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Perceived barriers, facilitators, and workforce recommendations from community health workers in Nebraska

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Abstract

Introduction Community Health Workers (CHWs) play a critical role in addressing health inequities and improving access to essential health services. However, their perspectives are often underrepresented in research examining their roles, challenges, and experiences within healthcare systems and communities.

Objective This study explored CHWs' perspectives on perceived barriers and facilitators influencing healthcare service delivery and identified recommendations to strengthen workplace supports and broader CHW workforce development.

Methods A qualitative phenomenological approach was used. A purposive sample of 65 CHWs participated in nine focus groups conducted across five health agencies in Nebraska. Data were transcribed verbatim and analyzed using thematic analysis.

Results Three major themes emerged: barriers to CHW healthcare service delivery, facilitators of health promotion, and recommendations for strengthening the CHW workforce. Community-level barriers included undocumented immigration status, cultural and gender norms, language barriers, transportation challenges, financial constraints, and limited access to affordable insurance. Structural and workplace barriers included limited awareness of community resources, healthcare provider shortages, excessive documentation requirements, restrictive eligibility criteria, unclear role definitions, low pay, heavy workload, and emotional stress. Facilitators included parental education, technology use, financial incentives, job flexibility, empowerment, communication, collaboration, trust-building, and recognition. Participants recommended strengthening funding stability, prevention-focused reimbursement policies, staffing support, workload management, collaboration, and cultural competence training.

Conclusion This study highlights structural, workplace, and community-level factors significantly shape CHWs' capacity to deliver effective services. Strengthening policy support, ensuring stable funding, improving working conditions, and integrating CHWs clearly within healthcare systems may enhance workforce sustainability and improve community-based efforts to reduce health inequities.

Keywords Community health workers, Barriers, Facilitators, Health promotion, Qualitative research, Community engagement



1 Introduction

Community health workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the communities they serve [1]. They act as cultural mediators between communities and healthcare systems, providing accessible and culturally appropriate health education and information, advocating for individual and community needs. They also offer informal counseling, social support, and facilitating referrals to appropriate healthcare services [2]. CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through outreach, community education, informal counseling, social support, and advocacy [3]. By bridging the gap between patients and practitioners, CHWs enhance care coordination, empower patients, and enhance trust within healthcare systems [4].

A body of literature demonstrated CHWs' effectiveness in improving health outcomes across various health domains. Systematic reviews and randomized controlled trials have consistently shown their positive impact on chronic disease management, prevention, and behavioral health [5–11]. CHWs play an essential role in assisting healthcare systems in achieving the “Triple Aim” of improving patient experience, enhancing population health, and reducing costs [9, 10, 12]. Furthermore, CHWs contribute substantially to the quality and cultural responsiveness of health and social services and facilitate system-level changes with long-term impact [13]. Moreover, CHWs can supplement the overburdened health workforce, particularly in underserved and hard-to-reach areas, helping to close gaps in access to essential health services and promote health equity [14].

Despite having the highest per capita healthcare spending globally, the United States (U.S.) faces substandard health outcomes and healthcare results compared to other high-income countries [15–17]. These disparities are exacerbated by social determinants of health (SDOH), environmental and socioeconomic conditions in which individuals are born, grow, live, work, and age [18]. Structural determinants of health, including cultural norms, policies, and institutional behaviors, further exacerbate inequities through the unequal distribution of resources and opportunities [19, 20]. CHWs in the U.S. primarily serve communities disproportionately affected by systemic oppression and historical marginalization, including Black, Latino, American Indian/Alaska Native, Asian/Pacific Islander, rural, and low-income populations [21, 22].

Workforce development remains important to sustain and expand the CHWs' impact. Persistence challenges, such as the absence of a clear career pipeline, limited opportunities for advancement, and high turnover rates, hinder the scaling up of the role of CHWs to address public health concerns in the U.S [23–26]. Although many CHWs have received much formal education, CHWs typically have invaluable lived experience with health inequities, social justice, and racism [27]. CHW workforce in the U.S. reflects the community they serve, with 65% identified as Black or Latinx, 23% as white, and 10% as Native Americans [28]. However, many CHWs occupy entry-level positions with low pay and limited responsibility, contributing to job dissatisfaction and high turnover rates up to 50%, which can be expensive for employers and CHWs [29–32].

