A GUIDE TO INTEGRATING

COMMUNITY HEALTH WORKERS

INTO HEALTH DISPARITIES COLLABORATIVES

Migrant Health Promotion & Migrant Clinicians Network **July 2007**

PREFACE

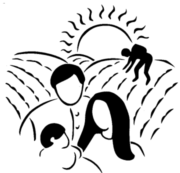
Community Health Workers, Lay Health Workers, Camp Health Aides or *Promotores y Promotoras de Salud* – whatever you call them, don't forget to call them into your Health Disparities Collaboratives improvement plan!

A quick look at change concept grids for most any Collaborative will reveal that using trusted and respected community members to promote Collaborative goals is not a new concept. Certainly anecdotal evidence and a growing body of quantitative research demonstrates the effectiveness of community members trained as cultural brokers and patient care advocates to reduce disparities and improve health status. Yet, when time and resources are limited, translating good ideas into reality requires information, tools and support.

To help Collaborative participants maximize the benefits of Community Health Worker (CHW) programs in their Plan-Do-Study-Act cycles, Migrant Clinicians Network is collaborating with Migrant Health Promotion, a national non-profit agency whose pioneering *Promotor(a)* program models and capacity-building efforts have established it as a leader in the field.

Out of this partnership, they have developed a new resource, specially tailored to the needs and objectives of Collaborative teams. The first section of the document is tailored to each Collaborative Topic (diabetes, cancer, etc.) with suggestions for how CHWs can promote significant outcomes within a variety of measures. The second section includes a grid describing roles for CHWs in five of six components of the Chronic Care Model, aligned with already-established Change Concepts such as "Set and document self-management goals collaboratively with patients." For each Change Concept, a number of high-potential Change Ideas are presented.

To help Collaborative participants implement the suggestions in this document, Migrant Health Promotion offers comprehensive capacity-building assistance to organizations starting or strengthening a CHW program. Assistance is provided free to 330-funded Federally Qualified Health Centers (FQHCs) through a grant from the Bureau of Primary Health Care. They also offer four hours of assistance to non-FQHCs; please contact them to see how they can help you!



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Using This Guide

This guide is designed to provide concrete tips, ideas and examples for incorporating CHWs into the Health Disparities Collaboratives. The guide is laid out in two sections. The first is organized by Collaborative Topics and the second by components of the Chronic Care Model. You can read through the entire document or skip to the section that is most relevant to your work.

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INTRODUCTION

Community Health Workers (also called Lay Health Workers, Camp Health Aides or *Promotores(as) de Salud)* are community members who are trained to promote health in their own communities. They provide leadership, peer education and resources to support community empowerment. As members of minority and underserved populations they are in a unique position to build on strengths and to address unmet health needs in their communities. Community Health Workers (CHWs) integrate information about health and the health care system into the community's culture, language and value system, thus reducing many of the barriers to health services. They also help make health care systems more responsive. With the appropriate resources, and ongoing training and support, CHWs improve the health of their communities by linking their neighbors to health care and social services, by educating their peers about disease and injury prevention, by working to make available services more accessible and by mobilizing their communities to create positive change.

CHWs are especially effective with management of chronic diseases, prevention and health education. This makes them ideal partners for much of the Health Disparities Collaboratives work. CHWs can help health centers serve hard-to-reach community members who may not otherwise access health center services. Because farmworkers are transient and often face language and cultural barriers, there is sometimes a gap between the farmworker communities and the health centers that serve them. CHWs serve as cultural brokers bridging that gap by helping health centers connect with and understand farmworkers. CHWs educate the community, but they also inform health centers of community needs, strengths and beliefs. The more farmworkers are included in decisions that affect their health, the more tailored health center services will be. Incorporating CHWs into health center services can help reduce disparities and improve health status in the communities served.

CHWs may be paid, receive stipends or work as volunteers. Migrant Health Promotion strongly recommends that they are compensated in some way for their time. Health centers should also consider opportunities for CHWs to advance to other positions within the center. For instance, experienced CHWs make excellent outreach workers.

Note: The examples in this guide focus specifically on farmworkers; however, many of the concepts and ideas are transferable to other populations. Feel free to adapt the information provided here to suit your Health Disparities Collaboratives effort.

