United
Hospital Fund

Shaping New York's Health Care:
Information, Philanthropy, Policy.

Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10118-0110
212 494-0700
Fax 212 494-0800

Resource ID#: 3497

A Practical Guide

Building Bridges: Community Health Outreach Worker Programs

Melina Hill Walker

The author would like to thank the members of the Primary Care Development Program team for their contributions to this guide, with special acknowledgment to co-directors Kathryn Haslanger and Deborah E. Halper for their time and valued insight.

United Hospital Fund of New York
July 1994

Copyright © 1994 by the United Hospital Fund of New York.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise (brief quotations used in magazine or newspaper reviews excepted), without the prior permission of the publisher.

Printed in the United States of America.

Library of Congress Cataloging-in-Publication Data

Walker, Melina Hill, 1960-
Building bridges : community health outreach worker programs/Melina Hill Walker.
p. cm. — (A Practical guide)
Includes bibliographical references.
ISBN 1-881277-18-6 : $10.00
1. Community health services—Citizen participation. I. Title. II. Series: Practical guide (United Hospital Fund of New York)
[DNLM: 1. Community Health Services—organization & administration—New York. 2. Social Work—organization & administration—New York. WA 546 AN6 N6W26 1994]
RA394.W35 1994
362.1'2—dc20
DNLM/DLC
for Library of Congress
94-26016
CIP

For information, write, Publications Program, United Hospital Fund, 55 Fifth Avenue, New York, NY 10003.

CONTENTS

EXECUTIVE SUMMARY

• If health care reform, and particularly managed care, are to improve access to services, community residents will need information about selecting and using appropriate health services and health providers will need to learn more about addressing the needs and preferences of the communities they serve.

• Community residents trained as health outreach workers are in a unique position to provide this two-way education while enhancing and supporting the work of primary care practitioners and public health professionals. By leading workshops, organizing health fairs, providing health-screening sessions, offering translation and interpretation services, and pursuing other health-related activities, these workers serve to educate community residents about primary and preventive health care measures, and sensitize providers to the problems and needs of particular communities.

• In addition to their primary role in working to improve a community's health status, community health outreach worker programs often serve another important function: promoting new health careers and providing the necessary knowledge, skills, and attitudes for community residents to become health educators, advocates, and counselors.

• Community health workers usually work as members of a broader health and social service team that typically includes physicians, nurse practitioners, dentists, psychologists, social workers, and case managers. In addition to this team support, affiliation with a sponsoring health facility can enable workers to draw upon the facility's resources for specific assistance when it is needed.

• Quantifying workers' activities is a major challenge. Some programs establish process measures or productivity levels, such as quotas for contacts or referrals, others use outcome measures such as the number of normal-weight babies relative to women in prenatal classes. Estimated cost savings from projected reductions in hospitalizations or overall community health status improvements are more difficult to measure, but equally valuable, evaluation criteria.

• Another challenge is finding innovative ways to address these common causes of worker dissatisfaction and turnover: a lack of opportunities for advancement; frustrations in dealing with immense needs and myriad family and bureaucratic problems; and tensions between workers' roles as community advocates and as employees of a sponsoring organization, such as a health center.

• Finally, how well community health outreach worker programs succeed in improving the delivery of health care is largely dependent upon appropriate long-term support and evaluation. Managed care plans may provide a breakthrough in funding strategies; however, legislated funding sources on a federal and state level will be needed to enhance and sustain any growth produced by managed care support—as well as to ensure that communities' health care needs and preferences do not get lost in the competition for managed care clients.

FOREWORD

Despite the extraordinary amounts of money that are committed to health care in New York City and throughout the country, the provision of health services to large segments of the population still leaves much to be desired. All too often, the people who could benefit most from primary and preventive care are the least likely to have good access to the health care system. Yet even with the best of outcomes in Washington regarding health insurance reform, easy answers to barriers to health care will not simply flow from the marketplace. Residents of underserved communities will still have to contend with multiple barriers to care, including a lack of information about the health care system; and health care providers will still have much to learn about the communities they serve, their languages and cultures, special health care needs and preferences, and unique personal resources.

To make genuine headway in improving access to health services, providers and recipients of care both need to change some ingrained perceptions and behaviors. This change is not likely to occur, however, without significant education regarding the organization and use of health care resources within underserved communities. Community health outreach worker programs can serve this goal admirably while involving community residents in the delivery of health care services in their neighborhoods, sensitizing providers and community residents to one another's needs and requirements, and improving two-way communication.

This guide identifies the basic issues to be considered in developing and operating health outreach worker programs, and describes how seven programs have dealt with them. It fits well with the United Hospital Fund's continuing involvement in developing community-based primary care services in New York's neediest neighborhoods, including our recent three-year Primary Care Initiative and the Primary Care Development Program, a $3.5 million, multiple-foundation partnership organized by the Fund to create new primary care networks in underserved areas of the city.

In this time of change, we are all going to learn from each other as we go forward. We hope that this guide will contribute usefully to the effort to organize a health care system that we would all like to see: one that succeeds at getting services to the people who need them, certainly, but that also excels at getting people to actively seek the kind of continuous, comprehensive, and coordinated care that represents the best hope for improving the health status of all our communities.

James R. Tallon, Jr.
President
United Hospital Fund of New York

INTRODUCTION

The prospect of national health care reform has fueled a growing interest in the availability, accessibility, and affordability of health care services in the United States. Increasingly, policymakers and health care providers realize that financial coverage does not ensure good access to services. To benefit from health care reforms and improve their access to services, much of the American populace will have to learn how to select the best plan for their health needs and how to best use the services provided. As managed care plans have been learning in recent years, it is no small task to educate consumers, particularly those who traditionally have not had insurance or a wide range of providers from which to choose, on how best to select and use services. Similarly, health care facilities and academic medical centers are increasingly finding that training current and future health care providers to focus more closely on the needs and preferences of community residents is a challenging endeavor.

Education of health care recipients and providers is vitally important to ensure that the care provided is accessible and effectively addresses the needs of the community, particularly in a managed care environment. From health maintenance organizations that serve low-income and Medicaid patients to policymakers responsible for developing state Medicaid managed care plans, there is an increasing emphasis on the need for recipient and provider education.

One means of providing this education is by training community residents as health outreach workers. Community health outreach workers enhance and support the work of primary care practitioners and public health professionals. Their first goal is to improve the health status and access to health care in a defined community, oftentimes one that is medically underserved. Activities of the community health worker are multiple and can vary widely, depending on the worker's training, the goals of the sponsoring organization, and the needs of the community. These activities may include health promotion, community and provider education, referrals, follow-up, case management, community development, advocacy, promotion of residents' self-sufficiency and ability to care for themselves in the home, and more recently, enrollment of residents into managed care plans. Community health workers may receive salaries or they may work as volunteers. They may focus on the diverse needs of special populations such as people with HIV/AIDS, substance abusers, teenage mothers, or the elderly; or on the general health needs of a defined community.

The community health outreach worker concept became widely recognized in the United States in the 1960s with the development of neighborhood health centers funded by the federal Office of Economic Opportunity. Local residents received training in programs developed by their neighborhood health centers or affiliated organizations, enabling program graduates to educate other residents on health promotion topics and to function as a link between the center and its service population. During the 1960s and 1970s, a number of training program models were

created and put into practice. Many of these same programs were forced to close, however, when the federal government cut funds as part of the cost-containment trend of the 1980s.

In today's changing health care environment, community health outreach worker programs once again offer a means to educate community residents and their health care providers and to bridge the gaps that can exist between them. The programs created and run during the heyday of the 1960s and 1970s, and those recently designed and functioning today, offer a wealth of information about training program models, the selection and tasks of community health workers, and the special issues surrounding the use of community residents. Program trainers may adopt various methods for interviews, evaluations, and assessments; recruit and select trainees based on unique sets of criteria; use different curricula and training modules; and create specific job titles and duties for graduates of a program. However, a number of commonalities do exist among community health worker programs: the programs train and encourage community residents to reach out to their neighbors, educate them, draw them into the health system, and promote good health practices and preventive health care. Many of these programs have the additional advantage of providing training and employment for residents in communities where limited opportunities exist.

The seven model programs used as examples throughout this paper (Exhibit 1; Appendix A) have been selected for the different ways in which they use community health workers, select their trainees, and structure their training programs. Six are based in the New York City area; one trains and uses community health workers in rural communities of North Carolina. Two of the programs, created in the 1960s and 1970s, are no longer in existence; however, the program designs and the lessons learned from administering them provide valuable examples.

Four of the programs train and use community health workers to address the needs of specific client groups rather than the general population of a designated community. Two programs train volunteer workers while the rest prepare salaried workers for their roles. Some of the programs use very structured and comprehensive training curricula, with examinations to evaluate the trainees' grasp of the material. Other programs are less formal, using their trainees as guides for structuring both the curriculum and the evaluation process. The more structured and comprehensive programs often provide trainees with a diversity of health training and in-depth knowledge of the issues affecting a community's health.

The seven model programs have varying titles for the community residents they have trained. These titles are representative of the unique features of each training program and the specific duties of each program's graduates. However, for consistency and simplicity throughout this paper, and without disregard for the importance of these unique aspects, we use the titles "community health worker" or "worker" to refer to all of these trained community residents.

