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Nurses' Perceptions of Community Health Workers in Health Care.

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Biosketch:

Karen Macdonald De Jong is a graduate of the Doctor of Nursing Practice at St Catherine University in St Paul, Minnesota. She also holds a Masters in nursing leadership. Karen worked for the Minnesota Department of Health in the health care homes section as a site evaluator for state certification. She has also worked as a CHW supervisor for a large safety net health system. This project was completed as a requirement for completion of the DNP program.

Abstract

The purpose of this study was to explore registered nurses' and social workers' experiences working with community health workers (CHWs) in clinics and homecare.

Six nurses participated in individual, semi-structured interviews. Analysis of interview transcripts revealed that CHWs are considered vital members of the health care team. Their expert knowledge of community resources and ability to bridge cultural and language gaps make them ideally placed to impact social determinants of health. The role of the CHW is evolving. Team building and role clarity are essential elements for successful integration of CHWs on health care teams. The investigator was unable to recruit social workers for this study. Further research is needed to solicit social workers' perceptions of the CHW role in health and human services.

Key Words: Community Health Worker, primary care, multi-disciplinary teams, health reform, health disparities, care guides, patient navigators, culturally competent care

Nurses' Perceptions of Community Health Workers in Health Care

In the U.S. low-income populations and communities of color are disproportionately affected by illness, premature death, and disabilities. The U.S. Department of Health and Human Services (HHS), defines health disparities as,

Persistent and well-documented health disparities exist between different racial and ethnic populations and health equity remains elusive. Health disparities — differences in health outcomes that are closely linked with social, economic, and environmental disadvantage — are often driven by the social conditions in which individuals live, learn, work and play (2011b, p. 1).

Although the existence of health disparities is well documented, the goal of achieving health equity still remains a significant challenge (Centers for Disease Control and Prevention [CDC], 2015; Smedley, Stith, & Nelson, 2003).

In addition to having poorer health outcomes, ethnic and racial minorities are also underrepresented among health care professionals. One of the recommendations from the Institute of Medicine's report on racial disparities in the U.S. is to "Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" (Smedley et al., 2003, p. 14). The report found that patients are more likely to participate in their care and adhere to treatment recommendations if there is more racial concordance between the patient and provider. Providers from racial and ethnic minorities are also more likely than their non-minority counterparts to work in underserved communities (Smedley et al., 2003).

Community Health Workers

One of the proposed strategies to eliminate health disparities and improve the delivery of culturally appropriate care is the integration of Community Health Workers (CHWs) within

health care teams and programs (CDC, 2015; Minnesota Department of Health [MDH], 2014; Islam et al., 2015). Community health workers are frontline public health workers who are traditionally members of the communities or populations they serve. They act as liaisons between patients and health care providers, provide basic health education, and help patients navigate complex health care systems (American Public Health Association [APHA], 2015). The title, CHW, is an umbrella term for a variety of job titles that include but are not limited to promotores de salud, care guide, patient navigator, community health advisor, peer educator, and lay health worker.

National standards for the training and scope of practice of CHWs in the U.S have not yet been established. In 2015, five states had laws or regulations that established CHW certification program requirements and one state had legislation pending. An additional seven states had 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. Six schools in Minnesota offer a standardized CHW curriculum that results in a certificate linked to Medicaid reimbursement (MDH, 2015).

Studies of CHW interventions in health care have increased dramatically as health care delivery systems look for innovative ways to improve the quality of patient care in multidisciplinary team models. In a systematic review of studies published between 1999-2009 of the effectiveness of culturally and linguistically appropriate interventions, Henderson, Kendall, and See (2011) found that the use of culturally competent bi-lingual CHWs may lead to better health outcomes by, a) improving communication between health care providers and patients, b) increasing patient satisfaction of care, c) increasing knowledge about services and

health issues, d) increasing cultural awareness among health care workers, e) increasing rates of health screening, and f) increasing follow-up and appointment attendance (p. 247).

Viswanathan et al. (2009) found mixed evidence of the impact of CHW interventions on patient behavior change and health outcomes. There was low to moderate evidence that the use of CHWs can lead to an increase in appropriate utilization of health care services. The greatest impact of CHW interventions was seen in the areas of mammography and cervical cancer screening, asthma management, and some disease prevention outcomes. With the exception of asthma, studies of CHW interventions for chronic disease management did not demonstrate consistent improvement in health outcomes over usual care. In terms of maternal and child health the reviewers concluded that CHWs are more beneficial in addressing existing health conditions rather than focusing on prevention.