COMMUNITY HEALTH WORKER ROLES

The 1998 National Community Health Advisor Study[1], conducted by the University of Arizona and the Annie E. Casey Foundation, identified several core roles of CHWs (called Community Health Advisors in the study):

1. Cultural mediation between communities and health and human services systems
2. Informal counseling and social support
3. Providing culturally appropriate health education
4. Advocating for individual and community needs
5. Assuring people get the services they need
6. Building individual and community capacity
7. Providing direct services

RESULTS

The study,[2] in which Migrant Health Promotion actively participated, found that CHWs:

- Reduced emergency room visits, length of hospital stay, and certain complications
- Increased trust between clients and the health care delivery system
- Promoted timely use of services and better adherence to treatment instructions
- Increased the focus on meeting individual needs associated with health care delivery, such as obtaining non-medical services that reduce barriers to medical care (including transportation, translation, emotional support, etc.)
- Increased the availability of cost-effective, culturally competent home- and clinic-based services

[1] Rosenthal EL. *A summary of the National Community Health Advisor Study.* [Web version]. Baltimore, MD: Annie E. Casey Foundation, 1998. Retrieved on Feb 2, 2007 from http://www.rho.arizona.edu/Resources/Studies/cha-study/documents/summarycore.swf

[2] Rosenthal, E.L., Wiggins, N., Brownstein, J. N., Rael, R., Johnson, S., & Koch, E. et al. (1998). *The final report of the National Community Health Advisor Study: Weaving the future.* Tucson, Arizona: University of Arizona, Health Sciences Center.

DIABETES

The work of CHWs is particularly suited to the nature of chronic diseases, such as diabetes, because chronic diseases require ongoing disease management. Having a CHW who lives in the community, is a trusted confidant, and may even migrate with patients means that clinics can follow-up with patients easily and can assure that they manage their diabetes effectively over time. CHWs can help improve the following measures:

HbA1c testing ♦ self-management goal setting ♦ eye exams ♦ exercise ♦ flu vaccines
dental exams ♦ weight reduction ♦smoking cessation ♦ foot checks

POTENTIAL ROLES FOR CHWs

- Clinic staff members use the registry to identify patients needing HbA1c testing and provide CHWs with a list of names and contact information. CHWs contact individuals discreetly by phone, at home or elsewhere in the community.
- CHWs assist patients in scheduling appointments and call or visit patients to remind them of upcoming appointments and help them reschedule, if necessary. They also assist patients in identifying and removing barriers to making and keeping appointments, including anxiety, work/family obligations, lack of insurance, transportation needs, child care issues and language barriers.
- CHWs share information about public transportation, help uninsured or underinsured patients apply for benefits, encourage collaboration between community members to arrange childcare or ride exchanges, and arrange for bilingual providers or translators.
- CHWs provide individual and group health education sessions on HbA1c testing, vaccines, nutrition, exercise, smoking cessation, weight management and other important topics.
- CHWs help calm anxious patients by explaining what to expect and by providing assurance that support systems are in place. In the case of HbA1c testing, they can assure patients that the purpose of the test is not to judge or criticize them, but rather to identify how well their self-management plan is helping them meet their goals.
- CHWs may follow up with patients after they receive their results. With guidance from clinicians, they reinforce the significance of the results, answer questions and work with patients to develop or update self-management plans. They also educate patients on self-monitoring and assist in procuring glucometers, testing strips and other aids.

Spotlight:

The REACH *Promotora* Community Coalition unites local *Promotoras* (CHWs), health providers, schools and community-based organizations to treat and prevent diabetes in the Rio Grande Valley of Texas. Formed in 1999, the Coalition has remained true to its mission of creating community-driven change on multiple levels. With the support of *Promotoras,* participating individuals have increased their weekly intake of fruits and vegetables and the minutes per week they spend walking or exercising. In addition, the Coalition has worked with two area school districts to replace sugary drinks from campus vending machines and has successfully advocated for local stores in the *colonias* to offer low-fat milk and healthier cooking oils.

