Community Health Workers: Social Change Agents Advancing Health Equity and Improving Outcomes

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Community Health Workers (CHWs)

Lay health advisors
Promotoras
Community health advisors
Community health representatives
Outreach workers
Patient Navigators
Doulas
Frontline workers

Ro, Treadwell, & Northridge, 2004
Integral Players in the Race towards Health Equity
“Bridging the gap is only the most basic element of what community health workers provide when assisting the poor, underserved, and disconnected in search of healing.”

Role of Community Health Workers

- Provide health advice
- Assist the community in accessing care and health insurance
- Indigenous health researchers

Ro, Treadwell, & Northridge, 2004
Reducing Disparities from a Social Perspective

CHWs help to eliminate social barriers inhibiting the achievement of health equity, such as:

- Historical mistrust of the healthcare system affecting patient-provider relationships
- Lack of culturally competent care provision
- Difficulty navigating the healthcare system

Ro, Treadwell, & Northridge, 2004
Defining the Role of CHWs

• Assist individuals and communities to adopt healthy behaviors.

• Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health.
Defining the Role of CHWs cont.

• May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening.

• May collect data to help identify community health needs.
Distribution of CHWs, 2015

Employment of community health workers, by state, May 2015

Blank areas indicate data not available.

U.S. Department of Labor, 2016
Distribution of CHWs, 2015

Annual mean wage of community health workers, by state, May 2015

- $24,320 - $35,050
- $39,040 - $43,220
- $35,100 - $38,930
- $43,420 - $65,990

Blank areas indicate data not available.

U.S. Department of Labor, 2016
Distribution of CHWs, 2015 cont.

- California (5,360), Texas (3,670), New York (3,070), Illinois (2,860) and Massachusetts (2,530) have the highest employment levels of CHWs.

- However, Washington D.C. ($65,990), Virginia ($46,740), Oregon ($45,580), South Carolina ($44,920), and Washington ($44,890) are top paying states for CHWs.

U.S. Department of Labor, 2016
# CHW Industry Distribution

<table>
<thead>
<tr>
<th>Industry</th>
<th>Employment</th>
<th>Percent of Industry Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual and Family Services</td>
<td>8,440</td>
<td>0.53</td>
</tr>
<tr>
<td>Local Government (OES Designation)</td>
<td>6,710</td>
<td>0.13</td>
</tr>
<tr>
<td>Outpatient Care Centers</td>
<td>4,930</td>
<td>0.67</td>
</tr>
<tr>
<td>General Medical and Surgical Hospitals</td>
<td>3,950</td>
<td>0.07</td>
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<tr>
<td>Offices of Physicians</td>
<td>2,870</td>
<td>0.11</td>
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U.S. Department of Labor, 2016
CHW Industry Distribution cont.

- Individual and family services is the industry that accounts for the highest level of employment of CHWs.
- Local government (excluding schools and hospitals) is the industry with the second highest level of employment of CHWs.
- Various health centers/institutions account for the remaining top 5 of industries with high CHW employment.

U.S. Department of Labor, 2016
EXAMPLES FROM THE FIELD

Community Voices: Healthcare for the Underserved
Who We Are

• Established in 1998 as a multidimensional, nationally recognized initiative to address issues plaguing underserved communities.

• Our mission is to listen to voices in the community that often go unheard and take an active leadership role in improving health for all.
Five Key Areas

1. Health and prison
2. Mental and behavioral health
3. Men’s health
4. Adult and childhood obesity
5. Health and social policy
SAVE OUR SONS (SOS)
A Focus on Diabetes and Hypertension among African American Men
SAVE OUR SONS OVERVIEW

• Pilot Location: Elyria, OH with the Lorain County Urban League (LCUL)
  • Expanded in 2009 to include The Urban League of Greater Dallas and North Central Texas (DUL)
• Partners: National Urban League, LCUL, DUL, Community Voices and Pfizer
• Based on the CDC and NIH developed “Power to Prevent” Curriculum
• Provided series of workshops and Group fitness activities in 3 month cohorts
Addressing Obesity and Diabetes Among African American Men: Examination of a Community-Based Model of Prevention

Henrie Treadwell, PhD; Kisha Holdren, PhD; Richard Hubbard, MD; Forest Harper, BA; Fred Wright, BS; Michael Farner, BA; Shara Houston-McCain, MSA; Gino Villani, MD; Aaron Thomas, MPH; Florence Washington, BS; Edward K. Kim, MPA

Funding/Support: This project was funded by Pfizer Inc.

