Community Health Outreach Workers: Voices and Issues

A Qualitative Research Study

Virginia Center for Health Outreach
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Summary

The purpose of this study was to solicit direct input from Virginia community health outreach workers (CHWs) about their concerns, needs and issues that the Virginia Center for Health Outreach (VCHO) can utilize to guide program development. A qualitative research design, the focus group process, was used to obtain a wealth of information, suggestions and ideas. A systematic process guided by focus group themes organized the key findings. Findings fell into the five discrete categories of CHWs' perception of their roles, concerns and issues, networking, education and training and role of the Virginia Center for Health Outreach. CHWs understand and relate to their clients and communities to the point of empathy, often finding it difficult to distinguish between themselves and those they desire to help. CHWs are well aware of the outside factors that influence their jobs and work, and face daunting barriers to advancement and education. Given the chance, CHWs recognize and demonstrate that they would readily utilize the inherent opportunities in networking. During the focus groups, CHWs identified a number of ways that VCHO can help them to help themselves. These include coordinating regional health and human services directories, providing requested resources, supporting public relation efforts and facilitating advocacy. CHWs also expressed their desire to hold an annual conference to provide networking and educational opportunities. Those in the CHW field must take steps to communicate worth, build capacity and maximize limited resources to successfully address the concerns, needs and issues identified by the focus group research study.

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Purpose and Procedures

The Virginia Center for Health Outreach (VCHO) creates a statewide infrastructure to support community health worker (CHW) programs across Virginia. VCHO most frequently uses the term CHW and occasionally, community health advisor (CHA) to include all lay health resource persons who work within their own communities. The purpose of this study is to solicit direct input from target CHW populations that the VCHO will utilize to guide its program development. Research, including this study, is one of the Center's primary activities. Other activities focus on coordination, education and training, policy, funding and sustainability.

Research Design and Sampling

The focus group process, a qualitative research design (Krueger, R.A. and Casey, M. A. (2000) Focus Groups. Thousand Oaks, CA: Sage Publications), was used to obtain report findings. The focus group process used a semi-structured discussion in a permissive, relaxed atmosphere to explore CHWs ideas, attitudes, beliefs, experiences and relevant issues impacting their role as a CHW. The focus group process emphasized the point of view of the group members.

Information packets describing the study, date and location of focus group and outlining the program director roles went to 12 individual CHW program directors or designees in predetermined regions. They selected one CHW and one alternate participant, establishing a pool of consenting participants. These program contacts were instructed to invite CHWs who represent a cross section of CHWs within their programs. These program contacts distributed necessary information explaining the study and distributed and collected the appropriate informed consent form. VCHO staff received these consent forms prior to the focus group. Program directors determined the final selected participant.

Participants drawn from identified community health worker programs across the state of Virginia formed the focus groups to explore their perceptions of community health worker problems and solutions. To achieve a purposeful sample, key informants selected CHW programs that were representative of the variety of CHWs and the vulnerable populations that they serve, e.g. ethnic diversity, age, illness, urban and rural. This captured diversity within CHWs. The geographical parameters for these groups were seven recognized regions of Virginia. To conduct the focus groups the researchers traveled 1,690 miles to the following sites: Tappahannock, Richmond, Norfolk, Lynchburg, Harrisonburg and Abingdon. In Northern Virginia, VCHO intended to use focus group data collected by Community Access Project partner, George Mason University (GMU) in Fairfax County. George Mason University used VCHO's focus group design but their research was moved to a different schedule. When their research findings become available, VCHO will amend this report.

Method of Collecting Data

Two Virginia Center for Health Outreach staff members conducted six focus groups. Sandra Hopper acted as the group moderator, facilitating the focus group discussion and Julie Gochenour recorded the field notes by hand and audiotaped the groups so that the information could be verified or clarified. The semi-structured script included introductory comments regarding the purpose of the study and a reminder of confidentiality. During the discussion, participants were identified only by first names. After an "ice-breaker" question to facilitate communication, a series of introductory, transition, key and ending questions completed the script. The sessions lasted approximately 1½ hours. Participants were assured of confidentiality and anonymity and that participation was strictly voluntary.