Although workforce development remains important for sustaining CHWs' contributions, there is limited qualitative research exploring how CHWs themselves describe the barriers and facilitators influencing their day-to-day service delivery within community and healthcare settings [33]. Therefore, this present study employed a qualitative

approach to gain a deeper understanding of the experiences of CHWs and the factors influencing their delivery service. The primary objective of this study was to explore CHWs' perspectives on perceived barriers and facilitators to effective service delivery and to identify recommendations that may strengthen workplace supports and broader workforce development efforts. By centering CHWs' lived experiences, this study will inform organizational practices and policy strategies that better support their role in advancing the community health and health equity.

2 Methods

2.1 Study design

This study is part of a larger project titled "Strengthening the Community Health Worker Workforce to Improve Maternal and Child Health in Nebraska: A State-Wide Assessment of Needs, Barriers, and Assets" which investigated the needs and interests of CHWs such as training, community engagement, workplace support, career ladders, evidence-based practices, team or collaborative models, sustained communication and networking channels, and Title V related activities [34].

The present study used a qualitative phenomenological approach to understand CHWs' perspectives on barriers and facilitators they encountered in performing their duties within communities and healthcare systems. These phenomena are difficult to capture quantitatively [35]. Our approach was grounded in social constructivism and phenomenological philosophies, concentrating on describing the lived experiences and meanings that CHWs associate with their work [36, 37]. Data collection and analysis followed an iterative process to develop a rich understanding of participants' perspectives.

The research team was affiliated with the University of Nebraska Medical Center and conducted this study as part of a statewide CHW workforce assessment initiative. The study team collaborated with the Nebraska Department of Health and Human Services and local health departments across the state to recruit CHWs and key informants representing diverse regions of Nebraska. Although the researchers had prior professional familiarity with CHW programs through public health collaborations, they did not hold supervisory or evaluative authority over participants. Focus group discussions were led by qualitative facilitators with over 5 years of experience.

2.2 Participants and settings

The study involved sixty-five CHWs from diverse community settings across Nebraska. Initial participants were recruited through collaboration with the Nebraska Department of Health and Human Services and participating local health departments, which disseminated study information to CHWs within their professional networks. Purposive sampling with snowball recruitment was subsequently used, with enrolled participants referring additional eligible CHWs to ensure diversity in experiences and work settings among those who deliver, manage, and coordinate services. To be eligible, participants had to be 19 years or older, self-identify as a CHW, be proficient in English, and work in Nebraska. The minimum age requirement of 19 years was selected to align with Nebraska's legal age of majority (Nebraska Revised Statute § 43-2101), which defines 19 as the age at which individuals may provide independent consent for research participation [38]. English proficiency was required to ensure consistency in focus group discussions and qualitative data transcription and analysis.

2.3 Procedure

The research team developed a facilitator guide to standardize focus group discussions (FGDs); the full facilitator guide is available in the Supplementary Appendix. FGDs were held in 2019: two rounds occurred in April-May and July 2019. In total, nine focus groups were conducted across five health departments (Public Health Solutions in Crete, South Heartland District Health Department in Hastings, Two Rivers Public Health Department in Holdrege/Kearney, Elkhorn Logan Valley Public Health Department in Norfolk, and Douglas County Health Department in Omaha). Two sessions were planned for each health department, with each session covering different topics of discussion. However, due to participant availability, one session at the Crete site did not have participants. As a result, a total of nine focus groups were conducted across the five health departments. The first session focused on CHWs' perspectives on their roles in the community, and the second on their roles within the healthcare system. A total of 65 unique CHWs participated across the nine focus groups. Participants at each site were invited to attend both sessions; however, attendance varied across sessions, and some participants attended only one session. Focus group size ranged from approximately 6 to 15 participants depending on participant availability at each site.