The Save Our Sons study is a community-based, culturally responsive, and gender-specific intervention aimed at reducing obesity and diabetes among a small sample (n = 43) of African American men. The goals of the study were to (1) test the feasibility of implementing a group health education and intervention model to reduce the incidence of obesity and diabetes among African American men, (2) improve regular access to and utilization of health-care services and community supportive resources to promote healthy lifestyles among African American men, and (3) build community networks and capacity for self-advocacy and addressing some of the health needs of African American men residing in Lorain County, Ohio. Trained community health workers facilitated activities to achieve program aims. Following the successful intervention, the protocol demonstrated that participants had greater knowledge about strategies for prevention and management of obesity and diabetes, increased engagement in exercise and fitness activities, decreased body mass index, and body mass index levels and visited a primary care doctor more frequently. Additionally, improved weight maintenance was observed among African American men's health and identified it as a priority in their community. This model of prevention appears to be a substantial, robust, and replicable approach for managing the health and well-being of African American men.

Keywords: diabetes, obesity, African American, and intervention

INTRODUCTION

Health Disparities and African American Men

African Americans face significant health challenges and disparities relative to other ethnic groups in the United States. Limited access and utilization of health care services place an immense burden on the social and economic realities that are central to their existence and ability to thrive in society. The overwhelming incidence among African Americans of preventable chronic diseases such as diabetes, stroke, heart disease, and cancer not only contributes to higher morbidity and mortality rates but also threatens the survival of healthy families. To nearly all measures and indicators of health, African Americans lag behind their white counterparts. In a study on racial and ethnic disparities, it was suggested that African Americans overall suffered 40.5% more deaths that year than would have been expected if they were Caucasian. Furthermore, African American men are particularly at risk and have significantly lower life expectancy: 66.1 years, compared to the national average of 73.6 years for all men, and suffer disproportionately from the effects of chronic disease more than any other group.

Additionally, among some African American men, high rates of incarceration, unemployment, and low levels of college graduation rates negatively affect their quality of life as well as access to health care insurance coverage and quality health care. Consequently, it is crucial that early attention be provided to heightening awareness of the prevalence and predictors of chronic diseases among African American men, such as obesity.

Data on the Save Our Sons Pilot Program conducted in Elyria, OH was published in the September 2010 JNMA.

New articles in development on cross site evaluation and impact of CHWs on diabetes education.
Project Goals:

- To develop, implement, and evaluate a health education model aimed at reducing diabetes and obesity among African-American men

- To improve access to primary healthcare services for African-American men
SOS PROJECT OBJECTIVES

- Establish a primary care home
- Access supportive community resources
- Improve selected health behaviors
- Increase awareness and knowledge of obesity/diabetes prevention strategies
SOS PROJECT ACTIVITIES

• Conduct six session curriculum intervention for program participants
• Provide exercise education and opportunities for program participants
• Collect medical screening and weight loss data for program participants
• Connect program participants with social services to meet their individual needs
KEY PROGRAM OUTCOMES

• Decreases exhibited in Stage 2 Hypertension (19% to 8%) and Stage 1 Hypertension (22% to 18%) levels among participants.

• Diabetes program rate dropped from 11% to 6% pre- to post- program.

• Decreases exhibited in High Cholesterol (6% to 1%) and Borderline High (18% to 9%) levels pre- to post- program.
I AM WOMAN (IAW)

A Focus on Diabetes and Healthy Living among African American women
IAW OVERVIEW

• Pilot project located in Columbia Urban League which targets African American Women and their children for health and nutrition education

• Funded by General Mills

• Key Partners:
  • Columbia Urban League
  • Community Voices: Healthcare for the Underserved
  • National Urban League
  • General Mills, Inc.
IAW PROJECT GOALS

- Conduct a Community Health Navigation program focused on nutritional and health education targeting African American women and their families
- Recruit a total of 100 participants for this project
- Employ community health workers (both chief and lay workers) to help participants navigate their community’s resources and track their activity
IAW PROJECT GOALS, CONT.

• Develop a community resource map that identifies hospitals, libraries, places of worship, food desserts, clinics, grocery stores and other resources for health care

• Educate participants on how to complete insurance forms and navigate complex healthcare systems
I AM WOMAN SESSION TOPICS

- **Introduction to Healthy Lifestyles Program**: Learning about the program, free health screenings, and how to develop goals for the family.

- **Nutrition and Chronic Diseases**: Learning about diseases such as diabetes, obesity and heart disease as well as learning the basics of good nutrition and healthy foods.

