Role of Community Health Workers and Partnership with Academic Institutions in Advancing Health Equity

Rosalia Guerrero, MBA, CHWI
Director of Vulnerable Populations
Texas Epidemic Public Health Institute (TEPHI)
UTHealth School of Public Health

What we will discuss in this session

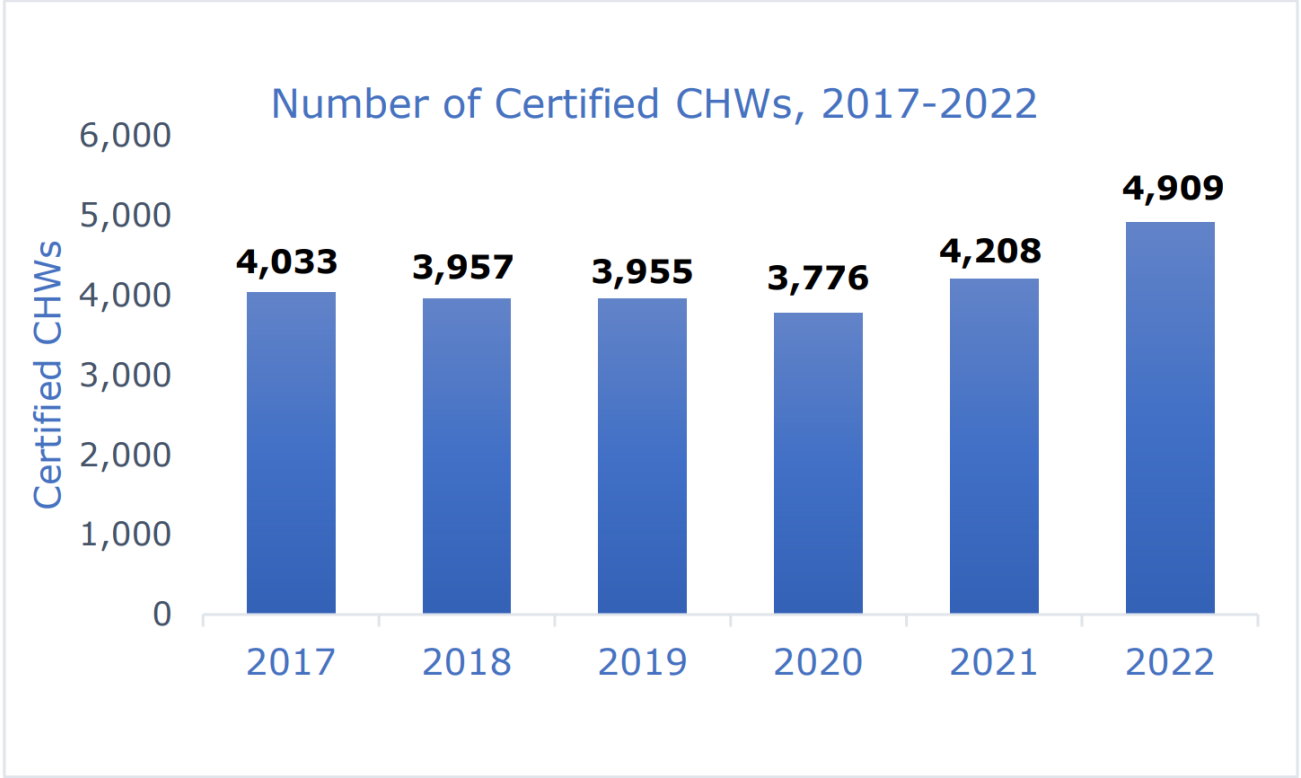
- CHW quick facts
- Health equity and CHWs
- Academic institutions and CHWs
- 2 case studies of CHW – academic partnership models
- 1 cautionary tale

Community Health Workers

- Frontline health worker
- Trusted member of the community
- Close understanding of community served
- Creates connections between vulnerable populations and healthcare and social services
- Builds individual and community capacity by increasing health knowledge and self-sufficiency through outreach, education, informal counseling, social support and advocacy

CHWs in Texas

- Certification by the Texas DSHS
- 160 hours of training or 1,000 hours of experience
- 8 core competencies – communication, interpersonal, service coordination, capacity-building, advocacy, teaching, organizational, knowledge base
- Some CHW training centers within academic institutions



Health Equity

The state in which everyone has a fair and just opportunity to attain their highest level of health . . .

