Who Are They? A Case Study of Community Health Worker (CHW) Programs in Primary Health Care

Constance Renee Williams Shepard

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Who Are They?
A Case Study of Community Health Worker (CHW) Programs in Primary Health Care

by

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Bachelor of Social Work
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Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy in

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Dedication

To my Savior and Father, who always allows me to participate.

In doing so, I connect and learn from and with others

What truly matters!

To Patience,

Your spirit is present helping us to defy the odds over and over again.

To my Family,

From whence we have come and will go.

And

To Everyone in the study,

It was an honor and a privilege to have shared these moments with you.

It is with the greatest esteem that I dedicate to each of you

this dissertation.
Acknowledgements

No words or space can capture my heartfelt appreciation to everyone who has supported me on this journey. In the deepest way possible, I honor my dissertation committee members. Your mentorship and unwavering support throughout this journey have helped prepared me for this moment. I am especially appreciative of my family, fictive kinfolks, friends, colleagues, students, and acquaintances who always found time to listen, encourage and support me in whatever way possible. You each contributed more than you’ll ever know and for that, I am eternally grateful.
Abstract

Community health workers (CHW) programs are an important emerging strategy to address the rising cost of health care, the shortage of healthcare staff, and the lack of accessible, affordable and quality health care (Sanders & Lehmann, 2007; WHO, 2010; CDC, 2012). The American Public Health Association (APHA) defines community health worker (CHWs) as frontline public health workers, trusted members of their communities and individuals that have a unique understanding of the people and communities they serve. CHWs develop trusting relationships that enable them to serve as an intermediary between healthcare, social services providers, and community members. By doing so, they facilitate culturally responsive patient-centered health care (APHA, 2010). Researchers have demonstrated CHW programs are effective interventions for increasing positive health outcomes in the management of chronic diseases (WHO, CDC, 2012). Missing from the literature is information regarding the nature of the cultural context of CHWs programs in primary health care settings with diverse populations.

The purpose of this ethnographic case study was to gain insight into the culture of CHW programs in primary health care (PHC). I explored CHW programs at three PHC sites in SC to craft rich descriptions of the provisions of CHW services from the perspectives of the people engaged in the day to day activities. The aim was to understand better the CHW services, the roles, and responsibilities CHWs provide in PHC. I identify and discuss the mechanisms in which CHWs provide culturally responsive
services. I share and discuss the perception of the CHW services from the people receiving these services.

*Keywords*: Community health workers, primary health care, culturally responsive, patients’ perceptions, ethnographic case study.
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Chapter 1

Introduction

“If true changes in healthcare systems are to come about, people must become more engaged in these systems improving their health and relationships with healthcare providers, and each must become more trusting, continuous, and mutually respectful” (Hector, Rosenthal, Brownstein, Rush, Matos, & Hernandez, 2011, p. 2199).

Each year health organizations in the United States (U.S.) release data that reflects a healthcare system embroiled in crisis. Millions of people in the U.S. are uninsured and lack access to health care despite the recent implementation of the Patient Protection and Affordable Care Act (PPACA), also known as the ACA of 2010 (Kaiser Family Foundation, 2014). Under the ACA, ineligible and uninsured people are now able to qualify for Medicaid. The increase in eligibility level from 100% to 133% of the federal poverty rate made this possible (Kaiser Family Foundation, 2014). The federal poverty level is a measure of income issued by the Department of Health and Human Services that determines eligibility for federal programs and benefits (Healthcare.gov, 2016). For example, a family of three with an annual income of $27,000 would be able to qualify for Medicaid under ACA. The Patient Protection and Affordable Care Act of 2010 also created a marketplace allowing individuals to compare benefits and prices to obtain the minimal required health insurance within each state (Healthcare.gov, 2015).
In the 2012 Supreme Court decision, states were given the choice to opt-out of the Medicaid expansion under ACA; this ruling is one reason that explains why many people with low incomes remain uninsured (The Kaiser Family Foundation, 2014). Residents in the states that decided to opt out of the Medicaid expansions and are ineligible for Medicaid coverage are not required to obtain insurance and will not have to pay the penalties for being uninsured (Obamacare Facts, 2016). Consequently, individuals in these particular states remain uninsured. The resulting coverage gap affects an estimated four million poor adults in the U.S. (Kaiser Family Foundation, 2014). These adults do not qualify for Medicaid, nor are they eligible for subsidies or tax credits to purchase health insurance in the marketplace (Garfield, Damico, Stephens, & Rouhani, 2014). The state of South Carolina was one of the thirteen states to opt out of the Medicaid expansion (Kaiser Family Foundation, 2014).

Figure 1.1 Medicaid Coverage Gap illustrates this troubling coverage gap.
In Figure 1.1, Medicaid\(^1\) refers to a health insurance program for low-income individuals and those with disabilities (Healthinsurance.org, 2015, n. p.). No coverage includes the individuals without any health insurance. The marketplace subsidies include two types of funding assistance.

The first type of assistance, called the premium tax credit, works to reduce enrollees’ monthly payments for insurance coverage. The second type, the cost-sharing subsidy, is designed to minimize enrollees’ out-of-pocket costs when they go to the doctor or have a hospital stay. To receive either type of financial assistance, qualifying individuals and families must enroll in a plan offered through a health insurance marketplace (The Kaiser Family Foundation, 2015, n. p.).

Effective January 1, 2014, under the ACA, South Carolina is required to use the Modified Adjusted Gross Income (MAGI) to determine individuals and groups’ eligibility for Medicaid (SC Healthy Connection, 2014). Table 1.1 highlights the MAGI eligibility requirements for Medicaid in SC. Medicaid eligibility is limited to certain individuals: pregnant women; families with a child under age 19; children who are or were in foster care; and children adopted. Other qualified individuals include those diagnosed with breast or cervical cancer and those who are blind, have a disability, need care in a nursing home, or are over the age of 65 with very little or no income (SC Healthy Connections Website, 2015).

\(^{1}\)Medicaid in SC is also known as SC Healthy Connections. (SC Healthy Connection, 2015).
Table 1.1 Modified Adjusted Gross Income (MAGI) for SC Medicaid Eligibility (SC Healthy Connections Website, 2016)

<table>
<thead>
<tr>
<th>MAGI Eligibility Group</th>
<th>Medicaid Category</th>
<th>Current Income Limit (%FPL)</th>
<th>MAGI-Based Income Limit (%FPL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents and other Caretakers</td>
<td>Low Income Families (LIF)</td>
<td>50%</td>
<td>62%</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Pregnant Women</td>
<td>185%</td>
<td>194%</td>
</tr>
<tr>
<td>Infants and Children Under Age 19</td>
<td>Partners for Healthy Children (PHC)</td>
<td>200%</td>
<td>208%</td>
</tr>
<tr>
<td>Non IV-E Adoption Assistance</td>
<td>Adoption Assistance (Special Needs/Subsidized)</td>
<td>50%</td>
<td>62%</td>
</tr>
<tr>
<td>Former Foster Children (Age 18-26)</td>
<td>New mandatory coverage group</td>
<td>N/A</td>
<td>No income standard</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Family Planning</td>
<td>185%</td>
<td>194%</td>
</tr>
</tbody>
</table>

The Health Care Needs of the Nation

The Centers for Disease Control (CDC) (2012) has estimated that 133 million people, or 45% of the total U.S. population, has at least one chronic disease. Chronic diseases (CD) include heart disease, strokes, cancer, obesity, diabetes, or other conditions and are major factors contributing to the health care crisis (CDC, 2012). Chronic disease treatment constitutes over 75% of health care costs in the U.S. As depicted in Figure 1.2, seven of the top ten causes of death are due to chronic diseases (2012; SAVE, 2014).
Chronic diseases are preventable when individuals change their unhealthy behaviors, increase exercise, adopt a nutritious diet, and maintain a healthier lifestyle without tobacco and excessive use of alcohol (CDC, 2012). Investing $10 per person in community-based healthcare focused on changing behaviors such as physical inactivity, poor nutrition, and smoking could save approximately 6 billion dollars annually (CDC, 2009).

Figure 1. 2 Leading Causes of Death in the U.S. (SAVE, 2014)

In 2009, the Centers for Disease Control made recommendations to curtail the rising cost of health care and prevent increased chronic diseases. They reached out to communities, policymakers, healthcare professionals, voluntary and professional organizations, the private sector and governmental agencies, and academic institutions. The CDC suggested that entities work together collectively to combine resources to
address critical areas affecting healthcare. These areas include but are not limited to the individuals’ well-being, policy promotion, health equity, research translation, and workforce development in health care. Echoing Hector et al. (2011), I argue that a paradigm shift must occur in the healthcare field to produce efficient and effective health care that is affordable, accessible, and accountable to the people it serves. The healthcare system needs “policies and practices that connect and engage individuals, families, and communities to health care providers so that trusting and respectful relationships may be developed and positive health outcomes for all people achieved” (p. 2199).

1.1 Statement of the Problem

Notwithstanding the factors contributing to the healthcare crisis in the U.S., researchers have found that problems related to the healthcare crisis exist at multiple levels (CDC, 2009; Hector et al., 2011). For example, at the micro level, an individual must be actively engaged in receiving and participating in the management of her or his health care (Perez & Martinez, 2008). At the mezzo level, primary health care (PHC) providers and other health care experts have been at the center of health care rather than patients and family members (Hector et al., 2011). At the macro level, the World Health Organization (WHO) (2010) posits that healthcare systems must address the social determinants of health to improve the population’s health. Social determinants of health include aspects of an individual’s environment, learning capabilities, work history or employment, and the quality or risks of life (Healthy People.Gov, 2014 & CDC, 2016). These social determinants are broken down into five areas: “economic stability, education, social and community context, health and health care, neighborhood and built environments all of which affect health outcomes and influence policy choices” (CDC,
Hector and his colleagues (2011) contend that the healthcare system will only change when there are mutual respect and understanding of the patient and the healthcare providers’ roles and responsibilities.

Given the number of the uninsured people and the high rate of chronic diseases, South Carolina’s health care system has, for many years, been in an upheaval demonstrating woeful signs of deterioration at multiple levels (Krugman & Wells, 2009). Among the reasons for the decline is the rising cost of health care. Krugman & Wells (2009) argue that rising health insurance premiums and new medical technologies, advanced medications, and the increased costs of treatment have made the U.S. health care system extremely ineffective and inefficient. The U.S. health care divides people into insiders and outsiders.

Insiders are individuals who have enough insurance, and can receive modern medicine provided, regardless of the expense. On the other hand, outsiders are those individuals who have poor insurance or none at all, receiving very little medical care. In response to new medical technology, the system spends even more on insiders. However, it compensates for higher spending on insiders, in part, by consigning more people to outsider status—robbing Peter of basic care to pay for Paul’s state-of-the-art treatment. Thus, we have the cruel paradox that medical progression is bad for many Americans’ health. (Krugman & Wells, 2009, n. p.).

For the uninsured individuals in SC, who need and are seeking health care, there are few options. If an individual cannot pay out of pocket, most health care providers will not provide treatment, and typically some payment is required before
treatment. Health care providers will not provide treatment to uninsured individuals because usually there are additional health care services needed to diagnose adequately and treat patients. On the other hand, if the person is seeking treatment at the local hospital’s emergency room, the staff is mandated by federal law to provide medical attention to an uninsured individual. The Emergency Medical Treatment & Labor Act (EMTALA) mandates that the public must have access to emergency services care, even if they are unable to pay for it (Centers for Medicare & Medicaid Services, 2015). Therefore, the hospital must stabilize the patient and then transfer or refer him/her to an appropriate level of health care. In chapters 4 and 5, I will discuss some of the charitable assistance available to help patients with medical expenses and services. Unfortunately, these funds are minimal and typically available for emergencies or limited health care procedures such as outpatient surgery.

Adding to SC’s health care challenges is the lack of accessibility to health care in rural communities within SC, which represent nearly 30% of the population (U.S. Census, 2010). Fortunately, the state has 22 Federally Qualified Community Health Centers (FQCHC).

FQCHC are community-based, non-profit organizations that provide PHC prevention, education, and case management. These health centers accept most health insurance plans including Medicare and Medicaid. Additionally, they service patients without insurance, by rendering services provided on a sliding fee scale based on the patient's income (SC Primary Health Care Association, 2016).
The FQHC receives federal funding from the U.S. Department of Health and Human Services to help cover the expenses for uninsured patients and those who cannot afford to pay copayments and other costs related to their health care.

**An Intervention for Change**

For a sustainable change in the U.S. healthcare system to occur, I argue that healthcare experts must advocate for the integration of community health workers (CHWs) into primary health care systems and patients’ health care teams (WHO, 2010; CDC, 2012). CHWs facilitate and promote individual and community wellness by assisting in the prevention and management of chronic diseases (WHO, 2010; CDC, 2012). Integrating CHWs into healthcare teams and community-based prevention efforts can make significant contributions to strengthening and building community healthcare systems (Hector et al., 2011). Hector et al. (2011) argued that such changes could cause a shift “from a ‘sickness care’ system to a healthcare system that provides ‘comprehensive care’ system for individuals, families, and community and tribal wellness” (p. 2199).

Typically, there is no current established relationship between a person’s community and the health care system. This suggests that the health care a patient receives is sporadic and focuses only on addressing the sickness and not necessarily in promoting good health.

Globally, CHW programs have served as important strategies to address the rising cost of health care, the shortage of qualified healthcare staff, and the lack of accessible and affordable healthcare (Sanders & Lehmann, 2007; WHO, 2010; CDC, 2012). The CDC (2012) has cited three significant reasons why CHW programs are effective. First, CHWs are frontline public health workers, trusted members of their communities, and
individuals with a unique understanding of the communities and the people in those communities that they serve. Second, CHWs can function as bridges that link together individuals from the communities, healthcare providers, social service agencies, and other key stakeholders interested in fostering positive health outcomes by providing culturally competent services (CDC, 2012). According to the CDC (2016), cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations (CDC, 2016). The last reason is that CHWs help strengthens the capacity of individuals and the communities by working collaboratively with community members and stakeholders to ensure that stakeholders understand relevant problems and issues affecting these individuals and communities. In summary, CHWs advocate for healthcare solutions on behalf of the people and communities they serve (American Public Health Association, 2014; CDC, 2012; Perez & Martinez, 2008). Community health workers help strengthen and build community systems of care as members of healthcare teams and community-based prevention efforts, (Hector et al., 2011).

1.2 Study Relevance

The Kaiser Family Foundation (2014) reported at the time the state of South Carolina opted out of the Medicaid expansion under the ACA that there were approximately 765,000 uninsured adults in the state of South Carolina. The legislature’s decision not to expand Medicaid under the ACA meant that nearly 194,000 individuals who would have been eligible for Medicaid under ACA were denied immediate access to health care. These individuals do not meet the state’s requirements for Medicaid, and their incomes are too low to be eligible for the marketplace subsidies depicted in Figure
1.1. Additionally, approximately 189,000 individuals did not qualify for SC Medicaid or healthcare coverage because they are undocumented immigrants or persons with incomes that are too high to be eligible for the marketplace subsidies (Kaiser Family Foundation, 2014). Another 289,000 uninsured individuals meet the income requirement for 100-400% of the poverty level, qualifying them to purchase insurance through the marketplace.

Governor Haley (2012) argued the expansion of Medicaid under the Patient Protection and Affordable Care Act (PPACA) “ultimately hurts the poor, South Carolina, and the country by doubling down on a system that already delivers some of the lowest value in the world” (n. p.). Instead of taking the Medicaid expansion, Governor Haley and the SC State Legislature,

invested $176 million of new recurring state funds in Medicaid to enroll about 65,000 low-income children through Express Lane Eligibility, replace the one-time revenue with recurring sources, and expand the number of home and community-based placements available to our beneficiaries (Keck, 2012, n. p.).

The rationale for the investment was there was plenty money already appropriated to SC’s health care system, but funding needed to be reallocated for “non-productive to productive uses “(Keck, 2012, n. p.). Tony Keck (2012), the director of Medicaid, pointed out the state’s strategy focused on three areas: payment reform, clinical integration, and targeting hotspots and disparities.

1) Payment reform through initiatives placed more of the responsibility at the providers’ level and rewarded them based on their performance. An example is the Greenville Hospital System. The Greenville Hospital, Blue Cross-Blue Shield (BCBS), and the
Medicaid managed care partnered together to manage better the Medicaid patients. This resulted in shared responsibility for the structure, performance and case management of the Medicaid beneficiaries.

2) Clinical integration created with stakeholders focused on multidisciplinary care teams that integrate physical and behavioral health with long-term care services for 65,000 beneficiaries. Effective July 1, 2012, SC began reimbursing primary care practices certified as patient-centered medical homes 50 cents to $2 per member per month depending on certification status.

3) The Hotspots and Disparities focus is to layer Medicaid on top of other state and local government agency and private resources to address geographic, population and disease hotspots to improve health where it is needed most. The hotspot map in Figure 1.3 shows geo-coding analysis of hotspots in South Carolina Medicaid for a collection of diseases. This effort has cost-savings targets, which identified those hospitals at risk. In a survey of over 3,000 Medicaid beneficiaries, 32 percent reported multiple ER use in the past twelve months and 48 percent cited lack of convenient physician office hours as the reason for these visits (Keck, 2012, n. p.).

The Hotspot map in Figure 1.3 depicts low and high disease prevalence among Medicaid by Zip Code Tabulation Areas (ZCTAs). The top 5 diseases in SC for adults and children are included in this analysis. Adult disease indicates a recipient has, at least, one or more of the following conditions: cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD), depression, diabetes, and/or hypertension”(Child and Adult Medicaid Recipient Disease Hotspots, 2014).
Figure 1.3 Child and Adult Medicaid Recipient Disease Hotspots by ZCTA, 2014

Lopez-DeFede, Mayfield-Smith, and Stewart (2011) pointed out hotspots existing throughout the state. For example, hotspots in Lexington, Richland, and Marlboro counties accounted for all age groups. Lexington and Richland counties are urban whereas Marlboro is rural. Hotspots for adult Medicaid recipients exist in Lexington, Richland, Chesterfield, Marlboro, and portions of Beaufort County. Of these counties, Richland and Beaufort are urban. Lopez-DeFede and her colleagues highlighted these areas and determined these areas were also adversely affected by the social determinants of health.

During 2012-2014, the South Carolina Department of Health and Human Services (SCDHHHS) implemented several interventions to address the problems
related to the hotspots and to coordinate healthcare for the chronically ill, Medicaid recipients, the uninsured, and high utilizers of emergency rooms especially in the rural areas (SCDHHS, 2014). Table 1.2 depicts the initiatives, their purpose, CHW involvement, and the oversight partnerships. SCDHHS solicited requests for proposals and/or grants from health care providers at the local level to collaborate and create partnerships to develop and implement the initiatives (Table 1.2) in their local communities. Of concern to this study are the HOP and the CHW Medicaid Pilot Program because they both used CHW programs in the provision of services.

Table 1.2 SC Health Care Initiatives Adapted from SC Healthy Connections (2015)

<table>
<thead>
<tr>
<th>Health Initiative</th>
<th>Program Description</th>
<th>CHWs Involvement</th>
<th>Oversight/Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Outcome Project (HOP)</td>
<td>Created platform, structure and funding, to develop local partnerships and coordinated care for individuals who were uninsured, chronically ill and over-utilizing hospital emergency rooms.</td>
<td>CHWs were employed by PHC providers and worked between emergency rooms at local hospitals and PHC providers.</td>
<td>SCDHHS, local hospitals, FQHC, insurance providers, state agencies PHC providers partnered together.</td>
</tr>
<tr>
<td>CHW Medicaid Pilot Program</td>
<td>Improved patient care and health outcomes through compliance with health screenings, maintaining office appointments as well as in adherence to medication therapy. These individuals will interface with the clinical practice and the community where CHWs programs in 16-20 PHC sites throughout SC.</td>
<td>SCDHHS/HeART Initiative (50 members include physicians, nurses, CHWs, hospitals, insurance providers, FQHC, state agencies community-based and</td>
<td></td>
</tr>
</tbody>
</table>
| Free/ Hybrid Clinics | Enable a free clinic to become a Medicaid provider, and maintain its “free” clinic roots and mission.  

Provide medical care to low-income patients uninsured and Medicaid.  

Utilize paid providers, often supplemented with volunteers (providers and otherwise).  

Charge a fee for services on a sliding scale, which can allow for free care for the lowest-income patients. | N/A | SCDHHS/HeART Initiative (50 members include physicians, nurses, CHWs, hospitals, insurance providers, FQHC, state agencies community-based and social services organizations). |

---

First, the SC Healthy Outcome Plan (HOP) was approved by the General Assembly 33.34 to provide “healthcare providers a platform, structure and funding, to develop local partnerships for the coordination of care of individuals uninsured, chronically ill and over-utilizing hospital emergency rooms” (SC Healthy Connections Medicaid, 2014). The purpose of HOP is to coordinate the health care for uninsured...
individuals, improve the health of Medicaid beneficiaries across the state and decrease the cost of SC healthcare. HOP’s Triple Aims are; 1) to improve SC’s population health; 2) to improve patients’ healthcare experiences, and 3) to reduce the per capita cost of healthcare in the state. CHWs assist in the provision of a system of coordinated care for those uninsured, and individuals with chronic diseases. They connect individuals with PHC providers and help them access other medical services, such as medications, supplies, and equipment (Gayheart, 2014). The ultimate goal is to reduce the cost of emergency room care and improve patients’ health care.

The SCDHHS organized and implemented the Health Access at the Right Time (HeART), a collaborative initiative with approximately fifty stakeholders statewide (PHC physicians, the hospital association, FQHC, CHWs, insurance providers, community-based organizations (CBO) state agencies, and nurses). The aim of the HeART initiative was to identify and implement viable interventions to address Medicaid geographical hotspots within communities in South Carolina (America Public Health Association, 2014). Members of the initiative developed a variety of health care strategies to identify alternative health interventions and resources for Medicaid recipients and uninsured individuals across the state.

Second, the Medicaid pilot program established the reimbursement for approved CHW services in PHC (Gayheart, 2014). The SCDHHS also provided PHC providers a $6,000 grant for CHWs to receive education and training and certification as a CHW. The purpose of this CHW program was to support and assist individuals receiving Medicaid and to encourage those individuals to take responsibility and manage their health (Gayheart, 2010). CHWs helped patients follow medication and treatment
recommendations, and keep medical appointments, and they served as a liaison between patients, health care providers, and community members (HeART, 2014). The four goals of their CHW programs are 1) to increase the value of the partnership between the patient and the primary care physician. 2) To decrease emergency room visits and hospitalizations by improving utilization of primary care physician. 3) To enhance Medicaid recipients’ chronic disease management skills and engagement with primary health care providers; and 4) to reduce costs and improve health outcomes (HeART, 2014).

1.3 Study Purpose

The purpose of the study was to understand the nature of CHW program services, and the roles and responsibilities CHWs perform in primary health care settings in South Carolina. CHWs are frontline health workers and trusted individuals who work to understand the people they serve (HeART, 2014). The findings reflect implications for CHW training and practice in the field. Data inform the knowledge and competencies CHWs need to facilitate better health outcomes for the individuals, families, and communities who receive CHWs’ services. I argue that to affect sustainable change in health care at multiple levels; we need a better understanding of the complex dynamics that exist between primary health care providers and the diverse individuals and communities they serve. In this study, I explored three CHW programs in primary health care settings in SC to construct rich descriptions from the perspectives of CHWs, the healthcare teams, and the individuals receiving CHWs’ services.


**Research Questions**

The study was an ethnographic case study (Merriam, 2002) about CHWs in the context of three primary healthcare settings in South Carolina. The research questions guiding the study were:

1. What is a day in the life of community health workers?
2. What services do CHW programs provide?
3. In what ways do CHWs provide culturally responsive services?
4. How do individuals receiving CHWs’ services perceive these services?

**1.4 Study Significance**

This study contributed to several bodies of knowledge that inform CHW training or education and programs in healthcare. In this study, I addressed the day to day activities of three CHW programs in PHC, the services, the CHWs’ responsibilities and roles performed in the provision of services. I explored the link between CHWs and the diverse people working with and receiving CHW services and described the mechanisms in which they provide culturally responsive services. Also, I provided the perceptions of CHWs services from the perspective of the individuals affected by the services, the patients, family and healthcare professionals working with the CHWs.

Researchers have demonstrated that CHW programs were effective in increasing positive health outcomes for persons with chronic diseases (WHO, 2010, CDC, 2012). Other researchers have suggested that CHWs provide culturally appropriate services, yet it is unclear how CHWs accomplish culturally responsive services. It is important to know the particular ways in which CHWs use their knowledge and skills to connect with
diverse patients and communities’ cultural backgrounds, traditions, and beliefs to affect better health outcomes. This study’s findings reflect implications for encouraging healthcare providers to work closely with CHWs and other healthcare team members to ensure culturally responsive delivery within communities for the prevention and management of chronic disease.

In summary, the study provides insight into CHWs’ service delivery from the perspectives of the diverse people and groups receiving CHWs’ services. I believe it is not only crucial for CHWs but also, other healthcare providers, to have an understanding of the human and cultural diversity of their patients to assist them in achieving better health outcomes. The study provides an understanding of the practical as well as the cultural mechanisms in which CHW programs operate in PHCs. As such, the findings reflect implications for understanding the roles, responsibilities, and duties of CHWs, as well as the critical issues CHWs encounter in PHCs. I present here a rich, detailed description of the CHWs in three PHC sites in SC, in hope that this study will help inform people regarding the resiliency of marginalized people and to help them understand the meaningful work CHWs perform. I also showcase the importance of collaborative efforts between healthcare professionals, groups, policy makers, state, local, health care, social services, and community-based organizations for social change in SC’s health care.
Chapter 2

Conceptual Framework

The conceptual framework acts as a guide for the research study. It may include the relationship between assumptions, beliefs, variables and theories (Miles & Huberman, 1994). In this study, I used three components identified as being essential to constructing a conceptual framework (Maxwell, 2005). First, I discuss how my experiential knowledge (i.e., personal, professional and educational experiences), positionality, critical reflexivity and personal assumptions have informed this study (Lincoln & Guba, 2013). Second, I share a rich body of knowledge from critical race theory (Delgado and Stefancic, 2012), culturally responsive pedagogy (Gay, 2000, 2002 & 2010), and CHWs as educators (Berthold, Miller & Avila Esparza, 2009). This body of knowledge is interdisciplinary from the fields of law, education and social work that informs my work and provides a context for this study. Finally, I review the literature related to the history of community health workers (CHWs) and services in primary health care (PHC) settings.

2.1 Situated Knowledge and Assumptions

Maxwell (2005) explained that traditionally a researcher's background, identity, and experiences were framed as biases that negatively affected the study’s findings. However, qualitative researchers have argued that one can not separate one’s self, nor
one’s real world experiences, from the research process. According to Maxwell (2005), “any view from someone’s perspective is shaped by the social and theoretical lens of the observer” (p. 39). There is no objectivity. Maxwell posits that researchers must be able to identify the influence of experiential knowledge and assumptions about thought processes and analysis of data. Knowledge of this process helps readers understand how the personal experiences of the researcher can influence study results. After all, experiential knowledge is lived experience. It is a way of knowing that incorporates actual experiences from which researchers ascribe meaning—the ultimate goal of qualitative research (Berg, 2008).

Personal Experiences. It is not a coincidence that I come to this study about CHWs in a primary healthcare setting. I believe it is the universal order my life, to learn and grow personally and professionally from this experience. I am included among the one in four people, in the U.S., diagnosed with a chronic disease. I am a diabetic. Nearly twelve years ago my doctor prescribed for me two forms of insulin that I needed to take three times a day. He included instructions for a particular diet to assist in the management of my disease. Approximately two years later, I continued the struggle to lose weight and manage my blood sugar levels. In hindsight, my lack of progress was directly related to not having access to the necessary tools and information I needed to make better choices (i.e., healthier food, exercise, etc.). At a deeper level, I lacked self-awareness. Once there was self-awareness, I acknowledged and accepted responsibility for the micro (personal) level reasons why I was unhealthy.
Now, I have realized that there were risk factors that influenced my overall health status, too. Those risk factors included my family heritage and medical history of diabetes, obesity, and high blood pressure. Likewise, race/ethnic disparities and the socioeconomic status in which I grew up resulted in limited access to healthier food choices and regular healthcare. On a broader level, factors such as the historical and sociopolitical contexts, policies, and practices I encountered while growing up in the 1960s played a role. Moreover, knowledge of health care was much more limited during that period.

Today, there is an increase in awareness of how family medical history, diet and exercise can prevent chronic diseases. Rogers (2013) contends that one should not assess or consider individuals solely based on their behaviors. One must examine the influence of factors beyond the control of the individual. This approach is the person-in-environment perspective which involves micro, mezzo, and macro factors that impact all our lives (Rogers, 2013).

**Micro Level**

The micro level is the individual’s characteristics, gender, race, age, medical history, and psychological and cognitive development, as well as SES and disability status (Rogers, 2013). According to the American Diabetes Association (2015), because I am an African-American woman, I am nearly two times more likely than people in other groups to develop diabetes.

**Mezzo Level**

The individual’s immediate cultural environment is the mezzo level. This level includes family members, friends, colleagues, cultural heritage, background, community,
work environment, social institutions systems, and access to resources at the local level (Rogers, 2013). Growing up in the South, my cultural traditions, lifestyle, social activities, and professional environments all center around food. On any given day or holiday, I am confronted with many more opportunities to eat unhealthy food than to eat healthy food. I have found that making healthier food choices is more difficult when family; friends, co-workers, and others encourage and reinforce unhealthy eating. Still, unlike millions of people in the U.S., for most of my adult life, I have had access to healthcare. During my childhood, I did not go to a doctor for regular checkups, and I seldom recall going to a physician when I was sick. This may help explain why I have never felt comfortable with my doctors. I do not think I ever seriously managed my health positively until I finally connected with a physician, Dr. Carter, whom I now understand provided me with culturally responsive health care (Gay, 2010).

Dr. Carter spent time talking with and getting to know me. We not only discussed my medical history; we discussed all aspects of my background, as well as my personal, family, social, emotional, spiritual, educational, and professional life. I believed that Dr. Carter’s attention to detail and her genuine interest in me (culturally responsive approach) would lead to an improvement in my health status. She began by asking me to think about what I wanted for my life. She then asked me to envision the physical, mental, and spiritual health I would need to realize my goals. Using the information relevant to me and from my cultural background, Dr. Carter helped me identify and set realistic SMART (Specific, Measurable, Achievable, Realistic and Time-phased) goals. Within 30 days, I had lost ten pounds, and my blood sugar levels began to decline. I am no longer in need of insulin. A year after meeting Dr. Carter, I had lost nearly 100 pounds and increased my
exercise regimen that lowered my A1C\textsuperscript{2} levels. The lower A1C levels resulted in a change in my medication status from taking insulin three times per day to a pill, Metformin 100 mg., on an as-needed basis (Pro Re Nata). I may always have a diagnosis of diabetes; however, I have successfully managed my health. Furthermore, with Dr. Carter’s medical guidance, care, and concern, I will continue toward my goal of optimal health.

My healthcare plan includes remaining insulin-free. I now look forward to going to the doctor for my routine check-ups. I now feel empowered to seek primary health care providers who support and encourage me, and to ask and get answers to my questions about my wellbeing. Moreover, I see my physician as a collaborator working with me to ensure a holistic approach to my health.

**Macro Level**

The macro level consists of broader social factors that impact an individual’s life and health status (Rogers, 2013). Included here are governmental and systems’ policies and practices, educational policy, media, societal norms, economic conditions and opportunities (Kirk and Okazawa-Ray, 2010). I believe these macro-level factors can inhibit an individual’s health status because of the historical, social, and political progression of healthcare systems in the US. For example, traditionally, the U.S. health care systems have not empowered patients to manage their health (Funnell, 2000). Historically, healthcare policies and practices and knowledge about a patient’s health

\textsuperscript{2} The A1C “reflects your average blood sugar level for the past two to three months. Specifically, the A1C test measures what percentage of your hemoglobin — a protein in red blood cells that carries oxygen — is coated with sugar (glycated). The higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications” (Mayo Clinic, 2015, n. p.).
belonged to the doctors and other medical staff (Funnell, 2000). Healthcare providers dictated what the patient was to do, and the patient played a passive recipient role. Healthcare experts insist a paradigm shift must occur for patients and healthcare providers to work as a team to ensure better health outcomes for patients (CDC, 2012). While I think making this shift in healthcare policies is essential, I also believe that in addition to teamwork, there are factors that influence health outcomes. I will discuss other factors below in more detail.

**Educational and Professional Experiences.** I am a first generation college graduate with bachelor and masters degrees in social work. As a social worker, I have been afforded the opportunity and privilege to work with many diverse individuals, families, groups, and communities in a variety of settings. These settings include a child welfare agency, a mental health hospital, a women’s prison, a residential substance abuse treatment program for women and their children, and several non-profit community-based service organizations. I have always worked with people from diverse cultural, racial and ethnic groups, which have helped shape and mold me to become the person I am today.

After thirty plus years of social work practice, I entered graduate school to pursue my doctorate. I wanted to learn methods and ways of thinking that would enable me to promote systemic change. I am interested in the type of change that allows people to live, work, and socialize in a world where everyone has respect, dignity, and opportunities for justice. I firmly believe that many of the people, whom I have worked with, were doing their best despite policies and practices that may have marginalized them. Given the complexities of the multilayered systems within our communities, I believe professionals,
regardless of their disciplines, who are committed to social justice, require a broad spectrum of knowledge and practical skills to affect social justice. I argue that we cannot affect social change, such as healthcare reform, only at the individual level. Rather, change agents must be active advocates and adopt models and interventions to initiate systemic change at all levels: micro, mezzo, and macro.

I am currently a doctoral candidate in Educational Foundations and Inquiry (EDFI). I am gaining knowledge of the perspectives and methods of multidisciplinary approaches to affect and sustain social action and change. Through my scholarship in EDFI, I have significantly expanded my worldviews to include applying an interpretative, normative, and critical lens to my practice (Phillips, 2010). This study about CHWs provided me a unique opportunity to draw on the scholarship of education, social work, and healthcare, in addition to qualitative inquiry, the use of multiple theories, and various approaches to learning. In doing so I collaborated with practitioners, policy makers, educators, researchers and other allies to inform, teach, educate, create, and critique interventions and strategies that promote better health outcomes for diverse people, and communities.

I became interested in conducting research about CHWs through my role as an instructor at Midlands Technical College in South Carolina. I taught a six-week educational and training course for individuals seeking certification as a CHW. In my role as an instructor, I have gained insight into the educational and training needs of CHWs from multiple perspectives. I frequently discussed recommendations for the design of the state’s certification training program with students, employers, and other HeART initiative stakeholders. As an instructor and contributor in the development and
design of the CHW curriculum, I administered the certification exam to students statewide.

The culmination of my educational, personal and professional experiences provides the technical knowledge needed to interpret and make meaning of the data gathered during this study (Maxwell, 2005). I believe my experiential knowledge will help strengthen and facilitate understanding of the cultural factors that exist with PHC providers and the diverse patients receiving CHW services. On a personal level, it is important to help inform healthcare and social service systems, administrators, providers, CHWs, and patients about ways to work collaboratively to promote better health outcomes in our communities.

2.2 Theoretical Framing

The theory is “a set of organized principles about particular events in the real world” (McKeachie, 1976, p. 829). Researchers use theory to expand findings from the study to a place within the broader world (McKeachie, 1976). Bennett (2008) defined theory as a systematic process of “thoughts, concepts, and ideas, inductive and deductive that express a hypothesis that can be tested to explain or predict phenomena” (p. 5). However, the goal of qualitative research is not to test a hypothesis, nor is it to make predictions. Rather, it is to make visible real world experiences (Denzin & Lincoln, 2013). Depending on its use, theory comes in many shapes, sizes, forms, and types (Schwandt, 2007). For example, social theories provide clear distinctions between the social and cultural factors related to real world experiences (McKeachie, 1976). McKeachie (1976) identified four primary functions of theory. A theory is 1) a framework for research to prevent data collection that does not contribute to an
understanding of the topic of inquiry; 2) a way to organize knowledge into a framework for specific items of information; 3) the identification of the complexity and subtlety of events, whereby an idea or concept such as “discrimination” entails unequal treatment, unfairness, pre-conceived ideas, and prejudice of others; and 4) a way to reorganize prior experiences, and add new principles, rules, concepts and explanations for an event. For instance, I use culturally responsive theory advanced by Gay (2000, 2002, & 2010) for culturally responsive teaching as a framework to identify the mechanisms in which CHWs provide culturally responsive services in PHC.

Many qualitative researchers prefer not to begin their studies with defined theoretical perspectives (Schwandt, 2007). Rather, the researchers allow the data to drive the development of theory. For this study, I used both emic and etic perspectives to address the research questions. An emic approach reflects an “insider’s” view. This includes language, concepts, or ways of expression used by the members of the cultural environment. An etic approach “uses the concepts and scientific language by researchers to refer to same phenomena of CHW in PHC” (Schwandt, 2007, p. 81-82). Table 2.1 presents research questions one, two and four that center on the experiences of the people in the context of CHW programs in PHC for explanations to the research questions. In Table 2.1, research question three represents an etic approach for which I use a culturally responsive theoretical framework to guide my coding and analysis of data to answer the question.

First, critical race theory (CRT) informs my understanding of the historical racial and social, economic class disenfranchisement that exists within the policies and practices in health care and other social systems (Delgado & Stefancic, 2012). I argue
that CRT is a valuable tool to contextualize CHW programs in PHC in South Carolina. Second, I discuss the CHW education and training model to inform my understanding of one of the multidisciplinary roles CHWs perform as educators on a broad range of topics. (Berthold, Miller, Avila-Esparza, 2009).

Table 2.1 Research Questions Emic/ Etic Approaches

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<th>Research Questions (RQ)</th>
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<td>1. What is the day in the life of CHWs?</td>
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<td>2. What services do CHW programs provide?</td>
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<td>3. In what ways do CHWs provide culturally responsive services?</td>
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<td>4. How do individuals receiving CHWs’ services perceive these services?</td>
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Third, I use cultural responsiveness (Gay, 2000) as a theoretical framework in which to consider the ways in which community health workers in PHC provide culturally responsive services.

**Critical race theory (CRT).** CRT and intersectionality, in particular, are valuable tools that helped me to contextualize and prepare for this study. In fact class and the intersection of class, male gender, and race were prominent among the patients receiving CHW services. In Chapters 4 and 5, I represent intersectional disenfranchisement. CRT is a global movement based on the history of racially marginalized people’s resistance to domination and oppression perpetuated by dominant groups (Delgado & Stefancic, 2012). According to Taylor, Gillborn, & Ladson-Billings (2009) the purpose of oppression is to sustain systems of racial, economic, and socio-political dominance.
Hegemony aids in the processes of maintaining oppression (Gramsci, 1971). Critical legal scholars and critical race theorists incorporated Gramsci’s (1971) idea of hegemony in their theoretical work on race, racism, and the dominance of white supremacy in the United States (Crenshaw, 1995). Hegemony is the domination of people’s minds where they unknowingly consent to a dominant group’s beliefs, systems, and oppressive practices as if they were their own (Bates, 1975). CRT scholars argue that racism and other “isms” are both conscious and unconscious (Delgado & Stefancic, 2012). Individuals may overtly demonstrate attitudes and behaviors that intentionally or unintentionally discriminate against people based on their race, or other identities. According to Delgado and Stefancic (2012), racism is maintained and perpetuated through the ideologies and practices in ordinary, everyday activities that are often invisible but are extremely powerful. Marginalized people unconsciously accept and consent to this imbalance of power. CRT scholars have argued that racism is normal, ingrained and fixed within the U.S. culture.

During the 1970s, CRT scholars Derrick Bell, Alan Freeman and others argued that the U.S. legal system exemplified and reinforced racism through rulings that maintained discriminatory laws (Taylor, Gillborn, & Ladson-Billings, 2009). Critical legal scholars asserted that the U.S. judiciary system and legal discourse must change to ensure social justice (Taylor, Gillborn, & Ladson-Billings, 2009). As a theoretical framework, CRT scholarship reflects ways to incorporate praxis and examine and analyze the influence of race on people of color. CRT scholars posited that race was a mechanism of power and dominance maintained by institutions of white supremacy that divided
people into groups based on their skin color and physical attributes and privileged Whites over other racial groups (Taylor et al., 2009; Delgado & Stefancic, 2012).

CRT scholars suggested that people of color experience oppressions that intersect with gender, class, national origin, and sexual orientation, and analyzed the intersectionality of such oppressions (Delgado & Stefancic, 2012). Critical race theorists insisted that understanding oppression at the intersections of multiple identities required “an examination of race, sex, class, national origin, and sexual orientation and their interactions in various settings” (Delgado & Stefancic, 2012, p. 57). By examining intersectionality, we can uncover the economic, social, and political contexts in which dominance operates based on individuals’ multiple identities. The intersection of race, gender, class and other identities may manifest in complex and harmful ways (Howard, 2008). For example, O’Conner (2001), who demonstrated that the process of receiving public assistance, especially for women of color, keeps them embroiled in cycles of poverty, invites us to consider a Black female who is employed but uninsured by her employer. Underpaid by that same employer she is unable to access health care without jeopardizing her access to food and shelter. If she is unemployed, she would likely qualify for Medicaid and other public assistance.

According to Delgado and Stefancic (2012), CRT scholars recognized that those in power portray the appearance of equality and humanity when it benefits them. One tenet of Critical Race Theory is interest convergence. Interest convergence occurs when the dominant group appears to function in a way that is socially responsible by taking action on behalf of marginalized groups but in fact only takes such action because in doing so the dominant group benefits. That is to say, to do so is in the dominant group’s
best interest. CRT scholars argued that racism advances the dominant groups’ interests materially by privileging the White elite and middle class. People of color have been exploited throughout the history of the U.S., regardless of changes such as civil rights legislation (Bell, 1992, Delgado & Stefanic, 2012). In this way, racial hierarchies determined who gets the best housing, access to the best schools and jobs with benefits such as health insurance.

Due to the hegemonic capitalist policies within healthcare systems, policies that require people with low or no income, living in poverty and uninsured to obtain health care in emergency rooms (ER). The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 ensures that people seeking health care treatment in hospitals’ emergency rooms are screened and stabilized regardless of their ability to pay (Zibulewsky, 2001). The purpose of the law was to prevent discrimination and hospitals from “dumping or transferring individuals to other facilities, who could not afford to pay without considering their health status” (p. 399). While hospitals have traditionally received funds for the expense, uncompensated expenses for EMTLA have skyrocketed over time (Zibulewsky, 2001). Due to the increasing numbers of the uninsured and changes in the U.S. healthcare system and to health management organizations (HMOs), this strategy is no longer effective. Because many people who are uninsured or underserved are forced to seek health care at the emergency rooms, policy makers and critics, place the blame the rising cost of health care in part due to the poor and uninsured individuals (Kaiser Family Foundation, 2014).
Critical race theory helps me to consider the ongoing rhetoric that often blames marginalized individuals for problems. Many of the individuals in this study lived in rural and urban communities where primary health care was not available. If it was available; often individuals lacked the health insurance to cover the cost of PHC services, medications and other treatments they needed to manage their health. Similar to the barriers and inequities students of color and with low or no income experience in education systems that result in low achievement, individuals in the study encountered health care inequalities that contributed to negative health outcomes. CRT prompted me to pay attention to structural elements that I discuss in Chapters 4 and 5 that highlights unemployment, the lack of transportation, jobs, education and the ways in which PHC systems track the uninsured and Medicaid population.

In addition, CRT scholars generate not only theoretical tenets but also critical race methodology (Solórzano & Yosso, 2009). Although I did not use tenets from CRT in an apriori framework for this study, the scholarship from the field and the methodology inform the ways I think about issues of race, racism, class and classism in the United States. According to Solórzano & Yosso (2009) critical race methodology

a) Foregrounds race and racism in all aspects of the research process…
b) challenges traditional research, paradigms, content, ideologies, and explanations… c) offers a liberatory or transformative solutions to racial, gender and class subordination and d) focuses on the racialized, gendered and classed experiences… (p. 23).

By challenging the dominant ideologies of social institutions, for example, education and healthcare systems, CRT scholars demonstrated ways in which such systems were not
neutral or objective, and did not provide equal opportunities for all people (Taylor, Gilborn, Ladson-Billings, 2009). They argued that such systems disseminate majoritarian narratives\(^3\), which served as smokescreens to hide self-interest, power and privilege within the systems. CRT scholars work to honor people of color’s ways of knowing and methodologies, at times eschewing the scientific practices of dominant groups (Delgado & Stefancic, 2012).

People of color “value experiential sources of knowledge that reflect their lived and cultural experiences” (Delgado & Stefancic, 2015 p. 10). Critical race methodologies include story-telling, counter-narratives\(^4\), parables, songs, poetry, and other forms of expression that authentically capture the essence of lived experiences for people of color (Solo’rzano and Yosso, 2009, p. 133). For example, lay healers and CHWs are knowledgeable about the economic, social, and political factors that contribute to health care barriers for people they serve (APHA, 2012). Analogously, many of the CHWs’ patients value experiential knowledge for healing. Praying, spirituality and faith, storytelling, songs, poetry, and other forms of expression that authentically represent their cultural background omitted from the dominant treatment practices (Berthold, Miller, Avila-Esparza, 2009).

Of utmost significance to this study are the commitments to social justice CRT scholars would support. They denounced all forms of dominance such as racism, sexism, classism, and ableism (Delgado & Stefancic, 2012). Delgado and Stefancic (2012)

\(^3\) Majoritarian narratives are the stories that portray “the majority culture attitudes should hold sway” (Delgado & Stefancic, 2012, p. 166).

\(^4\) Counter-narratives are” writing that aims to cast doubt on the validity of accepted premises or myths especially ones held by the majority. “(Delgado & Stefancic, 2012, p. 159).
asserted that all people oppressed “share the effects of abuse [and] although each group form of oppression may differ, they must have clear strategies for social change.” (p. 630). CRT informs this project through the ways it allows me to identify racism as both insidious and deeply embedded within systems of both education and health care. In particular, studying the tenet of interest convergence has taught me to question policymakers’ and governmental agencies’ policies that may not be in the best interest of the people they serve. Because of CRT’s strong advocacy and commitment to equality and social justice for all people, I argue that CRT provides an informative lens for considering CHW programs in PHC because it centers on racism and classism, allowing us to review policies and practices that marginalize the people they are intended to help.

**Cultural responsiveness (CR).** CHWs are diverse individuals, educated, trained, and certified to provide a broad range of health-related services. These services include health education to diverse individuals, groups and communities; culturally responsive teaching and practices are appropriate approaches to consider. According to Gay (2010), although called by many different names including culturally relevant, sensitive, centered, congruent, reflective, mediated, contextualized [competent, humility] and responsive, the ideas of why it is important to make the classroom instruction more consistent with the cultural orientation of ethnically diverse and how this can be done, are virtually identical (Gay, 2010, p. 31).

Culturally responsive pedagogy (CRP) began in the educational systems as an effective teaching strategy to address the education of diverse students and reduce the achievement gaps among students of color and those with lower socio-economic status (Gay, 2000).
Culturally responsive teaching is using the cultural knowledge, prior experiences, frames of reference, and performing styles of ethnically diverse students to make learning more relevant to and effective for them. Culturally responsive teaching is behavioral expressions of knowledge, beliefs and values that recognize the importance of racial and cultural diversity in learning (Gay, 2010, p. 31).

In other words, CRP honors the cultural backgrounds of all ethnic groups to ensure meaningful teaching and learning experiences for students. To do so, Gay (2000) suggested educators must create a community of learning that builds on the strengths, values, and cultural and family heritages, to guide the development and implementation of curricula. Teachers create a classroom climate that facilitates active caring, supportive relationships with students and “challenges racial and cultural stereotypes, prejudices, racism and other forms of injustices and oppression” (p. 31). Through the design of curriculum and instructions, teachers build on students’ relevant home and school experiences and integrate academic experiences to facilitate real-world application (Gay, 2000). These CR teaching practices yield six attributes that are validating and affirming, comprehensive, multidimensional, empowering, transformative, and emancipatory for diverse students (Gay, 2000). Below is a brief description of the attributes. I provide a detail description in chapter 5.

1). Validating and affirming by acknowledging and respecting the legitimacy of the cultural heritages of different ethnic groups, both as legacies that affect students’ dispositions, attitudes, and approaches to learning and as worthy content to be taught in the formal curriculum.
2) Comprehensive enables teachers to develop intellectual, social, emotional, and political learning by using cultural resources to teach knowledge, skills, values, and attitudes—in other words—they teach the whole child.

3) Multidimensional encompasses curriculum content, learning context, classroom climate, student-teacher relationships, instructional techniques, classroom management, and performance assessments.

4) Empowering helps students to be better human beings and learners that are more successful. This means having the confidence and competencies to achieve academically or socially to better themselves.

5) Transformative means helping students gain the knowledge, skills, and values that enable them to be advocates for themselves and communities.

6) Emancipatory is liberation. It releases the intellect of students of color from the constraining manacles of mainstream canons of knowledge and ways of knowing (Gay, 2010 pp. 31-38).

Similarly, Kea and her colleagues (2006) argued most educators need the training to prepare them to teach a broad range of diverse students. Therefore, diversity should be an integral part of the curriculum conceptualization and design (Kea, Campbell-Whatley & Richards, 2006). Cultural responsiveness should be transparent in all aspects of learning. For example, CR is needed within the description of the course and objectives to promote students’ awareness of their diversity and relates to the course topic. Training and all course materials, content areas, readings, exercises, activities, assignments, and projects should reflect diverse contributors and opportunities for students to explore content about diversity. These learning activities include “personal
history and family bios help students to understand their history and promote the development of their awareness of their identities and values” (Kea et al. 2006 p. 10). Students’ learning about “their history and the experiences of diverse groups helps them to learn about themselves as well as others and to understand better that personal views are not universal” (p. 10).

Because CHWs work with diverse people and they, too, are diverse. CHWs are uniquely situated to understand and appreciate the relevance of culturally responsive services. I believe many of the individual's CHWs work with, or they have experienced society’s oppressive practices of racism, classism, sexism, ableism and other “isms.” I know firsthand accessing health care, social services, and other systems require a set of skills. This can be challenging for professionals and even more so for the people we serve because of the many rules and criteria that one must follow to obtain needed services. There is not a process or system that enables individuals to qualify for multiple services. Each local, state and federal governmental agency, health care and social services organizations have their application and approval processes.

It is important for CHWs to understand human and cultural diversity to help individuals get the necessary health care, services, and resources. CHWs receive training to practice cultural humility and to become culturally competent (Berthold, Miller, Avila-Esparza, 2009). Cultural humility involves studying and understanding the histories of diverse people’s experiences with oppression and discrimination. It entails reflecting on one’s biases, prejudices, past experiences and assumptions about diverse people. CHWs learn how to resolve and set aside their biases to treat all individuals with dignity and
respect. CHWs are taught clients/patients are in charge of their lives and have valuable information that can help CHWs provide appropriate services they need.

Social services and health care systems frequently implement cultural competency policies. The Health Resource and Services Administration (HRSA), 2011) defined competency culturally as a “set of behaviors, attitudes and policies that come together within a system of professionals to facilitate the systems and professional to work effectively with different culture groups” (p. 17). Culturally and Linguistically Appropriate Services (CLAS) are “standards for health care systems and individual providers to encourage cultural and linguistically accessible health care services for all people. The federal regulations require all health organizations receiving federal funds to implement CLAS. The CLAS standards consist of fourteen themes organized around cultural competency, language access services, and organizational support for cultural competence.

The HRSA (2011) illustrated three fundamental concepts, empathy, curiosity and respect for cultural competency when working with diverse people in community and health care settings. Barriers to cultural competency include “cultural blindness, shock, conflict, imposition, ethnocentrism, racism, and discrimination” (p. 13). CHWs have available to them a cultural competency toolbox available through HRSA. It provides information that suggests ways to

1) Identify and be aware of their cultural values; 2) Remove the stigma that limited use of the English language indicates limited intelligence. 3) Encourage diverse people to communicate through stories, allow and encourage storytelling; 4) understand CHWs do not have to know everything
proficiently but recognize their cultural value. 5) Seek help from co-workers and others who are bilingual or have bicultural skills; and, 6) Find ongoing training in cross-cultural communication as culture evolves (HRSA, 2011, p. 14).

