Southwest Rural HEALTH RESEARCH CENTER

Community Health Worker Roles and Responsibilities in Rural and Urban America

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Purpose

In this study, our primary aim was to understand the evolving profession of Community Health Workers (CHWs) in the United States, a workforce that is projected to grown by 11% over the next decade.[1] Through focus groups held with CHWs in rural and urban regions of four states, we explore CHW roles and responsibilities, the growing professionalization of the field, and evolving interactions between CHWs and other care providers. Critically, we also provide an in-depth look at how CHW work varies between rural and urban environments and provide insight to support the continued growth of the field across rural and urban areas of the United States.

Background

Growing bodies of research in public health point to CHWs as vital figures in ensuring access to needed services in a cost-effective manner.[2-8] By engaging with patients to bridge the gap between the public and needed services, CHWs are positioned to help enhance patient knowledge and improve individual responsibility for care.[9-13] They are also uniquely situated, oftentimes armed with cultural competence and a personal understanding of the challenges their clients face in accessing services, to help their clients navigate a multitude of barriers and address the social determinants of health.

In serving as bridge figures who consider more than a client's immediate medical needs, CHWs can provide individual-level attention to detail. They can help to ensure, for example, their clients not only make an appointment to see a provider, but also

[i] We use the terms Community Health Worker and Promotor(a) interchangeably. While considerable variation in naming practices exist in the field, Community Health Worker and Promotor(a) are used most frequently and have gained acceptance in the health care communities in most states. In the context of our research, Promotor(a) was used widely in California but Community Health Worker was used by participants in our other states.

Key Findings

- CHWs serve as bridge figures, linking clients in local communities to needed health services.
- CHWs operate in a multitude of roles and settings, but share the common goal of addressing inequalities related to the social determinants of health.
- The CHW field continues to grow and professionalize, however disagreements exist between CHWs over what the minimum training expectations and certification requirements to work as a CHW should be.
- In our focus groups, CHWs agreed that more needs to be done to establish appropriate funding mechanisms for stable employment, with many only able to find CHW positions as volunteers or in short term grant positions.
- The relationship between CHWs and other medical professionals continues to evolve, with growing acceptance of CHWs as important to patient health by other medical professionals as they become more integrated into care teams.
- Due to fewer services available in rural areas, CHWs in rural environments have fewer options when trying to bridge clients to health services than their urban counterparts.
- In rural settings, CHWs often characterize themselves as generalists, while CHWs in urban areas tend to be more specialized, particularly in hospital settings.

that they have the means to arrive at that appointment on time. This high level of involvement in their clients' ability to access services requires building trust to ensure effective information exchange between CHWs and their clients. CHWs often need an encyclopedic knowledge of the services available in the area, the requirements clients must meet to be eligible for social services or programs, and the ability to help clients overcome personal challenges or barriers that could prevent clients from connecting with those services. The specific contextual knowledge and information CHWs need to be effective in their roles also means that the region where they work will drive the types of services that are available to their clients, barriers to access commonly faced by the local population, and ultimately, the types of roles, responsibilities, and job opportunities that CHWs have. We explored each of these topics, as well as how CHWs relate to other providers as the profession evolves, looking at important differences in the experiences of rural and urban CHWs.

Methods

To investigate the CHW field in rural and urban environments, this research relied on a series of focus groups conducted with CHWs in four states: California, Florida, Massachusetts, and Minnesota **(Table 1)**. These states were selected with the assistance of the National Community Health Worker Training Center at Texas A&M University and were chosen for several reasons. First, we chose these four states to ensure that our study reflects the views of CHWs from various regions across the country. These states are not intended to be representative of CHWs nationally or even regionally, but we studied CHWs from different parts of the U.S in an attempt to minimize the risk of missing unique patterns of results. Second, we selected these states because each has large populations of CHWs making it feasible to set up multiple focus groups.[14]

In each of our four study states, we held two focus groups – one in an urban environment with CHWs who work in urban areas and one in a rural environment with CHWs who work in rural settings. Specifically, our California focus groups were held in Los Angeles and Madera, our Florida focus groups were held in Tallahassee and Okeechobee, our Massachusetts focus groups were held in Boston and Greenfield, and our Minnesota focus groups were held in St. Paul and Bemidji. Focus group sites within states were selected through conversations between our research team, the National Community Health Worker Training Center, and state and local CHW organizations.