Before each FGD, the facilitator read the informed consent form aloud and obtained verbal informed consent from all participants and provided them with a copy of the consent form. Participants were informed about audiotaping during sessions. Demographic data were collected using a voluntary questionnaire; therefore, not all participants completed all items, resulting in varying sample sizes across demographic variables. Recognizing that CHWs are frequently unpaid when not engaged in their primary work assignment, participants were compensated \$60 for each 2.5-hour session and reimbursed for travel expenses by the local health departments.

2.4 Ethical consideration

This study was approved by the Institutional Review Board of the University of Nebraska Medical Center (IRB # 900-18-EX). Data collection started after obtaining verbal informed consent from all participants in accordance with IRB approval. Participants were fully informed about the study's procedures and were free to withdraw from the study or refuse to answer specific questions at any time during the data collection process. Only de-identified data were used for dissemination.

2.5 Data management and analysis

FGDs were audio-recorded and transcribed verbatim. Transcripts were assigned letters and numbers, uploaded to a password-protected computer, and stored using secure cloud software. A thematic analysis was conducted primarily by two researchers (GK and PC) [39]. The analysis followed a three-stage process: familiarization, reduction, and exploration [40]. During the familiarization stage, the transcripts were thoroughly read several times by GK and PC to ensure a comprehensive understanding of the data. In the reduction stage, both researchers (GK and PC) independently coded the transcripts using an inductive approach to categorize content into broad topics and then assigned descriptors to individual text units. Both researchers independently coded all transcripts to ensure consistency in the coding process. Initial codes were developed directly from the data and applied to meaningful segments of text. GK and PC met to compare their

thematic interpretations, discuss discrepancies, and refine the codebook until consensus was reached. Throughout the exploration stage, thematic maps were developed to organize content according to the assigned codes. Analytic decisions and theme development were documented throughout the process to maintain an audit trail of the analysis. The analytic process was iterative, with codes and themes refined through ongoing comparison of transcripts and team discussions. Themes were identified by integrating multiple data points consistently present in the transcripts and connecting them to various codes, reflecting both latent and manifest content. The research team met again to review and refined themes iteratively until consensus was reached. For the data analysis, QSR NVivo software version 13 was employed to support coding and data organization. GK and PC are doctoral-level public health researchers with more than 10 years of combined experience conducting qualitative research. They did not have prior personal or professional relationships with the participating CHWs and did not hold any supervisory or evaluative roles over participants. Reflexive discussions were conducted throughout the analytic process to acknowledge and minimize potential bias. The Standards for Reporting Qualitative Research (SRQR) guidelines were followed throughout this study [41].

3 Results

We conducted nine focus groups with 65 CHWs, of whom only three were male. These participants were mostly part-time, paid workers in clinical or healthcare settings, and the majority had received formal training or held another professional license prior to becoming a CHW (Tables 1 and 2).

The qualitative analysis revealed three key themes with subthemes: (1) barriers to CHW healthcare service delivery, (2) facilitators of health promotion, and (3) recommendations for strengthening the CHW workforce.

3.1 Barriers to CHW healthcare service delivery

CHWs identified a wide range of barriers to healthcare service delivery. These barriers were categorized into two broad domains: (1) community-related barriers to healthcare access and (2) structural and workplace barriers affecting CHW practice.

Table 1 Characteristics of the focus group participants

Category	Count (n, %)
Work setting (n = 50)	
Clinical or Health Care Organization	17 (34)
Community Organization	11 (22)
Not Currently Working as CHW	10 (20)
Other	12 (24)
Work status (n = 48)	
Paid	35 (73)
Volunteer	13 (27)
Work hours (n = 49)	
Full-time	23 (47)
Part-time or less	26 (53)
CHW Training (n = 50)	
Yes	41 (82)
No	9 (18)
Other Professional Licensure (n = 49)	
Yes	27 (55)
No	22 (45)

Numbers and percentages are based on respondents for each item, and it varies due to missing data

Table 2 Themes and subthemes identified from focus group discussions with CHWs ($n = 65$)