DEPRESSION

Farmworkers face unique challenges that can affect their mental health and well-being. These include: loneliness and missing family, isolation due to living in rural areas and/or not speaking English, poor housing conditions, work-related stress, frequent migration and concerns about their children's education and well-being. As part of the farmworker community, CHWs have unique insight into these challenges and can help health centers improve the following measures:

self-management goal setting ♦ follow-up appointments ♦ medication adherence
timely initiation of treatment ♦ depression symptom reduction

POTENTIAL ROLES FOR CHWs

- ❖ CHWs listen to community members facing difficult times and provide support and a place to go when they need to talk.
- ❖ CHWs identify community members who are exhibiting signs of depression and refer them to the health center. They give appropriate information about what happens when someone goes for help or talks to a counselor, which may help the person feel more comfortable asking for help. Through referrals, CHWs can increase the number of new clinic appointments for mental health services.
- ❖ CHWs report suicidal community members directly to the clinic. They can also be trained to contract with the person, making an agreement that the person will not do anything to hurt herself or himself until she or he talks with a health care provider, social worker or mental health specialist.
- ❖ CHWs are trained to facilitate group educational sessions to discuss some of the challenging issues that farmworkers face and how people can cope. They may also organize support groups and locate existing support group resources.
- ❖ CHWs help patients make and follow through with their self-management plans. This includes helping them make appointments, encouraging them to keep taking medications as directed by their health care provider and following up with them on a regular basis.

Spotlight:

Salud Para Todos (Health for All) trains *Promotores* and *Promotoras* (CHWs) to address mental health, substance abuse, stress and violence in their camps and communities. *Promotores(as)* provide health education, referrals and advocacy. In this way, the *Promotores(as)* help health centers improve their service delivery to farmworkers and rural communities.

Anecdote:

A *Promotor* in the *Salud Para Todos* Program noticed that one of the men in his camp seemed very sad and worried. He talked with him, and the man confessed that he was feeling depressed and had other health problems due to worry and anxiety about his family in Mexico. He asked the *Promotor* for help making an appointment at the clinic. The *Promotor* made the appointment and, during a follow-up encounter, the man told him that he felt much better after having talked with a specialist.

CARDIOVASCULAR

For many patients, effective management of cardiovascular disease requires significant lifestyle changes. CHWs are skilled in educating their community about healthy lifestyles and supporting those who are making changes to improve their cardiovascular health. CHWs can help with a variety of measures including:

self-management goal setting ♦ depression screening ♦ weight reduction ♦ exercise
smoking cessation ♦ medication adherence

POTENTIAL ROLES FOR CHWs

❖ CHWs discuss risk factors and prevention strategies for hypertension and strokes, including tips for good nutrition, exercise and stress management.

❖ CHWs organize exercise groups to encourage community members to work out together, providing social support and making physical activity more fun.

❖ CHWs can be trained to administer blood pressure checks for community members at high risk for cardiovascular disease.

❖ CHWs educate community members about the effects of tobacco use and refer people who wish to quit to health centers and smoking cessation hotlines.

❖ CHWs teach nutrition classes that include cooking demonstrations using foods that are affordable, accessible and culturally appropriate.

❖ CHWs help people make and follow through with their self-management plans. This includes encouraging them to keep taking medications as directed by their health care provider, to stick with dietary changes and to exercise regularly.

Spotlight:

In 2005, the Southeast Michigan Camp Health Aide Program trained a group of CHWs to do effective nutrition education in their communities. The class focused on avoiding saturated fats and lowering sodium intake and included food models and recipes that attendees could take home to cook for themselves. These nutrition classes were culturally appropriate and took into consideration the traditional food choices that community members were accustomed to, focusing on making healthier versions of favorite recipes. One of the CHWs also held a nutrition class for farmworkers during their lunch break.

Results:

In 2001, four CHWs in the *Para Nuestra Salud* (For our Health) Program led walking groups in South Texas with over 1,165 participants. More than 200 women participated in physical activity at least two times each week for a minimum of 12 weeks: “This is the first time I have ever really exercised,” said one community participant.

