People Improving the Community's Health: Community Health Workers as Agents of Change

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Abstract: People Improving the Community's Health (PITCH) uses teams of community health workers to provide targeted outreach, to enroll those eligible in health coverage plans, to provide information and linkages to health and social support services, and to engage community members in community improvement activities. The initiative is based on the assumption that communities must work on the determinants of health and effectively mobilize all their assets to improve not only individual health, but also community health. Developed with support from the Kellogg Foundation's Community Voices Initiative, PITCH addresses intertwined public health concerns about access to health care and community health improvement. Outcomes of PITCH include increased enrollment in health coverage plans as well as increased participation in community improvement activities. The PITCH initiative helps community members work together to unleash the enormous power for change that emerges when people connect to one another, thereby tapping the knowledge, skills, and resources of community members and institutions alike.

Key words: Community health workers, community improvement, health access.

The health of the individual is inseparable from the health of the larger community. A desire to increase access to health for individuals while improving community health prompted the Ingham County Health Department (ICHD) in mid-Michigan to work with community-based organizations. Teams of community health workers (CHWs), developed with support from the Kellogg Foundation's Community Voices Healthcare for the Underserved Initiative, had been used effectively in 2001 to conduct enrollment outreach during the initial implementation of the Ingham Health Plan (IHP), a local health coverage strategy for the uninsured administered by the ICHD. However, analysis of census tract data on the percentage of population below poverty level compared with current enrollment in the IHP showed that enrollment was lower than predicted in several areas of the community. The ICHD decided to expand outreach in 2003 to address both community health and health access, based on the success of the earlier IHP enrollment outreach program and evidence of effective use of CHWs in other communities.[1,2,3] In consultation with community partners, People Improving the Community's Health (PITCH) was

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designed to use CHWs to involve community members in identifying problems and framing solutions at the neighborhood level, as well as to provide outreach for health and support services for individuals and their families.

Initially, ICHD contracted with three community-based organizations to create CHW teams targeting residents in low-income, high-need neighborhoods in Lansing. The Northwest Lansing Healthy Communities Initiative serves an area with a population of 15,920 that is 50% White, 35% African American, and 12% Hispanic. Allen Neighborhood Center serves an area with 6,000 residents; 65% are White, 15% are African American, and 15% are Hispanic. Baker Donora Focus Center serves an area with a population of 6,340 that is 63% White, 23% African American, and 13% Hispanic. The proportion of the population living below the poverty level is 27% in Northwest Lansing, 59% in the Allen neighborhood, and 30% in the Baker Donora neighborhood. In addition to the neighborhood-based outreach, ICHD also contracted with the Greater Lansing African American Health Institute (GLAAHI) to address health disparities in the broader African American community.

Using health coverage status and IHP enrollment as a topic to initiate discussions, CHWs in the PITCH initiative engage residents in deeper conversations about health (both individual and communal). Monica Kwasnick, community health worker and health team co-coordinator at the Allen Neighborhood Center, puts it this way, "[Our] connection goes beyond simply handing [a community member] a flyer. They are our neighbors and they become our friends. [Outreach enables] conversations with people who really want connection, but short of someone knocking on their door, they're not going to get it." Wambui Demps, community health worker and health team co-coordinator, says, "There is something of primary importance we can give: one-to-one contact. They see you at the door and something transpires in that moment. I am present for them; I really listen to them. [Then they know] that there is a person who cares and wants to help."

Innovations in Outreach

The outreach strategies employed in PITCH differ from narrower ones in that they integrate outreach for access to health care coverage and effective utilization of services with engagement and mobilization of residents to improve community health. The initiative deploys CHWs in a role significantly expanded beyond the usual one of addressing specific health concerns such as diabetes, asthma, or hypertension.[4,5,6] In PITCH, CHWs help enroll eligible people in health coverage plans and link them to a broad array of services and resources, ranging from smoking cessation services to financial management and earned income tax credit application assistance, depending on the individual's needs and situation. As they do their work, the CHWs develop trusting relationships and are able to encourage community members to become actively engaged in community improvement, to move from being consumers and clients to being civic participants and problem solvers. Similar roles for CHWs as community change agents are documented in the literature.[7]