Theme	Subthemes
1. Barriers to CHW healthcare service delivery	Community-related barriers: undocumented immigration status; cultural and societal norms; gender norms; language barriers; transportation challenges; financial constraints; limited access to affordable health insurance Structural and workplace barriers affecting CHW practice: limited awareness of community resources; healthcare provider shortages; excessive documentation requirements; discontinued programs; restrictive eligibility criteria; unclear role definitions; inadequate compensation; heavy workload; emotional stress
2. Facilitators of health promotion	Community-related facilitators: parental education and support; technology use; financial incentives Structural and workplace facilitators supporting CHW practice: job flexibility; exposure to diverse communities; empowerment and sense of purpose; effective communication; trust-building; collaboration and teamwork; recognition and appreciation
3. Recommendations for strengthening the CHW workforce	Structural and policy-level recommendations: funding stability; prevention-focused reimbursement and policy support Recommendations for improving CHW working conditions: workload management; staffing support; collaboration; cultural competence training

3.1.1 Community-related barriers to healthcare access

Participants identified several community-related barriers that limit individuals' access to healthcare services. These barriers are undocumented immigration status, cultural and societal norms, gender-based norms, language barriers, transportation challenges, financial constraints, and limited access to affordable health insurance. The issue of undocumented immigration emerges as a major barrier. CHWs emphasized the fear and restricted eligibility that prevent undocumented individuals in accessing healthcare services for themselves or their children. One participant stated: *"Some people, they're here illegally, and how can they get health insurance? And how can their babies get health insurance? That's just scary. They don't have any healthcare benefits. They can't get it."* Participants also noted that some individuals with Medicaid or private insurance underutilized services due to limited understanding of coverage and benefits, further complicating access to care.

Cultural and societal norms were also noted as discouraging factors of help-seeking, especially when deep-rooted beliefs conflict with preventive care or mental health treatment. A participant noted: *"Trying to change that way of thinking is hard..., it's back to their cultural background."* Another CHW remarked the stigma surrounding mental health in some communities, noting: *"I have noticed [depression] that more in a Hispanic culture, it's more taboos and not so much admitted to or talked about."*

Gender norms may also influence healthcare utilization. Men may resist seeking treatment or screening until serious symptoms occur. One participant pointed, *"... If they don't feel or see anything, they will just keep going, and sometimes, even when they do, they don't care. Many times, they say, 'I don't want treatment. I just want to live my life.'"*

Additional less-identified barriers included language barriers, which make communication with providers difficult; transportation challenges, which delay or prevent visits; financial constraints, which force families to choose between medical care and basic needs; and lack of affordable health insurance, especially for individuals just above Medicaid income limits. These interrelated barriers collectively obstruct timely and equitable access to care.

3.1.2 Structural and workplace barriers affecting CHW practice

CHWs identified several structural and workplace barriers that affected their ability to deliver services effectively. These challenges stemmed from organizational constraints, healthcare system limitations, and resource shortages rather than from CHWs themselves. Participants described barriers including limited awareness of available community resources, shortages of healthcare providers, excessive documentation requirements, discontinued programs, restrictive eligibility criteria, unclear role definitions, inadequate compensation, and emotional strain.

A major challenge was limited knowledge of community resources, affecting both CHWs and the public. A CHW stated, *“Trying to reach everybody in the community that pretty hard...an ideal situation would be that everybody is aware of the different resources in a community...But a lot of times, people don't know or are afraid to go.”*

Shortage of healthcare providers constrained service delivery, especially in rapidly growing rural communities. One CHW expressed the concern, stating, *“They [clients] don't want to come in because they know that resource probably isn't going to be available that day that they want to come in.... with a lot of families moving to Crete, coming from other countries where it was very difficult to find healthcare.”*

Participants also stated that there was the discontinuation of valuable programs, such as the removal of the phone nurse services within the Department of Health and Human Services (DHHS). A CHW expressed disappointment, stating, *“Well, I would say a resource that was very disappointing to see that was cut within DHHS was the phone nurse. That educated a lot of people...and they decided that was a cut that was going to be smart.”*

CHWs also emphasized that restrictive Medicaid eligibility and authorization rules further limit healthcare access. One CHW explained, *“I'm frustrated with those physicians that are not understanding...we know this person needs help. And we're kind of it for our area to offer the help. So if they don't meet criteria with us, they're not going to get the help they need.”* Additionally, another participant expressed concern about the lack of Medicaid-accepting providers, stating, *“Well, I was thinking right now maybe in the doctor's office or dentist office more would ask, they need a lot of help because right now, the problem over in my community is no doctors taking Medicaid.”*

