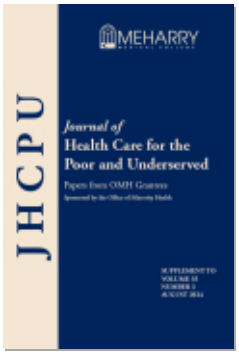
Actualizing the Full Potential of Public Health Community Health Workers



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Summary: Community health worker career paths that include policy, system change, program and process development, and advocacy will increase job satisfaction and sustainability. Community health workers employed at an organizational level can be liaisons between public health and community organizations to improve relationships and develop system-level culturally and linguistically appropriate services, information, resources, and policies.

Key words: Organizational community health workers, health literacy, career path, policy, system change, advocacy, health information, liaison.

Community health workers (CHWs) assist worldwide to improve the health of individuals and communities. They are trusted members of a community[1–3,4] who understand and connect with the community members.[1,3,4] They are often volunteer or paid workers who directly assist clients by linking them to health services,[1–5] providing them with education and resources,[1–5] and supporting their skill development.[1,5] Community health workers also ensure culturally and linguistically appropriate services (CLAS) and information are provided to those in their trusted community.[1,2,4,5] Community health workers are most often employed in health care services, social assistance programs, public health departments, and community-based organizations (CBOs).[2,3,6] Some CHWs, often those with little or no formal education, are unpaid volunteers, or receive an allowance or incentive for their work instead of a salary.[1,2,4,5] According to the Bureau of Labor Statistics, in 2022, CHWs in the U.S. held approximately 67,200 jobs.[6] The projected 2022–2032 job growth for CHWs is 14%.[6] It is imperative to expand opportunities for CHWs to help sustain this growing workforce by increasing job satisfaction through developmental and career ladder opportunities.

Introduction. Thinking innovatively and outside established norms about CHWs' traditional direct service role and how they engage with their trusted community can broaden their employment prospects. The core competencies of CHWs developed by the CHW Core Consensus Project[7] include communication skills, interpersonal and relationship-building skills, service coordination and navigation skills, capacity-building skills, advocacy skills, education and facilitation skills, individual and community assessment skills, outreach skills, professional skills and conduct, evaluation and research

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skills, and knowledge base. Lived experiences and personal community connections draw some CHWs to work beyond direct client engagement toward system-level changes[2,3,4] to develop policy, programs, initiatives, and training.[3] Some CHWs are interested in organizational career paths, including community engagement, training, advocacy, and management,[3] which align with the CHW competencies. Community health workers often possess leadership qualities that mobilize communities.[1,2] System-level work increases the opportunity for leadership and advocacy.[2,3]

Background. Salt Lake County, UT, an urban county of almost 1.2 million people, is Utah's largest and most diverse county.[8] Approximately 70% of residents identify as White alone (not Hispanic or Latino/a), 20% identify as Hispanic or Latino/a, and 10% identify as Asian, Black or African American, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, another race, or bi/multiracial.[8] Utah is home to approximately 60,000 refugees living mainly in Salt Lake County.[9] A language other than English is spoken in approximately 22% of homes,[8] and over 30 languages are spoken in Salt Lake District schools.[9] Of the foreign-born population in Salt Lake County, 57% are not U.S. citizens.[8] Understanding and advocating for the needs of ethnically diverse and underserved groups requires placing trusted members of the groups in positions where they can be bring about change and provide organizational support.[2,5]

In 2020, the Salt Lake County Health Department (SLCoHD) applied for and received an advancing health literacy grant from the Office of Minority Health (OMH). The SLCoHD developed a logic model (Appendix 1) and grant goals with evaluation measures (Appendix 2) to track grant activities. Using funds from the OMH grant, the SLCoHD developed a health literacy program within the health department's population health division, with full-time health literacy program staff consisting of a manager, three health educators, and six CHWs. The health literacy staff comprised seven females and three males, ages 25–45; seven staff spoke at least one language other than English, and seven were born in a country other than the U.S.

The SLCoHD desired to embed CHWs into the health department, using their experience, knowledge, and skillset to better inform policies, processes, and programs within the health department system. The CHWs were also to be intermediaries or liaisons between the health department and CBOs. The SLCoHD would contract with the CBOs to complete some OMH grant goals. Community health workers employed as liaisons in the health literacy program were given the job title of organizational CHWs (OCHWs). Their role was to develop trusting and collaborative relationships with CBOs, educate about and build capacity for organizational health literacy, advocate for internal and external system-level policies and processes, and conduct community assessments and evaluations. These CHWs had bachelor's degrees or higher in public health, social services, education, or a related degree, had experience conducting direct service outreach in their communities, and could use their knowledge base and previous expertise as part of a career ladder into an OCHW role to better inform policies, processes, and programs at a system level.