Each focus group was approximately 90 minutes long and was held in either English or Spanish based on participant preference. In total, 71 CHWs participated in this research across the aforementioned four states. Each focus group concentrated on participant responsibilities as CHWs, challenges they face in their roles, mechanisms they use to connect with their clients, and perceived differences between urban and rural areas. All focus groups were audiotaped, translated as needed, and then transcribed. Coding of focus group data was performed using the qualitative data software NVivo-11.[15] Our study relied on a thematic analysis that was both deductive and inductive. Data were coded independently by two researchers on the project team and a high degree of concordance was found across the coders.

Table 1. Focus Group Locations

State	Location	Urban or Rural	Date
Florida	Okeechobee	Rural	December 13, 2018
Florida	Tallahassee	Urban	December 14, 2018
Minnesota	St. Paul	Urban	April 12, 2019
Minnesota	Bemidji	Rural	April 15, 2019
California	Madera	Rural	June 24, 2019
California	Los Angeles	Urban	June 25, 2019
Massachusetts	Greenfield	Rural	June 28, 2019
Massachusetts	Boston	Urban	June 28, 2019

Results

Roles and Responsibilities

Our discussions with CHWs across the country revealed several important themes. First, in discussions about CHW roles and responsibilities, our participants consistently noted that their primary task—in both urban and rural areas was to serve as a bridge figure, connecting clients to needed resources. For example, one CHW in Madera, California noted:

> *"We are this bridge between the agencies, their resources, and the community. Promotoras are very successful here because we have this connection with people, we go to their level, we understand people because we belong to the community, we know their needs, a lot of times we experience them." (Madera, CA)*

This sentiment was echoed by another CHW in Los Angeles, who emphasized not just the community, but the broader health industry:

> *"I would say… linking clients to resources. That would be to providers whether it's medical, dental, where you can get vision, where you can get a hearing screening, diapers whatever the resources that the clients need. Linking them to those resources." (Los Angeles, CA)*

While this responsibility as a bridge figure linking clients to needed social services was widespread, how CHWs performed this task varied dramatically based on their position—supporting the common adage, "if you've met one CHW, you've met one CHW." Across states, we met with CHWs serving as care coordinators, counselors, educators, advocates, researchers, navigators, and even volunteers. They worked in a variety of settings including hospitals, medical and dental clinics, schools, non-profits, governmental agencies, and other community settings. In short, there is no single model of a CHW, but all share a consistent goal to fulfill client needs by connecting them to resources. By serving in this bridging role, CHWs are uniquely positioned to address inequalities related to the social determinants of health. CHWs across states noted that:

> *"We help with insurance, and then we help with homelessness, and then we help with food, and then we help with moving, and then we help with dental access, and behavioral health access. And that's all before noon." (Bemidji, MN)*

> *"…if you're worried about homelessness, if you're worried about where your next meal's coming from, or childcare, or all these things that are directly related to your family, you're not focusing on your health. You're focusing on these things. So, that's where we come into play... Nine times out of ten, they don't even identify anything health related. It's mostly social." (Boston, MA)*

To effectively address the social determinants of health, many CHWs stressed the importance of connecting with their clients outside of the workplace, in the community, and even in their clients' homes:

> *"…especially if you go into the home, you had the opportunity to see the whole client, not just the COPD, not just the diabetes, not just the person who is vulnerable….You had the opportunity to see the person as they live. And that's something that your doctor doesn't get to see or your nurse in the hospital doesn't get to see. You just have a better understanding of where they are." (Okeechobee, FL)*

> *"Then we can go back and relay to the doctor and the nurses what kind of problems [patients have]…. They [medical providers] actually get an insight on who their patients are and get to know them a little bit better because of us." (Greenfield, MA)*

Professionalization

As important as these CHW roles and responsibilities are to treating patients in the modern health care environment, our focus groups revealed that the professionalization of the CHW field is in its early stages of development. Supporting this idea, there is no consistent naming practice for someone who serves the primary

bridging function of CHWs. While the terms CHW and Promator(a) are becoming more widespread, CHWs across focus groups noted that consistent naming conventions do not yet exist:

"I think for one, because there's a misconception with the titles and labels, because a lot of people are doing CHW-type work, but they're called, employment specialist, or something like that. But, it's the work that they're doing, so that title is going to tie them to the position that they're doing. But, for the most of it, they are doing CHW work." (Tallahassee, FL)

