

## CHW Roles, Definitions, Models and Target Populations

Roles, Definitions, Models and Target Populations are frequently used as a way of filling out either CHW definitions or CHW models. Our example definitions can therefore serve as the starting point for a discussion of CHW roles – see Item 1 below for one example of the way roles flow into definitions.

The CHW “Functional Models” listed below as Item 2 provide some options for classifying CHW roles. Additionally, CHW roles may vary depending on the target population – Item 3 below lists some of the issues and approaches for different target populations, illustrated with Maryland examples.

The value of reviewing these various ways of classifying what CHWs actually do is they can move us towards the development of CHW competencies – one test of a valid set of competencies is that they will cover all the role requirements of a practicing CHW.

**Item 1: Roles and definitions:** CHWs are known by a variety of names, including ‘community health advisors’, ‘outreach workers’, ‘lay health advisors’, and ‘promotoras/promotores’, but regardless of the job title there is an overlapping commonality of role, activity and function which the Affordable Care Act summarizes by defining CHWs as “workers who promote health or nutrition within the community in which an individual resides by ...”:

- a) serving as a liaison between communities and health care agencies;
- b) providing guidance and social assistance to community residents;
- c) enhancing community residents’ ability to effectively communicate with health care providers;
- d) providing culturally and linguistically appropriate health and nutrition education;
- e) advocating for individual and community health;
- f) providing referral and follow-up services or otherwise coordinating; and
- g) proactively identifying and enrolling eligible individuals in Federal, State, and local private or nonprofit health and human services programs.”

(Affordable Care Act, quoted in Brownstein et al., 2011b)

**Item 2: CHW Functional Models:** CHWs cannot work in isolation – they operate by building strong connections with healthcare systems to accomplish health goals for the patient, but also by building connections with community, state and charitable resources which complement health interventions. The array of CHW relationships with the health care systems and communities they serve suggests six distinct functional models.

1. **Promotora or lay health worker**, where CHWs are themselves members of the target population and often act as a bridge between the healthcare system and the populations they serve.
2. **Member of Care Delivery Team:** where the CHW offers direct health services under the supervision of a health professional. Services typically include blood pressure and pulse measurement, first aid, medication counseling and health screenings.

3. **Care Coordinator:** as a care coordinator or case manager, the CHW works with individuals who have chronic conditions and/or need help navigating the health care system.
4. **Health Educator:** where CHWs deliver health education to the target population related to disease prevention, screenings and healthy behaviors, and may teach educational programs in the community.
5. **Outreach and Enrollment:** this is similar to the health educator model but with additional outreach and enrollment responsibilities. CHWs conduct home visits to offer various kinds of support, promote healthy behaviors, conduct home assessments, offer advice and make referrals for enrollment in government and community programs.
6. **Community Organizer:** CHWs act as community organizers and capacity builders, promoting community action, securing support and resources from community organizations to implement new activities, and work with communities to seek policy and social changes.

(HRSA, 2011)

It can be seen that in some models CHWs are lay members of communities where people live, work or pray, building community capital and self-confidence in community members; other models place CHWs as core members of the healthcare delivery team, breaking down cultural and linguistic barriers between health teams and members of the community and providing practical support in engaging with health and community resources. In practice, the different functional models are not mutually exclusive, and programs may select from and amalgamate between them in different combinations.

**Item 3: Target Populations:** CHWs can be targeted towards a wide variety of populations presenting an assortment of health needs and risks. Most CHW programs currently target specific populations with specific diseases and conditions, often in specific communities that experience health disparities. Disease-specific groups may address individuals with a chronic illness such as diabetes, cancer or HIV, or a high risk group like pregnant women. CHWs can also target very high utilizers of health services, chronically ill at risk of becoming a high very high utilizer, chronically ill but under control, and healthy (aiming for prevention), depending on the design and purpose of the program.

Other population attributes besides health status need to be taken into account when determining the best role for the CHW. For example, when the target group is a minority population, CHWs' language skills, cultural awareness and/or trust from community members enable them to reach out to people who have previously been substantially or completely isolated from health services.

The goal of the Asian Health Initiative in Montgomery County is to eliminate health disparities for Asian population; the "CHWs" are lay health care workers, an all-volunteer community based group that focus on health promotion. The CHW serves as a health promoter by educating on specific diseases (diabetes, hepatitis B, osteoporosis and cancer), assisting with transportation and accessing services in their communities. This model captures both the lay health worker and health educator CHW models.

CASA of Maryland's Health Program works to address public health and primary care needs in the community. CASA addresses the need for improved access to medical treatment by providing a bilingual telephone health line to inform community members of available services and to help them navigate the system, and provides medical interpreting services for limited English speakers. Health education and improved access to screening and treatment services for HIV, cancer and tobacco use prevention are facilitated by trained community health promoters who are trusted by their peers. HIV counseling and testing services and primary medical care are available on site.

When the target group is a vulnerable population whose self-efficacy and self-management is challenged through low health literacy, low socio-economic status, language barriers, limited education, migrant or immigration status, homelessness, urban or rural issues, race/ethnicity, disability, or cognitive impairment, the CHW provides the support necessary in order to access health services and/or self-manage the patient's health care.

33% of the 98%-African-American residents in Baltimore's Healthy Start's targeted communities live in poverty and more than half did not graduate high school. In the Healthy Start program, a Neighborhood Health Advocate (NHA) meets the client at home and uses the Perinatal Monitoring and Intervention Model to arrange, or provide, contraception, pregnancy testing, screening for pregnancy complications, center-based testing and treatment for HIV/STIs, home lead screening, mental health and asthma screenings, parenting classes and breastfeeding education.

Garrett County Health Department (GCHD) houses the community health education and outreach programs focused on healthy families in a population of 30,000. The purpose is to enhance perinatal maternal and child outcomes through home one-on-one safety, smoke detector use, car seats, bike helmets, housing and breast feeding. Community outreach workers are recruited from the community and receive rigorous training and supervision on the job. 12 outreach workers serve 25 families at any one time. CHWs attend health fairs and support the work of social work and nursing at discharge from hospital including care coordination, transport and housing connections. The observed rate of low birth weight rate has been halved compared to mothers not receiving services.

Faith-based organizations can be highly successful in engaging populations which the health system finds hard to reach.

St. Stephens African Methodist Episcopal Church (SSAME) is dedicated to charitable education and improvement of the human condition. Their CHW program addresses minority health through cancer and tobacco education and smoking cessation. About 60 CHWs have been trained as health educators and have conducted outreach to around 3000 individuals over 3 years through health and church fairs.

As these program examples show, Maryland already has CHWs working with many different target groups and population types.