What was done and what happened. The health literacy staff approached their work with partners using the Collective Impact framework (Appendix 3). This framework establishes five essential conditions for all participants involved in the collaboration: 1) a common agenda: participants collectively define the problem and create a shared

vision to solve it; 2) shared measurement: participants agree to collect data and measure results consistently to ensure efforts remain aligned and allow for continuous learning, improvements, and accountability; 3) mutually reinforcing activities: participants integrate differentiated, coordinated activities through a mutually reinforcing plan of action to maximize results; 4) continuous communication: participants communicate consistently and openly to build trust and relationships, assure mutual objectives, and create common motivation; and 5) backbone support team: the organization with dedicated staff and a specific skill set, aligning and coordinating the group's work.[10,11] The SLCoHD health literacy staff was the backbone support team, with OCHWs being a crucial part of executing efforts with CBOs.

Goal one of the OMH grant was to establish trusting relationships with CBO partners. To accomplish this goal, the SLCoHD health literacy manager first established contracts with CBO partners to develop a health equity workgroup rooted in the Collective Impact framework. Members of the workgroup included the six OCHWs, 13 contracted CBOs, and the health literacy program manager. The OCHWs were liaisons for two to three CBOs. In the beginning stages of the health equity workgroup development, the SLCoHD recognized the historical power imbalance between the health department and CBOs, with the health department historically holding the majority of the power. The SLCoHD recognized CBOs as experts in their community. Following the Collective Impact framework, CBOs controlled the agenda and decisions, and the OCHWs were the backbone support, there to help align and coordinate the group's collective efforts. The workgroup agreed to identify gaps in how community members access, understand, and trust health information for decision-making and then work collaboratively to address the gaps. The OCHWs ensured the CBOs had consistent direct contact with someone they trusted to voice concerns, thoughts, or ideas and kept CBOs actively engaged in workgroup efforts. Organizational community health workers fostered trusting relationships between the SLCoHD and CBOs, helping to attain sustainable, systemic changes through shared decision-making power.[10]

The CBOs and OCHWs conducted five in-person focus groups (Appendix 4) in the community members' preferred languages to identify the gaps in how community members access, understand, and trust health information for decision-making; the discussion focused on COVID-19 messaging. A SLCoHD evaluator analyzed the focus group data and found community members generally had a high level of trust in CBOs as a source of health information, expressed difficulty understanding messages that used medical terms and jargon, and found information was inaccessible when only available in English. The OCHWs used focus group information and observations to assess CBOs' organizational health literacy gaps, which provided a baseline for identifying needed improvements and opportunities for OCHWs to offer organizational health literacy training.

Goal two of the OMH grant was for all SLCoHD Health Literacy staff to learn and understand health literacy principles and support and expand their health information work to meet CLAS standards. The Health Literacy staff completed the Institute for Healthcare Advancement (IHA) Health Literacy Specialist Certificate Program, read the Agency for Healthcare Reseach and Quality (AHRQ) Health Literacy Universal Precautions Toolkit, and researched and learned about health literacy tools and best

practices on a weekly basis. Organizational community health workers then facilitated monthly technical assistance training and education sessions with CBOs on health literacy principles, tools, and best practices, such as following the Centers for Disease Control and Prevention (CDC) Clear Communication Index or the AHRQ's Patient Education Material Assessment Tool, providing information in multiple languages, understanding your target audience, and sharing information from the audience's most trusted source.

Goal three of the OMH grant was to build productive partnerships with CBOs to provide community members with correct health information through accessible, understandable, trusted communication sources. Working together, OCHWs and CBOs used learned tools and best practices to create culturally and linguistically appropriate and relevant health information that addressed the gaps identified in the focus group data. The CBOs tracked health information engagement through social media, newsletters, in-person presentations, and events, and as improvements were implemented, information engagement steadily increased. The education provided to the CBOs by the OCHWs helped CBOs implement new organizational health literacy processes that benefitted the CBOs and their community: They could provide more culturally and linguistically appropriate and relevant health information in a format that was accessible and understandable.