Transcription and Analysis

Twelve senior nursing students from James Madison University spent approximately 150 hours transcribing the audiotapes and conducting a preliminary independent analysis under the supervision of their professor, Dr. Linda Hulton. The researchers, Gochenour and Hopper, conducted the final independent analysis.

Participant Profile

Six regional focus group sessions were conducted with a total of 56 participants, of which only three were male. Participants' CHW experience ranged from less than one year to greater than 20 years. Examples of specific CHW titles included family support worker, resource mother, supervisor/family resource specialist, community health initiator, family outreach worker and prescription assistance counselor. Some participants had prior training in social work, recreation therapy, nursing and nursing assistant.

Findings

The framework of the report is composed of the major identified themes emerging from the focus group discussions. The findings of this study are derived from the scripted questions that guided the focus group process. Scripted questions drew out participants' concerns and perspectives and stimulated their individual responses. The following summaries consist of both spontaneous and thought out participant responses.

1. What it Means to be a Community Health Worker

CHWs consistently had difficulty distinguishing between their role(s) and the services they provided to clients. Once that distinction was understood, the CHW participant responses fell into six discrete categories of meaning listed in descending order of responses. The bulleted quotes are representative examples.

Being a Helper

It is no surprise that the majority of CHWs identified themselves as natural helpers and see this as the reason behind their choosing this work.

- I'm truly interested in helping people.
- It inspires me to be able to help someone . . . it is my desire to be of help.
- A job like this . . . gives me the opportunity to give back and help society. I mean it's not about the moneyand that is what I appreciate.
- I find it difficult for myself to say, I like helping people because I don't know if I'm helping them but I'm there for them.
- It is good to go into families . . . and help them see their strengths and help them build on that and watch them grow.
- I have a lot of (parenting) experience that I can really share with these girls and they really seem to appreciate it.

Satisfaction and Reward

While participants say there are limited material rewards in the CHW field, the second highest numbers of participants see their work as rewarding.

- I've been in outreach for the past 22 years and I think it's rewarding .. . believe it or not, I'm not burned out or anything.
- I find it very (rewarding) when the family reaches a goal; it makes you feel really good about yourself and them.
- This is the job that I WANT to have . . . it's not about the money. Because I'm not making the money.
- The self-satisfaction in knowing I'm helping someone.

Joy and Love

- I love working with families and children.
- I love what I do.
- It's just what I should do; I enjoy it and do pretty well. Better than I do other things.
- I enjoy the relationships . . . it makes me feel like I make a huge difference.

Spirituality

- I was born an outreach worker!
- I transitioned to this field because I felt this was my purpose. I was directed to do this internally.
- I think I have a gift – a service gift so it means a lot to me to have the opportunity to serve people.

Self-Transformation

- I'm a lay health promoter . . . it has been a great aspect to me because it has changed my life.
- I myself am learning and experiencing new things and that makes it gratifying.
- I learn a lot (that I can use) for my family and children.
- It's like a springboard for another opportunity.

Creativity

- It's a real frustration when you're tired, but you don't give up . . . you have to be very creative.
- (CHWs) are creative people and that's why they have this job.
- This job allows me to get out and find a way to creatively find resources for families.

2. Concerns and Issues

The findings in this category are based on both deliberate and spontaneous input. Focus group participants were asked to list and rank their most pressing concerns and issues regarding their role as a CHW. In addition, 24 CHWs from a statewide program were asked to do the same. All responses, both deliberate and spontaneous are folded into this section of the report. There were few differences in perceived issues between urban and rural geographic regions. All but two groups identified various workplace conditions as their most pressing concern. Two groups ranked it second behind problems their clients' experience and, again, these CHWs apparently found it difficult to focus on their own concerns as CHWs, rather than their clients' needs. Other major areas of concern were financial issues and relationships with health and human service agencies. Some discussion about concerns generated spontaneous problem solving among focus group participants. Their suggestions are included in italics below.

Workplace Conditions

Five subcategories within the workplace that cause CHWs concern are safety, policy, support, workload and respect.

Safety

Safety is the primary concern in both rural and urban settings. These concerns ranged from exposure to disease; physical threats due to animals, domestic violence or drug dealing to unsanitary environments and dangerous locales.