CANCER

The nature of farm work puts migrants at high risk for cancers due to exposure to pesticides and other carcinogens. Farmworkers have high rates of mortality for a variety of cancers including: stomach, skin, prostate, lymphatic and cervical cancers.[3] At the same time, many migrants face a variety of barriers to accessing care. CHWs can help people overcome these barriers, leading to improvements in health center services in the following measures:

mammograms ♦ pap smears ♦ colon cancer screenings ♦ treatment follow-up
documented notification ♦ timely evaluations

POTENTIAL ROLES FOR CHWs

- CHWs teach breast and prostate self-examination techniques.
- CHWs stress the importance of yearly exams for women and educate people about which exams are recommended at particular ages. They provide health education information and answer community members' questions regarding the exams.
- CHWs refer people to health centers for mammograms, pap smears, colon cancer screenings and other exams. They assist farmworkers in overcoming barriers to making and keeping appointments.
- CHWs organize and assist with support groups for cancer survivors.
- CHWs advocate for safe working conditions, including adequate protection against pesticides, which are linked to various types of cancer.
- CHWs encourage farmworkers to continue treatment and follow-up visits despite frequent migration. They help farmworkers link to the resources available near where they live.

Spotlight:

In 2005, CHWs in the Statewide Michigan Camp Health Aide Program contacted all female community members over age 18 to inform them of the importance of mammography and pap smears. They educated the women on what to expect during exams, reduced fears and concerns, answered questions regarding fees, helped them make appointments and assisted with Medicaid applications.

Results:

In 2001, four full-time *Promotores(as)* (CHWs) from Migrant Health Promotion educated 5,856 women in Rio Grande Valley *colonias* about breast and cervical cancer and referred 951 women for gynecological exams, mammograms and other services. As a result, 768 individuals, or 81 percent of those referred, received health care.

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[3] Hanson, E. and Donohoe, M. (2003). Health issues of migrant and seasonal farmworkers. *Journal of Health Care for the Poor and Underserved*, 14(2), p. 153.

ASTHMA

Farmworkers are exposed to many occupational asthma triggers such as pesticides, dusty fields and pollen. At the same time, asthma may not be on the top of farmworkers' list of health concerns. Therefore, CHWs play an important role in identifying environmental risk factors and advocating for change on behalf of their community. The work of CHWs can assist the clinic in improving these measures:

severity assessment ♦ self-management goal setting ♦ environmental tobacco smoke exposure
evaluation of environmental triggers ♦ influenza immunization ♦ depression screening

POTENTIAL ROLES FOR CHWs

- CHWs build relationships with families and provide asthma education and support in homes and other community locations.
- CHWs educate peers about environmental risk factors in their communities, help people assess environmental triggers and encourage household changes to decrease asthma attacks. They can also help health center staff understand the environmental risk factors unique to the farmworker community.
- Overburdened providers cannot always take the time to provide comprehensive health education. CHWs can teach their peers about health issues and treatment options. This leads to better compliance with treatment instructions and reduced frustration for clients and staff. With proper information, community members are better able to manage their asthma.
- CHWs refer patients to health centers for asthma evaluations. Then, they follow up with patients to ensure that they are following their self-management goals and Asthma Action Plans.
- CHWs help community members decrease exposure to asthma triggers. They organize trash clean-up days in the community and teach about proper home hygiene. They also advise community members about proper handling and storage of pesticides and help them get to know their rights regarding occupational pesticide use.
- CHWs assist with health center screening efforts and conduct home environmental assessments.

Spotlight:

CHWs in Northwestern Michigan taught their co-workers and neighbors about pesticide safety, pesticide poisoning and the federal worker protection standard. They conducted 600 individual educational encounters about pesticides and 26 pesticide safety group education sessions with 558 people. Evaluation results reveal that the CHWs informed 100 percent of the people in their camps about pesticide safety. The CHWs successfully organized their co-workers and advocated for changes in the workplace. They staged two work stoppages when they were sprayed with pesticides and informed the growers that it is illegal to spray while workers are in the field. Both growers stopped the practice of spraying while the farmworkers were at work.