Organizational factors within workplaces also affected CHW practice. Participants described unclear role definitions, lack of dedicated CHW positions, and reliance on fluctuating grant funding. One CHW explained, *“We don't have a position that's just for a community health worker...so you have to sort of make it fit in... depending on what funding is available at the time.”*

Inadequate compensation and increasing workload demands further contributed to strain. One CHW indicated, *“I take my time in the afternoon, and sometimes, I don't have— when they [client] come, they wait. And sometimes they leave. And I feel guilty because I'm busy with a patient. I think time is a constraint, any client or thing that you're working on takes time.”*

CHWs described emotional stress resulting from exposure to community trauma and unmet client needs. The emotional burden of wanting to address complex social and health issues, often without sufficient system-level support, contributed to feelings of stress and exhaustion. A CHW expressed, *“This is just stressful...Well, just the community*

that I work with, there's a lot of traumas, [and] different home issues. It's not just health... It becomes stressful for you."

3.2 Facilitators in health promotion

CHWs identified several facilitators that supported effective health promotion and service delivery. These facilitators were categorized into two broad domains: (1) community-related facilitators, which enhance engagement and participation among clients and families, and (2) structural and workplace facilitators supporting CHW practice, which reflect organizational supports and job conditions that enable effective service delivery.

3.2.1 Community-related facilitators

Parental education and support were stated as important tools for promoting family well-being. One CHW noted, *"I don't know if any of you have done [the Circle of Security class]. It's more focused towards the mental health aspect of parents, and the relationship with their children...So that's good training."* Additionally, another participant highlighted the importance of education on domestic abuse as essential for supporting vulnerable mothers, stating, *"I can provide the mom with as much information as I can in offering to be of assistance whenever they need something."*

CHWs highlighted the use of technology as an opportunity to strengthen and streamline service delivery. One participant shared her experience and challenges with paper-based systems and expressed interest in digital solutions, stating, *"I am relying on children to take parent permission slips home and relying on children to bring them back, signed... It would be great if you could link in an app or parents could pull that up and be like, 'Oh, I want to do E-sign.' It's in their face, readily available."*

Additionally, CHWs viewed financial incentives as effective motivators for encouraging participation in health screening and programs, particularly among men. One of the participants pointed out, *"The men are doing [screening] it because they want that gift card. So, incentives seem to really help. Isn't that funny?"* CHWs noted that the sustainability of incentives depends on available funding: *"We need incentives to get people to come to, but then once again, if you don't have the funding or the money, who wants to come sit for hours and listen to you?"*

3.2.2 Structural and workplace facilitators supporting CHW practice

CHWs described several structural and workplace conditions that supported their ability to promote health effectively. These facilitators reflected organizational support and job structures rather than individual CHW characteristics. Flexibility in their roles allowed them to organize workshops, collaborate with different organizations, and tailor services to community needs. One CHW stated, *"I really like that I have the flexibility collaborating with different organizations and then bringing in people that are informed on a certain topic and giving that information out to clients. I enjoy that."*

Exposure to diverse communities and cultures was also viewed as professionally enriching and motivating. According to one CHW, *"I've learned so many different things about so many different cultures and people, and it just makes my life, I think, richer."*

A sense of purpose and empowerment emerged as an important motivational facilitator, particularly when CHWs observed tangible improvements in clients' health and confidence. One CHW mentioned, *"I teach a living well class, and it's really nice to see the*

people become empowered to help themselves.” Another CHW expressed, *“I like it when I’m talking to the patients, hearing their excitement about how they’ve lost some weight, things are improving with those risk factors. So, I like hearing them be excited about the progress they’re making.”*

Additional facilitators included effective communication, trust-building, teamwork and collaboration, recognition, and expressions of appreciation. These characteristics promote strong community relationships, enhance service delivery, and reinforce CHWs’ motivation and commitment to improving community health.