**CHWs as educators.** CHWs require a multidisciplinary approach for the provision of CHW services much like scholars who study in Foundations of Education (Provenzo, 2008). Analogous to the education system in this study, the patients reflect similarities to students of color who live with low or no income and who face barriers and inequalities in schools. In this case, in health care patients of color who live with low or no income, face barriers, and inequalities in the health care system. Much like teachers in educational systems, CHWs educate a broad range of individuals at multiple levels. They teach patients, family members, healthcare and service social professionals in a wide range of topics related to the context of the patient. A primary role of the CHW is to educate patients for them to gain the knowledge and skills to manage their physical, mental and spiritual well-being.

One of the five identified services models for CHWs is a health educator (Berthold, Miller, Avila-Esparza, 2009). As a health educator, CHWs facilitate individual and group education and training in a variety of settings including patients’ homes, community centers, and doctors’ offices. According to Berthold and his colleagues (2009), CHWs provide education and training in a broad range of topics. Many of the topics relate to health care such as chronic illness, infectious diseases, reproductive health, and behavioral changes. Also, they learn violence prevention, healthy relationships, civil and human rights, stress management, and environmental and
occupational health. CHWs acquire new skills to promote teamwork and community building and to support the community planning and organizing (p. 459). CHWs educate individuals, families, patients, youths, parents, co-workers, faith groups, community members, health care professionals, teachers and all others within the environment CHWs work (p. 459).

CHWs themselves receive education and training in a broad range of topics that help prepare them for their multiple roles and responsibilities (HRSA, 2011). For their role as an educator, CHWs receive training on different approaches to learning. For example, CHWs are informed about Paulo Freire’s (1970) philosophy of transformative education and “conscientization,” the process of developing a critical consciousness about the social and political realities (p. 458). The focus is for educators to encourage and empower learners to engage actively in identifying, analyzing, and developing strategies addressing problems that affect them or their communities economically, socially, and politically (p. 458).

Lastly, much like other educators, CHWs also receive training in how to design curricula, establish learning goals and objectives, content areas, activities, and also the logistics of education and training (Berthold et al., 2009). As an instructor for the CHW certification programs, I train CHWs how to manage a classroom and instructional strategies that are relevant to the people they serve. For example, CHWs in my class plan a menu and grocery list for a week and then go to the grocery stores in communities ranging from low to high incomes to price the groceries. Afterward, they process with the class their experiences, costs, availability of items, and the challenges they may have encountered trying to purchase inexpensive healthy food. The purpose of this assignment
is teaching CHWs to meet their clients/patients where they are and in doing so, they can provide culturally responsive education and services.

### 2.3 Review of the Literature

In this section, I examine the relevant information and studies on community health workers (CHWs) in primary health care settings to contextualize my research. The purpose of this study was to gain insight into the provision of CHW program services in PHC settings in South Carolina. I focused on 1) identifying and describing the CHW program services, roles, and responsibilities; 2) collecting data to represent a day in the life of a CHW; 3) identifying the ways patients perceive CHW services, and 4) describing the mechanisms by which CHWs provide culturally responsive services. For the literature review, first, I provide an overview of the history of CHW programs globally and nationally in the U.S. to establish the context of the study. Second, I include a description of the CHW workforce and models of services, using empirical studies to situate the need for the study. Third, I synthesize relevant studies and address cultural responsiveness and related concepts in the context of education and PHC. I conclude each section with a discussion about the gaps in the literature and situate this study in the literature.

**Overview of the history of community health workers.** According to Berthold, Miller, Avila-Esparza (2009) community health workers originated from lay healers, community members that provided medical care and treatment for the sick. The first trained lay healers were the “fledshers” who provided medical care to rural communities to fill the void caused by a lack of physicians in Russia during the 1800’s (p. 26). During the 1920-30s, the first CHWs were known as the “barefoot doctors” (due to their inability to afford shoes) in Ding Xian, China (p. 26). The Chinese government began training
villagers to provide necessary medical care after urban doctors refused to live and work in poor conditions (Berthold et al. 2009; Perry, 2013). Dr. John Grant with the Peking Medical University and Jimmy Yen, a Chinese community development specialist and adult educator, trained villagers on medical procedures (Berthold et al., 2009; Perry, 2013). This education and training resulted in the barefoot doctors’ documentation of births and deaths (Perry, 2013). In the 1930s, this information provided valuable insight into the high infant mortality rate of 200 per 1,000 and a low life expectancy rate of 35 years (Perry, 2013). The program grew and, by 1972, there was an estimated one barefoot doctor per 800 individuals living in China.

The concept of community health workers originated with the Christian Medical Commission (CMC), a unit of the World Council of Churches whose members envisioned new approaches to healthcare in developing countries (Perry, 2013). Perry (2013) contended that the Western medical model of training physicians and healthcare professionals failed to meet the healthcare needs of rural and poor populations globally. Innovative approaches such as the barefoot doctors and other auxiliaries aimed at addressing health care inequalities worldwide influenced the creation of the Christian Medical Commission. The primary goals of the CMC were to develop new approaches to health care using principles of social justice, equity, community participation, prevention, and multi-sector collaboration. An important goal was to decentralize health care services to ensure that people received services from their communities and community members.

The foundation for primary health care (PHC) was the center of focus at the first International Conference on Primary Health Care Conference in 1978. In attendance at the conference were members of the World Health Organization (WHO) and the United
Nations Children’s Fund (UNICEF). The “conference resulted in the Declaration of Alma-Ata” (p. 2). The Declaration of Alma-Ata was a call to action for “all governments, health and development workers, and the world community to protect and promote the health of all people of the world” (p. 2). Article I included a definition of health care as a human right and one that encompassed physical, mental and social wellbeing, not only the absence of disease or infirmities. Health care is a fundamental human right with the attainment of the highest level of health the most important social goal globally that requires action from social and economic sectors other than the healthcare (Declaration of Alma-Ata, 1979, p. 3).

Articles VI and VII of the Declaration of Alma-Ata included a detailed description of how PHC functioned. It outlined and rated essential health care based on practical, sound, scientific and socially acceptable methods and technology accessible to individuals and families in communities and at a cost that the community and country could afford to maintain at every stage of health care provision. According to Article VI, primary health care was the first level of contact with individuals, the family, and community. The Declaration of Alma-Ata stipulated that each nation ensure that health systems were “as close as possible to where people live and work” (p. 3).

According to Article VI, primary health care needed to apply relevant services and experiences to address economic conditions, as well as sociocultural and political factors of the community. In addition, PHC should address main health problems in communities by working to provide education and services focused on cures, prevention, and rehabilitation, while also promoting self-reliance and community participation. Primary health care providers needed to deliver services while giving the greatest priority
to where there was the most need. The endorsement of CHWs by primary health care providers, thirty-seven years ago, increased interest in the creation of governmental programs to address health care worldwide (Berthold et al., 2009; Perry, 2013; WHO, 2012). It is important to note that nearly thirty-seven years after the first international PHC conference, South Carolina, and other states are beginning to provide preventive health care and health treatment for community members. These services address “environmental, social, and cultural issues that impact individuals and communities' health” (Perry, 2013, p. 3). The South Carolina healthcare system is currently piloting the integration of CHW programs in PHC (Gayheart, 2014).

**The history of community health workers’ programs in the United States.**

CHW programs in the U.S. date back to the 1950s when Native American and migrant workers’ coalitions addressed the lack of access to health care in rural communities (Perry 2013). The Federal Migrant Act of 1962 provided health care clinics within migrant labor camps (Berthold et al., 2009). According to Berthold and his colleagues (2009), this action prompted the demand for hiring CHWs in migrant programs across the country. Often CHW programs emerged through grassroots movements. For example, the Black Panthers and the Young Lords supported and provided community services aimed at addressing hunger, poverty, medical, and health care needs of oppressed groups (Berthold et al., 2009). The oldest CHW program in the U.S. is the Community Health Representative Program (CHR) established by the Indian Health Services collaboration of American Indian tribes. Today, there are approximate “15,000 CHR programs serving 250 tribes” (p. 29). Services include a broad range of health care services, maternal and
child health care, diabetes prevention and disease management, transportation, and referrals to social services.

Perry (2009) explained that CHW programs declined worldwide during the late 1970s and early 1980s. Because of the recession and the oil crisis in the U.S., the government cut funding to hire CHWs. Subsequently, the lack of knowledge about CHW programs caused critics to question the effectiveness of CHW programs. During the mid-1980s, there was a resurgence of CHW programs as CHWs fought against the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) epidemic. When AIDS advocacy efforts and coalitions successfully advocated for public health funding to hire CHWs within local health departments, CHW programs expanded (Rosenthal, 2009). CHWs provided education about HIV, conducted antibody testing, made home visits to help patients with medication management, facilitated support groups, and assisted health care providers with providing culturally competent services. Public health workers credited CHW programs for outreach efforts that led to a decrease in the spread of HIV and AIDS in the United States (Klitzman, 1997).

During the past two decades, more studies have focused on CHWs as a profession, representing increased opportunities for jobs and the creation of healthcare services typically unavailable to underserved groups (Berthold, Miller, & Esparza, 2009). CHW programs expanded in response to policy shifts during the late 1990s and early 2000 (Rosenthal, 2009).

CHW programs have developed during critical, social, political, and economic periods to address inequities in systems (Prez & Martinez, 2013; Perry, 2013). Often CHW programs were the vehicles that facilitated social change and justice for
marginalized individuals. CHWs played a significant role in promoting changes in policies and practices for the civil rights of migrant workers in the U.S., which helped provide migrant workers with access to much-needed health care (Rosenthal, 2009, Perry, 2013).

**Community health workers as a workforce.** In this literature review, I examine an array of studies about CHWs locally, regionally, and nationally. Mader (2012) argued that outcome measures differ in research about CHWs. Because of the variations among research studies, generalizing about program effectiveness, such as costs and clinical outcomes for patients, has been difficult. Furthermore, because job titles and duties vary, there is a lack of descriptive information about CHWs as a workforce. A few studies allow insight into CHWs as a workforce, the development of a profession, information about the roles of CHWs, core competencies, delivery of services, and recommendations for strengthening the CHW profession.

The National Community Health Advisors Study (NCHAS) in 1998 laid the foundation for the improvement of the CHW movement in the U.S. through its groundbreaking findings. Referred to initially as community health advisors (CHA), community health workers today have a broad range of titles (Berthold, Miller & Avila-Esparza, 2009). The NCHAS was conducted to gain a better understanding of CHW programs to help build the capacity of the profession (Rosenthal, Wiggins, Brownstein, Johnson, Borbón, & De Zapien, 1998). The study consisted of data from a national survey, individual interviews and focus group interviews with personnel in 150 programs in 66 districts. The study participants included 280 CHAs and 51 supervisors of CHA programs. Researchers argued that CHAs perform seven core roles and competencies. 1)
CHAs were cultural mediators between communities, health, and social service systems. 2) CHAs provided culturally appropriate health education and information to community members. 3) CHAs ensured that community members received the services they needed. 4) They provided informal counseling and social support for community members and 5) advocated for individual and community needs. 6) They provided clinical services and met basic needs, and 7) built individual and community capacity.

In 2007, a similar study was completed by the U.S. Department of Health and Human Services, the University of Texas, San Antonio, and the Community Health Worker National Workforce Study (CHWNWS). Researchers collected survey data from CHWs’ employers in 50 States and conducted interviews of CHWs in California, New Mexico, Arizona, and Texas. The CHWNWS used the National Employer Inventory (CHW/NEI) to identify approximately 6,300 employers of CHWs at the time of the study. Employers represented “social services (27%), advocacy organizations (14.2%), outpatient health centers (13.3%), education programs (12.9%), ambulatory care (8.2%) and physicians offices (5.3%)” (p. 24).

Researchers completed a review of the literature and provided a comprehensive description of CHWs as a professional workforce with information about the demographics, education, wages, and client population. An estimated 86,000 employed CHWs nationwide often worked under different titles (case manager, community health advocate, community liaison, patient navigator, peer counselor, health educator). California and New York employed the largest number of CHWs. The majority of CHWs were women between 30-50 years of age, and they represented diverse racial and ethnic groups. CHWs employed full-time earned an average of $13.00 per hour, making around
$6 more than the minimum wage in both states (CHWNWS, 2007). Approximately 35% of CHWs were high school graduates, 31% were college graduates, and 21% had some college education (CHWNWS, 2007). CHW services included maternal and women’s health, immunizations, sexual health, health education, chronic disease prevention and management, and infectious disease prevention and control. Eighty-two percent of CHWs provided culturally appropriate health education. Seventy-two percent helped the client access and obtained medical services and 72% provided non-medical services, such as counseling (34%) and transportation (36%).

Hardeman and Gerrard (2012) conducted an empirical study sponsored by the American Cancer Society (ACS). Hardeman and Gerrard examined CHWs as a workforce in four states in the Midwest: Iowa, Minnesota, South Dakota, and Wisconsin. The participants consisted of twenty-three informants including former employers, CHW stakeholders, and advocates promoting CHWs within the public health system. The first arm of the study was to address research questions from CHW stakeholders and employers. Research questions included: 1) what is the compensation, training and professional development trends, and unmet needs of CHWs? 2) What are the barriers experienced by employers who would benefit from integrating CHWs into their healthcare delivery team? 3) What does the future hold for the CHW workforce?

The study’s findings included the following data points 1) the education qualifications for hiring CHWs varied from a high school diploma to college degrees based on the job responsibilities; 2) Compensation varied widely based on full or part-time employment, education, and certification requirements, from $8.00 - $20.00 per hour. The salaries for CHWs in Minnesota were the highest, because of many of the
CHWs were certified; 3) Training, education and credentialing fluctuated among the states. For example, Minnesota required training, education and on the job training for a state certification. 4) South Dakota, Iowa, and Wisconsin did not have state certification programs. All three states were in the process of developing a state certification. 5) Informants identified the lack of sustainable funding as the most significant barrier for CHWs as a workforce; and 6) There was a lack of integration of CHWs’ services within health care systems, because of little awareness and knowledge about CHWs’ roles.

The study highlighted the successes of CHW programs in reducing emergency room costs, increasing patients’ visits with primary health care providers, and improving management of chronic disease among patients (Hardeman and Gerrard, 2012). Informants cited the Affordable Care Act (ACA) as a promising mechanism to advance CHWs as a workforce because of the inclusion of CHWs as a member of the health care team in the ACA. Given the increase of approximately 34 million people with insurance, many informants believed that there would be an increasing demand for trained health care workers. Lastly, informants identified the need for an increase in rigorous research and program evaluations of CHW programs to draw other community partners to invest in CHW programs. Another arm of the ACS study included an online and paper survey of 241 CHWs. Of the respondents, 79 were from Minnesota, 76 from Wisconsin, 63 from South Dakota, and 19 from Iowa. Of significance to this study was the finding that CHWs’ job titles varied. One-third of the CHWs job titles were community health representatives (CHR) and one-fourth of the informants referred to themselves as CHWs. Almost half of the informants, 40%, stated their job titles were “health educator” or
“community health educator” and 5% cited their job title as “promotora de Salud”\(^5\) (p. 44).

The studies on CHWs as a workforce were comprehensive because they involved nearly all of the states and surveyed employers, stakeholders, and CHWs. In the studies I reviewed, no two states were alike. The CHW certifications and training programs are varied based on the state’s legislation and the funding sources. There was variability as well among the CHW data, compensation, employment status, training and certification. Likewise, the findings reflect the need to seek input from multiple sources, including patients, healthcare team members, employers, and stakeholders, to make the roles and responsibilities of CHWs clearer. Different job titles might add to the confusion about who CHWs are and what they do. I believe these studies substantiate the need for a greater understanding about CHWs, in particular, the varying job titles, roles, and responsibilities within PHC. Moreover, the studies highlighted the need to have uniformity in the titles of the CHWs and the need to gain insight into CHW services from health care professionals.

**Models of services.** The 2007 CHMNWS identified five major models of care for CHWs services. CHWs were 1) a member of the interdisciplinary care team, 2) a care coordinator/manager who assisted clients in navigating the maze of complexities within healthcare and social services systems. 3) A health educator who taught clients pertinent

\(^5\) The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) (2012) defines promotora de Saluda as a CHW model of services wherein “CHWs are members of the target population that share many of the same social, cultural and economic characteristics. As trusted members of their community, promotoras provide culturally appropriate services and serve as a patient advocate, educator, mentor, outreach worker, and translator. They are often the bridge between the diverse populations they serve and the health care system. The promotora model has been applied in the United States and Latin America to reach Hispanic communities in particular” (p. 6).
health information such as how to self-monitor health, blood pressure, and glucose testing and promoted prevention efforts within the community. 4) An outreach–enrollment agent who recruited and enrolled clients in services and health insurance, 5) and a community organizer who worked with other community members to advocate changes or resolutions to problems.

In a quantitative study Matiz, Peretz, Jacotin, Carmen, Ramirez-Diaz, & Nieto (2014) examined the integration of CHWs into care coordination teams in five patient-centered medical homes (PCMHs). In a PCMH, a PHC physician coordinates home visits to ensure the patient receives appropriate treatment. A CHW consistently visits the patient’s home to assess the patient’s needs and then reports to the PCP. The purpose of Matiz et al.’s (2014) study was to understand the impact of integrating CHWs into care teams treating predominantly Latino children with asthma. They placed eight CHWs with one year of work experience working with asthmatic children in five PCHMHs for 8 hours per week for 20 months. The CHWs, all of whom were Latina women, were bilingual. They received training and education about PCMHs’ care teams and Asthma 101, a form created to facilitate better communication between patients and the care team. The care coordination teams made referrals to the CHWs of children considered high users of the emergency room and the CHWs met with children and family members, completing the Asthma 101 form on each visit. The form included questions regarding the definition of asthma, triggers, and treatment used at home. When the patients were in the clinic, CHWs consulted the care coordination team regarding their assessment. If appropriate, the care teams made changes in the patient’s care plans and medications. The CHWs provided asthma education to patients and families, too.
The study’s findings from the Asthma 101 forms, the care teams’ recommendations, the numbers of referrals and data from providers’ surveys indicated the CHWs integration into the care team as a “valued member” (p. 273). Surveys from 55% of the 100 medical providers demonstrated providers increased their referrals to care coordination teams from 67% to 79%. Thirty-nine percent of providers revised the care plans when prompted by a CHW and 55% referred patients to asthma education with CHWs. Patients’ outcomes indicated a significant decline in emergency room use and hospitalizations. CHWs provided support and education to hundreds of individuals with asthma and made patient referrals. Patients’ participation increased in PHC 39%.

Integrating the CHWs initially presented challenges as the staff and providers were not familiar with CHWs. I believe health care professionals and providers, at first, were skeptical of CHWs capabilities because the CHWs were not certified. My experience has been that health care professionals typically are required to have some certification, along with degrees. I believe the CHWs in this study lacked official credentials which may have also created distrust among health care professionals. After the professionals and providers could see positive CHW program outcomes such as the decline in ER use, they could see the value of integrating CHWs into the care team. I think the study’s findings reflect a need for awareness and understanding of CHWs’ roles and responsibilities in PHC. It is also important for CHWs to receive education and training that credential them as having knowledge and skills to perform their role of CHW in PHC. There is not a national certification program for CHWs; each state develops its standards and certification requirements and process (Berthold, et. al, 2009).
**CHW Education, Training, and Certification.** Texas and Minnesota’s legislators underwent policy development to address the states’ increasing problems and issues related to an ongoing health care crisis. Both states sought to address the problems with Medicaid recipients’ lack of access to health care and to reduce health care disparities (Eyster & Boybjerg, 2013). Richardson and Ormond (2013) conducted a case study that explored the Texas Community Health Worker Certification System. The case study described Texas’ process of developing and structuring the state’s CHW Certification Program and the promotion of CHWs as a profession with opportunities for employment.

Texas was the first state to legislate certification for CHWs; the process began in the mid-1990s with CHWs’ grassroots advocacy efforts within the state and the southwestern region. CHWs “throughout the state formed an alliance to help with networking, sharing resources, and advocating for statewide legislation for a certification for CHWs” (Richardson and Ormond, 2013 p. 2). Because of the CHWs alliance, the first legislation, H. B. 1864, in 1999 “formed an exploratory committee to identify and evaluate options for standardizing a training curriculum and certification for CHWs” (p. 2). Also, the committee explored the possibility and benefits of including CHW services for recipients of Medicaid and the Children's Health Insurance Program (CHIP). Within a two-year period, “the exploratory committee, the Promotor(a)(e) Program Development Committee (PPDC), created a standardized curriculum and core competencies and established the criterion for the certification of CHWs and instructors for certification training program” (p. 2). Over the years working with Texas legislators, the PPDC enacted four legislative bills that mandated promotores for outreach, health education,
and medical assistance services reimbursement through the Medicaid and the CHIP. (Richardson and Ormond, 2013).

Texas’ certification for CHWs required the CHWs and the instructors of training to receive 160 total hours of training, 20 hours on each of the core eight competencies (Richardson & Ormond, 2013). In 2012, there were “twenty-five certified training programs provided mostly by technical colleges within the state. There were approximately 864 CHWs, over 200 more than the previous year” (Richardson & Ormond, 2013, p. 6).

Within the past two to three years, Richardson and Ormond (2013) pointed out that advocacy statewide efforts for CHWs have focused on 1) reducing the cost of CHWs training. The expense of training is individuals' responsibility, in which they often cannot afford the costs that range from $500-$1000 depending on employers’ contributions, 2) the lack of knowledge and understanding about CHWs and their contributions to the community. 3) The need for training for employers about CHW services and funding options, 4) the need to make connections between the state-wide certification, increased pay, better working conditions, and opportunities for career development for CHWs. In Texas, there are initiatives underway to sustain CHWs’ services through reform of the Medicaid waivers, which will enable the state to move recipients of Medicaid to managed care (Richardson & Osmond, 2013). Under the waiver, CHWs’ role and services would be defined, and reimbursable by managed care organizations (MCOs). Also, there are reforms aimed at including community-based services in the Title V Maternal and Child Health Services programs for the prevention of breast and cervical cancer services.
CHWs working within primary health care will assist with screenings, outreach, health education and patient navigation.

In a similar case study of the Minnesota Community Health Worker Training Program conducted by Ormond and Richardson (2013), the Minnesota CHW Alliance was at the forefront of efforts to develop Minnesota’s CHW workforce. The Blue Cross-Blue Shield Foundation of Minnesota “sponsored a survey in 2002 of CHWs aimed at understanding the nature of the CHWs as a workforce and how CHWs might contribute to the findings” (p.12). The study addressed ways CHWs could enhance cultural competency and diversity of health care as well as reduce racially and health care disparities. The survey included current and potential employers of CHWs, who identified,

A strong interest in developing the CHW workforce to meet three goals.

(1) Improve health care access by helping people navigate the health care system,
(2) lower health disparities by increasing knowledge about health, and
(3) Improve health outcomes by serving as a bridge between communities and the health care system. Employers and potential employers were interested in having a standard set of skills that would define and characterize a community health worker (Ormond and Richardson 2013 p. 13).

The researchers presented the findings at a forum with policy makers, the CHW Alliance, employers, educators, health care organizations and other stakeholders who began the to promote CHWs within the state (Richardson & Ormond, 2013). Private foundations allocated the initial funds to form a coalition, the Healthcare-Education-Industry Partnership (HEIP) which consisted of representatives from the state colleges
and universities, health care providers, CHWs, and governmental agencies. The HEIP developed a “statewide 14-credit hours certification program and secured legislation for Medicaid payment for services provided by certified CHW” (p. 6). The CHW programs or related services received 41 grants, an estimated $3.3 million from the Critical Links program” (p. 13).

The certified training curriculum focused on the core competencies, roles, advocacy, outreach, organization and resources, teaching and capacity-building, legal and ethical responsibilities, communication and cultural competency (Osmond & Richmond, 2012). Also, health promotion was included in the curriculum on healthier lifestyles, heart and stroke, maternal, child and teens, diabetes, cancer, oral health and mental health. The CHWs’ certification training is at local community colleges throughout the state and available online to accommodate the national need for CHW training. Online students complete assignments and participate in conferencing sessions. More than “500 students have completed the certification program; however the state does not require a certificate for CHWs” (p. 14).

The above studies reflect the complexities associated with CHWs as a workforce, their roles and responsibilities, and issues related to funding CHW program services through Medicaid. First, the researchers clarified throughout the case studies the various contexts of CHW programs and individuals who received services in PHC. Second, the grassroots advocacy efforts highlight the need for policy development, within the broader community and in each of the cities and states. Third, each case study yielded a rich detail description of CHWs in each of the states and the social actors and social systems engaged in and affected by CHW programs.
These case studies fulfill a need in ethnographic case studies. They reflect in-depth exploration of the provision of CHW program services, specifically the roles and responsibilities CHWs perform in PHC. Missing from the literature are the perspectives of the individuals who engage in CHW services, the patients, family members, and healthcare professionals.

A qualitative study conducted by Squires and O’Brien (2012) explored the effects of assuming a new role, called a promotora. The promotoras were Latina CHWs working in a cervical cancer prevention program in a new Latino immigrant community. The researchers were interested in understanding the processes and effects of becoming promotoras using the framework of role theory (RT). According to Squires and O’Brien (2012), role theory is the “identity formation of culture, behavior, and cognition to help explain how roles evolve in societies or how people perform in them” (p. 458). This study addressed the following research questions: “What do individuals gain from assuming a CHW role and participating? Does the role change the individual throughout the process? If so, how does this change occur and how does assuming the CHW’s role affect the immigrant experience?” (p. 459).

The participants consisted of four female promotoras ages 29, 36, 42, and 55 who had lived less than five years in the U.S. The promotoras received 24 hours of training involving relevant medical content, research skills, and professional boundaries related to their roles as promotoras. Before program implementation, the researchers conducted a

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6 Promotor(a) (e)” is a woman or man who belongs to the same culture and speaks the same language as the people they serve. They are culturally-competent leaders who link people to health and human resources, encourage peers to seek care, empower community members, and promote healthy habits” (PASO, 2014).
series of eight 30 to 60 minute in-depth and semi-structured interviews in Spanish with the promotoras. The findings varied based on the backgrounds of the promotoras. Promotoras who came into the program with education and professional experience drew on their professional experiences from their native countries and found their new roles to be transformative. The promotoras without education and work experience still felt their roles affected them personally. Moreover, their roles influenced their self-concepts and engagement with their families and communities. They described “activist behaviors in which they engaged community members to new perspectives to promote the awareness and health of women” (p. 465). The researchers observed that the promotoras’ physical appearance and confidence levels were improved as well. For example, one promotora who had previously appeared depressed seemed renewed. The change was so profound that the researcher had not recognized her.

The researchers concluded that each of the promotoras demonstrated transformative qualities including positive self-image, empowerment, and self-actualization that propelled them to become leaders within their communities (Squires and O’Brien, 2012). Of importance, the researchers noted that while previous professional and educational backgrounds enhanced the role of promotoras, it should not preclude the hiring of those without. Squires and O Brian (2014) emphasized that the infrastructure and training of CHW programs could significantly enhance the experiences of promotoras. The study informs this inquiry in two ways. First, CHWs have transformative qualities for not only their patients but also themselves. Second, the educational and professional experiences add value to the work of the CHWs. However, it should not be a requirement for employment.
Culturally responsiveness services in the field of CHWs and health care. Gay (2000) points out that culturally responsive practice has different names. The aim is to use knowledge of the backgrounds and cultural orientation, beliefs and values of diverse people to provide services that are relevant and useful to them (Gay, 2000). In health-related fields, such as community health work, the term cultural competence and cultural humility are frequently noted in the literature. Cultural competency is a “system and workforce capable of delivering the quality care to patients regardless of race, ethnicity, culture, or language proficiency” (Betancourt, Green, & Carrillo, 2002, p. 3).

A conceptual study examining cultural competency and disparities conducted by Brach and Fraserirector (2000) used the literature to answer questions about whether cultural competency has the potential to reduce health care disparities. The researchers provided a conceptual model that included evidence of ways in which cultural competency techniques may have impacted the process and outcomes of health care for racially and ethnically diverse people. According to Brach and Fraserirector (2000), the literature broadly discussed the significance of cultural competency about cultural awareness, knowledge, attitudes, and skills. However, the research did not explicitly describe the ways in which healthcare organizations achieve cultural competency. They highlighted the importance of integrating cultural competency techniques that focused on the provision of engaging services. These cultural competency techniques included recruitment and training to improve communication and promote inclusiveness among individuals within healthcare organizations. The aim at the implementation was to incorporate cultural values, languages and traditions which could improve the overall quality of care.
I believe Brach and Fraserirector’s (2000) conceptualization of cultural competency provides a useful framework for understanding and applying cultural competency in PHC. I agree with their conclusion that no one cultural competency technique is enough. Moreover, I argue the implementation of cultural competency techniques at multiple levels is necessary for a culturally competent health care system. An implication of this study is that CHWs can play a significant role in primary health care. However, PHC providers must make sure policies, practices, and the people using them are culturally responsive (Gay, 2010).

In a similar study, Betancourt and his colleagues (2002) conducted a qualitative study to determine what experts in the field of cultural competencies identified as priorities for healthcare policies and practices. The study’s participants consisted of thirty-seven experts from managed care organizations (MCOs), the U.S. Department of Health and Human Services, state and county health departments, medical schools and professional organizations (Betancourt, Green, & Carrillo, 2002). The study participants received ten open-ended questions related to components of cultural competence. For example, what are the strategies to eliminate racial discrimination and disparities in health care systems?

The study findings reflect suggested from a managed care perspective, cultural competency in the future may drive the quality of services and business priorities within health care (Betancourt et al. 2002). Health insurance providers may market cultural competencies to employers as a mechanism for increasing member market shares for a diverse workforce. The researchers learned cultural competence required multilevel action, diversity in leadership and healthcare providers, systematic processes,
multilingual services, data collection, patients’ satisfaction, and training of healthcare staff. Experts expressed concern that cultural competency is a soft science that required buy-in from healthcare industries, as well as standardized training. However, participants focused on the need to integrate cultural competence into strategies for quality improvement. Although the majority of the participants linked cultural competence to addressing disparities, some were skeptical of the ability to make progress.

Reasons for the skepticism included the increasing cost of health care and the lack of knowledge about cultural competencies. However, trend data indicated significant advancements in managed care plans and health care purchasers. Experts pointed out the need for increased education and training in academic and other educational institutions on cultural competency to bridge the divide between future health care workers and diverse individuals and groups. The experts also stressed the importance of educating individuals and providers to improve the quality of health care. The study highlighted the significant link between cultural competencies from a macro level with an emphasis on the business of the healthcare industry and the ways cultural competency may improve the quality of services.

A 2014 empirical study conducted by the Texas Public Health Training Center (TPHTC) used an iterative curriculum development process for a culturally competent continuing education module for CHWs (Uriate, Cummings and Lloyd, 2014). This culturally competent curriculum aided in the development of Timpson, Yang, Barayo and Canetto’s (2005) guidelines for diversity in education and training. The iterative process required input from CHWs, CHW instructors, community members, and key stakeholders through focus groups. This input indicated a need for information regarding
the roles and duties of the CHWs. The assessments also reflected the importance of knowledge about working with pregnant women. A curriculum, *The Better Together*, was developed for training the CHWs in the prevention of birth defects. The TPHTC underwent a culturally competent iterative development process that involved four phases. 1) Researching the issues and needs related to pregnant women; 2) creating the curriculum that included an eleven steps process that involved with the key stakeholders; 3) obtaining approval from the appropriate continuing education authorities; and 4) implementing and evaluating the curriculum that consisted of three stages for each action.

In 2001 at the CHWs Across Texas Conference, training was held on *The Better Together* curriculum. Two hundred and fifty CHWs attended the conference with 116 participants attending the *Better Together* training in both English and Spanish (Uriate et al., 2014, p. 58). Results of the study indicated 87% of the CHWs strongly agreed, and 10% agreed that the training was beneficial and that they would use the knowledge gained from the training in their work or personal lives. The researchers concluded that curriculum development for CHWs must include all key stakeholders and must incorporate culturally appropriate and relevant mechanisms to meet the diverse workforce needs.

Mobulal and her colleagues (2014) examined the association between provider’s self-reported cultural competency and preparedness, in addition to the perceptions of providers regarding the usefulness of CHWs in reducing health care disparities (Mobulal, Okoye, Boulware, Marsteller & Cooper, 2014). The participants were 200 healthcare providers (physicians and nurse practitioners) and medical staff (nurses, medical assistant, and others) from six health care clinics in the Metropolitan Baltimore. Each site
served 24.5% to 31% African Americans and 24% of 44% Caucasians. Survey data assessed participants’ attitudes toward hypertension, quality improvement strategies, cultural competency, the motivation to learn about other cultures, attitudes toward power and assimilation, and the frequency of culturally competent behaviors.

The survey also included questions about how the health care providers and medical staff perceived CHWs in reducing the health care disparities. According to Mobulal et al., (2014), the study’s results demonstrated,

1) Providers and clinical staff rated high on willingness and motivation to learn about other cultures. 2) Providers had greater power and assimilation attitudes towards CHWs than clinical staff. 3) Both groups rated themselves high on using culturally competent behaviors. 4) The clinical staff related themselves slightly higher than providers as culturally prepared and culturally literate. 5) Thirty-seven percent of the clinical staff compared to 58% of the providers strongly agreed or agreed that CHWs would help reduce disparities in health care (p. 5).

The researchers found providers and clinical staff had the cultural motivation to learn about diverse groups demonstrated various culturally competent behaviors and increased cultural preparedness. Results indicated both groups showed an increase in cultural humility and recognized their limitations to address barriers to care for diverse groups. They were open to CHWs’ interventions. Overall, the attitudes of providers’ and staff’s power and assimilation were not associated with staff perception of CHWs’ helpfulness with reducing inequalities.
This study is significant because it was the first to address the association and perception of healthcare professionals in regards to cultural competency and CHWs in reducing disparities in health care. The study demonstrated positive attitudes among health care providers and clinical staff working with African Americans and Caucasians in PHC settings. However, it did not describe specific culturally competent, relevant or responsive techniques or practices implemented by the different cultural groups. These studies demonstrate the importance of addressing diverse cultural backgrounds and heritages in PH. There were variations in the names used (i.e., cultural competency, culturally preparedness).

The literature regarding cultural responsiveness informs my research about CHWs in several important ways. First, conceptually it is clear that “cultural competency” is the preferred terminology used in the health care field, but there are other conceptualizations of culturally responsive practice such as cultural humility. I have chosen to use the term “culturally responsive” throughout this study because culturally responsive implies that one is responding to diverse people’s cultural backgrounds, and other terms, such as culturally competent, imply there is a level of achievement one can reach when learning about diverse people. I argue that it is of vital importance that all health care providers understand and know how to demonstrate culturally responsive behaviors. For this study, I modified Gay’s (2000) model of culturally responsive practice in education. I chose to focus on identifying and acknowledging diverse patients’ cultural backgrounds, beliefs, values, and orientation to provide services that are personally meaningful.

Second, the researchers have indicated some positive steps toward cultural competency and responsiveness are beginning to occur at various levels within the health
care system. However, bringing to fruition the full implementation of culturally responsive services within the framework of CHWs requires action by health care systems at multiple levels (Mobulal et al., 2014). Health care systems that are culturally competent must demonstrate competencies at micro, mezzo, and macro levels, with people, policies, and practices (Gay, 2000). I believe it is not enough that one group within the health care system is moving forward towards cultural competency while other groups, policy, and practice remain static.

Finally, it is clear that CHW services can have an influence on the delivery of culturally responsive services by PHC providers (Mobulal, Okoye, Boulware, Marsteller and Cooper, 2014). CHWs are a valuable resource for connecting health care providers with diverse people and their communities. Given that there is little information about CHWs and the complexities involved in working with diverse people at multiple levels in PHC, my study offers much-needed insight into practical day-to-day activities related to culturally responsive practice in primary health care.
Chapter 3

Research Design

In this qualitative study, I wanted to gain insight into the culture and the social actors in the context of Community Health Worker (CHW) programs in primary health care (PHC) settings (Merriam, 2002). Schwandt (2007) broadly defined qualitative inquiry as research that facilitates an “understanding of the meaning of human action” (p. 248) to gain a deeper understanding of their day-to-day experiences. To do so, I designed a qualitative study that employed strategies grounded in the day to day practice of the CHW programs in PHC. I used an appropriate ethnographic case study to frame this research. Another important reason for choosing a qualitative design for this study is that I wanted to provide a space for the voices of the people engaged in the CHW programs in PHC. Finally, I think it is important in research to incorporate my reflections as a researcher and in this case as both an insider and outsider to CHW programs in PHC (Brayboy & Deyhle, 2000). In this way, I was able to make clear the significance of the personal experiences of the participants in the study and my personal experiences. Qualitative research designs are best suited for these aims (Patton, 2002).

The purpose of this chapter is to describe the ethnographic case study methodology and the strategies that I used to build the data and make the interpretations, leading to the study’s methods of data collection, and data analysis. Lastly, I discuss
methodological considerations, trustworthiness, my positionality, ethics and limitations of the study.

3.1 Role of the Researcher

**Epistemic orientation.** It is my opinion there are no truths, only diverse realities based on interpretations that shift depending on the context, individuals’ perceptions and interpretations of personal experiences. Schwandt (2007) referred to this thinking as “radical skepticism,” the belief that knowledge derives from multiple sources, there is no one authority, and no one can prove how individuals know what they know (p. 88). Denzin and Lincoln (2013) described my epistemic orientation as “constructivism with an ontological perspective of relativist, a transactional epistemology that employs hermeneutic, dialectical methodology and methods” (p. 191). In essence, I believe the people in the context of CHW programs in PHC offer rich and valuable interpretations of their everyday experiences, and my goal was to attempt to represent those experiences through the co-construction of knowledge and understanding with them.

The thrust of my ethnographic case study is to explore and understand the phenomenon of CHW programs in PHC. To do so, I predominantly used participant observations that involved me being immersed in the culture of CHW programs to gain insight, make meaning, and describe the people’s experience (Merriam, 2002). Knowledge is within the culture of the day-to-day activities wherein the participants know best what “knowledge is” based on their personal experiences.

**Insider Positionality.** The insider perspective “believes that knowledge of the social world must start from those inside. To know the world of human action is to understand the subjective meanings of that action to the actors” (Schwandt, 2007, p. 152).
My positionality as an insider includes my roles as an educator who is an instructor of the Certified Community Health Worker (CHW) Training Program at Midlands Technical College. I teach a six-week educational training course for individuals seeking certification as CHWs in the state of SC. As an instructor, I have a unique insider’s perspective of the realism of the personal experiences of CHWs, which greatly influenced my interest in conducting this ethnographic case study. Recently, I have been actively involved in the development of the South Carolina Community Health Worker Association (SCCHWA), for which I serve as a member of the executive committee. The purpose of SCCHWA “is for the organization of community health workers and supporters. Its mission is to improve population health by developing and promoting a Community Health Worker workforce for South Carolina. The vision is a healthier SC” (SCCHWA Bylaws, 2016, p. 1.).

In these roles, I am in a unique position to help influence the development of policy for the CHW practice. It is my desire to advocate for and support CHW programs and workers because I firmly believe that the work they do produces transformational changes for individuals and groups who are typically marginalized by society. Although each of these roles has uniquely influenced my desire and interest in this study, collectively they have inspired me to approach this inquiry from a strengths-based perspective (Rogers, 2013). All too often statistics paint a bleak picture for individuals and groups who are working class, low-income, impoverished, and especially people of color. This perpetuates a dominant narrative maintained by those privileged and in power (Delgado & Stefancic, 2012). In this study, I facilitate narratives of truth that reflect the
work and services CHWs provide to many individuals who are marginalized and underserved in PHC.

3.2 Methodology

**Ethnographic case study.** Ethnography derived from the field of anthropology (Merriam, 1988; Patton, 2002; Schwandt, 2007). It involves a process of describing and making interpretations about the cultures of an environment (Schwandt, 2007; Patton, 2002). A fundamental assumption of ethnography is that people are interacting together in the culture for a period (Patton, 2002). Culture refers to the “shared behavior patterns and beliefs among groups of individuals for determining standards of how people feel, act, and think” (p. 81). Noblit (1999) described ethnography as “simply the particular forms of everyday realities of life politics, moralities, and understandings” (p. 2). As the researcher of the study, I identified and described the patterns of formal and informal relationships between the people engaged with CHWs and I made interpretations about implicit and explicit interactions as they related to CHW program service delivery in PHC (Dewalt & Dewalt, 2002).

A case study is a “practical inquiry that allows the researcher to explore people, the social organizations, and systems (“the case”) in depth within the real world context” (Yin, 1994/2004, p. 16). A case study is a detailed description of a bounded system (Yin, 2014). The bounded system, or case, may include a program providing services to individuals or a group of people. For this study, I bounded the case with CHW programs in three PHC settings: Hillsboro Family Practice (HFP), Riverdale Health Center (RHC) and Montgomery Community Health Center (MCHC). The unit of analysis, or the case, was the three CHW programs. I used a descriptive case study to represent a “distinctive
situation in which there will be many elements of interest than data points and as one result” (Yin, 2014, p. 17). The situation in this case study involved me exploring day to day activities of the CHWs, their interactions with patients, family members, healthcare professionals, and policy makers, across different spaces, places, and times. I believe that this approach facilitated a holistic exploration of the CHW programs in PHC. Because there were complex elements under consideration, I gathered multiple sources of evidence about the three CHW programs including field observations, individual and focus group interviews, documents, and my reflections on the data I collected. The data I gathered and analyzed helped me to describe the experiences of the individuals, groups, organizations, and systems that operate in the context of the CHW programs (Merriam, 1988, Yin, 2014). The product is a rich, comprehensive description and analysis of CHW programs in three PHC settings (Patton, 2002; Yin, 2014).

In summary, I believe using an ethnographic case study was a sound decision for four reasons: first because it is a sound research design for social work, education, and health care for the purpose of describing and making interpretations of a phenomenon (Merriam, 1988). Second, ethnographic case study enabled me to collect data that was relevant to the culture of PHC, which included the socio-political environment, attitudes, values, and behaviors of the people. Participants engaged in activities using a broad range of sources for information. Third, the ethnographic case study allowed me to explore CHW programs in PHC in depth. As Merriam (1988) pointed out, case studies are useful when there not much is known about a phenomenon and basic information is needed to provide a description of innovative programs. Fourth, I had the flexibility to collect data
using multiple methods, and doing so enhanced the trustworthiness of the study (Merriam 1988).

The aim of this study was to understand the services, roles, and culture of the CHW programs in PHC to answer the following research questions (RQ): 1) what is the day in the life of community health workers? 2) What services do CHW programs provide? 3) In what ways do CHWs provide culturally responsive services? 4) How do the individuals receiving CHWs’ services perceive these services?

3.2 Case Study Sites Selection

I identified the three CHW program sites in PHC using a purposeful sampling strategy (Patton, 2002) with the help of the members of the HeART Initiative. A purposeful sampling strategy enabled me to select three pilot CHW program sites because they were information-rich and could help answer the research questions. First, I identified potential sites and used sampling criterion, which involved consulting with members of the HeART Initiative to ask them to identify potential CHW program administrators who would be interested in participating in the study. The HeART Initiative members included PHC administrators, health care professionals, community leaders, CHWs, and advocates who worked on the development and implementation of SCDHHS’ Medicaid Pilot CHW programs. As an insider, an instructor of the only state CHWs’ certification training program, I knew some of the HeART members were motivated and engaged with the progression of state certification for CHWs. Some of the members conveyed their support of a qualitative study because much of their current data collection and analysis was Medicaid driven.
For this study, I defined the PHC sites for the CHW programs to include a physician’s office, a community health clinic, and/or health center in SC. I identified the typical CHW program as a program with one or more CHWs working within a PHC with health care professionals. I used the following to select the three sites at the Hillsboro Family Practice (HFP), Riverdale Healthcare Center (RHC), and Montgomery Community Health Center (MCHC).

1. Each CHW program had been operating in an SC PHC setting for a minimum of one year and currently was reimbursed for services under SC Medicaid. My rationale was to add to the knowledge regarding the services provided by CHWs and clarify roles and responsibilities of CHWs. These criteria ensured the context of CHW programs in PHC.

2. The PHC sites included a physician’s office, health clinic, or center.

3. The CHWs working in the programs must have been employed a minimum of one year as a CHW. This requirement ensured that the selected CHWs’ program staff was experienced and more likely to be familiar with their roles, responsibilities, and duties.

4. The CHW program must serve a diverse group of clients (race, ethnicity, gender, age, etc.). I wanted to ensure the patient populations of the CHW programs were diverse as the Community Health Worker National Workforce Study (2007) indicated that the people who received CHWs’ services were diverse people based on race, ethnicity, age, gender, and other identities. By having this requirement of the CHW programs, I also ensured consistency among the three sites and that they represented the population of South Carolina. Additionally, significant roles and expectations of
CHW are to provide culturally appropriate health care services to clients, health care providers and communities. This criterion ensured that the selected CHW programs were diverse, and the participants could provide information regarding their experiences that addressed the research question related to the ways CHWs provide culturally responsive services.

5. Each of the CHW program’s administrators, CHWs, and participants had to consent to participate in the study. This criterion was to make sure everyone involved in the study would participate of their free will. No one would feel forced or coerced to participate. Also, this criterion ensured all participants understood the purpose and objectives of the study and their participation are confidential. See Appendix A, the Informed Consent

After HeART Initiative members had identified potential CHW programs, I contacted the administrator of each program to ascertain if the program met the criteria required for participation in the study. I met with each administrator in person and provided a brief orientation to the study and my role as the researcher, and answered their questions. Together, we determined the next steps for me to begin the study.

Table 3.1 depicts the three CHW program sites in PHC and the primary CHWs working in each site. It is important to note that I used pseudonyms for all three CHWs sites, and all individuals I discussed in the study. I provide a profile of each of the sites and the CHWs in Chapter 4.
Table 3.1 CHW Program Sites in Primary Health Care (PHC)

<table>
<thead>
<tr>
<th>Site</th>
<th>CHW Program Sites in Primary Health Care (PHC)</th>
<th>Community Health Worker (CHW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>Hillsboro Family Practice (HFP)</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Site 2</td>
<td>Riverdale Healthcare Center (RHC)</td>
<td>Sabrina Sams</td>
</tr>
<tr>
<td>Site 3</td>
<td>Montgomery Community Health Center (MCHC)</td>
<td>Margaret McGowan</td>
</tr>
</tbody>
</table>

3.4 Methods of Data Collection

According to Coffey and Atkinson, (1996) “there is “no single way to answer the research question” (p. 4). For this study, I used an emic approach to answering the RQ 1, 2, 4, and an etic approach to answering RQ 3. Patton (2002) described emic and etic approaches as,

The emic approach is the immersion of the researcher in the culture of the phenomenon as a “participant observer”. The researcher can see, feel, and experience the culture fully as a participant. In contrast, an etic approach allows some distance from the culture to consider and compare similar events and experiences (Patton, 2002, p. 268-269).

The methods of data collection I used for this study included participant observations, informal and formal individual interviews, focus group interviews, and document

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7 Before I collected any data from all of three PHC sites, I signed a statement of confidentiality and the protection of the patients’ privacy. The patients’ privacy was protected in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) during my observations at each PHC site. Mary, Sabrina, and Margaret introduced me as a researcher and educator to all patients and health care staff members. They explained that I was conducting a study about CHWs in PHC and asked for their consent to allow me to observe and to participate in this study. I assured every person I would protect their identities in the study’s information. No one refused to participate.
collection and analysis. Table 3.2 depicts the research questions, sources of data I collected and the data analysis for the study.

**Participant observations.** According to Dewalt and Dewalt (2002), participant observation is methodically important because “it strengthens the data gathered from the research context and the interpretation of data. Participant observations are beneficial both as a data collection method and as an analytical tool” (p. 8). For this study, I used participant observation to answer all four of the research questions. I spent two weeks (10 working days) in each of the three CHW program sites observing CHWs in day to day to operations.

**Table 3.2 Research Data Collection/Analysis Matrix**

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Data Sources</th>
<th>Method of Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is a day in the life of community health workers?</td>
<td>• Participant Observations Field Notes • Semi-structured Interviews • Focused Group Interviews • Analytical Memos • Documents</td>
<td>• Read and reread field notes, transcribed interviews, and analytical memos. • Conducted two cycles of coding: in vivo, descriptive, and protocol, coding to the research questions to identify codes, categories, patterns, themes, and subthemes. • From the descriptive coding, I developed and wrote the profiles of PHC sites, and the CHWs (Mary, Sabrina, &amp; Margaret). Using the themes, in vivo data and each site’s daily field notes, I developed the composite CHW site, the No Patient Left Behind (NPLB) Center as well as the composite CHW, Patience. I completed the same analysis to construct and write “The Day in the Life of CHWs” salient vignettes. • I integrated information from the</td>
</tr>
</tbody>
</table>
| 2. What services do CHW programs provide? | ● Participant Observations Field Notes  
● Semi-structured Interviews  
● Focused Group Interviews  
● Analytical Memos  
● Documents | ● Read and reread field notes, transcribed interviews, and analytical memos.  
● Conducted two cycles of coding: in vivo, descriptive, and protocol, coding to the research questions to identify codes, categories, patterns, themes, and subthemes.  
● From the descriptive coding, I developed and wrote the profiles of PHC sites, and the CHWs (Mary, Sabrina, & Margaret). Using the themes, in vivo data and each site’s daily field notes, I developed the composite CHW site, the No Patient Left Behind (NPLB) Center as well as the composite CHW, Patience. I completed the same analysis to construct and write “The Day in the Life of CHWs” salient vignettes.  
● I integrated information from the documents into the vignettes. |
| 3. In what ways do CHWs provide culturally responsive services? | ● Participant Observations Field Notes  
● Semi-structured Interviews  
● Focused Group Interviews  
● Analytical Memos  
● Documents | ● Read and reread field notes, transcribed interviews, and analytical memos.  
● Conducted two cycles of coding: in vivo, descriptive, and protocol, coding to CHW model of services and research questions to identify codes, categories, patterns, themes, and subthemes. I integrated information from documents integrated into codes and categories. |
I typically arrived at the sites between 8:00-9:30 am and I left at the end of the day between 5:00-7:00 pm. This scheduled varied, so I could be flexible and accommodate the CHWs’ schedules and priorities for each day. Likewise, my level of participation varied at each CHW site from moderate to active based on the CHW’s activities and circumstances at the time. Moderate participation meant I occasionally engaged in activities, and at times, I was actively participating in the activities. An example of my moderate involvement was observing Mary interviewing Mrs. Black. While Mary directed this interview and asked the questions, at the end of the interview, Mrs. Black requested that we both pray for her, so I did. I also offered her words of encouragement and hope for her to recover from her illness. An illustration of my active participation was assisting Sabrina with making telephone calls to homeless shelters and transition house programs to identify a place for Victor, a patient at RHC, to live. I made approximately five to eight telephone calls, and I received three or four follow-up calls. I actively engaged Victor intermittently throughout my observation period at RHC.

| 4. How do individuals receiving CHWs’ services perceive these services? | • Participant Observation Notes  
• Semi-structured Interviews  
• Focused Group Interviews  
• Analytical Memos  
• Documents | • Read and reread field notes, transcribed interviews, and analytical memos.  
• Conducted two cycles of coding: in vivo descriptive and protocol, coded to the research questions to identify codes, categories, patterns, themes, and subthemes.  
• Integrated information documents |

I typically arrived at the sites between 8:00-9:30 am and I left at the end of the day between 5:00-7:00 pm. This scheduled varied, so I could be flexible and accommodate the CHWs’ schedules and priorities for each day. Likewise, my level of participation varied at each CHW site from moderate to active based on the CHW’s activities and circumstances at the time. Moderate participation meant I occasionally engaged in activities, and at times, I was actively participating in the activities. An example of my moderate involvement was observing Mary interviewing Mrs. Black. While Mary directed this interview and asked the questions, at the end of the interview, Mrs. Black requested that we both pray for her, so I did. I also offered her words of encouragement and hope for her to recover from her illness. An illustration of my active participation was assisting Sabrina with making telephone calls to homeless shelters and transition house programs to identify a place for Victor, a patient at RHC, to live. I made approximately five to eight telephone calls, and I received three or four follow-up calls. I actively engaged Victor intermittently throughout my observation period at RHC.
To capture my observations of the CHW programs, I kept field notes. According to Dewalt & Dewalt (2002), field notes are the best method for capturing the day-to-day information within a setting. Field notes enable the researcher to describe and reflect on what is occurring. According to Dewalt & Dewalt (2002), “it is believed in qualitative research if you failed to write it down it did not occur” (p. 141). Field notes are essential, and researchers must judiciously write and keep organized the various types of notes, including descriptive and reflective methods used during the study.