As part of the Ingham Community Voices initiative, community members identify priority issues and develop effective and locally feasible solutions to address them through community dialogues and planning summits. The PITCH community

health workers create important synergy by connecting residents to these ongoing activities. Over time, a network of relationships grounded in respect and trust gives rise to connections among people and organizations, thereby building social capital and improving community health.[8,9]

A farmer's market developed in one neighborhood provides an example of an issue identified by community members and a solution developed with community members. According to Monica Kwasnick,

> the driving factor in developing the farmer's market [on the Eastside of Lansing] was the survey CHWs did with 503 residents in 2003. We found that 29% of the people surveyed were food insecure and concluded that the Eastside is a food desert. There is only one place to get fresh fruits and vegetables, and that is not easy to get to. [We live] in an area with clear health problems, and we're going door-to-door telling people to eat better. We had to do something.

The primary goal of the farmer's market is to bring local produce to people in the neighborhood. During the summer of 2005, its second season, about six farmers participated each week and volunteers from the community contributed over 900 hours to operate the market. The season closed in October with an average of 268 attendees per week, compared with 109 attendees per week in 2004.

A Shift in Public Health Policy

The community partners and institutional stakeholders involved in Ingham Community Voices believe PITCH has prompted a shift in public health policy: the community is encouraged to view the local public health department as its resource while the health department and other institutions are learning to view the community as their asset. Rather than always structuring services so that people must come to the health department, community organizations are supported by ICHD as venues for service delivery. Outreach team members believe their way of offering information, support, and services is different because they see the person in context, as a part of the neighborhood, an employee at a local business, a valued member of a family. In contrast, when a person goes to a clinic or an agency for help, the staff they encounter may see only the person's problem rather than the whole person and the problem in a larger context. Recognizing the special relationship that CHWs have with people in the community, the Ingham Health Plan is now reimbursing CHWs for provision of smoking cessation services in the neighborhood, a service that was previously delivered only at health department clinics. Currently, 68 individuals are enrolled in smoking cessation programs delivered in the neighborhoods.

The IHP has also involved the outreach teams in addressing the inappropriate use of local emergency departments by IHP members. The CHWs and IHP staff jointly conducted focus groups with community residents to determine why IHP enrollees were still going to the emergency room for primary care. Enrollees said they had not made their first connection with a primary care physician and continued to use the emergency room because they were comfortable there. Now there are dedicated appointment slots for new enrollees that CHWs can use to schedule community members' first appointments at the health department clinics that are part of the

IHP provider network. By making the appointment at the same time that they enroll the community member, CHWs help people overcome their mistrust of the primary care system and may decrease inappropriate use of the emergency room.[10]

Perhaps even more important, community members are helping the ICHD to tailor services and programming to meet community needs more effectively. The Ingham County Health Department's role has been pivotal in the development, evaluation, and refinement of PITCH. The department developed a funding strategy that embeds PITCH in community-based organizations while continuing to provide training, participatory evaluation, and technical assistance as PITCH is refined and expanded. This is a new model of practice for the public health agency. Community partners such as the Allen Neighborhood Center and Northwest Lansing Healthy Communities Initiative were closely involved in the development of PITCH. Each organization helped create the outreach model and recruited and trained its own CHWs. Each remains responsible for ongoing monitoring of its CHW team. Institutional partners provided additional supports, e.g., the county Department of Human Services provided funding, the City of Lansing provided funding and space, and Ingham Health Plan Corporation provided funding used to expand outreach. The local United Way has piloted a fundraising program that will help sustain PITCH over time.

The ICHD has afforded each community partner freedom to develop a CHW team that responds to the particular needs of the area it serves while using common practices of engagement and mobilization of community members to promote community involvement.[11] For example, the Allen Neighborhood Center, Baker Donora Focus Center, and Northwest Lansing Healthy Communities Initiative send their outreach teams door-to-door in the neighborhood. Since GLAAHI does not serve a defined neighborhood, it delivers outreach services in venues that high-risk populations are apt to frequent (such as homeless day shelters).