These programs were not designed to focus specifically on the needs of a managed care environment; however, they offer tools for educating the American populace about health care issues and building a bridge of communication between health providers and the communities they serve. Broad-ranging health care reform may still be on the horizon, but managed care is already here to stay. The degree to which managed care programs and future health care reforms improve access to needed services will depend, to a large extent, upon the ability of consumers to se-

Exhibit 1: Summary Of Programs*

Family Health Worker Program, Dr. Martin Luther King, Jr., Health Center (1966–1974). Part of a community health training program in the Bronx to promote comprehensive family care services to area residents while providing opportunities for meaningful health careers; trained more than 400 neighborhood residents as community health workers.

Community Health Participation Program, Montefiore Medical Center (1975–1989). Trained more than 100 residents of Bronx apartment buildings as volunteer health coordinators to educate and assist other residents in their buildings to access preventive and primary care services.

Lay Health Advisor Program, University of North Carolina at Chapel Hill and General Baptist State Convention of North Carolina, Inc. (1979–present). To date has trained approximately 700 church members as volunteer health advisors to their congregations; aims to strengthen primary prevention networks among the entire congregation rather than focusing on those who are already experiencing health problems or who are at risk of developing health problems.

Community Health Educator Program, Planned Parenthood of New York City/The Hub (1982–present). To date has trained approximately 60 community residents to teach teenagers to make informed decisions about drugs, sexual activity, and childbearing; exists among a range of other Hub activities including after-school educational and health sessions, training programs for parent education workers, and a small clinic specializing in family planning and gynecological services.

Community Health Worker Program, Bronx Perinatal Consortium and New York State Department of Health (1988–present). Trains and supervises community health workers to educate pregnant and parenting women and their families about the importance of early and continuous prenatal care, and timely primary and preventive health care for infants, children, and other family members. One of seven local agencies in New York City—and others throughout the state—contracted by the New York State Department of Health to establish community health worker programs in communities with poor birth outcomes and low socioeconomic and health indicators.

Community Follow-Up Program, Hope Case Management, Narco Freedom, Inc., and New York State Department of Health (1990–present). Trains community follow-up workers as part of a case management team providing intensive, family-centered services for women, children, and adolescents who are at risk for contracting HIV or who are already infected with the virus. One of 22 agencies currently certified in New York State, and 12 in New York City.

Community Health Advocate Program, Church Avenue Merchants Block Association and The Brooklyn Hospital Center (1992–present). Trains residents of communities with large numbers of recent immigrants to provide health education and outreach services, with a goal of improving access to primary care for people who may face linguistic and cultural barriers and who often lack any form of medical insurance. Has trained 34 community health advocates to date.

---

* See Appendix A for more detailed descriptions.

lect and use health services most appropriate to their needs and the ability of health providers and community residents to communicate with one another.

It is hoped that the information provided in this paper will facilitate the development of community health outreach worker training programs; reduce the number of obstacles faced by trainers, trainees, and community health workers; and encourage more organizations, through the development of such programs, to make better use of the too often untapped human resources within each community.

GOALS OF COMMUNITY HEALTH OUTREACH WORKER PROGRAMS

Community health outreach worker programs grow out of and respond to specific community needs; therefore, programs can vary considerably from neighborhood to neighborhood. Still, they often share two important goals: improving a community's health status, and providing training and employment opportunities in health care for community residents.

Improving Health Status

The primary goal of community health outreach worker programs is to improve health status and access to health care in defined communities. Within these communities, specific health needs often surface and many programs target special populations such as people with AIDS, substance abusers, teenage parents, and women at risk of delivering low-birthweight infants. One such program is the Community Follow-Up Program run by Hope Case Management and its parent organization, Narco Freedom, Inc., which trains workers to provide family-centered services for HIV-infected and at-risk clients. Primary prevention strategies such as the Lay Health Advisor Program administered by the University of North Carolina at Chapel Hill and the General Baptist State Convention of North Carolina, Inc., on the other hand, target entire populations—including those who are experiencing health problems, those who are at risk of developing them, and those who are healthy.

In their efforts to improve the health status of their target groups or communities, community health workers assist and encourage residents to care for their own health and that of their neighbors. They help people change unhealthy behavior and demystify aspects of medical care. Many of the programs have as a goal the empowerment of community residents to make decisions about their own health care.

Providing Training and Enhanced Possibilities for Employment

Community health outreach worker programs can open the health care field to community residents, promoting new health careers and providing the necessary knowledge, skills, and attitudes to become health educators, advocates, and counselors. Many of the programs hire or offer placement services to graduates, often in communities where there is a lack of employment opportunities. Employment as community health workers can lead to enhanced training in health outreach or to more advanced health care positions within or outside of the existing agency.

ROLES AND TASKS OF COMMUNITY HEALTH WORKERS

In general, the needs of the community and the goals of the sponsoring organization determine the roles and tasks of community health workers. A variety of activities result, from traditional health promotion and education to managed care patient assessment and enrollment.

Health Promotion and Education

The first order of business for community health workers is to educate community residents about primary and preventive health care measures, focusing on the needs and interests of a particular community. Workers provide information on subjects ranging from family planning to nutrition and exercise.

Toward this end, workers lead workshops, organize health fairs, provide health-screening sessions, undertake street outreach and door-to-door canvassing, post fliers and notices, and conduct information sessions with community leaders. Workers also share health information on a one-on-one basis. In the University of North Carolina's program, for example, workers screen their neighbors for hypertension and counsel them on nutrition, exercise, and management of chronic illness.

In addition to educating community residents, community health workers also provide a valuable service by educating health care providers. They sensitize providers to the problems and needs of low-income populations, particularly minority and non-English-speaking populations, and they offer translation and cultural interpretation for service providers and community residents.

Providers sometimes also need to be educated about the role that community health workers can play. In the University of North Carolina's program, university program staff and advisory board members, who include senior employees from the state department of health, are instrumental in assisting medical providers to view workers as important allies, influential individuals who can help people prevent and control illness and seek appropriate services when needed, rather than simply as clients.

Allied Roles

Referral, Follow-up, and Case Management. In an effort to identify and address medical problems early, before they require intensive treatment, community health workers help residents gain access to and appropriately use available services. Preventive and primary care, including prenatal, pediatric, nutritional, and social services, are often emphasized. Workers can also help residents gain access to rehabilitation and treatment services that they may not seek independently; this intervention can be especially timely for alcohol and substance abusers, domestic violence victims and offenders, and people with HIV/AIDS. They may also provide referrals to social service and community agencies for essential services such as emergency food, food stamps, clothing, housing, day care, and financial assistance.

To help community residents make good use of available services, workers may visit local service providers, conduct community resource assessments, and develop local resource directories. For example, workers in the Community Health Worker Program at Bronx Perinatal Con-

sortium make regular visits to providers to gain first-hand knowledge of their services, the type of background information they require of clients, and the procedures clients must undergo.

In some programs, workers develop and implement formal case management plans, monitor their clients' progress, document services provided, and follow up on missed appointments. Workers also help clients navigate the health care system by translating forms and helping clients to complete referral documentation or applications for services.

Services in the Home. Some community health workers assist residents with personal health care services in their homes. This assistance may include activities such as bathing, taking vital signs, performing tuberculosis and urine tests, collecting specimens, administering prescribed medications, and teaching about balanced or special diets.

Workers also provide child and adult day care services, companionship for people living alone, and assistance to families in crisis. They may offer advice and emotional support on personal, family, and financial matters or help clients obtain medical supplies or transportation. Workers can escort clients to health or social service agencies or remain in the house as a family substitute in an emergency.

Community Development and Advocacy. Recognizing the large role socioeconomic factors play in determining the collective health of a community, outreach programs often engage workers in community planning and events. Workers establish and maintain contact with community groups and organizations, such as Boys' and Girls' Clubs, YMCAs and YWCAs, parents' associations, community task forces, and networks, and work with them to address specific issues. Some of these joint efforts can include community-wide cleanups and flower plantings, block associations, and tenant groups.

Workers help their clients recognize their health needs and work to increase the adoption of health-promoting behaviors. They enable clients to maximize their social and emotional strengths and physical health, and help them progress toward self-sufficiency.

Finally, workers often play an important advocacy role. The workers organize residents to address medical and health problems proactively in their communities and to improve their access to the health care system. Workers also collaborate with health care providers to improve delivery of care to community residents.

Managed Care Service

In a relatively new role—one that may become increasingly important—community health workers are educating people about managed care. Through their multiple roles as community advocates, health care facilitators, and health educators, community health workers may provide a unique means of engaging communities in discussions about managed care and managed care plans. Similarly, managed care plans might benefit from workers' knowledge of their target communities, the residents' health needs and concerns, and the local service providers. The Brooklyn Hospital Center uses workers trained in the Church Avenue Merchants Block Association's (CAMBA's) Community Health Advocate Program to enroll residents in the center's new primary care consortium. Additionally, a pilot program, the Community Health Worker Outreach Pro-

gram of Lutheran Medical Center and the Institute for Urban Family Health, is examining the efficacy of employing community health workers to encourage members of Medicaid managed care plans to use the plans' services in an effort to reduce unnecessary illnesses and hospitalizations.

