses felt that CHWs were integral to the success of the study however retention of CHWs was an issue, only one of the four CHWs who started the program completed it. The researchers suggested that to improve retention, CHWs should be hired as full-time rather than part-time workers and training and supervision increased.

Community Health Workers and Multidisciplinary teams. Collingsworth, Bulimiri, Schmidt and Snead (2013) conducted semi-structured interviews with CHWs, primary care providers (PCPs), and patients involved in a project to reduce disparities in diabetes care. The development of trusting relationships was essential to successful implementation of the CHW model. Trust was built over time as PCPs saw the positive impact CHWs had on patients and as the PCPs began to understand the CHWs' role and scope of practice. The investigators concluded that to facilitate the incorporation of CHWs on traditional health care teams, infrastructure is needed to support the role. This infrastructure should include adequate training, well-defined roles, support from existing staff, and a sustainability plan (p. 57S).

Care guides were added to primary care teams in a pilot study to improve the efficiency and effectiveness of treatment of patients with chronic disease (Wholey et al., 2012). Investigators utilized a mixed methods approach to study occupational conflict, role interdependence, and resistance to change among primary care team members. Initially providers, staff, and patients were unclear on which tasks could be delegated to the care guides. In response to this lack of role clarity, care guides helped create a document that better defined their work. Care guides also found that they were most effective when they emphasized their non-clinical relationship with patients. Survey results of clinic staff showed that care guides were seen to "improve patient care, are an appropriate use of clinic resources, and fit well into clinic processes." (Wholey et al., 2012, p. 10).

CHWs were added to provide care coordination in a hospital-based family medicine clinic serving low-income community members (Findley, Matos, Hicks, Chang & Reich, 2014). CHWs connected patients to community services, assisted patients with making appointments, and provided follow-up as needed. CHWs also did home visiting that incorporated health

coaching. The department utilized a variety of means to introduce the CHW role such as continuing education, staff and team meetings, and on CHW rounds. Team members participated in determining when and how to refer patients to CHWs. The success of the program was contributed to a three-step recruitment strategy, thorough training, and supervision of CHWs, clear delineation of CHW team roles, career incentives to sustain commitment to the role, and documented return on investment.

In a study of the role of the CHW in medical homes (Volkmann & Castañares, 2011), providers were in agreement that CHWs allowed them to work more efficiently and see more patients by providing basic patient education. Providers saw an advantage to having CHWs embedded in the clinic because providers could ask CHWs to see patients for unexpected needs that came up during the appointments. Otero-Sabogal et al. (2010) also found providers were positive about the CHW role. CHWs allowed them to see more patients and that patients were better educated on chronic disease self-management skills. Salant et al. (2013) found that one of the major barriers to implementing a CHW integrated care model for diabetes was the lack of consensus around the core functions of the CHW role and disagreements about their work capacity. The researchers concluded that adequate resource allocation and broad buy-in from stakeholders during the planning and implementation of the program are necessary for collaboration to occur between research and health care organizations.

Diffusion of Innovations Theory

The diffusion of innovations theory, describes the adoption of change as a social process. In a rapidly changing health care work environment, the theory can help explain why some innovations are more quickly adopted than others. Diffusion is defined as

The process through which an innovation is communicated through certain channels over time among the members of a social system. The four main elements in the diffusion of new ideas are 1) innovation, 2) communication channels, 3) time, and 4) the social system. (Rogers, 2002, p. 990).

The theory postulates that the social context in which changes are implemented is a key to success. People are more likely to base their evaluations on peer attitudes and opinions rather than research. Therefore, interpersonal channels are more effective in developing and changing attitudes related to new ideas or new ways of working. Change can be slow at first however if early adopters of an innovation perceive that innovation as advantageous, the rate of adoption speeds up as they share their favorable experiences with others.

Health care professionals are working in an environment in which innovations in team-based care and payment structures to improve health outcomes and reduce the total cost of care are being implemented at a rapid pace. The diffusion of innovation theory proposes that in order for change initiatives to be successful people need to see that the new idea is better than the one it is replacing. Innovations must be compatible with individual's values and experiences, they need to be easy to understand, and positive results must be visible. Cunningham (2013) warns that the rapid improvement strategies to fulfill the dream of "harmony and teamwork" may seem exciting however the journey to achieve these goals "will entail arduous efforts and face many obstacles" (p. 1872).

The aim of this study was to answer the following question: Among registered nurses and licensed social workers in Minnesota, what is the perceived role of community health workers in health care? Based on the researchers' experiences working as a CHW supervisor the following assumptions were made 1) That nurses feel threatened by the integration of new health

professionals such as CHWs on health care teams and 2) That health care professionals lack

knowledge about the training and scope of practice of CHWs in Minnesota.

Methods

An descriptive qualitative design was utilized to explore registered nurses' and licensed

social workers' experiences working with community health workers in the health care setting. A

semi-structured interview format was chosen because it gives respondents the opportunity to

provide richer, more in-depth information about a phenomenon.