Equality

Equity

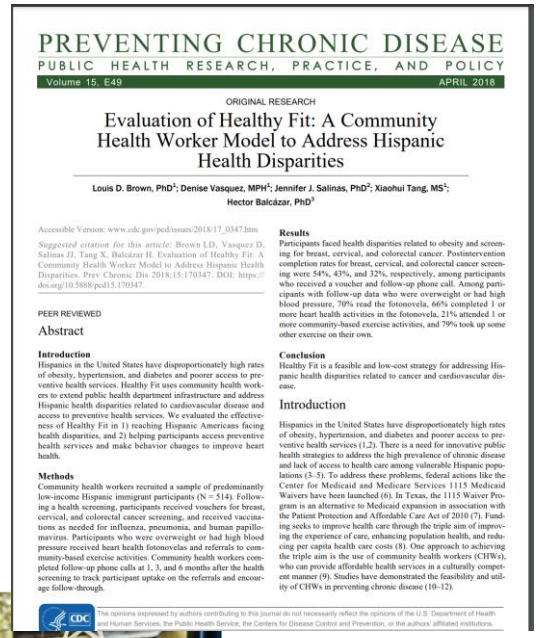
. . . regardless of race, ethnicity, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Health Equity – We Can

We can promote health equity by adopting policies, programs, and practices that:

- Recognize, respect, and support the communities we serve
- Build trust, strengthen partnerships, and promote social connections
- Partner with trusted messengers (**CHWs**) to share information and interventions tailored to the community
- Support equitable access to quality and affordable health and other social services

Academic Institutions & CHWs



PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY
Volume 15, E49 APRIL 2018

ORIGINAL RESEARCH

Evaluation of Healthy Fit: A Community Health Worker Model to Address Hispanic Health Disparities

Louis D. Brown, PhD[1]; Denise Vasquez, MPH[1]; Jennifer J. Salinas, PhD[2]; Xiaohui Tang, MS[1]; Hector Balcázar, PhD[3]

Accessible Version: www.cdc.gov/pcd/issues/2018/17_0347.htm

Suggested citation for this article: Brown LD, Vasquez D, Salinas JJ, Tang X, Balcázar H. Evaluation of Healthy Fit: A Community Health Worker Model to Address Hispanic Health Disparities. Prev Chronic Dis 2018;15:170347. DOI: https://doi.org/10.5888/pcd15.170347.

PEER REVIEWED

Abstract

Introduction
Hispanics in the United States have disproportionately high rates of obesity, hypertension, and diabetes and poorer access to preventive health services. Healthy Fit uses community health workers to extend public health department infrastructure and address Hispanic health disparities related to cardiovascular disease and access to preventive health services. We evaluated the effectiveness of Healthy Fit in 1) reaching Hispanic Americans facing health disparities, and 2) helping participants access preventive health services and make behavior changes to improve heart health.

Methods
Community health workers recruited a sample of predominantly low-income Hispanic immigrant participants (N = 514). Following a health screening, participants received vouchers for breast, cervical, and colorectal cancer screening, and received vaccinations as needed for influenza, pneumonia, and human papillomavirus. Participants who were overweight or had high blood pressure received heart health fotonovelas and referrals to community-based exercise activities. Community health workers completed follow-up phone calls at 1, 3, and 6 months after the health screening to track participant uptake on the referrals and encourage follow-through.

Results
Participants faced health disparities related to obesity and screening for breast, cervical, and colorectal cancer. Postintervention completion rates for breast, cervical, and colorectal cancer screening were 54%, 43%, and 32%, respectively, among participants who received a voucher and follow-up phone call. Among participants with follow-up data who were overweight or had high blood pressure, 70% read the fotonovela, 66% completed 1 or more heart health activities in the fotonovela, 21% attended 1 or more community-based exercise activities, and 79% took up some other exercise on their own.

Conclusion
Healthy Fit is a feasible and low-cost strategy for addressing Hispanic health disparities related to cancer and cardiovascular disease.

Introduction

Hispanics in the United States have disproportionately high rates of obesity, hypertension, and diabetes and poorer access to preventive health services (1,2). There is a need for innovative public health strategies to address the high prevalence of chronic disease and lack of access to health care among vulnerable Hispanic populations (3–5). To address these problems, federal actions like the Center for Medicaid and Medicare Services 1115 Medicaid Waivers have been launched (6). In Texas, the 1115 Waiver Program is an alternative to Medicaid expansion in association with the Patient Protection and Affordable Care Act of 2010 (7). Funding seeks to improve health care through the triple aim of improving the experience of care, enhancing population health, and reducing per capita health care costs (8). One approach to achieving the triple aim is the use of community health workers (CHWs), who can provide affordable health services in a culturally competent manner (9). Studies have demonstrated the feasibility and utility of CHWs in preventing chronic disease (10–12).