Implementation of PITCH

Since the beginning of the Ingham Community Voices initiative in 1999, the following steps have led to the implementation of PITCH.

1. Collaborative relationships among community organizations and institutions were established or enhanced through a series of community dialogues and summits during 1999–2001.
2. In 2001, to increase enrollment in the Ingham Health Plan, a local health coverage strategy, ICHD contracted with community organizations to create teams of CHWs to conduct enrollment outreach for a limited time. Evaluation of Ingham Community Voices showed enrollment increases following the implementation of enrollment outreach by CHWs in combination with a media campaign.
3. In 2003, a funding strategy was developed by ICHD to enable community organizations to hire outreach coordinators and recruit CHW teams for ongoing outreach, and to expand the role of CHWs to include community improvement.

4. Community organizations hired outreach coordinators and recruited CHWs from community members, most of whom reside in the targeted areas.
5. The outreach coordinators provided training for CHWs on how to carry out effective outreach based on principles of inclusiveness, respect, and nonjudgmental acceptance. Community health workers also received instruction from ICHD on eligibility guidelines for Medicaid and the Ingham Health Plan, as well as information about community resources.
6. In mid-2003, outreach workers began making contacts in the community, providing information on health coverage and facilitating connections between people and between people and organizations.
7. During 2004, ICHD developed reporting guidelines, in consultation with community partners, and provided technical assistance to community organizations to contribute to the sustainability of PITCH.
8. Monitoring and evaluation of outcomes for each of the teams, including the number enrolled in health coverage and the number engaged in community activities, is ongoing, as is technical assistance and training.

Four teams of CHWs currently serve low-income neighborhoods in Lansing, and a fifth team is being developed. The ICHD provides financial support to neighborhood-based organizations to recruit and manage these teams. Each team has a part-time coordinator and several community health workers, most part time and some full time, for the equivalent of two or three full-time positions. On-going costs for a team range from $42,000 to $84,000 annually. Ingham County Health Department's combined cost for the four teams is $252,000 in fiscal year 2005. While this core level of financial support from ICHD is anticipated to continue or grow in the future, other entities have also purchased CHW services from these neighborhood-based organizations on a one-time basis. For example, the Michigan Department of Human Services has provided $35,000 in fiscal year 2005 to the same neighborhood organizations to demonstrate and evaluate the effectiveness of using CHWs to support family preservation objectives.

The ICHD has bundled together multiple sources of funding to provide core financial support to these neighborhood-based organizations. Current sources of funding include grants from the Kellogg and American Legacy foundations, federal reimbursement for Medicaid outreach, and county funds. To simplify administration for neighborhood-based organizations and to enhance accountability to the various funding sources, the ICHD developed and entered into a braided contract with each neighborhood-based organization. This single contract specifies all the program and reporting requirements of the various funding partners, including the cost-allocation methods that are to be used to determine Medicaid's share of the costs.

To maintain and enhance core funding levels over time, the ICHD is working with additional financial partners to sustain funding when funds from the foundations are no longer available and/or to expand the initiative. For example, the braided contracts supporting CHWs will soon include funds and requirements from the Ingham Health Plan Corporation and the Capital Area United Way. The Capital Area United Way has created a health initiative category so that donors can designate their contributions to the outreach effort. These and other community investors

are beginning to coordinate and expand their investments in community practices, such as the CHWs, through the Power of We Consortium, a broad community collaborative body that promotes cooperation, information sharing, and joint action across agencies and organizations. The Investor's Steering Committee of the Power of We Consortium is developing funding strategies to sustain outreach, engagement, and mobilization activities over the long run.