Healthcare Workers' Perceptions of Community Health Workers

Although there have been many research studies conducted on the effectiveness of CHW interventions, only a few studies have examined the perceptions of traditional health care workers on the role of the CHW. Three studies were identified that examined nurses' perspectives on CHWs in health care settings. Doherty and Coetzee (2005) conducted a study of the relationship between CHWs and nurses working in resource poor urban communities in South Africa. The investigators identified three phases of relationship development. During the initiation phase nurses were unsure of the CHW role and felt threatened by their presence. Community health workers felt undermined and saw the nurses' lack of knowledge of their training as a barrier to building relationships with the nurses. In phase two nurses and CHWs became more comfortable working together and conflicts decreased. Patient clinic attendance increased and some nurses began to make a connection between increased attendance and the

CHWs' work. The third stage is described as uneasy cooperation. Nurses started to recognize the effectiveness of CHWs and see the CHW role as complimentary however only a few viewed the CHWs as colleagues.

Siemon (2014) utilized the Team Climate Inventory short form to examine the impact that state certification of CHWs had on registered nurses' perceptions of team climate. The results showed that there were no significant differences in team climate scores between nurses who worked in states that had certification standards and those that did not. Siemon concluded that state certification of CHWs may impact registered nurses' perceptions of CHWs but not to the extent that it affects their overall impression of team climate (p. 117).

Whittemore, Rosenberg, Gilmore, Withey, and Breault (2013) interviewed nurses and CHWs as part of a randomized study of a diabetes prevention program piloted in public health housing. The two nurses interviewed felt that CHWs were critical to the success of the program however they stated that more training was needed on how to work effectively with CHWs.

Additional studies were found that included qualitative methods to explore health care workers views of CHW roles and interventions. Salant et al. (2013) described lessons learned from an initiative to incorporate CHWs into diabetes care at a federally qualified community health center (FQHC). One significant barrier to successful implementation of the CHW integrated care model was the lack of agreement of the core components of the CHW role and a differing sense of their capacity. Areas where consensus was especially difficulty to achieve were in terms of the CHWs role in working with mental health conditions and in their capacity to work independently. This lack of understanding and familiarity with the CHW role resulted in, "downstream disagreements over the nature of the CHW intervention itself" (Salant et al., 2013, p. 160).

Lay food and health workers have been incorporated in community nutrition services in the United Kingdom (UK). Kennedy, Milton, and Bundred (2008) found that health professionals were generally supportive of the lay worker role and were optimistic about lay workers having the capacity to take on nonclinical and more labor intensive aspects of the community dietetics programs. On the other hand, analysis of the interview narratives with health professionals suggests that the health professionals were less certain about the ability of non-professional workers to address the complex issues faced by socially disadvantaged clients. The researchers note that lay involvement in National Health Service public health initiatives “has developed ad hoc, resulting in multiple interpretations of their role and function” (p. 206). They concluded that the lack of consistency in terms and definitions for the lay health worker hinders the effective implementation of the role in community health and dietetics.

Vulnerable Populations Conceptual Model

The Vulnerable Populations Conceptual Model is a middle range theory that provides a framework for nursing research, clinical practice, and ethical and policy analysis that focus on vulnerable populations. Vulnerable populations are defined as, “social groups who have an increased relative risk or susceptibility to adverse health outcomes” (Flauskerud & Winslow, 1998, p. 69). The model postulates that there is a dynamic relationship between resource availability, relative risk (degree of risk between groups that leads to poor health), and health status. Relative risk is greater in communities with limited social (income, housing, social connectedness) and environmental resources (access to quality health care). Increased exposure to risk factors leads to higher rates of morbidity and mortality. Poorer health status depletes the pool of resources available to community members and results in greater exposure to risk factors.

The VCPM can provide a framework for program development and evaluations that focus on the vulnerable populations CHWs represent and serve. Community health workers typically come from the communities they serve and therefore have a unique perspective on the strengths of community members and the challenges they face. According to Esperat et al. (2012), “By focusing on the patient’s own realities, first and foremost, providers have to deal with issues that create barriers to the patient’s ability to meet the demands that health care can impose upon that patient” (p. 11). Community health workers often act as a bridge between health care providers and individual patients and communities; helping providers understand the barriers patients face. Interventions and models that include CHWs have the potential to decrease relative risk and poor health outcomes by forming a link between health and human services and vulnerable populations.