FINDING THE RIGHT CANDIDATES

The success and effectiveness of community health outreach worker programs depend largely upon the skills and personal attributes of the workers. Programs use a variety of methods, often relying on input from the community, to find candidates who can achieve the right balance between technical and interpersonal skills.

Recruitment

Programs recruit workers through existing neighborhood and tenant groups, block patrols, community organizations, local churches, neighborhood workshops on health topics, and from among the program's clients. Some programs distribute fliers to local agencies and neighborhood gathering places to arouse interest. Word-of-mouth publicity is often found to be more effective than other means, including advertisements in local newspapers.

The University of North Carolina's program uses a unique recruitment process. University program staff ask pastors to recommend people in their congregations who would be effective community health workers, and then to inform their candidates individually and share with them the reasons for their selection. Interestingly, even though many of these people have been providing informal and spontaneous outreach services to the congregation for years, they often do not themselves recognize their contributions to the community until they are recruited into the program.

Qualifications

Requirements of community health outreach worker programs vary considerably. Not surprisingly, most programs require their workers to live in the community in which they will be working; to share in the community's language, cultural, and socioeconomic background; and to have some knowledge of the community's needs, organizations, and leaders. Candidates also must share a commitment to the community's welfare; have strong interpersonal, communication, and problem-solving skills; and be able to work in a self-directed, unstructured field setting. Some programs also require workers to work flexible hours, including evenings and weekends when necessary.

Many programs find that an age requirement facilitates selection and therefore set minimum ages ranging from 18 to 21 years. Most programs, however, focus on an applicant's maturity, sensitivity, and aptitude rather than age.

Many require a level of English and mathematics skills sufficient to comprehend course materials and participate in the training program, fill out referral forms for clients, and record case visits. This minimum level of English and mathematics ability is generally equivalent to a sixth-

to eighth-grade education. Some programs, however, in particular those in immigrant communities, specifically seek candidates who are proficient in a language other than English.

Programs in which workers focus on specific client needs and that require considerable written documentation and medical follow-up, such as case management activities, generally have more stringent educational requirements. In the Community Health Educator Program at Planned Parenthood of New York City/The Hub, for example, candidates are required to have two years' experience in community or reproductive health, as well as a commitment to Planned Parenthood's policies, goals, and activities. Most workers in the programs operated by The Hub, Bronx Perinatal Consortium, and Hope Case Management have a high school diploma or equivalency degree, and Hope Case Management looks especially favorably upon bilingual candidates with a college degree.

Some programs also have minimum health requirements. Candidates for the Family Health Worker Program at the Dr. Martin Luther King, Jr., Health Center had to meet the center's health requirements for staff, including a general physical examination, tuberculosis test, and immunizations for diseases such as rubella and hepatitis B.

The churches in the University of North Carolina's program have established less formal criteria for workers. The majority are women over 30 who are actively involved in church committees and events. Their pastors describe them as individuals who listen with an open ear and caring heart while maintaining confidences, who have a history of helping others, and who are respected by community residents.

Also employing less formal selection criteria are CAMBA's Community Health Advocate Program and the Community Health Participation Program that Montefiore Medical Center operated from 1975 to 1989. Neither have specific educational or age requirements; the qualities most looked for are an interest in helping others and a desire to improve the community. In the CAMBA program, an applicant's demonstrated interest in helping the community is of greater importance than a background in health care: CAMBA's outreach trainers believe their curriculum adequately prepares trainees irrespective of previous exposure to health care.

Selection

A community health outreach worker program's selection process does not have to be terribly onerous nor overly exclusive to determine an applicant's potential ability to handle the training material and later work responsibilities. As a first step, many programs require applicants to submit résumés or applications providing work experience, references, and background information. In addition, some programs require an acceptable physical examination and drug screening test.

The next commonly used screening tool is the group interview. By interviewing a number of applicants simultaneously, the interviewer can evaluate how well each applicant interacts within a group. In a typical group interview at the Dr. Martin Luther King, Jr., Health Center, applicants were asked such questions as "Your best friend tells you that his girlfriend is pregnant. He's asking you for advice. What would you say?"

The group interview at The Hub matches one applicant with numerous outreach team members. In addition to demonstrating how well the applicant deals with a group, this arrangement gives individual team members an opportunity to form an opinion of the applicant, and to share with the potential worker their own perspectives and insights about the organization's outreach activities.

As a follow-up to the group interview, many programs use the individual interview, in which the applicant meets with a senior staff member. During this interview the staff member seeks to learn more about the applicant and judge his or her level of interest, energy, motivation, and commitment. The interviewer is able to get a sense of the applicant's sensitivity to different populations, needs, and situations; ability to handle responsibility; commitment to the community; and willingness to teach and help others.

In the University of North Carolina's program, outreach program staff carry out a series of open-ended interviews with pastors of the selected churches in order to establish the selection criteria. Pastors nominate candidates from their congregations and make the initial contact, and then staff interview recommended candidates to explore their interest and willingness and select at least three trainees from each church.

Questionnaires and examinations are often used to evaluate the applicant's writing and mathematics skills. For example, Hope Case Management asks candidates to complete a sample case report to demonstrate their writing ability.

Public presentations are an important aspect of the job at The Hub; therefore, applicants are required to make a 15-minute presentation to team members. Applicants select a topic and describe a hypothetical audience, for example, teenage fathers. After a few days' preparation, the applicant makes the presentation to an audience of team members who ask questions that are appropriate to the hypothetical audience.

Finally, socioeconomic criteria may come into play in programs where providing employment opportunities are a priority. At the Dr. Martin Luther King, Jr., Health Center, for example, once the initial selection process was complete, staff ranked applicants according to their financial need and selected applicants based on both their qualifications and the perceived level of their financial need.

DEVELOPING EFFECTIVE WORKERS

Preparing community residents for their roles as community health workers requires a sensitivity to the strengths and weaknesses of the trainees and their target community. Most training programs attempt to build upon the strengths of both while providing ample in-class instruction and practical experience in areas of weakness and areas requiring specialized knowledge.

Training

All workers go through some form of training to ensure that they have the skills necessary to conduct effective health outreach. Training curricula generally include classes on the health and social services system, preventive and primary care, community assessment, communications,

Exhibit 2: Potential Course Topics

Preventive and Primary Care
adolescent health
anatomy (especially reproductive anatomy)
caring for chronic diseases
case management practices
child health
exercise
family health
first aid
health promotion and maintenance
HIV/AIDS prevention
immunizations
individual and family risk assessment
maternal health
nutrition
parenting skills
pharmacology
physical exams
prenatal care
relaxation
sexuality and family planning
sexually transmitted diseases
substance abuse

Community Assessment
accessing entitlement systems
advocacy
community and health assessment tools
community organizing
cultural issues
individual/family rights in the health and social services system
interpretation and use of health statistics

Communications
community education
health information and referral
interviewing
organizing health promotion activities (e.g., health fairs)

and health care careers in addition to basic mathematics and English courses (Exhibit 2). Length of training varies from 20 to 120 hours. Programs also vary as to whether workers must complete a full course of training before beginning work, or whether they may start after a short period of basic training.

Trainers. Training is generally provided by a combination of in-house staff and outside consultants who have expertise in a specific area. The New York State Department of Health urges its contracted agencies, such as the Bronx Perinatal Consortium, to use local trainers and educators in order to increase each program's emphasis on the community and its resources. In the University of North Carolina's program, training sessions are held at local churches in the evening and taught by local professionals, some of whom work in private practices, others in institutional settings. Some programs open training sessions to workers previously hired through the program and, when possible, to existing outreach and community health workers employed by local agencies and community groups. By including in-house and outside workers in the training, program staff hope to facilitate an exchange of information and ideas, to create contacts for future referrals, and to foster an environment of collaboration among agencies.

Tools and Methods. Training tools include anatomy models, illustrations, reading materials, discussion, role plays, and quizzes. Students are required to interact with one another and with outreach team members by participating in small- and large-group sessions and teaching games. Additional methods used during training include case studies, mini-lectures, and community presentations.

Certain programs use the apprenticeship method, in which trainees are taught on the job by following veteran workers through their work day. Hope Case Management uses this unstructured one-on-one method for their in-house training program. Veterans share their knowledge and experiences with the new recruits over a two- to three-week period. Additional continuing training opportunities for staff include courses at affiliated agencies and weekly "grand rounds" sessions, in which clinical cases are discussed in clinical settings. During grand rounds, which occur on site at the Narco Freedom offices or at affiliated agencies, health centers, or hospitals, veteran workers and trainees discuss specific cases and topics of interest. Generally two members of each case management team attend the weekly sessions.

Montefiore Medical Center employed a more flexible training program, as does The Hub. Although certain basic components were always included in Montefiore's training curriculum, trainers adjusted sessions to the needs and interests of trainees, and trainees helped design a large part of the curriculum. The curriculum and program length at The Hub also depend to a large extent on each trainee's previous knowledge and experience.

