Community Health Worker and Supervisor Experiences at KC CARE: A Qualitative Study

Final Report
Prepared for the Health Care Foundation of Greater Kansas City

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Joanna Veazey Brooks, Ph.D.
Jarron M. Saint Onge, Ph.D.

With the assistance of:
Tiffany M. Pothapragada

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TABLE OF CONTENTS

Introduction

The purpose of this study was to investigate the experiences and perspectives of community health workers (CHWs), supervisors, and leadership of the CHW program at Kansas City CARE. In addition to a short demographic survey, we conducted semi-structured, in-person interviews with 17 individuals, ranging from 34 minutes to 90 minutes over a period of 3 weeks between March 23, 2017 and April 12, 2017 (see Appendix A for demographic information on respondents). Interviews included questions about current work experiences, career motivation and aspirations, training and development experiences, and organizational dynamics (see Appendix B). Interviews with supervisors and leadership included additional questions about broader organizational and supervision topics. The semi-structured nature of the interviews allowed us to draw comparisons while simultaneously capturing unique information from each respondent.

This report summarizes the main themes our interviewees discussed. Our analysis of the interview content indicates that factors at the **Individual** (i.e., CHW, client, or supervisor characteristics), **Organizational** (i.e., specific to KC CARE or partners), and **Structural** (i.e., broader professional or societal issues) levels appear to uniquely impact both the effectiveness and satisfaction of CHWs. Factors at each of these levels can either facilitate or impede CHW tasks. Accordingly, we organized our findings according to each of these factors. While we have separated these themes for the purpose of clarity in this report, many themes overlap with each other and are difficult to disentangle in practice.

The Unique Role and Contribution of Community Health Workers: Why do they matter?

A. Community Health Workers occupy a unique position in our current health care system. One way to understand the value of CHWs is by looking at the impact of their work on the individuals they connect to new resources. CHWs are making a concrete difference in the lives of countless individuals every day, in the context of relationships, and respondents described many examples of "success stories" of their work impacting lives.

> What I've learned through this job is you meet someone either at an emergency room or you get a referral, and you kind of try to form a relationship with them. And they call on you whenever they need you for making sure they're getting what they need, and it's more of a kind of a personal relationship you create with some patients. That's the difference, I think.

> Community health workers also give hope to people. When you think that you have somebody that can help you […] You say, "Okay. Let's work together. I'll see if I—if we can find something that can help you." They have that feeling of hope […] as I told you before, this lady that she had cataracts on both eyes, and she didn't know how bad her vision was until she got them removed for free […] She looked more energetic just because she was happy that she could [see]—she said "Thank you." I was like, Well, I didn't perform the surgery or anything like that. But I gave her the path for where she could go. I helped her. […] But the look on her face. That's what you take, you know? You take home that, and that fills your heart and your spirit and that give you more, like, energy to help others. That's priceless.

B. A second way to understand the unique impact of CHWs is to consider their work in helping individuals navigate and understand the health care system and better utilize available resources. In particular, CHWs can "translate" between the health care system and patients, ultimately enhancing doctor-patient relationships.

> The piece that the community health workers really bring to the table is their shared life experience with our patients and their lack of over-education or over-professionalization […] our community health workers speak patient, if you will. […] They're going to make sure that patients really understand what it is that the care team's talking about, and then really be the person that builds the rapport and engagement with the client to make sure they keep coming back and get what they need and those sorts of things.

> I say the community health worker is a bridge between the patient and the provider.

> The word is getting out more about what we do and how valuable we are because we're the ones that can actually help our client turn around on their thoughts about the doctor or even going to get regular care every year […] community health workers can actually tap into what the individual is saying or needing and getting some type of understanding, and then can communicate to them a different aspect of the doctor in the clinic or the healthcare system in general.

Another respondent explained that "community health workers often find out information that from the patients that the patients never tell the doctor in terms of what's really going on in their life**." In addition, CHWs help patients navigate insurance, appointments, and access to other community resources.**

C. A third way to understand the role and value of CHWs is to consider their position in the broader health care system, and the gap that their unique skillset fills. CHWs can address areas that the U.S. health care system frequently overlooks, and enables the health care system to be connected to communities, and to be more patient-centered.

> It's a really great workforce to send into the community and do the labor intensive, but not terribly skill intensive work that the rest of that healthcare team (A) doesn't have time for and (B) isn't situated to do, especially when you think about hospitals. The idea of leaving the hospital with your patients is just not built into the framework […] So you know, the value add to the healthcare team is you get better engaged patients. You get patients that are more successful in terms of managing whatever it is in their life that helps manage their healthcare piece. As a system, when you start thinking about population health, this is a way to work on people's health, not just their healthcare.

> [CHWs] represent a job, a workforce, a skill set that is not available in a hospital system right now. They have that relatability. They're able to engage people. They're able to kind of walk with them through this system and teach them how to navigate the healthcare and social services systems. And I think that's no fault of the current, you know, the way a hospital runs that that's not available. Yeah. I think it's just a missing piece—an important missing piece.

> So along with public health, you're not only impacting one family, but you impact the community. […] And I think that definitely is something that a CHW can do, and that's a way that I see their work, like, yeah, you're working with a client one-on-one, but there's a bigger picture of what you're doing, like, a client might tell their mother-in-law and then their mother-in-law finds out about us. And then, we start working with them. And they tell someone else on the street. Then they call us and they're like, "How did you do that?" So like a lot of word of mouth and spreading out…

> Like, we can go into their communities and they're not afraid. We have a more trusting relationship with our patients. I mean, and we also have the ability to, like, answer to their needs—to the community needs when we have that bigger workforce, we can do that. That's kind of what we want to do is to start, you know, ask our communities, "What do you need? What do you want?" cause we're looking at every aspect of their overall health, not just access to clinics or hospitals or medications, but access to food, access to transportation.

PART 1: INDIVIDUAL-LEVEL

Consistent mentions of individual-level factors included (1) career trajectories (previous employment and career aspirations); (2) ideal CHW characteristics (traits, behaviors, roles) and (3) intrinsic motivations and stressors. Also included at this individual-level but occurring less frequently were: (4) characteristics of individual clients that impacted CHW work and (5) the social networks created to assist in their work.

1.1 Career Trajectories. Prior experience with CHW-type work (whether in a job or through volunteering) brought unique advantages and challenges. These CHWs were intrinsically motivated and knowledgeable about resources but sometimes encountered additional difficulty establishing new professional boundaries with clients.

Pre-existing experiences. Community health workers heard about the job in a variety of ways, and were drawn to the work for many reasons, including previous similar experiences.

> And so, when I first started hearing about it, I'm like, "Oh. Someone is actually combining those healthcare aspects as well as community, mental, physical."

> I heard about it through a friend of mine who is a community health worker […] and she said, "You know, you would be great at this because you love to work with people and you're so connected in your community, and this is something that would interest you." And I went ahead and applied and I got the job.

> So this is how I see myself, and you know, it's taken time to kind of—I'm like, "What is a community health worker?" But you know, it's like I feel like I've always been a community health worker because when I was at my other job, I used to take days off to help people, you know, cause we couldn't do it while we were working […] And now as a community health worker, I can do that, and it's my job. It's part of my job, so that's how I identify myself.

For those CHWs that were doing similar work beforehand, it was sometimes harder to establish firm professional boundaries with clients:

> And one other thing that I've found is that if we have somebody who really hasn't done the role professionally, but maybe they've volunteered to help people to get—to their doctors' appointments or help people, worked at a food bank and things like that. So most of their work was volunteer, they really don't know that when you become a professional, it has to look different. Maybe before you were able to transport that person in your car because you were volunteering or you were working with your church and it was a part at the ministry that you were doing or however the case may be, it changes when you become a professional.

There were some common career trajectory pathways—from the position of a CHW to a social worker, a medical interpreter, a nurse, or an educational degree.