However, we did find evidence that the field is beginning to coalesce around the CHW label and that more doors are opening for CHWs to work in a variety of settings:

"I see more people who identify themselves as Community Health Workers…. People were doing this job a long time ago, before there's this big Community Health Worker put on. Now, people are beginning to accept it and say no, that's what I am. I'm a Community Health Worker. So, they're actually accepting their title more…they're beginning to be a little more prideful, I guess, of the work that they do. So, they're bringing on more attention to themselves, at the same time, the work that they do is being recognized, and thus, it's drawing attention. So, more people are jumping on the band wagon…." (Tallahassee, FL)

"I began as a volunteer 8 years ago, then the doors were not as open as today for the promotoras." (Madera, CA)

Across states, CHWs also spent considerable time discussing training and certification. Certification processes were at various stages of development in each state, and CHW attitudes were understandably varied. Some CHWs felt that certification, continuing education opportunities, and even advanced degrees were important to the advancement of the field and CHWs' ability to find better jobs:

"… There's nothing above it. If you're a Community Health Worker today, you're going to be a Community Health Worker tomorrow and guaranteed, you're going to be one five years from now…. It would be nice if we had Masters [degrees]. (St. Paul, MN)

That said, this was a contentious topic, particularly in California where some CHWs felt that certification requirements could limit the ability of CHWs to serve as bridge figures between institutions and the community.

"The debate was about certification, there are a lot of states in which the state is the one providing a certification for the promotora, after having this certification you are prepared to work… [They] don't support that because they say: "you don't need a certification to be a promotora, we believe that being a promotora comes from the heart, you are born with it, you don't need a certification", because the certification will limit the promotoras…" (Madera, CA)

As the CHW field continues to grow, another emerging issue that our CHWs raised is payment. In some areas of the country, many CHWs work on a volunteer basis despite their desire to find a paid position. Even when in paid positions, many participants believed that their salaries were not commensurate with the services they provided. Part of the problem in having sufficient well-paid CHW positions is the challenge that organizations have in billing for CHW services. As many CHW activities are better categorized as social as opposed to medical, billing can be complicated. For example, CHWs expressed that:

"…all social determinants of health should be a billable service when you're helping someone to self-manage…." (Bemidji, MN)

"They should be looking at how much money is saved.... Our social workers are never questioned about whether they're making a difference. Our behavioral health people don't have to document that. Why is it that the community health worker has to do that?" (Bemidji, MN)

CHWs and Other Medical Professionals

In this rapidly evolving field, we also found that the relationship between CHWs and other health professionals continues to evolve. CHWs suggested a three-stage process. First, several noted that when they began at new workplaces, other health professionals were not sure what CHWs did or how to utilize them. For example, one stated that:

> *"When we first started, it was really .... Okay, what are you expecting from a community health worker, and all of them looked at me and said, 'We don't really know.'" (Bemidji, MN)*

Gradually however, as other health professionals learned what CHWs do and saw that some roles overlapped, conflict arose:

> *"...even nurses were feeling like we're stepping on their toes. And now we have the social workers feeling like we're stepping on their toes. It just gets to the point where it feels like a lot of things are changing now and either we're on board for the change, or you know... it just feels like this is being shaken up and a lot of people are like, 'Wait a minute. They're taking my job.' You know what I mean?" (Boston, MA)*

Importantly, several CHWs who had built longer-term relationships within their institutions saw a positive change in their interactions with other medical professionals, becoming a key member of the care team:

> *"When I started at the county 11 years ago the title was a Family Health Mentor and the public health nurses felt threatened and then when the Community Health Worker role came in they felt more threatened and now they beg for us to work with their families. So from the professional perspective, I have seen a huge change." (St. Paul, MN)*

Rural and Urban CHW Differences

While our research identified several commonalities between CHWs across sites, we did identify notable differences between CHW experiences in rural and urban environments. The primary difference was in the level of resources available to help clients. This resource discrepancy—with more resources in urban than rural areas—is particularly critical to CHWs, given their primary role in bridging clients to needed services.

