Executive Summary

The *Promotor(a)*/Community Health Worker Model and Why It Works

Promotores(as), or Community Health Workers, are community members who promote health in their own communities. They provide leadership, peer education, support and resources to support community empowerment. As members of minority and underserved populations, they are in a unique position to build on strengths and to address unmet health needs in their communities.[1]

Executive Summary

Community Health Workers (CHWs) encompass a wide variety of specific roles and titles, but they generally represent a link between members of the community and existing health care resources. While their primary role may be linking vulnerable populations and the health care system, additional roles may include case management, translation and cultural competence support, advocacy, informal counseling and building community capacity. CHWs are effective, because they use pre-existing networks to access populations that have traditionally had poor access to the health care system. The cultural capacity of these individuals allows them to deliver messages about available services in a well-received manner. Many existing CHW programs lack the funding or expertise to conduct ongoing evaluation. However, limited evidence suggests that these programs lead to improved health outcomes, and they may be a cost-effective alternative to many other preventative outreach programs. With a strong grassroots history, as well as recent endorsements from the WHO, HRSA and the CDC, it is increasingly apparent that this model is now key in the future of health care delivery. The ability to shift program emphasis onto education, care delivery, supportive services or advocacy and to target the health needs identified by the community make the possible combinations for success limitless.

About MHP Salud

MHP Salud implements Community Health Worker programs to empower underserved Latino communities and promotes the CHW model nationally as a culturally appropriate strategy to improve health.

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The CHW Model and Why it Works

Community Health Workers (CHWs) encompass a wide variety of specific roles and titles, but they generally represent a link between members of the community and existing health care resources. Organizations may know them as health advisors, health coaches, health aides, patient navigators, peer health educators, enrollment specialists or *Promotores(as) de Salud*[2]. They are ideally recruited as respected members of the community, and they share cultural links that may include ethnicity, language, socioeconomic status and life experience with the community members they serve[3,4]. While their primary role may be linking vulnerable populations and the health care system, additional roles may include case management, translation and cultural competence support, advocacy, informal counseling and building community capacity[2,5].

The true origin of the CHW concept is unclear, although some posit the model is based on China's traditional "barefoot doctors"[6]. CHW programs began receiving recognition in Latin America in the 1950s, where they were often used to promote health education and address sexual or reproductive health issues[7,8]. The U.S., the Health Resource and Service Administration (HRSA) identified several experimental programs as early as the 1960s that addressed medication compliance in impoverished neighborhoods and among indigenous populations[9]. In 1978, The World Health Organization (WHO) formally endorsed CHWs as part of the future of primary health care in the Alma-Ata[10]. The adaptability of these programs, which depends on the strong relationships between CHWs and their communities, has allowed this model to spread to many developing countries in Africa[11] and Asia[12] as well. The WHO still considers CHWs as a possible solution to the international shortage of healthcare workers and is increasing efforts to grow these programs in developing countries[6].

Over the last several decades, the CHW model has been used to aid vulnerable population, including migrants, inner-city minorities and sexually-active youth in the United States. As many CHW positions still lack occupational code recognition in national databases, it has been a challenge to estimate the size of the current workforce. Despite this, CHW programs have been reported in all 50 states and Washington D.C[7,9]. The U.S. Bureau of Labor Statistics (BLS) estimated that 47,770 CHWs were employed as of May 2014[5]. However, this number excluded volunteers and many similar positions with different titles, such as "health educators." The Community Health Worker National Workforce Study estimated that there were 86,000 paid and unpaid CHWs in 2000 and 121,000 in 2005[9] (no estimate is available from the BLS

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during these years). This discrepancy demonstrates the difficulty researchers have faced when defining the scope of this workforce today.