> I guess people don't really see it as their long-term career option, and I don't—myself don't see it as a long-term career option. It could be because of the pay or because of it's kind of hard work to do and doing it every day for years and years could be hard, I think. So there could be some other reason for it.
>
> So I like working with the community, obviously. If something different came along like—I don't know. I just don't see myself just being a community health worker in five years. I see something more than that.
>
> I absolutely love what I do. I do have plans to take a state test, which is for a professional interpreting.

Future Goals and Career Development. Within the job, there are some opportunities for career development. For example, participation in the KC Regional CHW collaborative has provided some CHWs with leadership opportunities. Many CHWs viewed the position as a "stepping stone" as one respondent put it, and not necessarily a long-term career option. Others felt that there was limited room for growth:

> The reason why I've stayed here for so long is because I enjoy what I do, and I have a heart for the people, but this place is not paying me. And it's, to me, there's no growth.

Even CHWs who find enjoyment and satisfaction in their work were frequently thinking about future career steps. This has implications at the organizational level in terms of recruitment and retention, which we address in greater detail later in section 2.1.

1.2 Ideal CHW characteristics.

There was general agreement about the ideal CHW. Identification and commitment to these traits appear to motivate client concern and lead to intrinsic rewards. Most respondents explained that CHWs should be passionate, patient, empathetic, relatable, and organized, and that their role was to connect clients to various resources. Other ideal characteristics include: being honest with clients, able to admit mistakes, and being nonjudgmental.

> The magical secret sauce to community health workers is the shared life experience, but not just that. It's they're people people, right? These are the natural social connectors. These are the people who they do this kind of work…they facilitate this process for other people.
>
> So a good community health worker is passionate. They're organized. They can compartmentalize, you know, life—their own personal life issues and then put that over there, and then, you know, any issues regarding their patients and what they have to do with their work. They also, you know, advocate not only for the patient, but for themselves, you know, for the actual work that they do. And also, just willing to learn, you know, cause we don't know everything. So it's a constant learning process and staying in the loop and very resourceful.

> The beauty of being a community member, so you might understand poverty. You might understand illness. You've probably experienced it yourself, your close family members. So you have that background of, "Life can be really rough, but at the same time, life can look a little bit better if you use the tool." […] So having the cultural understanding, having that humility and compassion and empathy as well as organizational task-oriented and pretty outgoing. I don't think we have room to be shy because there are things—we're advocating on someone's behalf, like, you're the advocate. So you're not going to—I feel like we don't have time for shyness, and we have to speak up. […] we have to pioneer a lot.

Some tension arose around the "ideal" CHW regarding <u>boundaries and professionalism</u>. Ideal CHWs connect to their clients and are "relatable," but they also need to be responsible and professional.

> So I feel like that is a hard candidate to [find], someone who is relatable and has lived a life experience but also has enough professional experience to be able to be a good employee, to show up to work on time, to be responsible and trusted when they're offsite not under the eye of their supervisor.

> They have to have passion for the population for sure, and a lot of that comes from, like, the similar life experiences. So they've walked the same life as their patients. I think somebody who has also overcome some of those life circumstances. So, like, not only do they have that understanding of what it was like to live that life, they've overcome it. And so, they can empower the community in a different way, like, they can motivate them. I also think, you know, someone, again, that has like the basic professionalism and organizational skills… I mean, the passion is really the number one thing. The passion and the, like, understanding are what makes a good community health worker.

Balancing Passion and Technical Skills. Ideal characteristics remain a point of contention for hiring and success. There was some disagreement about whether passion in an applicant was sufficient to predict success in their role as a CHW. Some respondents believed that being passionate was not enough, while others believed that some potentially great CHWs were being overlooked because they lacked additional technical skills (e.g., documentation, writing).

> I feel like now it's a little bit more challenging because we might find someone who's a great CHW, but maybe typing and writing is not their thing. So then, we start disqualifying folks because of that. So I feel like maybe before, we didn't think about, "This is really important." That the level of education is important as we do now, like, "Oh man. You're typing in electronic medical records that might be read by physicians and social workers." That people have to know how to—you have to have coherent sentences with proper grammar and sentence structure, or else no one's going to know what the heck you're saying. And I think that's something that maybe we didn't think about as much as we do, but now our level of documentation and who is reading that has increased.

> I would say the way that that answer has changed is just more the reality of if you only look at the passion and the life experiences and you don't also look for fit of where they're going to be placed, […] it goes back to "Are you really setting people up for success?" if they have

> to know technology and they're never going to be able to know technology, and [we] hire someone that doesn't know it? So that piece has changed for me at least. Like, those two things [passion and life experiences] aren't enough. They're important ingredients, but they're not enough.

So while the above respondents believed technical skills were increasingly important, others were concerned about an <u>over-emphasis on these technical skills</u> during recruitment and interviews.

> Who is a good candidate? They are making it so difficult at this point that I think if I were to be where I was when I started to work as a CHW and if I had to do the interview that they are doing now, I wouldn't pass it. I wouldn't pass it at all. And so, my concern is we are letting people that might be great go […] I think that we are at the point right now when we need to find a balance.

1.3 Intrinsic Motivators and Stressors.

Intrinsic motivators and stressors were shared by the majority of interviewees. Many individuals in both CHW and supervisor/leadership roles were intrinsically motivated to help connect others to resources even if it was not their "job." Yet, this commitment is frequently challenged by individual-level stressors.

Throughout interviews, respondents reported a number of <u>intrinsic motivators</u> to their CHW work or supervision of that work. Feeling like they make differences in clients' lives appeared to be the core motivator. Mentions of appreciation from clients appeared to be especially rewarding.

> And then, they come with a smile, and they're happy and they're grateful. So you can see. And then, you teach him how to do these things for themselves. You empower them. So that's something that is priceless.

For some CHWs, the <u>rewarding feelings</u> clearly outweighed the stress:

> If you love your job, it doesn't really matter, like, everything else just sort of falls into place. And I really—I like what I do. I like coming to work every day. Like, I don't think of it as a job. I think that makes the biggest difference. *Interviewer*: Yeah. That's awesome. I don't think many people can say that. *Respondent*: No. Not many people can. Yeah. I feel lucky in that respect that—to have that opportunity.

> This is the first time in my life that I feel like I am in the place that I want to be. For the first time, I feel like I'm not working. And even I feel bad, like, they pay me. You know? Because I really enjoy this. And yes, give you stress and yes, sometimes you feel sad out of here, but then when you have somebody to—that they have what they needed, that's a feeling that it doesn't compare with anything else. […], that made me feel so good on the inside. I was happy. So you know, again, if I start feeling like I'm getting really tired or I'm stressed, those are the kind of things that kind of remind me or push me, like, say, "Hey, you know, there are people that do appreciate what you do and need you."

> I was telling you about the […] lady who did not have any access of, like, driving or things. So when I saw the joy in her face that she was receiving some kind of help and which was supportive to her and with that really helped her stand on her feet and in return, she was hugging me and kissing my hand. I think that was most rewarding to me. It was like, "Okay. I am doing something. I am doing something that changes people, like, a person's life bringing joy in their house, in their family, and making sure they have food at the house." I think that was most rewarding to me to see that.

Intrinsic motivations of supervisors were connected to helping CHWs do their work:

> I think the sense of accomplishment is what makes it a good day. And what does that look like? I want to say when I see progress and growth in other staff members where I really see them truly being edified, like, they were able to learn how to use any assessment and they're doing great at it.

Stressors. While caring deeply about clients was a positive motivator, it also led to frustration and sometimes feelings of emotional distress or "burnout." A number of respondents talked about the work "wearing" on them and having difficulty compartmentalizing their CHW work from the rest of their lives:

> People say, "Okay. Go to work 8-5. Five o'clock, just turn it off. Go home." But that's kind of impossible, especially when you care for people. When you have this empathy for them that you want to provide the right resource and you want to help them. So it's like you're going home, but you're thinking, "Oh, maybe this would be good for them." Well, maybe this. You know? It's like if there is a method, teach me, but I cannot shut off completely. It's really hard.