- I have a big concern about my health with making home visits. Sometimes a person has a contagious disease that we know nothing about.
- The dog is all over me. We don't get trained to deal with a dog.
- One concern is visiting a home where I know there is an abusive partner.
- Cockroach infested houses!
- Going out in the county that is not populated where a worker may not receive assistance if needed.
- Going into low-income housing projects or homes where there are violence or drug issues.
- We were given reconditioned cell phones so we were safer in the field but none of them worked.

Suggestions

- *There was (CHW) who was concerned about safety . . . because it was a very rural setting. . . she resolved that problem by having the client meet her at a destination closer to town at a church or something like that . . . so she wasn't in the home by herself.*
- *Ours (cell phones) are set up such that our (CHWs) cannot use it except for emergencies.*

Policy

Policies span a number of work practice issues that include travel, paperwork, work schedules, legal concerns, dress code, etc. However, due to the great diversity of programs, few statewide patterns emerged from policy concerns. The number of items below reflects this diversity and not the frequency with which policy concerns were raised.

- Transportation – the cost associated with providing it yourself.
- Forms and paperwork (are) meant to provide a service, it's meant to tell a story, it's meant to provide information. If it doesn't do that clearly, we are wasting our time.
- Conflicting schedule.
- Our supervisor has us dressing professional every day. We make our schedules and we should have a choice that this is how I'm going to dress because of the situation . . . it should not be mandatory one way all the time.
- Honey, I always look professional. I look professional if I'm wearing jeans and tennies!
- Computer program used is inaccurate.
- Rules different for each worker.

- Concerned with personal privacy after being in outreach, as my car and my name are available to many people.
- The policies pertaining to the courts.
- Legal responsibilities.
- Being asked to manipulate statistics.

Support

Feelings of being overwhelmed, inconsistent supervisory support and a blurring of boundaries between CHWs and clients contribute to workplace stress and burnout.

- Our workers tend to burnout quickly, even though the work is very rewarding.
- My supervisor doesn't always understand my role (and) I don't always understand my supervisor's role.
- I would like to see more outreach workers in middle management . . . I would like to have someone who has worked in the field to be my supervisor.
- Lack of agency support – sent out to do a huge job with little support or resources.
- Feeling like the world is on my shoulders some days.
- It is a high job turnover rate.
- You want to do so much for the family; sometimes you tend to overstep your boundaries.

Workload

Reported limited program funding necessitates increased workload for the CHWs who stay in these programs.

- We have so many clients it is hard to do our job.
- Too many clients, not enough time and not wanting to turn families away.
- Too many clients, not enough time, caseload too large.
- (Need) enough time for the number of clients (in order) to do a good job.

Respect

This issue raised strong feelings in one focus group but did not arise in other groups.

- Our directors are our directors, we are not children and we are not their property.
- If you want your paycheck, you are their children.
- It's sifting down to respect, it really is.
- We have to do this - we have to be respected. We need the managerial skills so that our supervisors and our directors understand it's not always about clothes, it's about demeanor, it's about respect.
- Lack of respect from administrative personnel.

Workplace Funding

Funding impacts every aspect of a CHW's work. A lack of sufficient funding limits pay, benefits and advancement opportunities; client support; and available equipment, e.g., cell phone, computer and car for CHWs. CHWs often find themselves expected to make up funding shortfalls by soliciting funds or goods to meet program goals. Unstable program funding also creates steady tension around the issue of job security. CHWs deal with the fallout from these issues at home and work every day.

- Intrinsic rewards are not enough. You have to have enough income to go to the grocery store or pay the electric bill . . . so you're not standing in the food stamp line with them (your clients).
- Because of the low pay, you're just one step above the families you're serving . . . you're looking at what their bringing in and what you're bringing in and you're going, I just know how to manage it a little better than you do.
- We are the lowest paid in our agency.
- It takes time from your already busy schedule to go out . . . and ask for donations.
- (We need) more bilingual material from health programs or educational services to share with our clients.
- There is no incentive to grow.
- When you're an outreach worker, where do you go from there . . . you have all this experience and you can't further. It would be nice to see a senior (level) outreach worker.