I wrote field notes about my day-to-day activities, and because two of the CHWs’ sites were approximately two and half hours’ drive away from my home each day, I audio recorded these field notes, which I later transcribed. Field notes are evidence that the researcher uses to base meanings and understandings of context (Schwandt, 2007). Field notes vary depending on the researcher’s preference and the environment. They may include raw data based on observations, conversations, rough diagrams, charts, or all things collected in the field” (p. 115). As Dewalt and Dewalt (2002) indicated, data collection methods, present challenges as I was moderately actively engaged with people in the CHW sites and it was not always possible or appropriate for me to make notes. For an example of my field notes, see Appendix B.

**Interviews.** For this study, I used various types of interviews to elicit information from the individuals about CHW program services, including ethnographic, conversational, semi-structured and focus group interviews. Though interviews differed in type, the nature of the questions was qualitative—to obtain descriptions of the world of the people engaged in the CHWs’ programs (Kyale, 1996, Ralston, 2002). Seidman
(2006) asserted that at the core, interviewing shows a genuine interest and “value of other people’s stories” (p. 9).

Ethnographic Interviews. The purpose of ethnographic interviewing is “to explore the meanings that ascribe to actions and events in the culture worlds, expressed in their language. The focus is on gathering participants’ descriptions of aspects related to the cultural world” (Roulston, 2010, p. 19). During my participant observations, I used ethnographic interviewing to facilitate my interactions with the people engaged in the CHW programs to gain a deeper understanding of the culture of the service delivery. I generated data through friendly conversations in which I discussed similarities and experiences related to the topic at hand. As Roulston (2010) pointed out, at times, these conversations focused on getting individuals to answer specific questions about the CHWs. In doing so, I was able to identify and discuss with CHWs and other individuals the possibility of subsequent interviews to ascertain additional information.

Semi-structured Interviews. The semi-structured interviews I conducted for this study consisted of sequential questions that were open-ended to encourage individuals to answer questions without boundaries (Kayle, 1996, Patton, 2002). The aim of the semi-structured interviews was to gain insight into personal experiences, to interpret the meaning of central themes of these experiences and to obtain descriptions of particular situations and actions regarding the people engaged (Kayle, 1996). These interviews took place in a variety of settings, the PHC sites, patients’ homes, and over the telephone. For example, I had three interviews with Mrs. Black, a patient at RHC. First, I had a conversational interview with her in her hospital room, then I began interviewing her in the lobby at RHC, but we were unable to finish because the Medicaid transportation
arrived much earlier than anticipated to pick her up. Therefore, we completed the third interview by telephone.

Because I was interested in gaining insight into the services, roles, and culture of CHWs in PHC, I interviewed individuals who were actively engaged in the CHW programs and who could provide rich information about the CHW programs. I consulted the CHWs, their patients, family members, program administrators, and the health care team members to help determine the individuals I interviewed. Because of these efforts, I interviewed 18 individuals who represented a cross section of the people engaged in the CHW programs. These individuals consisted of nurses, administrators, doctors, nurse practitioners, social workers, patients, and family members. In preparation for individual interviews, I developed an interview guide with questions based on my prior observations in each of the CHW program sites and including open-ended questions that led to the individuals describing their experiences, events, and perceptions of CHW program services. All of the interviews were audio-recorded and transcribed verbatim into Microsoft Word documents. Examples of the initial interview guides for CHWs and patients are in Appendices C and D.

Focus group interviews. A focus group interview is an interview with a small group of people to elicit information about their opinions and perspective on a particular subject (Patton, 2002; Schwandt, 2007). In this study, I used focus group interviews with the individuals receiving CHW services 1) to understand the way they viewed CHWs and the services and 2) to identify the ways CHWs provide culturally responsive services. Initially, I hoped to conduct focus groups with patients and family members; however, that was not feasible, as many individuals did not have transportation and were only
available at the time of their appointments at the PHC or during home visits. I was able to conduct two impromptu interviews with three health care professionals at HFP and four at RHC. The rationale for conducting focus groups was to generate dialog about the CHW programs in an atmosphere where individuals felt empowered to talk amongst their peers. These individuals had the opportunity to “hear others’ responses, and they made comments based on what they heard” (Patton, 2002, p. 386). They were able to consider their responses in the context of others that I believe added information and enhanced the quality of information they provided. Because these interviews were impromptu, I developed the questions based on the group’s already unfolding discussion. An example of the focus group’s questions is in Appendix F. The focus group interviews were audio recorded and transcribed verbatim into a Microsoft Word document.

**Document collection.** Patton (2002) asserted, “in contemporary society, all kinds of entities leave a trail of paper and artifacts. Organizations of all kinds produce mountains of records, both private and public “(p. 293). Schwandt (2007) defined documents as those items that include policies and procedures, forms, letters, minutes, notes, clients’ records and all types of written information that can inform the researcher about the activities and/or people in the setting. Because the PHC systems are laden with paperwork, I collected 80 documents and reviewed even more computer-generated files from the three CHW program sites. These documents were representative of Schwandt’s (2007) definition of documents that provided “valuable information and led me to pursue other paths for inquiry of the behind-the-scenes at the CHW program history and processes” (Patton, 2002, p. 295). For example, documents collected at all three sites revealed the tremendous and varied paperwork Mary, Sabrina, and Margaret was required
to complete monthly. Moreover, these documents indicated that the role of the CHW included the role as a researcher as the CHWs collected and tracked data on patients’ health outcomes for evaluating their patients and the CHWs’ services. As Patton (2002) argued, had I not collected and reviewed these documents I would have missed relevant information that I could not obtain through other forms of data collection. A list of examples of the documents from the three CHWs’ site is in Appendix F.

3.5 Data Analysis

According to Coffey & Atkinson (1996), data analysis is a complex process. Data analysis is not a stage rather it is a reflexivity activity that informs data collection, writing, and further collection of the data. Nor is there one correct way to analyze data. There are fundamental characteristics of qualitative analysis that are common in analyzing data. The analysis is a “cyclical reflexivity activity that is comprehensive, systematic, but not rigid. The data is divided into meaningful parts based on content and reconnected to the whole to make meaning of the phenomenon” (p. 10). In this section, I describe how I conducted data analysis, which included the process of coding, use of reflexivity in writing analytical memos, and constructed the vignettes to answer the research questions. I analyzed the data for the study that I collected from my field notes, transcriptions of the semi-structured interviews, and focus group interviews, and analytic memos. I used the documents as a source of additional information in the developing the themes and the crafting of the vignettes to answer the research questions.

As Saldaña (2013) recommended, as I collected data, I created a comparison chart that listed the site number, date, and type of data and source of data. This process helped me to manage the data better and to compare information about the data across sites.
used Atlas Ti, a qualitative software program, and Microsoft Word to help organize and manage the data in a secure password protected system. This process took place the first day I began collecting data. I listened, transcribed my audio recordings of the field notes of the day’s observations, and combined them with my written field notes in Microsoft Word documents that I uploaded to Atlas Ti. For the most part, I followed the same process after each of the individual interviews and the focus groups interviews. I added demographic information about the interviewee to interview data. Likewise, I organized an electronic copy of the documents I collected and uploaded them into folders with the name, date, and type of document. For the paper documents, I dated and grouped them into types (letters, emails, education information, etc.) and then I filed them in a colored file folder labeled with CHW site number.

**Coding.** Coding is a process that “breaks data into manageable segments, identifying, and naming each segment with descriptive meanings” (Schwandt, 2007). It involves a consistent process of comparing and contrasting segments of data into categories (Saldaña, 2013, p. 3). The term code is a “word or short phrases constructed by the researcher that attribute an iterative meaning for the purpose of detecting patterns, categorizing, and connecting meaning to the data” (p. 8). I developed a codebook file in Atlas Ti of the compilation of codes. Each code consisted of a description, criteria for the code, and illustrations of the code and the source. For example, I established an early code, “description of the CHW office.”

The CHW office is a place where the CHW perform the tasks associated with their job duties. Mary, the office is very festive with personal momentous. A bright colored love seat seats two. Next to it, a side table with a picture of a black
angel, a white ceramic angel, a rose, and above the table, her CHW Certification is mounted in a black frame. The source of the data: Site 1 field notes dated; 5/5/2015.

During my observations with Mary in her office, I noticed more details, and I made notes of the details of my field notes to which I later added the code, “description of the CHW office.” I followed a similar process for each of the CHWs’ offices and continued to add codes to the codebook.

Saldaña (2013) suggested, “Seven attributes researchers must possess for analysis, especially during the coding process” (p. 36). These attributes include “organization, perseverance, and the ability to deal with ambiguity, as well as being flexible, creative, rigorously ethical, and have an extensive vocabulary” (p. 37). During data analysis, I read and re-read all of the forms of data that I collected to gain an understanding of the participants’ experiences. I conducted multiple cycles of coding, as described above, to achieve a deep awareness and understanding of the experiences and the culture of CHW programs. I used Saldaña’s (2013) suggested coding cycles, methods of codes, and types of codes aligned with the studies’ research questions.

My first cycle of coding began with in vivo coding (emic), and description coding focused on the individual’s words, language, interpretations and descriptions (Saldaña 2013). As I read through the information, I highlighted the descriptions, characteristics, and demographics about the individual’s activities and the settings. I completed the first cycle of coding across all of the data sources. This process began when I entered the field Site 1 at HFP. I coded my daily field notes and the interviews as they were transcribed. As I coded this information, I wrote these early codes in the codebook using the
terminology of the individuals. Within these codes, I was able to identify sub-codes under each code that helped clarify elements central to the code. Moreover, highlighting these subcodes enabled me to get the particularities of the codes. As I coded, I wrote analytical memos that helped identify similarities, patterns, and outliers across data sources and the codes. By using an emic approach, I emphasized participants’ understandings and their words.

My second cycle coding methods involved more complex analytic work, which helped me to refine the first cycle coding (Saldaña 2013, p. 206) and answer RQ 3 on CR in particular. I used protocol coding; the aim was to “harmonize the data with the protocol” (p. 151). Protocol coding enabled me to use Gay’s model of cultural responsiveness as a pre-established coding system. Additionally, I used the pattern and focused codes and categorized the data as an initial analytic strategy. The goal was to develop a sense of “categories, major themes, and conceptual and theoretical organization from the first cycle of coded data” (p. 207). The transitional process after the second cycle involved the post-coding and pre-writing (p. 246). For this transition, Saldaña (2013) suggested identifying three major codes, themes, categories, and meanings directly from the data.

As a result, of the second cycle coding, I created 30 codes with 60 plus sub-codes that I then coded to the four research questions. Using the research questions as a guide, I was able to establish codes coupled to each question. For example, RQ1, What is the day of the life a CHW in PHC? The codes for this question included: 1) the drive to the office, with sub-codes finding peace and tranquility, and talking with patients on the telephone before work begins. 2) The office, subcodes: Doing paperwork, using the brain
(computer) to inform health care team members, tracking patients’ health outcomes and writing reports, making phone calls and following through with referrals; writing and responding to emails. 3) The clinic, sub-codes: preparing for patients’ visits, consulting the physician and other health care professionals; seeing and interviewing the patients. 4) Making home visits, sub-codes: preparing for home visits, meeting the patients and family members, reviewing the purpose of the home visits, reviewing the patients’ health status and medications and providing health education. 6) End of the day, sub-codes: following through with referrals, advocating for patients, reading and responding to emails, writing clinical encounters, and there is always one more thing to do.

At the end of this cycle of coding, I coded the salient point’s specific for each of the CHW sites, which resulted in three salient categories for each of the CHW sites. For the first site, HFP, the salient point was “rounds at the hospital”, the second site, RHC, the salient point was “CHW at the emergency department’, and the third site, MCHC, the salient point was “patient coordination”. Lastly, I grouped the in vivo, descriptive and protocol codes from all of the data sources into narrow categories (themes) and sub-categories (sub-themes) based on all four of the research questions. I then used the data to construct the vignettes.

**Analytic memos.** According to Saldaña (2013), “the purpose of analytic memos is to capture the researchers’ reflections during the research process, and the choices made during coding about emergent patterns, categories, subcategories, and concepts within the data” (p. 40). The memo is the researchers’ journal, a place to “dump your brain “about participants, phenomenon, or process (p. 41). Throughout the analysis process, I audio recorded and hand wrote memos to reflect my critical thinking about
what I did and my assumptions regarding the things that influenced my thoughts and actions. Afterward, I listened to the recordings and jotted down additional information that expanded my ideas and thoughts and listed further questions I had. For example, I began the process of developing a profile of each of the CHW sites and the CHW employed at each site after the first cycle of in vivo coding and descriptive coding. These memos also included other information about my frustrations, concerns and insights about specific topics or issues in the context of the inquiry. As I indicated earlier, I coded several analytical memos that I categorized into appropriated themes that I established.

**Constructing the Vignettes.** According to Finch (1987) vignettes are brief stories that are representative of hypothetical or real-world scenarios or incidents. Coffey (1996) pointed out these stories can be “collected naturally as they occur during participant observations or solicited during the research setting” (p. 56). As such, vignettes are stories that enable the researcher to retell the people stories about their experiences in the context of the inquiry. For this study, I chose vignettes as a method of representing the findings to the RQ1, “What is the day in the life of CHWs in PHC?” because an aim of this study was to provide a rich description of the lived experiences of CHWs working in PHC. I represented in Chapter 4 the intricate details of the of the day-to-day CHW services provided by Mary Moore, CHW at Hillsboro Family Practice (HFP), Sabrina Sams, CHW at Riverdale Health Center (RHC) and Margaret McGowan, CHW at Montgomery Community Health Center (MCHC).

The process of constructing the vignettes began the day I met each of the CHWs at their PHC sites. I used the data I collected from individual and focused groups interviews with a total of nine patients, family members and thirteen healthcare
professionals, ten days of field observation at each site and 80 documents that I collected from the three sites. I developed and began writing a profile of Mary, Sabrina, Margaret and their PHC facilities to which I added information throughout my engagements with them. I recorded and documented in my field observations notes the detailed descriptions of the spaces and places I visited as well as the behaviors, attitudes, spoken, and unspoken words of the people I encountered. As I collected, reviewed, coded and analyzed the data, I wrote memos that further described my interpretations of the data.

To represent the data, I crafted composite stories (Wertz, Nosek, McNiesh, & Marlow, 2011). Originally, the unit of analysis was the CHW program site. However, during observations, coding, and analysis I noted that many of the scenes I coded were common to all three locations. Distinctions across the three sites became less salient in my coding than the multiple and intersecting roles which the CHWs fulfilled. Consequently, to answer the research question, “What is a day in the life of CHWs in primary healthcare settings?” I represented findings of the CHWs’ experiences in a composite characterization of a typical day. Therefore, I coded across observation notes and interviews with each CHW to create composite representations. Wertz, Nosek, McNiesh, & Marlow (2011) explained:

The composite is not a simple retelling. It is an interpretation by the researcher in several important ways: through her knowledge of the literature regarding the phenomenon under inquiry, through listening and hearing the stories told by the informants, and through her reflexivity during the process (p. 2).

I developed the composite CHW that I identified as “Patience” and the composite PHC site that I called “The No Patients Left Behind (NPLB) Center.” Using the themes as
a guide, I reviewed the field notes from each of the CHW sites to reflect on and write the composite stories for each of the themes.

The composite vignettes represent the day to day experiences of three participants: Mary Moore, Sabrina Sams, and Margaret McGowan. In the vignettes, I created the composite character, Patience Richardson, to represent the composite of all three women’s experiences (Mary, Sabrina, and Margaret) as community health workers (CHWs). The context of the first vignette was provided by the CHWs when I joined them for ten days as a participant observer and from interview data when I asked them to describe their mornings before we began our day together. I based the context of the second vignette on my direct observations of the CHWs engaged in the provision of services and the conversational interviews I had with the CHWs, patients, health care team members and others interacting with the CHWs. I also used information from the documents I collected. The context of the third vignette came from my observations of the CHWs in the clinic area or the examining rooms at each site. I also included content from conversations I had with the patients and health care professionals and information from documents I collected from three sites and gathered from the literature. Vignette four’s context was constructed using my field notes from observations of each CHW during home visits with patients, conversations I had with individuals and information from the documents I collected. Finally, I developed vignette five from my participant's observations, ten days at each site for a total of 30 days, conversational interviews with CHWs, patients, and healthcare team members. I followed the same process to construct the vignettes for the Section 4.2, “The salient points of the day in the life of CHWs in PHC.”
3.6 Methodological Considerations

Trustworthiness. Trustworthiness in qualitative research is an essential component of the inquiry process as it determines whether the study is credible and/or authentically represents the phenomenon of inquiry (Patton, 2002). Maxwell (2005) pointed out that qualitative “researchers are threats to the validity. The researcher’s bias and the effects of the researcher on the individuals studied, often called reactivity” (p. 108). Lincoln and Guba (1985) argued qualitative research is a matter of judging the quality and goodness. They suggested there are four criteria for establishing trustworthiness: 1) Credibility and confidence the findings are truthful. 2) Transferability, the results apply to other contexts and other participants; 3) Dependability, the consistency and logic of the data collected with the results; and 4) Confirmability, neutrality, whether the findings reflect the participants rather than the biases, motivation, and interest to the researchers.

For this study, I adopted three of Lincoln and Guba’s (1985) criteria for established trustworthiness. Credibility can be achieved using several strategies including prolonged engagement, triangulation, member checking, peer debriefing, and reflexivity. First, to ensure prolonged engagement, in which I spent 10 working days and an average of 8 or more hours each day observing the CHW program services at HFP, RHC, and MCHC. For the most part, I had complete access to CHWs’ activities. They allowed me to shadow them and to participate in all of their day-to-day activities with permission of the patients and health care team members.

Secondly, triangulation is a process wherein the researcher uses multiple sources of data to confirm themes, patterns, interpretations, and the study’s findings (Lincoln &
Guba, 1985; Maxwell, 2005). To ensure triangulation for this study, I gathered observational data from approximately 60 individuals and engaged in informal and formal interviews with people associated with all the three CHW programs. I documented my firsthand accounts of these observations in my field notes. I also interviewed 22 individuals, nine who were patients, family members and the other 13 who were health care professionals, working with Mary, Sabrina, and Margaret. I also included content from conversations I had with the patients and health care professionals and information from documents I collected from three sites and gathered from the literature. Lastly, I used Gay’s (2000) six attributes of being culturally responsiveness as a framework to determine the findings for RQ 3.

Third, member checking is a process that involves “receiving feedback from the respondents on the researcher’s findings. By doing a member check, the researcher can “claim the findings are valid and meet the criterion of conformability” (Schwandt, 2007, p. 187). For this study, I invited the patients and the CHWs I interviewed for the study to review their transcripts and the preliminary findings to all four of the research questions. None of the patients responded to my invitations through the CHWs; many had changed telephone numbers, some just did not respond. Two of the three CHWs responded and confirmed the findings. Each added anecdotal information that I included in the data analysis.

Fourth, peer debriefing is “the process that involved discussing the researcher’s inquiry with a group of like-minded peers to receive genuine feedback and critical thinking and consultation that will enable the researcher to think and reflect” (Lincoln & Guba, 1985, p. 308). Throughout this inquiry, I consulted a group of qualitative scholars
at various levels of their research with the guidance of a senior qualitative research scholar. This process was very helpful in addressing issues as they arose about the research, for example, researcher bias in editing a letter for a CHW.

Fifth, as I have indicated, I am both the researcher and an insider uniquely situated in positions of power and privilege. An essential strategy that I used throughout this inquiry was the use of reflexivity. In so doing, I reflected consistently and critically on myself as a researcher, a ‘human instrument’ in qualitative research (Lincoln & Guba, 2013, p. 254). I captured these reflections through audio recording and analytical memos.

Lastly, this is an ethnographic case study. The product of this study is a rich description and analysis of CHW programs services in three primary care settings. I do not claim that my findings are generalizable to other contexts or communities, nor do they reflect all CHW programs in SC. It is essential for readers to think about the purpose of this study and the research questions before anticipating anything other than what I have described in the study design. This study is not an evaluation of SC primary healthcare system, CHWs, their employers, services, healthcare professionals, patients, or communities. It is a case study uniquely situated to represent one iteration of the services, roles, and culture of CHW programs in PHC settings in SC (Patton, 2002).

**Ethical Issues.** Ethical issues are a combination of factors that relates to ethics of the researchers and ethical application of the research methodologies and methods (Schwandt, 2007). The “researcher must also consider their actions throughout the inquiry process as it relates to human accountability, ethics, epistemology and politics intertwined” (p. 90). For this study, I used the research questions to explore the culture and the dynamic process of CHW program services in PHC. With this opportunity came
many responsibilities that I took seriously. For example, before beginning and throughout the study, I tried to educate individuals about qualitative research and participant observations, as I believed many individuals think the researcher must be very distant from the inquiry. I often said I am fortunate: “I have the opportunity to learn about CHWs, so I can be a better trainer and develop a more realistic curriculum that reflects what CHWs need to know do their jobs.” As I conducted participant observations each day, I interacted with the people engaged in CHW programs at HFP, RHC, and MCHC with the utmost respect for their privacy and confidentiality, and awareness of their spaces, places, and cultural backgrounds and beliefs. I represented much of data in the people’s voices to reflect the representation of their experiences with the CHW program services accurately.

I believe an important ethical consideration is my positionality at the intersection of insider’s status. Because I am an instructor of the CHW Certification Training Program, social work, and educational courses, the CHWs, and others in the context of the inquiry often referred to me for advice. I believed some individuals might have perceived me as a threat, or having power and influence because I chose to conduct research regarding the CHW program. As I encountered individuals, I tried to establish a good rapport and minimize my role as educator and researcher. There are times during the study when my identities merged naturally to address a circumstance. For example, my role as a social worker frequently arose where I advocated for patients and the CHWs. As much as I possibly could, I asked those who asked me for advice to think through what they thought was best, and then I validated or made suggestions regarding their ideas. Still, there were times when I felt there was nothing I could do as individuals did
think of me as an expert. During these incidents, I would say, “I think …. However, I would suggest you consult…” someone whom I believed could give them sound advice.

Another important consideration is my subjectivity and the level of reflexivity I think is required in this ethnographic case study. Lincoln and Guba (2013) remind researchers that reflexivity “forces one to come to terms with various issues related to the inquiry, the people engaged, ourselves and the multiple identities that are fluid in the research context” (p. 255). Throughout this study, I was aware of my critical lens and attuned to issues of power, racism, marginalization, and inequalities for people of color and people with low or no income that exist within all social institutions and all levels of culture. I reflected in memos my frustrations and asked questions of myself and others when I was unsure about issues related to injustice. Reflexivity requires one to ask questions of all identities, lenses, and assumptions as well as with the “binaries, and paradoxes that shape them” (Lincoln and Guba, 2013, p. 255). By writing memos, and journaling, I was able to discover things I had not thought about, and I was able to deconstruct and reconstruct meaningful experiences in the forms of narratives. Still, I believed there were times when I felt compelled to speak up, and I think I did so appropriately. At times, I sought, too, the advice of trusted colleagues and my dissertation committee members who provided me a place to vent and sound off about my concerns; they offered meaningful and useful advice that I followed as well.
Chapter 4

A Day in the Life of Community Health Workers in PHC

Introduction

In this study, three community health workers (CHWs) served as members of patient healthcare teams and worked in coordination with other healthcare professionals at three different sites to ensure that patients received comprehensive quality healthcare services. In this chapter, I discuss findings for two of the research questions (RQ) for the study in the context of PHC: 1) What is a day in the life of CHWs? And, 2) what services do CHW programs provide? First, I represent the data to answer RQ1 in the form vignettes. I introduce the participants and the primary health care providers’ sites, and I share composite vignettes that reflect all three CHW programs in PHC. Then, I represent the salient points in the form of vignettes that is unique for each of the three sites. Second; I represent the data reflecting the findings to the RQ2 and discuss tensions that exist within the provision of the CHW programs.

Composite Vignettes. The CHW participants work at three primary healthcare providers in South Carolina: Hillsboro Family Practice (HFP), Riverdale Health Center (RHC), and Montgomery Community Health Center, (MCHC). The composite site, No Patient Left Behind (NPLB) Health Center, represents a composite representation of these three sites. Table 4.1 illustrates the relationships between each site and community health worker. Although each vignette was designed to represent a
typical day in the life of a CHW, a day in the life of a CHW was anything but typical. As a result of this study, I have learned that a CHW knows to expect the unexpected. In practice, expecting the unexpected meant being flexible, and being open and willing to allow the patients’ needs to determine CHW activities often from moment to moment.

Table 4.1 Primary Healthcare Providers

<table>
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<tr>
<th>Site 1</th>
<th>Primary Healthcare Providers</th>
<th>Community Health Worker (CHW)</th>
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<tr>
<td>Site 1</td>
<td>Hillsboro Family Practice (HFP)</td>
<td>Mary Moore</td>
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<td>Site 2</td>
<td>Riverdale Healthcare Center (RHC)</td>
<td>Sabrina Sams</td>
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<td>Site 3</td>
<td>Montgomery Community Health Center (MCHC)</td>
<td>Margaret McGowan</td>
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<tr>
<td>Composite Site</td>
<td>No Patient Left Behind (NPLB) Health Center</td>
<td>Patience Richardson</td>
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Site 1: The Hillsboro Family Practice

The Hillsboro Family Practice (HFP) is ten minutes away from downtown Hillsboro, SC. Hillsboro is an urban city with a population of 140,000 residing within the city limits. On any given day, however, the city of Hillsboro’s population increases more than 50% (Hillsboro, SC City Information, 2014). This flux in population is due in large part to commuters. Hillsboro is adjacent to some small towns and communities, and the city connects several highways and interstates leading to other states. The HFP is a part of the Habersham Healthcare Consortium (HHC), a large private non-profit health care organization operating in South Carolina (Hillsboro Family Practice Brochure n. d.). In the Hillsboro area, the HHC provides a broad range of comprehensive primary health care services in ambulatory and hospital facilities. According to Mary, the HFP is located in a large medical complex with 16 physicians and a multidisciplinary health care team that annually provides 15,000 children and adults with complete family health care.
The Hillsboro Family Practice (HFP) is diverse. Through my observations and interactions, the health care team, staff, and patients represent diversity racially, socio-economically, and religiously. The focus of the HFP’s comprehensive and integrated health care is the prevention, diagnosis, and treatment of acute and chronic diseases. As such, the HFP health care team is working to eradicate chronic diseases through providing education, promoting good health, and ensuring patients’ quality of life (Hillsboro Family Practice Website, 2015).

According to Mary, a survey conducted in 2012 with patients about the HFP revealed that the HFP had a reputation for being one of the most innovative and progressive primary health care facilities in the southeastern United States. Likewise, employees’ satisfaction survey respondents indicated that their healthcare professionals were satisfied and motivated to work with a broad range of diverse people. Nearly half of the employees receive their primary health care at the HFP. In 2012, HFP integrated the Medicaid pilot CHW program into its services delivery model. The CHW was the newest member of a multidisciplinary team of healthcare professionals which includes physicians, nurse practitioners, social workers, nurses, speech, occupational and physical therapists, and laboratory and radiology technicians.

Community Health Worker: Mary

The first time I saw her, I immediately thought that Mary looked just like Mary Tyler Moore—the star of the popular television sitcom during the 1970’s. The sitcom focused on a young, attractive single female, who depicted the lifestyle of an independent career woman determined to make it in the male-dominated news media profession in Minneapolis. Similarly, Mary, a community health worker (CHW) at the Hillsboro
Family Practice (HFP), is an attractive, 36-year-old career woman, but she happens to be Black. She is not White like Mary Tyler Moore.

Mary had worked for three years as a CHW at HFP when I met her. She is approximately 5’9 tall and is medium size. Her skin is medium brown – the color of pecans – and her face is oval shaped, not too round. She has soft brown, slightly slanted eyes. Mary wears just the right amount of make-up to accentuate her natural beauty and unique style. Her hair is a medium-length style cut with curls just above her shoulders. Mary’s smile is bright. She is smart, witty and a sincere, genuine, caring and dedicated individual. For work, typically she dresses professionally though somewhat conservatively by today’s standards. The day I met Mary, she was impeccably dressed in a knee-length black skirt, white blouse, black suit jacket, and black tights with medium-height black heels. She carried a matching black purse and wore tastefully understated jewelry.

Mary’s body weight is proportionate based on her height and age by medical standards. However, three years ago, Mary shared she was fifty pounds overweight. Mary credits learning about diet, nutrition, and exercise through her training as a CHW, with helping her gain control of her weight. Mary said, “I believe educating patients about the consequences of obesity made me realize I was jeopardizing my health.” Mary readily shares that managing her weight continues to be a challenge. By doing so, she believes she has prevented chronic diseases, such as diabetes and hypertension that are a part of her family history. “I eat more fresh fruits and vegetables and choose fewer processed foods,” she said. “Eating healthy and exercising three to five times a week enables me to
live a healthier lifestyle today.” As a single parent, Mary shared her two children “need and deserve a mother who is healthy physically, mentally and spiritually.”

Mary disclosed that she divorced her husband after ten years of marriage. She had married her childhood sweetheart when she became pregnant as a teenager. Mary said that she knew firsthand the struggle of trying to work and provide for a family of three with a salary of $25,000 a year. Mary’s oldest son is 17 and a senior in high school; he learned he was awarded a full academic scholarship to a college. Her youngest child is 14 years old, and she described her as “an outstanding track and field athlete.”

Mary is a college graduate with a bachelor’s degree in Theology. Mary said, “I pursued a degree in theology because I was very interested in doing ministry, but not becoming a minister.” The ministry, she said, “is about serving people.” Mary knows a lot about helping people. “I grew up with family, church members, friends, and neighbors who voluntarily assisted each other through life’s sometimes very difficult circumstances,” she said. Most of Mary’s previous work experiences have been as a certified medical assistant (CMA), a counselor’s aide, and a patients’ assistant. “I have also had numerous volunteer roles with the church,” she stated, “and each of these positions has helped prepare me for my job as a CHW at the Hillsboro Family Practice Center.”

**Site 2: Riverdale Healthcare Center (RHC)**

The Riverdale Health Center (RHC) is a member of the network of federally qualified health centers located in Riverdale, South Carolina. Riverdale is an old rural town established over two hundred years ago. The town population is nearly 2,500 individuals in an area of 4.1 total square miles. The town has a total of almost 700
households with a median household income of $25,833 (Riverdale, SC City Information, 2014). The RHC is a private non-profit comprehensive primary and preventive health care center. Because RHC is located in a rural community and is federally funded, it provides a full range of primary health care services. These services include family practice, OB-GYN, pediatrics, geriatrics, internal medicine, immunizations, referral to specialty services, case management, health education, nutrition, self-management, outreach, translation, social services, clinical counseling, pharmaceutical services, laboratory and X-Ray. The RHC is in the old county health department situated on the west end of Riverdale. The building is dated; however there have been recent upgrades to accommodate the increasingly technological and medical changes. Space is very limited. However, the healthcare professionals are very creative in managing the space.

The RHC healthcare team consists of physicians, nurse practitioners, nurses, a social worker, a family services worker, pharmacy staff, nursing assistants, laboratory technicians, a community health worker, and administrative personnel. On any given day, RHC serves approximately 25-35 patients. The majority of RHC’s patients have private insurance or Medicaid, and the center is the major resource for primary health care for all residents in Riverdale. The individuals with or without insurance are encouraged to seek primary health care at RHC. In partnership with two local hospitals, RHC’s staff works diligently to help patients to secure a primary health care provider rather than seek health care through the emergency department (ED). (See Chapter 1 for a discussion on primary care services at emergency rooms.) The RHC is a system of healthcare that works collaboratively with hospitals, other health care providers, service organizations, and
community leaders across the region to ensure unified services and continuity of care for patients.

Community Health Worker: Sabrina

Sabrina Sams is a tall, slender Caucasian woman with a pale complexion and a sprinkling of freckles on her face. Her short blonde hair has a part on the side and a blunt cut. She is 48 years old and has greenish brown eyes. She is a friendly, kind, and thoughtful person with impeccable manners. She dresses professionally, with carefully matched accessories, jewelry, shoes, and purse. With her boyish figure and unique style, Sabrina stands out. Sabrina grew up in Freeport Maine, a small town 21 miles from Portland. Her mother and father owned a local filling (gas) station and grocery store. They employed the locals in the community. Sabrina has two older sisters and one younger brother. She attended private schools and graduated from a major university with a degree in business. During the 2009 financial crisis, Sabrina, and her husband Jacob both lost their jobs in the financial industry. “We decided to relocate and purchased 200 acres in Riverdale, South Carolina to farm,” she said. They have two children: Julia, age 20, who is a senior in college and Janice, age 15, who is in high school.

Sabrina explained that she had difficulty finding work in her new rural community (population: 2,500). One morning while reading the local newspaper, she stumbled upon an announcement for a new training program for community health workers at Tri-County Technical College. Reading the program description “reminded me of the ways in which the people in my hometown supported and took care of each other,” Sabrina said. She signed up for the training. Because the training program required clinical hours in a healthcare setting, Sabrina had the opportunity to work as a
CHW with a social worker at the Riverdale Health Center. More than two years later, Sabrina continues to serve patients at Riverdale Health Center.

**Site 3: The Montgomery Community Health Center (MCHC)**

Montgomery County is a rural county with 800 square miles that encompass four small towns and four unincorporated communities. According to the 2010 Census, the county’s population comprised nearly 43,000 people. The racial backgrounds are as follows: 51.1% White, 33% Black/African-American, and 8.3% Hispanic. The county’s unemployment rate of 6.2% is slightly lower than the state’s rate of 6.7%. The S.C. Department of Employment & Workforce Department Business Initiative Report identified the top five major industries for employment as 1) manufacturing, 2) healthcare and social assistance, 3) transportation and warehousing, 4) retail and trade, and 5) accommodation and food services.

The Montgomery Community Health Center (MCHC) was established thirty years ago during a period in which individuals residing in rural towns had little or no access to healthcare (Margaret McGowan, 2015). Healthcare for individuals who were uninsured or living in poverty meant trips to the emergency room for treatment because of their inability to pay for routine and regular health care. Federal policies mandated that hospitals receiving any federal funds must treat everyone requiring emergency health care regardless of their ability to pay. Today, MCHC is one of 22 Federally Qualified Health Care Centers (FQHC) in South Carolina (HRSHA, 2014). An FQHC qualifies for funding under Section 330 of the Public Health Service (PHS) Act, with specific reimbursement systems under Medicare and Medicaid. As a result of this funding, MCHC can provide healthcare services to all persons in the community regardless of the
individual’s ability to pay. A sliding fee discount is available based on income, and there are free programs available through health care foundations and partnerships for underserved communities and people.

The MCHC’s mission is to “enhance and improve the health and wellbeing of everyone” (MCHC, 2015, n. p.). The MCHC regards its patients like family members; as such, MCHC is committed to ensuring patients have access to a broad range of comprehensive and quality healthcare services to meet their needs. These services include primary health care, family, senior and pediatric care, women’s health and OB/GYN services, behavioral health, a community pharmacy, dental medicine, chiropractic services, HIV/AIDS health care, community outreach, health screenings, education, social services, and a medical home. MCHC has a diverse team of healthcare professionals who work together as the patients’ team members. The team includes physicians, nurses, nurse practitioners, pharmacists, social workers, community health workers, outreach workers, and other employees, many of whom grew up in the area. The MCHC has a positive reputation, with national and state accolades for being a community health center that provides innovative and quality health care to patients (MCHC’s Website, 2015).

Community Health Worker: Margaret

Margaret is an attractive, 50-year-old white woman. Her red hair is a stylish cropped short hairstyle that compliments her round, plump face. From a distance, she looks younger than her years. Upon closer inspection I could see she is older because the lines on her face give away her age. She has a smoker’s raspy voice, and a deep southern accent with a distinctive way of saying “Y’all.” Margaret grew up in Montgomery
Montgomery County, SC in a rural farming town, with a population of 2,650. Margaret attended the Montgomery County Public Schools and graduated from high school. She did not attend college but worked at various other jobs including that of a factory worker, home health aide, and patients’ assistant. Margaret said, “I grew up poor, but my parents always made sure I had plenty to eat and a clean, safe place to live.” Both of her parents worked hard. Her father worked in a local factory for 30 years. Her mother cooked at a small hotel during the day and worked as a seamstress at night. Growing up in a small town “meant that you knew everyone, and everyone knew you and your family,” she said. Margaret was an only child until the age of twelve, when her twin first cousins, Marvin, and Andrew, came to live with them. “I learned at an early age the significance of having the support of family, friends, neighbors, church members and the community in times of needs and challenges,” she explained. Helping each other was commonplace in Montgomery, and Margaret said that she is proud to continue this legacy in her role as a community health worker (CHW).

Margaret is married to James for over 20 years, and they have a daughter, Amber, who lives in Virginia, and a son who lives in a nearby town. Margaret currently works at the Montgomery Community Health Center (MCHC). Most days she dresses in pastel colored scrubs adorned with her official nametag. She wears sensible shoes and says that her feet often “hurt” because she is on them all day. She is very personable and friendly. She appears to be the type of person who makes her patients feels welcome and comfortable almost immediately.

Becoming a community health worker was a natural fit for her. “I performed many of the duties before the CHW position was official here,” she said. Margaret
attended the Montgomery County Technical College to receive six weeks (120 hours) of training to become a CHW. Her role as a CHW “continues to expand based on both the patients and the healthcare team’s needs,” she explained. Margaret interacts with patients in the health center and their homes and often checks patients’ vital signs and monitors their health status. She is now receiving additional training to become a certified nursing assistant (CNA).

The Expanded Model of Care for PHC

It is important to note that all three of the PHC sites reporting using or being in the process of integrating the expanded model of care of services depicted in Figure 4.1. According to the Agency for Healthcare Research and Quality (2013), the Expanded Care Model focus is six core elements: community resources, health systems, self-management support, delivery system design, decision support, and clinical information systems. The patient-centered medical home’s (PCMH) services are comprehensive, patient-centered, coordinated, accessible, evidence-based, timely and efficient. When patients and family members are informed and empowered, and the health care team is prepared and proactive, the results are positive health outcomes for patients and communities (Coleman, Austin, Brach & Wagner, 2009).
Figure 4.1: Expanded Care Model

Vignette 1: The Drive to Work

Most mornings Patience shared she feels pressed for time. After all, before 7:30 a.m. she usually has cooked or prepared breakfast for her family and dropped the kids off at school on her way to work. The drive to the No Patient Left Behind Health Center is no more than 15 minutes away in light traffic — just enough time for Patience to praise God for all of the things He will bring her way today. According to Patience, “there is no better way to ‘get your praise on’ than the sound of sweet music.” In her car, there is a variety of CDs, mainly inspirational music, books, and some contemporary music (jazz, country, and Rhythm & Blues). Patience shared that one of her favorite songs is an
instrumental, “What a friend we have in Jesus.” She commented, “the sound of the instruments, blending melodies together always provide a place of tranquility. My mind wanders in peace and serenity,” she said. Patience shared that her drive to work is “one of the most precious times of my day” because she connects with God, “the highest power” and “the universe,” knowing “all is well, no problems, worries or concerns” in those moments—“just peace and love.”

Not much time will go by before one of her cell phones rings. She carries two cell phones, one for work and the other for personal use. Her family and friends know to call her personal cell phone instead of the work number. Though her work hours are 8:00 a.m. to 5:00 p.m., Patience reported answering her work cell phone regardless of whether or not she is on duty. Patience shared her conversation with her first caller of the day. It was with Mrs. Annie Taylor, a patient. Patience conveyed: I answered, “Good Morning, this is Patience Richardson with the No Patient Left Behind Health Center.” Mrs. Annie replied, “This Annie Mae. I am doing pretty good, how are you? You know I was released from the hospital Saturday morning. I was calling to see if you know if the lady is coming today to help me out.” Patience said, “I explained to her that I was unsure if a personal assistant would be there because I had not heard back from the Caring Companion Program (CCP).” Last week, she left several telephone messages, but she never received a callback. She explained:

I am not sure why neither you nor I have heard from them. I faxed their office your application along with the required documents about three weeks ago.

Ms. Hack, the Intake Worker, told me that they would notify you in about week or so to let you know if your application was approved or denied.
Mrs. Annie Mae reminded Patience she was in the hospital seven days. She said, “my church members checked on me over the weekend and brought me food.” She explained that her only daughter could only stay Saturday night because she had to return home out of town to take care of her three young children. Patience said, “I listened, and occasionally I would say ‘Yes ma’am.’ I tried to remind her I met the church ladies and spoke to her daughter by phone. However, she continued telling me she had not had a bath, and would feel better if she had a real bath, not a sponge off.” Patience said, “I just kept saying, ‘yes ma’am,’ because I knew she just needed to vent. She has been very ill, and I think she is worried she may have to go to a nursing home if she does not get someone to help her in the home.”

Patience said, “I told her, I was driving to the office, but when I got there, I would call the CCP to follow-up. I assured her I would call her back, and before I hung up, I asked if she had breakfast and took her medication.” She said Mrs. Annie Mae reported taking the medicine but she did not feel like eating. Patience explained she needed to eat before taking the medicine and not to take the medication on an empty stomach unless the doctor tells her to do so. She said, “I told her to drink a can of Ensure. It would coat her stomach so she will not get nauseated,” Patience already knew Mrs. Annie Mae had a case of Ensure because she enrolled her in a program that provided dietary supplements for elderly patients who could not afford to purchase them. Patience said, “I promised to call her back to check on her after I followed-up with CCP.”

Patience said, “After I had hung up I have to admit I was very frustrated because last week I left several message for Ms. Hack at CCP. Patience shared that three weeks ago, the CCP office confirmed receipt of the completed application which consisted of the
doctor’s order and other required documents. “In my last message, I told her Mrs. Taylor was in the hospital and will go home over the weekend, and the doctor wanted to make sure someone would be available to help her live semi-independently in her home.” I asked, “Is this a reoccurring problem with CCP?” Patience acknowledged CCP’s services have changed some since they hired a new director three months ago, and the agency was undergoing some organizational challenges. She said, “the CCP staff is typically responsive to patients and referring agencies.” They help patients remain in their homes and avoid unnecessary or premature residential care placements. CCP is unique in that they provide services to anyone over the age of 18 years old who requires assistance with daily living skills as a result of a disability or illness (CCP, Brochure, 2014, n. p.). The CCP services include general household activities, such as cooking, cleaning, and laundry. Personal care services include helping patients with bathing, dressing, monitoring health, short-term relief for caregivers, personal care assistance with grocery shopping and other errands the patient may require.

**Researcher’s Reflections**

I noticed as Patience recounted her morning, several times she took short deep breaths. I said, “You took several deep breaths; what are you feeling?” She replied, “whenever I am feeling frustrations, disappointments and feelings of being overwhelmed, I breathe in deeply. It calms me down, and I teach my patients to do the same if they are feeling stressed out”. I smiled. “Did you learn that in the CHW training course?” I asked. She replied, “Yes, do you teach your students the breathing techniques too?” I laughed, and said, “I also use it to reduce my stress.” Almost at same time, we said,“It works.” It is not enough for CHWs to follow up with social services and community agencies.
According to Patience, “You must always follow up with agencies until the patient receives the services. Sometimes it takes repeated calls and multiple emails to the referring agencies to get patients the help they need to obtain the services they need,” she said.8

To follow up on the behalf of patients, each CHW must quickly educate him/herself about each agencies’ services, eligibility requirements, application processes and specific policies related to the services provided to the patient. As a CHW trainer and social worker, I can confirm that the referral process can be daunting and could take weeks, even months before a patients’ needs may be met. It may entail the CHW contacting many agencies located within a community, statewide, or even, at times, across states. Patience stated, “It takes the time to build a rapport and relationship with all these people. Once you do, they work better with you and then I can educate and help my patients get the services they need.”

Vignette 2: Patience’s Office

Patience and I arrive at the office and walk through the sliding doors of the No Patient Left Behind (NPLB) Health Center. Upon entering, we overhear a woman saying, “I am hungry.” We looked to our left and noticed an older woman sitting in a wheelchair and a middle-aged woman standing nearby. Patience cheerfully called out, “Good morning! How are y'all doing?” Both women replied in unison, “Good morning.” Then the older woman said, “I am not doing so well this morning.” Out of concern, Patience

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8 In order to contact each agency on behalf of the patient, however, the CHW must first get a release of information form signed by the patient. This form gives the CHW and the referring agencies the authority to share specific information about the patient for the purpose of obtaining services with the referring agency.
stopped walking and began questioning the woman to find out what the problem was and if she could help. Patience learned from the woman that she had been dropped off at the health center at 7:15 am by the Jackson Transportation Services (JTS). The JTS is a private transportation service awarded a contract with the South Carolina Department of Health and Human Services (SCDHHS) to provide non-emergency transportation for medical appointments for SC Medicaid recipients. The woman explained to Patience that she was picked up at 6:00 a.m. before she had a chance to eat breakfast. Patience offered the woman a banana and the yogurt she had packed in her lunch box. The woman was appreciative and accepted the food. Patience explained to the woman that in the future when she was at the health center if she were hungry, she could let the receptionist at the desk know. Patience told her the receptionist would gladly provide a snack with a drink (water or juice). The woman said, “Bless y'all hearts. That is so sweet of y'all to think about us.” “Yes ma’am,” Patience replied.

Patience later explained to me,

“We recognize many of our patients sometimes are dropped off early or have to wait for transportation which means they may be delayed eating their meals. Many of our patients have chronic diseases such as diabetes and hypertension; they must eat and take their medication regularly.”

Several years ago, she shared, the health care staff created a snack pantry for patients. Staff continues to donate fruit and healthy snacks, such as protein bars, yogurt, nuts, crackers, and peanut butter in to-go cups. Patients can get something to eat or drink when the transportation is running late or as in this woman’s case, when she had to leave home so early to make her appointment, she missed breakfast.
After Patience had explained that the woman could always ask for something to eat from the receptionist, the woman took the opportunity to voice her complaints about JTS. Patience listened. She shared later with me, “I frequently hear complaints about the Medicaid transportation system.” The JTS requires patients to give them three business days’ notice for the medical appointments. Often patients with Medicaid face challenges in getting transportation to their healthcare providers when they are sick or in the case of urgent appointments such as blood work or unexpected medical tests. On many occasions, Patience shared, she has had to transport patients herself because JTS can provide transportation only to medical appointments. Patience helps patients find transportation to other important non-medical appointments, too.

For example, when a patient needed to have a procedure done at a hospital outside the county, the JTS would not transport him, and because scheduled surgeries are not emergencies, neither would an ambulance service. Patience worked with a local social services organization to provide the cab fare for the patient. Another patient with diabetes tried to schedule an appointment with a podiatrist. Unbeknownst to Patience, Medicaid does not cover expenses for podiatry services. After getting the podiatrist to see him for free, Patience got a private transportation service to transport him to the appointment. Later that day, she and I went to the private transportation service office. Patience paid them for the service with her money.

I learned that the logistics involved with scheduling and getting Medicaid recipients to appointments at times was prodigious. JTS requires that patients be ready for pick up two hours before their appointment. Often patients wait another two hours to be picked up after their appointments. As the woman shared with us when we arrived at
NPLB, “I had to leave home at 6:30 for an an 8:05 appointment.” After the woman had finished talking about JTS, Patience offered her a toll-free anonymous telephone number so that she could make a complaint. Then noticing it was already after 8:00 a.m., Patience and I headed to her office. Typically, Patience takes the stairs for the exercise, but because of the time, she decided to ride the elevator to the 4th floor.

Unlike many CHWs, Patience has a private office on the 4th floor of the nine-story medical complex building that houses the NPLB health center. Once you exit the elevator, Patience’s office is on the left, less than 20 steps from the elevator. The room is small, about 8 x 10; yet it is a nice size. As you enter the door, on the left wall, there is an end table filled with personal mementos. A framed picture of a woman with a message of hope and faith, an angel, a long-stemmed silk rose, a ceramic (white) praying hands, and a copy of the Strengths Based Leadership book by Tom Roth and Barry Conchie are all organized on the table. On the wall above the end table is Patience’s framed CHW certification certificate. Next to the end table, there is a bright peach colored floral loveseat with large comfortable cushions and decorative pillows tossed on it. At the other end of the loveseat, there is another table with a small refrigerator. Above it are shelves with books, folders, and stacks of brochures, pamphlets, and health educational materials. Patience’s desk is walnut colored, and she has a black swivel chair behind it. Patience’s desk has stacks of papers. She apologized for the disorganization, explaining, “it may look disorganized, but I know what is in each of these stacks.”

On her desk, there is a picture of Patience and her family, as well as a computer and monitor that Patience refers to as the “brain”. When I asked why she called it the “brain,” she said in a serious tone of voice “because it is the mechanism for connecting
everyone to the operations of the health center.” She shared that the “brain” is how health care team members gain access to the patient’s medical records. Later I learned the significance of the “brain” when I observed CHWs using it for patients’ care during home visits, as a system for communicating and for webinars, meetings, and training. Just above the brain is a huge bulletin board on the wall with information thumb-tacked to it. There are lists of telephone numbers, the health center’s departments and offices, billing codes, HMOs and insurance companies, local pharmacies, important dates and deadlines, and emergency contact information. In the middle of the board, there is a sign that reads “Community health workers making a difference in individuals’ lives and communities.”

After unlocking the door, turning on the lights, and putting away her purse, laptop and other things in her hand, Patience sat in her chair and took a deep breath. Today, like every day, while she waits for the “brain” to boot-up, Patience closed her eyes and began praying; I joined her:

Oh, heavenly Father, I come to you for all things,

I know you are the Alpha and Omega. Everything begins and ends with you.

I ask for your guidance and inspiration for the work you put before me each day.

Thank you for the opportunity to serve the people you send each day.

It is through you, Lord that I will help them restore what man has tried to take from them, the will to live, and the hope for better days and the belief in something greater and more powerful than mankind. It is you, heavenly Father. Amen.

Patience immediately picked up her “to do” list. Each day before leaving work, she updates her “to do list”. The list consists of priority tasks for the day and those that are ongoing. Patience explained, “I add to the list daily; some things require my attention
immediately, and others are ongoing. Rarely do I complete everything I have listed. The list helps me to remember the priorities because they change quickly.” She begins reading the list under the heading, Today. 1. Follow-up with CCP regarding services for Mrs. Annie Mae. 2. Review patients’ files scheduled for appointments today. Ms. Brown at 10:00, Gloria Jackson at 10:20 (check to see if she kept her appointment with the substance abuse counselor). Mr. Johnston at 10:30 (update information for his pending Medicaid application). Mr. & Mrs. McGray at 10:45 (get a release of information signed by Mr. McGray to verify his dates of employment for the prescription assistance program (PAP), Medicaid and SSI applications). 3. Submit Mr. McGray’s applications. 4. Attend the teleconference at 1:00 pm about changes in the Medicaid application process. Then, under the heading of Ongoing, she reads, “Document the patients’ records I encountered [via telephone and in person] today. Confirm home visits with patients this week. Review patients record seen this month and determine if they are compliant with the Healthcare Effectiveness Data and Information Set (HEDIS)⁹. Score and record patients’ assessments [PAM and GAIN¹⁰]. Collect and input data for the Medicaid and NPLB’s quality reports. Review and revise health education powerpoint presentations.

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⁹ The Healthcare Effectiveness Data and Information Set (HEDIS) is a health care tool used a tool for monitoring and measuring dimensions of care and services. The HEDIS consist of “of 81 measures across five domains of care.” For example, the guidelines for physician measures includes the effectiveness of preventive care, acute care, chronic care, accessibility/availability of care and utilization of care for all patients (National Committee for Quality Assurance, Website, 2015).