COMMENTARY

Listening to Community Health Workers: How Ethnographic Research Can Inform Positive Relationships Among Community Health Workers, Health Institutions, and Communities

Kenneth Maes, PhD, Svea Closser, PhD, MPH, and Ippolytos Kalofonos, MD, PhD

Many actors in global health are concerned with improving community health worker (CHW) policy and practice to achieve universal health care. Ethnographic research can play an important role in providing information critical to the formation of effective CHW programs, by elucidating the life histories that shape CHWs' desires for alleviation of their own and others' economic and health challenges, and by addressing the working relationships that exist among CHWs, intended beneficiaries, and health officials.

We briefly discuss ethnographic research with 3 groups of CHWs: volunteers involved in HIV/AIDS care and treatment support in Ethiopia and Mozambique and Lady Health Workers in Pakistan.

We call for a broader application of ethnographic research to inform working relationships among CHWs, communities, and health institutions. (*Am J Public Health*. 2014;104:e5–e9. doi: 10.2105/AJPH.2014.301907)

PARTICULARLY AFTER THE Alma Ata Declaration of 1978,[1] many countries institutionalized community health worker (CHW) programs as a strategy to extend primary health care to impoverished populations, and to address the relationship among poverty, inequality, and community health.[2–4] Currently, many actors in the field of global health are reaffirming the importance of CHWs in achieving universal health care. For instance, 2011 saw the Frontline Health Workers Coalition and the One Million Community Health Worker Campaign emerge in the United States through partnerships among universities, philanthropic foundations, international nongovernmental organizations (NGOs), and multinational pharmaceutical companies. Major global health institutions have identified massive shortages of CHWs, and have called for innovative and evidence-based policies that improve recruitment, retention, and performance of community health workforces.[5–9]

Across contexts, CHW programs vary considerably in terms of job descriptions, remuneration, and structural relationships to intended beneficiaries and to governmental, nongovernmental, and donor organizations. Complex political and economic challenges also surround CHW policy and practice in many contexts. Our work as ethnographers in 3 CHW contexts—Ethiopia, Pakistan, and Mozambique—suggests that positive working relationships among CHWs, the institutions that deploy them, and communities are crucial, yet are rarely treated as an explicit goal.

On the basis of our findings in these diverse contexts, we identified 3 underresearched areas of ethnographic inquiry that, if given sufficient attention, can greatly inform such relationships. The first is CHWs' life courses, and how they have shaped CHWs' desires for alleviation of their own and others' economic and health challenges. The second is the quality of existing relationships between CHWs and intended beneficiaries, particularly those who are poorer and more marginalized. And the third is the ways in which policymakers, donors, and CHWs themselves negotiate and compromise on CHW policy decisions. These areas of inquiry may be more crucial in contexts where CHWs are regarded more as labor resources deployed by health institutions and less as partners with a seat at the table of policy development, but will still be important in places where CHWs are more active in the process of policy change.

We elaborate on our ethnographic research involving participant observation and interviews with CHWs and policymakers and implementers in Ethiopia, Pakistan, and Mozambique. In Ethiopia, research focused on volunteer CHWs specializing in HIV/AIDS care and treatment support in the capital city, Addis Ababa, between 2006 and 2009. In Mozambique, research focused on volunteer CHWs working within HIV/AIDS treatment programs in the town of Chimoio between 2003 and 2010. Although both of these urban contexts are characterized by high rates of unemployment, chronic malnutrition, HIV infection, and inequality, people—including CHWs—in these contexts have different historical experiences of, for instance, colonialism, war, structural adjustment, and the role of religious institutions in health care.[10] In Pakistan, research focused on Lady Health Workers (LHWs) employed by the health department, between 2008 and 2011. These CHWs provide a variety of health services to their neighbors, from family planning education to tuberculosis treatment support, in a severely underresourced and sometimes corrupt health system that lags behind those of other countries in the region.[11–13]