Suggestions

- *It would be nice if you could have a step up, a half step up, a quarter step up would be an incentive.*
- *You shouldn't have to have a degree to be whatever that next phase is, if you have all the experience.*
- *Career track.*
- *Experience could equal up to (college credit) . . . assign college credit to our training.*

Workplace Relations

Community health workers do not work with clients in a vacuum. A wide variety of agencies, e.g., social services, health providers, schools and courts interact with clients and therefore CHWs. A lack of networking, cooperation and coordination among these entities contribute to gaps and/or duplication in client services. Additionally, CHWs consistently report that they receive little or no respect from their peers in these agencies, making it difficult for CHWs to assist their clients. Limited or absent community resources and services for clients deepen the challenges that CHWs face. These include, but are not limited to housing, employment, health insurance and transportation for clients.

- It's frustrating to have to make 15 phone calls to get someone to call me back from social services or from food stamps.
- At a lot of departments of social services, the workers are so jaded that they really look down on clients. I have taken workshops with social services workers and they spent the whole workshop laughing, ridiculing the people that they are supposed to be serving.
- The schools sometimes buck at you. They don't want you there.
- I feel like I can't complete my job because there are not public services out there.
- Watching clients suffer due to lack of resources.
- Need more doctors to offer services.
- We don't have any access to mental health (services) for our low-income families.
- I think the very worse thing is that people fall through the cracks. I mean they seriously fall through the cracks.
- Not being taken seriously when I contact Child Protective Services.

Suggestions

- *We need to be able to collaborate more so we know exactly what resources are out there for our clients. And so we won't be duplicating services and we will also know where to direct our clients for resources.*
- *Partnerships with stores, e.g., Kmart, Target, Food Lion, Farm Fresh so if the client needs something we can go as a worker and say we need the pampers, juice, pedialyte, etc.*
- *Increased interagency case staffing as a way to better coordinate services.*

Client Issues

CHWs care deeply about the clients they serve. In many cases, they worry more about their clients' lack of resources than they do their own. Client concern is a burden that many CHWs carry. On the other hand, difficult clients are equally draining, but for very different reasons.

- What if I don't fully address an issue and something happens to a baby.
- Cultural and language barriers.
- How to help client realize how important it is to stay in school or get a GED.
- Client's fear of knowing possible health problems, e.g., cancer, diabetes, etc.
- Letting some people know that all doctors are not out to take their money.
- How to tell a client you are reporting them (to Child Protective Services).
- Hostile clients.
- Noncompliance of clients.
- Addressing abuse issues – child and domestic violence.

Suggestion

- *I'd like to see more advocacy where we work on the strengths of the family and you bring them from where they were to here.*

3. Networking

Community health workers in every focus group recognized the value of networking and expressed interest in planned networking opportunities with other CHWs both regionally and in the state. They identified a number of barriers that must be overcome for this networking to occur. CHWs' limited email capability and computing resources hampers electronic networking.

- I think a lot of people in administrator or supervisor positions are very much afraid of the outreach workers' getting together and talking.
- It's a learning experience, too, because you learn from others.
- Transportation is a problem – somebody transporting me where I need to go.
- Some of these issues are always going to be there. Just learning how to deal with them (through networking), to make them workable situations.
- The more you do the job, it gets easier, you learn the nook and crannies, you learn who to call. That's why if there were some kind of network set up (we could learn from each other) . . . that's hands on stuff.
- To connect with other people (CHWs), for me it would be a learning experience to associate with something that I know nothing about . . . and to relate some of that information back to families would be a good thing. So that is why I would like an organization.

- Outreach workers are being asked to do more and more . . . the workers need advocacy.
- Coordinating an organization for the outreach workers, I think that would be really good.
- I just want to say that it's nice to meet other people. I didn't even know there was a program in this area. It was good to hear other people who are doing the same kind of work.
- I don't even know how to get on it (computer) to tell you the truth.
- I don't have a computer to access it (email and internet) with.
- One email address for the whole floor.