A purposeful sampling method was selected to obtain a representative sample across

multiple organizations. Registered nurses and social workers were invited to participate if they

met the following requirements: a) were licensed to work in Minnesota, b) worked in either

primary, specialty, or public health clinics or worked in homecare, and c) had a minimum of six

months experience working with CHWs in one of the prescribed settings. Eligible participants

were recruited by two methods. The investigator reached out to nurses and social workers known

to her either by phone or email. She also reached out via email to a CHW supervisors' support

group connected to the Minnesota CHW Alliance with the request that invitations be emailed to

nurses and social workers within their organizations.

Six registered nurses agreed to participate in the interviews. The investigator was unable

to recruit social workers during the recruitment period. Five of the nurses had been licensed as

registered nurses for more than two years. Four had Bachelor's degrees and the remaining two

had graduate degrees. Two participants had six to twelve months experience working with

CHWs, the remaining four had two to five years' experience. Work settings were evenly split

between clinic and home care settings. Each nurse worked in an organization that served high

percentages of low-income and ethnically diverse populations.

Individual interviews were conducted by the investigator and audio-recorded. Participants were also asked to fill out a short demographics survey. Interview questions were developed based on the investigator's experiences working as a CHW supervisor. Two individuals who are knowledgeable about CHW practices in Minnesota reviewed the interview questions. Questions were revised based on their feedback. The investigator transcribed recordings verbatim. Data analysis consisted of reviewing transcripts to identify patterns and themes.

Informed consent was obtained from participants just prior to the interviews and participants were given the opportunity to ask questions or withdraw consent at any time. Transcripts, surveys, and audio-recordings were coded to maintain confidentiality. The St. Catherine University Institutional Review Board approved the study.

Results

During the process of data analysis three major themes were identified. The first theme was the importance of role definition or clarity. The second was the ability of CHWs to form strong relationships with patients, external service providers, and other community resources. The final theme was the importance of filling in gaps in care that would otherwise be tackled by licensed heath care workers or left unaddressed.

The importance of role clarity

One of the most predominant themes identified through review of the transcripts was the importance of well-defined CHW roles. Sub-categories within this theme are lack of understanding of the CHW background and the role of communication.

One of the key factors in the issue of the role confusion is that among health professionals there is a general lack of knowledge about the training and scope of practice of CHWs. When asked about the education background and scope of practice of CHWs the

majority of the participants could not give an accurate description. Three nurses likened the role to basic social work activities. One participant stated,

> I do think though that most often including myself , aren't completely educated on what all a CHW can do and their scope of practice. And I think some people don't understand what their roles are and what all it entails.

Although CHWs have been active in community settings for decades their transition to more traditional health care settings in Minnesota has recently started to build momentum. One nurse remarked that "the role is so new, I don't think a lot of places know exactly what a CHW can do and so they are kind of hesitant because you know they have always worked with RNs."

Participants suggested that role clarity could be improved by seeking care team members' input on team staffing needs and the CHWs' roles and responsibilities from the start. Nurses also agreed that it is important to have clearly delineated between nurses, social workers, and community health workers and that these need to be communicated to the whole team. According to one nurse improved communication would decrease the likelihood that team members ask CHWs to do something that is outside of their scope. "Once you start blurring the lines then things happen that aren't appropriate and could be a liability."

The nurses also remarked that care teams need clear direction on which populations CHWs can serve. In many organizations initial funding for CHWs is through grants that focus on specific populations. Therefore, as funding sources and organizational priorities change so may the responsibilities of the CHWs. Nurses felt that organizations could do a better job of communicating changes in CHW roles when they happen. Several participants also voiced frustrations that CHWs are not allowed to work with the entire patient population. As one participant stated, "we have other patients at risk."

Relationship building.

The CHWs ability to build strong relationships with patients, service providers, and other community resources was viewed by participants a major strength of CHWs. Regarding patient relationships one nurse stated,

> He (the patient) really really likes the CHW and he feels he benefits more from the CHW
> than he does nursing services. So that was very interesting for me to see cause you know
> it is not just about her bringing the food its about her sitting there and educating him
> about each food and what these food groups mean. And just that nutritional education
> that that client receives has helped him get to where he is right now from where he was
> before.

A second nurse commented on the importance of CHW and patient relationships, "Some CHWs are in the home more than I am and that's when they really help us out because they get really close to the families and to the patients."

Because CHWs are traditionally members of the communities they serve or are familiar with those communities they often provide insights to other team members about the patients' cultural context and barriers to care and self-management. Several patient examples were given of how bi-lingual CHWs were able to build relationships and provide information that nurses could not obtain on their own or through the use of interpreters. One nurse stated, "I've noticed here that they (patients) relate to their CHW cause they come at it with a little bit different eyes and ears…I think that sometimes patients respond differently." The same nurse also commented that,

> We give those patients the direct dial number of that CHW and you know we don't give
> them the direct dial number of anybody in the clinic so you know it's they really have an

in to the clinic. I think they like that. They'll call them my CHW. MY … (CHW name). I

think they really get to know our patients and some of the barriers.