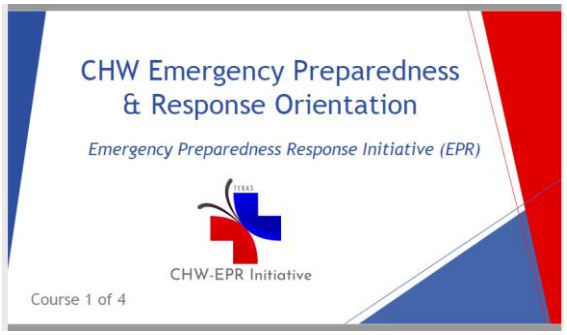
HOW AND WHY PEOPLE BECOME COMMUNITY HEALTH WORKERS

Recent ethnographic studies show that CHWs have many motivations, including hopes for better job opportunities and patron–client relationships, and desires to reduce others' suffering and live up to values of sacrifice and service.[14–19] However, studies rarely examine how CHWs' motivations are related to their life histories. Use of in-depth interviews to

Case Studies

TEPHI – CBPR Model

Israel, B. A. (2005). Methods in community-based participatory research for health (1st ed.). San Francisco, CA: Jossey-Bass



HEC – Collective Impact Model

Backbone Organization (anchor the work and strategies): Following the FSG guidance for backbone role, the backbone organization is focused facilitating the 6 functions of backbone support:

1. Guiding vision and strategy
2. Supporting aligned activities
3. Establishing shared measurement practices
4. Cultivating community engagement and ownership
5. Advancing policy
6. Mobilizing resources

Goals for Implementation – HEC Collective Impact

Technology Capacity (CIE)

- Access to services for all, meeting people where they are: Resource directory exchange infrastructure.
- Ease of referral and care coordination: Referral Network Infrastructure

Human Capacity (CHW)

- Facilitate CHW Network for the Greater Houston area to coordinate efforts.
- CHW workforce development and training to meet SDoH needs in the community.
- CHW access to CIE.
- CHW employer engagement.

Community Voice

- Building community voice and community engagement strategies to inform the CIE and CHW efforts.
- Community voice to inform policy.

Priority outcomes

- *Improved SDOH care*
- *Improved food security*
- *Improved mental health*

Establishing continuous learning and evaluation model of care
Develop policy agendas, inform policy implementation, evaluate policy


Another cautionary tale...

WHO Community Health Worker Guideline Recommendations Using Lifecycle Approach

BUILDING

COMMUNITY HEALTH NEEDS INFORM NEW SKILLS | ENHANCED SCOPE

CHW Selected

1. Based on educational level, community membership and trust

CHW Trained

2. Based on responsibilities, baseline knowledge
3. Curriculum includes service package, health system links, interpersonal skills
4. Curriculum is practical, blended, training close to community

CHW Certified

5. Formal, competency-based certification

CHW Contracted

7. Adequate remuneration
8. Formal agreement

CHW Retained

6. Supported through supervision
9. Career path opportunities

PLANNING, SUPPORT, MONITORING AND POLICYMAKING

HEALTH FOR ALL

Optimal, high-quality health system that is Accessible, Accountable, Affordable, and Reliable.

OPTIMIZING

CHW Integrated in Health System

10. Appropriate workload and population size
11. Data generation and use
12. CHW skill mix / diversified by type
13. Community engagement to use and inform services
14. Community resource mobilization and solutions
15. Contributions to "last-mile" supply chain management

EDUCATION SECTOR

COMMUNITY HEALTH LABOR MARKET

DRAFT v2 May 2019 - SOURCE: USAID / HRH2030 2019 and WHO 2018. Adapted from Sousa et al. 2013.

CHW POLICY IMPLEMENTATION ENABLERS: Tailoring CHW policy options to context | Considering CHW rights & perspectives | Embedding CHW program in health system | Investing in CHW programs

Community Health Worker Ecosystem

"We are training more CHWs but do we know how to keep them?"

CHW Training Centers

CHW Employers

"CHW supervisors are rarely other CHWs, and as such do not know what to do with us and we end up doing all their dirty work"

Source: Rosenthal et al., 2021; https://link.springer.com/chapter/10.1007/978-3-030-56375-2_2

"These are my people!"

Communities served by CHWs

Communities CHWs live in and come from

"As I was talking to the patient telling them they couldn't be served that evening, I realized that I was just one paycheck away from being in their place."

Thank You

Rosalia Guerrero, MBA, CHWI

Rosalia.Guerrero@uth.tmc.edu

UTHealth Houston
School of Public Health