REDESIGN & FINANCE

Streamlining health center operations and improving quality of care is often seen as a process that occurs from within the center. However, CHWs can be an integral part of such efforts because they understand the cultural, language and financial barriers to care experienced by migrant communities. They can help health centers improve the following measures:

value-added time ♦ no show rate ♦ percent self-pay collections
percent of patients who would recommend the health center

POTENTIAL ROLES FOR CHWs

- ❖ CHWs help eligible families enroll in public health insurance programs such as Medicaid and the Children's Health Insurance Program (CHIP). They can assist with applications and make sure people use their benefits to receive health care services.
- ❖ CHWs provide valuable insight on organizational policy and practice. They can help health centers improve systems of care in order to serve hard-to-reach patients and increase appropriate use of services.
- ❖ CHWs work with health care providers to improve cultural and linguistic competence of services. They provide in-services for the providers and assist with case management.
- ❖ CHWs make effective research assistants. They can sample for surveys, administer questionnaires, contact hard-to-reach respondents, organize focus groups and conduct interviews with their peers. They can help your health center gather valuable data from current and potential patients.
- ❖ CHWs help patients overcome barriers to making and keeping appointments. They help arrange for transportation, interpreters, child care and other non-financial needs.
- ❖ CHWs promote increased use of preventive care and screening services and help families use medical services when they are most suitable. As a result, community members use the health center's services appropriately, maximizing limited resources.

Results:

According to the Journal for Minority Medical Students,[4] clinics that incorporated Migrant Health Promotion's Camp Health Aide Program saw increased usage. They reported seeing fewer people with colds and more people with early infections. Because of the increase in early interventions, emergency room visits declined. CHWs (called Camp Health Aides in this study) were pivotal in decreasing cultural, language and geographic barriers to care.

"Can you imagine what it's like to see in a week and a half what you haven't been able to do in three years? Our health promoters have come up with 22 new families, with an average of five or six people each, in just a week and a half. I believe that the health promoter strategy is the only one that's going to allow us to really serve people."

– Cindy Treaster, Program Manager
Kansas Department of Health and Environment, Topeka, KS

[4] Hart, K. L. (Ed.). (1997). Bureau of Primary Health Care's models that work. *Journal for Minority Medical Students*, 9 (3), BB1-BB12.

PREVENTION

You might say that prevention is a CHW's specialty. CHWs are trained to educate community members and encourage behavior changes that will result in healthier lifestyles. They also work to remove barriers to accessing preventive care and living a healthier lifestyle. Their work can help you improve the following measures:

Self-management goal setting ♦ blood pressure screenings ♦ smoking cessation ♦ cholesterol screenings
weight management ♦ immunizations ♦ pap smears ♦ mammograms ♦ colon cancer screenings
blood lead screenings ♦ STI screenings ♦ dental visits

POTENTIAL ROLES FOR CHWs

- CHWs bring door-to-door health education to their communities. Their access to community members is difficult to match with traditional clinic-based health education programs.
- CHWs educate community members about diabetes prevention, smoking cessation, pesticide safety, cancer screenings, heart health, mental health, substance abuse, HIV testing and prevention, maternal and child health, physical activity, nutrition and other prevention topics.
- Creating a coalition of health providers, CHWs and community-based organizations can help your health center bring prevention efforts to the broader community level. For example, the REACH *Promotora* Community Coalition in Southern Texas collaborated with area schools to replace sugary drinks from vending machines. They also successfully advocated for local stores to offer low-fat milk and healthier cooking oils.
- CHWs lead educational classes, healthy cooking demonstrations, physical activity sessions and other accessible activities designed to encourage healthier lifestyles and prevent disease. These activities take place in homes, schools, churches and other community gathering places.

Spotlight:

Farmworker teens face the pressures of adolescence compounded by constant mobility, isolation, poverty, high dropout rates, dangerous work and early childbearing. That's why Migrant Health Promotion started *Infórmate* (Inform Yourself), a program that trains and supports teens as peer health educators called Teen Health Aides. They provide health education, peer support and fun, healthy activities in their labor camps and rural communities. These activities include games, contests, bilingual newsletters, one-on-one health education and most prominently, the *Infórmate* Teen Theater Troupe. *Infórmate* focuses on HIV/AIDS prevention, substance abuse prevention, leadership, community building and related issues.