Another interviewee talked about her concern for co-workers that she believes are working and investing in clients at unsustainable ways. She cautioned:

> I feel like if you take the oxygen and put it on everybody's face, sooner than later, you're going to just pass out and not have oxygen for yourself. How do you help people when you are broken? How do you help people when you're not—when you don't have the strength that you need to help people? You cannot. […] So I feel like emotionally, mentally as community health workers, you have to have that stamina […] You have to have that because if you don't have that, sooner than later, you're going to break. And when you break, you wouldn't want to give up. And when you give up, you're just going to leave. And when you leave, you leave 20 clients. And then, when somebody else comes and picks it up, not all the clients are going to want to respond to the new one because they're used to you. You know? And every counselor, every psychologist doesn't offer or do—give the same help. Everybody is unique. You know what I mean? And so, it's like if you have to leave because you have to grow, that's fine, but if you have to leave because you're broken, that's sad. You know?

Many respondents explained that they were most frustrated when they lacked the necessary resources for their clients.

> Difficult? The most difficult parts are when you can't find help for them, and you're looking and looking and knocking doors with them, and you can't find anything that can help them, but you keep looking and looking. And then, more if they have a deadline or they have a sickness that they, you know, that they need help. And then, you keep waiting, waiting, waiting, waiting with them, but you keep knocking on doors is when you get stressed.
>
> A bad day would be getting a call from a patient that they are in crisis and they've used every resource they can, and then—and you've done everything you could, and then there's nothing else that can be done.

Additional stressors included organizational pressures and time demands:

> I think what makes a frustrating day for me is like if I have planned to spend two or three hours documenting […] and then all of a sudden, something comes up like, "Oh, we have to be here" or they give you a new patient and it's an emergency. ASAP. Get a hold of them. And then, […] that day is not used for what I had already planned, and then I have something more on top of that. It kind of makes it frustrating…I kind of feel like it kind of deteriorates the efficiency of a community health worker.

Caseloads and workloads created stress at both the CHW and supervisor levels. Here, one supervisor described the concern:

> With the number of referrals she was getting, I mean, I can just imagine her stress level cause it was stressing me out. Every time I opened it up, I could see all these referrals, and I'm like, "She's doing all that she can within the time that she can." And now, it's going to be a game of catch-up, even now that having our new person ready to take referrals, there's still all that time that she's going to have to catch up from where she was being buried, you know, so yeah. That's rough. I imagine for them, which again, even though they're the ones who are actually working directly with the patients, it's stressful for me cause, again, I see it and I see the stress on them, and I'm trying to think of ways how we can alleviate it […] because it's just really stressful.
>
> What makes it frustrating is I feel that I am being overloaded or sometimes I feel overwhelmed with the amount of referrals. [CHW]

Finally, organizational growth can create stress:

> I think sometimes what gets frustrating is when there are a lot of things to do. So we keep growing rapidly, and then that requires more work. So let's say that you have a team that's finally going steady, but then you make a change or an addition. So you keep putting stressors in there.

Because their jobs could have such high levels of stress, several respondents mentioned ways that they deal with their stress. As one respondent stated: "we can get burnout easily if we don't take care of ourselves." **Some talk to their spouses or co-workers. Another explained how faith helped her:**

> I take a deep breath, listen to what [the client] has to say, and then just reassure him that even though we don't get the whole problem solved, we're going to try to tackle it one bit at a time. And the emotion—I'm very emotional, but I try to compose my[self] […] they'll be some days that, yes, I get overwhelmed and at the end of the day, I'll drive home and just talking to God and that. I'm very strong in my faith and I'm a strong believer that God will work things out, and that's basically how I deal with it. Just leave it in God's hands, so other than that, sometimes it's overwhelming, and I will reach out to my other community health workers…

1.4 Social Networks. CHWs who actively created social networks at their sites appeared to benefit in both job satisfaction and effectiveness. They emphasized the importance of clearly establishing their role as a critical team member in client care. Integration within sites frequently relied on individual-level motivation and ingenuity.

> So the main thing about working in the hospital is like you have to know people. You have to have good relationships with the other staff, especially the staff that has a huge influence on how you do your job, and I'm referring to admitting.
>
> They're going to have to talk to every single patient that is of the population we're trying to target, you know, they're going to have to go out and introduce themselves to physicians and to nurses and like market the program constantly, and [if] they're kind of shy and they don't do technology well, they're going to fail.

Frustration resulted from a lack of strong social integration (i.e., when the role of CHWs was unclear) and they were subsequently omitted from site-specific resources or underutilized.

> I guess just having more people be aware of the program. I feel like we kind of have to do a lot of outreaching to the new doctor, new residents, new nurses. People that aren't really aware that I'm here, I mean, and what I do. And it'd be cool—nice to get, like, referrals from them directly cause a lot of the times, they go to social work and social work will then come to me. And by then, they're probably discharged. So it'd be nice to have a direct referral from doctors or nurses if they see a self-paid patient that might need my help.
>
> But the frustration with [partner organization name] is that sometimes I have to constantly remind them, "Hey, I'm here" you know, to the nursing students that are there. They volunteer on those nights, and it can be various ones, but some of them are the same repeating ones that come to help and sometimes I have to, like, remind them, "I"m here. Use me. I need to see all the patients." And I have to always explain what I am, what I do. So that can be frustrating at times to feel like we're being overlooked sometimes.

> It's very easy to just sort of kind of hide in a hospital system if you're not care[ful] you know, and that's happened to some community health workers where they just kind of couldn't do their own self-promotion to get the care team on board, and they just didn't gain the respect of the care team versus some of the community health worker positions that we now have.

1.5 Client Characteristics. In some cases, individual client characteristics either facilitated a CHW's work or created obstacles to it. Clients that were motivated to ask for help, follow advice, and make changes often experienced great benefit from CHWs and the available resources.

In turn, CHWs expressed intrinsic rewards in assisting these clients, as they felt like their work and resources were immediately and significantly helpful.

> The most satisfying part of my job is when you get a patient—the ideal patient—that wants to work with you and that is willing to take that extra step and let you hold their hand to show them how to navigate the system and then they become independent and then do it on their own. That's the ideal patient, and the most rewarding part is that they accomplish the goals that you set with them.

External Client factors, such as language differences, ineligibility, personality conflicts, or perceived unwillingness to change were indicated as barriers to care.

> I think the most challenging patients are the patients who don't have self motivation and, […] And at the end of the day, the patient has to do their part, and their part is to work with the CHW, to take the tools the CHW has identified, and that part is out of the CHW's control.

> I talk to these people and these patients, and it sticks for some people, and others it doesn't. So I work with those who want to do things basically. If you're proactive and you want—I got a plethora [of resources] for you. Let's go over here and there and there and here. And those who are just going to be lazy and wait for somebody to do something for you, it's not going to happen cause it's not coming from me. So I'll give you the information, but I mean, I'm not going to put in more effort than what you put in.

Individual-Level Recommendations

- Continue to hire in terms of people who have ability to "make things happen." The ideal CHW is passionate but also organized and adept at interacting with other professionals and documenting work efficiently.
- Emphasize consistency around the definition of an ideal CHW to assist in developing a sense of motivation and intrinsic reward.
- Recognize the need for appreciation.
- Provide early efforts to recognize time-demands and "burnout."
    - Continue with CHW wellness training.
- Maintain effective training opportunities.
- Assist CHWs with establishing social integration within sites.

PART 2: ORGANIZATIONAL-LEVEL

The organizational-level refers to the factors impacting CHW work specific to KC CARE as an organization. We identified key factors as: (1) Organizational Dynamics (i.e., growth, change, recruitment and retention, training and supervision of CHWs); (2) Organizational capital (i.e., access or challenges associated with available resources, tools, or support provided by the organization); (3) Measurement and Accountability (i.e., documentation, expectations from funders); and (4) Partner factors (i.e., factors related to the specific sites where CHWs work). Finally, (5) Boundaries emerged as a consistent theme across interviewees. Boundaries are negotiated at the organizational level through both formal rules and informal customs.