3.3 Recommendations for strengthening the CHW workforce

CHWs proposed several recommendations to enhance their practice and strengthen their roles. These recommendations were categorized into two broad domains: (1) structural and policy-level recommendations for strengthening the CHW workforce and (2) recommendations for improving CHW working conditions.

3.3.1 Structural and policy-level recommendations for strengthening the CHW workforce

3.3.1.1 Enhance funding stability and reimbursement structures Participants emphasized that stable and sustained funding is critical for effective program implementation and long-term workforce sustainability. Funding instability was perceived as limiting program continuity and contributing to service delays. CHWs also highlighted the lack of funding as a significant barrier to the implementation of effective programs and services. They called for more stable funding to address unmet health needs. As one participant put it straightforwardly, *“... Funding is always the biggest barrier to a lot of things.”*

3.3.1.2 Policy changes and reimbursement support CHWs highlighted the importance of policy changes that support and reimburse prevention-focused programs. Participants observed that healthcare systems tend to prioritize treatment over preventive services. One participant emphasized the need for policy changes, saying, *“Some policy changes that are embracing and truly talking the talk... There’s a lot of talk about prevention, but there’s not enough... reimbursement with our program for prevention services.”*

3.3.2 Recommendations for improving CHW working conditions

3.3.2.1 Improve workload and time management CHWs expressed a need for less responsibility, suggesting that reducing the number of programs they oversee could lead to more efficient work and enable them to exceed high standards. One participant mentioned, *“If you are in charge of two programs instead of four, you’re going to do your job more efficiently, and you might be able to go above and beyond what your high standards are.”* Further, participants mentioned the heavy workload and expressed a desire for more hours in the day. However, several participants emphasized that achieving balance could be accomplished by reducing responsibilities rather than increasing working hours. A participant explained, *“Maybe not more hours, but less responsibilities.”*

3.3.2.2 Strengthening collaboration and staffing support Collaboration was identified as a key factor in achieving success. Participants emphasized the importance of working together within teams and departments to pool ideas and resources. One participant stated that shared resources and collective problem-solving lead to better outcomes, *“Our best successes are when we work together and pool our ideas and resources. If you’re trying*

to do it yourself on an island somewhere, then you're not going to have access to as many things." Also, participants emphasized the importance of quick referrals to resources and services, as delays often lead to frustration and disengagement. Another participant highlighted the need for immediate assistance, stating, *"We could do a lot better things if we didn't have to put people on a waitlist because by that point, they're frustrated, and they've either wandered off or given up."*

CHWs highlighted the need to recruit additional staff and volunteers to support home visitation programs that promote healthcare and preventive care. A participant stated, *"More staff or volunteers."*

3.3.3 Expand cultural competence and training

Participants recognized the importance of cultural training in delivering effective and respectful care to diverse populations. One participant stated, *"I would love to have Vietnamese, Sudanese, whatever it is, I would like to learn myself so I know, and I can be respectful towards them."* CHWs emphasized that understanding cultural backgrounds enhance communication, trust-building, and overall service effectiveness.

4 Discussion

To our knowledge, this is the first qualitative study in Nebraska to explore CHWs' perspectives on the barriers and facilitators influencing their ability to perform their jobs within their communities and the healthcare system. Several themes and subthemes were identified through thematic analysis, providing a complete picture of the numerous barriers, facilitators, and recommendations related to CHW for improving healthcare service delivery. These findings provide insights to inform policies and practices strengthening the CHW workforce and enhancing community health outcomes. Importantly, these insights are particularly relevant within Nebraska's healthcare landscape, where rural service gaps, provider shortages, and diverse immigrant communities shape the daily work of CHWs.

One of the main themes in the findings was the complex network of barriers that significantly prevents the utilization of healthcare services within the community. These barriers were undocumented immigration status, cultural and societal values, language barriers, transportation difficulties, and financial limitations. Participants frequently described encountering these challenges while attempting to connect community members with available healthcare services, illustrating how broader structural factors directly shape their day-to-day practice. Undocumented immigration status has emerged as a significant barrier to accessing healthcare services. Countries across the globe have implemented policies that limit healthcare access for undocumented populations [42–45]. In the US, the Affordable Care Act excludes undocumented immigrants from health insurance coverage [46, 47], and Medicaid and CHIP eligibility require lawful permanent residents and green card holders to live in the US for at least five years after receiving "qualified" immigration status before receiving or qualifying for benefits [48]. Although Nebraska and some other states expanded Medicaid and the Children's Health Insurance Program (CHIP) to nearly 36% of immigrants living in the US for more than five years, many in non-expansion states remain uninsured, increasing healthcare costs and straining the system [49]. Participants in our study described how these

structural and eligibility constraints often create fear and uncertainty among community members seeking healthcare services.