Organizations under contract with the New York State Department of Health, such as the Bronx Perinatal Consortium, have more structured programs. The Department of Health allows contracted agencies to assume full responsibility for training their workers, but provides an outline of general topics to be covered (see Appendix B), technical and training assistance, support, and direction, and occasionally arranges group training sessions on a regional or statewide basis.

At Montefiore, training was conducted whenever possible at a site physically removed from the hospital. Outreach program directors made a conscious effort to separate the basic and in-service training site from the hospital with the goal of establishing a distinct identity for the program, which emphasized care on a smaller and more human scale than in the larger hospital setting.

Specialized Training. In general, training programs seek to maintain a balance between technical training and training in process, attitudes, and group formation.

Specialized training is included in those programs with a special focus. Hope Case Management's program, for example, focuses on HIV-infected and at-risk women; therefore the training includes a number of HIV/AIDS-specific classes. Training topics include the history of the HIV epidemic and epidemiology, clinical issues of HIV infection, HIV and tuberculosis, HIV counseling and testing procedures, psychosocial aspects of HIV infection, and HIV confidentiality law.

Trainees in the University of North Carolina's program learn to understand health statistics and morbidity and mortality rates. Upon completion of their training, they are expected to understand and use health data to define and measure improvements in the health status of their community. These data include maternal and infant health statistics, prevalence levels for chronic problems such as diabetes and hypertension and the percentage of uncontrolled cases, primary reasons for disproportionately high levels of preventable morbidity and mortality, and the availability of institutional and professional health services and related resources. Trainees also learn methods by which to impart their newly gained health knowledge to family, friends,

and community residents, including counseling, referral, and education and screening opportunities.

Most programs offer a continuing program of in-service education and supervision for workers once they have completed their initial training. At The Hub, educators attend ongoing sessions to enhance their knowledge. With a professor's recommendation, exceptional graduates of the basic training course at the Dr. Martin Luther King, Jr., Health Center could advance to a more specialized training program. Professors based their recommendations on a student's maturity, flexibility, warmth, and concern for social advocacy. The specialized program included classwork, on-the-job training, and fieldwork. Topics included growth and development, physiology, physiotherapy, common diseases, health education, special diets, and interviewing techniques.

Evaluation and Graduation

Methods used to evaluate trainees differ from one program to the next and range from traditional examinations and quizzes to more innovative approaches, including role-play observations and debriefing sessions after fieldwork. Throughout the evaluation process, outreach programs generally attempt to determine whether trainees have understood and are able to successfully apply the basic principles of their training.

Training staff at the Dr. Martin Luther King, Jr., Health Center's program evaluated trainees regularly and tested their attitudes, cooperation, flexibility, responsibility, and ability to accept supervision. In addition to examination results, evaluative criteria included completion of assignments, quality of work, class participation, relevance of comments, and initiative (see Appendix C). Staff also evaluated community resources projects and on-the-job training. Trainees who did not receive passing grades were held beyond the training period and given extra help. Trainees were not allowed to work without passing all written and practical examinations.

Program staff at Montefiore Medical Center evaluated trainees using skills testing and interviews. Skills that were tested included cardiopulmonary resuscitation and blood pressure measurement.

The Bronx Perinatal Consortium's program uses an evaluation technique recommended by the New York State Department of Health to evaluate both trainees and workers. Debriefing sessions, scheduled immediately after each field experience, provide trainees and workers with an opportunity to note strengths and weaknesses and to resolve difficult situations. Sessions include assessments of each individual's strengths and weaknesses in working with the educational material or during family or community agency interaction. Additional session activities include reviews of unique or unexpected accomplishments, with an emphasis on successful strategies, unusual efforts, and creative problem solving; identification of areas needing improvement; and summaries to review accomplishments against objectives and actions planned for the following period.

Trainers are often concerned about trainees' test-taking anxieties and, as a result, may create evaluations that examine overall productivity and relationships with community residents rather than test-taking aptitude. Trainers in programs at The Hub and at CAMBA evaluate

trainees by observing their participation in role plays, responses to case studies, and presentations in the community. They also provide general feedback. Trainers attempt to develop an atmosphere that encourages teamwork and allows trainers and trainees to learn from each other, without the traditional teacher-student hierarchy and test anxiety.

Most programs have some kind of ceremony at the end of training at which diplomas or certificates are awarded. Many program directors consider the graduation exercise, often followed by a group celebration, a significant part of the training program. During the ceremony, trainees receive recognition for efforts made during the training, are sometimes presented to important members of the community, and may receive gifts from trainers or other individuals. The diplomas and certificates also provide trainees with tangible evidence of their training, and might facilitate future job searches.

DEFINING THE JOB

The ability to work collaboratively with and balance obligations to the community's residents, health professionals, and the sponsoring organization can be a major challenge for workers. Team structure, affiliation with supportive institutions, and a flexible work schedule are some methods programs use to enhance their workers' effectiveness.

Team Structure

Community health workers usually work as members of a broader health and social service team that typically includes physicians, nurse practitioners, dentists, psychologists, social workers, and case managers. Often these teams designate a team leader or supervisor. In some programs, the leader will be a licensed professional such as a public health nurse or senior social worker; in others, a community health worker may take the lead.

Affiliation

Affiliation with a sponsoring health facility can enable workers to draw upon the facility's resources for specific assistance when it is needed. For example, Montefiore Medical Center assigned a hospital staff member to each worker in its community health outreach program to provide medical expertise and support in their daily activities.

In those programs in which staff are hired by one organization but based at another, workers must relate to their contact person at the employing organization and their day-to-day supervisor at their base agency. Workers employed by the Bronx Perinatal Consortium are expected to be directly responsible to their day-to-day supervisor and to develop a close working relationship with their particular center.

All community health workers must balance the requirements of their organizations with the needs of their community. Workers at Hope Case Management, for example, face the challenge of providing a high volume of services while documenting their weekly activities to ensure state reimbursement. In addition, workers sometimes must play go-between or informed advocate for community residents who have concerns or issues that relate directly to the worker's base health facility.

Work Schedule

Although most community health workers keep regular business hours, many programs require some flexibility for evening and weekend activities. For example, every worker in the Hope Case Management program is on 24-hour call for one week every three to four months. While on call, the worker carries a beeper to receive pages from clients who require immediate counseling or back-up services.

Caseload

Caseloads vary depending on the nature and size of the community, the barriers to care, and the needs of the clients and their families. Workers in the Bronx Perinatal Consortium carry a caseload of 25 clients; in rural communities, where distances between clients are greater and public transportation options fewer, caseloads are generally smaller.

A worker's relationship with clients and their families can last for many months: at the Bronx Perinatal Consortium, workers follow their clients through their pregnancy and often through their baby's first year.

Frequency of contact varies from program to program. Some programs require workers to contact their clients monthly; others have no such requirements, expecting workers to determine the frequency of contact.

Of course, caseloads vary in size and complexity over time, as some clients and families become more independent, begin to solve their own access problems, and learn methods of health promotion and health maintenance. Discharge planning in the Bronx Perinatal Consortium is especially comprehensive, with workers assisting their clients in anticipating difficulties, discussing available community resources with them, and facilitating their access to appropriate services. Only after a client has achieved identified planning goals is the case closed.

Advancement

Community health outreach worker programs generally encourage lateral and upward mobility to the extent possible. Opportunities to advance on a community health worker career track or move into a related but newly challenging position are important motivations for ambitious workers. At the Bronx Perinatal Consortium, workers can rise to a senior community health worker position, and senior workers can move into other challenging positions. At Hope Case Management, exceptional workers may have a number of advancement options: they may review client charts and train new workers to make sure documentation is complete; they may provide substance abuse counseling at Hope Case Management's parent organization, Narco Freedom, Inc.; or they may become case managers while working toward a master's degree.

When community health workers at the Dr. Martin Luther King, Jr., Health Center suggested the creation of new positions with increased responsibility and salary based on experience, the center created a senior community health worker position. Even with this solution, however, the number of senior community health worker positions will often be fewer than the number of experienced workers seeking advancement.

In those programs in which the next position above community health worker is case manager, a promotion may require a master's degree. Some programs, Hope Case Management among them, provide funding for exceptional workers to pursue a master's degree part time. A few workers have made use of this benefit to move into more senior positions within the organization.

Compensation

Many programs begin paying workers' salaries once training starts; others, while not paying salaries during training, provide small stipends to cover transportation, meals, and the cost of child care. Some programs, however, offer compensation only upon completion of training and official commencement of employment. Admittedly, salaried trainees can be a financial burden to the training organization: for example, although Hope Case Management gives full salaries to their trainees, the New York State Department of Health cannot reimburse the program expense because the trainees are not actually providing services to clients.

In the New York City metropolitan area, community health workers' salaries range from $18,000 to $25,000.* Workers' salaries are determined in part by existing levels paid to employees in similar positions within the community and the sponsoring agency.

Additional benefits commonly offered to community health workers include flex-time and time off for educational purposes. In addition to Hope Case Management's educational benefits mentioned in the preceding section, other incentives include overtime compensation at The Hub and work-release time for educational purposes provided by the Dr. Martin Luther King, Jr., Health Center.

Finally, although volunteer workers, such as those in the programs at Montefiore Medical Center and the University of North Carolina, work without pay, their organizations can provide meaningful recognition through such means as institutional announcements, news releases to local newspapers, reimbursement of travel expenses, and provision of baby-sitting services.