2.1 Organizational Dynamics. Rapid organizational growth has presented challenges for recruitment, supervision, and processes for CHWs. For example, growth has created an increased need for standardized documentation from CHWs. In addition, the entry-level nature of the CHW position makes long-term retention difficult.

Recruitment. Due to rapid organizational growth and turnover, recruitment needs and strategies were frequently discussed. The organization recruits in many ways, including posting jobs on their website, emailing listservs, recruiting students in the CHW course at Metropolitan Community College (MCC), announcements at the Marc Regional Coalition, and finally more informally through word of mouth. It is these latter methods that appear to be most effective:

> I think a lot of the people who have been hired not just recently, but historically is through—it's not really our website or our advertisements or job link. It's more about announcing it at those Marc meetings and then someone emailing their friend or their CHW class or someone who attends that meeting or forum knowing that—knowing someone who might be interested. So just kind of word of mouth of—or, "This is my former colleague and they're interested." "I used to work with this person. I went to school with them." So a lot of the people that we've gotten, if not majority, have been maybe the same church person. So even within community health, it's been very community based, and I think that's been the most effective way or the most—the way we've gotten the most people and sometimes like our partnerships.

Retention and Turnover. Respondents were unable to provide the exact turnover rate. However, respondents acknowledged there was a fair amount of turnover and could remember multiple people that had left in recent months or were considering leaving the CHW position. Turnover was apparent even in our interview process, as one CHW left the job prior to completing an interview and several CHWs came on board during the data collection period. Understanding turnover is complicated for this position, however, because many individuals, including supervisors and leadership, recognize it as an entry or starting point position. In other words, it is not expected that it would be a career-long

position. Therefore, CHWs leaving to advance to other jobs is not necessarily indicative of any type of problem. Sometimes, it is simply the outcome of individuals learning new skills and progressing, and that the CHW position has succeeded in being a "launching board" **as one interviewee put it, or a** "catapult for other possibilities" **as another said. As one respondent described, when this happens:**

> To me, it's kind of—it's bittersweet cause you're like, "Oh gosh. I'm losing this person." And usually it's people that we really like because they're doing so great because they've learned so much."

> I think that totally feels like a success, right? Because if you're going to empower communities or change systems and you take people from a community that otherwise wouldn't have had these opportunities and they get training, and then they go on to get education, like, the trickle down impact that that has on their family and also their community is really huge…that's kind of how you change communities and get people to like see things differently.

Despite feelings of hope and success when a CHW moved forward to another job, <u>turnover challenges</u> persist for the organization. Specifically, training and preparation for partner sites requires time and resources.

> Hiring somebody else that is new is going to take time to put them out there in the community. Like, a couple of months. And that's not the worst. But for the hospitals when you hire somebody, you go through all the process of, "Here is your badge. Here is your rotations. Here is everything you have to do. Oh, you already know how to use the system and the EMR from them." And then, that can take four months. And then on the fifth month, that CHW tells you, "I'm out." Okay. Let's start it all over again and guess what? In four months, you didn't serve patients. So you are decreasing the numbers.

Turnover also leads to <u>loss of institutional knowledge</u> (e.g., local resources and processes) as well as client- relationships:

> I don't want to take all the value that I do have and the expertise on some things and whatever it may be and take them somewhere else. I feel like I'm cheating this place because I'm a good employee…you just los[e] so much by that employee leaving and taking their skills somewhere else.

For supervisors, <u>continuous training and fluctuating team members</u> can be difficult:

> So let's say we have 10 people starting together, then we have 4 who drop out. So we have people maybe 6 are at the same level. We have a new person. So that starts off again, and you have another person. So you have people at multiple levels of their growth curve. And you have to be, like, I just trained someone for the last two weeks. I'm going to train someone again in three weeks. Then I'm—so you keep bringing in new folks. So then, that makes your job worse because you can't have a steady flow of like, "All right. Everyone is trained now. Like, let me just chill and focus on daily tasks versus, like, let me start over and over and over."

In terms of organizational dynamics, many respondents mentioned various types of frustrations or growing pains that have accompanied the rapid growth of the CHW program. There are formal restructuring and integration efforts from the top, and changes resulting from the transition from a free clinic to a FQHC.

> Once upon a time, we were the free health clinic, and we kind of made our own rules, and there was very little oversight. So as we're growing up as an organization, so I guess [with] program growth, organizational growth, you've got more levels of bureaucracy and you've got more oversight and you've got more players involved, and you've got more levels of control that slow things down. We're currently waiting on just things to move through our own internal processes that are just taking longer than it feels like they should to start doing work in the community, and it's just frustrating.
>
> We're in a time where sometimes we grow beyond what our administrative capacity is to support and then some of it's not just the processes themselves, but sometimes the processes are really people. And so, you're just putting too much on people's plate for their—them to be able to manage the demands on their time. And so, it's not really necessarily an intentional delay. It's more of a you're just stretching people too thin. So there's that push/pull. You have to grow so big before those additional resources can be reallocated to indirect things and build the infrastructure. And so, you know, it's like a stair step sort of approach. You have what you need, then you grow. And you don't have what you need until you can get big enough that you can buy what you need, and then there's an implementation lag time.

For the CHW program, growth and more employees have created a need for establishing more policies, processes, and standardization. A few respondents described what this looks like in their everyday work:

> Sometimes the resolution is like, "Oh, we really need a policy around that. Oh, we really need consistency around this." […] over time, so we've gotten more and more formal…I think that's true relatively across the board… things have gotten more formal and more standardized.
>
> We just learned something. Let's change it. We changed it. Let's change it again. That didn't work. Let's do it differently and let's continue modifying a thing. So I think it's not really what we're doing or how it's going to look like immediately […] Like, is there a different way to do it? Is that really the most effective? Is that currently giving us the outcomes that we need?
>
> Being able to support [growth is] a constant struggle […] I as a supervisor often feel like we're thrown projects, but not the infrastructure or the logistics to carry them out. […] Contracts are written and we are from a supervisor perspective, we're just waiting for the contracts to be signed, but we're not in any way involved in those. And then, we find out in the weeks or sometimes days after the contract being signed that the expectations of the partners were different than what we were told all along in terms of deliverables they want us to achieve, demographic information they want us to gather. Small stuff like that, but it affects the work flow absolutely.

Finally, from an organizational dynamics perspective, <u>funding sources and uncertainty</u> also impacted turnover and growth:

> It's just that, like, I don't know if the grant is going to be renewed and how long my job is going to be, you know? I—the uncertainty of not having a job also motivates me to look into other options […] Are we going to have this grant again or am I going to have a job in the future?

> There's obviously people who get upset with things at their jobs, but I think the majority of it is, like, your funding. Like, we're all funding based. So you know that your funding's going to be up in a year. So you may already start looking for another job, and then that opportunity comes so you take it because you know your job's going to be out a little while anyways. And for the turnover, like, we just had a whole bunch of people leave, but it seems like they left because they didn't like their job or something like that, but they really just lost their funding.

2.2 Organizational Capital.

Respondents frequently discussed their perceptions of the key organizational resources (i.e., organizational capital) that facilitated their work. Respondents were consistently satisfied with the use of supervisor meetings, case conferencing, and the numerous trainings, including those specific to mental health and wellness.

<u>Trainings</u> appeared to be invaluable to career advancement.

> I am grateful for the training, and yes, it is necessary because, you know, things that you're going to encounter after and you know, from people who have been there what you do in certain ways, but it's always different. And yes, we need the training constantly because things change more in days. Programs, I tell you, they change a lot and quick. So we need the training for that on things like we are not experts.

> We turn them out into external organizations. They get exposure to not just our healthcare environment, but other people's healthcare environments… So it's with some more advancement in a bigger system. So some of the turnover's been career advancement for people that [previously] didn't have other opportunities.

<u>Training gaps</u> remain. There was some concern over identifying the appropriate amount of trainings and a need for training for management and leadership positions.

> I still think that some sort of either management or leadership training is something I'd appreciate. So we've been to kind of very basic, simple trainings, but not like an ongoing of—I don't know—conflict resolution or conflict management, like, other classes or courses that we could take.