Cultural and societal norms emerged as another crucial determinant influencing healthcare utilization trends. For example, deeply rooted ideas and traditions significantly shape individuals' perspectives on health and healthcare, leading to hesitancy to pursue or prioritize optimal healthcare services [50, 51]. Furthermore, a recent study by Butkus and colleagues [34] identified transportation and work-related challenges as significant hurdles impeding patients' access to timely preventive care. An additional barrier to effective communication is the language barrier. It has been noted that around 20% of households in the United States utilize a language other than English [52]. This presents a progressively complex situation for healthcare systems as they strive to effectively meet the linguistic needs of their patients [53, 54]. In the focus groups, CHWs emphasized that these barriers often intersect, requiring CHWs to rely on culturally responsive communication and trust-building strategies when working with diverse communities. The challenges CHWs face in assisting their clients stem from the influence of their work environment on service delivery and community involvement [55]. The above-mentioned issues involved limitations and constraints regarding available resources and the scope of their duties and responsibilities [55, 56]. In alignment with previous research, the dynamic nature of community health has demonstrated changes in occupational responsibilities, heightened workloads due to financial constraints and escalating demand, and conflicting job objectives, all of which have presented obstacles to the existing norms and care rationale of community personnel [55–57]. These findings suggest that CHWs frequently operate within constrained systems where they must balance administrative demands with community engagement, reinforcing their role as frontline navigators of complex health and social service systems.

In addition to barriers to healthcare access, the findings from this study revealed several factors that contribute to facilitating health promotion and community engagement. Health promotion was influenced by several key elements, including parental education and support, the promotion of technology, and the provision of financial incentives. Participants described these facilitators as practical tools that helped them engage community members and encourage participation in health programs. Consistent with previous studies, community engagement and educational initiatives empower individuals and families to make more informed health decisions [58, 59]. The integration of technology [60, 61] and financial incentives [62, 63] may further influence health promotion effectiveness.

Job satisfaction among CHWs is influenced by work flexibility, a sense of empowerment, and the opportunity to serve their respective communities. Participants frequently noted that flexibility in their roles allowed them to adapt services to the needs of their communities and collaborate with multiple organizations. These findings are consistent with prior research by Chaidez and colleagues [64], who found that work satisfaction, flexibility, diversity, and empowerment were positively associated with the motivation of CHWs. The findings highlighted the importance of offering CHWs sufficient support and resources, such as equitable remuneration, adaptable work schedules, and opportunities for professional growth and retention [29, 55, 65].

The present study unveiled the urgency of organizational and policy-level interventions to strengthen CHW programs. Effective service delivery requires a manageable

workload, strong time management, and strong collaboration across health systems. Participants highlighted that heavy workloads and limited staffing often restrict their ability to fully meet community needs, emphasizing the importance of workforce support and organizational investment in CHW roles. Consistent with previous studies, reducing unnecessary workload can substantially enhance CHW efficiency [55, 56, 66]. Also, studies emphasized the need for multidisciplinary care teams and interprofessional collaboration between healthcare facilities and communities [55, 67, 68]. To optimize CHWs' role in community health and reduce health disparities, programs must address workload, encourage teamwork, and sustain provider support.

Addressing CHW understaffing and high turnover requires investment in workforce development and fair compensation. Both monetary (e.g., salaries, financial incentives) and non-monetary (e.g., professional identity, respect, trust, and recognition) incentives are essential motivators for CHWs [69]. Cultural competency training is necessary for engaging with varied people and tailoring interventions to specific cultural situations. A study in Nebraska highlighted CHWs' overwhelming support for a statewide certification program to validate their involvement in healthcare systems [70]. Participants in this study similarly emphasized the importance of professional recognition and workforce support to sustain their roles within the healthcare system.