MAINTAINING AN OUTREACH WORK FORCE

The ability of a community health outreach worker program to retain effective workers is often dependent upon the degree of supervision and support provided to workers in the field and at the sponsoring organization. Consequently, programs have developed a number of ways to observe workers' activities and encourage them in their efforts.

Ongoing Evaluation

Given the demanding nature of the work and the constant need to balance organizational requirements with the needs of clients, community health outreach worker programs can benefit

---

* Throughout this guide, salaries are reported as accurately as possible, as of publication. They should be taken as approximations, to be verified with programs in specific communities.

greatly from effective supervision. Programs often incorporate frequent review sessions to evaluate their workers' activities and to provide support and guidance.

Reviewing the activities of their volunteer community health workers, program staff at Montefiore Medical Center learned that the volunteers had undertaken such activities as talking with neighbors about health matters, administering a blood pressure test, referring a neighbor to a hospital or clinic, escorting a neighbor to the hospital, shopping for an ill neighbor, organizing a smoking-cessation group, or conducting a security check of an apartment house. The amount of time varied widely according to circumstances, ranging from two hours a week to two hours a day.

At Hope Case Management, a case management program director is responsible for reviewing all case management plans at the time of initial development and every 90 days thereafter. In addition, case managers present client-specific plans, which the workers have helped to develop, to an agency-wide peer-review team, and workers complete weekly evaluations of their "grand rounds" sessions to examine the effectiveness of each session and determine the need for further review of the subject area. Twice a year, the case managers evaluate each worker's job performance based on a number of factors, including productivity, cooperation, initiative, and attendance.

The Hub and The Brooklyn Hospital Center evaluate their workers through an informal process, including observations of community presentations and reviews of audience responses. To foster cooperation and collaboration and to minimize competition among workers, the Brooklyn Hospital Center focuses its evaluations on teams of workers rather than on individuals.

Objective Measures. Quantifying workers' activities is a major challenge facing community health outreach programs. Some programs establish process measures or productivity levels, such as quotas for contacts or referrals, others use outcome measures such as the number of normal-weight babies relative to women in prenatal classes, or the number of infants receiving their full vaccination schedule as a result of outreach efforts to parents. Estimated cost savings from projected reductions in hospitalizations or overall community health status improvements are more difficult to measure, but equally valuable, evaluation criteria.

The New York State Department of Health uses both process and outcome measures to monitor the programs of all of its contracted agencies, including the Bronx Perinatal Consortium. In addition, the consortium produces a quarterly statistical summary and an annual report to provide aggregate data about its workers' activities and general community health outcomes for the period.

Montefiore Medical Center created a unique measurement scale, its "Index of Activity," to determine factors contributing to the efforts of its volunteer community health workers.* The program also surveyed its volunteers to evaluate its success in supporting them. Two frequent

---

* Montefiore's Index of Activity tabulated volunteers' responses to two questions: "What kinds of things have you done as a Health Coordinator since you joined the program?" and "Describe the activities you have carried out in your role as a Health Coordinator in the last two weeks." Volunteers could select their answers from 20 possible responses.

comments were that the program increased workers' knowledge and confidence and taught them about preventive medicine. Among workers' suggestions for improvements were more training opportunities, more stimulation at meetings, and better communication among groups of workers.

Retention

Holding on to trainees through the entire training process and graduation is sometimes very difficult. Among the most common obstacles are family obligations, previous commitments, and lack of funds if stipends or salaries are not available. One-third of the trainees in the Dr. Martin Luther King, Jr., Health Center's program did not complete the basic training course. Trainees left for a number of reasons, including problems with finances or with child care; health, family, or personal problems; competing educational goals; better-paying jobs; and family relocation. In addition, some trainees were expelled from the program, primarily because of consistent absenteeism, inattention, or poor performance.

Even after training, retention can continue to be a significant problem, for many of the same reasons. In its first five years, the Montefiore Medical Center program lost 28 of a total 89 trained workers. Program staff found that a strong sense of camaraderie and commitment to service encouraged volunteer workers to remain active in their roles. The New York State Department of Health's Community Health Worker Program also experiences a fair amount of turnover due primarily to familial constraints and problems, and outside job offers.

Camaraderie gained through the team structure, in addition to organizational support and opportunities for advancement, can provide incentives for salaried workers to remain in their programs. Some programs have had more success than others at retaining workers. Most workers in the Bronx Perinatal Consortium program stay in their positions about three years, and those who leave generally move on to other positions at the consortium or at other agencies. Workers at the Dr. Martin Luther King, Jr., Health Center tended to remain in their positions for eight to ten years, and a few pursued additional training to become nurses or social workers. The health center's success in retaining workers might have been due, in part, to the program's goals and its worker support structure. The program was part of a comprehensive effort to provide employment opportunities for local residents and to inform the community of services offered by the center. Toward that end, workers' input in the center's weekly multidisciplinary team meetings was considered vital due to their close contact with and knowledge of community residents and specific patients. Team meetings occasionally focused on strengthening interaction between team members, especially if workers believed their contributions were not being acknowledged. The workers were encouraged to make recommendations, based on their experiences in the community, concerning changes in the health center's general and medical administration.

SPECIAL ISSUES

In developing community health outreach worker programs, planners should be aware of some particular issues that traditionally have posed special challenges.

Program Goals

In planning a program, it is important to be explicit about goals. The goals of a program should drive its training curricula, the roles and tasks of its workers, and the evaluation of the workers' activities. With clearer definition of goals and outcomes, programs make the best use of their workers, better address residents' health care needs, and more accurately determine the program's effect upon the community's health care utilization and health status.

Confidentiality

When a neighbor becomes privy to the most intimate aspects of a family's life, concerns about confidentiality can become an important issue. Like all health care professionals, community health workers must be aware of the importance of maintaining confidences, and must be able to instill trust. A worker's experience with the community and proven discretion over time are probably the best means of dispelling community mistrust.

Worker Frustrations

One of the primary causes of worker dissatisfaction and turnover is a lack of opportunities for advancement. In many programs, inadequate funding and smaller size limit advancement opportunities. Larger programs, especially those that are part of an integrated network, sometimes have the advantage of providing opportunities for workers to advance on a career ladder or into a different part of the organization.

Each organization must define its own policies regarding opportunities for advancement and retaining trained workers. For example, although the New York State Department of Health seeks to provide local residents with an employable skill and the self-confidence to seek additional education, training, and job opportunities beyond the community health worker role, it also wants to encourage workers to remain in their positions once they are trained and accepted by their communities.

Like many health professionals working in medically underserved areas, community health workers experience frustrations in dealing with immense needs and myriad family and bureaucratic problems. Programs have found a variety of ways to support workers, including informal worker support groups, weekly or biweekly case review sessions, and special recognition of workers who have resolved particularly difficult problems. Programs may also employ a psychologist to meet with workers on a regular basis to talk about cases. The psychologist can help workers acknowledge the limits of their activities and encourage them to recognize their accomplishments, which are often truly impressive.

Finally, workers may experience tensions between their roles as community advocates and as employees of a sponsoring organization, such as a health center. As health professionals who are also active members of their communities, workers often have unique relationships with community residents that provide them with insights into the residents' daily challenges and frustrations. For such a person, representing or defending an employer in a community conflict may sometimes be difficult. For this reason, program directors have found it important to allow workers enough independence to advocate for residents' concerns to their employers and to other

health and social service agencies when the need arises. These directors state that these supportive working relationships are essential to providing workers with the confidence to address such issues.

Program Support

A major concern in the establishment of outreach worker training programs is the availability of appropriate long-term program support and funding. Training programs can range from the more comprehensive and complex—and costly—to the more basic. Successful programs do not always require huge outlays of funds. For example, many of the simpler models, such as those used by The Hub and Hope Case Management, use program staff members or veteran workers as on-the-job trainers. These models have a number of benefits: a flexible training curriculum that can focus on a trainee's specific educational needs; early exposure to clients and the working environment; and involvement of veteran workers in training others while they continue their outreach activities. Of equal, if not greater, significance are the lower training costs incurred by using the simpler models. Trainers, whether in-house or hired from outside, are not required, nor is classroom space or an abundance of didactic materials. Veteran workers are not taken from their activities to participate in training, and trainees often begin their on-the-job activities sooner.

On the other hand, the simpler models often do not include a wide variety of course topics, discussions of social and economic factors affecting the community's health, or the significant attention to in-class lectures and course work that are generally included in the more comprehensive, structured training programs. Not surprisingly, comprehensive programs, such as those at the Dr. Martin Luther King, Jr., Health Center and the Bronx Perinatal Consortium, often depend to a much larger extent on outside funding for their survival.

Of the seven programs studied in this report, two (Dr. Martin Luther King, Jr., Health Center and Montefiore Medical Center) were forced to cease operations because of funding cutbacks, and the other five programs are currently dependent upon grant or special state funding. Program directors and other advocates of community health outreach worker programs argue passionately that sustainable funding sources need to be created. As mentioned earlier, a new pilot program, the Community Health Worker Outreach Program of Lutheran Medical Center and the Institute for Urban Family Health is currently examining the feasibility of using community health workers to work with Medicaid managed care populations. If successful, the program could point the way to opportunities for funding community health outreach worker programs through affiliations with managed care plans.