Suggestions

- *My suggestion would be to do it like by planning district . . . if there are enough of us to do a group in the area, then you become familiar with what the resources are in your own area, which is what we need. Then the different (regional) groups could share that information.*
- *A stipend for travel.*
- *Childcare*
- *Time needed to participate.*
- *Support groups just for outreach workers or people in this profession, just being able to talk, communicate and vent out things.*
- *I think that particularly regional would be good because in this area no one would have that far to drive.*
- *(Meet) once a year or quarterly.*
- *I think if every agency knew when there was a budget hearing and all of us drove together to Richmond and was like - look, we vote for you all.*

4. Education and Training

Both basic and continuing education is a necessity for CHWs. CHW feedback indicates that basic training length and kind vary between and within programs. CHWs reported that the quality and quantity of continuing education are equally varied. In addition, they identified cost and/or lack of funds and location as barriers. Teleconferencing capability exists statewide. Many CHWs lack Internet access.

- I had ten weeks of training and it was about 21 different (syllabi).
- We had a week of initial training and ongoing training about twice a month.
- We have forty hours of training.
- I just shadowed the staff that was already there for about a month or two.
- We did a week of . . . training.
- We did 80 hours of training.
- Just because we went to a week of training doesn't mean it was appropriate and we came away with (information to) use on a daily basis.
- Saying she's trained and out in the field doesn't mean a thing about . . . going into people's homes and being appropriate.
- There are some great things out there but we can't afford them. However, the supervisors can go.
- We have some training available but usually it's at such a high cost that we're told we can't do it.
- (We) have to pay for it and that takes money out of our program that could be going to the families that we serve.
- I'm always told that we don't have the money . . . they're asking an awful lot and they're not giving us the education we need.

- Sometimes you wonder if the people that are doing the training have ever seen a child, ever seen a family, ever been outside their office.
- We go somewhere and what do they do? They read to us! . . . I don't need anybody to read to me.
- They change Medicaid and stuff all the time . . . they have a great training for Medicaid and FAMIS but it is hard to find out about them.
- I don't even know how to start to go to community colleges and universities.
- I'm 20 hours a week and if you take me out for a five-hour training or an eight-hour conference, that takes away from my family and to me they are number one.
- (No computer) at home or at work.

Suggestions

- *I would like to see some training where you can bring in some of the different resources. People that supposedly network with you, trainings with family support workers and social work. When you know them you can do the system a lot faster.*
- *I think that they (programs) should seek funding themselves and offer the training to their people at a lower cost.*
- *A small group about this size (12) is the best for training.*
- *Hands-on training is best.*
- *Informative reality training.*
- *Working with someone else helps.*
- *I would like more training in fatherhood.*
- *We can have training on organizational skills for agencies in general and also in form design.*
- *The ideal is that a representative from social services or the school system teaches you so that you have that information to educate your parents or clients.*
- *There is something called the Welfare Game (Poverty Simulation) and everyone of us should play.*
- *. . . we need is cultural diversity (training) and not just black and white. We need Hispanic, Pakistani, Indian, Muslim, Jehovah Witness and Christian Science.*
- *Training in immigration.*
- *Being able to use Asthma machines.*
- *Provide hotel money.*
- *Learning a second language, e.g., conversational Spanish.*

5. Virginia Center for Health Outreach

The mission of the Virginia Center for Health Outreach (VCHO) is to create an infrastructure to support community health workers in Virginia. During the focus groups, CHWs identified a number of ways that VCHO can help them to help themselves. These include coordinating regional health and human services directories, providing requested resources, supporting public relation efforts and facilitating advocacy. CHWs also expressed their desire to hold an annual conference and turned to VCHO for assistance.

- Is there a way we can contact some people in those (health and human services) that maybe have some power to let them hear the pervasive concerns throughout the state?
- A great need for us (is) resources in different languages – Spanish, Vietnamese and French.
- I didn't know if there was anything out there but it would be good to know what support there is for different situations.
- Can you help us lobby and get more money for these services?

- In going to workshops . . . it wasn't just the information but that was also the place where you got to network with people.
- You not only need the perspective of the leaders or directors, you also need the perspective of the paraprofessional, that person who is down there at the bottom rung who really doesn't have a lot of education, but has the HEART. It could be skill-based for them, giving them what they need, but it also needs to be experiential.