The health literacy manager tasked the OCHWs with evaluating the accessibility of the health department service programs. They were asked to investigate the following questions: Are materials written clearly and available in multiple languages? Are interpreters available for all services? Are hours of service compatible with clients' needs, and are services affordable? The OCHWs felt there was a gap in language accessibility. They distributed a language access survey, adapted from the Department of Justice (DOJ) Language Access Assessment and Planning Tool (Appendix 5), to all health department staff to assess this possible gap. The survey had an approximate response rate of 25% with representation from all five health department divisions. It revealed that most staff interacted with individuals with limited English proficiency (LEP) in person and by telephone daily. The health department provided services to hundreds of LEP individuals monthly. Many materials were difficult to read or understand and unavailable in commonly needed client languages such as Chinese and Arabic, and the health department did not have consistent interpretation service processes. The OCHWs suggested implementing a policy to provide interpreters for all services and a process to train staff to work with interpreters. They also spearheaded a mass translation project. They reviewed and edited over 50 health department materials for understandability and then used OMH grant funds to translate the documents into the needed languages.

The SLCoHD implemented OCHWs' skills, lived experiences, ideas, and perspectives in other system-based capacities. Some OCHWs were asked to join short-term and long-term health department task forces or workgroups that involved developing internal policies and processes. Some OCHWs were asked to join or consult on community coalitions on initiatives, and most were asked to be part of hiring committees, which involved developing interview questions, sitting on interview panels, and consulting on hiring decisions.

Discussion. Organizational community health workers implemented internal and external organizational policies, processes, and programs with their communities in mind. They developed relationships with partners, provided training, advocated for and made system-level changes that benefited their communities. Organizational community health workers participated in and had consistent access to educational and professional growth opportunities. Health department leadership continually supported OCHWs, their perspectives, and ideas, helping to nurture and develop a new career path for CHWs within the SLCoHD. Job satisfaction of OCHWs increased as they found continual opportunities to use their skills and they felt they had continual growth opportunities. The possible sustainability of CHWs also increased as the SLCoHD leadership saw their versatile skills and the diverse ways to implement CHWs into the organization.

Future expectations. Job satisfaction and retention for CHWs will require multiple job opportunities beyond providing direct services to community members.[1,3] Creating OCHW positions adds the perspective of lived experience to policy, programs, organizational training, program development, and decision-making. As OCHWs are integrated into systems, how CHWs use their skills to assist in implementing policies, processes, programs, and standards needs to be evaluated to measure the effectiveness and impact of OCHWs in the workforce. Measurements should include 1) policies developed and implications; 2) hours spent consulting various projects, programs, and initiatives that engage CHWs' skill set, e.g., lived experience, trusted relationships, advocacy, and education, and 3) training sessions developed and delivered to internal staff and external partners.

Appendix 1. Logic Model

Inputs	Activities	Outputs	Outcomes	Impacts
• Staff (Manager, CHWs, Health Educators) • Partners • Community members • OMH grant • Equipment • Materials • Technology • Software • Facilities	• HL Certificate course • Monthly CBO collaboration workgroup • Project collaboration between Organizational CHWs-CBOs • Quality improvement project implementation with health care clinics (Health Educators)	• # of staff complete HL certificate course • # of contracted partners attending workgroup • # of developed policies, processes, tools • # of CLA messages disseminated AND engaged	• Increased staff HL skillset • Increased partner network system • Increased capacity for systematic changes • Increased reach of CLA health information	• Increased prioritization of HL among staff and partners • Improved HL and trust in health information in the target population • Sustainable information sharing processes for public health and partners

Model acronyms—HL: Health Literacy; CLA: Culturally and linguistically appropriate

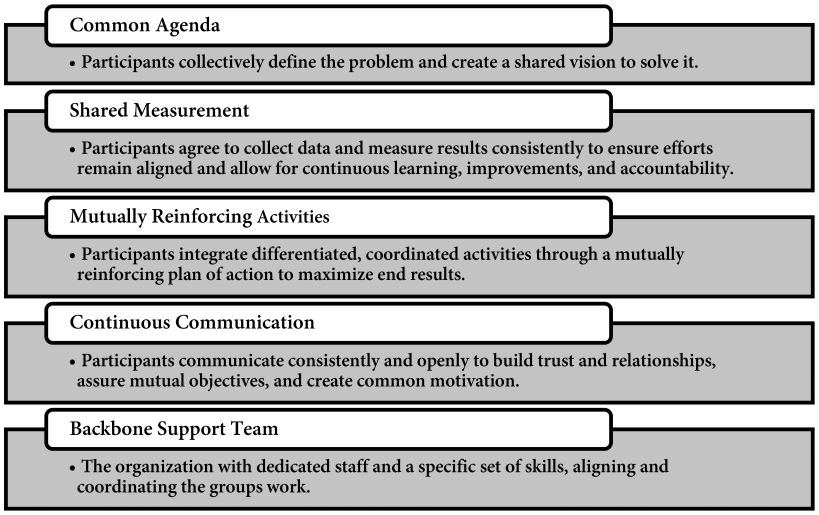
Appendix 2. Goals and high-level evaluation measures

Vision: Determine how a local health department can become a trusted partner and resource to organizations that provide culturally and linguistically relevant, appropriate, and trusted health communication to underserved groups.