¹⁰ The Patient Activation Measure (PAM), “is a tool used for measuring the level of patient engagement in their healthcare. It was designed to assess the [patient’s] knowledge, skill and confidence for self-management (Mukoro, 2012).” The Global Appraisal of Individual Needs (GAIN) is biopsychosocial assessment tool (GAIN Website, 2015). The PAM and the GAIN are two quality measures that the three CHW programs are required to complete and report on for all patients receiving CHW program
Just as she finishes reading today’s to-do list, the “brain” beeps, indicating that Patience has emails. There are 15 emails in her inbox. Patience first reads the emails marked with the word “priority” in red. The health center established the priority code to alert staff that their immediate attention is needed. There are only four today. The first email was from Dr. Jackson. The e-mail read:

Hello, Patience. Ms. Brown has an appointment today at 10:15. Would you please see her today in the clinic to determine what assistance she needs with getting her medications? I have prescribed six medications; however, I am not sure if she can afford the prescriptions. Is there a program that can assist her with getting her meds? Thanks.

Patience responds back, “Yes I have Mrs. Brown on my schedule today. Thank you.”

The second email is from Dr. Chou:

Patience, I just want to make sure you are available for rounds on Friday at the hospital. I have two patients, Willie Williams, and Hattie Jeffers I would like you to meet with them and begin working with them regarding managing their diabetes. Please review the patients’ charts before rounds and I will update you during our rounds. Thank you.

Patience’s third e-mail is from Dr. Powell:

Hello, Patience. Were you able to get Mrs. Anne Mae some help with personal care assistance? I had three voice messages from her over the weekend, and a church member left another message this morning. Can you provide me an update? Dr. Powell.

services by SCDHHS, and other federal, state, and local sources of funding and reimbursements.
The last priority email was from James Knight, Licensed Clinical Social Worker. It read:

Patience, per your request, I am following up to let you know Mr. Willie Johnston missed his second appointment. I left him a voice message to call you or me to let us know if something has changed or if he is unable to come into the office.

As Patience reads the priority emails, she adds tasks to her to do list and marks the priority messages in red with a due date. Patience estimated that she spends about 30–60 minutes reading and responding to emails each morning and an additional 20–30 minutes listening and responding to voice messages. Some mornings the process can take two to four hours to complete. Typically, she rechecks her emails and voice messages every 2 hours during the day whether she is in the office or the community. It became apparent to me that it is crucial that Patience read and respond to communications before moving on to other tasks.

Things at NPLB Health Care Center are frequently changing which requires Patience to reprioritize continuously. Patience contended that emails and voice messages were a great tool for communication with patients, providers, team members and everyone connected with the CHW program. However, she admitted, “Typically, it means I need to add more tasks to my ‘to do’ list.”

As she promised Mrs. Annie Mae, Patience dials the number at the CCP. While the CCP office hours are 8:30 am–5:00 pm, Patience waited until a few minutes after 9:00 before calling because she knows firsthand how hectic things can be in the office on Monday mornings. As the phone rings, Patience multitasks and responds to an email from a colleague about the training on Medicaid for the afternoon. A voice answered the phone, “Good morning, the Caring Companion Program, this is Jill, how can I help you?” Patience says, “Hello Jill; this is Patience Richardson with the NPLB Health Center. May
I speak with Mrs. Hack?” Jill says, “She is on another line, can I take a message?” Patience responds, “May I hold for her?” Jill answers, “Yes, I’ll put you on hold.” Patience does not want to hang up for fear she will not get a chance to speak with Mrs. Hack. Additionally, Mrs. Annie Mae’s circumstances required immediate attention and given Patience’s busy schedule; she needs to resolve the problem as soon as possible. Meanwhile, while she is on hold, Patience continues reading an email from Beth, a CHW working with the Healthy Outcome Plan (HOP). The e-mail reads:

Good morning CHWs, I hope everyone is doing well. Hopefully, everyone can attend the Medicaid Application training today in-person or via teleconference. We need your support at this meeting to try to get some answers about the delay in Medicaid applications. According to the email we received from Jack Nicholas at SCDHHS yesterday, all Medicaid applications are up to date with no pending applications more than 30 days. I spoke with him Friday regarding applications I have pending, and he asked that CHWs make a list of any applications they have pending. Please make a list of patients who have pending applications more than 30 days. I have 25 applications pending more than 90 days, and 15 waiting 60 days. I know several of you have shared with me you have the same problem.

A voice interrupts Patience’s reading. “Hello, this Janet Hack.” “Hello, Mrs. Hack, this is Patience Richardson with the NPLB Health Center I am following up regarding Mrs. Annie Mae Taylor’s application.” “Yes,” says Mrs. Hack “I got your messages. Unfortunately, I have been on medical leave and unable to return your call. I am in the process of trying to get through the stack of applications on my desk. I am sure Mrs. Taylor’s application is among them.” Patience says, “I am sorry you were ill, and I hope
you feel better.” Mrs. Hack says, “I do. Thank you.” “Mrs. Taylor recently was hospitalized due to an acute medical condition and was released Friday,” Patience explains. “She desperately needs a personal assistant as she has no one in the home to help her out. Her family is out of town, and we are afraid if she does not get help ASAP, we may have to find a nursing home bed for her. Dr. Powell wrote the first order for a personal assistant three weeks ago and since then her health has worsened. Is it possible for her application to be approved, so she gets assistance right away?” “I am so sorry,” Mrs. Hack says, “You know when you are out of work, there is no one to pick up your workload; therefore, applications are delayed. I apologize again. Yes, let me review the application quickly to make sure I have everything while I have you on the phone, and if so, we may get her approval today.”

Mrs. Hack proceeds to go down a checklist of required documents including a signed release form, application, Medicaid numbers, proof of income, doctors’ orders, and family and medical history. After she has named about ten documents, she says, “I think we have everything we need. I will put a rush on the application and get to you before the end of the day.” Patience replies, “Thank you so much. I will be in and out of the office today so you can reach me on my cell phone at 555-5555.”

Hanging up, Patience breathes a sigh of relief, although she shares, “I will not be satisfied until Mrs. Annie Mae tells me she has a personal assistant helping her in the home which may take another week. I will follow-through until she receives the services.” Noticing she has only 20 minutes before she needs to be downstairs to see patients in the clinic, Patience quickly responds to Beth’s email from HOP.
Hello Beth:

I will attend the meeting today via the teleconference. I have a busy schedule this afternoon so I will need to leave the meeting promptly at 2:00 pm. I have approximately 30-40 applications pending Medicaid approval. About half of the applications are more than 60 days awaiting approval. One of my patients, who was pregnant just delivered a week ago with her Medicaid application pending now four months. It is imperative that we find out how they plan to handle the backlog of applications. If the SC Department of Health and Human Services (SCDHHS) think they have caught up on the applications, does this mean we have to resubmit the pending applications? I hope not; I have the verification forms for the applications I submitted. Also, we may see an increasing number of patients in the emergency department (ED) because they could not receive health care treatment. Therefore, they have felt they had no other option but to go to the ED. We might want to point out this delay in processing the Medicaid applications is creating barriers for patients and creating more work for healthcare providers as we have to be creative in trying to find a way to provide and pay for patients’ health services. See you soon, Patience.

Patience takes a few minutes to review the health care records of patients she is scheduled to see in the clinic. Just before she leaves the office to head to the clinic area to see patients, Patience checks the “brain” to see if her first patients have reported. The computer indicates Mrs. Brown checked in 10:00. The NPLB policy states patients cannot wait in the lobby more than 15 minutes after their arrival and must be seen by the
physician within another 30 minutes. Patience explains that the “brain” tracks data regarding services delivered to patients and the average wait time for a patient to see a physician at NPLB is 25-35 minutes from the time of arrival. As she leaves her office, Patience grabs the red pocket file folder labeled “patients in-office [clinic] appointments”. Inside the folder, there are pens, paper, pink and yellow sticky notes with information that Patience has written that she needs to address with each patient and documents that the patient must complete and sign.

**Researcher’s Reflections**

The office in the context of a CHW’s day in primary health care can vary widely. Typically, one might think of “the office” as a fixed, physical location from which to work. In fact, Webster’s Dictionary defines “office” as a particular building or room where people work at desks, conduct business, or provide professional services (Webster Dictionary, 2015). According to Sabrina and Margaret, however, an office for a CHW in primary health care settings is “a spot.” A “spot” can be any place they can find to complete whatever work must be done. Margaret insisted that most CHWs do not have a specified workspace within primary healthcare facilities because CHWs are so new to the healthcare team. She explained, “Hardly anyone understood the role of a CHW. Team members do not understand the roles and duties of CHWs. Because we are new, and there is limited space, we do not have an office.” So, CHWs work wherever they can find “a spot.” For example, although Patience has an office, we can see that before she arrives at her office, she has assisted two clients, Mrs. Annie Mae in her car and the elderly woman waiting for her appointment in the lobby.
Vignette 3: The Clinic Area

The clinic located in the No Patient Left Behind (NPLB) Health Center is the area where physicians and other health care team members see patients. The first-floor entrance is a sliding door that opens into a large lobby and sitting area. The receptionist area encased with plexiglass. Patients and visitors check-in this area. Signs on the receptionists’ window instruct everyone to “Please sign in and have the insurance card and ID ready for staff to review.” Three staff members are available to check-in patients by computer. There are two sections of seating, with five rows of six tan faux leather upholstered chairs. Each section has a wide screen television. The television is one of the tools NPLB utilizes to educate and communicate relevant information and events to patients. Patients who wait can watch educational health videos, for example, the hazards of smoking, which can lead to Chronic Obstructive Pulmonary Disease (COPD). There are magazines, brochures, fact sheets, and children's books available for patients to read. On any given day, morning or afternoon, there are 15-20 people in the lobby. Patients are diverse: old and young, Black, White, Hispanic, children, women, and men. The NPLB Health Center’s comprehensive care includes a spectrum of health care services from acute to preventive care. Health education and inpatient surgical procedures, as well as physical and behavioral health care services, are available.

According to Patience, the NPLB’s patients have access to the latest medical technology, resources, and treatment available for outpatient health care. By providing patients integrated health care services, NPLB claims they save patients’ time and money, and provide them quality health care service. Typically, Patience enters the clinic using
the back stairs from her office. The three floors below the 4th on which Patience works consist of offices, radiology, other specialty areas, the lab, and the pharmacy. Within the clinic area, there are examining rooms. Patience explained to me, “Each physician has assigned exam rooms. The color-coordinated signs and numbers on the exam doors indicate the physician’s exam room.” She explained further, “the signal flags adjacent to each exam room door indicate the status of the room. The red signal flag means the doctor is examining the patient; typically, no one other than a nurse can enter the exam room. The yellow flag indicates a patient is waiting to see a physician. The green flag indicates the exam room is available for another patient.

My observations of the exam rooms are that they are typical rooms one might see in a doctor’s office in an industrialized country, about 10 feet by 10 feet with an exam table and sink/cabinet area. The exam rooms have exam tables lined with white paper and a privacy curtain adjacent to the back walls of each room. Opposite the exam table, there is a small glass cabinet with medical supplies and a sink, hand sanitizer, and a paper towel dispenser. On top of the counter, there is a box of medical gloves. There is a computer on a small, mobile table with wheels and a stool with wheels. The computer allows the physician and the healthcare team member to input information about the patient, request labs, and write prescriptions during the exam. Mounted on the same wall with the exam table are diagnostic instruments: an otoscope, ophthalmoscope, ear speculum dispenser, sphygmomanometer, and thermometer. Beneath the instruments is a red and bright yellow waste receptacle on the wall. Adjacent to the wall is a chair for patients to sit in while the nurse checks their vitals (blood pressure, pulse rate,
temperature, and blood sugar). Each examining room has framed artwork of landmarks located in the small town.

As Patience and I make our way to the nurses’ station, Patience greets everyone with a smile and “Good morning.” Everyone including the physicians, nurses, and other healthcare staff responds with a cheerful, “Good morning.” The atmosphere is friendly, cordial and pleasant. Patience’s first stop is at the nurse station to let the nurse manager know the names of the patients she will be seeing. The nurse manager checks the computer and confirms that Mrs. Smith is in exam room number 3 and that the nurse has just entered the room to check her vitals. The nurse manager confirms, too, that Patience’s next appointment has signed in with Behavioral Health on the second floor. Waiting for the nurse to complete checking Mrs. Brown’s vital signs, Patience, and the nurse manager chat briefly about the community health fair they attended Saturday. The NPLB Health Center co-sponsored with community churches and agencies a health fair for nearby neighborhoods. Patience handled the coordination of the health screenings, health education, and referrals for services. Patience worked with the physicians and nurse manager to recruit staff from the NPLB to complete health screenings for hypertension, cholesterol, diabetes, and skin cancer. Patience states, “Two doctors, three nurses and five certified nurse’s assistants (CNA) helped screened 23 adults and 31 youth from aged 5-17 years old.” The nurse manager shares with Patience that she has heard only positive comments about the health fair and that she thinks it was “successful.” Patience thanks the nurse manager for the positive feedback. She comments, “I have heard high accolades from everyone thus far.” Patience works collaboratively with local
organizations and groups conducting outreach efforts through health education, screenings, and health literacy activities throughout the community.

Once Dr. Jackson meets up with Patience at the nurses’ station, she asks Patience to go to the exam room to see Mrs. Brown. She states, “I will come in a few minutes.” Patience knocks on the door. Ms. Brown says, “Come in,” and Patience says, “Good morning, Mrs. Brown. How are you?” She replies, “I am doing well this morning.” They both smile. Patience introduces herself and me. She explains I am doing a study on CHW programs and asks if I can observe her session today. Mrs. Brown consents. Patience explains to Mrs. Brown that Dr. Jackson will be joining them in a few minutes to review her medications. Then Patience asks, “Mrs. Brown, did you remember to bring me the list of documents I left on your answering machine?” Mrs. Brown replies, “I have everything except my social security card.” Patience says, “No problem. I can get a copy later.”

Just as Patience is about to explain the prescription assistance program (PAP), Dr. Jackson knocks on the door. Dr. Jackson speaks to Mrs. Brown and asks how she is feeling. Mrs. Brown states that she feels “great.” Dr. Jackson explains that today she will review her prescribed medications so Patience will have an accurate list before she applies for the PAP. Dr. Jackson states that she has asked Patience to help Mrs. Brown receive free or reduced priced medication so she can take her medicine regularly. “I think your blood pressure, diabetes and cholesterol levels will get better once you take your medicine daily,” she says. Dr. Jackson shares that after they review the list of medications, Patience will take Mrs. Brown to the office to complete the necessary paperwork to determine if Mrs. Brown qualifies for one of the PAPs covered by the pharmaceutical companies. Patience interjects, “You must complete an application to
determine if you are eligible for assistance.” Patience adds that the PAP provides free or discounted medicines to patients who are unable to pay for them. She explains that each program has its qualifying criteria that require a separate application. Dr. Jackson reads each prescription aloud and asks Mrs. Brown to confirm each medication.

Mrs. Brown confirms with Dr. Jackson she understands she needs to take each medication. She states, “I take the medications when I can afford to purchase them.” Dr. Jackson explains again that Patience will assist her with getting her medicine so that she can take them daily. Patience nods her head “yes” and comments, “I’d let Dr. Jackson know if she needs to write prescriptions for generics.” Dr. Jackson explains to Mrs. Brown that sometimes the PAP might only pay for generic medications. If that is the case, then she will rewrite the prescription. She explains that the drugs are very similar. “Do not worry about it,” she says, “Patience will let me know of any new changes to the brand name, and I will need to rewrite the prescriptions.” Dr. Jackson gives Mrs. Brown a 30-day sample of all her medications to take until she can get into a PAP. Dr. Jackson stresses to Mrs. Brown that the medications will help with managing diabetes and other health problems. She says, “You also need to work improving your diet so you can lose weight to better control your health. Patience will work with you to provide some education on nutrition, exercise, and how to manage diabetes.” Dr. Jackson further explains, “I will monitor your progress quarterly to make sure your blood sugar and blood pressure levels are normal.” Mrs. Brown responds, “I will try and do the best I can.” Patience tries to reassure Mrs. Brown, saying, “It will take time, but I will help you to develop a plan of action. However, first, we need to make sure you are taking your
medications as prescribed.” Dr. Jackson articulates she is very optimistic that Mrs. Brown will make progress. She says, “I know you can do it, and Patience will help you.”

Table 4.2 Mrs. Brown’s Medication List

<table>
<thead>
<tr>
<th>Medication/ Strength</th>
<th>Signa(^{11}) (sig)</th>
<th>Day/Quantity</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucophage 500 mg(^{12})</td>
<td>1 PO BID(^{13})</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Glyburide 100 mg</td>
<td>1 PO q AM(^{14})</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Hydrochlorothiazide 25 mg</td>
<td>1 PO BID</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Atorvastatin 10 mg</td>
<td>1 PO BID</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Geodon (Generic), 20 mg</td>
<td>1 PO BID</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Duloxetine 20 mg</td>
<td>1 PO BID</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Aspirin 325 mg</td>
<td>1 PO BID</td>
<td>60</td>
<td>30</td>
</tr>
</tbody>
</table>

While Mrs. Brown is waiting for the nurse to bring her the sample medication and the paperwork to check out, Patience confirms her next appointment has checked in. Mr. Johnston had not checked in, but Mr. McGray is in exam room number 5. Patience knocks on the door and after speaking with Mr. McGray, she inquires about his wife. Mr. McGray smiles, stating, “She let me come to the doctor today by myself.” They both laugh. Patience says, “Tell her I asked about her.” She introduces me to him and explains that I am conducting a study. He consents for me to observe. He smiles again. Patience

\(^{11}\) Signa is a medical term used by physicians in writing prescriptions and is followed by the physician’s signature (Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition, 2003).

\(^{12}\) mg is an abbreviation for milligram, a unit of measurement of mass in the metric system for dispensing medications (MedicineNet.com 2015).

\(^{13}\) 1 PO, typically seen on prescriptions means 1 pill by mouth and BID is an abbreviation for "bis in die", a Latin term that means twice a day (Common Medical Abbreviations, n. d.).

\(^{14}\) q AM on prescriptions means every day before noon (Common Medical Abbreviations, n. d.).
informs him that she needs to get his signature on the NPLB’s Release of Information to obtain the verification of his last day at work, salary, and work compensation. She explains, “Once I receive proof of employment I can submit your application to PAP and Medicaid.” Patience shares with me that she interviewed Mr. McGray the week before for the Medicaid Program and PAP; however, he did not have the mailing address for the trucking company that had employed him for ten years. According to Mr. McGray, the company went out of business six months after Mr. McGray had an accident and was unable to return to work. Mr. McGray received worker’s compensation and had health insurance for six months after the accident. However, his physician informed him a month before that he would be unable to go back to work until he fully recovered and suggested he apply for temporary disability. After Mr. McGray signs the form, Patience gives him a copy and informs him that she will be back in contact with him.

Patience then escorts Mrs. Brown to her office. While they are in the elevator, she checks her voice messages on her cellphone. Two of the messages are patients confirming appointments, home visits, on Tuesday. Another message is from Mr. Avery, patients’ coordinator for The Best HMO. He wants to schedule a meeting with Patience about her patient education and outreach efforts. The last message is from a physician confirming he will meet her Thursday morning at 8:30 to make house calls.

The House Calls Program (HCP) provides health care for patients in their homes—those patients unable to come to the NPLB Clinic to see their physicians. Typically, second-year resident physicians rotate bimonthly to complete house calls or the nurse practitioner and the CHW make house calls. The patients enrolled in the HCP are elderly or individuals who are homebound and/or who cannot travel to the doctors’
office. For example, Patience enrolled patients in the HCP who were in need of medical care but who did not have transportation and were waiting for approval from Medicaid before they could use JTS. Once the patients qualified for Medicaid or obtained transportation, they no longer received services from the HCP. Patience acknowledged the HCP benefited the patients and the NPLB: patients received the medical attention they needed in their homes, and the physicians got a realistic picture of the patient's living environment. She added, “I believe as a result of the HCP, the physician-patient's relationship has improved because there is a greater awareness of the patient’s living conditions and the physicians can address factors within the home that may hurt the patient’s health.”

After a short time, Patience and Mrs. Brown reach her office; Patience offers Mrs. Brown a seat. Patience gathers and reviews the documents from Mrs. Brown. She explains to Mrs. Brown that the application process for the PAP could potentially take 30-35 minutes as each prescription requires a separate application. Mrs. Brown informs Patience that her son will pick her up at noon. Starting the application process, Patience first logs onto the NeedyMeds Website at [http://www.needymeds.org/](http://www.needymeds.org/) and clicks on the “Generic Medications”; this link generates an alphabetical list of medications. Using Mrs. Brown’s list of prescriptions that Dr. Jackson updated, Patience clicks first on G, then clicks Glucophage and Outreach to access the PAP application. To complete the application Patience reads the questions aloud and Mrs. Brown provides the answers. The questions require demographic information (address, income, and social security number). Patience asks, “Do you have allergies?” Mrs. Brown says, “Yes, I am allergic to cats.” They look at each other and laugh. Patience remembers that Mrs. Brown is not
allergic to cats, but she frequently complains about her neighbors’ cats. Another question is where to ship the medications and Mrs. Brown states to the home.

Patience shares patients sometimes request that their medications come to the NPLB pharmacy because they do not have a stable mailing address. Patience explains to Mrs. Brown that it appears she qualifies for free medication based on her income. She notes that Dr. Jackson wrote a 90-day prescription that will be updated every quarter at her doctor’s visits. She explains to Mrs. Brown that she will complete and print an application for each prescription, then have her sign each one. Then Patience reads the following statement to Mrs. Brown and repeats the application process for the six other medications:

I attest that the information provided in this application is complete and accurate. This authorization or copy shall be valid for 12 months from the date of signature. I understand that Rx Outreach reserves the right to request income verification from me or refuse my application based on any misuse, abuse or illegal distribution of any products in this program. I will not seek reimbursement of any fee I pay to Rx Outreach from my health insurance, including Medicaid, Medicare or similar programs (PAP, NeedyMedicine Website, 2015).

Mrs. Brown signs each application. Patience explains that she will receive the medications in the mail within 15-20 days and that if she does not receive them to please call her and let her know. Before escorting Mrs. Brown back to the lobby area, Patience schedules a home visit for two weeks to develop a plan to work with Mrs. Brown on managing her diabetes.
Shortly after Mrs. Brown leaves, Patience faxes each application and the required documents to each of the pharmaceutical’s PAP. As she faxes each application, she receives confirmation from the PAP. The process takes another 20 minutes to complete. Afterward, Patience documents the CHW’s notes in the record of each patient she saw in the clinic. Patience shares that it is imperative to record the CHW notes as soon as possible for several reasons. First, the information is fresh on her mind. Therefore, she can reflect accurately the work she completed and billed the insurance provider. She notes, “the only billable services for CHW through Medicaid is educational services, face to face.” Second, she states, “documenting patient’s records promptly keeps other health care team members updated with information.” Third, she acknowledges, “because I am very busy, I do not have time to backtrack to record the patients’ records.” She says, “I have learned the lesson early in my career in the medical field not to put off what you can do now because others are depending on your information.”

By the time Patience finishes documenting the patients’ record, she has ten more emails, three priority emails from health care team members and five voice messages. Eager to see if she has heard back from the CCP, Patience checks her voice messages before reading the emails. Mrs. Hack left a message to confirm that she had spoken with Mrs. Annie Mae and told her they approved the personal assistant effective Tuesday morning at 10:30 am. Patience breathes a big sigh of relief. She immediately dials Mrs. Annie Mae’s number to confirm the message. Mrs. Annie Mae answers the phone with more spirit in her voice than she had in the morning. Patience says, “Hello, you sound much better this afternoon.” Mrs. Annie Mae explains that Mrs. Hack had called and that “the lady” is “coming” tomorrow. She went on to say, “Thank you, Patience, for putting a
“rush on things.” Then she asks Patience to help her with the interview and paperwork process. Patience explains she has several home visits the next day but feels she can come by to assist her.

Later on, Patience shares that Mrs. Annie Mae has low literacy; although she claims she can not see well, Patience explains, Mrs. Annie Mae admits that she was never a good student and dropped out of school in the 9th grade. Patience acknowledges that many of her patients cannot read or have difficulty understanding the embedded text in many of the documents they must complete and sign as patients. Instead of embarrassing them, often Patience begins reading the information to them unless they tell her they want to read it for themselves.

**Researcher’s Reflections**

My observations of Patience in the clinic area prompted me think about the three important factors regarding CHWs in PHC. First, Patience was extremely knowledgeable and comfortable discussing health care information with the care team members and patients. She was well versed in the medical terminology, prescription medication, and chronic disease information. Second, Patience was actively engaged with a broad range of people at multiple levels, doctors, nurses, receptionist staff, patients, and family members. Because of the various ways she interacted with these individuals, it was crucial for Patience to demonstrate excellent interpersonal, oral and written communication skills. Very often, CHWs must explain complex health care information in layman’s terms to patients and family members. By the same token, they must explain equally complex information about their patients and their family members to healthcare team members. In this way, I observed Patience being a bridge that connects patients and
PHC. Third, I was surprised at the amount of time it takes Patience to read and respond to emails and phone calls.

Although these tasks are crucial in the efficient delivery of services, Medicaid does not reimburse the PHC providers for the CHW services in this area. It is important to know that before CHWs can ensure patient’s social needs are met, they must complete the necessary paperwork required by social services agencies. Moreover, as Patience demonstrated, follow through is extremely important to ensure the patient gets the services he/she needs. As such, this finding reflects a need for the reconceptualization of Medicaid reimbursement codes to reimburse CHW services of helping the patient navigate health care, social services, local resources and other governmental systems.

Vignette 4: The Home Visit

Typically, Patience sees patients in their homes on Tuesdays, Thursdays, and Friday afternoons. Patience explained, “Of course if there’s an urgent matter, I will see patients immediately.” She shared that NPLB’s policies required her to sign out each time she leaves the health center. She indicates as well what time she expects to be back on the white board hanging in the staff break room. Also, NPLB requires her to document her whereabouts on her online schedule to which all health care team members have access. Before leaving for the home visit to Mr. Willie Thomas, she records his name and address on the online schedule. “I called him yesterday,” she says, “but I will call again to let him know I am on my way—as I do with all my patients.” When she calls, there is no answer, so she leaves a message. After hanging up, she says, “He is expecting us. I told him you will be observing, and he agreed for you to observe and ask questions.”
Mr. Willie Thomas is a 34-year-old African American male who looks much older than his age. He is approximately 6 feet tall and weighs over 320 pounds. His diagnoses are hypertension, chronic heart disease, high cholesterol, sleep apnea, asthma, obesity, substance abuse, addiction, and depression. Mr. Thomas checked in the ED about six weeks before the home visit. According to Patience,“ Mr. Thomas came to ED complaining of chest pains, he thought he had a heart attack. He was released after he received treatment the same day.” Before the ED visit, Mr. Thomas had seen a primary care physician (PCP) at the NPLB Health Center. His doctor suggested he see Patience for an assessment regarding his non-compliance in keeping his appointments and taking his medicine.

Upon reaching Mr. Thomas’s apartment, Patience rang the doorbell and knocked on the door several times before anyone answers. We can hear people moving about and a small dog barking, but it takes several minutes before anyone answers the door. An older African American woman responds; Patience introduces herself and me, and then says, “I have an appointment with Mr. Thomas at 1:00 pm. Is he here?” The woman says, “I am Pam, Mr. Thomas’s aunt.” Pam invites us into the living room. The room is dark until Pam opens the blinds. Mr. Thomas is sitting on the sofa. I notice next to him there were blankets and pillows. It is apparent that when Patience knocked on the door, she woke him as well as others in the home. Aunt Pam introduces us to her grandchild, age 4, and Mr. Thomas. Mr. Thomas acknowledges that he had had a late night and overslept. Patience and I both shake his hand. Another woman comes down the stairs from upstairs and introduces herself as Mr. Thomas’s sister. Everyone is cordial. Mr. Thomas’ aunt and the child remain in the living room during the interview.
Patience begins with introductions. She says, “This is the lady I told you about on the telephone.” I briefly explain the study I am doing and read him the release form; he agrees to participate and signs it. Patience tells him that his doctor, Dr. Powell, referred him to her to assess his needs and to develop a plan of action to address his priority needs. She states, “I will access your medical records at NPLB’s database from my laptop computer. Dr. Powell will be able to read my notes and the assessment I will complete with you today.” She encourages Mr. Thomas to stop her at any time to ask questions or express any concerns.

Her first question is, “How have you been doing since you were in the emergency room?” Mr. Thomas replied, “Much better, but my legs are giving me problems—swelling.” Patience asks if he has been taking his medication. He says, “Whenever I can remember.” Patience fixes her eyes on Mr. Thomas and with firm voice states, “I am going to need you to take your medicine regularly, or I am afraid you will be back to the emergency room.” Mr. Thomas’s eyes widen; he appears more alert as he begins describing his ER visit. “That day I had shortness of breath, chest pains, and pain in my left side. I was afraid; they gave me some medicine and said I had a heart attack.” Patience explains, “Records indicate you had a mild heart attack, but there is some blockage.” Mr. Thomas shares he experienced similar chest pains when he was in prison, but no one told him he had a heart attack. Mary shares,

I have ten years’ experience working with cardiac patients, and it sounds as if the medicine they gave you reduced the severity of the heart attack. You have to remember each experience is different; you may not have had a heart attack then. However, your heart is sick now, and that is why you need to take your
medication every day. I need to review and evaluate the consistency with which you take your prescribed medications.

Patience says, “What is the pharmacy you use?” Mr. Thomas responds, “Walmart on Jefferson Boulevard.” She says, “Okay, I am updating your records. Dr. Powell’s nurse will forward your prescriptions to Walmart on Jefferson Boulevard. They will call you when they are ready. Please pick up your medicine and begin taking it as prescribed.”

Reading from the medical records on the computer, Patience reads each medication, explains when he is to take each medication, and the purpose it serves. Patience says, “As I call each medicine, tell me the last time you took the medication and on a scale of 0-7, say the frequency with which you take the medicine. Seven reflects every day.” Patience starts: “Metformin 500 mg is for Diabetes, one pill three times per day before meals.” Mr. Thomas replies, “I do not know when I last took that medicine. I think it was two months ago. I do not believe I have diabetes.” Patience asks, “How is your blood sugar level?” Mr. Thomas says, “I checked it last week. It was 84 fasting and after meals, it ranges from 110-130.” Patience says, “Good, keep checking your blood sugar levels. I will contact the doctor to see what he would like to do since you are doing so well without taking this medication.” The next medication is Lipitor 50 mg, 1 per day, for cholesterol. Patience explains, “This medication lowers your bad cholesterol and increases the good cholesterol.” Mr. Thomas replies, “I take that one about 3 out of 7 days.” Patience continues, “The Benazepril 50 mg 1 time per day at bedtime is for your high blood pressure and to prevent heart attacks and strokes.” He says, “I take this more regular since the heart attack.” She asks how often and he replies, “About 5 out of 7
days.” The next medication is Wellbutrin 100 mg, 1 per day for depression. Mr. Thomas can not recall the last time he has taken the Wellbutrin and shares that he never took the aspirin, prescribed one per day.

Patience states that all these medicines except for the Wellbutrin contribute to making his heart function better. “When you do not take them,” she explains, “you are jeopardizing your health.” Demonstrating with her hands and fingers, Patience explains that the heart functions with the coronary arteries supplying blood to the heart muscle; however, Mr. Thomas’ arteries have hardened and narrowed due to plaque and scars on the arteries’ inner walls. She says, “Plaque builds up, as well as cholesterol, fat, and other substances which ultimately constrict the blood flow to the heart. This causes blood clots to the heart, and it stops working.” Mr. Thomas listens and says, “Thank you, Patience. No one ever explained it to me that way.” We all agree that Patience has provided an excellent demonstration. Patience says, “If you ever have any questions, feel free to ask.”

Just then, the doorbell rings. Aunt Pam leaps from her chair and answers the door. A young African-American man who appears to be in his early twenties steps inside. Aunt Pam starts to push the young man out; she says, “He is busy talking to somebody now.” He and Mr. Thomas briefly make eye contact. “I am here to pick up a package,” the young man mumbled. Mr. Thomas tells him to come back in about an hour or so. The young man leaves and Aunt Pam closes the front door. At that moment, Patience looks at Mr. Thomas saying, “yes this is important for your health.” Mr. Thomas smiles saying, “I…I know.”

After reviewing his medications, Patience makes a notation in Mr. Thomas’ medical records about his medication use and the location of his pharmacy. “I am
emailing Dr. Powell to request that he review my notes and update your prescribed medications,” she says, “I am asking him to reassess the Metformin since you have not had the medication in two months.” She goes on to say, “According to your last blood work, your A1C level was 5.5% which is within the normal range. You may not need the medication for diabetes. Dr. Powell will check it again when he sees you.” Mr. Thomas nods his head with a smile.

Patience proceeds through her assessment, addressing the barriers to getting his medications and getting to his medical appointments. Mr. Thomas states, “I do not always have transportation, so I cannot get to my appointments and sometimes I do not have the money to purchase my medicine.” Patience says, “I can help you get transportation to your medical appointments.” She gives him the number to the JTS for transportation and says, “It is only for medical appointments, and you must contact JTS 3 days before the appointment, or they will not pick you up.” Regarding his medication, Patience says, “All of your prescriptions are covered by Medicaid, and most of them will cost you $3.00 per prescription.” She asks if he has a monthly budget, and, if not, she offers to help him develop one. Mr. Thomas appears defensive when Patience asks about a monthly budget. He states, “It is hard when everyone counts on you to pay the bills.” Patience responds, “What will they do if you are not alive to pay the bills? Mr. Thomas, your health is the priority, and if you do not take this medicine, you will not be around to do anything.” Mr. Thomas looks at his aunt and me and says, “I know. Did you all hear that?” His aunt quickly responds back: “You do not listen to me when I tell you to eat right or to take your medicine.” Mr. Thomas and his aunt glare at each other for a couple of seconds. Patience states, “It is up to you, Mr. Thomas, to take care of you. No one can
do that for you, so what is it going to be?” In a slightly softer voice, Mr. Thomas states, “I am going to do better.” Patience says, “I cannot hear you.” He repeats it again in a stronger, louder voice: “I promise. I am going to do better with my diet and take my medicine.” We all laugh at his tone of voice. In hindsight, I believe now we all realize Mr. Thomas is seriously making a commitment to take care of himself. It seems as if a lightbulb came on and he realizes he can do and feel better.

Following her checklist, (see Appendix G), Patience asks Mr. Thomas to tell her about his diet and exercise. Mr. Thomas, looking toward Aunt Pam, replies, “I eat whatever they cook.” His aunt quickly responds, “And he eats potato chips, sweets, and other things we do not cook.” We all laugh again. Mr. Thomas report, “That is true.” Patience asks, “Well, how much exercise you get?” Mr. Thomas looks downward as he responds, “Not too much because of my legs swell so bad.” “How far can you walk?” Patience inquires. “I can walk to the corner store sometimes,” he said. His aunt added, “To get junk food, potato chips, sweets, and beer.” Laughing, he says, “Stop telling on me.” Patience states, “On my next home visit, we will set some goals for your diet and exercise. In fact, I will walk with you to the store, not to get junk food but to get you moving so you can feel better.” Continuing, she says, “For now, I just want you to concentrate on taking your medicine as scheduled and keeping your doctor’s appointments. Okay?” Mr. Thomas says, “Okay,” in a high voice.

Patience checks Mr. Thomas’s medical record again; she says, “I see you have an appointment next Wednesday with Dr. Powell. I will see you at the doctor’s office to follow up to make sure you are taking your medications.” Then she asks, “Do you have any questions for me?” Mr. Thomas says, “No, I do not think so.” Patience says, “If you
think of something, you can call me on my cell or office telephone number.” She hands him her business card. We both thank Mr. Thomas and say goodbye to his aunt and her grandchild.

**Researcher’s Reflection**

After the home visit, I ask, “do you know why Mr. Thomas went to prison?” Patience responds he spent five years in a federal prison for trafficking drugs. She shares that he has a history of recreational drug use. On our way to the second home visit as Patience and I are in the car, I ask her, “Who do you think the guy was that came to pick up a package while we were there?” She replies, “He may have been someone trying to buy drugs.” I recalled Mr. Thomas saying to the young man, “Come back in about an hour.” The man’s word “package” could have been a coded way to indicate drugs or something illegal. For Patience, the way Mr. Thomas’ aunt rushed the man from the house made her think he might be there to buy drugs. She comments, “Adding to my suspicion that the man wanted to purchase drugs was the way in which Mr. Thomas’ aunt rushed him out of the house as soon as he stepped his foot in the house.”

This conversation leads me to ask Patience if she ever feels in danger during home visits. She says, “I always sit where I can see the door, and I am vigilantly observing everyone.” She continues, “Because I visit patients in their homes, people in the community sometimes recognize my car.” She says, “I would not doubt that if something illegal is happening, folks may be texting to alert people.” I nod my head in agreement. Patience is very clear about her awareness of people using and purchasing drugs. She offers, “I know how folks talk and behave when they are trying to buy drugs or do something illegal because I have friends, family members and associates who have
used and sold drugs.” I agree with Patience, and add, “These days it is hard to know someone close who is not affected by illegal drug use.”

For me, I was surprised at the way in which Patience responded to Mr. Thomas. Even though it would have been easy to judge him, she did not. Her concern for her patient’s health care was her priority. She told me after she develops a better rapport with Mr. Thomas, she can address his use of alcohol and other substances and the potential effects on his heart and overall health. Still, I had concerns about the CHW’s safety during home visits.

**Vignette 5: The End of the Day**

**There is Always One More Task to Do**

After Patience and I visit Mr. Thomas we complete two more home visits. After our last visit on our way to the car, Patience says, “I need to make one more stop before we head to the office.” I look at the time. It was 4:30 p.m., and I recall that Patience was scheduled to get off from work at 5:00 p.m. She has shared with me previously that she picks her children up from school at 5:30 p.m. Some days her children are involved in extracurricular activities, which means that most days, it is after 6:30 p.m. and sometimes even 7:00 p.m. before the family arrives home. As Patience is driving, she provides me some background information about the last stop. She asks, “Do you remember Mrs. Talbot? The lady with the mold in her apartment in the public housing complex? You met her last week.” I nod my head yes. She says, “I have been working on this case for several months now trying to get the housing authority to clean up the mold.”

I recall that Mrs. Talbot is a 72-year-old African American female. She s sitting quietly on the front porch with both hands folded in her lap when we arrived. Her eyes lit
up when she saw us. Her husband, Joe, had recently been placed in a nursing home for physical and cognitive rehabilitation after a stroke. She had two adult children, a daughter who lived out of state with her family, and a son who lived nearby but who “is not very supportive,” Mrs. Talbot explained. “He uses me sometimes, and since his father has been ill, you would think he would help out around here,” she said. Patience turned to me and explained, “Joe has been vigilant in maintaining the property for the housing complex. Although he is not paid, he keeps his yard, the neighbors’ yards, and the playground neatly manicured and free of trash and debris.” Mrs. Talbot showed us her flower bed as she commented, “It needs weeding, but I am afraid there may be snakes that come up from the creek behind the house. Joe would have a fit, worrying about the kids in the neighborhood and me.” She and Patience began telling me a story about a snake he had killed in the yard. After listening to them, I got the impression that Joe was a man who was hard working and cared about his neighborhood.

Mrs. Talbot has a diagnosis of diabetes and asthma. Dr. Jackson referred her to Patience because she continues to experience difficulties breathing. Her persistent coughing has led to her use of her inhaler more frequently. When Patience made the first home visit, she noticed mold. She took pictures of the mold around the vents in the ceiling and the bathroom. “After I had shown Dr. Jackson the pictures, I drafted a letter to the housing manager explaining that the mold in Mrs. Talbot’s house was likely causing her to have upper respiratory breathing problems,” Patience said. “The letter asked the housing authority to remove the mold,” she continued. “Mrs. Talbot told me that the maintenance man came and used bleach to clean the vent a week ago, but he did not even change the filters.”
During this home visit, I noticed that Mrs. Talbot appeared to cough frequently. Patience asked, “Do you need your inhaler?” Mrs. Talbot took several small puffs which seemed to help some. Patience then showed me the mold in the bathroom. She took a picture, and said, “I am going to show this to the housing manager.” She explained to Mrs. Talbot, “I have left him several messages, but he will not call me back.” Mrs. Talbot said, “I know.”

Back in the car, Patience repeated, “I have left four or five messages with the housing manager of the complex. Every time I call he is not in, or he is on another line. This afternoon, I am going to his office unannounced. Maybe I can see him before they close at 5:00 pm.” We turn into the parking lot. The office building is red brick typical of a housing complex rental office. There are signs all over on the door and windows. The signage contains information about office hours and contact information in case of maintenance emergencies. I notice people are entering and leaving the building. Patience says, “Before we go in, I want to call first to see if he is in the office.” She dials the number on her cell phone, but she gets a voice message. We get out of the car and go into the office building. Behind the plexiglass window, there is an office area with two women on the telephone. Two people are standing in the line ahead of us. As we wait, I am somewhat surprised at all the written information that is visible. There are signs cluttering the walls and a large bulletin board and stacks of pamphlets on the table. The information includes policies regarding checks, late fees, and maintenance orders, as well as health education information, safety information, and relevant telephone numbers. I recall thinking that this is cognitive overload; this is too much information, which makes it difficult to focus on what is important to know.
After about ten minutes, the older of the two women behind the plexiglass asks, “May I help you?” The woman’s name badge identifies her as Natasha Henry, office manager. Patience introduces herself and says, “Ms. Henry, we have spoken several times. I am Patience Richardson, a CHW with NPLB. Is Mr. McCoy in?” Ms. Henry replies, “No, he is not here. Can I help you?” Patience said, “I have left several messages regarding Mrs. Talbot’s apartment, but he will not return my call.” Ms. Henry replies, “I am sorry he has not called you back, but I am pretty sure a maintenance order was put in about the mold problem.”

Mrs. Henry goes to her files and begins flipping through the orders. Patience does not hesitate. She responds, “Yes, Mrs. Talbot told me the maintenance man came to clean the vents with bleach last week. However, he did not change the filters, and there is still mold in the bathroom; she showed it to us.” The woman says, “Well, I can put in another order.” Patience leans forward and replies, “I brought a letter from her doctor. We are very concerned about Mrs. Talbot’s health.” She shows the woman the photograph. In a calm but firm voice, Patience says, “I just took this picture today, and as you can see, there is still a considerable amount of mold in the bathroom.” I notice Patience is professional and persistent. She asks, “When can Mr. McCoy call me? Alternatively, should I have her physician call him directly?”

The woman’s body language changes; she folds her arms, her eyes widen, and she says, “I do not know what else to tell you.” Patience quickly responds, “I am not trying to give you a hard time. However, this mold is causing Mrs. Talbot’s health problems. The mold needs to be taken care of right away. Would you please personally
ask him to call me? Otherwise, I will have the doctor call him.” The woman says, “Okay.” Patience thanks her, and we leave.

As we walk to the car, I can see that Patience is frustrated. She inhales deeply and says, “I am practicing my deep breathing to help me with stress.” We both laugh, and I say, “Good for you.” Patience says, “It is so frustrating when people will not do their jobs, which creates more problems for people like Mr. and Mrs. Talbot.” She notes, “Now this man kept the housing authority property clean and the grass cut for 15 years without pay, and they cannot clean up the mold at his apartment?”

At 5:05 pm, we head back to the office. We arrive 20 minutes later. Patience asked, “Are you coming in?” I reply, “How much longer will you be?” She says, “I still have several things to do before I can leave for the day.” I say, “Okay, I will come with you and stay until you leave.” Forty-five minutes later, I observe Patience ending her day much like it began: navigating through a multiplicity of administrative tasks, all of which involve aspects of coordinating her patients’ health care. She documents interventions follows up on incomplete tasks and communicates with the healthcare team. For example, she calls Mrs. Talbot to update her regarding the conversation with Ms. Henry at the rental office. Patience tells her, “If you do not hear from the manager or the maintenance man in several days, please call me.” Then she says, “Better yet, call me tomorrow by 4:00 pm to let me know if you have heard anything. If they do not make contact with you, I will get Dr. Jackson to speak to the manager personally.” After the phone call, Patience updates Mrs. Talbot’s CHW notes in her medical record and sends Dr. Jackson an email to review the updated file. Then she checks her office phone messages.
There are eight voice mail messages: five from patients, and three from community resource persons following up on her telephone calls. Patience listens to each of the messages. As she listens, she makes notes. She adds several items to her “to do” list for tomorrow. She returns one call to Tamekia, a patient she has been working with for nearly a year. Patience says, “Hello Tamekia, I got your message to call you back. Is everything okay?” I can hear Patience’s end of the conversation which reveals that Tamekia is calling to see if Patience will be able to see her in the office tomorrow during her doctor’s visit. Patience says, “Yes, in fact, I have you on my schedule. I will drop by to see you while you are here to see the nurse practitioner.” Patience confirms the appointment for 11:00 a.m. After she hangs up, she explains that Tamekia sees the nurse practitioner once a month to check her weight, blood sugar, and blood pressure. “She gets anxious when it is time to weigh in,” she says, “although she has lost nearly 100 pounds in a year.” I say, “Wow! That is great!” Patience says, “Yes, and she may be willing to talk with you about her experiences.” We agree that Patience will introduce me to Tamekia the next day.

Patience checks her cell phone messages then. There are three messages. The first one is from Mr. McCoy at the Housing Authority, stating that he got her message and that he would call her back tomorrow. Patience laughs out loud. “I knew I would get results when I said I would have Dr. Jackson call him personally. He does not want us to call the Department of Health, Environment and Control (DHEC),” she says. At that moment, Patience appears to enjoy a sense of accomplishment. She comments, “It is challenging when you have to make people do their jobs for which they receive pay.” The other two messages are from the South Carolina Department of Health and Human Services (SC
Patience had previously called them about the status of two of her patients’ Medicaid applications; both had been pending approval for more than 45 days.

Looking at her watch, Patience states, “I need to document several more things in my patients’ records and check my email before I can leave.” I observe Patience recording updates on referral information in two patients’ records. Next, she reads and responds to six emails. She shares that the last email is from Kerri, the program manager overseeing the Medicaid pilot CHW program. The email reads:

Good Afternoon, Patience: I am confirming our meeting on Thursday afternoon at 1:30 pm. I have asked Jack Nelson, the program manager for approved insurance providers, to join us to help answer some of your questions. Jack thought it would be helpful if you could send him a list of your questions before our meeting. In this way, he will hopefully have answers to your questions. Thank you,

Kerri Pinkerton

Program Manager of Health Services

Patience responds:

Hello, Kerri: Yes, I will be at our meeting Thursday. My questions are the same that I gave you at our last meeting. I will, however, review them to determine additional questions and send them to you before our meeting. Thank you again for the opportunity to get clarification on the Medicaid insurance providers’ services.

Patience Richardson, CHW

Patience composes an email then to Derrick Williams and copies Dr. Jackson:
Hello Derick: I have confirmed a meeting with Candy Pinkerton and Jack Nelson for Thursday at 1:30 pm. Jack is requesting a list of questions in preparation for our meeting. I remember from our weekly team meeting that you and Dr. Jackson had several questions regarding the type of patients’ data that is shared among insurance providers when patients change providers. As you indicated, it takes the insurance providers up to 30-45 days to update records. This sometimes results in a duplication of requested information and services. Nevertheless, would you and Dr. Jackson please send me a list of questions or concerns and I will try to get some information for you.

Thank you,

Patience Richardson, CHW

Patience looks at her watch again, and exclaims, “Where does the time go? It’s nearly 6:30. I have to pick up my children and let you go home.” Although I am completely worn out, I say, “No problem. I’m ready whenever you are to leave.” She says, “Okay. However, one more thing: I need to review the schedule for the patients’ in-office visits tomorrow to determine if I need to update the doctor or healthcare team member regarding unresolved issues.” This process takes another 10-15 minute as Patience cross-checks the online schedule with her CHW clinical notes in each patients’ record. She notes that there are three patients she needs to see during the doctor’s visits tomorrow and adds their names to her to-do list for the next day. I ask if I can see her “to-do list.” She hands it to me. I notice there are 13 items listed for tomorrow: five phone calls, three patients’ in-office visits, five Medicaid applications, and two meetings. Under another column
labeled Ongoing, there are five more items: a CHW progress report, a status update on Medicaid applications, an online policy & training update, and a Hypertension Education Seminar. At last, Patience rolls back in her desk chair and announces, “Let’s go home.” I smile, and she asks, “Did I wear you out today?” I reply, “Yes, you did.”

As we walk to the parking lot, I ask Patience how she can transition from being a CHW to her life with her family each day. She laughs. “My time in my car is all mine,” she says. “On my way to pick up the kids, I listen to spiritual music and messages. I thank God for all he has done for me another day. Then, I ask God to give me the strength to give my best to my family and He always does.”

**Researcher’s Reflections:**

At the end of each day of observations with Patience, I was exhausted. It quickly became clear that the CHW has to be flexible, open to many changes and unexpected detours. Patience was extremely skillful at juggling many balls, although some of these balls I believed belonged to other people. For example, the mold problem at Mrs. Talbot’s house was the responsibility of the housing authority. Patience needed to address the problem because it was potentially affecting her patient’s health. I observed Patience performing a broad range of administrative tasks that again are crucial to the provision of CHW services. As she completed these tasks, she embodied a variety of roles such as a health educator, advocate, case manager, and home visitor. I identify and discuss these roles in more details in section 4.3. Most significantly; I noticed the challenges Patience faced trying to ensure all the appropriate people were informed about her service delivery and actions. I am in awe of the broad range of knowledge and skills CHWs demonstrate
in the performance of their duties. However, I question and wonder how these duties can be streamlined to lessen the amount of work the CHWs must do. Lastly, I am concerned about CHWs’ ability to care for themselves. This is critically important as individuals who help others tend to neglect themselves which can cause stress and health related problems. I frequently wanted to intervene and advocate for CHWs, especially with their managers and supervisors. I wanted to say, “I think you should spend a week or so shadowing the CHW and afterward collaborate with them to define the CHWs’ priority services and tasks.”

4.1 A Day in the Life of CHWs: Salient Points

The proceeding vignettes represent salient points relevant to each of the CHW’s program sites. Salient points are based on coded data that “capture the essence and evocative attributes” (Saldaña, 2012, p. 3). I chose to represent salient points in addition to the themes I generated to create the composite representation of “A Day in the Life of CHWs” because salient points also emerged as outliers for the CHW programs. The literature validates CHW services are common across programs but also vary based on the context of the programs (HRSA, 2014). A study finding is that CHW programs vary largely due to contextual factors that I believe significantly influence the services, roles, and tasks of CHWs. Here I considered contextual factors, the providers’ location, rural or urban, history, mission, values, goals, partnerships, and patient population. Also, the health care provider’s human, financial, technological, and community resources including the economy, transportation, employment and education opportunities and community organizations (HRSA, 2014). The first vignette titled “Rounds at the Hospital” details Mary Moore’s experiences as a CHW at Hillsboro Family Practice
The second vignette, “CHW and the Emergency Department,” illustrates the services performed by Sabrina Sams, at the Riverdale Community Health Center’s (RCHC). Lastly, in the “Patient Health Coordination” vignette I denote the significant role of Margaret, a CHW for Montgomery Community Health Center, in the overall scope of patient services.

**Rounds at the Hospital.** Context: The Hillsboro Family Practice (HFP) links with the community hospital and a medical school in a neighboring city. Since the late 1970’s these partnerships have enabled HFP to provide a residency program for physicians training in family medicine\(^{15}\). National Committee recognizes the HFP as a level three Patient Centered Medical Home (PCMH) for Quality Assurance (NCQA). The distinction of a level three PCMH means HFP provides patients quality health care with a strong emphasis on the patient/physician relationship (HFP Residency Brochure, 2014).