Study Aim

The purpose of this project was to explore registered nurses’ and licensed social workers’ experiences working with community health workers in the health care setting. An interview format was utilized 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? An Institutional Review Board from the researcher’s University approved the study.

Study Design

A descriptive qualitative study was conducted utilizing semi-structured interview questions. Questions were developed by the DNP candidate and reviewed by two other professionals knowledgeable about CHWs in Minnesota. Questions were modified based on their input. Questions focused on a) the role the participants played in their work setting, b) their knowledge of CHW training and scope of practice, c) the role of the CHW in their work setting,

d) gaps in care that CHWs could address, and e) recommendations for organizations that are considering the addition of CHWs to the care team. Interviews were digitally recorded after obtaining written informed consent. All recordings, transcripts, and demographic surveys were coded to maintain confidentiality.

Sample

Registered nurses and social workers were invited to participate in individual, semi-structured interviews. A purposeful sampling method was utilized in order to obtain a representative sample across multiple organizations. The investigator directly contacted potential informants known to have experience working with CHWs. In addition, members of a CHW supervisors' group were asked to send out an email invitation to nurses and social workers in their organizations. Participants were included if they worked in a primary or specialty clinic, a public health clinic, or in home visiting and had six months or more experience working with CHWs. Because training and scope of practice of CHWs varies from state to state only nurses and social workers licensed to work in Minnesota were included.

A total of 6 nurses participated in interviews. The researcher was unable to recruit social workers during the time allotted for the study. Participants completed a short demographic survey that included a history of their work experience. Four of the six participants had five or more years experience in their profession. All of the informants had Bachelor degrees; two completed Masters degree programs in their field of expertise. Two had less than one year's experience working with CHWs and the remaining four worked with CHWs two to five years. Participants represented one home health agency and two clinic systems in a large urban area. The populations served by these organizations were primarily low-income, and ethnically and linguistically diverse.

Analysis

Interviews were audio-recorded and transcribed verbatim by the investigator. Content analysis consisted of identifying themes and patterns in the data and coding data in alignment with the category themes. A summary of individual interviews was sent to each participant to verify accuracy of the themes identified through data analysis.

Results

Three themes were identified during the analysis of the data and are as follows 1) role clarity 2) relationship building, and 3) filling in gaps in care. These themes reflect the characteristics and roles of the CHWs as experienced by the study participants.

Theme 1: Role clarity. The participants all agreed that CHWs are vital members of the care team however the lack of role clarity was one of the most predominant themes identified. One of the basic reasons for this role confusion was that four out of the six participants knew very little about the training and scope of practice of CHWs in Minnesota. This lack of understanding of CHW training contributed to their confusion as to what tasks could be referred to the CHWs. Knowledge of the role of the CHWs was based more on their experiences working with CHWs rather than an understanding of the CHWs' scope of practice.

Community health workers are often introduced to health care systems through outside grants that focus on specific populations and tasks. Participants stated that this is confusing to providers and other team members who, in their busy practices, rarely have time to consider which patients meet the requirements for CHW services. Several informants voiced frustrations that the CHWs could not work with the general clinic or home care population because, as one participant stated, "we have other populations at risk."

In order to improve role clarity several participants suggested that care team members be included in decisions about the role of the CHW from the start with ongoing feedback built in to evaluate the new team role as it evolves. There was a also a consensus that clear boundaries between nurses, social workers, and community health workers need to be developed and articulated to the whole team. This would avoid the danger of having team members ask CHWs to do tasks that are outside of their scope. As one participant put it, “Once you start blurring the lines then things happen that aren’t appropriate and could be a liability.”

Theme 2: Relationship building. Nurses consistently commented on the CHWs ability to build strong relationships with patients. Community health workers often come from the communities that they serve and act as a bridge between community members and health providers. Several participants felt that CHWs’ provide greater insights into patient needs and barriers to care because of their ability to communicate in the patient’s primary language and/or because of their understanding of the patient’s cultural context. One participant 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.” Another participant characterized the relationship with a patient as moral support,

He 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.

Community health workers also build strong networks with other service providers. Participants reported that CHWs have a wealth of knowledge of community resources and know whom to contact to connect patients to these services. One informant 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.” Participants also commented that the relationships CHWs have with other service providers and community organizations also help teams find patients who are lost to follow-up. If the CHW is not able to go out to a patient’s home or into the community to find the patient, he or she will reach out to other service providers to locate the patient.