Successes and Challenges

Initially, community health worker teams were determined to be effective based on increased enrollment in the Ingham Health Plan (IHP). Use of CHWs to enroll community members in the IHP, in combination with a media campaign, resulted in a significant increase in the number of people enrolled during 2001, the first year the plan was available. In 2003, there were an estimated 27,386 adults in Ingham County without insurance. As of July 2004, 13,744 adults, 50% of the baseline number of uninsured adults, had coverage through the IHP. As of July 2005, 14,304 adults had coverage through the IHP, due in part to the efforts of CHWs. There were 28 new IHP enrollments completed by CHWs from January through March 2005, another 99 enrollments from April through June 2005, and preliminary reports of more than 180 new enrollments by CHWs during the third quarter of 2005. In addition, there were 134 people enrolled in Medicaid as a result of CHW outreach from January through June 2005. The types of information and links provided most often to community residents by CHWs during 2005 include breast health, chronic disease self-management, food resources, smoking cessation, home ownership, and income assistance, in addition to health access. Community partners (outreach coordinators and neighborhood center directors) also have attributed increased participation in programs and activities offered through neighborhood centers to the relationships established between CHWs and community members. The ability to offer a concrete benefit (immediate enrollment in the IHP) to community members was cited by community partners as a key factor in engaging community members in broader community improvement activities.

Challenges encountered in expansion of PITCH include staff turnover, in outreach coordinator or CHW positions, and delays in the authorization of CHWs to enroll community members directly in the IHP. Addressing staff turnover results in additional time spent recruiting replacement staff has led to recognition of the critical role that the coordinator plays in the recruitment and management of successful teams. In addition, attempts are being made to obtain funding to make more CHW positions full time, in order to improve retention. Since enrollment in the IHP was a key incentive that CHWs could offer community members, ICHD administrative staff worked closely with managers of the IHP to expedite the authorization of CHWs as IHP enrollment agents as plan capacity increased.

As the community health worker model has expanded, record keeping and reporting procedures have been established to monitor progress in implementation of PITCH in targeted neighborhoods. Documentation of efforts and outcomes across diverse neighborhood-based organizations with multiple funding sources has presented its own challenges. Development of systems for tracking referrals,

follow-up, and participation in community events required time for researching and identifying the data elements required by community partners, the ICHD, and funding sources. Community partners tested drafts of outreach logs and reporting forms for six months. Feedback from community partners was used to refine the reporting system to reduce the burden on CHWs, while improving the consistency and completeness of information collected. The revised reporting system, which includes information on the number of outreach interactions, the type and purpose of interactions, and the number of residents newly enrolled, was instituted within one year of the project start date. Quarterly reports from community partners also include narratives describing coordination, recruitment and training, and implementation of community health worker teams, community improvement activities underway, and the level of participation by neighborhood residents, as well as lessons learned and best practices.

Lessons Learned

Based on evaluation of the first three years of the Ingham Community Voices initiative and experience with PITCH to date, community partners and key stakeholders believe the implementation of successful CHW teams and community engagement and mobilization efforts depends on the following key factors.

- *Ongoing administrative support.* Providing ongoing administrative support for community organizations contributes to their stability, which in turn contributes to their ability to garner further resources and their capacity for community improvement. Investing resources in existing community organizations is effective in nurturing leadership and community engagement.
- *Flexibility in design.* Encouraging flexibility in the design of structures and development of activities and processes, as well as adapting programming available through the neighborhood centers to meet the needs expressed by community residents, results in use of community resources in ways that are responsive to the community.
- *Clear strategy.* However structures, activities, and programs are designed, a clear strategy is needed for deploying CHWs (where, when, and how they will connect with community members) and a commitment on the part of coordinators and CHWs to carry out the strategy.
- *Lasting relationships.* Building lasting relationships between CHWs and community members is necessary in order to support individuals making healthy decisions and to help them overcome personal and structural barriers to achieving good health. While brief, door-to-door canvassing is effective for initial contact and information sharing, deeper conversations allow the CHW to tailor information, support, and referrals to meet individual needs. These relationships create a connection between the CHWs and community members and build a sense of urgency on the part of the CHW to conduct prompt and thorough follow-up.
- *Incentives.* Offering a product, such as health coverage, a quit smoking kit, or walking club, that assists community members in their personal efforts to achieve good health provides an effective incentive for individuals to participate.