Residents at HFP receive training in family medicine in a variety of settings including the office, hospital, patients’ home, community, and long-term facilities. Every Friday morning, Mary Moore, the CHW for HFP participates in “rounds” at the hospital with the HFP’s attending physicians and residents. On a Friday morning, I observe Mary’s participation in rounds. As we walk through the community hospital, Mary explains to me,

The physicians including the residents typically make rounds in the HFP’s patients’ rooms very early in the mornings, sometimes as early as 6:30 a.m. – 7:00

\(^{15}\) Family medicine is “focused on providing total health care of the individual and the family. As such, physicians receive training to diagnose and treat a broad range of medical conditions for patients of all ages. Such training includes internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and geriatrics” (Association of American Medical Colleges, 2015).
am. Afterward, we continue rounds in a meeting with an attending physician facilitating the meeting with residents and me. In this meeting, we discuss each patient. The process usually takes an hour or two depending on the number of inpatients. Once we complete our discussion, I visit the patients in the hospital that the physicians refer to me and/or I will follow-up on any requests for CHW services. I am normally here at the hospital 2 to 4 hours every Friday.

After walking for approximately five minutes, we enter the 6th-floor conference room. It is a small conference room with glass windows and white curtains that are open. There is a round conference table with swivel chairs for eight people and a computer on a portable computer stand. There are two medium size white boards with color markers and dry erasers. Seated at the head of the table is Dr. Williams, the attending physician and an associate professor. Dr. Williams is a Hispanic American woman who appears to be in her mid to late forties. Seated next to her are three physicians in the residency program. Drs. Jay and Henry, African American males who appear to be under the age of 30. Mary introduces me to everyone and explains that I am conducting a study about CHWs in primary health care. I have met Dr. Williams, as she authorized the approval of HFP as one of the sites for the study. Dr. Williams smiles. “How is everything going?” she asks. I reply, “Very well. Thank you again for the opportunity to learn about CHW’s.” Dr. Williams says, “We are very fortunate to have you observe Mary; she is awesome, and there are times I am not sure what we would do without her. Much more information is needed about CHWs, they are valuable resources.” Both Drs. Jay and Henry begin smiling. Dr. Henry replies, “Yes, I can tell you all the good things she does, if she will pay me and if she does not pay up, well...”. As they are making jokes, three other
physicians join us, Dr. Greene, an African American male, Dr. Bulter, a Caucasian male, and Dr. Orsay, a Caucasian female whom all appear to be in their late 20’s or early 30's. Mary introduces me to them. They, too, seem excited to share information about Mary. Dr. Greene shares, “Mary is the best, whenever I make home visits with her, she always briefed me on the patients’ environment, and she is very helpful with getting patients the things they need.” I ask, “What kinds of resources?” He replies, “You name it, and she can get it—adult diapers, Ensure, adult walkers, food, clothes, a place to stay and whatever else the patient needs.”

Dr. Williams interrupts, “Okay, we better get started if we wanna get out of here today.” She passes around a document, the HFP Inpatient List. Mary takes my list and darkens the names of all the patients and dates of birth before handing it back to me. On the list, there are 19 patients’ names alphabetized with the following information.

**Table 4.3. Hillsboro Family Practice (HFP) Inpatient List**

<table>
<thead>
<tr>
<th>Patient Information (Race, age, hospital room number, Primary Care Physician (PCP) name, and resident’s name)</th>
<th>History of present illness (HPI)/Patient Medical History (PMHx)</th>
<th>Problems (presenting medical issues and list of medications)</th>
<th>Notes/To Do (information about the patients’ labs and dietary needs, pain monitoring, call family members, and other medical tests or procedures needed)</th>
</tr>
</thead>
</table>

Each physician presents her or his patients to discuss the patient’s illness, medical history, and unresolved clinical issues. The physicians ask questions about each patient and discuss possible treatments and resolutions for each patient’s personal medical problem. Mary contributes to the discussion only if the patient is on her caseload or if a
physician has referred the patient to her. For example, Dr. Orsay discusses a patient who is having seizures. The patient has been diagnosed with an intellectual disability\(^\text{16}\) and is hearing impaired. He resides in a group home. Dr. Orsay asks “Mary would you please contact the director of the group home to find out more information regarding the patient’s dietary habits, the level of exercise, medication regime and if there are any behavioral problems?” Mary replies, “Yes, is there other specific information you need?” Dr. Williams comments, “It would be helpful to know the frequency and durations of the seizures or if there are extenuating circumstances before the seizures.” Mary responds, “I will check with Elaine Petterson, the hospital social worker. She may have a good contact person at the group home.” Several physicians nod their heads in agreement.

The meeting continues with each physician presenting patients. It is apparent from their discussions that they are genuinely concerned about the physical, psychological and spiritual well-being of the HFP’s patients. Several times, a physician references a patient’s fortitude. Dr. Greene comments about one of his patients, “Although she is a very sick, she has the best attitude, and she believes strongly in God.” Another physician references a patient’s lack of support, limited income, and inability to purchase his medication. He asks, “Mary, do you think you can help this patient get his medications and connect him to social service resources in the community?” Mary answers, “Sure, I think he may qualify for the prescription assistance program (PAP), and I will assess his other needs to determine what other resources he may need.” Mary explains to me later

\(^\text{16}\) Intellectual disability is a disability characterized by significant limitations in intellectual functioning and in adaptive behavior including many everyday social and practical skills. This disability occurs before the age of 18 (American Association on Intellectual and Developmental Disabilities Website, 2015).
that depending on the medical needs of a patient, physicians may refer either short-term or long-term services. For example, a patient needed a wheelchair ramp at his home. Mary said, “I was able to refer him to an organization who is building the ramp. I will follow up to make sure he gets the ramp.” Regarding another patient, Mary comments,

I have been working with another patient for almost a year now. She was referred to me for diabetes education and management. However, she also needed help with housing, transportation, and losing weight. Since I have been working with her, she has lost over 100 pounds.

The next patient that the physicians discuss is Ms. Yevette Black, a relatively new patient on Mary’s caseload. She has been on Mary’s caseload approximately 60 days. Dr. Henry presents the following:

Mrs. Yevette Black is a 68-year-old Caucasian female that suffers from symptoms of swelling in the left lower extremity (LLE), specifically her foot. Mrs. Black’s medical diagnosis includes Diabetes Mellitus 2 (DM-2), Hypersensitivity Lung Disease (HLD), Hypertension (HTN), and Anxiety. To treat her medical problems, she takes several medications. (1) Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin for Clostridium Difficile intravenously (125mg) for 14 days, and Zithromax, 5 times per day (2) For Shortness of Breath (SOB) Cough, Obesity Hypoventilation Syndrome (OHS), the treatment is Positive Airway Pressure (PAP) as needed (PRN). (3) For her May-Thurner Syndrome, the treatment is low-molecular-weight heparin (LMWH), Coumadin, and Stent output. (4) For HTN, her medications are Lotensin, 40 mg, Coreg 12.5 mg twice per day (BID), Hydrochlorothiazide, 25 mg. (5) For DM2, she takes Metformin
1000 mg once per day, Lantus 50 units at bedtime, and Gabapentin, 400 mg as needed (PRN). (6) For HLD, she takes Simvastatin 10 mg., and (7) For Anxiety, her medication is Hydroxyzine, as needed (PRN).

Dr. Henry adds:

Mrs. Black is a relatively new patient who moved from New Hampshire. Her physician in New Hampshire prescribed her medical diagnosis and medications. According to Mrs. Black, she was diagnosed with cancer. We have not been able to confirm it. Because I have not been able to find a copy computerized axial tomography (CT) scan in her hospital medical record, we may need to order another CT scan.

Mary interjects, “I think I saw a copy of the CT scan in her outpatient medical records.” As the physicians continue to discuss Mrs. Black’s medical conditions, Mary begins searching Mrs. Black’s outpatient record for the copy of scan. Mary leans towards me and in a lower voice, she says, “The patient has two medical files—an outpatient file we use at HFP, and if they are admitted to the hospital, they opened an inpatient hospital medical record.” Pointing to Mrs. Black’s outpatient medical record. Mary states, “As you can see this file is huge because it contains all of her prescriptions, the doctor’s visits, labs, screenings, invoices, including other information we received from her doctor New Hampshire.” I glanced at the file. It was very thick; there were countless documents. Shortly after that, Mary interrupts, “Dr. Henry, are you looking for this?” As Dr. Henry looks at the report, he proclaims, “Yes, it is, Mary. You have just saved this patient over a $1,000.” Mary is beaming. As she smiles, she raises both of her arms, showing her muscles. She boasts, “The CHW saved the day.” We all laugh. Dr.
Williams, the attending physician, explains, “This was one of the ways Mary saves our
team time and the patient money.” Later, Mary explains that the physicians have access
to both medical records, but because they are so thick, they usually do not have the time
to go through them to find documents.

The patients’ rounds discussions last approximately two hours. Periodically, Mary
makes notations in her notepad of the things the physicians ask her to get involved with
or to follow-up on. Shortly after the meeting, Mary and I walk to the nurses’ station on
the 6th floor. Mary greets the nurses, and they speak back. She explains to the nurse
sitting at the nurses’ station counter, “I just wanna check with you about several of our
patients on your floor. How are Mrs. Black and Mr. Johnston doing today?” The nurse
answers, “Mrs. Black is doing okay, although she has not felt like eating much today;
and Mr. Johnston has a test in radiology.” Mary asks, “Is Elaine Peterson, the social
worker, on the floor? I need to follow up with her about one of Dr. Orsay’s patients.”
The nurse replies, “She is with a patient. I will let her know you would like to speak
with her.” On the way to Mrs. Black’s room, Mary comments, “These are the best
nurses at this hospital; I always check in with them before I visit a patient. They keep me
informed of the patients’ issues. I really like working with them.”

As we approach Mrs. Black’s hospital room, we see a red and white STOP sign
that read in bold letters, “All staff and visitors, Gowns, Gloves, and Masks are
required before entering this room. Wash your hands or use a sanitizer before
entering and after leaving the room.” Adjacent to the door, there is boxes with
dispensers for the sanitizer, blue paper gowns, plastic gloves, and white mouth and nose
masks. Mary reminds me, “We need to sanitize our hands and put these on before we
enter because Mrs. Black has MRSA.” We both follow all the directions written on the door before we enter the room.

Mary knocks on the door, and we hear, “Come on in.” Mrs. Black is sitting on a small sofa, next to her are an IV stand and an oxygen tank. I notice there is a small tube in her nose that is connected to the oxygen tank and in her right arm, an IV. Her left foot is swollen double or triples its normal size, and the appearance is very dark. I think to myself: her foot looks very painful. Mrs. Black’s eyebrows are slightly raised, her lips partly downward. Mary greets her, “Good afternoon Mrs. Black. How are you doing?” She replies, “Pretty good.” Mary asks, “Do you feel like visitors?” Mrs. Black says, “Yes.” Mary says, “This is Constance Shepard, a researcher, and trainer for CHWs. She is observing me today. Is it okay for her to observe our visit today?” Mrs. Black replies, “Yes, it is nice to meet you.” I say, “Thank you for the opportunity,” and I explain that my observations are confidential. She signs a confidentiality form later as she agrees to an interview about the CHW services.

Mary asks, “How have you been doing?” Mrs. Black responds, “I was feeling better, but not so good today.” Mary notices her lunch tray is on the stand and comments, “I see you don’t like the food they serve here.” Mrs. Black smiles slightly, “Oh no, I just do not have an appetite today.” Mary says, “Well, you need to eat so you can get well.” Mrs. Black responds, “Dr. Henry said he may need to run some more test, and I can not leave until the infection is out of my body.” Mary offers, “I just left Dr. Henry. He updated me about your condition. I just wanted to check on you and follow-up on several things.” Mrs. Black asks, “Were you able to find anything about someone to help me at the house?” Mary replies, “Yes ma’am.” She explains Dr. Henry wrote the
order that states Mrs. Black requires a personal assistant due to health and physical limitations. Mary says, “We can complete the application Monday. Hopefully, you will feel better.”

Mary begins flipping through her notepad. “I spoke with your son on Tuesday. He assured me he will help at your apartment once you are discharged,” she says. Mrs. Black makes a strange face, her eyes widen, and she turns away from Mary. As if she is only speaking to me, she says, “Well, I do not want to bother him and his family with anything.” Mary responds immediately, “Mrs. Black, I know you do not want to ask your son for anything else, but you need his help until you get to feeling better. He knows you need his help, and he wants to help out. I told him I anticipate we will be able to get you a personal assistant in your home for a couple of hours each day.” She replies, “He called this morning, I reckon he will come to see me later today.”

Mary changes the subject. “I have good news. You are approved for the prescription program. Nearly all of your medications will be covered by the pharmaceutical company, and I think you will only have to pay a small co-pay for one.” Mrs. Black’ smiles, “Thank you, Mary, every bit helps.” She says, “God is good.” Mary replies, “Yes, ma’am, we are going to get you straightened out, just keep the faith, and get well.” They continue talking for a few more minutes. Mary says, “I will be back Monday to check on you. Dr. Henry will let me know your discharge date, and I will see you before you leave the hospital.” As we are saying goodbye, Mrs. Black’s telephone rings. We wave goodbye and leave. Outside of the room, we take off the gown, gloves, masks and discard them in a trash can. We sanitize our hands again before leaving.
Mary and I walk back to the nurses’ station. Mary speaks with the social worker about the patient residing in the group home. The social worker shares that the patient is scheduled for a psychological consultation at the request of the group home. Mary explains later that the social worker says the group home staff states the patient’s behavior has “worsened.” Mary informs the social worker that Dr. Orsay wants additional information about the patient and asks her if she will share the contact person’s information at the group home. The social worker gives Mary the name and number of her contact person. Mary then inquires about Mr. Johnston. “Is there someone here in the hospital who can sign and interpret a visit with Mr. Johnston? The social worker replies, “Yes, you can request a hospital staff member proficient in American Sign Language (ASL) through the Patients’ Relations Department.” Mary makes a notation on her notepad. She says, “Regarding, Mrs. Black, I will be back on Monday to see her. If you are available, I’d like to update you then.” The social worker says, “Call my cell phone after you see Mrs. Black, and I will meet you on the floor.”

Later when we debrief in Mary’s office, Mary asks, “What did you think of the rounds at the hospital?” I tell her, “I was impressed with the level engagement between you and the physicians and among them with each other. Although I train CHWs in the certification program, I was unaware of the specificity of medical information CHWs needed to know to work in primary health care.” Mary comments, “A lot of the medical information you pick up on the job. However, it has helped that I have a medical background as a certified medical assistant (CMA).” I ask, “Are the physicians typically as diverse?” Mary explains, “Our HFP physicians are diverse. However, it varies based on the residency program; for example, this year we have more people of color.”
During 2014-15, HFP had 18 physicians in the residency program (HFP, Residency Brochure, 2015). The physicians rotate through a curriculum based on the resident’s year— the first year through the third year. Third-year residents provide community care at HFP and in the hospital.

As we talk, I inquire about Mrs. Black. Mary is forthcoming. Mrs. Black has consented to allow Mary to share information about her. She agrees to let me interview her when she is feeling better as well. Mary relates the following:

Mrs. Black was very active and independent when she lived in New Hampshire. She ran her own business, and except for diabetes, I don’t think she had any major health issues. After her husband had got sick, she took care of him in the home. Subsequently, her health began to decline. When her husband passed away, she began having problems with her diabetes. She did not have transportation and [had] limited support in New Hampshire. Her only son suggested his mother move here because of her declining health and to be nearer to him. She stayed with him and his family when she first moved here until she was able to get her apartment. I believe she is having problems making the transition to a more sedentary lifestyle. Her son has several children, and his wife is a health care professional. They are very busy. At times, I think Mrs. Black may feel left out, now that she is in her apartment. ……Several times, she has called me upset, because she believed her son is inattentive to her needs. While I empathized with her, I also pointed out; he is very busy trying to be a supportive husband and son, raise his children, and he works full-time. I think as her health gets better she will be able to develop a support system. She has already found support from her
church family and her son is very supportive. I will continue working with her to connect her to local resources like the senior center. Right now, I just listen a lot. And I try to encourage her to focus on first getting better, the rest will come later, but for now, she needs to be patient with herself and others.

After the rounds, my conversation with Mary helps clarify my understanding of the way she functions with the physicians during rounds and her interactions with the hospital staff. I learn many of her patients are very ill, and they sometimes feel vulnerable or may experience sadness or depression. She often feels the need to reassure patients that things will get better once their health is improved. In this way, the CHW performs the role of an encourager and supporter for patients and provides informal counseling.

**Researcher’s Reflections**

As I indicated earlier, Mary is uniquely situated to work with a diverse team of physicians because of the HFP’s residency program and Mary’s background as a certified medical assistant (CMA). Mary shared, “Because of the residency program I can attend a broad range of medical seminars and training held weekly at HFP.” Mary participates weekly in care team meetings with a variety of health care professionals, nurses, physicians, physical and occupational therapists, and pediatric staff. In these meetings, the care team members discuss pertinent information affecting the HFP’s patients and operations of the practice. During one care team meeting I observed, Mary updated the care team about the status of the SCDHHS Medicaid application process. There were many questions Mary could not answer about Medicaid applications. She
explained, “I have requested a meeting with SCDHHS to get some answers. Please email me your questions and I will take them to the meeting.”

While Mary’s primary role is to provide services to patients, she assists the health care team members, too, in a variety of ways that indirectly impacted patients care. For example, she explained:

I assist my supervisor with making sure patients receive the required health screening and tests for preventive medicine and management of their health care. I identified many of our children [patients] were not getting their scheduled immunizations. My supervisor and I presented the problem at the care team meeting. As a result, we have created a pediatric panel that meets twice a month to monitor and consults about our pediatric patients who may be high risk or non-compliant. I serve on the panel and do outreach activities to educate parents regarding the importance of immunizations and well child check-ups.

It was beneficial for me to observe the level of direct engagement of the doctors with the CHW and their willingness to address the economic and social issues affecting patients. It occurred to me that the physicians were racially diverse and because of their residency in family medicine had been trained in culturally responsive services. I recalled later both Dr. Williams and Mary had shared with me before my observation at HFP that the staff are trained in delivering culturally responsive services. Moreover, they were fortunate to provide their patients with some of brightest physicians, the latest technology, and quality health care.

Vignette: CHW and the Emergency Department (ED). Context: In 2013, the Riverdale Health Center (RHC) and the Riverdale General Hospital (RGH) developed a
collaborative partnership to implement a new service model called the Healthy Outcomes Plan (HOP). Service providers in the HOP focused on coordinating care for the uninsured and chronically ill patients who were high utilizers of the hospital’s emergency department (ED). The goals of the HOP’s Triple Aim Initiative were 1) improved health outcomes of populations, 2) improved patient experiences, and 3) a reduced per capita cost of health (Healthy Outcomes Plan, 2013). The SC General Assembly under Proviso 33.34 of the Medicaid Accountability and Quality Improvement Initiative (Healthy Connections, 2013) established the HOP. The HOP is based on the local hospitals and primary health care providers developing a plan using best practices and measures to improve the coordination of health care for an at-risk population and to lower health care costs in a way that best works in their community (Healthy Outcomes Plan Guidelines, 2013, p. 1).

The proviso designated the funding and program administration for the HOP through the South Carolina Department of Health and Human Services (SCDHH).

Sabrina Sams is the community health worker (CHW) for the Riverdale Health Center (RHC) and is responsible for implementing the HOP at the hospital. Before Sabrina and I visited the Riverdale General Hospital, she explained, “The HOP patients are called ‘frequent flyers’ because they use the emergency room as their main source of health care. One of my roles is to examine these patients’ social determinants to assess how their lifestyles affect their health.” Social determinants are the social and cultural conditions and environments people live in, and the impact of these conditions on patients’ health (Healthy Outcome Plan, 2013). Sabrina continued, “It is my job to help these patients access resources such as housing, food, income, medications, and a primary
care provider where they can receive appropriate health care rather than using the emergency rooms.”

As Sabrina and I drive to the hospital, she updates me on the recent merger of the local hospital with a large regional medical center; she tells me about the closing of another small local hospital in a neighboring county less than 30 miles from Riverdale. When we reach the hospital’s parking lot, Sabrina says, “It is great to see that the parking lot is full. There was a time when there were hardly any cars here, and we worried if our hospital would remain open.” I ask, “What was the problem?” “It is a long story,” she says, “and I am not sure why the hospital was not doing well financially. I think it was because we had another hospital nearby. Between the two, neither had enough paying customers or patients with insurance.”

As we exit the car, Sabrina takes off her RHC identification (ID) badge and put on the hospital ID. “I need this ID to navigate throughout the hospital,” she explains. “It is the only way you can get through some of the doors.” The hospital lobby has chairs and a large waiting area. I notice the lobby is busy with people moving about conducting business. As we walk down a long hallway on the way to Sabrina’s office, several hospital staff members speak and chat briefly with her. Sabrina shares space with the Sleep Study staff, who observes patients as they sleep. Their shared office space is the size of a small walk-in closet, roughly four feet by five feet, with a cabinet, a counter top, and several computers. “My office is a small office, or I should say it is more like a closet. It is a place just to do paperwork and make calls when I am here at the hospital,” she explains. “It is too small to meet with patients, so I usually have to find a place in the hospital when I need to talk to them.” Sabina visits the hospital daily to see patients in the
emergency department. After discharge from the ED, Sabrina meets with the patients in their homes, at RHC, or within the community, wherever it is convenient for patients. “Some patients do not like for you to come to their homes,” she says. “I think they are unsure of me at first, and sometimes, I think they are ashamed for me to come to their homes. So I have met patients at McDonalds, nearby restaurants, or other places.”

As soon as we enter her office, Sabrina grabs the container of Clorox wipes and begins vigorously cleaning the countertops, computer, mouse pad, and door knob. She then uses hand sanitizer to clean her hands. “Would you like to sanitize your hands?” she asks. I reply that I would and inquire, “Are you required to disinfect the space before using it?” Sabrina laughs and says,

As healthcare workers, we are taught to sanitize our hands frequently, but I have been accused of having a phobia because I always sanitize spaces before I use them, and I clean my hands often. About a year ago I developed a real bad staph infection in my nose that was difficult to cure. My doctor told me that I am more susceptible to infections because I work in the healthcare industry. He suggested that I become vigilant because many germs are airborne.

Our next stop in the hospital is the ED. We first approach a window area with a woman sitting behind the desk. She calls out, “Hello, Sabrina, how are you?” Sabrina replies, “I am great! Would you please click us in?” [to enter the ED]. She introduces me and explains that I am doing research about CHWs and that I will be observing her today. The woman says, “You need a visitor’s badge. Please sign in here.” After we enter the area, Sabrina asks, “Are ya’ll busy? Is there anyone I need to see today?” Sabrina reviews a list of patients signed into the ED. The list identifies the patient’s name, primary care
provider, the purpose of the ED visit, the patient’s insurance provider, and status (admitted or discharged). “I review the lists to determine if the patient is a habitual user of the ED, and if they do not have a primary care provider (PCP) and/or insurance,” she explains. “If the patient meets any of these criteria, then I can work with them. The goal is to get the patient a PCP medical home to prevent them from using the ED for primary health care.”

Because the ED is not busy, Sabrina suggests we go to the break area to see if there are ED staff on break that we can talk to about the HOP program. Sitting at the table are two nurses on break. Sabrina introduces me and tells them that I am doing research on CHW programs. I ask, “How would you describe the characteristics of the ‘frequent flyer (FF)?’ ” Immediately, the older of the two nurses [who later told me that she had worked at the hospital for 37 years] explains, “FFs are the folks who are often homeless, cannot get appointments with a doctor, or have used up all of their allocated doctor visits.” Medicaid patients can have only twelve doctor visits per year covered by Medicaid.17 She adds, “Ninety percent come here seeking pain medications; they are addicted. Sometimes they try to get pills to sell, things like Percocet and other pain medications.” Sabrina interrupts, “Many of these people cannot afford to go to the doctor because they do not have insurance.” Both nurses nod their heads in agreement. The older nurse says, “Yeah, but many of them are also lazy or will not work. They will come here and sit all day, but they won’t go to work.”

17 According to the South Carolina Department of Health Human Services (SCDHHS) Medicaid Physicians Providers Manual (2016), “Medicaid patients ages 21 and older are allowed 12 ambulatory care visits (ACVs) per year, commencing on July 1st of each year. Beneficiaries under age 21 are exempt from this limitation “(p. 2-15).
The younger nurse begins describing patients who come to the ED and stay all day. She says, “They have nowhere to go. They don’t have a job.” I ask, “What are you required to do for them?” The older nurse replies,

If they sign in, we have to examine and treat them if they actually need medical care. However, if they are just hanging out in the lobby, we call security to escort them out of the hospital. There are some who will wait until shift change to see another doctor and try to convince him to give them pain medication.

The younger nurse adds, “If they’ve waited for several hours because we are busy, Dr. Anderson will sometimes ask us to order them a meal from the cafeteria. Sometimes, I believe people come here to get food.” Sabrina turns to me and says,

Dr. Anderson is one of our best doctors. He cares about people and tries to get them the help they need. He will not give them pain medication if they do not need it, but he will often refer ED patients to me so I can assist them with a place to stay, food, and financial assistance for medication and other health care needs.

I notice that the nurses sound frustrated as they talk. The older nurse exclaims, “These people do not care about how much it costs for the emergency room services. Medicaid was not designed to let people have it for life. But for many of these folks, Medicaid is a way of life.” I ask her to give me an example. She responds, “I have been here so long I have seen multiple generations of families on welfare and Medicaid. There is one FF, who is able to get pre-arranged Medicaid transportation, which requires three days notice, to come to the ED almost every month. If it is a true emergency, just how is it that he can arrange for transportation ahead of time?” The younger nurse adds, “Because they do not have to pay, they do not care about how much it costs. And they
will lie and sometimes steal.” Just when I think the nurses have nothing good to say, Sabrina interjects, “Now, have you seen any changes from anybody?” “No, not really,” says the older nurse. “What about Ms. Pattie?” Sabrina asks. “ Didn’t she use to come every weekend?” The nurse replies, “Yeah, I must admit she don’t come quite as often, but she still comes unnecessarily.”

Sabrina asks, “What about Mr. Reggie Brunson?” Both nurses laugh. The younger nurse says, “Now he did do a 360 on us. We never see him in the ED now.” The older nurse says, “Yes, he used to come to the ED several times a week. He would be sloppy drunk, and think that he was having a heart attack or dying.” The woman continues, “Now that you mention it, we used to see him regularly, but it has been more than a year or so since I saw him in the ED.”

Sabrina explains,

He has come a long way. I am very proud of him. After his last visit to the ED, when he did have a heart attack, we helped him get financial assistance with his medical bills. He got a pacemaker; he got approved for disability, and he stopped drinking alcohol.

The older nurse says, “He looks good too. I saw him in the grocery store one day, and I did not recognize him! But he knew me, and he spoke to me.” She sighs and says, “I sometimes think people just lack education and support. I know people who come here regularly because their family members have given up on them and they have nowhere else to go.” Sabrina adds, “I think it takes time, especially in a place like Riverdale, where there are not many opportunities for people, especially for people who are uneducated and do not have skills.” Both nurses nod their heads in agreement. The older
nurse acknowledges, “If you are uneducated and unskilled, you will not find work here.” She then shares several stories about FF patients and efforts she made previously to assist or support them. “We live a small rural town,” she says, “and everybody knows everybody and their business.” We thank the nurses and left the ED. As we walk to the car, Sabrina says,

I think the nurses are tired because they see the same people over and over again. They are supposed to be working here for medical emergencies, not to address social problems. So that is my role: To help these patients get a primary healthcare doctor and connect them with the resources that can assist them with their social issues.

It was clear to me that Sabrina understood the roles of the nurses and the CHWs on the healthcare team. I reply, “Yes, I know that nurses have a different perspective, but what do you think it will take to get the healthcare professionals to understand the role of the CHW?” Sabrina responds, “Education, education, education, and, of course, some training. I am not sure what the hospital staff was told about the CHW program before I came to work here.”

On the way to our next stop, Mavis, a student who is in training to become a certified CHW, joins us for observations and mentoring from Sabrina. Tri-County Technical College has an agreement with RHC for Sabrina to provide on-the-job training for students in their CHW Training Program. Sabrina comments, “Our next stop is to see a person I work closely with, who helps with identifying ED and HOP patients and getting them financial help to cover their hospital bills.”
Betty is the patient financial counselor at Riverdale General Hospital (RGH). Betty receives daily lists of the patients who visit the emergency room or outpatient services. She reviews the records of the patients who may be eligible for the HOP program and refers them to Sabrina. After Sabrina introduces us, she asks Betty, “Can you explain how we work together and the common themes we encounter with patients?” Betty turns to me and asks, “What have you been told?” Before I can reply, Sabrina says, “No, she wants to hear it from you. First, could you please tell us what you do?” Betty smiles and explains, “My job entails working with the self-pay patients, the patients who are uninsured, and the patients who are eligible for and/or are receiving assistance from federal programs such as Medicare, Medicaid, and/or disability.” Betty is in charge of collecting payment from self-pay patients. She says,

I am responsible for collecting payment from all the self-pay patients. If they are unable to pay, and they used out-patient services, like the lab, X-Ray, surgery, or other outpatient services, I help them apply for financial assistance through hospital charities and foundations.

Betty shares, “I assist patients with making applications and help them get the needed benefits to cover their expenses here at the hospital. I also arrange time payment plans for patients to cover their bills here at the hospital.” She concludes, “There are many patients in the county that cannot afford healthcare, and it is my job to make sure the hospital receives payment for its services.”

Betty explains that the process is very involved and requires working with many moving parts. As she describes the process of working with patients, Sabrina fills in the blanks when she senses I did not clearly understand something Betty is saying. At that
moment, it becomes clear to me Sabrina is acting in the role of a co-researcher, asking pertinent questions for data collection. For example, Sabrina suggests, “Maybe you can tell us about when the HOP Program started two years ago.” Betty replies, “In the beginning, I did not know what Sabrina’s position was here at the hospital. This lady was attacking my patients and asking them questions, and my patients were telling me about her. I was wondering who this lady was!”

Sabrina and Betty eventually realized that they were seeing the same patients and began working more closely together. According to Betty, “Our roles intertwined. A lot of our self-pay patients qualified for the new HOP program, because they were uninsured, using the ED for health care, and had low or no income.” She adds, “Sabrina and I decided that I would make referrals directly to her. Sabrina could connect these patients to a PHC doctor at RHC, which would prevent them from using the ED for primary healthcare. If they came back to the ED, I would alert Sabrina to follow up.” Betty explains further,

If HOP patients needed outpatient services, the doctor ordered labs, surgery, or X-Rays, Sabrina and I worked together to get authorization from the business director, who is now the chief financial officer (CFO) since the hospital merger. I would first make sure the patients met the criteria and could verify proof of income, assets, and other documentation. Many times Sabrina helped me get the needed documents. We sometimes together presented the case to the CFO for authorization for financial assistance from the Charitable Funds to cover outpatient procedures.
Sabrina says, “At first, it was nerve-wracking. We presented a brief history of the patient’s financial and medical record to the CFO and explained why financial assistance was needed.” Betty adds, “If approved, the patients were able to register for services. If not, we worked to find other resources.” Sabrina states, “Betty knew all the details. She was extremely helpful because she knew the hospital jargon. I did not. Because she could speak the language, the CFO trusted her.” She notes, “Now we always work together as a team. Most of the time they authorize the charity funding for the HOP patients which is a big help to the overall health of the patient.”

At last, Betty says the words Sabrina is hoping to hear as indicated by her response to Betty:

Sabrina’s program has helped the hospital save money. She has been especially helpful in reducing the number of frequent uninsured flyers who were reoccurrences because they did not have the means to purchase medication, or to see a physician on a regular basis. The FF numbers have dropped tremendously.

Sabrina interrupts, saying, “Could you please say that again?” We laugh as Sabrina appears to feel vindicated. Sabrina says, “You are the first one to be brave enough to say that the CHW and HOP program is making a difference. That is a great statement about the program.” Betty’s eyes widen and her mouth gapes open in amazement as she asks, “Who did ya’ll speak with?” Sabrina replies that we spoke to Deb and Ann, who are the ED nurses…. and briefly with Dr. Jennings, who is the physician in the ED. Betty responded,

They do not see the financial side, but they have to admit they do not see the repeaters as much as they have in the past. Because I do not see the repeat
offenders, and I see all the self-pay patients that are seen here at the hospital. When I spot one of these patients, I call Sabrina, and she intervenes. She signs them up for the program and redirects them back to their primary care doctor.

Betty adds, “Oh, yes. And Sabrina saves me time, because if the patients come back to the ED after 30 days, I am required to do another application and reverify all the same information.” Explaining to me, she says, “All of this takes a lot of time and time is money. If they are not coming back in the ED, it saves the hospital money.” Betty shares that since the merger and the concurrent closure of the nearby hospital, the numbers of self-pay patients had doubled within a month from 30 to 60 people. Since the merger, RGH serves multiple counties. “The HOP and CHW programs are working!” Betty exclaims. Sabrina smiles and nods her head yes. I ask, “In what other ways do the programs benefit the hospital?” Betty replies,

Sabrina has a very trusting relationship with the patients and this in turns helps our relationships with patients. We also do field visits together, and Sabrina takes patients to court hearings for disability or to get other resources they need. She does whatever it takes to make sure the patients’ needs are met. They like her because she is excellent at her job; she is very passionate, patient, kind, and devoted. I think the CHW at the other hospital was not as good, and the program did not work well.

Sabrina continues to guide the interview. She says to Betty, “Talk about some of the cases where we were successful.” Betty replies, “You most definitely need to include May Bell because it took us 11 months to get her the help she needed.” Sabrina nods and Betty adds,
May Bell, an HOP patient, had cancer and badly needed an outpatient procedure. Her husband refused to provide proof of income and property value, which is required before we can ask for charity assistance. Sabrina wrote letters, made telephone calls, and made several home visits to explain to the husband why the information was needed. But he would not give us the information.

I ask, “Why do you think he refused to give you the information?” Betty says, “He was a veteran, and I think he just did not want us in his business.” Sabrina nods her head in agreement. “Yes,” she says, “He was paranoid that someone was going to take his money. He did not trust anyone.” A few weeks later the husband was hospitalized for a severe illness. He finally allowed his wife to contact Sabrina and share with her the proof of income Sabrina and Betty needed. “She just walked in one day with the last letter Sabrina had written to them, and asked if we could still help her,” Betty explains. The request occurred within days of the hospital merger, so Sabrina and Betty had to learn quickly a new process to help. They explained that no one knew what to expect with the merger. Betty says, “Thanks to our teamwork, May Bell had the procedure, and I believe she is doing well.” Sabrina adds, “We helped her get medication assistance, and she has applied for disability.”

Betty continues, “Only God knows where Mr. Reggie Brunson would be if wasn’t for Sabrina. I believe she saved his life.” I ask, “How so?” Betty describes Mr. Brunson as an “FF,” who was killing himself with alcohol. “He came to the ED every week, and sometimes 2 or 3 times during the week,” she says. “I believe he had mental problems along with heart problems.” Sabrina nods her head. “Since he’s been working with Sabrina, however, he stopped drinking, and he stopped coming to the emergency room
because he sees a PHC doctor at RHC,” Betty says. Sabrina adds, “I am very proud of Mr. Brunson; he has come a very long way.”

**Researcher’s Reflection**

That day, I spent eight hours at the hospital with Sabrina. Everyone we encountered was extremely open and willing to share her or his perspectives. For example, a health care worker I met in the cafeteria told me a story about how Sabrina had connected her to a community resource for a family member. She commented, “This is a good woman. I am not one of her patients; she did not have to do this. She will help anyone if she can.”

Although at first the nurses in the ED appeared to be judgmental about frequent flyer patients, they softened their stance as they shared other stories about the ways in which they, too, had tried to help patients with food, money, transportation, prayer and other resources. It was apparent that many people living in this small town are invested in helping those in need. Even though they were frustrated, they never stopped giving of their time and resources.

I could sense Sabrina’s frustrations that the ED nurses did not immediately recognize and discuss the impact of the CHW and HOP programs with patients who were high utilizers, “frequent flyers” of the emergency department services. Sabrina is very committed to the work she is doing, and I believe she needed validation that she is making a difference. Betty validated the positive financial savings and the patients’ management effects from the CHW and HOP programs. I too was relieved to hear Betty’s validation because I could see first-hand the challenges CHWs faced working with many patients who have long-term, complex economic, social and health care
problems. My experiences teaching the CHW certification training program provided insight into the lack of recognition of the challenges CHWs face and the progress they believe they are making with individuals receiving CHW program services.

Sabrina’s role of a researcher emerged from my observation at the hospital and of her work as a CHW. Sabrina clearly guided the interview questions with the individuals she introduced to me in ways that I was unable to do. Because she and I previously discussed the purpose of the study, Sabrina was able to garner meaningful data from these individuals. This action by Sabrina is called purposeful sampling (Patton, 2002). During my analysis of the data, the theme of CHWs as researchers emerged not only in the ways they assisted me during the study but also during the CHWs’ everyday tasks of collecting and analyzing data for their respective health care providers’ program evaluations and reporting systems.

My interview with Betty was very informative. During the interview, I asked if she experienced problems with Medicaid applications. Immediately she responded, “Yes, and do you know someone who could help with the problem?” Betty validated the concerns and issues that Patience at NPLB Health Center was experiencing. Patience was having trouble getting Medicaid applications approved. Betty showed me a stack of approximately 60 Medicaid applications that were pending approval. I shared I attended the HeART meeting in April at the SCDHHS office, where the program managers of health services announced the problems were rectified, and there should not be any applications pending approval more than 45 days.

Betty sighed and said, “Many of these applications date back to December 2014.” She added, “In this stack are applications pending for pregnant women who have now
had their babies. They keep calling me, and I do not know what to tell them. Also, I have not been able to meet my budget for the past several months, because of pending Medicaid applications.” Betty further explained that she was concerned about how the new administrators would view the fact that she has not met her budget for several months. Betty offered to provide a list of names of the pending applications to whoever needed it. Later on that day, I connected Betty and Patience to each other, in hopes that together they could advocate on behalf of people awaiting approval for Medicaid.

**Patient Care Coordination.** Context: In keeping with its mission to enhance and improve the health and wellbeing of everyone, the Montgomery Community Health Center (MCHC) services delivery uses the expanded care model and a community engagement approach depicted in Figure 4.1 (MCHC’s Mission Statement, n. d.). The “understanding is [that] health care and the health of the individual is linked inextricably to health and well-being of the community” (Community Development, n. d.). For MCHC health care is more than medical support and access to a pharmacy; it is also the outreach, family support, and behavioral health.

The MCHC recently integrated support services for families into its health care delivery systems. SSF includes assisting people with social and economic issues, housing, food, transportation, employment, and health education. In addition to providing the clinical services, diagnosis, primary healthcare treatment, specialty care, and pharmacy, “SSF connects the patient in the community to the patient in the examining room” (Community Development, n. d.). The integrated model is a “four-tier system that uses a process to identify and treat patients based on the patient’s social determinants, behavioral, medical, and family health. SSF includes a level system of case management
support and medical services based on the patient’s health status, excellent to poor “ (Community Development, n. d.). For over three decades, CHWs have functioned in some capacity at MCHC (Evolution of CHW’s Roles, n.d.). According to Michael Chisholm, the Community Services Manager, “CHWs at MCHC work within the SSF model, which is a continuum of health care services based on the individual’s health status and the level of services.”

As I did with the other two program sites, I observed a CHW for ten days. I joined CHW Margaret McGowan at MCHC upon the recommendation of Mr. Chisholm, the supervisor of CHW services. Margaret is uniquely situated as she functions in dual positions as a CHW and a CMA providing SSF at levels 2 and 3. In this capacity, Margaret works at multiple sites in the county and the MCHC satellite office in Oakland, a small community 15 miles away from the MCHC main office. Because of her dual functions, Margaret has two supervisors, Mr. Chisholm, the community services manager and Mr. Davidson, the director of health services.

Every day that I spend with Margaret, she is dressed in scrubs; today’s color is a pale peach-colored top, with matching bottoms, comfortable looking tennis shoes and her MCHC’s ID badge around her neck. Margaret’s mornings at MCHC begin with a “huddle”. Margaret explains,

Huddles are brief meetings, no more than 10 to 15 minutes with our care teams in which we review and discuss pertinent information regarding the patients we will see for the day. My job is to help coordinate the patient’s health care.
As at all of the CHW sites, I observe MCHC use the Healthcare Effectiveness Data and Information Set (HEDIS), a tool for monitoring and measuring dimensions of care and services (National Committee for Quality Assurance Website, 2015).

The MCHC’s reporting system tracks all of the patients’ care including physician visits, prescriptions, labs, screenings, follow-up diabetic and hypertension visits, ED visits, prenatal care, well–child check-ups, immunizations, health education and other information. Margaret explains,

a copy of this information is provided for each doctor, and his or her nurse and a copy is placed on each patient’s medical chart. I print a list of this information and review before our huddles. During the huddles, I review this information with the team to make sure team members know what preventive and treatment services patients need during the visit.

For example, Margaret discusses with the care team the preventive and treatment service that Ms. Doe needs:

Jane Doe is due a comprehensive screening for diabetes. We check her diabetes screening tests, Hemoglobin A1C blood level, give her an eye examination, cholesterol and weight check, and other labs. It’s time for her mammogram, pelvic exam, pap screenings, cervical and colorectal cancer screenings. She needs the smoking cessation education that I most likely will do depending if the nurses are not on the schedule for the day.

Team members in the huddle also briefly discussed unresolved problems or concerns team members may have about patients. For example, Margaret shares,
Dr. Moore asked me to make a home visit with one of his newer patients. He wants me to check on the patient’s caretaker who is his mother, Mrs. Lillie. The patient is extremely ill, totally paralyzed, is being tube fed, and has brain damage as well as other severe health conditions. Dr. Moore is concerned the mother may be unable to take care of the patient in the home. He wants me to assess the situation.

Margaret follows up by saying, “I will call to see if we can make a home visit today.”

Approximately a year ago, MCHC upgraded its technology. A new electronic medical record system (EMRS) was implemented partly to increase easy access to patients’ health care information, and replace the mounds of paper kept in patients’ medicals. According to Margaret, the ERMS was piloted for six months and after revisions in the training, the EMRS has been implemented in phases. The EMRS enables the care team members to have access to all patients’ demographic, insurance, and clinical information.

The EMRS includes the recently implemented i2i system, which tracks the patients’ health outcomes, better manages a broad range of quality measures and standards required by the insurance companies, state and federal funding sources. Margaret comments, “These systems help us to track and manage our patients’ health outcomes. I spend about 8 hours each week inputting data into the system.” I ask how she likes the new system. She explains,

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18 The i2i system “is a population management tool that tracks and standardizes data from different electronic health records, practice management, and other systems with outputs information on the entire patient population receiving services” (The i2i Systems’ Website, 2015, n. d.).
The old paper records were a nightmare because staff would not always sign out the records, and we spent a lot of time searching for the files. Now, everyone has access to the patient’s record. Once we all are comfortable with using the EMRS, and it is fully integrated into our systems, it will be great for the patients and us because we can better monitor our patients’ health outcomes.

Margaret shares the EMRS was especially helpful when completing the reports and added, “We have received much training on this system, and we frequently receive updates.” Describing the three monthly reports she completes, Margaret says,

I have three monthly reports, one for SCDHHS Medicaid, Family Support Services, and information for our Uniform Data Systems (UDS). The UDS is a required online data reporting system of all FQHC by Health Resources & Services Administration (HRSA). These reports are a necessary step. We get paid this way, and we can demonstrate we comply with these agencies to receive federal funding. The i2i system consolidates most of the data in one place and makes it visible to the care team and the management. Ideally, I would like to enter the data to the reports daily. However, that is impossible given all I have to do, so I carry a notepad to write down everything I do with patients, so when I do a report, I can refer to my notes.

In addition to completing three monthly reports, each time Margaret works with the patients she completes an encounter form. “After each patient’s visit, I complete and submit an encounter form like the doctors,” she explains. “I write down everything I did with the patient.”
One of the days I spent with Margaret was near the end of the month. Because all three reports were due on the first, I observed Margaret entering information for approximately four to five hours. “It takes me about three to four days each month to complete all of the reports,” she said. As she worked on the reports, Margaret demonstrated the process on the computer. She noted, “The only information I can not access is the behavioral health records because they are confidential.” I asked, “Who else can see the behavioral health records?” She responded:

The social worker is the only person. The doctor can not see the records, which I understand why we can not see the clinical notes, but it would be helpful if I knew if the patient kept the behavioral health appointments, because I can help encourage and facilitate the patient compliance with their visits.

Later I learned from the social worker who worked with patients through MCHC that Health Insurance Portability and Accountability Act (HIPAA) behavioral health guidelines differed from physical health to protect the therapeutic relationship between patients and therapist. Some information can be shared only through a subpoena issued by the courts. I shared this information with Margaret. The social worker explained,

If a patient is not compliant with appointments, I refer him or her to the CHW. Many times there are problems with transportation, finances or basic needs. The CHWs are extremely helpful with getting patients the resources they need. Sometimes they perform magic.

I noticed while Margaret was completing her reports, health care team members stopped by her office and interrupted her to ask questions or to get her assistance with a patient. Tammy, MCHC’s patient’s advocate, asked questions about the best way to
follow up with a patient whose telephone number had changed and who had not responded to the letters she had sent. Margaret suggested, “I would check the next of kin contact information and give them a call. But the only thing you can tell them is you are from the doctor’s office, and you just need to get contact information.” Tammy responded, “I did not think of that. Sure, I’ll try that. Thank you so much.” Tammy came back later for help with coding an interaction with a patient on the ERMS. She asked, “Can I code the contact with a family member?” Margaret explained, “You can only code the contact if you spoke directly to the patient or saw the patient face to face.” Another team member stopped by and asked Margaret if she would “teach the patient how to check his sugar levels on his Blood Glucose Monitoring Device and how to check his blood pressure.”

Margaret went to break room area where the team member was working with the patient. She approached the patient, introducing herself, “I am Margaret McGowan, the CHW. I understand you got some new toys you want to play with.” The man smiled. With gloves on, she first demonstrated how to check his blood sugar. As she began demonstrating to the patient, she explained,

You need to have everything you need right in front of you. An alcohol wipe to clean your finger before you stick it, the monitor, and the strips. Then, slightly prick the tip of your finger, and press lightly with strip catching a little of the blood, then place the strip on the monitor for a reading. Now you do it.

The man looked as if he was a bit nervous, but he successfully demonstrated each step. Margaret commented, “You are a pro. You sure you have not done this before?” He laughed and said, “Yes ma’am.” Margaret also showed him how to use and read the
blood pressure monitor. Throughout her demonstration, I noticed she was very personable and connected to the patient as she described the steps. For example, she said, “Okay, now you show me”, and when the patient completed a step correctly, she praised him for “Good job” and gave him a high-five. Both the care team member and patient thanked Margaret. She said, “No problem” while laughing and added, “That is why they pay me the big bucks.” We all laughed sarcastically as if we knew Margaret was not paid much money for the work she does.

After four to five hours of entering patient data, Margaret and I made the home visit that Dr. Moore had requested in the morning huddle. Margaret needed to assess the new patient’s home environment and if his mother could provide all the care that he would need. The caretaker consented for the home visit and for me to join Margaret on the visit. On the way to the patient’s home, Margaret shared that Dr. Moore’s patient, James had suffered a stroke which left him totally paralyzed and was unable to speak. James is an African American male, 45 years old, who is taking approximately 15 to 20 medications, on oxygen and a feeding tube as well. Margaret said,

Dr. Moore is concerned the patient may need to be in a nursing home, instead of being cared for by his 75-year-old mother at home. He wants to make sure Mr. James is receiving the appropriate care. He asked me to assess what services the patient and his mother may need. Margaret shared that hospice was involved but that, “Dr. Moore thinks the hospice services is premature, because he is not at the end of life, and they [the hospice services] may be motivated to provide services for financial gain.” Margaret continued, “Dr.
Moore thinks his mother is an angel because she has been through so much trying to care for him; and she is very devoted to her son.”

Upon reaching James’ home, Margaret rang the doorbell. His mother Ms. Lillie answered the door. She said, “Hello, are you Margaret with MCHC?” Margaret replied, “Yes ma’am.” Margaret introduced herself and said, “This is the lady I told you about on the phone.” She explained once again that I was observing her for a study about CHWs and asked again “Is it okay for her to observe our session today?” Ms. Lillie, said, “Of course, Y’all come on in.” I explained that her identity will be kept confidential in the information I use for the study.

As we entered the living room and walked to the kitchen area, I noticed there were bright signs throughout that read: “NO SMOKING OXYGEN IN USE.” Ms. Lillie offered us a drink, “tea, coffee or soda” as she invited us to sit at the dining table adjacent to the kitchen. On the wall in the dining area, there was a big bright pink sign that read, “Welcome Home James and Lillie, We love you!” The sign had about 25 signatures and notes written on it. Diagonally, from the kitchen, was James’ room. I could hear hissing and a beeping sound coming from the room. The sounds were loud. Margaret said, “How are you doing, Ms. Lillie? Dr. Moore wanted me to check on you to see how you are doing and what services you and James may need.” Ms. Lillie responded, “I am doing well, just a little tired. I did not sleep too well last night, but I am thankful for the rest I got.” She continued,

Dr. Moore is such a kind man; I met him at church. At first, I did not know he was the same doctor that saw James at the hospital, but I was so stressed out that night. He and his wife are sweet people. He told me he would do whatever he could to
help James. He saw James at the hospital the night we brought him there to the hospital in an ambulance from Atlanta.

Explaining the trip from Atlanta to South Carolina, Ms. Lillie said, “James had a stroke while he was on his job in Atlanta and was hospitalized for months. I was living in New York at the time, so I just moved in a hotel in Atlanta during his time at the hospital.” They later moved him to a nursing home in Atlanta. Ms. Lillie described the nursing home experience:

I was not happy at all with his care there. I spent every day with him, 10 -12 hours some days. I only went home to bathe and get a little sleep, and I was back there. The nurses were horrible, especially the older ones, even the Black nurses. In my opinion, they did not want to do their jobs. The younger nurses, both Black, and White were more compassionate and attentive to his needs. The color of your skin do not matter; it is the heart that matters; the blood that runs through it is red.

She told us when her son was in pain, he moved his head from side to side and made the sounds like he was in distress, and when she asked the nurses to get him pain medication, they questioned how she knew he was in pain and refused. Ms. Lillie said,

I just kept praying to God for help each time they refused him medication or when they did not treat him well. Praise God. He always came through. The doctor would just show up, and I would explain, and he ordered the medicine.

Margaret and I sat listening to her tell story after story about the nursing home. Her tone of voice was soft spoken, and though she was not satisfied with his care in the nursing home, she did not seem angry at all. She commented, “I learned a lot about healthcare, and I do not ever want him to be mistreated, so I decided to bring him home where I...
could care for my child.” As she spoke about her experience, I felt she needed someone just to listen to her, and that is what we did for the first 30-40 minutes.

Margaret began asking her questions. She said, “Tell me about you. What is your support?” Ms. Lillie responded,

I brought my son home because my brother is here. He grew up in this house. I have not lived here for 20 or more years, but we have family, cousins, friends, and church members who come by to check on us, and they sit with James while I get out to church or to run errands. I have a nurse who comes daily to check on James and me and a personal aide who comes a couple of hours each day to help with light cleaning, getting the groceries and other things James may need for his personal care.

Margaret asked, “Is there anything you need?” Ms. Lillie, said, “I think I am okay right now. I have problems sleeping at night because I keep getting up checking on James. But, I will be all right.” Ms. Lillie then asked if we wanted “to see James.”

When we walked into the room, we saw that James was laying in a hospital bed, with tubes in his mouth and an intravenous (IV) in his arm. He began making a sound that is hard to describe. It was like a moaning sound. As his mother spoke to him, the sounds got louder. She said, “James, you have visitors to see you. This is Margaret and Constance. Your doctor sent them to check on you.” James moaned a little louder. We both said, “Hello James,” he moaned louder. Ms. Lillie went closer to his face and began stroking him gently. She said, “What’s the matter?” He appeared to moan louder. She said, “I think he heard us talking about him, and he gets excited when he hear me talking about him.” She then asked Margaret, “Do you think you can help us get a longer hospital
bed? He is a tall man and as you can see his feet are almost hanging out of the bed.” Margaret replied, “Yes ma’am. I will let Dr. Moore know he needs a longer hospital bed.” She wrote it down on her notepad.