Theme 3: Filling in gaps in care. The general work activities of the CHWs were similar across the three organizations. The primary exception was that clinic-based CHWs did not conduct home visits but rather provided care coordination as part of health care home teams (medical home). The most common CHW responsibilities were setting up appointments for people, arranging transportation, contacting patients between visits for follow-up and reminder calls, and connecting patients with community resources such as food, clothing, shelter. 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.

Each study participant provides services to a patient/client population with high psychosocial needs. The consensus of the informants is that patients’ basic needs have to be addressed in order for patients’ health to improve. CHWs’ extensive knowledge of community resources was viewed as a significant benefit for both patients and other team members. According to one participant,

“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 informant commented on the creativity and resourcefulness of the CHW in her clinic. It is the CHWs “out-of-the-box thinking” that helps disengaged patients become more involved in their care.

Participants felt that the CHWs enable them to focus more clinically on their areas of expertise and 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, whoever, will help you with that and that saves me time. I can focus on what I am actually there for.”

Discussion

This purpose of this study was to explore nurses’ and social workers’ perceptions of CHWs in health care. Interview questions were based, in part, on the investigator’s experiences working with CHWs and multidisciplinary teams. In writing the questions, the investigator made the following assumptions; 1) the majority of health professionals and other care team members have limited knowledge about the training and scope of practice of CHWs, 2) the role of the CHW is unclear to other team members and needs to be better defined, and 3) that other

professionals such as nurses may feel threatened about the introduction of CHWs and therefore be resistant to the addition of CHWs on care delivery teams.

The first two assumptions were confirmed during the interviews that health professionals currently working with CHWs have limited knowledge about the educational background of CHWs and that there was an overall lack of clarity about the tasks that they can perform. The study participants viewed CHWs as essential members of the team but felt that the development of roles and responsibilities needed additional work. This is in alignment with observations made by Ricketts and Fraher (2013) that physicians, nurses, other health care professionals have been inadequately prepared to work in new team structures and with emerging health professions.

The assumption that health care professionals such as nurses and social workers felt threatened by the addition of CHWs to their teams was not validated by the interviews. This may be in part due to the small sample size. However, Doherty and Coetzee (2005) found that once nurses saw CHWs as people who were there to help they no longer regarded CHWs as a threat. The participants in this study under discussion had over 6 months experience working with CHWs and felt that the CHWs provided a valuable service to clients. As one participant stated, “I feel like they fill in the gaps, the gap in between nursing services and social work services and they fit in there quite perfectly because the liaison with both of us.”

Study limitations. The sample size was small and although data saturation was achieved within 6 interviews this may be the result of the small sample size and convenience sampling method. If the sample was larger there may have been more variation in the responses. Also, participation was voluntary and subject to self-selection bias. The researcher was unable to recruit social workers. Because the work of the CHW overlaps with work that has traditionally been in the domain of the social worker additional research is needed to include their views of

the CHW role. Due to lack of funding for the project, the DNP candidate conducted the analysis of the data. However, the data analysis consisted of coding data according to themes and frequent rechecking transcripts for verification of themes and conclusions.

Implications for Nursing Practice

Esperat et al. (2012) suggest that nurses can play a key role in developing, managing, and evaluating programs that incorporate paraprofessionals (p. 11). This study was intended to begin the discussion among nurses about the role of CHWs in health care. Further studies are needed that examine the interrelatedness between nurses, CHWs, and other health professions. Emerging health professions are part of the current health care landscape and their intent is not to supplant nurses but rather to compliment and support their work. Their cultural and linguistic backgrounds coupled with expert knowledge of community resources makes them ideally placed to work with other health and human service providers with the ultimate goal of helping patients achieve optimal physical, mental, and social health.

Additional qualitative research is needed to explore the relationships between health professionals in team settings and to seek their perceptions of new care models. Ricketts and Fraher (2013) recommend that, “Workforce planning needs to be more ‘bottom up’ as it seeks to identify the ‘right kind’ and the ‘right number’ of workers” (p. 1879). Nurses make up the largest group of health care workers and as such they have the wisdom and collective power to influence the future of health care. It is important that nurses take on leadership roles to help guide workforce decisions otherwise those decisions will be made for them.

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