> So it's leadership and then separately management. Two distinct sort of training needs, and then there's the ongoing continuing ed. at all of those levels for community health workers or supervisors of community health workers, okay, and you achieve this certificate and you've gotten your on-the-job training of how you do your job, but how do you stay up-to-date on things as they develop?

Workload and time demands were primary organizational concerns. Time commitments and institutional expectations appeared to frustrate or overwhelm CHWs and supervisors (e.g., tensions between client interaction and documentation or time-intensive training).

> They give us everything. I don't think that there was anything that I think is a lack of support. I think what there is a lack of is a lack of manpower.

> To devote my time—more time to the CHWs, and I'm not talking about overprotecting them or anything along those lines, but I think that sometimes I'm working, and I feel it. I'm just typing emails or I'm doing something and a CHW will come in and they see that I'm working, and they just walk away. You know what I mean? And I don't like having that sensation. I don't like not being helpful for them. So more time.

Frequent suggestions to address organizational shortcomings included mentions of higher pay, more structured appreciation, and more flexibility.

2.3 Measurement and Accountability.

As the KC CARE program matures, CHWs and their supervisors continuously work to achieve success with their clients as well as meet the needs of continued program development. This was noted in the occasions where participants discussed how outcomes and progress were being measured, documented, and tracked, as well as who was responsible for these tasks. Interviewees were aware of goals such as the number of clients being served, both the organization and client-specific goals, the need for adequate support and tools for CHWs to enable them to reach those goals, and the importance of timely and clear communication regarding changes in the program or processes.

There is ongoing tension between the quality of help and the growing number of clients per CHW.

> The other thing is just program development. So looking at who our partners are. Are we meeting our deliverables? So when we have grants, like, are our outcomes on track? And kind of in addition to supporting them, supervising the employees, like, how are we making sure that we have a solid program? So with our hospital systems, what do our utilization numbers look like? How many patients are we serving each month? Does that seem appropriate based on how many people are using the hospital system? Do we need to do different targeted efforts? And then, working with the supervisors on how we can, like, implement that in the hospitals.

> Or like the workload or when our funders want us to meet certain numbers and we're like, 'That's not realistic' but we have to try. We have to work harder to meet those numbers. For awhile, my complaint about meeting numbers was, 'I'm not here to meet numbers. I'm here to help people.' And I care more about the quality of service that we're giving than the quantity of people I'm seeing. I know, like, more people, that's great. That's good. But I also want to make sure that I'm giving at least, you know, giving 100% to each person that wants to work with me.

Documentation. One of the recurring themes mentioned by the CHWs and their supervisors was a recent change in the documentation process to improve the standardization and coordination of services provided by CHWs. Previously, CHWs were documenting client encounters in numerous physical places such as site-specific electronic medical records (EMRs) as well as internally for KC CARE using Excel spreadsheets. This created a duplication of documentation efforts and potential fragmentation of client records which led to frustration among the CHWs. These inefficiencies decreased the amount of time CHWs spent directly with clients and increased the amount of time spent on documentation. BluePrint database software was recently implemented to improve the documentation process.

> So when I started, we'd been in spreadsheets. So documenting a disgusting amount of demographic information in spreadsheet…but it's a great improvement in terms of we have a database where our progress notes, our demographic information, our care plans, assessments, everything lives in one place, and that was not the case before.
>
> And if we're going to be addressing their health insurance need, their housing needs, their need for food assistance, and all this other stuff, that's going to take some time if we're doing that for every—almost every patient that enrolls in our program. And out spreadsheet that we were using was not capturing all of that work.

Blueprint reaction has been positive. The overall reaction to the BluePrint implementation has been positive in comparison to the reactions to the spreadsheets once used. CHWs feel that more of their work is being captured electronically and is more representative of the actual time spent working with each client.

The system has also enabled CHWs to enter information in a more standardized process by answering the same questions for each enrollee in the program thus improving the workflow.

> So once upon a time, we were much looser in terms of the formality of how you assess somebody, how you documented, what your care plan looked like, but the challenge was that really from our perspective it probably made that harder for a community health worker because it kind of required more decision-making than maybe they really had the training for...So formalizing 'This is the assessment. These are the questions you ask. This is how this should flow through.' Has created some standardization and hopefully more formalized it while at the same time, trying to simplify the task piece of it…

To a lesser degree, BluePrint has also been a source of stress and frustration for both CHWs and their supervisors. CHWs mention lack of time for documentation. They struggle to find the time to complete their documentation requirements for several reasons including language barriers; standardized initial assessments of *all* enrollees; continued use of transcription from a paper system; insufficient resources at specific sites (i.e., weak WiFi connectivity); and technological barriers due to a lack of familiarity with the increasing use of computers and more complex databases.

> Whatever we document in BluePrint, we have to copy and paste to [another program]. So, and I'm going to say about 50% of our job is documenting. A lot of documenting. Like, and then there's steps. There's a work flow that we follow from when the patient is referred until the patient is discharged. So whatever happens in between there, has to be documented. And then, that, what we're documenting, if the—we're not copying and pasting to the [other] program, then the providers don't know what's going on with the patient.

CHWs experienced difficulty with managing time for documentation while maintaining their case load which included contacting new clients, serving walk-in appointments, or in cases of emergencies.

> Like, you're trying to find resources or you're trying to call clients for enrollment, and you're trying to call clients even like to reach out for the first time and we have that 48 hour gap only to do that. And we still have to document on those that we've been helping, and we have walk-ins coming. So it's like 'Oh my gosh. What am I doing? Eight hours is not enough.' Sometimes we're here and it's like 4 o'clock and we're like, 'Oh my gosh. No. We need two more hours just to finish everything.' Because that happened and it's like the documentations a little bit get behind and thank God we have an amazing supervisor. "S/He helps us a lot, like, to try to help us manage our time so we can prioritize."

> I cannot work with 30 people and document for 30 people and still keep going besides and putting more people to my list. Come on. It's ridiculous. I think that if I was given the time, the adequate time to document, I would be able to discharge some of these people so that I could add more people. But if you're not letting me document, if you're interrupting me when I'm documenting, it is impossible.

In addition to time constraints surrounding documentation, there have also been minor frustrations with BluePrint training, data management, and report generation. BluePrint has allowed for the assessments of case load, client and CHW goal achievements, and other analyses, though these features may not be fully implemented at this point. The responsibilities of report generation and presentation may also impinge on the ability to achieve success since the time spent on additional training and learning opportunities would further detract from time spent working with clients or supervising CHWs.

> The reporting part of it has been a struggle, which we're just now starting to learn about how to pull reports. It has been, to me, a nightmare, which I think, you know, other people would agree. To me, it's just difficult to understand the process of navigating through that. To me, that's been the hardest part is learning how as staff, that we're going to be able to pull reports that we need…

> Then what happens, is that the way that they are teaching us how to report is really high level to the point that they were like, 'Oh, you might need to learn SQL.' And it's like, 'Well, we are not programmers.'

On a positive side, interviewees looked forward to <u>increasing capabilities of BluePrint</u>, such as syncing to Outlook calendars and providers' systems, to improve their workflow.

> And I think there's other things that are coming online, like, later, like, it doesn't sync with our Outlook calendar yet, but it still cause currently what I do is I set all my appointments, when I need to call somebody back, all that information, like, it's completely separate from BluePrint. It'd be easier if it was just, you know, like, you click a link or check a tab, you know, "You need to call this person in two weeks." "Call this person in a week." And then, it automatically just shows up in your calendar would be really helpful.

2.4 Partner Factors. Partners are easy to work with when they 1) communicate openly and frequently; 2) understand what CHWs do; and 3) have on-boarding systems that are efficient with clear expectations.

> To me, what makes a good partner is communication. That's the first part, and we have a couple of partners that literally it's almost there is no communication. We have a monthly phone call for follow-up, but still I just go to the places—to the clinics just to make sure that they have everything. [At another partner location] that director was on top of everything. Literally. Like, okay. Let's have a minute for this. Let's talk about this. Let's talk about the outcomes. Let's talk about how the CHWs are feeling. She was super concerned about everything going okay […] So, but regarding two partners, again, we have partners that are great. Partners that are on top of everything. […] So that's the, I guess, is the pros and the cons a little bit.