While we were in James’ room, the doorbell rang. It was three church members, two women, and a man; one was a cousin. They came to check on Ms. Lillie and James. Ms. Lillie introduced us to the visitors. Margaret said, “I will be checking on you periodically.” She gave Ms. Lillie her contact information and told her, “You call me if you need anything. I will be back in touch with you after I speak to Dr. Moore about the bed.”

On the way back to MCHC, both Margaret and I were in awe of Ms. Lillie. Margaret said, “James’ mother is a saint. No wonder Dr. Moore called her angel.” I agreed wholeheartedly. Ms. Lillie was extremely humble. She never once complained although it was apparent she was tired. There were dark circles under her eyes. For me what was most noticeable was how extremely patient and accommodating Margaret was. She allowed Ms. Lillie to talk as long as she needed to do so. Margaret appeared very comfortable listening and periodically nodding her head or laughing when it was appropriate. Margaret said, “I hope I will be as compassionate to my family members if they ever become ill.” She added, “I am in a quandary, because James probably does need to be in a nursing home, but she is not going let him out of her sight after his experience in the nursing home in Atlanta.” I agreed. I suggested maybe in time she would be able to let him go to a nursing home, especially because she was back home where she could check on him daily and where they have a support system. Margaret said, “Meanwhile I will be involved as needed unless Dr. Moore indicates differently.”
Researcher’s Reflection

My observation of Margaret at MCHC highlighted four important factors regarding the integration of CHW services in primary health care. First, it seemed essential for everyone working for the PHC provider to understand the mission, vision, values and expected outcomes. Throughout my observations at MCHC, the staff appeared to focus on its mission and frequently demonstrated the values of serving the patients and community partners with teamwork, excellence, joy, respect, integrity and trust (MCHC’s Mission, Vision and Values’ Statement, n. d). The care team was engaged in making sure the patients’ health outcomes were at the center of care. In fact, Margaret and other CHWs played a pivotal role helping to meet the patients’ needs. She asked questions of the health care team members regarding patient’s needs and was always willing to help patients whenever the CHW’s services were needed. I noticed the mission and values statements posted on Margaret’s bulletin board over her desk. She frequently reminded me that she and other team members’ purpose was to fulfill the mission of MCHC and treat all the patients with dignity and respect.

Second, the model of services delivery was transparent for all employees and community stakeholders, and each employee received consistent education and training that aligned with the strategic goals of the health care provider. In nearly every space (office, lobby, break rooms, and clinic areas) I entered at the MCHC, the mission, vision, values and strategic goals were visible on bulletin boards, pamphlets, brochures, and laptops. Moreover, I observed and attended with Margaret and other MCHC staff, approximately 25 hours of training during my ten day observation period. Because Margaret served as both a CHW and a CNA, she received a broad range of training and
education that directly affected patients’ care. For example, Margaret participated in an online webinar on social determinants and the impact on health care. On another occasion, Margaret and two other SSF staff members received training for 14 hours on how to use the Optovue OCT, a screening device for detecting diabetic retinopathy\textsuperscript{19}. Margaret explained to me,

as soon as we are trained and demonstrate proficiency with using this screening device, all of our patients with a diagnosis of diabetes will automatically receive screening for Diabetic Retinopathy. We each will screen the patients at our health care centers.

A finding from the study is that integration of the CHW and the CNA expands the CHW services model identified in the literature, Table 4.3 (HRSA, 2014). By integrating both positions, CHWs can provide more health care services such as screening patients with diabetes for diabetic retinopathy, taking patients’ vital signs, assessing and monitoring patients’ health conditions as well as setting up medical equipment (Nursing AssistantGuides.Com, 2016).

\textsuperscript{19} Diabetic retinopathy “is a condition occurring in persons with diabetes, which causes progressive damage to the retina, the light sensitive lining at the back of the eye. It is a serious sight-threatening complication of diabetes. Diabetic retinopathy is the result of damage to the tiny blood vessels that nourish the retina. They leak blood and other fluids that cause swelling of retinal tissue and clouding of vision. The condition usually affects both eyes. The longer a person has diabetes, the more likely they will develop diabetic retinopathy. If left untreated, diabetic retinopathy can cause blindness” (The American Optometric Association Website, 2015).
Third, at MCHC, the care teams’ priority appears to be patient-centered care and coordination. I believe MCHC’s leadership has made a commitment to ensure all patients receive the recommended preventive health care and management services. The leadership has put in place a systematic process that includes technology and CHWs as a gatekeeper for making sure there is continuity in the provision of patient-centered health care. Margaret played a pivotal role in the coordination of patients’ care by being a gatekeeper for all MCHC patients during morning huddles. Each morning, she discussed with team members the priority health screenings, health education, treatments and other services needs for the patients scheduled for an office visit. The aim was to prevent and close any potential gaps in care. Likewise, the physicians, nurse practitioners, nurses and other care team members also briefly discussed the patients’ health or the care team’s priority needs for the day. As such, Margaret was able to support the care team by following up with patients’ needs or in the case of staff shortages, filling in by assisting with taking patients’ vitals, conducting health education or doing other tasks needed to facilitate patients’ service delivery.

Fourth, the monitoring of system-wide measures at MCHC for all patients through the use electronic of records and the i2i system helps facilitate updated information to the care team regarding each patient's health outcomes that determine and drives the delivery of health care services. The patient’s health outcomes are discussed with the care team to ensure full integration with patient’s healthcare management and services. Again, Margaret had access to and knowledge of the priority health outcomes for all patients. With this knowledge, she was able to encourage, motivate, and support patients as well as advocate for the patients when necessary with the care team. I believe because the
patients at MCHC health outcomes are visible to everyone, there is an integrated system that monitors patients’ health outcomes and enables the care team to work more cohesively when attending to the needs of the patients.

4. 2 CHW Program Services in PHC

In this section, I will address the research question: What services do community health worker (CHW) programs provide? To answer this question, I will discuss the findings from the data I collected and analyzed from ten days of observations at three primary healthcare sites, which are the Hillsboro Family Practice (HFP), Riverdale Health Center (RHC), and the Montgomery Community Health Center (MCHC). The data collected includes conversational interviews with CHWs, patients, health care professionals, and documents collected from the three CHW programs. Firstly, I will discuss the models of CHW services that were previously described in the literature review from Chapter 2, to remind readers of the frameworks in which CHW programs operate in the United States (HRSA, 2011). Secondly, I will share the findings that either corroborate, contradict and/or augment information that compares these models. Thirdly, I will discuss CHW programs’ services, and the roles and tasks CHWs perform to facilitate the delivery of program services. Additionally, in this chapter I have identified the tensions that exist between services and the roles CHWs perform in these three primary health care sites. Finally, I will share my reflections regarding the CHW program services at each of these primary health care sites.
CHW Models of Services

As I described in Chapter 2, CHW programs exist in diverse settings for the purpose of providing services to target populations and communities to facilitate better health, economic, education, and social outcomes (HRSA, 2011). CHWs are employed by a broad range of employers to provide services to primary health care providers, hospitals, insurance providers, non-profit organizations, community-based organizations (CBO), and local and state governmental agencies (the health department, housing authority, and others). There are variations in CHW programs, such as the CHWs’ job titles and responsibilities, which are dependent on the employer’s expectations. These variations are a result of there being no established national model (HRSA, 2011). However, programs typically align with one of the models summarized in Table 4.4. CHW programs may represent one or a combination of the models of services (p. 6).

The study findings from observing a day in the life of a CHW are in the form of vignettes illustrate aspects of each of the models in Table 4.4. From my analysis, I can conclude that five of the six models of services were consistently present at each of the three primary health care sites. These five models of services include: (1) lay health worker, (2) care team member, (3) coordinator/manager, (4) health educator, and (5) outreach enrollment agent. I will go into further detail about each of these models.
### Table 4.4 Community Health Workers Models of Services

<table>
<thead>
<tr>
<th>Community health worker model</th>
<th>Role of community health work</th>
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<tbody>
<tr>
<td>Promotoras de Salud/lay health worker</td>
<td>Represent the community they serve; serve as a bridge between the community and health care system; provide culturally appropriate services; and serve as a patient advocate, educator, mentor, outreach worker and translator</td>
</tr>
<tr>
<td>Member of care delivery team</td>
<td>Collaborate with medical professionals including nurses and physicians; render health services such as measuring blood pressure and pulse, first aid care, medication counseling, health screenings, and other basic services; and work alongside a medical professional to deliver health education or basic screening services while the provider conducts a medical exam</td>
</tr>
<tr>
<td>Care, coordinator/manager</td>
<td>Help individuals with complex health conditions to navigate the health care system. Liaise with the target population and different health, human, and social services organizations. Support individuals by providing information on health and community resources, coordinating transportation, and making appointments and delivering appointment reminders; develop a care management plan and use other tools to track patient progress over time (e.g., food and exercise logs)</td>
</tr>
<tr>
<td>Health educator</td>
<td>Deliver health education to the target population related to disease prevention, screenings, and healthy behaviors; teach educational programs in the community about chronic disease prevention, nutrition, physical activity, and stress management; and provide health screenings</td>
</tr>
<tr>
<td>Outreach and enrollment agent</td>
<td>Provide similar services to the health educator model with additional outreach and enrollment responsibilities; conduct intensive home visits to deliver psychosocial support, promote maternal and child health, conduct environmental health and home assessments, offer one-on-one advice and make referrals; and help individuals to enroll in government programs</td>
</tr>
<tr>
<td>Community organizer and capacity builder</td>
<td>Promote community action and garner support and resources from community organizations to implement new activities. Motivate communities to seek specific policy and social changes. Build relationships with public health agencies, grassroots</td>
</tr>
</tbody>
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organizations, health care providers, faith-based groups, universities, government agencies, and other organizations to develop a more coordinated approach to serving their target population; and participate in local groups and committees to network, increase their knowledge about the program and strengthen their professional skills

**Lay Health Worker Model of Services.** Each of the three primary health care sites had individuals who represented the definition of lay worker model services from Table 4.4. The CHWs are important; they are representatives of both the community/patients and the healthcare provider. One of the aims is to establish and maintain healthy and trustworthy relationships between the PHC providers and the community. Particularly, in CHW programs at Hillsboro Family Practice (HFP) and Montgomery Community Health Care Center (MCHC), lay health worker services are essential assets for meeting the organization's goals for assisting their patients. Additionally, these three programs use the model of lay health worker services as a contributing factor in the hiring process for a CHW position. Mary Moore at HFP and Margaret McGowman at MCHC both self-identified as having similar social and cultural characteristics of the patients whom they serve. They each credited their connection to the community as a significant factor in deciding to become a CHW. During my first day of observation, I asked the CHWs, “How did you come to work as a CHW?” Mary Moore explained;

I am very active in my faith community. In fact, this role of a CHW came about because of my work with the church and the community. I do not have a big name or nothing like that. I started working with the community because of my church.
Every time I was put in a position, and it was community-related, I established a trusting relationship with the people we served. I never went in the community shaking my head or judging people.

As indicated in the above statement, Mary identified with the community through her volunteer work with her church.

Margaret McGowan at MCHC commented;

I grew up in this community. Because we are a small town, everyone knows each other or is a family member. I think the MCHC hired me as a CHW because I know the community, I also have the skills, compassion and I can relate to all of the people we [MCHC] serve.

The study’s data is explicit that the lay health worker represents the community she serves and serves as a bridge between the community and health care system. Each provides culturally appropriate services, as well as serves as a patient advocate, educator, mentor, outreach worker and translator. A summary of the CHW’s position description at MCHC reads:

The CHW provides activities and programs that improve the health and overall quality of the life of community residents by decreasing barriers that may prevent them from accessing health and medical care. They bring educational messages about health and MCHC into the community and engaging residents to improve individual health outcomes. Duties include door-to-door outreach, community neighborhood canvassing, successful medical home and social services referral, increasing public education and awareness and the integration of community services into MCHC’s current delivery of services.
A focus group interview with HFP’s health care team members validated and described the lay health worker services and the connections formed between health care team members and the patients.

Mr. Harris, the CHW program supervisor, shared:

Mary has been here for a while. She knows many people. She knows the different health disparities within each zip code here, knowledge of what to expect in this county and surrounding counties—especially in this zip codes [patients typically served at HFP]. She is well groomed in that which enables the care team to work cohesively with patients establishing a trust that we may otherwise require more time to establish.

A physician at HFP offered:

I think [the CHW] has to be important, because they’re not typically a medical professional. If you’re not a medical professional, and you go into the community, then what is your reason for me talking to you? Then it has to be, “I’m a layman,” but also, “I’m of your culture.” I think that’s a major tenet. Otherwise, it wouldn’t work. If you’re a medical professional, the patients’ perception may be you have something that they need. But if you’re a layman saying, “I want to help you” and I’m from your community,” there is a different perception. “I want to help because I know.

Health care team members at MCHC expressed similar comments. Mrs. Patterson, a nurse practitioner at MCHC, explained:

I think there’s just a lack of connection with patients [and health care professionals] sometimes. They [the patients] don’t really feel like we care. If you
send somebody out to their home, and you’re like, “What are you eating? How much have you exercised? ” to help the very poor find joy in life. Money doesn’t bring joy. You can go to the library and read a wonderful book. You can go for a walk. You can go to the park. Anything we can do get these people to invest in themselves. I think the solution to that is the community health worker. It’s a bridge between the practice, the home, and the patient. You [CHWs] go in there, and you tell me [nurse practitioner] what they’re eating, how much they’re sleeping, how clean their home is. Do they have what they need? Is it warm? Is it cool in the summer? Do they have a nice place to lay their head at night? I want this information. Can you do this for me? Can you find this out? Can you connect them to this resource?

Mr. Chisolm, the community services manager, at MCHC commented:

They’re from the community. They live in the community. They’re neighbors. They go to church with them. They see them at the convenience store. They live in the community they serve. That’s the first major step right there. They know them. They’re part of the community. We also have individuals that care and they’re able to express that to the patient, that they care about them, that they’re going to fight for them, that they’re concerned about them.

On the other hand, Sabrina Sams, a CHW at RHC, does not share the social and cultural attributes of her patients. However, my observations of Sabrina reflect other essential elements of the lay person model of services, such as being a patient advocate, educator, and mentor. The sub-themes I coded from the data reflect Mary, Margaret, and Sabrina exercised nonjudgmental, compassionate approaches to their work and the
ability to interact and represent the patients they serve genuinely with care and compassion. Sabrina consistently demonstrated a keen sense of awareness regarding her patients’ economic, social and cultural needs. She was very connected with patients and worked diligently to ensure her patients received the appropriate services necessary for their needs. She illustrated these characteristics in her work with Reggie, an African American male who frequently showed up at the ED inebriated and with symptoms of a heart attack. Reggie shared;

I was getting sick. See I used to drink too, and Sabrina knew about all that too, so I had to tell her the truth about that. I was getting fluid around my lungs and heart so bad I could hardly breathe. Before I started coming here [RHC], every time I went to the emergency room, she [Sabrina] showed up too. She asked me, “Why do you keeping coming to the emergency room?” I told her, I come to the emergency room because I didn’t have no choice, there was no other place else to go. Every time she and I would meet up she would tell me about this here [RHC]. She got it to where now I don’t really pay any money for somebody [health care] to see me. They sometimes help with my medicine. She got all that done for me. I mean she helps me and never once judge me or treated me bad, just help. She really does, and I appreciate it.

Sabrina explained to me the first day I met her;

My patients are good people; many of them have had a rough life for many reasons. They lack basic education; some cannot read and write. A big part of what I do is explaining information to patients that help educate them and their family members regarding matters of significance to their lives. I address a broad
range of information about their personal, economic, social and health care needs. I am not a doctor or nurse, but I can teach them how to take better care of themselves and help them to connect with the resources in the community.

These patients describing the roles of lay health worker services demonstrates the importance of these services at the PHC sites. Lay health workers such as Mary, Margaret, and Sabrina are needed in PHC to develop relationships with patients and communities. The lay health worker is an individual whom patients in the communities are comfortable interacting with for patients can relate to these individuals. This is a result of the Mary, Sabrina, and Margaret equipping themselves with a holistic understanding of their patients instead of just their health problems. The lay health service at HFP, RHC, and MCHC is just one of the CHWs’ functions.

**Member of Care Delivery Team Model of Services.** CHWs at the three sites are members of the care delivery team. The care delivery team is a collaboration among medical professionals including nurses and physician. CHWs render health services such as measuring blood pressure and pulse, first aid care, medication counseling, health screenings, and other basic services; and work alongside a medical professional to deliver health education or basic screening services while the provider conducts medical exams. As a member of the care delivery team, the CHW was an important link that facilitated better relations between patients and health care team members.

Two sites, HFP, and MCHC, varied from this model by employing one CHW with skills as a certified medical assistant (CMA) and requiring another CHW to become a CNA. In a group interview at RHC, I asked the care team members, “Who do the CHW interact and work closely with here?” Dr. Williams and Mr. Harris said, “Everyone.”
replied, “Everyone?” Dr. Williams said, “Yes everyone, nurses, the faculty, the residents, the social worker, the nurse manager. Mary is a member of the care team for the patients. Naturally she works with everyone.” The statement that the CHW works with everyone indicates CHWs require a broad range of competencies. CHWs must have good interpersonal and strong communication skills, as well as the ability to engage and interact with people from all walks of life regardless of their positions and/or status within the health care system. It also suggests the health care professionals not only expect but have confidence in CHWs’ ability to be fully integrated into health care.

Regarding the competencies needed to deliver CHW services, I asked, “What competencies do CHWs need to perform their duties?” Mr. Harris responded, “Because she [Mary] is not a provider [physician, nurse practitioner], more clinical knowledge is always going to be a push. Hopefully, community health workers as a new workforce in health care will require more clinical training.” Dr. Williams added:

Because it will vary, we’re lucky because Mary does have a CMA, whereas others are coming totally from the psychosocial. They have no clinical, and we’re happy that Mary does. It’s not a prerequisite, but if we have that, that’s an added benefit.

To our patients and health care teams. Mary’s knowledge and credentials as a CMA enabled her to navigate health care systems. As such, Mary is equipped with the necessary skills for her to speak and comprehend the medical terminology, policies, and practices within the clinical environment. I believe because of Mary’s additional competencies, healthcare team members and patients see the significant roles she performs as a member of the care team. CHWs at all three primary health care sites are members of the care team. The
data not only suggest CHWs are members of the care teams, but because of their vast interdisciplinary knowledge and skills, they add value to patient-centered health care and support the care team members functionality.

**Care Coordinator/Manager Model of Services.** I coded and analyzed the theme of the care and coordinator/manager’s services at all three of CHW program sites. In the care, coordinator/manager service model, CHWs work closely with patients, providing services to address a variety of complex economic, social, and health–related problems. Specifically, in this study, the CHWs educated patients and helped patients navigate health care and social services systems.

The three CHW programs’ levels and type of care coordination and case management services varied based on their aims, targeted population’s needs, and skill levels of the CHW. For example, Mr. Chisholm at RHC explained the CHW’s services of care coordination and management in this way.

The HOP CHWs were assigned to manage the patients in the Healthy Outcomes Program. What these individuals do is like case management. They started out looking at patients that meet certain criteria. They usually have several comorbidities, hypertension, diabetes, and are the frequent fliers at the emergency room, high utilizers. Many have depression issues and/or are uninsured. Those prime candidates or individuals could be signed up for the HOP program. The CHW’s first job was to go out, locate those individuals, and connect them to a primary healthcare provider. Sabrina worked closely with the patient to obtain needed health care insurance, financial assistance to cover co-payments to doctor’s visits and to pay for prescriptions, other health care needs
such outpatient surgery, medical equipment, and supplies. A goal of the CHW’s services is to divert the patient from using the ED, rather facilitate patients’ receiving ongoing health care services through a primary health care provider. Sabrina provided short-term case management services for the first year that patients enrolled in the HOP. Once she helped stabilize the patient and connected him/her to a primary health care provider, the patient’s case was closed. However, Sabrina often continued monitoring patients using the ED and followed up with both the patient and primary health care provider if the patient returned to the ED.

At HFP and MCHC, the CHWs’ care coordination and case management services involved the CHWs working with patients referred by members of the healthcare team. Often these referrals involved complex issues that required the CHW to assess the patient’s needs and help the patient develop and implement a plan of action. Mary and Margaret routinely provided oversight and monitored the patient’s plan while working with the care team to facilitate better health outcomes for the patient. Illustrated throughout the vignettes in Chapter 4 are examples of the care coordination model. As a case manager, Mary and Margaret assisted patients with taking their medications, regularly monitoring their blood pressures and blood sugar levels, keeping medical and social services appointments, and following the plans they had developed for better health outcomes. For example, the CHWs worked with the patient’s health outcome to lose weight, ultimately lowering the patients’ blood pressure.

As I indicated earlier, MCHC required Margaret to receive training as a CNA. The dual functions of a CHW and CMA enabled Margaret to oversee and coordinate patients’ care based on the healthcare outcomes established by both the patient and care
delivery team. For example, Margaret engages daily with healthcare teams through “huddle meetings” to oversee and ensure patients receive preventative and healthcare management services. Margaret would point out preventive screenings the patients needed and at times assist the nurse with implementing services. She demonstrated to the patients how to use monitoring equipment, take medications, and recognize the side effects of the medications.

In summary, the care coordinator/manager service model is a vital service that helps ensure the continuity of the health care service delivery. The data suggest because Margaret and Mary have received training as medical and nursing assistants, their duties were expanded to provide patients clinically related services. I believe this finding indicates the need to add CHW functions under the care coordinator/manager model of services depicted in Table 4.4.

**Health Educator Model of Services.** Throughout the study, Mary, Sabrina, and Margaret actively conducted health education services. In doing so, they provided health education to target populations related to disease prevention, screenings, and healthy behaviors. They taught educational programs in the community about chronic disease prevention, nutrition, physical activity, and stress management and provided health screenings. A critical component of the health education services required the CHWs to assess the patient’s health literacy\(^{20}\). Often, the process of determining a patient’s health literacy meant that CHWs had to adapt educational materials and supplies to accommodate the patient’s level of understanding. For example, both Mary and Margaret

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\(^{20}\) Health literacy is defined by the Patient Protection and Affordable Care Act of 2010, Title V, as “the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions” (CDC Website, 2015).
at HFP and MCHC respectively created a checklist with graphics for patients to use daily as a reminder to take medications and to check their blood sugar levels and blood pressures. At all three sites, many of the patients had low literacy, which meant the CHWs spent additional time explaining health information and filling out forms and other documents for patients.

Frequently, CHWs taught patients health care information and provided them health educational materials, such as brochures and easy to read fact sheets to help inform patients about a particular health topic. For example, Margaret taking the time to show Mr. Barton how to use the blood glucose monitor is an example of providing health education in a primary health care setting. The CHWs at all three sites were required to conduct health screenings, behavioral and health questionnaires to determine patients’ health needs, readiness, and motivation to make behavioral changes. The educator health model of services is essential to the CHW service delivery. Knowledge and information are powerful tools for patients as the data reflects throughout the study. With the health information provided by CHWs, patients are better equipped to make informed decisions and to take charge of their health and well-being. Moreover, CHWs teach and educate patients in a broad range of information that ultimately helps patients learn how to resolve the day-to-day problems they faced.

**Outreach and Enrollment Agent Model of Services.** Consistently, I observed CHWs reaching out to patients, communities, and agencies to address patients’ economic, social, and health care needs. At all three of the CHW program sites, the CHW was actively helping patients connect with resources within the community. In this model, CHWs provided services similar to the educator health model. Additional outreach and
enrollment responsibilities included conducting intensive home visits to deliver psychosocial support, promoting maternal and child health, conducting environmental health and home assessments, providing one-on-one advice, making referrals to resources, and enrolling individuals in government programs. Outreach services varied based on the availability of services, which frequently required CHWs to be knowledgeable of eligibility requirements for local, regional, state, and federal resources. Once the CHWs identified the resources, they had to enroll the patient in those services. CHWs Mary Moore at HFP and Sabrina Sams at RHC were trained as certified enrollment agents to help patients with applying for assistance through the Benefits Bank21. The Benefits Bank assists patient with gaining food stamps, Medicaid/Medicare, and Social Security.

Community health workers reached out to community members by educating patients about resources and services that were available to them. CHWs served as enrollment agents by enrolling patients in a broad range of services, prescription assistance programs, health insurance, food stamps, Medicaid, Medicare, transportation, Social Security, and disability. Mary, Sabrina, Margaret assessed the home, neighborhood, and other environments within the community to educate patients about hazards that might affect their mental and physical health. For example, in the vignette previously discussed, Patience advocated on behalf of Mrs. Talbot to eliminate exposure to mold in her home. Patience worked tirelessly to help Mrs. Talbot address the mold problem the housing manager was ignoring. Patience consistently followed up with the

21 The Benefit Bank of South Carolina is an online technology that enables individuals to access financial health and social services assistance. Trained enrollment agents assist patients with completing online applications for different services provided by multiple organizations.
Hillsboro Housing Program, who eventually promised to rectify the problem with the mold. Constantly following up on referrals was an integral part of the CHW’s job. All of the CHWs connected patients to resources through referrals and acted as an advocate and broker of services.

As the data reflects, the outreach/enrollment agent model of services is vital to connecting patients to much-needed resources that help facilitate patients to care for themselves and manage their health care. Through the delivery of these services, the CHW is constantly engaged in following up and advocating on behalf of the patients. By successfully connecting patients to the available resources, in particular, financial programs such as the prescription assistance program, the CHWs continue to ensure patients can access and maintain primary health care.

**Community Organizer and Capacity Builder Model.** The findings represented in this study did not reflect models of service that included *community organizer and capacity builder at the community level*. Mary Moore at the HFP was the only CHW, who briefly talked about this model of service. She shared,

> Initially, when we began the CHW program, I engaged with community members in the public housing to help them increase their capacity and reliance on each other to address community-related problems. I briefly worked with some of the HFP’s patients who lived in the housing project.

Given, the context of the primary health care sites and the responsibilities and roles of the CHWs in this study, the community organizer, and capacity model is not applicable. However, it is clear from the study findings that all three CHW program services fulfilled
the criteria for five of the models, lay health worker, a member of the care delivery team, care, coordinator/manager, health educator and outreach and enrollment agent.

**Tensions within CHW Service Delivery.** Before I discuss the findings from the study regarding the tensions in CHW service delivery, I want to remind the reader as I discussed in Chapter 1 that incorporating CHW programs in PHC is an emerging strategy in South Carolina’s health care. The purpose of integrating CHWs into health care is to address the problems related to the high cost of health care and the shortage of healthcare professionals in the state. The participants in the study are from the three PHC providers sites, HFP, RHC, and MCHC, who are also participants in the SCDHHS’ Medicaid Program pilot CHW program that authorizes Medicaid reimbursement for CHW services. The goals of the pilot CHW programs are: 1) to increase the value of the partnership between recipients and health care providers. 2) To decrease emergency room visits, hospitalizations, and hospital readmissions. 3) To improve Medicaid recipients’ engagement in their health care management; and 4) to reduce costs and improve health outcomes (SC, Medicaid and CHW Program, 2013).

To achieve these goals, SCDHHS’s Medicaid Program required primary health care providers participating in the pilot program to develop and implement the following:

As members of care delivery teams, CHWs will assist individuals within their Medicaid patient community in managing their health. This includes promoting compliance with appointments, screenings, treatment and medications. Assist patients in navigating the health care and social systems, improve patients’ health knowledge and self-sufficiency by helping them understand their health condition(s), and develop strategies to improve their health and well-being.
CHWs are particularly adept at promoting health and extending primary care compliance since they are a member of the community for which they serve and do in-home peer-to-peer education. CHWs will continue to schedule follow-up visits as recommended. CHWs will help the health care service systems become more culturally relevant and responsive to their service population. They will be required to help build understanding and social capital to support healthier behaviors and lifestyle choices among Medicaid recipients (SCDHHS Website, 2014)

I argue that the findings from this study reflect that the services CHWs provide vary somewhat from the medical definition of service. There are non-medical tasks and roles which are necessary for CHWs to perform to aid in the development and sustainability of health provisions for patients. Table 4.4 depicts the CHW model of services and represent the data that recast the roles CHWs perform delivering services.

These guidelines by SCDHHS Medicaid Program along with other data that I coded and the literature regarding health care systems and CHWs programs indicated three key areas where tension exists. First, the term “services” has different meanings based on the context and content of the services. The health care field and CHW programs use various models of knowledge and practices. Health care has traditionally relied on a medical model based on ideas and assumptions that illnesses (diseases) should be examined and treated using a scientific framework (Rogers, 2013). In health care, the traditional model of services for patients meant “the physician assumes the role of the expert who is authorized to diagnose the patient’s illness based on a set of symptoms and prescribe treatment to cure the disease (p. 60).” The focus is at the micro (individual)
level. An assumption is “the problems and illness exist because of something related to the individual. Services are the treatments prescribed by physicians aimed at dysfunctional factors, biological, physiological and psychologically based on the medical science” (p. 60).

As I discussed in Chapters 1 & 2, in contrast, CHW programs are rooted in a public health model that considers the social determinants of health, economics, social, political, and cultural factors of populations as significant contributing factors to people’s health status. Moreover, I suggest these social determinants are impinging on why individuals are unable to access health care and the resources needed to maintain healthy lifestyles (Berthold, Miller, Avila-Esparza, 2009, p. 51). The public health model is concerned with the health and well-being of all people. At the mezzo level, population health is concerned with a group of people who may be defined geographically, demographically, and/or health-related data (p. 46-47). This framework relies on a variety of science, social science, and the expertise of professionals across disciplines. An interdisciplinary approach considers multiple factors that are causing, contributing to, and intervening with health problems.

I believe these variations in the models create discrepancies and tensions in the conceptualization of problems and the models of services that are needed to integrate CHW services in PHC. Evident from this study’s findings, the five models of CHWs services are within PHC. The integration of CHW services in PHC demonstrates a significant shift in health care. The SC Medicaid guidelines appear to endorse the concept of CHW services; data from the study indicate the conceptualization of how to operationalize the CHW programs has been vague at the policy and practice levels.
Secondly, policymakers at multiple levels (SCDHHS, health care systems insurance and providers administrators, and health care professional) need more knowledge and understanding regarding CHW’s tasks, roles, and non-medical approaches. An aim of this study is to provide a detailed description of CHW programs to provide stakeholders insights about CHW programs to inform the development of the comprehensive plan with strategies to address the resources (policy, financial, education, and training) needed to operationalize CHWs services systematically within health care.

Lastly, I believe the lack of a comprehensive plan to integrate CHW programs in PHC created contradictions between the health care providers (HFP, RHC, and MCHC) and the SCDHHS’ Medicaid expectations of CHW’s services delivery and the type of services and the rate of reimbursement for services. The data from the study suggest these contradictions and tensions may be in part because of the different models and approaches PHC and CHW programs use. I discuss some implications for planning and developing policy and practices for CHW programs in PHC further in Chapter 6.

4.3 CHWs’ Roles and Tasks.

The CHW models of services and the SCDHHS Medicaid Pilot Program’s description of services have explicitly outlined roles, and tasks CHWs need to perform to provide the services indicated. My analysis of the data from this study reflected similarities in the roles the CHWs perform; CHWs embodied five of the six models of services in their everyday work. However, in addition to the roles and services required by SCDHHS, CHWs also perform additional roles to facilitate service provisions in primary health care. Although these roles are necessary and essential in providing services to patients, the SCDHHS does not acknowledge these roles in the system of
Medicaid reimbursement for CHWs services. Figure 4.1 depicts a graphic of some of the roles represented in Chapter 4, which CHWs performed.

Figure 4.2 CHWs Roles in PHC

I believe many of the roles indicated in Figure 4.1 are new concepts to many healthcare professionals in part because CHW programs are new emerging strategies in healthcare systems in the United States. We know little about CHW programs and the successful integration of CHW programs in primary health care. Healthcare professionals may have difficulties conceptualizing the operations of CHW programs within the traditional medical settings. For example, CHWs develop a trusting and supportive relationship with their patients. They do whatever they can to facilitate the patients reaching their optimal health outcomes. This involves the CHW calling and checking in frequently with patients and reminding and encouraging them to keep important appointments, take medications, or complete activities they need to do to
In fulfilling this duty, the CHW assumes the role of a life coach, counselor, and motivator to empower their patients in other aspects of their lives.

A finding of the study indicated CHWs’ roles and tasks are not exclusive to the CHW models of service presented in Table 4.3, nor are they linear in practice. Rather CHWs’ roles are a function of a dynamic process for service delivery for which CHWs draw from a broad range of knowledge and competencies to help patients feel empowered and acquire the health knowledge and behavioral strategies to manage and improve their health and well-being. Because each patient’s quality of life differs based on changing personal, social, economic, and cultural factors, CHWs must address the social determinants that may be interfering with the patient’s ability and resources to make positive changes in their health (APHA, 2012).

**Table 4.5: CHWs’ Roles in Service Delivery**

<table>
<thead>
<tr>
<th>Services</th>
<th>*Expanded CHW Roles Based on Analysis</th>
<th>Tasks for service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay health worker</td>
<td>Friend/Mentor</td>
<td>Establish a trusting relationship based on mutual respect. Act as a bridge, linking the community to providers through active communication and engagement that facilitate culturally responsive services delivery. Help clarify and facilitate understanding of information between the provider and the patient. Bring services to the patient, in the home or community center whichever is convenient for the patient.</td>
</tr>
<tr>
<td></td>
<td>Cultural worker/interpreter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advocate/ Gatekeeper</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home visitor</td>
<td></td>
</tr>
<tr>
<td>Member of the health care team</td>
<td>Analysts</td>
<td>Home visitor/ Educator</td>
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<td></td>
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<tr>
<td>Assess patient’s need to help the patient prioritize, develop and implement a plan of action. Monitor the patient’s health and make appropriate health recommendations. Encourage and motivate the patient to follow actively the plan reaching the objectives and goals. Actively support and speak on behalf of the patient’s interests.</td>
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<table>
<thead>
<tr>
<th>Care coordinator/ manager</th>
<th>Case manager/gatekeeper</th>
<th>Medical Assistant</th>
<th>Case Manager</th>
<th>Life coach</th>
<th>Monitor Investigator/ Analyst/Researcher</th>
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<td></td>
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<tr>
<td>Oversee patient’s case working with the care team to bring together information and resources to address the patient’s priority needs and services.</td>
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<td></td>
</tr>
<tr>
<td>Serve as an advisor on matters of concerns to the patient encourages and offers hope that builds on the patients’ strengths to address priority problems. Track medical data to ensure the patient is complying with preventive and health care management recommendations. Evaluate patients and the CHW program progress, collect data on targeted patients to determine intervention needed and to report to stakeholders regarding the target population health outcomes.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Health educator</th>
<th>Educator</th>
<th>Interpreter</th>
<th>Facilitator/Organizer</th>
<th>Life Coach</th>
<th>Mediator</th>
<th>Medical Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read, explain and interpret information to help patients understand a wide range of relevant information. Assess the health literacy of patient and educate based on the patient’s level of understanding and ability to manage health care needs. Teach patient skills, healthcare information, how to use equipment and materials, nutrition, prevention, and other health-related topics.</td>
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</table>
I argue and the findings from the study indicate in contrast to the medical definition of service, there are non-medical tasks and roles CHWs must perform to aid in the development and sustainability of health for patients. Table 4.4 depicts the CHW model of services and represents the data that recast the roles CHWs perform while delivering services. This finding validates the need for the reconceptualization of how CHWs programs operate in primary health care settings.

In conjunction with the finding regarding the contradiction of the tasks and roles CHWs provide in the day to day provision of services depicted in Table 4.4, there appears to be conflicting and contradictory information in the Medicaid reimbursement policy for the CHW pilot program. This is in part, because the Medicaid Program’s expectations do not match the codes they established to reimburse health care providers for CHWs’services. According to the SCDHHS Medicaid Program (2013), the integration of CHW programs into primary health care is an important strategy based on three pillars:

1) Payment reform—CHWs will reach the most underserved populations and work with the care team to improve access, quality of care and health outcomes.
2) The clinical integration—CHWs will provide care coordination by linking the patient to a primary care provider and involve the clinical team and patient in health management. 3) Targeting the “hotspots”—CHWs will serve rural areas and underserved health populations (p. 5).

The SCDHHS Medicaid Program (2014) authorized only two CHW services (face to face patient’s education, both individual and group, and outreach encounters) for reimbursement under the following Medicaid guidelines:

The CHWs should use the two codes allocated for education and outreach services and should document every patient encounter or session. The CHW will submit services rendered through the agreed upon physician National Provider Identifier (NPI) number. The two Current Procedural Terminology (CPT) codes are 1) the Individual Encounter Code S9445 Patient education, not otherwise classified, non-physician provider, face to face, individual per session. The rate is $20.00 per patient for no more than 4 units per day (30 min units=2 hours) with no more than 8 units per month (4 hours). The Group Encounter Code S9446 is for Patient education, not otherwise classified, non-physician provider, face to face, group interaction. The rate of reimbursement per session is $6.00 per patient with a maximum of 5 recipients in a group for no more than 2 units (1 hr)

22 The American Medical Association (2015)” defines Current Procedural Terminology (CPT) as “a listing of descriptive terms and identifying codes for reporting medical services and procedures.” The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians and other healthcare providers, patients, and third parties” (The American Medical Association Website, 2014 ).
maximum session per day with no more than 8 units (4 hrs) per month. (South Carolina Medicaid and the Community Health Worker Program, 2013, pp. 36-41).

Billable services under Medicaid do not include the social services CHWs perform daily that indirectly and directly affect the patient’s ability to consistently access and comply with the primary care providers’ treatment recommendations. Examples of non-billable services include “social services, enrollment assistance, case management, referral services, advocacy and interpreter’s services” (SCDHHS, 2014, p. 13).

In the representation of A Day in the Life of CHWs and the three salient vignettes, I documented multiple occasions where CHWs provided social services for patients recommended by the patient’s physician and services SCDHHS renders as labor that is both invisible and uncompensated. Moreover, if the CHWs did not provide the social services such as enrolling patients in prescription assistance programs, Medicaid/Medicare or other insurances, many of the underserved patients would remain underserved because they do have money or insurance to cover medical expenses.

The CHWs and primary health care providers throughout the study demonstrated a strong commitment to providing their patients the services they needed regardless of their ability to receive reimbursement for the services. As a result of the conflicts and contradictions in the Medicaid program, participants’ frustration existed regarding both unrealistic expectations from SCDHHS for services delivery and systematic limitations regarding reimbursement for services delivery. All three CHWs shared they were worried that the health providers, RHC, HFP, and MCHC, did not receive reimbursement for their services. Mary said, “SCDHHS told us that 50 % of our time needs to in the community.” She asked,
How can we do that when most of our time are spent trying to get patients’ the resources they need before we can address some of their health care issues? Many of our patients are among the most vulnerable people in SC; they have complex problems and issues. It will take long-term case management and other resources to help them manage their health.

**Researcher’s Reflections**

As the data reflect CHWs provide a broad range of services in PHC. While all of these services are essential, I argue the role and responsibilities related to a CHW as an educator is of utmost importance in the context of PHC. As a scholar of the Foundations of Education and Inquiry, I am informed of various pedagogies, social work practices and interdisciplinary approaches (Provenzo, 2008). Because of the complexity of the context and content of education in PHC, interdisciplinary approaches are needed to educate the individuals and groups in PHC at multiple levels. For example, in this study, approximately one-third of the patients receiving CHWs’ services had low literacy which meant the CHWs had to not only adapt written materials but also spend additional time explaining and making sure these patients understood the content. The role of the CHW as an educator is salient throughout the study and has implications for training CHWs as educators, which I discuss in Chapter 6.

I am sure reasons exist for excluding social services from reimbursement under Medicaid. However, given the contemporary context of the needs of underserved and/or targeted populations, there is a need for reform. I argue there is a huge disconnect between policymakers, health care providers, health professionals, other stakeholders, and the existing knowledge regarding community health worker in primary health care.
It will take time and commitment from all interested stakeholders to develop a comprehensive plan with short and long terms goals to fully integrate CHWs into PHC in SC. I believe the pilot project was an important step, and I hope the findings from this study will yield insights that facilitate discussions about CHW programs in PHC in South Carolina. We need a shift in policy as to how the state addresses and pays for population health care services. It is clear SCDHHS Medicaid is seeking innovative strategies to address the healthcare problems they have outlined. It is, however, unclear if they are willing to be less rigid and open to models of services that are reimbursable by Medicaid.

As an insider (instructor for the CHW training program at Midland Technical College), it became clear to me during my field observations why there is a lack of understanding about CHW programs and services within PHC. As indicated by the literature (CDC, 2012, Hector, Rosenthal, Brownstein, Rush, Matos, & Hernandez, 2011) and data analyzed from the study, the successful integration of CHW programs into primary health care requires a redesign of the existing healthcare models of services, especially to underserved populations. I believe this indicates a need for systemic changes that require greater understanding through education and awareness about the services, roles, and tasks CHWs provide to patients and the health care professionals.
Chapter 5

Illustrations of Community Health Care Worker (CHW) Services

When clients do not understand what their healthcare providers are telling them, and providers either do not speak the client’s language or are insensitive to cultural differences, the quality of health care can be compromised. (Anderson, Scrimshaw, Fullilove, Fielding, Normand and the Task Force on Community Preventive Services, 2003, p. 68).

In this chapter, I present and discuss the study findings for the last two research questions. I use data from participant observation, patients and healthcare professionals’ interviews, documents from HFP, RHC, and MCHC, and I refer to information from the literature. In the first section, I address the research question: In what ways do CHWs provide culturally responsive (CR) services? Also, I define CR services, the four pillars, and the six characteristics of cultural responsiveness that I adapted from Gay’s (2002) culturally responsive model to answer this research question. I conclude this section with illustrations and evidence from the findings regarding the ways CHWs in the study provided CR services in primary health care. The second section of this chapter addresses the research question: How do the individuals receiving CHWs’ services perceive these services? As indicated earlier, I use all forms of data collection to answer this question. I conclude the chapter with my research reflections.
5.1 Culturally Responsive CHW Program Services.

Depending on whom you ask, the term “culturally responsive” may evoke different terms: cultural competency, cultural humility, culturally sensitive, culturally appropriate, relevant or proficient (Gay, 2000). Gay (2000) suggested that all of these terms may be used in some way to practice culturally responsive teaching. Other scholars question the use of terms, such as “culturally competent,” suggesting it may provide a false sense of competency about diverse groups. Pitner (2016) posited that the term cultural competency implied a “cookbook model” with various types of recipes individuals could look up to gain knowledge and skills about a particular group. For example, he suggested individuals might look up the recipe for ‘Native American”, and after obtaining information consider “themselves knowledgeable—and by extension, culturally competent” (Pitner, 2016, n. p.). In a similar way, Carteret (2016) pointed out that there is an ongoing relevant debate around the use of “culturally competent”; Carteret suggested the term implies “a form of measurement, competence versus incompetence. When in fact being culturally responsive is a work in process” (Carteret 2016, n. p.). She argued the

National Standards for Culturally and Linguistically Appropriate Services (CLAS) required of all health care providers receiving federal funds are intended to ensure health care services are culturally and linguistically accessible. The standards may suggest that there is a level of achievement, a measure that can determine competency (Carteret 2016, n. p.).

I support the use of cultural responsiveness versus cultural competency because we live in a global world that is representative of all people, their values, beliefs, and
traditions. I believe researchers, educators, and practitioners can no longer afford to make assumptions about individuals and groups based on our limited knowledge of them because culture is fluid, forever changing. Likewise, diverse individuals, groups, social institutions, social policies, and practices are constantly shifting to adapt to the economic, sociopolitical and cultural environment and circumstances (Rogers, 2013). It is essential that researchers, educators, and practitioners gain the knowledge and skills to be responsive to people with whom we engage and provide services that are relevant to their needs.

The concept of being culturally responsive has a rich body of literature in social justice, equality, and multicultural education (Banks, 1990). Aimed at addressing and eradicating the disparities and underachievement of ethnically and culturally diverse students in schools, culturally responsive teaching is “using the cultural knowledge, prior experiences, frames of reference and performance styles of ethnically diverse students to make learning encounters more relevant and effective” (Gay, 2000, p. 31). Gay’s (2000) model of culturally responsive pedagogy uses four pillars: 1) the attitudes and expectations of the teacher/instructor, 2) cultural communications within the learning environment, 3) culturally diverse content in the curriculum, and 4) culturally congruent instructional strategies.

To address the last two research questions, I build on the scholarship of Gay (2000), Ladson-Billings, (2009) and Carteret (2016) to define culturally responsive services in the context of CHW services in health care. Culturally responsive services provided by CHWs are focused on the patient’s cultural, social, and experiential knowledge to facilitate and encourage healthy and positive self-care and management of
the patients’ health and well-being. Gay (2000) suggested there are six characteristics of culturally responsive pedagogy: (1) validating and affirming; (2) comprehensive; (3) multidimensional; (4) empowering; (5) transformative; and (6) emancipatory. I have adapted Gay’s (2000) framework for the context of CHWs’ services in primary health care. The uses of these six characteristics overlap and yield multiple results that demonstrate evidence of the ways CHWs in the study provided culturally responsive services.

**Validating and Affirming**

Gay (2010) writes that,

> Culturally responsive teaching is validating and affirming because it acknowledges the legitimacy of the cultural heritages of different ethnic groups, both as legacies that affect students’ dispositions, attitudes and approaches to learning and as worthy content to be taught in the form curriculum. It builds bridges of meaningfulness between home and school experiences as between academic abstractions and lived sociocultural realities. It uses a variety of instructional strategies that are connected to different learning styles. It teaches students to know and praise their own and one another’s cultural heritages. It incorporates multicultural information, resources, and materials in all subjects and skills routinely taught in schools (Gay, 2010, pp. 31-32).

Reflecting Gay’s (2000) ideas, CHWs recognize the importance of their patients’ cultural backgrounds, ethnicity, family heritage, religious affiliations, race, gender, language, beliefs, values and the sociopolitical factors, such as economics, education, and health that have influenced them. As a result, the CHWs in the study have a greater
understanding of the factors that helped shaped individuals’ dispositions, attitudes, and approaches to health care. This knowledge acquired by Mary, Sabrina, and Margaret helped them build bridges of understanding between the patients’ home life, communities, health care providers, and others engaged with the patients.

Additionally, the CHWs used this orientation to facilitate their work and knowledge to develop and implement program strategies that were relevant to each of the patients. Mary, Sabrina, and Margaret acknowledged the economic and sociocultural realities patients encountered, and they helped facilitate patients’ ability to access health care and social services resources within their respective communities. Each used various teaching strategies based on the patient’s level of understandings. At each of the sites, the CHW adapted health education materials, created checklists, explained, and interpreted healthcare information using terms easy for patients to understand. The CHWs used multicultural information, resources, and materials to educate and build on their patients’ strengths. Mary, Sabrina, and Margaret praise patients for their accomplishments, regardless of whether they are small or large, and they encourage patients to validate and affirm themselves daily for making progress.

Illustrations

Dr. Williams, a physician at HFP, discussed the ways Mary incorporates knowledge regarding the cultural and sociopolitical factors to provide health education and services.

If it turns out we have a patient we think has some challenges that impede their health but are not directly medical, such as patients not making appointments, why is that? It turns out it might be transportation, or health literacy might be an
issue, but we’re not quite sure. We just know we’re having difficulty. [Mary the CHW] can go in, do an interview, assessment and find out just what they need. For example, medications counter. If they’re confused about that or is it, they’re having difficulty with weight management? Mary looks in the community and finds the resources. This place is located near you. These are some things you can do.

The CHWs in the study consistently demonstrated their knowledge and understanding of the economic and sociocultural realities their patients’ encountered, and they helped facilitate their patients’ ability to access health care and the necessary resources within their communities. Denise Taylor, an African American patient who was unemployed and had a kidney transplant stated,

You know, it makes it more difficult if you don't have some skill. If you have a skill, it's still difficult to find a job. The pay is very low. I just started looking around. [Sabrina, the CHW] was looking at some places for me to work and I told her I was looking some places, too. She did find one job for me, but I was already working temporarily at an Assisted Living agency. They eventually hired me full-time.

One of Margaret’s patients at MCHC, Yianna, a Caucasian female, provides an illustration of how the CHWs in the study used various teaching strategies based on a patient’s level of understandings.

I had brain surgery back in the eighties. I have memory loss, and it seems like the older I get, it gets a little worse. You can tell me something one minute, by the next night, I won't remember what the heck you said. It depends on what it is that
sticks there, I guess. It's just like [Margaret] has to adapt information for me sometimes or she calls me to remind me of appointments or things I need to do.

**Comprehensive**

Culturally responsive teaching involves being comprehensive, Gay (2010) described the following;

Ladson-Billings (1992) explained culturally responsive teachers develop intellectual, social, emotional, and political learning by using cultural resources to teach knowledge, skills, values, and attitudes. In other words, they teach the whole child. Along with improving academic achievement, teachers who practice these approaches to teaching are committed to helping students of color maintain identity and connections with their racial and ethnic groups and communities; develop a sense of community, camaraderie, and shared responsibility; and acquire an ethic of success. Expectations and skills are not taught as separate entities but are woven together into an integrated whole that permeates all curriculum content and the entire modus operandi of the classroom. Students are held accountable for one’s another’s learning as well as their own. They are expected to internalize the value that learning is a communal, reciprocal, interdependent affair and manifest it habitually in expressive behaviors (Gay, 2010, p. 32).

The patients in this study represent individuals who are marginalized and underserved in SC. Their health care needs are due largely because of missing support in the social determinants of health. Chapter 4, A Day of the Life of CHWs, depicted CHWs’ vast knowledge and skills that helped them to facilitate the needs of the whole
person. Their knowledge of community resources enables them to connect with and help patients navigate and receive resources to meet the patients’ needs. CHWs acted as a bridge that connected patients, health care providers, and community resources. Mary, Sabrina, and Margaret encouraged patients to have self-determination using their patient’s personal beliefs, values, interests, familial backgrounds, and spirituality to help them through life’s circumstances. They helped create a sense of community with patients, health care providers, family members, and others, who, too, felt a sense of shared responsibility for the patients. By building and contributing to a shared community, Mary, Sabrina, and Margaret facilitated a caring, supportive, and mutually respectful relationship with patients, family members, healthcare professionals services providers and others within their communities.

Illustrations

As previously stated, all three CHWs were knowledgeable in a broad range of topics and skills that addressed the social determinants of health their patients faced. Mary, Sabrina, and Margaret were certified CHWs, which means they attended six weeks of training and passed a comprehensive exam that certified them to be competent in eleven core competencies identified by SCDHHS Medicaid program and Midlands Technical College. The competencies include 1) outreach methods and strategies; 2) client and community assessment; 3) effective communication; 4) culturally based communications and care; 5) health education for behavior change; 6) information about common chronic diseases; 7) to support, advocate and coordinate care for clients; 8) application of public health concepts and approaches; 9) community capacity building; 10) writing and technical communication skills; and 11) ethics (SC Community Health
Workers Training Manuals, 2013-15). They also routinely attend training on a broad perspective of knowledge to help address patients’ needs. Each of them had a wealth of experiential knowledge working with people within their communities.