CONCLUSION

To ensure access to adequate health care services, especially in medically underserved communities, it is essential that consumers and providers learn about and communicate well with each other. Even in our traditional health care environment, educating community residents about primary and preventive health care measures and educating providers about the communities

they serve are crucial activities. The changing structure and dynamics of the country's health care system bring new roles for consumer and provider alike, and make ongoing education and communication all the more necessary. Community residents trained as health outreach workers are in many ways ideal mediators to bridge the gulfs that too often separate health care providers from their surrounding communities.

Whether volunteer or salaried, community health workers bring invaluable knowledge about the community's history, its strengths, and its weaknesses to the development of community-based health services. As the seven models described in this guide have shown, the programs that train these residents will vary, depending upon the needs of the community and the sponsoring organization; however, all endeavor to use in-class education and on-the-job experience to transform residents into community health advocates and, as such, into allies of both their fellow residents and their communities' health providers. How well the programs succeed in improving the delivery of health care is largely dependent upon appropriate long-term support and evaluation. Certainly, managed care plans may provide a breakthrough in funding strategies; however, legislated funding sources on a federal and state level will be needed to enhance and sustain any growth produced by managed care support—as well as to ensure that the communities' health care needs and preferences do not get lost in the competition for managed care clients.

Particularly in this era of reform, community health outreach is clearly a concept deserving renewed support. By educating health care consumers and providers about health care needs and resources, and facilitating communication between providers and their potential clients, well-run community health outreach worker programs can give our evolving health systems a vital edge in the effort to produce truly significant improvements in the health of our neighborhoods.

APPENDIX A: PROGRAM DESCRIPTIONS

Family Health Worker Program
Dr. Martin Luther King, Jr., Health Center (1966–1974)

Sponsor: Dr. Martin Luther King, Jr., Health Center, 3674 Third Avenue, Bronx, NY 10456.

Contact: Lionel Stewart, Assistant Vice President, Ambulatory Care Services, Bronx-Lebanon Hospital Center (718) 960-1038 (formerly Executive Director, Dr. Martin Luther King, Jr., Health Center).

Program goals: To provide meaningful jobs for community residents; to provide well-trained health center and health agency personnel; to promote new health careers and opportunities for advancement in existing health jobs.

Worker roles and tasks, and relationship to sponsoring organization: *Family Health Workers* formed part of a health care team (consisting of four to five workers, an internist, a nurse practitioner, a pediatrician, a dentist, and a secretary) that provided comprehensive family care services to area residents. With the guidance of team members or other colleagues, workers undertook tasks combining many of the functions traditionally performed by public health nurses, nurse's aides, health educators, and social workers, including the following: encouraging patients and families to seek and continue health care, assisting families in carrying out recommendations that affected good health, and performing specified health care activities and social services in the patient's home and in the health center. Worker were based at the Dr. Martin Luther King, Jr., Health Center or at a satellite health facility.

Qualifications: 21–55 years of age; residence in health center's service area and considerable knowledge of community; eighth-grade English and mathematics skills; fulfillment of health center's health requirements.

Selection process: Group interview; questionnaire; individual interview; common-sense examination.

Training: 8-week core training (basic courses in mathematics, English, basic health skills, community resources, pharmacology, health careers); 16-week post-core training program (intensive on-the-job training and fieldwork with strong emphasis on patient education, case finding, preventive care) available upon professor's recommendation; continuing program of in-service education and supervision.

Evaluation: Biweekly evaluation during core and post-core training (dismissals primarily due to lateness, absenteeism, inattention, or consistently poor performance).

Compensation/recognition: Small stipend during core and post-core training to cover transportation, meals, and child care; graduation party and diploma upon completion of core training; cer-

tificate upon completion of post-core training and $25,000 annual salary;* financial assistance for college education through work-release time (until 1973).

Community Health Participation Program
Montefiore Medical Center (1975–1989)

Sponsor: Department of Social Medicine, Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467-2490.

Contacts: Victor Sidel, Distinguished University Professor of Social Medicine, Montefiore Medical Center, Albert Einstein College of Medicine (718) 920-6586; Sally Kohn, Deputy Director, Opening Doors, Greater Southeast Healthcare System (202) 574-6943 (formerly Program Director, Community Health Participation Program, Montefiore Medical Center).

Program goals: To develop a community-based network of trained community residents to educate and assist their neighbors in accessing preventive and primary care services; to help people change unhealthy behavior; to increase consumer participation in decision making for the health care delivery system; to evaluate a model for increasing individual and community participation in health and medical care.

Worker roles and tasks, and relationship to sponsoring organization: Working with other residents in their apartment buildings, *Volunteer Health Coordinators* provided education and assistance in four major areas: health promotion and prevention of disease, mental health and family problems, improvement of the environment, and access to the health care system. Specific tasks included arranging and leading workshops about primary and preventive care, offering social support to families in need, and organizing residents to address medical and health problems in their communities. Volunteers worked under the supervision of program staff, and each volunteer was assigned to a hospital staff member whom the volunteer could contact if a particular health problem was beyond the volunteer's expertise.

Qualifications: Residence in community; approximately sixth-grade English or Spanish skills; interest in and commitment to the community's welfare.

Selection process: Application; group interview; individual interview.

Training: 16-week program (course content and frequency of sessions determined by needs and interests of trainees); continuing training following graduation.

Evaluation: Trainees evaluated by interview prior to 1980, by skills testing and interview after 1980; volunteer health coordinators evaluated by quantitative and subjective review of activities.

---

* Throughout this guide, salaries are reported as accurately as possible, as of publication. They should be taken as approximations, to be verified against current figures.

Compensation/recognition: Travel expenses and child care services (no financial remuneration); graduation ceremony and certificate upon graduation from training program.

Lay Health Advisor Program
University of North Carolina at Chapel Hill and General Baptist State Convention of North Carolina, Inc. (1979–present)

Sponsor: Department of Health Behavior and Health Education, School of Public Health, University of North Carolina, Campus Box #7400, Rosenau Hall, Chapel Hill, NC 27599.

Contacts: John Hatch, D.P.H., Professor of Health Behavior and Education, University of North Carolina at Chapel Hill (919) 966-3906; Georgia P. McClain, Project Manager, Maternal and Child Outreach Ministry Project, General Baptist State Convention of North Carolina, Inc. (919) 821-7467.

Program goals: To increase health information and knowledge of available services among church members; to improve communication skills of members; to teach self-care skills to at-risk members; to establish linkages with agencies for a more efficient system of access and referral; to provide channels for exchanging and coordinating resources for members with common needs.

Worker roles and tasks, and relationship to sponsoring organization: *Lay Health Advisors* provide informal and spontaneous assistance to members of their community by virtue of their community roles, occupations, or personality traits. Based in churches, they share health information and conduct health screening sessions, offer child and elder day care services, and provide links to health and social service providers.

Qualifications: Identification by church pastor as church members with "open ears and caring hearts" who are trusted for maintaining confidentiality and respected for being in control of their own life circumstances; plans to remain in the community for at least two years after training.

Selection process: Open-ended interviews between university program staff and pastors of selected churches to establish selection criteria; selection and preliminary contact of candidates by pastors; individual interviews by program staff.

Training: 10 two-hour weekly sessions held at a local church and taught by local professionals; successful completion of three examinations with a score above 70 percent to obtain lay health advisor certification.

Evaluation: Informal (with particular care taken to monitor changes in the level and quality of social support provided by lay advisors without jeopardizing their reputations for maintaining confidentiality or giving the impression that they are inspected and rated).

Compensation/recognition: Certificates awarded to program graduates; recognition of advisors through church announcements and news releases (no financial remuneration).

Community Health Educator Program
Planned Parenthood of New York City/The Hub (1982–present)

Sponsor: Planned Parenthood of New York City/The Hub, 349 East 149th Street, 3rd Floor, Bronx, NY 10451.

Contact: Anum Nyako, Director of Education and Training, The Hub (718) 292-8000.

Program goals: To teach young people to make informed decisions about their actions, especially concerning sexual activity, childbearing, and involvement in drugs; to encourage youngsters to postpone sexual activity and childbearing until they feel prepared to assume the concomitant responsibilities; to provide general and specific information about sexuality, family planning, and sexually transmitted diseases; to provide community residents with health-related information that will enable them to access the health care system to their advantage.

Worker roles and tasks, and relationship to sponsoring organization: *Community Health Educators* work in three different settings: the community, The Hub's main office, and The Hub's clinic. Educators provide community workshops on sexuality, family planning, sexually transmitted diseases, and other topics of community interest; conduct semiweekly rap sessions on contraception and weekly patient education sessions; and participate as active members in at least one community-based organization.

Qualifications: 18 years old or older; residence in community; high school diploma or equivalency degree; at least two years' experience in community or reproductive health activities; commitment to Planned Parenthood's policies, goals, and activities.

Selection process: Résumé; group interview; 15-minute presentation; individual interview.

Training: Typical training program lasts six months; includes in-class training on specific topics and ongoing Hub educational sessions after graduation.