Collectively, these findings highlight how both structural conditions and workplace environments shape CHWs' ability to effectively support community health promotion efforts. By centering CHWs' lived experiences, this study provides a nuanced understanding of how systemic barriers, workplace realities, and community dynamics interact to influence service delivery. By examining these experiences within Nebraska, this study contributes context-specific insights to the broader literature on CHW workforce development and the practical implementation of community health programs.

4.1 Strengths and limitations

The present study highlights notable limitations that warrant attention. The use of convenience and snowball sampling may limit the generalizability of our findings beyond the Nebraska community settings and could introduce selection bias, as participants may share similar perspectives or organizational affiliations. The study did not stratify findings by types or levels of health centers, which future research could examine to capture more nuanced differences across practice settings. Only CHWs who were proficient in English were eligible to participate. These criteria may have excluded non-English-speaking CHWs and limited the representation of perspectives from a linguistically diverse CHW workforce. In addition, detailed demographic information such as age and race/ethnicity was not collected, limiting our ability to describe participant diversity beyond employment characteristics. Furthermore, over half of participants with available data reported holding an additional professional licensure. While this may reflect real-world workforce diversity, where some CHWs hold dual roles or additional certifications, it may not fully represent the broader CHW workforce, in which formal licensure is less common, thereby potentially limiting generalizability. Additionally, demographic data were not available for all participants, as these were collected using a voluntary questionnaire and not all participants completed all items, resulting in missing data for approximately 20% of participants. Finally, data were collected in 2019, prior to the COVID-19 pandemic and subsequent shifts in healthcare delivery and workforce

policy; therefore, findings should be interpreted within the context of that period, and future research is needed to assess post-pandemic changes in CHW practice and systems integration.

Despite these limitations, our study had several notable strengths. We consistently used a systematic data-collection strategy, which increased the reliability and validity of the data. We cross-referenced transcripts with audio recordings to ensure quality assurance. We also used a triangulation approach among several coders to enhance the reliability and validity of the findings. Most importantly, we conducted research with individuals from multiple health departments across Nebraska, providing a diverse and comprehensive understanding of the CHW workforce in the Midwest.

5 Conclusion

This study provides insight into how structural conditions, workplace environments, and community contexts shape the work of CHWs in Nebraska. Participants' perspectives highlight that barriers to effective service delivery are not only community-level challenges but also reflect broader workforce and health system conditions, including resource constraints, administrative demands, and limited institutional support. These findings suggest that strengthening the CHW workforce requires coordinated organizational and policy efforts that support stable funding, workforce sustainability, and clearer integration of CHWs within healthcare systems. By centering the lived experiences of CHWs, this study contributes context-specific evidence that can inform workforce development strategies and guide policies aimed at strengthening community-based health services and addressing health inequities.

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12982-026-01994-z>.

Supplementary Material 1.

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Author contributions

Study concept and design were contributed by G.K, D.S, and D.M.T. Acquisition of data was conducted by G.K, D.S, and D.M.T. Analysis and interpretation of data were performed by G.K and P.C. Drafting of the manuscript was completed by G.K, and critical revision of the manuscript was provided by P.C, P.G, D.S and D.M.T. All authors reviewed and approved the final version of the manuscript.

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Data availability

The datasets generated and analyzed during this study are not publicly available due to confidentiality protection but may be made available from the corresponding author upon reasonable request.

Declarations

Ethics approval

This study was reviewed and approved by the Institutional Review Board of the University of Nebraska Medical Center (IRB #900-18-EX) in accordance with the Declaration of Helsinki.

Consent to participate

All participants provided informed consent prior to participation, were notified of the voluntary nature of the study, and were assured that their responses would remain confidential and de-identified.

Consent for publication

All participants were informed that anonymized data and findings from this study may be published in peer-reviewed journals, and informed consent to publish de-identified findings was obtained from all participants prior to data collection. All authors contributed to the manuscript revision, read and approved the submitted version.

Competing interests

The authors declare no competing interests.

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