> So I would say the systems that are like really smooth and are easy are the ones that are also have very firm, like, processes in place and just like really strong good staff. So some of the hospital systems, you know, they're just—they're a little more savvy with the data […] Additionally, like, their onboarding is really smooth […] Those are some of the easier systems. Some of the ones where it's like a little more challenging is where there's—it's harder to get someone in your system. You don't have, like, good data systems. So like we want to show success, but we still have to go in and like hand pull the data out of your system, right? Like, that makes some of this stuff a little bit more challenging.

<u>On-boarding requirements</u> at partner sites can extend training time significantly for CHWs. This, in turn, impacts turnover and ease with which CHWs can replace each other:

> With our partnerships, one of the things we've tried to like prepare them for is like—it's not like a plug in model. You know, we start working with you or we lose someone and we immediately can't, like, just put someone right back in there. You have to train them and make sure they understand the role and how to work with people and sometimes it takes long, like, the hospital systems, the onboarding, depending on the place, sometimes takes quite a long time to get people in the systems. So there can be a little lag time with that too.

> Oftentimes, a community health worker has to start and we're paying them. They can't be at the hospital yet because—and usually, well, it's a combination of we haven't oriented them yet. They don't know how to do their job, and then secondly, often the hospital—so this is why I headed down this road—some of the hospitals, it'll take 6 to, six weeks plus to get through their credentialing process with things like their internal orientation that they want to do, their training on their EMR system, and those things before. So they're—typically, even from the time we identify the community health worker and get them started working here, it's often 6-8 weeks on the front-end where they can actually start doing their job at the hospital.

Additionally, it emerged from interviews that a good partner will <u>have physical and organizational space</u> for CHWs, as well as having <u>CHW advocates</u> at the partner site:

> So for awhile—just starting on physical space—for awhile, there wasn't, like, a designated CHW desk or somewhere for us to sit. So I would kind of be floating around the ED, going to the waiting room and sitting, trying to find somewhere to sit in the ED. There is one case management desk that's a social worker's and everyone shared. So that was kind of always busy. So I would kind of find somewhere to sit, but then they kind of opened up a new office for social workers, a nurse case manager, and a community health worker. So that was a great—a pretty good improvement in my work and just having somewhere to go and having somewhere to sit and keep my stuff. And also, being in a room with the social workers is nice too, having—being able to collaborate with them on different patients and everything. So that's one thing I like that they improved while I was here.

> [At partner clinic] there's a lot of people. There's a lot of patients. It's really challenging to find a spot, you know, to be at, because everything is taken up.

> One of the things that seems to be likely necessary to ultimately kind of succeed with an external organization is somebody internal to their system really has to buy in. You have to have a champion […] The places where this works really well for us historically, there's been at least one or two people that really will bend over backwards to make sure things get done.

2.5 Boundaries.

The topic of boundaries came up in interviews in several ways. First, boundaries came up when respondents were talking about specific work tasks that fell outside of their role as CHWs. The most common tasks mentioned that they are not supposed to do were: 1) transport clients in their own vehicles and 2) serve as an interpreter for clients.

There was a clear <u>recognition of boundaries.</u>

> A poor boundary would be meeting a client, developing a friendship, giving them your cell phone, engaging with them out of work, all that kind of stuff. Giving them rides, giving them money. Like, those are pretty black and white boundary issues […] We don't do the interpreter part because if we do, then it's too much for us. So the interpreter will be there with us, but what we do is we can help the client understand or to make the client feel that someone is there for them. So those kind of support. We want to make our client feel that they have it.

> I help the nurse practitioner with, you know, the understanding the language and overcoming that barrier cause that's a barrier. […] if my patient [has] limited English proficiency, then I'm going to do what it takes to get that patient the help that that patient needs.

Tension between relatability and professionalism. As noted in the Ideal CHW Characteristics section 1.2, one key attribute of effective CHWs is that they are relatable to their clients and can understand (typically from personal experience) what challenges their clients face. But, as CHWs, they require boundaries. These boundaries are important to both CHWs and supervisors.

> How do you train them? How do you coach them? […] it's murky water, you know, we're hiring people who are like our patients. So how do we support them knowing that, like, that is a great skill set, but also they have to […] have changed their circumstances enough that they can still be in a professional environment. So that one's just continually been really tough throughout time. Cause you do. I mean, you have people that, like, they're really great at their job, but they can't show up to work on time or, you know, they missed so many days that it's just like we can't continue to employ you, but when you're good at your job, like, it's just this really hard balance.

Learning boundaries. Some respondents reported that the MCC classes were especially helpful in learning how to set boundaries:

> That class helped me to set my boundaries. It helped me mentally and physically, like, just not to be emotionally, you know, just to keep, like, level of understanding the needs, whether it's physical needs, whether it's emotional needs, or whether it's both ways. So it helped me to train myself to know my side of my bridge and their side.

While it was clear about some of the boundaries CHWs should not cross, there remained boundary ambiguities.

> In certain professions, the boundaries are very black and white. Like, you do this. You don't do this. It's not the same with community health workers, right? Like, they're a part of these communities or even these cultures. So […] if you're in a home, like, and someone offers you food or drink, like, what are the rules around that? […] So then you start working with someone from your community and you go in and they're like, "Actually, I made dinner." And if you don't eat the dinner, it's very offensive to them.
>
> A lot of times you're going to be working with patients who have stories that are, you know, because it's relatable to you, it's going to hit home. So you feel like you have to take a personal stake in making sure this person gets there. So when it comes to that, just really remembering what your role is and explaining that to the patient upfront when you're meeting with them, your role as a professional.
>
> But some of the boundaries that may feel uncomfortable to other professions that are helpful in a CHW's relationship is when you go to help somebody apply for food stamps,

saying something like, "Well, when I completed this application..." you know? This is what happened or, "When I had to apply for Medicaid, it took this long."

Organizational-Level Recommendations

- Continued support and trainings, with an emphasis on leadership and management.
- Established priorities pertaining to expectations and time management.
    - Recognition that relationships with partners in different locations and different populations require clear decisions about standardization and tailoring across CHW case-loads.
- Clear documentation goals and requirements.
- Prioritizing onboarding, dedicated space, and increased communications with partners about CHW roles and needs as an organization.
- Well-established and defined organizational boundaries between CHWs and clients.
- Balanced understanding of professionalism and community engagement.

PART 3: STRUCTURAL-LEVEL

Structural-level refers to factors impacting CHWs and their work that originate from forces outside of individuals and the organization. Here, we identified two main structural factors: (1) occupational dynamics of CHWs and (2) health and social services and resources available.

3.1 Occupational Dynamics.

Our interviews made clear that any study of CHWs' work should not be separated from the larger dialogue about advocacy and recognition of the profession of community health work. Most respondents believed that the important work of CHWs merits classification as a *profession,* along with the increased pay, recognition, and job stability that would accompany that designation.

The development of professional identity was important to CHWs. One barrier noted by several respondents was the need to defend their work as professionals, while balancing the label of being a "lay worker" without the traditional educational background attained by other health professions.

> One of the issues with the state or with other people within the state was like, "Well, you guys aren't really professionals because you're lay workers." And I was like, "Well, it's both. Yes. I'm a lay worker, but that doesn't mean that we're not professional." So kind of fighting for that title has been a challenge for them, but I really do see it, like, what I think people need to do is incorporate CHWs into their workforce."

> I really, really like this program, and I like this profession. I'm going to use it as the word profession cause it is.

> I see it going more towards a position that is being recognized as a professional cause I don't think they are at this point, and I think a lot of it has to do with the education that a community health worker, you know, requires because it doesn't require that you have to have a degree. You don't have to. It's not a position that's recognized or certified through the state. Those type of things, but hopefully it will move towards people, not only hospitals, providers, just the medical community altogether recognizing the community health worker as a professional because they are.