Evaluation: Training program effectiveness evaluated by pretest and posttest assignments; informal evaluation of educators through letters of thanks, requests for additional presentations, and program director's observations.

Compensation/recognition: Annual salary of $25,000 once training begins; overtime and flextime on individual basis.

Community Health Worker Program
Bronx Perinatal Consortium and New York State Department of Health* (1988–present)

Sponsor: Division of Family Health, New York State Department of Health, Empire State Plaza, Corning Tower, Room 890, Albany, NY 12237.

Contact: Linda Thornton, Director, Community Health Worker Program, New York State Department of Health, Division of Family Health (518) 474-6968; Susan Bluestone, Case Manager, Community Health Worker Program, Bronx Perinatal Consortium (718) 367-8024.

Program goals: To achieve optimal health status among low-income populations in high-risk areas, particularly among pregnant and parenting individuals; to educate patients about the importance of early and continuous participation in prenatal and other needed health, social, and community services; to encourage timely and continuous primary and preventive health care for infants, children, and other family members.

Worker roles and tasks, and relationship to sponsoring organization: *Community Health Workers* encourage pregnant women and their families to gain access to and appropriately use available health and social services including prenatal, pediatric, nutritional, alcohol, substance abuse, domestic violence, HIV/AIDS prevention, treatment, and rehabilitation services. Activities include case finding and case management; basic preventive health education; health risk assessment; language and cultural interpretation with service providers; referrals to health, social, and community services; follow-up; and ongoing support to families.

Qualifications: Sufficient English skills to comprehend training materials, record case visits and referral forms, etc. (most trainees have a high school diploma or equivalency degree); strong interpersonal, communication, and problem-solving skills; ability to work in an unstructured field setting; residence in community and similar language, cultural background, and socioeconomic level of client population; knowledge of community, community organizations, and leaders; ability to work flexible hours, including evenings.

Selection process: Application form, including references; individual interview.

Training: New York State Department of Health course outline comprising five-module program with pre-service and in-service components, requiring approximately 120 hours (see Appendix B); continuous Bronx Perinatal Consortium training program, with new staff trained individually by field supervisors and all staff receiving monthly training.

---

* Other New York City agencies with New York State Department of Health contracts to train and supervise community health workers are Bushwick Community Services Society, Caribbean Women's Health Association, Center for Children + Families, Nachas Healthnet, New York City Department of Health Homeless Health Initiative, and the New York Urban League.

Evaluation: Contract monitoring and on-site program review by New York State Department of Health; training examinations by Bronx Perinatal Consortium including debriefing sessions immediately after each field experience.

Compensation/recognition: Workers' salaries determined by salaries paid to employees in similar positions in the community and at the base agency; $16,000 annual salary to trainees during probationary period and $18,000 after completion of training; $20,000 to $22,000 for senior workers; flex-time and time off for educational purposes.

Community Follow-Up Program
Hope Case Management, Narco Freedom, Inc., and New York State Department of Health* (1990–present)

Sponsor: The AIDS Institute, New York State Department of Health, Empire State Plaza, Corning Tower, Room 384, Albany, NY 12237.

Contact: Jay Freedman, Assistant Director of Case Management Unit, Division of HIV Healthcare, The AIDS Institute (518) 486-1323; Lisa Hill, Program Director, Hope Case Management (718) 402-2614.

Program goals: To provide intensive, family-centered case management services to HIV-infected and at-risk women, children, and adolescents, and other persons with HIV infection or AIDS, especially those identified as having had difficulty accessing medical care and other services and who require frequent personal contacts or home visitation to ensure their return for medical treatment and access to social services; to increase universal access to HIV information, counseling, testing, and services.

Worker roles and tasks, and relationship to sponsoring organization: Combining the roles of community follow-up workers and case management technicians, *Case Management Technicians/Outreach Workers* form part of a paraprofessional case management team that includes a case manager and one or more technicians/workers. Workers assist in implementing case management plans, monitor the progress of the plan and the client, escort the case manager on home and agency visits, maintain contact with clients, assist clients in completing referral forms and applications for services, establish relationships with the community, and conduct outreach activities. Narco Freedom, Inc., is the parent organization of Hope Case Management, which employs and supervises the case managers and workers.

Qualifications: 18 years old and above; high school diploma or equivalency degree; 12th-grade writing skills; ability to work well with people; college degree, bilingual skills (especially English/Spanish), residence in and familiarity with the community helpful, although not required.

---

*Currently 22 agencies are certified for this program statewide, 12 in New York City. Other certified agencies in the Bronx include Albert Einstein College of Medicine, Bronx AIDS Services, Citizens Advice Bureau, Community Family Planning Council, and the Salvation Army.

Selection process: Résumé; individual interview; completion of sample case report; group interview; physical examination including drug-screening test.

Training: In-house training, in which trainees shadow veteran workers over two to three weeks; "grand rounds" sessions; Narco Freedom training sessions; AIDS Institute and affiliated agency training.

Evaluation: Review of case management plans by program director at initial development and every 90 days thereafter; annual peer review of client-specific cases; "grand rounds" worker evaluations.

Compensation/recognition: Workers' $23,000 annual salary paid once training begins, with benefits package after three months' probation (salary increases based on merit and budget); flextime for exceptional workers' educational use, and full tuition for job-related study available to exceptional workers with two years' experience.

Community Health Advocate Program
Church Avenue Merchants Block Association and The Brooklyn Hospital Center (1992–present)

Sponsors: Church Avenue Merchants Block Association (CAMBA), 1720 Church Avenue, Brooklyn, NY 11226; Department of Family Practice and Department of Volunteer Services and Community Relations, The Brooklyn Hospital Center, 121 DeKalb Avenue, Brooklyn, NY 11201.

Contacts: Joanne M. Oplustil, Executive Director, CAMBA (718) 287-2600; Betsy Alexander, Coordinator of Community Outreach, Community Outreach Project, The Brooklyn Hospital Center (718) 596-7385 (formerly Director of Health Education, CAMBA); Paul Beach, M.D., Associate Director, Department of Family Practice, The Brooklyn Hospital Center (718) 403-8621; Suzanne Krase, Coordinator, Special Projects, Community Outreach Program, The Brooklyn Hospital Center (718) 250-6801.

Program goals: To train community residents to provide education and outreach that will improve access to primary care in their communities.

Worker roles and tasks, and relationship to sponsoring organization: *Community Health Advocates* are hired by the Brooklyn Hospital Center, among other organizations, after being trained by CAMBA. The hospital places the advocates in teams of six or less, supported by a community outreach nurse. Currently these teams focus on providing health education and referrals to community residents; making and maintaining contact with community groups; and enrolling community residents in the Stay Healthy Brooklyn Primary Care Network.

Qualifications: Sufficient reading and writing skills to understand course material and complete client referral forms; language skills as needed by community; history of community activism.

Selection process: Interview with representatives from CAMBA and the Brooklyn Hospital Center.

Training: 16-week program including four major components: the major health care issues of the community; New York City's health care system; resources available to the community; communication and community-organizing skills.

Evaluation: A no-test evaluation model developed by CAMBA employing observations of trainees' participation in role plays, responses to case studies, and community presentations (the Brooklyn Hospital Center evaluates advocates by keeping track of their activities and reviewing response forms from community presentations).

Compensation/recognition: Course materials and small stipend (roughly $10 per day) to cover transportation and incidental expenses during training; certificate from CAMBA and the Brooklyn Hospital Center upon graduation; $10.50 hourly salary thereafter for an average of 20–30 hours per week.

APPENDIX B: COMMUNITY HEALTH WORKER TRAINING OUTLINE
New York State Department of Health

The New York State Department of Health provides its contracted agencies, such as the Bronx Perinatal Consortium, with an outline of general topics to be covered in their training programs (see below) and makes individual training modules available upon request. In addition, the Department of Health provides requested technical and training assistance, as well as support and direction. Occasionally it arranges group training sessions on a regional or statewide basis.

Module I

1. Orientation to community health worker role
2. Community assessment; personal safety issues and training in the assessment of potential for high-risk situations
3. Communication skills
4. Community resource directory development
5. Therapeutic communication skills
6. Cultural beliefs and practices regarding health

Module II

1. Maternal focus; prenatal/perinatal/newborn care
2. Child and adolescent focus; infant and toddler; preschool; growth and development patterns, nutrition, immunization, and socialization
3. Family unit; sexuality, family planning

Module III

1. Maternal focus; sexuality, family planning
2. Child and adolescent focus; school-aged children, adolescents
3. Family unit; loss and bereavement, adult health promotion

Module IV

1. Maternal focus; domestic violence
2. Child and adolescent focus; child abuse and neglect
3. Family unit; substance abuse, AIDS, sexual abuse

Module V

1. Important issues and health concerns of particular communities or special populations; communicable diseases, injury prevention, working with the developmentally delayed; small group facilitation skills
2. First aid; cardiopulmonary resuscitation
3. Other identified topics; developed at the request of community health workers and as determined by the program supervisory staff

Didactic presentations are followed by role plays and planned field experiences. Life experiences are used as a basis for much of the discussion and role play situations.