Mary illustrates the way in which CHWs provide health education services, connection, and help for patients navigating community resources to meet their needs. Ms. Mae, a 75-year-old African American patient at HFP, was relatively new to the Hillsboro area. She moved here to be closer to her son. However, his job transferred him to another state, and Ms. Mae did not want to move again. Her physician initially referred Ms. Mae to Mary, so she could help Ms. Mae better manage her diabetes and blood pressure, as well as determine what was needed for her to remain in her home. Also, Ms. Mae had difficulty ambulating and required the use of an electronic wheelchair, which she was unable to use at her apartment. Mary had been working with Ms. Mae for six months when I met her. Ms. Mae shared,

She's been very helpful to my health care needs, um; she got me out the house. I go to the Senior Center three days a week. I'm making something they call ‘Crackpots.' I do ceramics. And, that gets me around more people my age. And, they have different stuff out there that we do that involves things. [Ms. Mae proudly showed me 5 or 6 pieces of ceramics that she made and painted. I commented, “Your worked looked as if they were done by a professional.”] I want to learn how to quilt. And do needlepoint. So I got myself involved in that. I want to learn how to sew too. I've been buying different dresses for my granddaughter. I don't like the dresses they got for little girls out there now. So I'm going to learn how to make dresses. I'm going to make her a prom dress.
Mary understood and used the patient’s personal values, beliefs, and strengths to address other needs beyond Ms. Mae’s physical health, which included her psychological, social, and spiritual needs. Throughout my observations and interviews with patients, the CHWs displayed awareness and sensitivity to the importance of personal, social, and cultural factors that were significant to patients. Spirituality was a salient point. For example, Mrs. Black, a patient in the hospital, asked Mary to pray for her that she would get better.

Sabrina consoled and comforted Tom, a patient who was in his fifties, a Caucasian male who had lost his common-law wife. Sabrina said, “Tom, I know it is hard for you to sleep in the bed that she passed away. You can take comfort and faith that she knows how much you love and miss her. I am so sorry for your loss. Have you talked to Jack, [social worker]?” Tom replied, “No.” Sabrina said, “I want you to see him today before you leave, okay?” Tom said, “Okay.” After talking with Tom, Sabrina went directly to the social worker, Jack, and explained what was going on with Tom. Sabrina stressed to Jack that Tom needed grief counseling.

Because many of the patients live in rural communities, the CHWs in the study connected them to transportation and as such addressed critical health and non-medical factors that contribute to a patient’s wellbeing. Because the healthcare teams were interdisciplinary; Sabrina linked Tom to grief counseling provided by the social workers. As seen here, Tom was at RHC to see the doctor for a prescription refill, but during the visit, Sabrina took the initiative to help Tom in other aspects of his life.
Multidimensional

According to Gay (2010), “multidimensional culturally responsive teaching encompasses curriculum content, learning context, classroom climate, student-teacher relationships, instructional techniques, classroom management, and performance assessments” (p. 33).

To do this kind of teaching well requires tapping into a wide range of cultural knowledge, experiences, contributions, and perspectives. Emotions, beliefs values, those opinions, and feelings are securitized along with information and physical behaviors to make curriculum and instruction more reflective of and responsive to ethnic diversity. In the process of accomplishing these goals, students are held accountable for knowing, thinking, questioning, analyzing, feeling, reflecting, sharing, and acting (Gay 2010 p. 33).

The CHWs in the study were multidimensional in the delivery of culturally responsive services. They formed a positive, trusting relationship with their patients. Moreover, they worked closely with patients to develop and implement a plan of action to address and meet their patients’ short and long-term goals. Mary, Sabrina, and Margaret and their patients shared responsibility in monitoring the progress toward their patients’ goals. The CHWs connected patients to needed resources and assisted in navigating through systems of health care, social services, and other services in the community. Throughout this study, Mary, Sabrina, and Margaret demonstrated various levels of engagement required to help patients access and receive necessary services. They each used their knowledge and skills to interact and collaborate with diverse individuals and groups at multiple levels to meet the patient’s economic, social, and
healthcare needs. Each CHW formed a partnership with her patients in which she worked in unison with others (care team members, service providers, family members), to equip patients with knowledge to manage their health and well-being.

**Illustrations**

I described in Chapter 4 the multidimensional ways that Mary, Sabrina, and Margaret provided culturally responsive services. They each developed a positive, trusting relationship with their patients. Consider Yianna’s, a patient at MCHC, description of Margaret:

“She’s sweet,” Yianna said, and when I asked, “What do you mean sweet?” She explained, “She does [not have] a mean tone of voice nothing like that. She is just sweet. ’Do you need this? Do you need that?’ A real concerned person, real caring. It's very hard to find people like that.” I asked, “Do you trust her?” Yianna replied, “Yes, I trust her one hundred percent right now. I’d let her stay at my house and wouldn't worry about her. That's how much I trust her.” In Yianna’s description, you can see she referred to Margaret as sweet, concerning, caring and that her tone of voice makes her approachable. Yianna suggested that Margaret was an anomaly, and she apparently trusted Margaret so much so she would let her live in her home.

Because patients’ needs are complex and interdependent, the CHWs in the study needed to perform many roles to address and solve problems. For example, Tyrone, a 52-year-old African American male patient at RHC, required eye surgery because of untreated diabetes and hypertension. He was uninsured and did not have the funds to cover the expenses. Sabrina explained,
It took months for us to find a charity to help him out. He told his doctor, he was going blind, and the doctor referred him to me to help get him to an ophthalmologist because no one would see him without insurance. We finally found a doctor 45 miles away who examined his eyes, did the surgery and provided post-surgery treatment pro bono [without charge]. I had to find a charity to pay for outpatient surgery at the hospital where the doctor practiced. I worked with Betty at Riverdale Hospital, who connected me with the charity at the hospital 45 miles away. After doing all the paperwork because Tyrone cannot read or write, we finally got it approved, and he had the surgery.

The day I met Tyrone he was recovering from the surgery and had just returned to work. Sabrina took his employer, an owner of the restaurant, a flower that she purchased with her money as a thank-you for holding his job. Tyrone has low literacy skills; he unloads the trucks, cleans the kitchen and dining room, and does other manual duties 15-20 hours per week at the restaurant. During Tyrone’s period of recuperation, Sabrina stayed connected to his employer, encouraging her to hold his job. As a result of Tyrone being a good worker and Sabrina’s engagement with his employer, Tyrone was able to return to his place of employment.

Empowering

Gay (2010) pointed out “culturally responsive teaching is empowering it enables students to be better human beings and more successful learners “(p. 34).

Empowerment translates into academic competence, personal confidence, courage, and the will to act – in other words, students have to believe they can succeed in learning tasks and be willing to pursue success relentlessly until
mastery is obtained. This is done by bolstering students’ morale, providing resources and personal assistance, developing an ethos of achievement, and celebrating individual and collective accomplishments. (Gay, 2010, pp. 34-35).

Patients in the study reported the CHWs helped them to take better care of themselves and address the issues they faced. Mary, Sabrina, and Margaret encouraged patients to become proactive in the management of their health and overall well-being. Empowering patients enable them to live a healthier lifestyle, physically, mentally and spiritually. As indicated throughout the representation of data, the patients asked questions about their health to increase their knowledge of their medical conditions and learn how to take and comply with the medications prescribed. Throughout, the study I have provided descriptions of patients gaining skills and confidence to care for themselves, which improved their health and well-being. Mary, Sabrina, and Margaret facilitated empowerment by building on the patient’s strengths, reinforcing positive thinking, behaviors, and self-advocacy, mentoring, and coaching patients as they navigated resources within the community. They each encouraged patients to be self-determined.

Illustrations

I observed the CHWs at HFP, RHC, and MCHC empowering patients through encouragement and support, facilitating access to needed resources so that patients could take better care of themselves. In Chapter 4 are vignettes that described the ways Mary, Sabrina, and Margaret demonstrated attributes of empowerment. I collected written documents (job descriptions, flyers, SCDHHS’ scope of services, and CHWs encounter
notes) at all three sites that substantiated that a principal objective of the CHW programs was to empower patients so that they would improve and manage their health care.

Tamekia, a patient at HFP, illustrated how Mary empowered her to live a healthier lifestyle, physically, mentally and spiritually. Tamekia, an African-American woman age 40, shared that she was born with a learning disability (developmental disability). She was assaulted sexually at the age 10, and she could not read or write. Her physician at HFP referred Tamekia to Mary because she weighed 500 lbs. and had a diagnosis of diabetes, hypertension, and depression. Because she kept falling, she also used a wheelchair. According to Mary, she began working with Tamekia over a year ago. First, they worked on Tamekia taking her medications regularly and then dieting for her to lose weight. Tamekia explained:

Well, she [Mary] would come out and we would talk about something [things of importance to me] like twice a week. She [Mary] would write down my goals and the things I needed to do each week. My goal was to lose weight and get more sleep. We discussed a whole lot of stuff that kept me from being depressed. She's real good to me. Anything I needed all I needed to do is just make a call; she'll take me to the doctor, or whatever. Made me feel better, and she would make me laugh. She's hilarious; she's good to me.

I asked how much weight she lost. Tamekia replied, “I started off at 500 pounds. I'm down to 407 now. I said, “Wow, you go, girl, congratulations.” Tamekia said,

She [Mary] had me on a diet from the morning, noon, and night. I have to eat a little portion of everything; I had to stop the foods that I was eating. I had to start getting what I needed for my husband and me, and my husband needed a whole
lot of help too. He's the one that did all the cooking, cleaning, washing me, washing my clothes, anything. I had to do better for myself, and I am.

Apparently, Tamekia felt empowered, as she should. Mary developed a caring and supportive relationship where she was able to motivate and encourage Tamekia to take charge of her health by losing weight. Given the difficulties, Tamekia has experienced, Mary’s engagement with her was intentional, structured, and goal oriented. Tamekia described feeling empowered not only influenced her health but her relationship with her husband, too. Mary shared with me that frequently Tamekia’s husband participated in their weekly session.

Mary, Sabrina, and Margaret taught patients how to problem-solve and negotiate in matters of conflict as well. They helped their patients to develop and maintain good relationships with family members, friends, community members, health care professionals and others. Mrs. Black, a patient at HFP, who recently moved to South Carolina from New Hampshire, explained,

When you’re in a city, and you have nobody, no relatives, not even friends here, you really need to go to your doctor or someone like Mary to make you feel comfortable to live here. I’ll be honest with you; it was really making me nervous. I am a person that was used to attending my own business and getting around and doing what I want to do, and then I got sick and everything, and now I am here in another city, and I don’t know anyone. And if your family starts ignoring you or you have fallout, what do you do? So, I thank God for Dr. Williams and Mary. They helped me accept things better. It made me feel more comfortable living here. She connected me with services and people in the community.
Mrs. Black meant Mary reassured her that she could make the transition from the North to the South. Equally importantly, Mary helped Mrs. Black to accept the fact her life was changing, and she needed the assistance of others temporarily during her illness. Mary ensured Mrs. Black that a support system was available to her. When I did a follow-up call several months later with Mrs. Black, I believe she felt even more empowered. She shared, “I like living here; things have come to together thanks to all the support I have had.”

**Transformative**

Gay (2010) asserted “culturally responsive teaching is transformative; it defies conventions of traditional educational practices on students of color “ (p. 37).

It is very explicit about respecting the cultures and expression of African American, Native American, Latino and Asian American students and uses these cultures as worthwhile resources for teaching and learning. Being transformative involves ‘helping students to develop the knowledge, skills, and values needed to become social critics who can make reflective decisions and implement their decisions in effective personal, social, political, and economic action” (J. Banks. 1991, p. 131). Students must learn to analyze the effects of inequities on different ethnic individuals and groups, have zero tolerance for these, and become change agents committed to promoting greater equality, justice, and power balances among ethnic groups. The transformative agenda of culturally responsive teaching is double-focused. One focus deals with confronting and transcending the cultural hegemony nested in much of the curriculum content and classroom instruction of traditional education (Gay, 2010, p. 37).
Illustrations

All of the CHWs in the study genuinely respected all of the individuals they served regardless of their race, gender, SES status, age, religious affiliations, sexuality, cultural backgrounds, and other identities. They demonstrated respect in numerous ways. Most frequently, I heard CHWs dispel myths or microaggressions\textsuperscript{23} that were sometimes expressed by others in the environment. One example of this was Sabrina talking with the nurses at the hospital I discussed in one of the vignettes in Chapter 4, wherein Sabrina attempted to clarify why patients were unemployed rather than insisting that they were lazy. Another example shared by CHWs included the inappropriate ways patients were treated by other health care and social services professionals because of their untidy physical appearance, personal hygiene, or low literacy. These acts were often subtle. As Mary said, “You know when people are treating people differently when you at the DSS office and they are nice to you and then act like they are mad at people because they are asking for help.”

The CHWs in the study actively sought information about the patients’ cultural and family backgrounds to better understand them individually. Using this information, each CHW developed a plan of action to help patients achieve their short and long-term goals. As indicated in the vignettes from Chapter 4, CHWs frequently connected patients to their family members and faith community for support.

\textsuperscript{23} Microaggressions refer to “the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership” (Diversity in The Classroom, UCLA Diversity & Faculty Development, 2014, p. 1).
In Chapter 4, the vignettes depicted the CHWs did not always comply with traditional health care services and the ways health care professionals interact and delivered services to patients. Mary, Sabrina, and Margaret shared, there were times they spent their money to help a patient with some needs. Sabrina acknowledged she knew it was against the policy, but she sometimes gave patients money. For example, during my observations of Sabrina, she paid a transportation fee to the provider for transporting a patient who did not qualify for the Medicaid Van. Also, during my observation, I was compelled to help one of Sabrina’s patients. The patient needed to purchase a solution to soak his severely burned feet, but he did not have money to buy the solution. I told Sabrina, “Let me pay for it.” She said, “No, I will get it,” but I insisted as I had observed all of the CHWs spending their money several times on behalf of patients. The patient never knew where the solution came from as Sabrina gave it to the nurse who instructed the patient to soak his feet twice daily.

Mary, Sabrina, and Margaret helped patients to develop the desire, ability, skills, confidence, self-advocacy, and values to make informed and healthy choices regarding their physical, mental, and social well-being. As a result, their patients became agents of change in their lives making significant and sustained health changes. The CHWs in the study acknowledged the economic and sociopolitical marginalization of diverse people and those of lower economic status. They were strong advocates for policy changes in health care and social services systems. They advocated for efficient service delivery within their health care system and other systems of care in the community.
Emancipatory

Gay (2010) declared culturally responsive teaching is emancipatory.

It liberates students of color from the constraining manacles of mainstream canons of knowledge and ways of knowing. Central to this kind of teaching is making authentic knowledge about different groups accessible to students. The validation, information, and pride generate both psychologically and intellectually liberation. This freedom allows students to focus more closely and concentrate more thoroughly on academic learning tasks. The results are improved achievements of many kinds (Gay, 2010, p. 37).

One important finding of the study was that all three CHWs validated patients and helped liberate patients from the belief that they were not in control of their health and well-being. They used health education, prevention, self-care, and management techniques to help patients free themselves from dependency on others and to manage their health and wellbeing. As the patients in the study gained knowledge and skills, they were able to make better and informed lifestyle choices that helped shape healthier outcomes for themselves and in some cases their family members. The power of information and behavioral changes resulted in healthier individuals in this study who are better able to care for themselves, family members, and their well-being. According to Gay (2010), cultural responsiveness “lifts the veil of presumed absolute authority” (p. 38),” in this case of health care systems.

Illustrations

Reggie Brunson’s story illustrates the ways in which the CHWs services were emancipatory. Reggie Brunson is a 50 plus-year-old African American male who
frequently showed up at the emergency department (ED) at the hospital intoxicated and fearful he had had a heart attack. Sabrina enrolled him in the Healthy Outcomes Program (HOP), connected him to a primary care physician, now his medical home, and other community resources to help offset the barriers he faced accessing and maintaining health care. Reggie did have a heart attack and eventually had to get a pacemaker with the assistance of Sabrina. Sabrina explained, “When I met him at the ED, at first, he did not believe we could help him. Finally, he came here [RHC] rather than the ED.” I asked Reggie why he kept “going to the ED?” Reggie explained, “The difference was I had no income. Moreover, by me going to the emergency room, they got to look at you. I didn’t even have a ride; sometimes I wouldn’t even call the ambulance. I would walk there and be out of breath.”

Both Sabrina and Reggie shared that he could not read and write, which according to Sabrina, made it difficult for him to understand much of the information health care providers gave him. Reggie explained,

See that’s why I bring it [papers, documents] here or I’ll call her and let her know I got something in the mail and she’ll ask me to meet her here. She reads it and then explains it to me. If I have to fill out something, she’ll help me fill it out and everything. All I got to do is call and let her know what paper and she’ll ask me to meet her here.

Reggie shared that he moved to the South from up North. The transition was difficult as Reggie explained,

I would’ve stayed up there [Washington, DC] I would have had all my business straight. And that’s what was stressing me out, too, moving here, staying there,
can’t really get nobody to do nothing for you. Like I was trying to get half my medicine sometime – my father used to know, my sister used to know that I ain’t had no money to get my medicine, and they would not help me…Sabrina used to tell me…you know you gotta take better care of yourself.

I asked, “What did she mean?” He replied, “Eat better, stop drinking alcohol and messing around with the wrongs folks. Now I just come in, you know, for like check-ups, make sure my breathing is good, you know my heart is beating right and stuff like that.”

Reggie also shared that he would worry a lot about family problems. Sabrina referred him to the social worker for counseling. Reggie offered,

I talk to her [Sabrina] about stuff, like my sister and father and them…You know how they treat me and stuff like that sometimes. I just talk to her about it, and she had got me to talk to a counselor here – down the hall. She [Sabrina] says, ‘Well you know Reggie, you still got to love them.’ And that’s the one key to me. They might do this, but you still have to love them -- cause sees, they the ones that are going to need my help, especially my Dad, because he’s getting old. I told him you treat me like this here, but you are going to need me—see you’re the one that can barely walk and stuff like that. And with my sister, she going to come around, every blue moon she comes around, and she always got something to talk about, but I still got to love her, but I ain’t got to deal with it.

Reggie eventually stopped drinking alcohol and began making better and healthier choices and decisions as he indicated.

I don’t know what it was; I think I was big headed, didn’t care but like I said, I was drinking and didn’t even care, didn’t care. However, I care now I do not drink
alcohol. And I kept saying to myself, why I keep coming to talk to her [social worker]? I know what I got to do. I can’t worry about family. I shouldn’t have to talk to nobody; I know what I got to do and make sure it’s the right thing.

As Reggie’s story demonstrates, patients eventually learned and believed they were in charge of their health, and that health care is only one tool that can be used to facilitate a healthier lifestyle. I think Reggie’s story highlights multiple attributes of Gay’s (2000) model. He was validated, affirmed, and empowered by Sabrina. He received comprehensive services, and ultimately I believe Reggie experienced a transformation.

Another important goal of all three CHW programs was for their patients to become healthier and to transmit healthier thinking and behaviors to their families and communities to ultimately prevent and eradicate diseases. Denise Taylor, a patient at RHC, shared her experience with kidney disease, and how gaining knowledge about her health is changing her and family members.

It [kidney disease] was through high blood pressure, and then...I always tell people ‘You should do a medical history in your family.’ Because once I got the kidney disease, I didn't understand why my mom, she was on dialysis, too. So then, after I had the kidney disease, I did a little research and found out that, like, about six women in our family had kidney disease. Three of the women had glomerulonephritis24, and that's exactly what I had. So, then I was telling all of the girls in the family, ‘You know, y’all need to go get tested for your kidneys to make

24Glomerulonephritis is a “group of diseases that injure the part of the kidney that filters blood. When the kidney is injured, it cannot get rid of wastes and extra fluid in the body. If the illness continues, the kidneys may stop working completely, resulting in kidney failure” (National Kidney Foundation Website, 2015).
sure that your kidneys [are] okay.’ So, then a couple of them were doing that and find out stuff about themselves, but...that's the whole thing. Kidney disease runs in my family, and I never knew it.

In spite of Denise's kidney disease and transplant, she has been transformed. Through health education and treatment, Denise is mindful that genetics are a reality of health. She uses this information to care for herself and to educate her family members so they, too, can be freed of the lack of knowledge about their family’s health legacy.

In summary, the illustrations that I present demonstrates that Gay’s (2000) model of culturally responsive attributes is appropriate and applicable to the context of CHW programs in PHC. While the context, social actors, and the problems are different from educational settings, the application of culturally responsive teaching strategies are a useful tool for analysis in the delivery of CHW services in PHC.

5.2 Perception of CHW Services

Before I present the study’s findings to answer the research question, how do the individuals receiving CHWs’ services perceive these services, I clarify my interpretation of the “individuals” receiving CHWs’ services. I also discuss the concept of perception in the context of health care and the way in which I consider the term “perception” to address the research question.

When I proposed the research questions for the study, I assumed that individuals who received CHW services would be only patients and their family members. I based this assumption on my limited knowledge about the CHWs’ service delivery. Though I was an educator and trainer for the SC Certified CHW Training Program before this study, I never observed the CHWs in the direct provision of services. The data I analyzed
reflect there are other beneficiaries of CHWs services. Most notably, the PHC system and specifically health care team members (physicians, nurse practitioners, nurses, and others who work directly and indirectly with patients and the CHW. In the representation of the findings to answer the research question, I include patients, family members, and healthcare professionals from the three CHW program sites, HFP, RHC, and MCHC.

**Perception Clarified**

The emergence of patient-centered health care systems is due in part to” mandated federal government-supported community health planning and consumer-led governance of community planning agencies. They have prompted a focus on defining and measuring patients’ perceptions of the health care services” (Sofaer and Firminger, 2005, p. 515). Sofaer and Firminger (2005) pointed out two elements that are significant to this study regarding the shift toward ascertaining patient’s perception of health care. First, in spite of evidence that demonstrates there is a link between the onset and prognosis of illness and psychosocial and behavioral factors healthcare systems continue to rely primarily on the bio-medical model. This means individuals’ perceptions, attitudes, and behaviors may significantly affect their health and the ways in which they manage illness. Sofaer and Firminger (2005) argued research shows diverse patient populations require individualized health care services based on the patients’ needs. Still, health care systems are slow to make changes in policies and practices. Second, with half of all adults having, at least, one chronic disease, “evidenced-based practices indicate the healthcare providers and patients’ relationships must be stronger and productive, which will result in patients’ compliance with health care providers’advice” (CDC, 2015, p. 514). This statement
suggests to facilitate patient-centered health care, healthcare professionals and educators need a greater understanding of patients’ perceptions of health care services.

Sofaer and Firminger (2005) suggested patients’ perceptions are often used interchangeably with patients’ satisfaction. However, patients’ satisfaction is only one aspect of patients’ perceptions. Conceptually, patients’ perceptions encompass a variety of factors, such as the patients’ expectations, which in turn, consist of multiple elements based on the patients’ health care needs, values, beliefs, cultural backgrounds, age, and other factors that influence and contribute to the patients’ healthcare experiences. Wolf (2012) argued that one must consider each patient’s perception as no one patient’s experience is like another. For the purpose of this study, I rely on the patients’ and healthcare professionals’ perception of their experiences with CHWs and the services they provided. I include my direct observations of CHWs delivery of services to patients, patient’s families, and health care professionals. I identify and describe three important themes from the data regarding the perception of CHWs’ services. They include 1) providing patient-centered care; 2) being caring and supportive; and 3) being comprehensive and efficient. Within each of these themes, I identified sub-themes that the study’s participants used to describe further their perception of CHWs’ services.

**Patient-Centered Care.** The patients, family members, and healthcare professionals in the study all agree that patient-centered care is a significant theme in the services that the CHWs in the study provide. According to the Insitute of Medicine (IOM) (2001), patient-centered care is being “respectful of and responsive to individual patient preferences, needs, and values, and the inclusion of the patient's values to guide
the medical decisions and treatments” (n. p.). Denise Taylor, a patient whom I discussed earlier in Section 5.1 who had a kidney transplant, described the services she received from Sabrina at the Riverdale Health Center (RHC)

She [Sabrina] helped me with the prescriptions, stuff I needed. She helped me with finding a doctor where I could go to RHC before I got my medical coverage. I got a mammogram, and I needed bloodwork, and she got the doctor to do it for me...For a little while, I was going to my nephrologist. It did not do any good to go to the nephrologist if I couldn't get certain medicines and stuff, so she helped me get the prescriptions free; whatever I needed, she helped me.

Denise’s statements underscore the importance of patient-centered care. Sabrina was actively providing patient-centered health care that met Denise’s priority needs and could adversely affect her health status. Denise too, acknowledged the significance of patient–centered care, as she understands that all of the healthcare needs are interdependent and require attention for her to have better health.

Dr. Williams provides an explanation as to how the CHW’s services at HFP enhanced the patient-centered treatment with both inpatient and outpatient services.

It can be after I’ve seen the patient, later on calling them back with results and they don’t understand. [Mary] may be that person to get them involved as well. The other one has been for our hospital discharges. We recognize that insurers want to know can we keep our patients out of the hospital within 30 days for readmission. By her [Mary] being available for our inpatient service, we found that when patients are discharged we give them this wonderful summary, give them their medications, tell them to come back in two weeks. Sometimes on the
weekend when the office isn’t open, they don’t make that appointment, or when they do call, maybe that Monday or Tuesday, it turns out that slot is gone. Mary has access to make appointments. She can do that, so that helps us there. The other part of people coming back for readmissions is we have this litany of things we’re going to give them. It turns out they can’t afford the medication. We won’t know that. Sometimes they wait until they come in in two weeks and say, well, no, I never started the antibiotic because I didn’t get it, Why not just think to call? Sometimes patients just don’t think that way. I don’t know why. So having that ability, her [Mary] being a layman in the community, gives you a lot of buy-ins, and patients will communicate things to her they wouldn’t communicate to us. By having someone contact them, make sure they have their appointment, make sure they have their medications, and ask ‘do any of those instructions make sense to you?’ and they say yes or no, then she can explain that.

Dr. Williams’ statements highlight the significant ways in which Mary provides and facilitates patient-centered care. Mary assists both the physician and the patient in the delivery of health care services. Mary ensures patients leaving the hospital understand and know how to follow the physician’s recommendations. Also, she helps patients obtain the resources (education, equipment, supplies, etc.) they need and teaches them ways to comply with the doctor’s recommendations. Lastly, the statement suggests not only do the CHWs provide services to the patients, but also to the physician and other health care team members. While it is not clear from this study the influence CHWs services have on the quality of patient-centered care, it is clear CHWs services are beneficial to the patient and the health care team members.
Culturally responsive. A subtheme of patient-centered care echoed by both patients and healthcare professionals was that CHW services are culturally responsive (CR). In chapter 5, I discussed the ways in which the CHWs services mirrored Gay’s (2002) six characteristics of cultural responsiveness teaching. Mr. Chisholm, the community services manager at MCHC, shared the following about the CHW services:

I am of the opinion that 90 percent of your health care is outside the clinic. It shows how you live. It’s how you interact with your family. It’s all of those emotional and physical needs that a patient has that affects their health. I’ll give you an example of a success story that Margaret is working on. The patient can’t read and write, but a brittle diabetic. How is that person supposed to take care of himself when he can’t read the labels on the foods? He can’t read the labels on his medication. She’s working with him to make sure he understands how to take his medications, what to eat, how to eat. Also, they’ve been working with him on getting him signed up for some literacy classes so he can learn how to read.

Imagine the success story on that once he learns how to read.

Mr. Chisholm also recognizes and appreciates the cultural heritage and backgrounds of patients and how all aspects of individual’s lives are interrelated and impact the patient’s health and wellbeing. He acknowledges and values that Margaret's (CR) approaches are patient-centered, meeting and addressing the patient’s short and long-term goals.

In another example, a patient, Mrs. Black at HFP, described how Mary validated her without showing a difference because of her age.

I’m older than she [Mary] is, and to me, that never was a problem. Okay, if she’s doing her job, which she has, the patient feels comfortable with her. It has nothing
to do that she’s younger than me or older than me; it’s the whole thing. Are you professional with what you’re doing? Do you know what you’re doing? And you make me feel comfortable; then it's someone I can trust.

Mary shared that being responsive to patients’ needs also means encouraging and respecting them. She explained, “I respect her experience and wisdom, and I try to be mindful of her needs and many strengths to address them.” Here Mary demonstrates attributes of CR that affirm and validate Mrs. Black’s experiential knowledge and use her strengths to help empower Mrs. Black to address her needs. In doing so, Mary demonstrates how CR facilitates patient-centered care.

Caring and Supportive. Mary, Sabrina, and Margaret’s interpersonal relationships with patients are perceived to be essential in the CHWs service delivery. All of their patients and health professionals echoed the message that their CHWs are caring and supportive. Demonstrating “patience” and “persistence” were subthemes I coded in this theme of being caring and supportive. According to the patients and health care professionals, the CHWs displayed care and kindness in the delivery of services. Dr. Williams, a physician, shared,

She [Mary] helps the clinical outcomes. I think that’s it. That’s what we’re looking for. Can the patient be successful? Her [Mary’s] role of going out there, identify it, encouraging, acting almost like a cheerleader really help us [health care team] and the patients. She [Mary] was working with one young lady. Her A1c came down tremendously. You know the doctors did their part. You know the patient did her part. She was coaching them on why you need to take the medicine and take it this way. She [Mary] helped her find ways to do that, and it
really came down. The patient was like, “it’s just nice to know someone really cares about my health.” It was crucial to the patient that someone really cares about my health.

This indicates Mary had a supportive and caring relationship with her patients. By developing trust, Mary and the patient form a partnership and sense of shared responsibility. The patient was inspired and empowered to take care of her health.

One patient’s mother struggled to find the words to describe Sabrina’s kindness:
I don't know how to tell you this. But, I just have never met anybody like her [Sabrina]. I've been near a lot of people that have been nice to me. But not like she's been.” I responded, “When you talk about her, you are tearing up.” As she wiped the tears from her eyes, she said. “It is her kindness. Yes, she's very sweet and kind.”

Sabrina’s relationship with the patient’s mother is an example of the level of care and support she provided the patient and family members. The patient’s mother developed deep feelings of gratitude for Mary’s level of kindness that surpassed everyone else she knows. Although, it may be simple, being kind and caring are essential attributes CHWs display in providing services. Gay (2010) argued, “caring teachers expect high expectations, relate genuinely and facilites relentlessly” (p. 47).

Erica, a social worker at MCHC, explained although Margaret is “compassionate,” she also knows how to set boundaries with patients without offending the patients.

Oh, all I ever hear is how wonderful Margaret is and how compassionate she is. She [Margaret] can be, you know, restrictive if she needs to be, but she does it in
a very tactful manner. I mean, I've witnessed it. They [patients] don't have to tell me. I watch, you know, all the things the patients have had to say about the CHW has been remarkable how wonderful she has been as far as taking care of them, making sure that they[patients] have what they need.

Ellen’s statement indicates Margaret had a good understanding of her relationship with patients. However, she can be persistent whenever it is appropriate.

**Being Patient.** Being patient is indeed a virtue that all three CHWs displayed at high levels with their patients, family members, and health care and services professionals. This was especially apparent when patients faced challenges or barriers such as low-literacy, older age, or physical or mental disabilities. Mr. Reggie Brunson, a 50 plus-year-old African American male patient at RHC, shared the following regarding Sabrina:

She tries to tell me everything that I need to do to try to better myself and stuff like that. And I don’t have any problems, and I like working with her. She’s real nice; she takes her time with me. Like she knows I can’t read so she can read the paper and explain it to me.

Mary recognizes and understands her approach with Mr. Brunson requires that she “takes her time” to explain information to him because of his limited literacy abilities. She is patient and encouraging and supportive. In another example, Mrs. Black, an older African American woman, explained the ways Mary demonstrated patience:

She takes time out for you and everything. She doesn't rush you. I think she sets up the appointment where she give you time to be with you, so that you know she can take time. She writes down everything on the computer. And then I ask her
questions. And she would write those questions down, and get back to me, which is what I needed.

Again, the CHW, Mary, is not in a hurry and takes time with the patient. Mrs. Black’s perception of Mary’s patience is in her statement, which follows: “she doesn’t rush you.” According to Mary, because of Mrs. Black’s age and health status, there are times she does not feel good. Her comment that “she [Mary] give you time to be with you” speaks to Mary making patients feel this time is set aside especially for them. Mrs. Black becomes the center of the CHW’s services.

Frequently, the CHWs in the study worked with patients who wanted and needed someone just to listen to them. As I described in Chapter 4, Margaret, the CHW at MCHC, and I made a home visit to James’ home. While there, Margaret patiently listened to James’ mother, Ms. Lillie, as she discussed at length the barriers she faced advocating for her son while he was in a nursing home in Atlanta. This action required patience and understanding that James’ mother needed someone to listen.

Persistence. Demonstrating persistence was another attribute both the patients and health care professionals recognized in the CHWs. A patient, Mr. Reggie Brunson, explained the following regarding Sabrina, a CHW at RHC:

If I don’t call her [Sabrina] within a week or so, believe me, she either going to call--cause she got the number to my grandmother house, and if I ain’t there she’s going to come and check cause she says she’s concerned. Whatever I do, I always call her and let her know, if I want her to know.

Reggie did not appear annoyed that Sabrina persistently checked in with him. In fact, he seems to feel accountable and shared accountability with Sabrina by checking with her
regarding matters he feels important. In this way, I believe Sabrina’s persistence translated to being caring and creating a sense of shared accountability between the patient and the CHW

In an interview with Erica, the social worker at the MCHC, I asked if Margaret was intimidated by the doctors, nurses, or other healthcare professionals. Erica described how persistent Margaret could be in getting answers to her questions:

She [Margaret] does not mind saying, “What do you mean by that?” to get clarification. She does not act like she knows it all, and she does not mind saying it, and our providers do not mind explaining, you understand. You know, she's been through the training, she's certified, but she does not mind asking if she does not understand, and she won't leave until she does.

Margaret was persistent in trying to get answers to her questions and “won’t leave until she does” understand. In doing so, Margaret envokes determination to obtain the information she needs. This is an example of the ways the CHWs are persistent not only with patients but with their health care team members as well. Mr, Chisholm, Margaret's supervisor summarized why he believes the CHW needs to be persistent.

I want [Margaret] to be persistent. You really want them to. We chose people with strong personalities for that. An example, full disclosure, I’m a diabetic myself. I hadn’t been in the last 91 days to get my A1C like I was supposed to. Guess, who got a call the other day from the CHW? Me!

Because primary health care is limited in the rural communities, the CHWs frequently provide services to everyone. Being persistent is a requirement for the job according to
Margaret’s supervisor and, given the context of CHWs services delivery, being persistent is necessary for engagement with patients and health care professionals.

**Comprehensive and Efficient.** The patients and health care professionals in the study perceived all of the CHWs’ services to be comprehensive and efficient. Mary, Sabrina, and Margaret provide holistic services to their patients. Similar to patient-centered health care, the health care provider considers the needs of patients to determine the course of treatment. The CHWs services at HFP, RHC, and MCHC provided not only health related services but also social problems and issues their patients faced. As a result, each CHW addressed the social determinants of health care, which vary based on the patients’ background and needs. My analysis of the data indicated they each provide services to patients to address and meet their housing, food, transportation, financial, employment, and health care needs as well as other barriers such as low literacy.

The patients and health care professionals perceived their CHWs’ services as efficient. Mary, Sabrina, and Margaret demonstrate this effectiveness using their vast knowledge related to a broad range of topics and the many skills they perform in their roles and responsibilities. Within the theme of comprehensive and efficient, I analyzed three sub-themes: 1) CHWs provided coordination and continuity of services; 2) CHWs were analytical and problem solvers; and 3) CHWs were knowledgeable, professional, and successful with helping patients making changes that improved their health and overall well-being.

**Coordination and continuity.** Coordination and continuity of CHWs’ services mean that CHWs were actively engaged in collaborating with healthcare team members, social services agencies and other community services providers to ensure patients
receive health care and social services. I shared in Chapter 4 that Patience worked tirelessly with the healthcare team members to provide patient-centered health care that also addressed the patient’s economic and psychosocial needs. The following excerpts, below, from patients and healthcare professionals, further reflect the level of coordination and continuity of care individuals received.

Previously, I discussed Mrs. Black in Chapter 4. The following is her description of how Mary provided comprehensive services that reveal coordination and continuity.

My son was taking me around. I don’t know how to drive, and everything and he got kinda tired of taking me everywhere so we were having like a little problem, cause it was the time that he was supposed to come get me, and he couldn’t come get me. She [Mary] helped me get transportation set up, [Jackson Transportation Services] for medical needs and Medicaid paid. Then, Mary got me connected with SC Department of Transportation (DOT), which is transportation where you pay a small fee going and a fee coming back, which was excellent cause they take you better places, you know shopping and things like that. I’m glad for that. And so um, she’s also helped me to get in contact with different food banks, you know, go to the churches or the different places to go pick up food when needed. She helped me if I had a question concerning any of my personal affairs, if she could help me, she’ll get on it right away. And she’ll get back to me she’s good.

Mary provided Mrs. Black patient-centered services. To do so, Mary had to help the patient address multiple needs, which required Mary to identify and coordinate services that met all of her needs. Meanwhile, Mary also shares this information with the healthcare team to ensure they are aware of Mrs. Black’s needs and the services she is
providing her. Because one of Mrs. Black’s goals is to be self-sufficient, Mary is actively engaged in ensuring that the continuity of services addresses the needs of the whole person.

Similarly, Dr. Marilyn Jacobs, a physician, described the ways in which Margaret coordinated and ensured the continuity of services at MCHC.

[Margaret] works with me, helping me to determine the patient’s needs. I think the importance is observation, communication, and connecting; being able to report back. The patient is not taking their medicine. Dr. Jacobs, there’s bologna and cheese in the refrigerator. This person can’t read that kind of information. Apparently knowing when to seek help, when to communicate, some red flags are valuable information health care providers need. This person doesn’t have food. There’s nowhere for them to sleep. Get her in, go to my next patient, and know that she was going to see to it. This person needs a biopsy. There’s no money. Will you find them a charity program?—That kind of thing. I consider the CHW a valuable part of the team.

Dr. Jacob’s perception is Margaret’s work is comprehensive in assessing patients’ needs, holistically and identifying and obtaining the resources they need. Also, the physician’s perception is Margaret will coordinate the patients’ services and inform the physician and other team members to ensure continuity in services delivery.

Analytical and Problem-solvers. The second subtheme of being comprehensive and efficient is that the CHWs are analytical and problems solvers. Erica, the social worker at MCHC, described a situation wherein a patient who was homeless showed up at MCHC late one afternoon. The man had walked to the hospital from four or five miles
away because he was extremely nauseated, having abdominal pain and chest pain, and he was fatigued. The hospital turned him away several times. Erica said:

He came here because he had nowhere else to go. The man received a check but had spent it up living in a hotel, because he had worn out his welcome with everyone else. Our health care team members went to work. Dr. Moore saw him and felt he had serious problems with his gallbladder. He could not keep anything on his stomach. Dr. Moore got the EKG and did the full work up and everything on him got some bloodwork and everything.

While he was seeing the patient, Erica started working behind the scenes. She stated, “I was like, well let us call different places, let us try to find him somewhere for tonight, you know.” Erica took up money from staff and was able to get him a hotel room for the night. She contacted the CHW, who began working with others and found a place approximately 50 miles away where he could go. According to Erica, the CHW said, “they would work with him to get him back on his feet, help him to try to find a job if he could, and you know, help him to build up the money that he needed so he could maintain a quality of life.”

According to Erica, she had to counsel the man because he was reluctant to trust anyone. She was able to get the man some food and a male staff member drove him to the hotel. The next day, he came back in and Margaret, the CHW, worked with him to get a place to stay. Since then he has been stable for a year according to Margaret. Erica’s words best described the Margaret’s services.

So, as you see, it's really great to have the CHW here, because things, especially with me, I have a period of time I can stand with the patient and then, you know, I
have another patient. So, like, whenever they tell me they have these financial problems, it’s nice that I can say, we have a CHW I can refer you to. Let them do their thing. Let's see if you qualify for anything. If nothing else, they get that support that they matter, you know, because many places that you go, you don't get that. You walk in, you see a doctor, and then you walk out. I mean, you'll get your chronic conditions and everything, but whenever it comes to the social aspect of it, you don't get any of that. And I use [the CHW] just like an extension of my arm. Because whenever it comes down to it, in any other field, the social worker would have to do all those things.

The social worker’s statement clearly demonstrates her reliance on Margaret to analyze and help her solve patients’ immediate problems. She referred to Margaret as her right hand because as the social worker provides counseling to address the patients’ emotional and mental health needs, Margaret can discuss and solve problems for the patient related to the social determinants.

Johnny Harris, the supervisor of the CHW program at HFP, explained how Mary helps with analyzing relevant data that relate to the practice standards of quality.

We’ll able to provide data from insurance providers. [Mary] will analyze that data. She’ll look at that data. Then she will help us in making sure the next run or the next update that we get is either reduced or better than what it was from a quality standpoint. Then we also use [Mary] as ways to be that bridge for some of the patients that can’t come in or they have other reasons for transportation or other issues that may not allow them to come into the clinic. One more thing I’d like to add, the promotion aspect of it. For example, the health fair that she’s
doing. She [Mary] actually took this up on her own and led the way. This is a way for us, with this health fair and the other events that she goes outside into the community, to help promote patients and bring more patients in, especially patients that have different health outcomes or may have some issues. This is a good marketing process for us. It’s also a good approach to being more knowledgeable about your community and the different types of issues that you have going on.

Mary’s supervisor is clear that she helps HFP analyze data that is essential to the HFP quality standards. She resolves problems and takes the lead in the implementation of health fairs to provide health education and information to individuals in the community.

Yianna, a 50 plus-year-old Caucasian woman, shared that Margaret went beyond the call of her duties to help her with problems she encountered.

Well, when I first came here with the bed bugs she gave me a bed. Since I’ve been here, I mean, it's like they’re doing everything they can to help me, so why should I leave? It's like a family thing, you know? They make sure you got what you need. When I first came here with the bed bugs she [Margaret] gave me a bed. She called somebody. They came out from a warehouse the next morning it was at my house. It's a bigger bed, comfortable. So, she went beyond, in my expectations of whatever. I didn't expect any of it.

I asked about the other ways Margaret helped, to which Yianna responded, “Well, at the time, I didn't have jack [anything], and she [Margaret] made sure I had a towel, rag, and soap, you know? A[ few] dishes, a [few] clothes. You know, stuff to get by on.” I asked if she had been homeless, to which she responded:
Well, at one time, yeah, because I was living here and yonder, here and yonder. After my Mama passed, I just went downhill. I know I'm still not up there, but, you know, I just... I do have some things of my own now because I'm paying rent where I'm at. No one's paying for it but me, and I get satellite where I can keep my mind occupied.

Yianna’s stories highlight the social determinants of health these patients face. After Margaret had identified the priority needs, she began the process of solving the problems. Margaret used her knowledge of how to access resources to meet Yianna’s needs.

Lastly, Dr. Williams summarized the significance of problem-solving. Indeed, she called it a form of “expertise” of the CHW:

The expertise would be, I think, problem-solving, interfacing with health literacy, figuring that out. She [Mary] has expertise in evaluating community resources and relegating those to them. Assessing the patient per-se, and find out what their needs are. Maybe they’re [patient] not even aware of the dysfunction they have and what they may need. Just having that ability to feel comfortable with patients, being able to assess where they are, and then understand the resources they can connect. She’s [Mary] the liaison. She is putting things together, the provider and the patient, the patient and the community, patient, community, and provider, being that kind of bridge, closing the circle, closing the link.

**Knowledgeable, Professional and Effective.** Overwhelmingly, the perception is that Mary, Sabrina, and Margaret are knowledgeable and professional, and they are effective in helping their patients. The patients, family members, health care
professionals and others engaged with the CHWs in this study affirm the CHWs have a wealth of knowledge in many different areas and across disciplines. In the vignettes in chapter 4, the CHWs demonstrate their knowledge, skills and the ways they effectively work with patients and others to address and meet the patients’ needs. A reoccurring theme in this study is that CHWs possess a wealth of knowledge of an array of information and resources that enable them to become instruments that facilitate meeting the complex and comprehensive needs of patients. Ms. Mae, a patient at HFP, shared:

One of the things is she is knowledgeable about what she's doing. She's a caring person; she's helping you. It doesn't matter what you need she helps find it. From what I get from her, it's not a job; it’s not something that's she's punching a clock. She, it's like she enjoys it.

Mr. Harris, Mary’s supervisor at HFP, also highlights the knowledge the Mary has regarding the health insurance and reimbursement for patients health care services.

She [Mary] has to be knowledgeable of the insurance companies. That is probably one of the big ones. Different insurance providers, what they allow, what they are able to pay for, what services that they’re covering.

Dr. Baxter, a physician, working with Sabrina, describes the health care knowledge the CHW needs to work in primary health care.

She [Sabrina] has a basic grasp of nursing, healthcare, medicines. Cause if something is going wrong, she needs to be able to catch it and inform the doctors quicker.

The previous illustration from health cares professionals validates the broad range of information CHWs need to know to perform the varied tasks they are expected to
complete. Because of this wide range of knowledge, the CHWs can work effectively to meet their patients’ needs.

Describing Sabrina’s knowledge of resources, a patient at RHC, Denise, said,

If she can help you, she’ll try to help you out. When I was staying with friends, she was saying, “Do I need to send you over to the Housing Authority and get you help like that?” And I said, “Well, I don’t know, I’ll see. For a while, I had custody of my grandson, and she was even trying to help me figure out that part. She said she didn’t understand how come I couldn’t get Medicaid, and I had custody of my grandson. So she even helped me fill out a Medicaid application so that I could get Medicaid. So that worked toward my grandson having insurance too.

Sabrina is very knowledgeable of a variety of resources that can assist Denise as she encounters and experience the circumstances of her life. Because Denise has had a kidney transplant, a question that I ponder is the relationship of the CHW services to the prevention of stress and anxiety on the patients’ health status.

Mrs. Black, Mary’s patient, speaks to the CHWs’ professionalism and the ways she is efficient. She [Mary] was very friendly; I think we connected because of her personality. She was very business-like, but she was still very friendly to me, and it made me feel at ease like I could sit and talk with her. She did her job to me excellent. You know she told me what she was about and what she could do for me. She asked if I had any questions concerning what she talked with me about, and what she do for the community, and that why I share with her the things that I need to be done that will be helpful. There was a time; I don’t know how long ago, that it really benefited me. I guess
I might be calling her for things that may be her job. She took the role of a personal social worker, so I needed that. The patient perceives Mary as friendly, easy to talk and work with, yet professional, which indicates the patients, had high expectations of Mary’s services. Mrs. Black’s validates the notion that Mary is effective at doing her job as she describes her work as excellent.

The perception that the CHWs in the study are knowledgeable, professional and efficient is reflected in the written documents I collected. The October 2014 monthly HOP report written by Riverdale Health Center and Riverdale Hospital states:

The HOP’s CHW is creatively linking participants with every community resource and support available. We are witnessing patients utilizing primary health care instead of the emergency room and individuals who had previously been very passive recipients of their health care are now taking ownership. The CHW model (home visits, social services, referrals and follow-up) is creating a level of trust and confidence with patients that is leading to improved access and outcomes. The HOP is implemented by Sabrina Sams, and the perception of RHC is the patients are being connected to primary health care providers. And the numbers are decreasing in the ER, which is one of aims of the HOP and the Medicaid pilot of CHW programs in primary health care. This indicates CHW services are making progress in the intended health outcomes.

Another excerpt from the monthly report dated February 2015 showed anecdotal data of the ways the CHW at RHC provided multiple levels of services.

A male patient of 52 with skin cancer was referred into the HOP due to his situation. RHC and the CHW worked together in 2013 to get a specialist to
remove the lesion. In 2015, the physician at RHC advised the patient he needed to have another lesion addressed. The CHW wrote a letter to a plastic surgeon who at no charge saw the patient and performed a biopsy on the site at no charge. The CHW observed the patient during an office visit scratching the lesions on his arms and hands so they bleed and then proceeded to touch [others and objects]. The CHW provided the patient education on blood born pathogens (in a very nice way) and explained how he should be aware of spreading disease.

Again, we see Sabrina’s broad knowledge and skills at work facilitating the removal of lesions and also educating the patient on the how to prevent the spread of blood-born infections. No doubt, the patient received the help he needed, but Sabrina was also successful at preventing potential health concerns for other patients.

**Researcher’s Reflections**

The findings to the research questions in this chapter reflect valuable information for two reasons. First, they allow the opportunity to consider a framework for the ways in which CHWs are related and connected to culturally appropriate services. The utility of Gay’s (2002) model of CR enables us to consider the use of an educational approach to understanding CHWs services in health care. To do so, I recast the school context as the primary health care sites, the teachers as the CHWs, (Mary, Sabrina, and Margaret,) and the diverse students as their patients. Using a modified version of Gay’s (2002) six attributes of cultural responsiveness, I illustrate six ways the CHWs in the study provide culturally responsive services in primary health care. As a result of this knowledge, I can work with other stakeholders in making sure we develop CHW training curriculums building on the pillars and attributes of CR.
Second, the findings that I present to answer the question “how do individuals receiving CHWs’ services perceive these services?” is valuable because it provides insights into who are the beneficiaries (patients and health care team members) of CHW services, as well as the beneficiaries’ perceptions. The perception is Mary, Sabrina, and Margaret’s services are 1) patient-centered, 2) caring and supportive, and 3) comprehensive and efficient. These findings reflect a picture that suggests CHWs add value to primary health care and patient-centered care. Given the context of health care, today, I argue we need to pay attention to the perception of health services from all consumers of health care, including the underserved, marginalized individuals and diverse patients who live in rural and urban communities who are insured and uninsured. As an emerging strategy in primary health care, stakeholders must continue to develop the strategies to educate everyone about the significant and diverse ways CHW services benefit the patients and the healthcare professions.
Chapter 6

Insights, Implications, and Conclusion

In this chapter, I present my insights from the study and the study’s implications, theoretically and methodologically. Additionally, I share implications for practice for healthcare policy makers and stakeholders who are engaged in the work of innovative health care strategies such as the community health worker (CHW) programs. Following implications, I discuss the study’s limitations and offer suggestions for future research and the ways this study has informed my research agenda. I conclude with some final thoughts about CHWs in primary health care.

6.1 Theoretical Implications

Applying Gay’s (2002) framework of culturally responsive teaching informed the way I answered the research question, “In what ways do CHWs provide culturally responsive services?” Using Gay’s (2002) work enabled me to examine an educational approach in the context of PHC services. Instead of the classroom, I explored Gay’s framework across CHW program services. I positioned the CHWs as teachers in Gay’s work and patients receiving CHWs’ services as students. I am motivated and committed to the successful integration of CHW programs in PHC. I am not only a researcher in this work but also a social worker and educator who is intricately involved with CHWs and individuals who often seek their services. I presented in Chapter 5 my
direct observations of Mary, Sabrina, and Margaret that reflected a narrative about the way in which each exhibited elements of Gay’s (2002) cultural responsiveness in the service delivery.

Bell hooks, (1999) ponders questions from Sufi mystic and poet Rumi: “What is the real, is it the theoretical knowledge? Do you want the words or will you live what you know?” (p. 44). For Mary, Margaret, and Sabrina, being culturally responsive is the life they live as CHWs. Their work reveals that they each provided culturally responsive (CR) services to the people they served by being affirming and validating, providing comprehensive and multidimensional services that are empowering, and emancipatory.

In chapter 2, I discussed the connections across cultural humility cultural competency and cultural responsiveness and the key tenets involved in working with diverse populations. Gay (2002) suggested terms such as cultural humility, sensitive and competencies are appropriate in the context of schools. However, I disagree, to be culturally responsive means always engaging people in the context in which they live; it is not about knowledge as a competency regarding people in the abstract. Rather, understanding and responding to culturally diverse people in their context which transcends time and the educational curriculum. Pitner and Sakamoto (2005) would agree, they argued the application of knowledge needs to be contextualized and that knowledge based on cultural generalizations are not useful at all. Context demands culturally responsive attributes not a “cookbook” approach to diverse people (Pitner, 2016). Each of the CHWs received training in cultural humility, however, their employers at HFP, RHC and MCHC prescribed to a policy of providing cultural competence. I believe the difference in the models of cultural humility, cultural
competency, and cultural responsiveness has implications that one should consider in the identification of a model for culturally responsive services in the context of CHW programs in PHC.

Gay’s (2002) six attributes of cultural responsiveness is an appropriate framework for the CHWs working with diverse populations. These attributes include (1) validating and affirming; (2) comprehensive (3) multidimensional (4) empowering (5) transformative, and (6) emancipator. To be clear, I believe it is important to have cultural humility, sensitivity, and competency. However, the difference in the models of cultural humility, cultural competency, and cultural responsiveness have implications that one should consider in the identification of a model for training CHWs and other healthcare professionals.