> **"The cornerstone of [Community Health Worker] programs is the recruitment of community members who possess an intimate understanding of the community's social networks as well as its strengths and its special health needs."**
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> **-National Community Health Advisor Study**

Several distinct types of CHW models exist, though many overlap or include positions with the same title. HRSA identifies six distinct models that are currently recognized and used by the Office of Rural Health, which provides funding for such programs. The *Promotor(a)* model, which aligns with MHP Salud's past and present programs, emphasizes the use of community members themselves to serve as the link between their neighbors and health education and resources. In the Care Delivery Team model, CHWs may accompany direct care providers as part of an integrated team, in a mobile clinic setting, for example. The Care Coordinator model uses individuals to help patients navigate the health care system to address complex chronic conditions, such as diabetes or cancer. The Health Educator model emphasizes education related to disease screening and healthy behaviors. The Outreach and Enrollment Agent model also provides education but has an increased emphasis on referrals and, more recently, Affordable Care Act marketplace assistance. The Community Organizer/Capacity Builder model works to promote community action and coordination of local resources[4,9]. It is no coincidence that many of these roles overlap and other program combinations also exist. Whether a generalist approach or a targeted focus on outcomes is more effective is currently a matter of some debate. One thing that is clear is most agree that paid CHWs provide a much higher level of sustainable results as compared to volunteer CHWs[13]. There is no single model that encompasses the full scope and potential of CHWs in health care.

CHWs are effective, because they use pre-existing networks to include populations that have traditionally had poor access to the health care system. The cultural capacity of these individuals allow them to deliver messages about available services in a way that is well received and less likely to be perceived as threatening. In many minority communities, or communities where English is not the dominant language spoken, in the United States, families may be fearful of approaching clinics or state-funded events where they may draw unwanted attention to their immigration status. Many are also alienated from existing programs due to language barriers, transportation issues and a lack of knowledge about the importance and availability of various health screenings and care providing services[14,15]. CHWs recruited from within a community can speak the native language and approach people from these hard-to-reach communities as a neighbor with advice, rather than

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as an outsider. Alternative outreach methods, which may include phone outreach, radio advertisements and posters, often do not penetrate the most at-risk populations. The face-to-face interaction CHWs can offer is a powerful tool that many others, including clinicians, are rarely able to provide in a similar manner. This allows for an increased level of trust and a sense of shared responsibility established between the patient and the health care system. CHWs are also able to adapt their messages to suit the needs of their community, providing them with an advanced level of flexibility[2,4,16-18]. Advanced cultural competency and high adaptability are driving forces behind CHWs' success.

Many existing programs lack funding or expertise to conduct ongoing evaluation efforts[4]. However, limited evidence suggests that these programs lead to improved health outcomes CHW may be a cost-effective alternative to many other preventative outreach programs. For example, programs based on diabetes and cardiovascular health have been successful among Hispanic communities in the U.S.-Mexico border region[3], while HIV/AIDS prevention programs have shown promising results among inner-city youth, men who have sex with men (MSM) and other at-risk populations[19]. Other positive examples of CHW use among Hispanic communities include breast and cervical cancer screening promotion[20,21] and mental health support[22]. Furthermore, the cost of these programs is often low; CHWs do not require a college degree, and many states do not require specific certification or a minimum level of education[8], though the strengths and weaknesses of such a system are under debate.

In recent years, there has been an increased focus on developing a business case for these programs. One program in Denver found a savings in health care costs of $2.28 for every dollar invested in such a program[23], and more resources are being developed to assist with carrying out similar analyses on smaller programs. As these evaluation efforts continue to evolve, more is learned about the variety of ways these programs can benefit the community.

CHWs have shown the capacity to improve access to care among vulnerable and hard-to-reach populations in a variety of settings. With a strong grassroots history and recent endorsements from WHO, HRSA and the CDC, it is increasingly apparent that this model is key in the present and future of health care delivery. The ability to adapt program emphasis to meet community need through education, care delivery, supportive services or advocacy and the ability to target the health needs identified by the community make the possible combinations for success limitless.

For more informaiton on CHWs and their emerging role in health care innovation, visit us at mhpsalud.org, where you can find dozens of free resources for CHW programs and sign up for our email list.

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