Among the nurses interviewed, CHWs are viewed as community resource experts who

build strong networks with other service providers. One nurse remarked that they had all the

phone numbers and contact information that would be time-consuming for other team members

to find. The same nurse reported, "I am able to delegate to a person, to a person who has the

knowledge which allows the client to get what they need." Nurses also commented that CHW's

knowledge of the community and service providers helped them find patients that were lost to

follow-up. CHWs in outreach or home care roles were able to go to the home or into the

community to locate patients and update contact information. Clinic-based CHWs are not able to

go out in the community however one nurse commented that the CHW in the clinic is likely to

know another community service provider who could reach out and locate the patient.

Filling in gaps in care

CHWs in both clinic and home care settings had similar work responsibilities that

focused on care coordination and patient education. Care coordination responsibilities included

arranging transportation, connecting with patients between visits for follow-up and reminder

calls, and helping patients access community resources such as food, clothing, shelter, and

transportation. Basic health coaching or teaching was also considered part of the role in both

homecare and clinics. In two of the organizations CHWs utilize a basic survey to identify patient

needs and barriers to care that helps patients identify personal goals and aids in the development

of the care plan.

The consensus of the nurses was that it was difficult to engage patients in their care if they are unable to meet their basic needs. Patients and care team members benefited from the CHWs' expert knowledge of community resources. According to one nurse,

"If all of those social situations are not addressed I can't do anything related to health because people can't learn if they don't have housing, if they are going to get kicked out of the apartment and the shelter that they paid rent for or if they are going to, if they don't have food that month…I can't do skilled nursing if all of those things are not addressed first. So they (CHWs) really help with that gap."

Another nurse commented that the creativity and resourcefulness, the "out-of-the-box thinking", of the CHW in her clinic helped disengaged patients become more involved in their care.

There was also a consensus that CHWs help other team members focus on their areas of expertise and work at the top of their license because they can address patients' non-clinical needs more efficiently. This also allows nurses to serve more people. According to one participant

I'll go to clients and I'm there for health related issues but they are asking me about social services or CHW services and it's like I'd love to do that but I don't have time. So when the CHW comes in now what I do when clients ask me about that, I say look your CHW, will help you with that and that saves me time. I can focus on what I am actually there for.

Discussion

The researcher conducted individual interviews with six registered nurses to explore their perceptions of CHWs in health care. Nurses are integral members of health care teams. Siemon (2014) points out that "their ability to collaborate and work with CHWs is critical to the

integration of CHWs into existing health care organizations (p. vi)." The investigator approached

this study with the assumption that nurses feel threatened by the integration of CHWs in

traditional health care settings however this was not true of the nurses interviewed. All of the

participants felt that the CHWs were essential members of their health care teams who increase

nurses' capacity to focus on clinical work. They also recognized the important role CHWs play

in acting as a bridge between health care providers and their patients and in connecting patients

to community resources.

Another assumption that the researcher made was that nurses and other health care

professionals were confused about the roles and responsibilities of CHWs. Previous research

literature has demonstrated that role clarification is one of the barriers to implementation of the

CHW in health care (Doherty & Coetzee, 2005; Wholey, 2012). This assumption was supported

by the interview data. First, health care professionals and other care team members need to have

a clearer understanding of the educational background and scope of practice of CHWs in

Minnesota. This will help alleviate some of the confusion about which tasks can be referred to

patients. Second, confusion about the CHW role reflected how new roles are developed and

implemented in team settings. Several nurses commented that better communication strategies

are needed as CHWs are introduced, when their roles or population focus change, and when new

staff are oriented to the organization. One nurse also suggested that team members have more

input when new roles are considered and that organizations invest more time and resources in

team building.

Limitations

The study sample size was small. Although data saturation was achieved a larger sample

may show more variation in attitudes. Nurses with less than six months experience with CHWs

were not included in the study. This was in part based on the findings of Doherty and Coetzee (2005) that indicated that the relationship between CHWs and nurses develops over time. The aim of the study was to explore the experiences of social workers as well as nurses however due in part to time constraints the researcher was unable to recruit social workers within the 2-month recruitment period. Because CHWs perform some of the less clinical roles that have been associated with social work it is also important to solicit their impressions of the integration of CHWs on health care teams.

Conclusion

This study demonstrates that nurses see the CHWs as a valuable resource in both home care and clinic settings. Because of the small nature of the study there is a need for further research into the perceptions and attitudes of nurses and other health professionals regarding emerging health professions such as community health workers. Communication is a key component in the implementation of new team roles and ways of working. Because diffusion of innovations is a social process, Rogers (2002) encourages the use of champions and peer networks to speed up adoption of changes. It is also important to incorporate qualitative methods into program evaluations. Interviews, focus groups, and surveys can provide rich data and also provide opportunities for team members to have a voice in the change process.

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