*Goal 1: Establish trusting relationships with CBO partners		
By September 10th, the Health Department will have secured 9 initial contracts with CBO partners representing the grant's target populations (NHoPI, LatinX, or refugee cultures).	From January 2022 to January 2023, the PI will assess CBO reports quarterly to determine whether additional contracts should be established to reach the desired populations.	By June 2022, develop a health literacy workgroup of Organizational CHWs and CBO partners to develop processes for sharing specific health information with target communities.
*Goal 2: All staff working on the Health Literacy Grant will learn and understand Health Literacy principles to support and expand efforts of culturally and linguistically appropriate health information services.		
By February 2022, all staff working on the Health Literacy grant will have completed the Institute for Healthcare Advancement (IHA) Health Literacy Specialist Certificate Program and read the AHRQ Health Literacy Universal Precautions Toolkit.	During monthly technical assistance meetings, Organizational CHWs will facilitate training sessions on health literacy principles for CBO partners.	
Goal 3: Health Care providers will implement evidence-based interventions in their practice to meet the needs of all patient health literacy levels. (Healthy People 2030 objectives)		
By July 2022, eight Primary Care Clinics and by July 2023, eight more clinics in Salt Lake County will have implemented processes in their clinics that 1. Increase the proportion of providers who check their patient's understanding of information by employing the Teach-Back Method. 2. Decrease the proportion of adults who report poor communication with their primary care provider. 3. Increase the proportion of primary care providers that involve their patients in the decision-making process.		
Goal 4: Health Care Providers will improve communication with all patients by providing accurate, accessible, and actionable health information.		
By June 2023, primary care providers working on quality improvement projects will have implemented CLAS standards and Universal Precautions to share health information for improved health outcomes.		
*Goal 5: Build productive partnerships with CBOs to provide community members with correct health information through accessible, understandable, trusted communication sources.		
By June 2023, NHoPI, LatinX, and refugee community members will report trusted primary sources of health information who implement CLAS standards and share health information to improve health outcomes.		

*Organizational CHWs worked on activities for grant goals 1, 2, and 5.

Appendix 3. Collective Impact framework



Appendix 4. Focus Group Discussion Guide

1. Did you receive health information from a community-based organization about Covid-19? *If no, where did you get health information about Covid-19?*
   a. What type of information did you receive (vaccine info, healthy behaviors, testing info, etc.)?
   b. Where did you see or hear the information (social media, website, radio, pamphlet, etc.)?
   c. Did you trust the information you received from the community organization or other indicated organization? Why or why not?
2. How did information from these community organizations about COVID-19 influence your decisions to get vaccinated, wear masks, stay home when sick, and other COVID-19-related decisions?
3. On a scale of 1–5, please describe your confidence in making these health decisions after receiving health information from community-based organizations.

1-5 Visual Scale

   a. Please explain your rating.

4. What other health topics (or health issues) are important for you that would reduce the impact of diseases like COVID-19 in the future (i.e., diabetes, heart disease, managing stress, healthcare access, medical annual check-ups, access to healthy food)?
5. How can messages about health be more:
   a. Accessible—(i.e., you can find it)
   b. Understandable—(e.g., the message is in your preferred language, it is stated/written clearly)
   c. Usable—(i.e., you can use the message to make a decision)
6. What would the perfect health message look like to you?

Appendix 5. Language Access Survey

1. What Division and Program do you work in?
2. Please describe how your program interacts with LEP individuals (Select all that apply).
   a. In-person
   b. Telephone (call or text)
   c. Electronically (video call/meeting, email)
   d. Third-party correspondence
   e. Other
3. How does your program identify LEP individuals (select all that apply)?
   a. Assume LEP if communication seems impaired
   b. Self-identified by the LEP individuals
   c. Ask open-ended questions to determine language proficiency
   d. Respond to requests for interpretation services
   e. Based on written material submitted to the agency/program
   f. Use of "I Speak" language identification cards
   g. We have not identified LEP individuals
   h. Other
4. Do you collect primary language data from individuals when they first contact your program?
   a. Yes
   b. No
5. How many LEP individuals use your program or services each month?
   a. 1–10
   b. 11–50
   c. 51–100
   d. Hundreds
   e. Varies each month
   f. Unknown
6. Does your program have contracts with language assistance service providers?
   a. Yes
   b. No

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