Implementing strategies that lead to concrete action, such as increased enrollment in the IHP, is critical for mobilizing communities as a whole.

- *Valuing diversity.* Offering opportunities for everyone's voice to be heard during the design and implementation of community improvement plans and placing value on diversity will promote efforts to improve community health that mesh with community needs. Listening and responding to community members is key to effective programming.
- *Recruitment and training.* Recruiting skilled coordinators and providing ongoing training and support for CHWs is necessary in order to increase and maintain the capacity of CHW teams. Ideally, CHWs should have a natural ability to talk to people, be able to understand individuals' situations, and have a long-term stake in the community. Training should include teaching CHWs to assist individuals to overcome personal and institutional barriers to health and to understand the relationship between individual and community health, as well as to provide specific information on the resources available to community members and the procedures for accessing these resources.

Community health workers and coordinators in PITCH also recommend the following strategies to increase the effectiveness of CHWs:

- Personal invitations (e.g., personal door-to-door contact followed by postcards and/or a phone call) are effective in encouraging participation in community improvement activities in which the individual has expressed an interest.
- Multiple contacts and ongoing support may be necessary to assist individuals with achieving their personal health goals (e.g., support for smoking cessation participants). Follow-up is critical to ensure that information requested by community members during initial canvassing is actually provided to them.
- When contact is made with either an individual or multiple members of a household, CHWs should assess the entire household to identify all opportunities for improving the health of household members.
- Door-to-door canvassing must be scheduled during days and times when the most people will be at home in the targeted neighborhood.
- It may be useful (or even crucial) to offer incentives in order to encourage participation by more community members in initial surveys/canvassing.
- Good relationships between CHWs and other institutional partners (e.g., the Medicaid enrollment agency) are critical to facilitate the exchange of information that may be helpful to neighborhood residents.
- Forms for recording necessary information must be streamlined for CHWs who have limited time to spend on reporting.

Evaluation

The PITCH initiative is being evaluated using a participatory evaluation approach; ICHD administrative staff and community partners have worked with evaluators in the overall evaluation design and the development of the evaluation matrix, evaluation questions, and data recording and reporting tools. The evaluation design identifies both program measures and policy measures for PITCH.

As part of the program measures for PITCH, qualitative data describing the outreach models developed by community partners and the activities undertaken are being collected through regular progress reports to ICHD. Quantitative data are being submitted by community partners in aggregate reports to the ICHD, based on logs completed by CHWs. Policy measures for PITCH include description of the process used to design, implement, and sustain outreach models; institutionalization of outreach models; and efforts to disseminate the outreach model at the local, state, and national levels. Information on policy measures is being collected through written progress reports completed by ICHD and interviews with ICHD administrative staff and other institutional partners.

Conclusion

The PITCH initiative is based on an assumption that communities must work on the determinants of health and effectively mobilize all their assets to improve not only individual health, but also community health. The PITCH initiative helps the community work together to accomplish these ends by connecting people to one another, connecting people with organizations, and connecting community-based organizations with institutions, thereby tapping the knowledge, skills, and resources of community members and institutions alike. Preliminary data after the first year suggest that PITCH effectively uses teams of community health workers to provide targeted outreach, to enroll those eligible in health coverage plans, to provide information and links to health and social support services, and to engage community members in community improvement activities. Outcomes of PITCH to date include increased enrollment in health coverage plans as well as increased participation in community improvement activities. Of particular importance is the successful leveraging of funding from multiple partners to finance the strategy, including IHP and Medicaid reimbursement for outreach services provided to eligible populations.

To replicate PITCH, strong relationships must exist or be cultivated among local public health agencies, institutional partners, and community organizations to provide a basis for collaboration on planning, implementation, and evaluation of the initiative. Community organizations and community health workers, the vital interface between the local public health agency and the neighborhoods, must be supported as a foundation for ongoing community dialogue and action.

As PITCH continues, aggregate data will be analyzed to determine further progress made toward the objectives of helping eligible, uninsured persons enroll in health coverage plans and utilize services effectively while increasing involvement of neighborhood residents in ongoing community improvement initiatives.

Notes

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