- **Nutrition Literacy and Building Nutritional Competence**: Learning about the USDA food pyramid, healthy grocery shopping on a limited budget, menu planning, and portion control.
I AM WOMAN SESSION, CONT.

• **Combating Stress and Emotional Eating**: Leaning about stress, coping with stressful situations, depression, and emotional eating.

• **Strategies for Healthy Eating and Exercise**: Learning about healthy meals, weight loss, and how to add physical activity to your day.

• **Partner with Your Healthcare Provider**: Learning about questions to ask your healthcare provider, the importance of primary care, and how to promote healthy lifestyles.

• **Celebrating Your Healthier Family**: Learning about ways to continue living a healthy lifestyle, free health screenings, and establishing goals for a healthier life.
KEY PROGRAM OUTCOMES

• Thirty-one percent of participants visited a primary care physician and 14% established a medical home.

• Participants lost an average of approximately 1 kilogram each; increasing the percent of participants who had a normal body mass index (BMI) of 18.5 to 24.9 kg/m² pre-intervention (8%) to 9% after the intervention.

• Participants exhibited a 7% increase in knowledge pre- to post-program regarding their knowledge of healthy nutrition, chronic disease prevention and management, and physical activity engagement.
Family Engagement

Participant Graduation

Workout Session

Family Engagement

CHWs and Participants

Program Kick-Off Cookout
ORAL HEALTH WORKFORCE OPPORTUNITIES

Expanding the Oral Health Workforce to Meet the Needs of Underserved and Unserved Communities
Project Overview

• Three-state initiative to examine current capacity and barriers of the oral health workforce in Georgia, Florida, and Mississippi.

• Primary goal: To use qualitative and quantitative data collection to develop discussion points and a potential scope of work for a midlevel dental provider or other emerging workforce model to improve oral health access.
WORKFORCE DIVERSITY MATTERS

ORAL HEALTH DISPARITIES = COMMUNITIES OF COLOR

ORAL HEALTH WORKFORCE ≠ PROVIDERS OF COLOR
PROJECT ACTIVITIES

• Collected cross-sectional surveys in each state to determine barriers in the workforce and the establishment of oral healthcare homes as perceived by dentists and community members.

• Conducted focus groups with community members concerning oral health needs, consumer experiences, and perceived oral health care barriers and/or accessibility.
• Conducted focus groups with practicing dentists and dental hygienists in each state concerning provider impressions on barriers to care, bureaucratic burden, social stigma, and perceived workforce capacity and diversity.

• Convened national and regional stakeholders to discuss the practice and policy implications of implementing emerging workforce models in the Southeastern United States.
Leading the Way to the Establishment of Dental Homes

- Workforce Diversity and Cultural Competency
- Expanding Access: Integrating Emerging Workforce Models
- Oral Health Literacy and Education
Transforming the Delivery of Care in the Post–Health Reform Era: What Role Will Community Health Workers Play?

The Patient Protection and Affordable Care Act (PPACA) affords opportunities to sustain the role of community health workers (CHWs).

Among myriad strategies encouraged by PPACA are prevention and care coordination, particularly for chronic diseases, chief drivers of increased health care costs. Prevention and care coordination are functions that have been performed by CHWs for decades, particularly among underserved populations.

The two key delivery models promoted in the PPACA are accountable care organizations and health homes. Both stress the importance of interprofessional interdisciplinary teams, the ideal context for integrating CHWs. Equally important, the payment structures encouraged by PPACA to support these delivery models offer the vehicles to sustain the role of these valued workers. (Am J Public Health. 2011;101:61-65. doi: 10.2105/AJPH.2011.303335)

Martinez, Ro, Villa, Powell & Knickman (2011)
Post Health-Reform: Role of CHWs cont.

• Stress the importance of interdisciplinary and interprofessional health care teams as ideal approach to integrate CHWs.

• Fully or partially capitated payment systems hold the most potential for supporting CHWs.

• Innovative outcome-based incentive models for providers to encourage the use of health team approaches.
LOCAL, STATE AND NATIONAL ISSUES

• Need for clear definitions and differentiation between CHWs and PNs

• Identification of core competencies

• Assess workforce demand

• Education and training programs with multiple access points for credit/career pathways
LOCAL, STATE AND NATIONAL ISSUES CONT.

• Credentialing options for unlicensed CHWs and PNs

• Evidence based interventions- application and development

• Measuring outcomes

• Assuring sustainability
GENDER DIVERSITY

• Who are the CHWs?
• Who Can be CHWs?

• Do we need a larger employment strategy?
• Do we need a publication strategy?

• VISIONING THE FUTURE and ADDRESSING EMPLOYMENT
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