Results:

Promotores(as) (CHWs) at five Migrant and Community Health Centers in Michigan ensured that 97 percent of the pregnant farmworker women in their camps received prenatal care in 2003. In comparison, only 61.5 percent of Hispanic women in Michigan accessed timely prenatal care.[5]

[5] Michigan Department of Community Health (2002). *Percent of live births by level of prenatal care, race and ancestry of mother, Michigan residents, 2002.* Retrieved June 25, 2004, from http://www.mdch.state.mi.us/pha/osr/natality/tab1.8perc.asp

Roles of Community Health Workers in Change Concepts

Click each blue hyperlink for ideas specific to each change concept[6]

Self-Management	Decision Support	Clinical Information System	Delivery System Design	Organization of Health Care	Community
Use self-management tools that are based on evidence of effectiveness.	Embed evidence-based guidelines in the care delivery system.	Establish a registry.	Use the registry to review care and plan visits.	Make improving chronic care part of the organization's vision, mission, goals, performance improvement and business plans.	Establish linkages with organizations to develop support programs and policies.
Set and document self-management goals collaboratively with patients.	Establish linkages with key specialists to assure that primary care providers have access to expert support.	Develop processes for use of registry, including designating personnel for data entry, assuring data integrity, and registry maintenance.	Assign roles, duties and tasks for planned visits to a multidisciplinary care team. Use cross-training to expand staff capability.	Make sure senior leaders and staff visibly support and promote the effort to improve chronic care.	Link to community resources for defrayed medication costs, education and materials.
Train providers and other key staff on how to help patients with self-management goals.	Provide skill-oriented interactive training programs for all staff in support of chronic illness improvement.	Use the registry to generate reminders and care-planning tools for individual patients.	Use planned visits in individual and group settings.	Make sure senior leaders actively support improvement efforts by removing barriers and providing necessary resources.	Encourage participation in community education classes and support groups.
Follow up and monitor self-management goals. Use group visits to support self-management.	Educate patients about guidelines.	Use the registry to provide feedback to care team and leaders.	Designate staff responsible for follow-up by various methods, including outreach workers, telephone calls and home visits.	Assign day-to-day leadership for continued clinical improvement.	Raise community awareness through networking, outreach and education.
Tap community resources to achieve self-management goals.			Use *Promotoras* and community health worker programs for outreach.	Integrate Collaborative Models into the Quality Improvement program.	Provide a list of community resources to patients, families and staff.

[6] Text in chart from *Health Disparities Collaboratives (HDC) Chronic Care Training Manual*, pub. April 2002 by Institute for Healthcare Improvement (in partnership with HRSA Bureau of Primary Health Care). Boston, Massachusetts, USA. "Care Model Checklist, Changes to Improve Care," p. 9. Accessed 6/11/07 at http://www.healthdisparities.net/hdc/hdcsearch/isysquery/5f90e498-e341-4447-ac51-d381a2198080/2/doc/

Roles of Community Health Workers

Within each Change Concept

SELF-MANAGEMENT SUPPORT

1. **Use self-management tools that are based on evidence of effectiveness.**

   As bilingual community members trained in health education, CHWs are excellent screeners for self-management tools. They can review materials for cultural appropriateness and reading level and suggest modifications, if necessary. They may also translate materials and screening tools or suggest appropriate vocabulary and phrasing. As trusted community members, CHWs have access to community groups and faith-based organizations where they can distribute copies of self-management tools. While working with patients to set and meet self-management goals, CHWs also have the opportunity to solicit candid feedback and suggest revisions to materials based on that feedback.

2. **Set and document self-management goals collaboratively with patients.**

   CHWs can assist with goal setting and follow-up, allowing for longer sessions with patients while freeing up other staff. As members of the same culture and socioeconomic background as the patients they serve, CHWs are intimately familiar with the barriers many patients face and can act as motivators and partners in identifying steps to overcome barriers. By establishing trust and spending more time with each patient, CHWs are able to elicit honest reflections from patients on their level of confidence in achieving self-management goals.

3. **Train providers and other key staff on how to help patients with self-management goals.**

   CHWs can help train providers about barriers to effective self-management. They can present in-services to give providers an opportunity to learn first-hand about the cultural and practical barriers experienced by the farmworker community.