Again, there is an emphasis on role definition in relationship to more established health care team members (e.g., social workers).

> A lot of times, we're associated with social workers and usually when that comes about and I go ahead and explain the difference between us and a social worker. You know, we're just not going to give you the information. We're going to actually help, you know, hold your hand if you would like us to and walk you through the process. We will go up there to the clinic or to, you know, that organization that's giving you something free and you don't understand the process or help you fill out an application, you know? We will go to your home and, you know, and visit you just so you can just talk if you want to do that, but it goes

beyond a social worker. I'm not discrediting social workers at all, but just saying that we're allotted that time to be able to do that with the individuals.

CHW Collaborative. CHWs view participation in the KC Regional CHW Collaborative through the Mid-America Regional Council (Marc) as beneficial for their professional development. The collaborative provides an environment for CHWs to network and discuss challenging cases, available resources, or solutions to commonly encountered barriers. The collaborative was also mentioned as a setting where they can voice their opinions, ideas, and concerns with other CHWs. Finally, some of the CHWs held leadership positions within the collaborative. This respondent explains more about the collaborative:

> So we go to that every—the last Thursday of every month. There's a lot of different community health workers—community health workers that maybe not call themselves community health workers, but do the same work. They all meet and just discuss different things, and there's also case conferencing time during that too where we can talk about different cases we have, and I think a lot of it is just about furthering the community health worker career and kind of making it into a career and trying to get funding for certification and all of that, so that's been the main focus recently. […] It's kind of nice being involved in kind of like the policy side of CHW and just learning more about how to get certification done and whenever you get to do that, the benefits, the pros and cons of it. It's cool being involved in that.

In addition, through the collaborative, CHWs described building momentum towards <u>professionalization</u>:

> So from what I understand of what the collaborative is doing is kind of seeing what is happening in the CHW world at a regional and sometimes a state level. So by state. Not only in Kansas City, but also in Kansas, in the entire [state of] Missouri. So kind of being able to bring in an answer of, like, what is happening? What is going on? So I think one of the things that happened last year was the bylaws that the State of Missouri was developing of trying to make CHW a profession. So if that just become a profession, what should it be under? Should it be under the Association of Public Health? Should it be its own association? If it does become an association, what are the bylaws? Like, what are the code of ethics? Kind of formalizing all that. […] we had set around internal core competencies and what that should look like. A lot of that stuff is like the ball is rolling on it now. So like community health workers are actually being recognized, like, there's core competencies. There's a curriculum that they can go through.

Upcoming Workforce Challenges. The interviews revealed potential CHW workforce challenges. CHWs mentioned feeling <u>undervalued and underpaid</u>, as well as expressing some concern about funding.

> I think the main story that I want to project is that the work that the entire department of care coordination does is more than what I think any other department does, whether it's a CHW and the amount of work and, like, sweat, tears, effort, stress that they put into their assignments is huge. And sometimes I feel like we're a little undervalued. Like, I don't think

people know how precious these stones are and how worthy they are to exist and how we need more, not less. And I think that applies to the CHWs and our supervisors.

Interviewer: What do you feel like are the biggest obstacles to [more CHWs?] *Respondent*: Funding. Funding and a lot of having to explain that we are professionals and that our work is valued and necessary, that we can be a huge influence on how healthy the community is as a whole. So just advocating as well as kind of being part of our job is advocating for the profession and advocating for our clients.

I think just keeping the work going, not only with funding, but just having more awareness of it, getting—advocating more for the position as an actual position and getting it more professionalized. I don't know if that's the word or not, but getting it more as an actual, like, career option in the future would be a good thing to do, I think. And that would probably help the turnover rate as well.

Recruitment and Retention via Professionalization. There was also concern about being able to recruit and retain individuals in this evolving position with increasing demands and lagging rewards (pay and status). Some respondents argued that CHWs should no longer be considered an entry-level position given the job requirements and demands, including knowledge about a vast variety of available programs and resources, being able to work directly with clients and other health care professionals in accessing these resources, and learning to use technology and documentation programs and processes that are new to them.

With the perception of the CHW profession as a high demand job came an accompanying concern about retaining workers, who may leave the CHW workforce for jobs with increased pay or status.

To me, […] the CHW position [is] no longer an entry level position. Not everyone can do this position because there—it requires you to have a high level of technology. It requires you to have a high level of organization, a high level of knowing the resources, and then there is the turnover because people are like, "I don't feel rewarded. I feel like I'm not getting paid enough." And that, I get it.

I think that this community health worker job is not entry level position. I think the pay needs to be increased and the caseload need to be set up like specific or like arranged that the person can handle so that the community health worker will not be burnt out, overwhelmed.

It pays 15 bucks an hour. That's one of the reasons. This is not a job that you get a college degree to have. This is—in my opinion, this should be a starting point for a lot of people. If the profession can get to the point where we can support larger salaries, I think—so I believe that the rate—I believe that because the work we require of the CHWs is comparable to the other case managers we employ here and case managers and other professionals, we should pay them accordingly, but we don't. So the CHWs who we have, we have several CHWs employed here who have skills that could transfer to other positions and they could be making more money.

3.2 Community Resources. The work of CHWs is largely facilitated or constrained by the health and social resources available in the communities in which they work.

Even the most effective CHWs cannot connect clients to resources that do not exist:

> Community health workers are very successful. I still feel like we're only as successful as the system that exists though. And that, I think, is something that, like, as people think about this workforce that they also keep in mind, like, I can't impact a patient if the resource isn't there […]. So [CHWs] are very successful. I think when you look at impact and the data—also being realistic with that—because there can be limitations with what a community health worker can do if systematically, like, things can't change or don't exist."

> The area where the patient exists would have to expand the bus system for me really to be able to get the patient, like, where they need to go. So like we can be a short-term solution. Like, you know, our program can fund the cabs, like, to the appointments, but like long-term, the system has to change. There has to be more buses in place in Wyandotte for people to really truly be able to navigate the system effectively or like same in the Northland.

Limited community resources. The reality of <u>limited resources</u> for clients can be extremely frustrating for CHWs, as this CHW explained when asked what was most frustrating about his work:

> When I can't find any resources to help somebody, like, that's really—I have a client who he wants a job really bad and he was a drug user, but he's not anymore. And he has prior convictions. And so, it's really hard for him to get a job with that already, and because of his prior drug use, like, he lost the majority of his upper teeth. So he looks, I mean, smiling it's like big gaps in his teeth and it obviously impacts his ability to have an interview and to talk to somebody. So we were trying to find him dentures and he's unemployed, and like how do you? Like, there's no resources for somebody in that respect. Nobody offers dentures for free. You can do a reduced rate, but he can't afford to pay his rent. So paying for his teeth is like the last priority.

> I would say just maybe having a patient that you can't help, you can't find a resource for. So there's no other options for you to do anything. That's pretty—that's hard. […] There's a patient I've been working with or trying to work with for awhile now who needs dialysis, and she's undocumented or she's only here on travel visa and can't get her permanent residency, so she can't qualify for any kind of Medicaid or any kind of insurance. So she just comes to ED for dialysis twice a week. And she's been doing that for months and months now, and there is really nothing I can do to help her. I've tried different resources. Nothing really came through. And I see her whenever I walk by her and I don't know, like, what to say or what to do cause I can't really help her anymore. It's hard.

> It's stressful when there's no resource for the client. So it's like the client has a lot of needs, but the client doesn't meet the criteria, you know, documents required and stuff like that, especially for the undocumented clients that we have.