APPENDIX C: INTERVIEW, EVALUATION, AND ASSESSMENT FORMS*
Family Health Worker Program, Dr. Martin Luther King, Jr., Health Center

Core Training

GROUP INTERVIEW FORM

Name _____ Date _____

Your Name _____

Group Leader _____

Observer _____

Evaluation Scale

Alertness						
Nervous or Relaxed						
Verbal Ability						
Assertiveness						
Maturity						
Perceptiveness						
Sensitivity to others						
Lack of arrogance						
Appearance						
Knowledge of Community						
	1 very poor	2 fair	3 aver.	4 good	5 excel.	6 not observed

General Recommendations: _____

_____

_____

_____

_____

Comments: _____

_____

_____

_____

_____

* Reprinted, by permission, from Singley, W.G.; Plaut, T.F., eds. *Training Community Health Workers* (Bronx, NY: Dr. Martin Luther King, Jr., Health Center, 1974).

Screening and Selection

QUESTIONNAIRE

NAME _____ DATE _____

ADDRESS _____

_____

1. How did you hear about the program?

_____

_____

_____

_____

_____

_____

2. Describe a problem in the community:

_____

_____

_____

_____

_____

_____

3. How do you think it can be solved?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Core Training

INDIVIDUAL INTERVIEW

Date: _____

Name: _____ Interviewer: _____

1. What did you think of the group interview?

   There are some questions I would like to ask you so we'll know a little more about your job interests and your present situation in relation to employment. O.K.?

2. Are you head of your household?

3. Are you presently employed?

4. Where do you live? (Please check one)

   ☐ Projects
   ☐ East of Third Avenue
   ☐ North of 171st Street

5. What kinds of jobs have you had?

   a. Which did you enjoy the most?

      Why?

   b. Which the least?

      Why?

6. What are you interested in being trained to do? (Interviewer–please explain this job would not be guaranteed, but serve as basis for development).

7. How do you feel about having to do several hours of homework each night?

8. What are your plans for taking care of your children if you are accepted into the program?

9. What difficulties will you have in working weekends, holidays and different shifts?

   If you could have any type of job, which would you prefer?

   a. a job in which you could work closely with people, patients or clients either giving them physical care, providing a service, counseling or all three of these.

   b. a job in which you do not come in contact with the public but may do technical or clerical work.

   c. a combination of the above.

The remaining questions are to be answered by the interviewer based on impressions of the applicant.

INDIVIDUAL INTERVIEW (cont.)

Does the applicant have any physical disabilities or physical characteristics which would make it difficult for him to function on the job or obtain a job? (cardiac condition, high blood pressure, extremely overweight, varicose veins).

Yes ☐ No ☐ If yes, explain.

1. Would you want this person to work with you or for you?

   Yes ☐ No ☐ Explain.

2. What type of job could you see the applicant doing?

3. How motivated do you think the applicant is to enter the program?

   low 1 / 2 / 3 / 4 / 5 / high

4. Likelihood of success in the training program

   poor fair average good excellent

5. Likelihood of success on the job?

   poor fair average good excellent

6. In the following, please evaluate and give a reason for your decision:

   a. Do you see this person as someone who is open to change (flexible)?

      Yes No Unable to evaluate Why?

   b. Do you see this person as someone who is willing to work with others?

      Yes No Unable to evaluate Why?

   c. Do you see this person as someone who is able to accept supervision?

      Yes No Unable to evaluate Why?

   d. Do you see this person as someone who is able to accept responsibility?

      Yes No Unable to evaluate Why?

   e. Do you see this person as someone who is able to follow directions?

      Yes No Unable to evaluate Why?

7. Please write your recommendation whether to accept the applicant or not. Please give your reasons for your recommendation.

Evaluation of Trainees

TRAINEE EVALUATION REPORT

Two-week period ending (date): _____

_____
(Name of Trainee)

_____ times late _____ times absent

_____ on probation

_____ subject to probation

Key:
1. Unsatisfactory
2. Adequate
3. Satisfactory
4. Good
5. Excellent

O No opportunity to observe

	Basic Health	Comm. Skills	Math	Health Careers	Community Resources	Pharmacology
ATTITUDES						
1. Respect						
2. Cooperation						
3. Responsibility						
4. Flexibility						
5. Accepting supervision						
COURSE WORK						
1. Quality						
2. Participation						
3. Comments are relevant						
4. Assignments are complete						
5. Prepares for class						
6. Shows initiative						

What special abilities, skills or special knowledge has this trainee acquired or demonstrated since last evaluation:

What special behaviors, knowledge, qualities, or skill does this trainee need to improve his performance:

What special behaviors, knowledge, qualities, or skill does this trainee need to improve his performance:

Counselor's Signature _____

Trainee's comments on evaluation:

Trainee's Signature _____

DR. MARTIN LUTHER KING, JR. HEALTH CENTER
3674 Third Avenue
Bronx, New York 10456
INITIAL ASSESSMENT OF HOUSEHOLD

Patient Identifying Information

Name Apt. #
Address
Family ID
Team Telephone
Informant
Interviewer
Date

IN CASE OF EMERGENCY notify:
Name
Address Apt. #
Telephone Relationship

I. HOUSING: Type _____ Rooms _____

	Plumbing	Electricity	Heat
Adequate	☐	☐	☐
Inadequate	☐	☐	☐

	Yes	No
Elevator	☐	☐
Pests	☐	☐
Pets	☐	☐
Lead in Walls	☐	☐

REMARKS:

II. ECONOMIC STATUS:
Income Amount _____
Adequate _____
Inadequate _____

REMARKS:

III. MAJOR SOCIAL PROBLEMS:
Present _____
Absent _____

REMARKS:

IV. FAMILY STRUCTURE – Medical History (Circle, if yes)

PATERNAL

1. Allergy
2. Anemia (iron, sickle, etc.)
3. Asthma
4. Bleeding & bruising
5. Birth defects
6. Cancer
7. Cerebral palsy
8. Diabetes
9. Hypertension
10. Kidney disease
11. Mental retardation
12. Rheumatic fever
13. Nervous breakdown
14. Seizure disorder
15. Substance abuse
16. Tuberculosis

MATERNITY

FAMILY TREE

Others in household (but not family members)

Name	Rel.	Age	Med. Prob.

V. AGENCIES KNOWN:

Name	Address	Name of Contact

VI. PROBLEMS & PLAN

APPENDIX D: INTERVIEW FORMS
Community Health Participation Program (CHPP), Montefiore Medical Center

INTERVIEW: NEW HEALTH COORDINATORS

1. Name 2. Age

3. Address

4. No. of years lived there

5. Occupation

6. How many neighbors do you know

– in your building	– in your neighborhood
many	many
some	some
few	few

7. How did you hear about this Program?

8. Why do you want to be a Health Coordinator?

9. What do you think are the main problems in your neighborhood?

health other

– how do you think these problems could be solved?

10. What have your experiences with the health care system been?

11. Have you been involved in community work before? (formal/informal)
What was it?

12. What skills do you bring to the Program that you think will be helpful to you?

INTERVIEW: HEALTH COORDINATORS' NEIGHBORS

(1 person to be interviewed by each Health Coordinator)

Name Age

Address

No. of years lived there

Occupation

How many neighbors do you know

– in your building		– in your neighborhood	
many	_____	many	_____
some	_____	some	_____
few	_____	few	_____

What do you think are the main problems in your neighborhood?

drugs	_____	safety	_____
alcohol	_____	elderly	_____
crime	_____	teenagers	_____
housing	_____	nutrition	_____

other health problems:

problems in other areas:

What groups in the community do you belong to? (church, tenants group, block assoc., etc.)

None _____

Where do you go for health care?

HIP	_____	private M.D.	_____
Montefiore	_____	other	_____
NCB	_____	none	_____

Would you say you are
very satisfied _____
somewhat satisfied _____
somewhat dissatisfied _____
very dissatisfied _____ with the care you get there?

TO THE HEALTH COORDINATOR:

How do you know the person you are interviewing?

_____

Health Coordinator name date

REFERENCES

Eng, E.; Hatch J.; Callan, A. "Institutionalizing Social Support through the Church and into the Community." *Health Education Quarterly* 12 (1985): 81-92.

Gagnon, A.J. "The Training and Integration of Village Health Workers." *Bulletin of PAHO 25* (1991): 127-138.

Hatch, J.W.; et al. "The Fitness through Churches Project: A Description of a Community-Based Cardiovascular Health Promotion Intervention." *Hygiene International 5* (1986): 9-12.

Laver, S.; Saunders, C.R. "Curriculum Development for Health Education—Preliminary Report on a Holistic Approach." *The Central African Journal of Medicine* 30 (1984): 202-204.

Singley, W.G.; Plaut, T.F., eds. *Training Community Health Workers*. Bronx, NY: Dr. Martin Luther King, Jr., Health Center, 1974.

Thompson, P.I.; Jones, T.S. "Monitoring and Documenting Community-Based Organization Outreach Activities for Populations at Risk for HIV." *Hygiene International 9* (1990): 34-38.

Werner, D., Bower, B. *Helping Health Workers Learn: A Book of Methods, Aids, and Ideas for Instructors at the Village Level.* Palo Alto, CA: Hesperian Foundation, 1982.