4. **Follow up and monitor self-management goals.**

   By involving CHWs in follow up, health centers emphasize their commitment to this crucial element of self-management without overburdening clinical staff. Because CHWs live and work in the communities they serve, they can follow up at the patients' convenience, often making home visits or calls during evening or weekend hours when clinic staff is unavailable. When devoted CHWs are in place, follow-up on self-management goals can take place on a weekly or even daily basis. CHWs can track follow-up schedules themselves or use existing systems such as the registry.

5. **Use group visits to support self-management.**

   Working with CHWs who are experts on their own communities takes the guesswork out of assessing the cultural needs of the group and identifying appropriate materials for patient education. CHWs are selected in part for their comfort with public speaking and are trained in group facilitation skills. They often have access to local venues, such as churches and community centers, and can remind people to attend the event. CHWs are also aware of locally-significant dates and events that may conflict with the scheduling of group education sessions, and they can assist in addressing patients' needs for transportation and child care.

6. **Tap community resources to achieve self-management goals.**

   The communities from which CHWs come are often linguistic and ethnic minorities that experience mistrust or alienation, even from social service agencies intending to serve them. By acting as

intermediaries who visit health centers before recommending them, CHWs can offer personal testimonials to patients. Because they have time to spend with patients in their own homes and at the hours that are convenient for them, CHWs can provide quality, in-depth support with patients.

DECISION SUPPORT

1. **Educate patients about guidelines.**

   CHWs can assist in developing and distributing culturally appropriate, "patient friendly" guideline handouts or wallet cards. Because they occupy the unique role of being simultaneously inside and outside the healthcare system, CHWs are especially effective as cultural brokers and intermediaries who explain guidelines and expectations to patients. Patients view CHWs as advocates who are "on their side" and thus may be more likely to accept and internalize guidelines and expectations when explained by a CHW.

   Patients who don't speak or understand English, are illiterate, are older, and those with learning disabilities may have difficulty understanding materials sent in the mail or handed to them in the office. CHWs can take the time to sit individually with patients who learn better through listening or experience rather than reading.

   Patients from cultures that elevate the status and authority of doctors may not feel comfortable asking questions or expressing concerns about complying with their prescribed course of treatment. They may also feel shame or embarrassment about their lack of money to afford drugs or lack of understanding regarding their condition or treatment. Through establishing trust and a sense of solidarity, CHWs are often able to access the fears and uncertainties beneath the surface, help clarify and problem-solve.

CLINICAL INFORMATION SYSTEMS

1. **Establish a registry.**

   CHWs can help identify cultural indicators such as language, ethnicity, insurance coverage and mobility that should be included in the registry, and can assist in gathering demographic data on patients for whom this information is not available. CHWs can also help detect who may need to receive diagnostic services that would lead to their inclusion in the registry. A key role of CHWs is to stay abreast of changes in the communities they serve. They can assist in "cleaning" the list by noting patients who have moved from the area or have died.

2. **Use the registry to generate reminders and care-planning tools for individual patients.**

   After using the registry to generate a list of patients who are missing a service or have a service that is overdue, CHWs can be responsible for following up by phone or in person. CHWs are knowledgeable about the special needs of the population they serve, and can advise clinic staff in categories that would be prudent to include in the registry, as well as ways to meet the special needs of these groups.

DELIVERY SYSTEM DESIGN

1. **Assign roles, duties and tasks for planned visits to a multidisciplinary care team. Use cross-training to expand staff capability.**

   Incorporating CHWs into the multidisciplinary care team will expand the team's capabilities. CHWs can be trained to provide valuable services, but they can also help train clinic staff on issues of cultural competency and communication with farmworkers.

2. **Use planned visits in individual and group settings.**

   CHWs can call and visit patients in person to schedule individual and group visits and remind them when visits are approaching. As members of the cultural groups they serve, CHWs can educate clinic providers on traditional beliefs about the origins and treatment of various ailments, helping providers to better implement models of cultural competency.

   CHWs are selected in part for their public speaking and presentation skills and make excellent co-facilitators. CHWs can open the session with general education and then have the provider(s) join or remain to teach and/or answer questions after clinical staff have left. In this way, group sessions can provide venues for longer and more in-depth interventions while allowing clinical staff to attend to their other duties. During group visits CHWs can take on various roles other than presenting, including setting up and welcoming patients, facilitating sign-in, taking vitals, assisting patients with special needs, arranging healthy refreshments, creating and assembling materials and translating.