In addition, restrictions on eligibility and coverage sometimes created walls that were insurmountable. Specific areas of needed services discussed in interviews were: transportation; unmet needs (e.g., dental care, mental health services); and health insurance coverage. Also, timely scheduling of appointments, especially for specialty care, remained a problem:

> Just trying to get them appointments somewhere and not—and it's hard to get patients scheduled within a certain timeframe if the doctor's like, "Hey, this person needs to be seen within a week." These clinics that we're referring patients to fill up very quickly because they're safety net clinics and these are for folks who don't have insurance most of the time, like, they accept insurance now, but the majority of the patients going to these clinics do not have insurance. So they're paying on a sliding scale fee based on their income, and they might not have good enough income to afford health insurance. So then, they won't be able to afford to go to any other clinic, and if we're seeing—if the hospitals are seeing 100 uninsured patients a week and a third of those become inpatient and then they all discharge around the same time, and then you want them to have appointments scheduled within the week. That's a lot of appointments to be scheduled within the week and that might not ever happen.

Changing resources. Frustration results from frequent rules, policies, and eligibility changes.

> *Interviewer*: How frequently do your resources change, would you say? *Respondent*: It just depends on the entity, but pretty—it's I can see stuff changing a lot. Yeah. I know there's a clinic that was accepting self-pay patients, but they aren't anymore. And I just found that out last week through another CHW that tried to refer someone there. So I mean, getting that information, like, that was by luck that she found out, like, it wasn't like we all knew about it. So stuff like that happens. I know Truman changes their financial counseling information quite frequently. Yeah. And then, just the requirements for different programs change too.

Structural-Level Recommendations

- Continue to seek external funding opportunities.
  - To hire CHWs.
  - To provide resources necessary to maximize CHW-client interactions.
- Advocate role of CHWs
  - Maintain professionalization programs with boundaries to clarify roles of CHWs both in organization and in the broader community.
- Seek out and maintain and on-going collaborations with leadership opportunities.
- On-going training to recognize impacts of changing community resources.
- Maintain community partnerships to address broader structural community needs.

Appendix A: Methods

Recruitment: Interviewees were recruited from community health workers, supervisors, and administrators employed by the KC CARE Clinic in the Kansas City metro area. Interviewees were contacted by the Primary Investigator (PI) directly through email and invited to participate in a voluntary research study. Twenty-two emailed invitations were sent out to recruit participants for the study. One left before completing an interview, three did not respond to the invitation, and one had scheduling conflicts. Seventeen (17) people participated in the study for a response rate of 81% (17/21). All recruitment and study materials were approved by the University of Kansas Medical Center Institutional Review Board.

Procedures: All interviews were conducted by the PI. Prior to the interview, interviewees went through an informed consent process with the PI or an assistant from the research team. Participants were assigned a random two-digit identifier during the consent process which was utilized throughout the research study. Interviewees had the option to end the interview at any time. Participants were not compensated for their participation.

Data Collection: A brief one-page, front and back, questionnaire was administered prior to the interview to collect basic demographic information, job satisfaction, and perceived effectiveness. Demographic questions were closed or open-ended while questions pertaining to job satisfaction and effectiveness were collected on a five-point Likert scale. Interviews were conducted using a semi-structured interview guide (see Appendix B) and were audio-recorded. Recordings were transcribed verbatim by an external transcription service and identified only by the two digit identifier assigned to the participant. Interviews ranged in length from 34 minutes to 1 hour 30 minutes (Avg= 52 minutes) and were conducted over a three-week period from March 23 to April 12, 2017.

Characteristics of Interview Participants: A total of 17 interviews were conducted during the data collection period. Participants serviced 3 hospitals, 7 clinics, and 4 community sites throughout Kansas City, as well as, their supervisors and administrators from KC CARE (See Table 1).

Data Analysis: Qualitative analysis of the transcripts followed an inductive approach which allowed themes to emerge within each identified domain. The PI and another member of the research team read selected transcripts in their entirety and identified the major domains and recurring themes in order to construct a codebook. The codebook was developed and finalized using an iterative process. The PI and second researcher applied the codebook to a selection of excerpts. Inter-rater reliability was calculated after each series of excerpts until reliability reached a target kappa >0.80. All discrepancies were discussed prior to the subsequent round of reliability checks. This process was performed to ensure that codes were capturing all of the content and were being applied consistently across transcripts. Once consensus was reached, the PI coded all transcripts and analyzed them using NVivo (QSR) qualitative software. Descriptive and interpretive summaries of the data for each theme were produced and supplemented with quotes from participants.

Table 1: Participant Characteristics

	N= 17 (%)
Female	12 (70.6)
Age	
18-25	3 (17.6)
26-35	3 (17.6)
36-45	10 (58.8)
46-55	1 (5.9)
Race	
Asian	2 (11.8)
Black/ African-American	5 (29.4)
Hispanic White	5 (29.4)
Non-Hispanic White	10 (58.8)
Length of time at job	
< 1 year	5 (29.4)
1-2 years	8 (47.1)
3-4 years	1 (5.9)
5+ years	3 (17.6)
Education	
HS Grad/ Some College	7 (41.2)
College Graduate	7 (41.2)
Post-Grad/ Adv. Degree	3 (17.6)
Role	
CHW	11 (64.7)
Supervisor/Administrator	6 (35.3)

Appendix B: Interview Guide

CHW Interview Study: Semi-Structured Interview Protocol

Thank you for taking time to meet with me. The Health Care Foundation of Greater Kansas City has asked me to conduct interviews with community health workers and their supervisors in order to understand more about your work. So, I would like to ask you some questions about your day-to-day work, your experience recruiting and helping clients, and about your career history and intentions. This interview is voluntary, and you are free to end it at any time or to skip any questions you would prefer not to answer. With your permission, I will record and transcribe our conversation, but what you share will only be used in an aggregate or de-identified form (your name will be removed). The interview will last 30-45 minutes. Is it ok to begin?

Motivation to be a CHW

- How long have you been working as a CHW?
- Tell me a little bit about your journey to this position.
    - How did you learn about the job? What did you know about it beforehand? Why did you want to do it? Etc.

Current Work Experience as CHW

- I would like to understand more about the details of your work. First, could you describe what a typical day looks like for you?
    - Setting(s)—Where do you work?
    - Who do you interact with? (Ask for examples)
    - How do you get patient referrals?
    - How much time, on average, do you typically spend with a client?
- Do you consider yourself to be part of a team?
    - How do other team members (clerical staff, doctors, nurses, social workers, medical assistants, etc.) interact with you or other CHWs?
- Think about a really good day that you have had at work recently. What made it a good day?
- Similarly, what are the factors that make a day bad?
- [Building on what factors they bring up in above 2 questions], what other barriers make it difficult for you to do your work?
- What do you think it means to be effective in your job?
    - What helps you be effective in your job?
- What sort of resources, if any, do you wish you had that you don't?
- [If they haven't mentioned technology, ask]: How does technology facilitate or frustrate your ability to do your job?

Training + Development

- Think back to when you started as a CHW.
    - Can you describe the initial training you received?
    - Was the initial training workshop sufficient to begin your role as a community health worker? [What components of the training have been most useful? Are there any components of the training that were not useful?]
    - Are there additional topics you would like added to the training?
- Have you been involved in the KC Regional CHW collaborative?
    - If so, how are you involved? How many hours/week etc.?
    - What do you think about it?

Organizational Dynamics (KC CARE)

- How are CHWs treated and viewed in your organization?
- [Optional depending on if this has already come up above] What within your organization helps you do your job as a CHW?
- [Optional] What (if anything) about your organization gets in the way of your doing your job?
- What organizational changes have you noticed, if any? How have these changes impacted your work?

CHW Career

- So far, how has your position as a CHW been similar or different than you expected?
- Can you describe a moment/experience that was extremely satisfying or rewarding? Why?
- What are you career plans and goals?
- High turnover rates are a significant concern for community health workers. Do you feel like this is an issue at your organization? What suggestions do you have for how to address this issue?
- Are there any other questions that I should have asked you but didn't? Is there anything that you shared that you'd prefer I didn't report?

Additional Section for Leadership/Supervisors:

- How do you recruit CHWs? What are the most effective strategies?
- What do you think makes an effective CHW?
- What is the CHW turnover rate at your organization? What are the barriers to improving their retention?
- What are the biggest challenges you face to doing your job effectively?
- What do you consider to be your biggest success?
- What do you see as the most important factors impacting the work of CHWS in the future?