In fact, in some urban areas, CHWs noted that resources were widespread and could overwhelm clients:

> *"Everybody in Boston that has something going on has been offered some kind of program. And, really, they're so overwhelmed by, 'Oh, I have five different programs. I don't want another program.'" (Boston, MA)*

At the same time, CHWs in rural areas struggled to find clients the services they needed:

> *"[In] rural areas here, there's less transportation, there's less resources, there's less funding. Sometimes it can be trying. We have a program right now that the CHWs work with where if you're struggling with food...we can give you a gift card of a certain amount for each person in the house, but that's limited. We can't give it to everybody and everybody at some point has problems with food insecurities." (Greenfield, MA)*

CHWs also noted differences in the level of specialization of CHWs in urban versus rural environments. CHWs in urban areas were far more likely to be involved in research and were more likely to focus on a specific disease or condition than their rural counterparts:

> *"I think in an urban setting often they're adding a CHW specialized in diabetes, specialized in prenatal care, specialized in something that they can really train that individual [in], and they have a large enough population that they can serve just that population, and that it really makes that difference in those urban areas. And I think the big thing I've seen different for us in a rural area is we have to be very generalist." (Bemidji, MN)*

Discussion

Through detailed conversations with Community Health Workers throughout the U.S., this brief highlights the responsibilities and professionalization of the CHW field. It suggests that there is not a 'typical' CHW and that instead, CHWs work in a multitude of settings on a vast array of tasks. Despite this reality, our results show that CHWs in rural and urban areas share two commonalities—their role as bridge figures between communities and needed resources, as well as their unique position in helping the health care industry address social determinants of health.

Our results demonstrate that the CHW field is still evolving. While there is growing recognition of the field, there is not yet consistent nomenclature for individuals doing health promotion work. The use of the terms CHW and/or Promotor(a) are becoming more widespread, but they are far from universal. In addition, CHWs vary dramatically in their views on training and certification, which many have argued is crucial to professionalization. While CHWs in some states have embraced certification requirements for CHWs, and have even pushed for the development of more advanced or specialized degrees, others have resisted this change, arguing that it separates CHWs from the communities they serve. CHWs do not believe they are being paid at a sufficient rate that is commensurate with similar workers from fields with longer track records.

Our research also identifies important differences in CHWs across rural and urban areas. CHWs in rural areas consistently noted that they struggled to fulfill their primary responsibility as bridge figures because rural communities often lack the resources, providers, and services clients need. In rural areas, CHWs often reported that they served in more "generalist" roles. This contrasted sharply with urban areas where clients were sometimes overwhelmed with the services and resources available for high-need patients, and CHWs therefore took on a more "specialized" role.

Implications

This research suggests that the CHW field continues to evolve, professionalize, and gain wider acceptance in the medical community. Our work suggests that training and certification is a topic of considerable debate among CHWs and that state policy actions to mandate certification could be met with mixed reactions from the CHW community. It also suggests that academic units that build curricula for CHWs, particularly Masters-level programs, could see engagement from CHWs seeking career advancement. Additionally, our work notes the need for improved billing practices, particularly regarding ways to bill for the activities that CHWs do to address the social determinants of health that are not necessarily medically focused. Next, our findings related to initial lack of understanding and eventual endorsement of CHWs by other medical professionals in institutions suggests that more needs to be done to promote how CHWs can help other health professionals so that they are more quickly accepted as an important part of patient care teams. Finally, our results suggest that CHWs in rural environments can struggle to serve their primary function as bridge figures due to limited resources in rural environments.

Our research lends itself to several pathways to improve the effectiveness of CHWs in helping to meet client needs. First, additional support is needed in rural America so that rural CHWs can best serve their clients. Without well-funded social programs and other traditional resources like behavioral health programs, food security programs, housing programs, and adequate public transportation services, CHWs in rural areas will continue to struggle to meet client needs.

Second, our findings suggest that the medical community may benefit from looking at CHWs as a mechanism to address the inequalities associated with the social determinants of health in patients. Other health professionals' interactions with patients often stop when they leave sites of treatment, but CHWs natural placement in the community makes them well positioned to address the social determinants of health. Recognizing this fact, and integrating CHWs into holistic health coverage, could be an important step forward to improve patient health.

Next, our brief emphasizes that reimbursement opportunities are limited for services provided by CHWs. Our research suggests providing reimbursement can support greater uptake and effectiveness of the CHW model. Without appropriate billing mechanisms, many health care institutions will be hesitant to hire CHWs, limiting the growth of this field.

Finally, this brief emphasizes the need for additional research on the CHWs. This exploration of CHW attitudes and experiences is helpful, but more work is needed to understand the applicability of our findings nationally, how various CHW laws across the country influence CHW roles and responsibilities, and to hear from the broader medical community about their relationships with CHWs across rural and urban environments.

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