3. **Designate staff responsible for follow up by various methods, including outreach workers, telephone calls and home visits.**

   Using CHWs for follow-up may be more effective than using clinical staff because they have greater access to the community and are often more effective than volunteers because their effort is dedicated, sustained and reliable. For example, a front desk secretary may spend two hours making phone calls and not getting an answer, whereas a CHW can reach people quickly after hours, at their homes or in their work environments.

4. **Use *Promotores(as)* and Community Health Worker programs for outreach.**

   Outreach may be completed by CHWs or by other staff, such as health educators, nurses, physicians, social workers or case managers. The distinction between CHWs and other outreach workers is that CHWs, by definition, come from the community they serve. They may fulfill some of the same tasks or activities as outreach workers, but they are from the farworker community and can thus better understand and serve the community. Ideally, an outreach program includes both CHWs and other staff who work together with the health center and other organizations to serve farmworkers. Former CHWs may also be employed by health centers as outreach workers.

COMMUNITY

1. **Establish linkages with organizations to develop support programs and policies.**

   CHWs can help identify key organizations (churches, civic groups, clubs, schools, hospitals, banks and others) that are used and trusted by the community. They can approach community organizations about hanging posters, distributing educational materials, and featuring prevention/treatment/referral messages in their communications with constituents.

2. **Encourage participation in community education classes and support groups.**

   CHWs can follow up with patients to affirm the benefits of attending classes and support groups and to problem solve barriers such as lack of transportation. In the absence of culturally and linguistically appropriate classes and support groups, CHWs can lead workshops and groups on topics in which they have been trained. CHWs can advocate for school districts, social service agencies and other community groups to offer more classes on health topics and help sponsors remove barriers to participation for people who are low-income, minority and non-English proficient.

   CHWs make excellent spokespeople for promoting the efforts of health centers to reduce health disparities. They can give presentations to community groups, professional or university-based organizations, etc.

3. **Raise community awareness through networking, outreach and education.**

   CHWs can represent the health center at health fairs and ethnic festivals, where they can conduct basic health screenings, distribute educational materials, answer questions and make referrals. They can also work with churches or faith-based organizations or in other places where patients naturally gather.

   Boards, steering committees and other leadership groups in the public and nonprofit sector often wish to include members of the underrepresented groups they seek to serve. Inviting CHWs to serve in leadership roles is beneficial to all parties: the groups and boards gain a new perspective and tie in to the community, CHWs develop their leadership skills and advocate for their communities and sponsoring health centers gain impact, exposure and connections for information. CHWs can also identify other local leaders who would make good candidates to serve on advisory committees.

4. **Provide a list of community resources to patients, families and staff.**

   CHWs can help compile a list of community resources, including those services used by their communities but unfamiliar to health center staff. They can also provide valuable insight into the most culturally appropriate design, language and literacy level for the target population. CHWs can distribute the listing or resource guide during home visits and group sessions. Community members may feel more comfortable acting on a referral from a CHW whom they know and trust.

Many health centers participating in the Health Disparities Collaboratives also have successful CHW or *Promotor(a)* programs. Others are just beginning to consider a new CHW program. Whether you have an existing program or want to start a new one, Migrant Health Promotion can help.

Migrant Health Promotion offers a wide range of services FREE to Federally Qualified Health Centers serving migrant farmworkers and at low cost for others. Services include:

- Consultation on adapting the *Promotor(a)* model to a specific health center or community
- On-site training for administrators, Program Coordinators and *Promotores(as)*
- Culturally-competent health education tools written especially for *Promotores(as)*
- Guidance on pursuing funding, including information on funding sources, sample proposals and budgets
- Two email groups:
  - *Promotor(a)* Program News: www.groups.yahoo.com/group/promotora_programs
  - *Promotor(a)* Funding Email Group: www.groups.yahoo.com/group/promotora_funding
- Evaluation tools and consultation
- COMING IN 2008: Evaluation Toolkit

Need more information?
Contact the Capacity-Building Team at Migrant Health Promotion:

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