Suggestions

- *What we really need to do is sell (market) our name as outreach workers.*
- *We need some good public advertisement . . . to educate the general public about the fact that there are (client) needs out there.*
- *You need to get hold of the politicians.*
- *There is a need in each community to have a cross-reference of resources.*
- *We need to know which counties have what and maybe work at getting those resources in other counties.*
- *The directors need to network and receive information on how to do grant writing and those kinds of things.*
- *Statewide (conference) would be so much better – you would be able to meet the other people and experience some of the different ways that they work in the state.*
- *Tailor the conference to the outreach worker and to their issues.*
- *Do separate workshops for directors and outreach workers.*
- *Have multiple workshop topics so programs so people from the same program can learn different things.*
- *Topics suggested include burnout prevention, job-related stress issues, depression, personal safety, protecting ourselves from contagious diseases.*

Conclusions

The researchers conducting the focus groups were pleased how easily the participants spoke of their concerns as well as how insightful they were in identifying solutions. Most of the participants viewed the focus groups as a helpful process and indicated that felt that they were being listened to and that what they said had value. Also, the researchers were surprised by the spontaneous problem solving, connecting and networking consistently generated by the group process.

Generalizability is not the purpose of focus group research, rather it is to provide insights into the attitudes, perceptions and opinions of participants. It is important to remember that because the participants did not identify something as an issue it still could be.

Recommendations

The Virginia Center for Health Outreach self-commissioned a focus group study because it desires Center policies and activities to be CHW driven. A number of critical issues emerged during the research, however, that can only be discussed and addressed by multiple partners in the Commonwealth. For effective action to occur, these key players must (1) come to the table, (2) leave territoriality at the door, (3) engage in out-of-the-box thinking to do serious problem-solving and (4) be willing to implement necessary changes.

There are many factors in the CHW field that currently send CHWs the unintentional message that they are of little or no worth. Deliberate action to address these factors on the part of key players in the CHW arena will go a long toward reversing this message. Based upon focus group feedback and analysis, the Virginia Center for Health Outreach strongly recommends consideration of the following actions:

Education and Training

The Virginia Center for Health Outreach will guide and participate in efforts to:

- Develop a statewide conference that meets criteria provided by the focus groups with appropriate content, teaching methodology, cost and location for CHWs
- Provide bilingual and culturally appropriate materials for CHWs to use with clients
- Work with key players to provide CHW training to addresses shared concerns e.g. safety, etc.
- Work with key players to help provide more standardized training for CHW programs in Virginia
- Explore and attempt to develop ways to provide CHWs with educational opportunities including a career track and acquiring college credit for experience.
- Assist CHWs, programs and health care providers in reframing the CHW role as a career or vocation with valuable skill sets
- Explore differences in perceptions between paid and volunteer CHWs
- Develop opportunities to publicize CHWs, their work and value
- Offer training support for program supervisors in management and grant writing
- Explore distance education as a means of delivering training to CHWs and programs

Networking

The Virginia Center for Health Outreach will guide, assist and participate in efforts to:

- Establish eight regional CHW networks that meet a minimum of twice a year and once at an annual statewide CHW conference
- Hire CHW regional coordinators to support regional CHW networks
- Facilitate regional CHW networks' use of existing community resource directories or their efforts to develop new resource directories where they do not exist
- Conduct focus group research among CHW supervisors, coordinators and directors

Concerns and Issues

The Virginia Center for Health Outreach will facilitate and join key players' efforts to:

- Apprise health and human service agencies of CHW perceptions
- Increase interagency contact, communication and information sharing, e.g., inter-agency case staffing
- Examine how programs and agencies treat the CHWs they employ or use to deliver services
- Provide forums or settings for CHW/supervisor dialogue
- Address perceptions that being a CHW is a dead-end job
- Explore and address impact of Virginia state pay bands or other types of salary structures on CHWs
- Address emotional repercussions of CHW work, e.g., stress, depression, etc.
- Assist CHWs in coping with job realities caused by severe financial limitations including the lack of equipment, safety concerns and tension around the lack of job stability