The cultural humility model includes recommendations of self-reflection and self-critique coupled with the understanding that one cultural group is not better than others (Berthold, Miller & Avila-Esparza, 2009). In this work, I found that CHWs were encouraged to learn about different cultural groups to broaden knowledge and understanding so that they could facilitate a client-centered approach. While it is essential for CHWs to go through the process of self-reflection and to have knowledge of the diverse cultural groups they may encounter, I believe cultural humility does not provide explicit behavioral techniques that help guide CHWs in the methods of being culturally responsive. Rather, its methods appear to be more implicit which may create ambiguity as to how one should interact with people of different race, ethnicity, SES status, and other identities. Similarly, cultural competency—the development of a knowledge base about a particular culture—implies that levels of skills exist that one can achieve to gain
knowledge about a diverse population. As I discussed in Chapter 5, I believe both of these concepts, cultural humility, and cultural competency, add value to the process of being culturally responsive. However, I argue the use of these models in the education and training of CHWs working with diverse populations could potentially give a CHW a false sense of competency about their diverse patients. Moreover, I believe a false sense of competency could lead to CHWs stereotyping or typecasting patients based on the limited generalized information.

According to Gay (2010), cultural responsiveness is "always in the process of becoming rather than a fixed destination or finished skills" (p. 236). As such, she put forth four essential pillars which I describe as explicit attitudes and behaviors that enabled CHWs to be culturally responsive. First, in their attitudes and expectations of patients, the CHWs demonstrated genuine care for their patients and their patients articulated experiencing that care. The CHWs respected their patients and believed that their patients could achieve their goals. Second, the CHWs used culturally appropriate communications, speaking and using words that patients understood, in layperson’s terms, and demonstrated they respected each patient based on their knowledge of their familial background and heritage, racial and socioeconomic history, values, beliefs and desires for the future. Third, the CHWs used diverse content in the healthcare curriculum information and delivery of services based on an individual patient’s needs and goals. Fourth, the CHWs applied a broad range of content in the provision of the relevant services that meet the needs of their patients. The CHWs’ attitudes and behaviors led to their patients feeling validated and affirmed, and perceiving that they had received
comprehensive and multidimensional services that met their needs—both of which reflect Gay’s (2002) model.

Some of the evidence I represented in Chapters 4 and 5 indicates exchanges between CHWs and their patients that illustrate patient empowerment. The CHWs encouraged and provided tools and education to their patients to empower them to transform their attitudes and behaviors to better care for themselves and manage their health and well-being. Ultimately, some patients shared they felt free to make their choices, cope better with life circumstances, care and manage their health and well-being.

According to Gay (2010), the very nature of culture is fluid, and health care is no exception. Culture “is contextual, situational and an individual process that is a never ending journey” (Gay, 2010, p. 22). For example, the status of the patient’s health, the primary care physicians, other health care team members, and the CHWs are constantly shifting to adjust and accommodate everyday demands of health care. Carteret (2015) argued that being responsive in primary health care required “the capacity to respond using tools, questions, and skills to ascertain the cultural knowledge that can be incorporated the patients' plan of care and service delivery” (n. p.). She put forth the notion that cultural responsiveness in health care is an extension of patient-centered care. She would argue, and I concur, that all health care providers must have the tools to be culturally responsive.

Previously, researchers have suggested that CHWs’ cultural connections to the populations they service are critical to their ability to provide culturally appropriate health care services (CDC, 2012, APHA, 2010, WHO, 2010 HRSA, 2010). Typically, CHWs are members of the community in which they work and act as a bridge connecting
health care and social services to community members. An important study finding reflects the CHWs’ micro-level factors also contributed to their delivery of culturally responsive services. As I discussed in Chapter 4 the profiles of Mary, Sabrina, and Margaret each reflect diverse cultural and ethnic backgrounds. While Mary and Margaret have similar backgrounds as their patients, Sabrina’s grew up in Maine. Her cultural background and experiences differ from the RHC’s patient population; yet, Sabrina embodied explicit attitudes and behaviors that resulted in the delivery of patient culturally responsive services to patients. Moreover, a salient point that I identified from the data was the essential need not only for CHWs to be culturally responsive but also for other medical and support staff. My findings echo Gay’s (2000) agreement for CHWs to be culturally responsive, all of the people, policies, and practices in the PHC must also be culturally responsive. The demonstration of cultural responsiveness throughout service delivery by PHC organizations and systems means that patients are much more likely to receive patient-centered care—a finding I represented in Chapters 4 and 5.

6.2 Methodological Implications

Merriam (2002) suggested that researchers consider the link between their epistemology and methodology to understand a study. In Chapter 3, I discussed the variety of research methods I used in this inquiry. Of these methods, I believe participant observations and my process and practice of reflexivity contributed deeply to my analysis of findings.

First, I offer my insights from my fieldwork and participant observations in particular with CHWs in primary health care from the perspective of a novice researcher who is an experienced practitioner. Though I have decades of experience in conducting
research in various positions, when I began this inquiry, I self-identified more as a practitioner than as a researcher. As I discussed in Chapter 2, after 30 years of social work practice, I returned to graduate school because I wanted to gain an understanding of the different perspectives and methods that connect education, social work, and other disciplines for the purpose of promoting social justice. During the study, I completed countless tasks and performed many roles that helped me describe the CHW’s programs at HFP, RHC, and MCHC. Of these functions, I believe reflexivity provided meaningful insights that contributed to my interpretations and understandings as I tried to make sense of the social actors in context (Dilthley, 1911/1977). Denzin and Lincoln (2013) defined reflexivity as the “process of reflecting critically on self as the researcher, an ‘instrument’ (Guba & Lincoln, 1981), consciously experiencing the self as an inquirer and respondent, teacher and learner” (p. 254). In this way, “reflexivity enables both the participants and researcher to produce interpretations of their experiences that becomes data” (p. 280). Patton (2002) pointed out that reflexivity “allows the process of deconstruction, [to] examine what I know and how I know it” (p. 67).

Reinharz (1997) acknowledged the researcher has many identities that he/she brings to the fieldwork and categorizes them into three categories. First, the brought self, which includes the different identities of the researcher, the knowledge, skills, and experiences that have shaped the researcher's lens and perspectives. I discussed in Chapter 2 the multiple identities which situated my knowledge and experiences for conducting this research. For example, as an African American female who grew up poor in the South in 1960's and 1970’s, I know firsthand the consequence of being Black, poor, and female. Similar to the patients receiving CHWs services, I know firsthand the
impact of marginalization when my multiple identities converge with social policies and practices in social institutions. Because of these experiences, I am committed to social justice and working collaboratively with other practitioners, policy makers, educators, scholars, and allies to bring about equity in our world.

I brought the self to fieldwork that is a lifelong learner, educated with life’s experiences and degrees, a Bachelor and Master of Social Work, and soon a Ph.D. in the Educational Foundations and Inquiry (EDFI). As a scholar of the EDFI, I am keenly aware education must be considered and examined in the cultural context (Tozer, 2001). This means I used multiple lenses that allowed me to consider education and the role of CHWs as educators using interpretative, normative and critical perspectives (Provenzo, 2008). An interpretive lens enabled me to analyze and understand the significant role and effects of the provision of CHW program services in PHC considering multiple perspectives, the CHWs, patients, and family members, health care professionals and the literature. By using a normative lens I was able to situate CHW within PHC recognizing the significant role and influence CHWs have in shaping, and developing values, norms, and ethics with patients, healthcare professionals, and others engaged in CHW programs. Through my critical lens, I observed and questioned assumptions, policies, and practices within the culture of PHC and social services systems that posed” contradictions and inconsistencies that benefited social institutions, individuals, and groups and subjugated others” (Provenzo, 2008, p. 967).

I brought the self that is a committed and competent social worker with 30 years plus experience working with diverse people at different levels and contexts. I brought the self that is an educator with many years of experience teaching and training a broad
range of people, friends, family, students, clients, patients, professionals, policy makers, and myself in the educational and community settings. I currently am a contract instructor of the CHW Certification Training Program at Midlands Technical College. There were times during the fieldwork; I found myself sharing knowledge and exchanging ideas with the CHWs, the health care professionals, and patients about the topic of the conversation. For example, Erica, the social worker and I discussed the use of fragrances and soothing music to relieve stress. I shared several techniques that I used in therapy sessions, and she did the same. Because I love and value learning, I am comfortable sharing and receiving information. Denzin and Lincoln (2013) argued it is important to recognize and understand these “selves” in fieldwork as they have “distinctive voices that come into play” (p. 255).

The second self is the research-based self that includes the researcher's ontology, epistemology, and methodology for the study (Reinharz, 1997). My ontological understanding of the world positions reality in the eyes of the beholder. That is to say, from the perspective of an interpretive paradigm, knowledge and understanding are through multiple lenses (Denzin & Lincoln, 2013). Epistemologically, I believe we can gain valuable knowledge through experiences—including those engaged in CHW program services in PHC settings. I think, and the findings reflect, that the experiential knowledge Mary, Sabrina, and Margaret possessed enabled them to work effectively with a broad range of diverse people. Moreover, the collected knowledge of the health care team helped patients to care better for themselves and manage their health. In this way, all knowledge is valuable in PHC and yields valuable information and insights about the diverse needs of the diverse patient population in PHC.
An example of my commitment to my ontological, epistemological, and methodological beliefs emerged when I met with each CHWs’ primary care health provider and administrators with whom I shared information about the study to gain insight into the sociocultural context of the study’s settings. I explained that to potential study participants and gatekeepers that my study was an ethnography, and that my aim was to explore the culture of CHW programs through direct participant observations of CHWs in their day to day delivery of services. As the gatekeepers made suggestions about the logistics of the study, one administrator indicated that I might not be able to interview “their patients”. She wanted to recheck with the chief administrator to make sure it was okay for me to move forward with the study. At first, I was struck by the statement “their patients” and her reluctance to allow the patients to make their choices about participating in the study. After reflecting, I honestly believe her statement “their patients” was symbolic of a fictive kinship. Fictive kinships are “people regarded as part of a family even though there are not relatives by blood or marriage. Fictive kinship may bind people together in ties of affection, concern, obligation, and responsibility” (Medical Dictionary Online, 2016). I believe her reluctance was in part to protect the patients and because she was relatively new in her position, too.

In my mind, there could be no study without having access to the patients and the health care professionals working with CHWs. While I waited for the administrator’s approval to move forward, I reflected the following in my journal:

I am concerned that one of health care provider’s administrator suggested that I do not include “their patients” in the study. The term “their” implies ownership. While I understand she may feel uncomfortable, I will not conduct the study at a
site without the ability to engage with the people receiving the services. The patients must be able to determine for themselves if they would like to participate in the study. Often, I believe those working with vulnerable people think they have the right to make important decisions for them without consulting the individual. How can I do this study without the patients’ input?

As I thought about potentially losing the permission of the administrator to conduct the study and about other ways I could gain access to the patient, it occurred to me to revisit two of my principal aims of the study. 1) To gain insight into the provision of CHW program services, the roles, and responsibilities of CHWs in primary health care settings. 2) To provide a rich description of CHWs’ services with the hope that such description might contribute to the development of CHW knowledge, skills and competencies to facilitate better health outcomes for their patients.

Through practicing reflexivity, I was able to reflect and think critically about each PHC site and its administrators. I delved deeper to understand each provider’s background, history, and ties to the community. I quickly learned they each had a long history of providing health care services to people who are underserved and marginalized. Learning the background information from each of the PHC websites and articles they and others wrote about their work in health care allowed me to layer my understandings of each administrator. Over time as the study unfolded, I witnessed leaders demonstrating smart, innovative decisions and leadership as well as a commitment to social justice in healthcare. I chuckled to myself as I realized I developed these new understandings. I immediately felt a fictive kinship with these health care providers based on our shared commitments to social justice. It became clearer that the
administrator’s use of the term “their patients” might have been an indicator of her aim to protect patients from exploitation.

As a social worker, mother and caretaker, I am very familiar with this sense of protection; however, a critical social work ethic I learned as a social worker is understanding and respecting individuals’ self-determination. My concerns about having access to patients in PHC dissipated because I reconciled that administrators, too, were allies. Ultimately, a week or so later, the administrator emailed me, “Hello Constance, I spoke with our [chief officer]; she is in agreement with your work here.”

Lastly, the third self, Reinhartz (1997) suggested, is “situated” (p. 3) and evolves as the researcher engages in the fieldwork. My situated self emerged authentically in the roles I performed routinely in my personal and professional life. Most frequently, the educator/trainer, social worker and a person of faith emerged as I interacted with participants in the study. At all three sites, the CHWs appeared to identify me as an educator/trainer—an expert about the CHWs. Moreover, I performed the role of an educator/trainer; the CHWs frequently consulted me for advice regarding the ways in which they should handle a situation or use an intervention. I worked collaboratively with each of the CHWs trying to think through strategies for addressing their patients’ needs and problems they encountered doing their jobs as CHWs. To illustrate the self as an educator/trainer, I share the following excerpt from an analytical memo I wrote 5/2015 about an exchange with Mary.

I felt this tension throughout the day, who was I, the researcher, the insider (CHW training instructor, advocate, social worker, or educator). I quickly became aware of these roles as they overlapped during my interactions with Mary and others at
HFP. I felt comfortable eliciting information from her. However, I noticed I am
guarded and uncomfortable at times when she asks me questions and my opinions
on how to handle certain situations. For example, Mary shared how frustrating it
is working with systems such as the DSS, Medicaid, and the transportation
service. Following up on a call from a patient, who complained that JTS refused
to transport her to a podiatry appointment, Mary found out Medicaid no longer
authorized transportation to a podiatrist. Mary turned to me and said Constance, is
that true? What am I do? How can I help a patient with Diabetes when she can not
get transportation? Is footcare essential for Diabetics? Mary’s barrage of
questions was in response to her frustration with systems as well as her need for
answers which, I did not have so I suggested she call JTS to ask them if they
transported Medicaid patients to the podiatrist. She did, and a JTS’s staff person
told her Medicaid terminated the reimbursement for podiatry about a year ago.
The statement befuddled both Mary and I. We tried to contemplate a logical
reason Medicaid did not cover transportation to a podiatrist for a patient who is
morbidly overweight 517 lbs. at intake, now 416 lbs., and diagnosed with chronic
diabetics. Mary wrote an email to another contact person at Medicaid to make
sure the policy did change. After six phone calls and an email, Mary ended up
calling the client to say yes, you are right. She discussed with the patient
alternative modes of transportation we had brainstormed for her podiatry
appointment.

I later resolved that more tension would exist because of the varying roles I performed
inside and outside the context of the study. This was one of the realities of direct
participant observations. I reminded myself that I needed to resist the dominant thinking that to be an effective researcher, I needed to be objective, and instead acknowledge and use my prior knowledge, roles, and skills to help me better understand CHWs in PHC.

As a social worker, I seek “to enhance the well-being of humanity and help meet the basic needs of all people, especially individuals who are vulnerable, oppressed, and living in poverty (National of Social Work Ethics, 2016, n. p.). I am knowledgeable of many perspectives, approaches, values, and beliefs which I routinely use in my provision of services. Foremost, I firmly believe and affirm the social work ethic that individuals must and should have the right to self-determination. I am keenly aware of the person in environment perspective which centers individuals within the environment at multiple levels, the micro, mezzo and macro level (Rogers, 2013). I recognize at each level of a social context that there are mechanisms that affect individuals positively and negatively. Because individuals are the center of the social context (Rogers, 2013), I consider them first and try to help each one build on her or his strengths to maintain and navigate social relationships and social institutions. In doing so, I advocate for individuals at multiple levels. First, at the micro level, I help individuals adapt to a social context, which often means an individual gains knowledge and skills to facilitate the production of outcomes she or he desires. Second, at the mezzo level, I advocate policy and practice revisions in social organizations and systems when those in place adversely affect the people I serve. An illustration of the situated self that presented as a social worker was during my participant observations with Sabrina at RHC. The following is an excerpt from my June 2015 fieldnotes.
As we drove into the RHC parking lot, Sabrina pointed out to me, Victor, an African American man with long dreadlocks. Victor looked to be in his late 20s or early 30s. He was sitting on the steps at the front door of the RHC with his head down in his hands. Sabrina rolled down the window of the car and yelled to Victor, “I am on my way to the building, do not leave.” Victor motioned back that he heard her. As soon as we entered the back door, several team members commented to Sabrina, “Victor has been waiting for you.” Sabrina previously shared that Victor was an HOP patient that frequently used the emergency room until she was able to get him a primary care physician at RHC. Earlier today we stopped at the local Walmart to purchase a solution the doctor said Victor needed to soak his feet. He had no money, so Sabrina wanted to make sure he had the solution. According to Sabrina, Victor had limited family support although his family lived in the community. Victor was homeless, living from place to place or wherever people would let him sleep and until he wore out his welcome. Sabrina was very concerned and dismayed about his circumstances. She stated, “He is young and besides his diabetes, he appeared to be able-bodied to work. Because there are very few jobs for unskilled individuals in the area, he cannot find a job. I suspected he was on drugs, so I asked, and he admitted he smoked pot.

While Victor was waiting to see the nurse practitioner (NP), Sabrina introduced me to him. She asked if he would be willing to talk to me about her work with him. He immediately said, “Yes.” As the NP examined his feet, Sabrina asked questions, “Should he have the bandages on or off?” The NP stated, “I just want him to protect his toes so they will not become infected.” Victor explained the bandages came off while he was
walking to RHC. Victor stated he put peroxide on his feet. The NP stated, “No, do not pour peroxide on it, because it strips the good stuff, natural healing process. Do not put iodine or Clorox on it either. The goal is to keep your toes clean, dry, and with ointment.” The NP asked him, “Do you have any clean socks?” The ones he was wearing were not clean. He said, “No ma’am.” The NP Said, “You need new sandals; the ones you are wearing look germy.”

While Victor sat in the examining room soaking his feet in the solution, I asked if it was okay for us to begin the interview to which he earlier consented. As I described the study and began the interview, I occasionally digressed from the researcher’s role asking the interview questions to the social worker role exploring and assessing his needs. While both roles require a set of open-ended questions, they yield different responses. I said, “Tell me about you.” Victor said, “There is nothing to tell.” I reassured him of confidentiality again and reminded him of the form he signed. I said, “Although I am conducting research, I am a social worker, too; my priority is you. I first want to make sure you are okay. In fact, I can interview you later for the study; let’s just talk for now.” Before I knew it, I relinquished the researcher’s role and situated myself with the familiar—my role as a social worker.

I established rapport quickly with Victor and learned more about the lack of his family support due in part to the family’s SES, history of alcoholism, drug abuse, and lack of resources to address the family needs. I asked Victor to tell me his strengths. He said he had none. I said, “Not one?” Then he smiled slightly and said, “I can rap.” Smiling back, I asked, “If you could rap about how you are feeling, what would be the title of the rap?” He replied, “I don’t want to go on.” This comment led me to probe
further, and I began processing with him his thoughts of suicide which he admitted he had at times, but added that he would not kill himself because he believed suicide was an “unforgiven sin.” As we talked, I learned he has a diagnosis of depression and is to take prescribed medication, which he was not taking. He attended one or two counseling sessions but never went back. I asked why he did not want to go. He said, “I am not crazy.”

As our conversation proceeded, it was apparent to me he was displaying symptoms of depression. I spent some time discussing and trying to dispel his stereotypes and misunderstandings about taking psychotropic medications and seeking help from a professional. I encouraged him to see the social worker at RHC, and he agreed to see her. I informed Sabrina, and she told the social worker who saw him and informed his physician he was not taking the anti-depressant medication.

The self that is an advocate arose for both for the patients and the CHWs. For example, several days before my observations were to end with Margaret at MCHC, she was upset because one of her supervisors openly shared changes in the CHW programs during a staff meeting. From the information I could gather from Margaret, these changes were partially because MCHC needed to transition from the pilot CHW services funded by Medicaid to other sources of funding. Margaret shared,

I am upset over his derogatory statements he made about the CHW program … He minimized the work CHWs do, saying anybody can do the work we do. When I asked, ‘What was I to tell the health care team members?’ he said, ‘You tell them to talk to me.’ I have worked hard as a CHW; I worry what will happen to our patients and the team members without these services. I had to go our executive director last year,
because when he began working in the position, he made changes in the CHW program that I was unclear about his expectations. I met with the executive and his supervisor to get a better understanding.

Margaret asked me to read a draft of an email that she wrote to her supervisor voicing her displeasure with the meeting. After reading the email, I suggested she not personalize her comments about him but instead speak to her concerns about the gap in services because of removing the CHW services. I asked, too, if she felt it best to talk to him in person rather than writing an email. Margaret did not want to speak to him in person and was still visibly upset. After she had edited the email, I suggested she not send it until she had time to think further about the issues, about 24 hours. We discussed whom she should copy on the email, and she chose to copy her supervisor who was over the pilot CHW program and his supervisor. At the end of the day, I asked, “How are you feeling?” She replied, “Much better. I decided to send him the email because I want him to know I am very concerned, and I believed he has put me in an awkward position.”

Later, I pondered if I had made a mistake helping her to edit the letter. I discussed it as I did other issues with the study with my qualitative group of scholars who met routinely for peer review and consultation. They, too, had experienced similar circumstances. Our senior colleague asked me to contemplate what would I have done differently in another context. When I replied nothing, I knew then I was performing what was natural for me. In this situation, the self that is an advocate and supporter for all individuals is always present.

Several months later when I was member checking with Margaret, she informed me that she had received a promotion as the lead CHW over in another service area, and
she received a significant increase in pay. She thanked me for encouraging her to advocate for the CHW program. In the process, she also advocated for herself. I admit I was relieved to hear her news, as I worried if I had advised her wrongly.

I brought the self to fieldwork that is a lifelong learner, educated with life’s experiences and degrees, a Bachelor and Master of Social Work, and soon a Ph.D. in the Educational Foundations and Inquiry (EDFI). As a scholar of the EDFI, I am keenly aware education must be considered and examined in the cultural context (Tozer, 1996). This means I used multiple lenses that allowed me to consider education and the role of CHWs as educators using interpretative, normative and critical perspectives (Provenzo, 2008). An interpretive lens enabled me to analyze and understand the significant role and effects of the provision of CHW program services in PHC considering multiple perspectives, the CHWs, patients, and family members, health care professionals and the literature. By using a normative lens I was able to situate CHW within PHC recognizing the significant role and influence CHWs have in shaping, and developing values, norms, and ethics with patients, healthcare professionals, and others engaged in CHW programs. Moreover, through my critical lens, I observed and questioned assumptions, policies, and practices within the culture PHC and social services systems that posed” contradictions and inconsistencies that benefited social institutions, individuals, and groups and subjugated others” (Provenzo, 2008, p. 967).

The situated self also encompassed my roles as a researcher; CRT informs me, and I believe that racism and classism is normal and endemic in the U.S. Because I inform the research process as the qualitative researcher, being informed by CRT also means I use the knowledge of CRT during the study. Studying CRT taught me to pay
attention to hegemonic policies, and practices, and structural power that exists in hierarchies and bureaucracy at the intersections of race and class “(Delgado & Stefancic, 2012). An illustration of this occurred during a meeting in which I accompanied Mary at the local community center to discuss changes in the Medicaid system that affected individuals applying for Medicaid, the primary health care providers, and issues affecting the pilot CHW programs. At the meeting, Janet Davis and Annie Long with health services, and Ronald O'Brien, an assistant administrator, explained that the Medicaid applications’ computer system had undergone a major update which would occur in phases. As a result, applications had been delayed, but according to their information, there were no applications pending approval 45 days or more. Mary explained, “I have at least 15-25 applications pending for more than 60 days approval/denial and other CHWs have some, too.” Ron asked, “Are you sure because our information indicates the applications are up to date, for it may take time two –three more weeks before people to see the changes.” Ron suggested that Mary and other CHWs send him a list of the patients’ names pending whose Medicaid applications were pending 45 or more days.

Mary shared, “Our patients and many CHWs report the Medicaid eligibility workers at DSS are not knowledgeable about the application process”. She suggested patients and the CHWs] were frequently placed on hold for 20-30 minutes and patients using the Obama phones have limited minutes for the telephone calls. Moreover, if the patients were Spanish-speaking, they lack accessibility to an interpreter to address their questions. Janet responded, “I think they hired 40 new workers statewide, this may help with the problem. Mary shared that she too recently experienced the problem and for a lack of better words, the Medicaid worker got an attitude with her. Ron responded,
“Well, the Medicaid eligibility workers are not under our department, you can contact someone in that department and let them know the problems you are experiencing.”

As Mary continued asking questions and sharing problems, I sensed her frustrations as she giggled nervously and kept saying, “I respect what you are saying but…”. At one point during the conversation, Janet commented, “It is going to take time. We, too, are frustrated because the Medicaid computer system was more than 20 years old and the changes are costing us millions of dollars.” It is important to note, at the time of meeting there had been changes in the staff leadership within the Medicaid system, and there was uncertainty about policies and practices regarding the Medicaid program and the pilot CHW program which may have contributed to everyone's’ frustrations at the meeting. I too was frustrated as a trainer of CHWs Certification Program. I inquired what were the mechanisms in which patients, CHWs, and PHC receive information about policies changes in Medicaid. Ron and Janet both explained that patients could go the website at https://www.scchoices.com/Member/Step3PBECompare.aspx?frommenu=true to compare the plans. Janet explained that Medicaid bulletins are available on the Medicaid website, and she implied that PHC providers received notifications of changes although she was not explicit how this occurred. Mary shared her concerned over the lack of accessible information for Medicaid beneficiaries. She explained,

People are confused about health care plans because they offer different benefits, and not all patients can access the website. Is it possible to give them a copy of the health insurance plans at the time they are making an application or explain the options? That way if they are approved they can better choose the plan they want to enroll?
Ron commented that some patients were enrolled mandatory in some plans, and others have choices. While he did try to explain the process, it was cumbersome, and I was not able to comprehend his explanations.

It appeared the more problems Mary identified, Ron’s and Janet’s frustrations shifted to defensiveness. While both Ron’s and Janet’s comments appeared to demonstrate genuine concern, at times, they were over talking Mary (talking at the same time as Mary). Mary professed, “I am here to tell you what is happening and to advocate on behalf of the people in which the changes in Medicaid system is having a toil on people’s lives.” She exclaimed,

The Medicaid system is creating barriers for patients and health care providers to access and provide health care. I respectfully ask you to consider these systems changes as you consider the numbers that may not show a decrease in patients going to the emergency room or individuals connected to a primary health care provider and the number of encounter claims.

I believe this meeting about changes in the Medicaid system highlights several valuable insights that are connected to advocacy work CHWs perform at multiple levels. First, Mary is a CHW, one of her major roles is to advocate on the behalf of patients, and to be an intermediary between health care and the communities they serve. However, it appeared the representatives from the Medicaid program were frustrated that Mary was doing her job by advocating for policies that aligned with goals of the pilot CHW programs in PHC. Critical race scholars might suggest this action reveals that social systems and institutions are not neutral or objective in perpetuating the best interest of individuals marginalized by race or class, such as the uninsured or Medicaid beneficiaries
(Taylor, Gillborn & Ladson-Billings, 2008; Delgado & Stefancic, 2012). Second, the intersectionality of race, class, welfare and poverty and distribution of materials within society highlights the powerful and significant role of social systems such as health care. For example, I described in chapter 4, Betty, the financial counselor at Riverdale General Hospital showed me a stack of approximately 60 Medicaid applications pending approval for more than 45 days. She also shared patients who were pregnant at the time they applied for Medicaid had since delivered their babies while waiting for approval of their applications. This delay in processing applications created barriers for patients and delayed PHC providers receiving reimbursements for patients’ healthcare services.

Lastly, although, subtle, there are microaggressions that exist in the Medicaid policies and practices that suggest that impoverished individuals in SC have access to computers and internet services, and they can follow the ongoing changes within the SC Medicaid system. Even more disturbing is the lack of awareness and sensitivity of policy makers regarding many of the individuals receiving Medicaid have low literacy. These actions on behalf of health care policy makers suggest more than ever, the policies, practices and the people in health care must be culturally responsive in the provision of health care (Gay, 2002, 2010; Carteret, 2016).

Lastly, the situated self, a person of faith, emerged throughout the study with patients and CHWs in discussions and when they asked me to pray with and for them. For example, Mrs. Black was extremely ill in the hospital; she asked Mary and me to pray for her. And we did. I later journaled, “I felt uncomfortable at first praying with Mrs. Black, but that feeling quickly dissipated when I heard an inspiring and much stronger voice emerged from this woman who at first seemed fragile and vulnerable.” During my
interview with Victor, I discussed his faith and religious affiliation to discern his religious views about suicide, which is a strength to use in offering hope to individuals who may be depressed or contemplating suicide (The QPR Institute, 2014). Likewise, I had many discussions with each of CHW about faith. In Chapter 4, I described the composite Patience’s strong affiliation with a higher power and the ways she connected to her higher power for inspiration throughout her day.

Merriam (2002) said it best, “Qualitative research is sometimes a struggle but allowing oneself to participate in that struggle can result in a study that deepens understandings of aspects of the social life” (p. 261). I offer these insights from my fieldwork with CHWs in primary health care because I learned and believed both novice and experienced researchers need to reflect on the process of inquiry to help eliminate some of the mystery sometimes associated with conducting research. Referred to as “experience-tales” by Merriam (2002), this information has the “potential to deepen our understanding of the interplay between real people, process, and the research setting” (p. 260). She, however, warned in the sharing these experiences-tales, researchers, myself included, open themselves up to even more questions—such as the process of conducting qualitative inquiries.

6.3 Implications for Practice

For more than 50 years experts in primary health care (PHC) have been working to develop and implement strategies to progress population health through the use of lay health workers such as CHWs (The United States Agency for International Development (USAID) and Maternal and Child Health Integrated Program (MCHIP) 2013). Over time, these strategies have shifted to accommodate a changing global community and despite
advances in health care more than ever CHW programs are a vital strategy to address the gaps in health care (p. 2). As I have indicated in the study’s findings and as the literature reflects, what has not changed much are the challenges policy makers and other stakeholders face in the designing, funding, operationalizing, and managing CHW programs to fit their communities’ health care needs (p. 2). Of the utmost importance is determining the purpose of CHW programs, and whether or not CHW programs are appropriate services for the health care system and targeted populations. As stakeholders ponder these challenges, they should also keep in mind,

CHWs work within the context of a program, community, and health care system. How effectively he or she contributes to improving health [outcomes] in the community depends on the effectiveness of the system. By nature, systems are interconnected, nonlinear, self-organizing, and dynamic. Although there may be some utility in categorizing components of the system as building blocks, to understand the functioning of the system requires that we acknowledge the dynamic interactions among the various systems’ elements [CHW programs] (USAID & MCHIP, 2013).

I find the quote above supports my insights and findings from this study which have implications for the provision of CHWs’ services in PHC. The aim of this study was to provide insights into the services, roles, responsibilities and culture of CHW programs in primary health care in SC. As such, I provided a rich description of the CHWs’ services at HFP, RHC, and MCHC, and I believe my findings have implications for the planning, policies and the practice of CHW programs in PHC.
**Planning.** One finding from this study is the broad range of services CHWs provide patients, PHC, care team members and the other healthcare professionals working with patients. Because of the multitude of responsibilities and tasks Mary, Sabrina, and Margaret were expected to perform, at times, they appeared conflicted and unsure about the CHW program’s goals, their responsibilities, and their roles. My observations of the CHWs indicated that this broad range of duties is a benefit and a curse. The individuals receiving CHWs services received comprehensive and complex services that addressed the complex problems and issues they faced. Also, I believe having so many responsibilities and tasks was a curse because the CHWs were very committed helpers and change agents who at times experienced undue stress and anxiety because of being pulled in many directions. Similarly, the health care members and other health care professionals working with the CHWs also appeared unsure about CHWs’ responsibilities and roles. I believed this added to some of the confusion and contributed to a lack of understanding of the CHW job responsibilities and roles in a PHC setting.

While this study’s purpose was not to detangle the contributing factors to the lack of knowledge and the confusion regarding CHW programs in PHC, the findings do suggest there was a lack of specificity concerning the expectations of the CHWs responsibilities and roles. I represented discrepancies in the provisions of CHWs’ services among PHC and the SCDHHS Pilot Medicaid Program. These were evident in the conflicting goals and outcomes of the Medicaid Pilot CHW program and its policy of reimbursing PHC providers for CHW services that I discussed in Chapter 4. At a broader level, I believe the SCDHHS Medicaid Program and PHC providers at multiple levels lacked the knowledge and understanding about CHW programs and to know how to
design and operationalize CHWs’ services within the health care. Though CHW programs are an emerging strategy within primary health care, there are examples in the literature of CHW programs for policy makers to consider that can aide them in the process of developing and implementing a comprehensive strategic plan for the integration of CHWs services in PHC (USAID & MCHIP, 2013).

Far too often, decision-makers in organizations and systems fail to take the time to develop a strategic plan that would enable them to consider the necessary components required at all levels for implementing and sustaining innovative programs (Allison & Kaye, 2005). For the purpose I this study, I define a strategic planning as,

a systematic process that organization(s) agree on and build commitment among key stakeholders to prioritize what is essential for the purpose and responsive to the needs of the environment [CHW programs in PHC]. The strategic planning process guides the acquisition and allocation of resources to achieve these priorities (p. 1).

The strategic planning process requires multiple phases that organizations, systems and their stakeholders must accomplish to create a successful plan.

Planning alone does not produce the results; it is a means, not an end. The plan has to be implemented and consistently monitored to produce the results. These plans increase the chances that the day to days activities will lead to desired outcomes (p. 3).

For the past three years, stakeholders across the state through the HeART Initiative and other partnerships have been working collaboratively to develop effective strategies to address the priority health care problems and issues related to Medicaid and
South Carolina’s uninsured population. I believe these stakeholders attending these meetings were well-meaning and very committed individuals who represented organizations who genuinely cared about the impact of SC health care policy on people affected by the policy. However, not everyone engaged in this network had knowledge and understanding of CHW programs, the history or workforce, nor did everyone have illustrations of CHW programs in PHC that have been effective and ineffective. Armed with the knowledge and skills needed for planning, these stakeholders would be better prepared to work collaboratively in the development and implementation of a comprehensive strategic plan if they had evidence of effective CHW programs.

In the planning of stakeholders initiatives, consideration should be given to who are all of the stakeholders and how they each can participate in the planning and decisions regarding the CHW programs. There appears to an uneven balance of power among those who are organizing, planning, and evaluating the health care strategies, such as the pilot CHW program, and those who work every day in service delivery to meet the needs of targeted populations. Moreover, there are more health care policy makers, administrators, physicians, insurance providers, and other high-level health care officials at the planning- and policy-making a table. Missing from these spaces and in the discourse about strategies to address SC’s healthcare problems and challenges were the voices of the Medicaid and uninsured patients, CHWs, and the health care professionals who actively engage daily in SC’s primary health care systems. I argue that these individuals can provide important insights into the policy and practice issues CHWs encounter in PHC and can offer valuable input and feedback regarding the appropriate strategies to address the challenges. There have been some efforts to include CHWs and
other health care professionals in monthly meetings; however, because of the nature of these practitioners’ work, it is not always feasible for them to participate. With today’s technology and resources, more efforts are needed to make more inclusive decision-making spaces. After all, the people affected by the decisions made are the “experts on their experiences” (Ayers, Ryan-Alexander-Tanner, 2010, p. 65). According to Ayers and Ryan-Alexander-Tanner (2010) since “the people with the problems are also the people with solutions, health care in the [state of SC] can not afford to be hierarchical or patronizing, but horizontal and shared” (p. 65).

**Policies.** The study’s findings reflect implications for policy regarding CHW services. The SCDHHS Medicaid Program, other insurance providers, and the healthcare providers engage at different levels in the oversight of CHW programs. It is essential for these organizations to make clear to key stakeholders (CHWs, health care professionals, patients) the purpose of their partnerships, as well as the shared vision, mission, and operating procedures which delineate each organization’s roles and responsibilities in the provision of CHW services. Most notable in the findings were patients’ remarks on the positive influence of cultural responsiveness demonstrated by the CHWs. Cultural responsive health care policy is needed at all levels to provide service to a diverse patient population. According to Gay (2010), to provide culturally responsive services, organizations’ policies, practices, and people must also be culturally responsive to the diverse people they serve. By implementing policies and practices that are culturally responsive, policy makers would promote and encourage patient-centered care.

The pilot CHW program is a significant step that is yielding valuable information and insights into the challenges and barriers regarding the integration of CHW services
into PHC. However, policymakers should not only consider Medicaid data as an indicator of the pilot programs’ success, as Medicaid reports paint only part of the picture. Rather, policymakers should consider qualitative data from the people who have provided descriptive information about their interactions with CHWs and service delivery. The people affected by CHW services, like, Mary, Sabrina, Margaret, their patients, health care team members and other PHC professionals who know firsthand the CHW services delivery, ought to inform policy and practice. As Wolfe (2012) asserted, to be successful in the provision of patient-centered health care, policymakers and administrators must also consider the patients’ perceptions of the health care services delivery. Qualitative data provides a unique medium from which stakeholders can draw conclusions that would enable them to make informed and realistic decisions that I believe would produce overall better outcomes for those individuals the system is designed to serve.

As I discussed in Chapter 4, the framework of CHW programs is rooted in public health, specifically population health that focuses on addressing the social determinants of health, (APHA, 2015). The emphasis is providing health care to the community. This model differs from the traditional medical model of providing health care services. I believe population health care must also consider homeopathic\textsuperscript{25} models although not salient in this study, several patients referred to use homeopathic care was a part of their health care. I argue there is a need for the reconceptualization of CHW services in PHC. As such, policy makers at SCDHHS Medicaid Program, PHC providers, and other

\textsuperscript{25} Homeopathic is the “practice of medicine that embraces a holistic, natural approach to the treatment of the sick. Homeopathy is holistic because it treats the person as a whole, rather than focusing on a diseased part or a labeled sickness. Homeopathy is natural because its remedies are produced according to the U.S. FDA-recognized \textit{Homeopathic Pharmacopoeia of the United States} from natural sources, whether vegetable, mineral, or animal in nature” (the American Institute of Homeopathy Website, 2016).
insurance providers must be willing to expand their rigid policies, be open to creating other billable codes and identifying other sources of funding that encompass and reflect the type of services CHWs provide to one of the state’s most vulnerable and underserved populations.

At the PHC level, the CHWs struggled to follow the organization’s policies, because they interfered at times with services delivery. Frequently, Mary, Sabrina, and Margaret worked many hours officially off the clock to accommodate the needs and circumstances of their patients and health care team members—hours for which they did not receive pay. For example, sometimes patients were unable to come to the PHC to see the CHW until later in the day, or other problems occurred during the day that required the CHW to shift priorities based on the patient's needs. This resulted in the CHW completing paperwork after hours and off the “time clock”. As a social worker, I know firsthand; there are times when you make choices that are incongruent with agencies’ policies but that benefit the people to whom you provide services. Allowing flexibility in the CHWs’ schedule would enable CHWs to plan and provide services that accommodate their patients’ needs.

**Practice.** The study’s findings suggest the CHW programs in the study are an important service within PHC, which has implications for practice. Because CHWs are lay health workers and a part of a new strategy for health care, it is crucial to educate, train, and then teach again about their roles at all levels within health care organizations. Education is not only needed about CHWs but also about other important topics. For example, what do it mean to provide patient-centered care and culturally responsive services? Again, a comprehensive strategic plan is needed that delineates the operations
of CHW programs, clarifying responsibilities, roles, and duties related to patients, care team members, other health care and social service providers. This action would enable health care administrators of CHW programs to have the necessary oversight, guidance, resources, and support, as well as the education and training that CHWs need to allow the delivery of efficient and relevant health services.

As I described in Chapters 4 and 5, Mary, Sabrina, and Margaret often worked with limited resources. A study finding indicates there is a misunderstanding that CHW services should mostly occur in communities. CHWs provided services in multiple places as can be seen in Chapters 4 and 5. The lack of office space to complete administrative tasks and paperwork, make phone calls or meet with patients privately created barriers to CHWs’ service delivery. Likewise, the CHWs in the study need updated laptops, mobile devices and wifi that would have allowed them to access patients’ health care information and other resources they needed to provide patients’ services in the appropriate settings. Because the CHWs’ services delivery took place in a variety of settings within the community, there was a need for clear safety policies and access to safety devices that the CHWs could utilize in case of an emergency. Each CHW shared that there were times when they used their personal funds to assist patients with low-cost expenses. This suggests the CHWs need to have access to a petty cash or funds for patients’ assistance.

As an instructor of the Certified CHW Training Program and the researcher of this study, I am keenly aware of the findings that suggest CHWs’ training needs. While the current training program includes aspects of the following recommendations, what is missing is an in-depth curriculum that addresses these areas. Foremost, I believe a starting point for stakeholders at all levels is to work together to develop a comprehensive
plan for the education and training of CHWs, and for instructors. This plan should also include a component that addresses the CHWs and instructors’ ongoing professional development similar to continuing education units (CEUs). Again, learning from others who have developed and designed CHWs educational and training programs is essential. There are examples of these training programs in the literature. Notably, states, such as Minnesota, Massachusetts, and Texas have models that stakeholders can consider and learn from the lessons learned. Through my work as a CHW Instructor, I hope to complete a comprehensive review of the literature on CHW educational and training programs so that I can help facilitate the redevelopment of the CHW training curriculum.

In Chapter 5, I described the five models of services Mary, Sabrina, and Margaret performed. The data from the study reflects that the CHWs performed many similar duties. However, there were tasks unique to each of CHW program sites as well. The diverse demands of each respective site have implications for CHWs’ education and training. CHWs need required training in core competencies as well as in specialized areas. Essential to CHWs is understanding how to navigate the culture of health care which requires knowledge of the models of services, terminology, basic medical procedures and administrative procedures related to the oversight of health care regulatory guidelines. As seen in Chapter 4, CHWs are expected to track patients’ health outcomes collect and help analyze data to meet local, state and federal requirements. Much of the education and training in this area will need to occur at the PHC level. However, the state’s certified training program needs to consider developing a curriculum to address this function of CHWs.
I recommend considering the cross training of CNAs and CMAs in the content of CHWs. For example, one of the findings was that MCHC employed Margaret in dual roles and HFP utilized Mary’s professional experiences as a CHW and as a CMA, which significantly enhanced her ability to function on the healthcare team. Cross training can provide stackable credentials which include “degrees; diplomas; credit-bearing, noncredit, and work readiness certificates; badges; professional/industry certifications; apprenticeships; and licenses all of which in different ways testify to people’s skills, knowledge, and abilities “(Ganzglass, 2014). Training the CHWs in multiple areas will enable them to gain skills and the credentials that will increase their value that is congruent with the provision of health care.

In Chapters 4 and 5, we see Mary, Sabrina, and Margaret engaged with many individuals at different levels within and outside of the PHC. They all exhibited good interpersonal and professional relationship skills to which colleagues and patients responded positively. This indicates that there is a need for CHWs to be equipped with the knowledge and skills to work with people at multiple levels. Each of the CHWs at times assumed leadership roles, and as such they needed education and training regarding developing leadership skills, interacting and working with others, and navigating the politics of other leaders in PHC. All three of the CHWs in the study had two years or more of experience in their position which may account for their vast knowledge and expertise. Both Sabrina and Margaret served as mentors for individuals attending the CHW education and training program at the local technical college. Using a CHW mentor model could greatly benefit those in training and those who lack the job experience. I suggest that the CHW certified training curriculum includes a mentor
component that goes beyond the training hours required for certification as a CHW. Having access to colleagues who are experienced and knowledgeable would provide CHWs a valuable resource for much-needed consultation and support.

Lastly, one finding that I found compelling as well was the need for the CHWs themselves to practice self-care. The CHWs needed to ensure that they, too, were healthy physically, mentally and spiritually. I know firsthand working with marginalized and underserved people with long-term problems and the social institutions and systems whose policies and practices sometimes create more barriers can take its toil on change agents. The issue of self-care is not only a personal responsibility of the CHWs, but I believe it is also the responsibility of the employing PHC. First, the employer should ensure the CHWs have clear expectations of their responsibilities and roles as well as policies and resources that enable them to perform their duties providing patient-centered health care. Second, I believe the employing PHC need to advocate for systematic changes that support the wellbeing of their employees who help them achieve their missions and visions. As such, they should work to create policies and practices that do not result in undue stress, and that reduce barriers and complications for the people providing and receiving the services. The CHWs have a responsibility to care for themselves not only at the micro level but also at the mezzo level. Developing strategies to ensure self-care as a workforce and self-advocacy positions such as an increase in wages and better health care coverage will help CHWs have a healthier lifestyle.

Lastly, it is important that I highlight the leadership and commitment of the CHWs statewide. Over the past year or so they have worked tirelessly to form the SC Community Health Worker Association (SCCHWA). Its mission is “improving
population health by developing and promoting a CHW workforce for South Carolina.” and its vision is “a healthier SC through the work of CHWs and their supporters” (SCCHWA Bylaws, 2016). As a member of the executive committee of the SCCHWA, I know firsthand that many of the implications I have discussed in this chapter are currently under discussion in SCCHWA and efforts are being made to address them. Most notably, the members and leadership of SCCHWA are working in partnership and collaboratively with healthcare stakeholders, the HeART Initiative, SCDHHS Medicaid Program, SC Department of Health and Environmental Control, and other state agencies, PHC groups, organizations, and insurance providers to fulfill their mission and vision. The SCCHWA has a unique opportunity to shift SC health care policies and practices, to be the “bridge for marginalized people from the margins toward the center” (Ayers, Ryan Alexander-Tanner, 2010).

6. 4 Study Limitations

To conduct this study I used four research questions to explore the culture and the dynamic process of CHW programs and services in PHC settings in SC. Because the study design is an ethnographic case study, I used a variety of data collection methods, observations, individual and focused groups’ interviews, documents, and the researcher’ reflexivity. Because of these methods, I collected a large volume of data, which at times created challenges for managing and analyzing the data. In hindsight, I believe I could have streamlined the data collection to answer the research questions. Another challenge has been representing the results of this study in a concise manner because the aim here is to produce a rich, detailed description of the complex and dynamic process of CHW services delivery (Baxter and Jacks, 2008). Therefore, I represented the study’s findings
in Chapter 4 in the format of vignettes, and I tell stories in Chapter 5 to reflect the voices of the participants in answering the research questions to help readers understand the dynamics and complexities involved in the provision of CHW program services in PHC.

Another limitation of the study is that all of the CHW program sites are participants in a pilot study. One site, MCHC, had a history of using CHW program services before the Medicaid pilot study. The other two sites implemented the CHW program under the scope of the SCDHHS Medicaid Pilot CHW Study. As such, the findings from this study reflect the CHW programs and services while they are in still in the development phase, not yet refined or experienced. It is important for readers to understand it was not an aim of this study to provide an evaluation of the CHWs programs services in PHC. Rather I sought to describe the CHWs’ services from the perspectives of those currently affected, Mary, Sabrina, Margaret, their patients, family members, and the healthcare professionals working in the context of CHW programs. I request readers consider this information as they make interpretations and draw conclusions about the CHW programs in PHC in SC.

Lastly, I believe my positionality as an insider at times was a limitation. Mary, Sabrina, and Margaret at times perceived me as the expert because I am an instructor for the Certified CHWs’ Training Program. I believe my insider status was beneficial, helping me to gain access to rich, detailed information about the context of the CHW program services. However, it may also have skewed the CHWs’ perspectives. For example, instead of consulting me regarding complicated problems and issues they encountered, I cannot help but wonder who or what other choices and decisions the CHWs might have made. As much as I tried to minimize my role as a CHW instructor,
clearly my other identities as a social worker, instructor of social work bachelor and master level courses, and a person of faith presented themselves in the natural process of engagement in fieldwork.

6.5 Future Studies

CHW programs are emerging strategies to help fill the gaps in primary health care (PHC). There is an interest in gaining knowledge about the integration of CHW programs in PHC and the dynamic ways programs operate. This study was an ethnographic case study that provided insight into the services, roles, and tasks of CHW programs in three PHC settings in SC. The results of the study yielded a rich description of CHWs’ services. I explored CHW programs 1) to understand the services, responsibilities, and roles CHWs perform day to day. 2) To identify and understand the mechanisms through which CHWs provide culturally responsive services to their diverse patient population, and 3) to find out what the perceptions of CHWs’ services were from the people receiving services.

I believe there is a need for future studies about CHWs that would address an array of topics. I specifically recommend further research in four areas, and I include them in my plans for future research. First, there is a need to understand the process of integrating CHW programs into PHC. Because CHW programs and traditional healthcare models differ, it is crucial for health care policy makers and stakeholders to have access to information regarding the process of integrating CHW programs in PHC. For example, what are the critical issues and factors needed for developing a comprehensive plan for the integration of CHW program into PHC? What are the best practices for undertaking this type of project?
Secondly, I believe it is imperative that future studies about CHWs in PHC focus on various aspects of the services delivery from people like the CHWs, patients, healthcare professionals, partnering organizations, and other stakeholders who are affected by these services. As we can see from this study, health care policy and practices are incredibly important at each level, the state, local and PHC. To better understand the healthcare needs of the people affected by the policies and practices, questions need to be asked of them. Again, much knowledge can be gained from those experiencing the day to day realities of our social programs. Third, more research is required to explore the application of multidisciplinary approaches in CHW programs and PHC. Far too often, policymakers and administrators spend valuable time developing new programs and strategies to address similar problems and issues across different contexts. There exists a wealth of knowledge and models that research has shown to be very useful in addressing related problems and questions. For example, family-centered education puts learning in the context of the family (Greathea, 2002). Parents, children, and family members learn together. The results are parents strengthen their parenting skills, and the children demonstrate readiness for school. It seems wasteful to not consider utilizing existing resources for which we have spent countless dollars and time determining that they are useful. Fourth, there are many, many quantitative studies about CHWs in general and in PHC. These studies provide valuable knowledge that helps us to understand CHW services from the large-scale perspective. However, I believe more qualitative studies are needed to provide us with a different lens to consider CHW programs in PHC settings. The rich descriptive information that provides data for readers to make their interpretations and hopefully will help them to draw conclusions needed to make informed
decisions. More researchers should look specifically at descriptive case studies concerned with what is important in the context of the people working day-to-day in primary health care.

6.6 Conclusion

Perez and Martinez (2008) argued that since their inception, CHW programs in the U. S. consistently emerged during critical, social, political, and economic periods such as the ongoing health care crisis to address inequities in social institutions and systems. CHW programs facilitate social change and justice for individuals otherwise marginalized by these inequities. For instance, CHWs played a significant role in helping migrant workers access much-needed health care, providing lay health care within migrant camps when physician care was unavailable (Perry, 2013). In view of the changing demographics of people of color with the majority status, the ACA of 2010 that expanded health insurance to 34 million people and the ongoing rising cost of health care and the lack of access to affordable care in urban and rural communities, there is a demand for more health care workers such as CHWs. Moreover, the CDC and the WHO call to action for primary health care providers to work more closely with diverse individuals and communities in the prevention and management of their health has set the stage for a paradigm shift in primary health care (CDC, 2010). In the era of health care reform, CHWs have stepped in to help facilitate social change within the broader community of health care in their local cities and states.

Given the above and the backdrop of health care in SC in which I discussed in Chapters 1 and 2, CHW programs have an opportunity to become a vital strategy to address the gaps in healthcare services for the uninsured and Medicaid populations. South
Carolina’s health care policy makers and stakeholders have already made great strides to implement innovative approaches, the CHW program to address significant gaps in PHC. I present this study and its findings to underscore the day to day activities of CHWs in PHC. I believe Mary, Sabrina, Margaret, the patients, and healthcare professional at HFP, RHC, and MCHC validated CHW program services in PHC are viable interventions worthy of SC healthcare policy makers and stakeholders investing the time, money and resources to implement. However, in doing so, there is a need for multilateral changes within the SC healthcare system. This study provides a rich description of community health workers in primary health care in SC.
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Appendix A: Informed Consent

Community Health Worker (CHW) Programs in Primary Health Care Case Study - Informed Consent

I am Constance Shepard, the principal investigator for the CHW programs in the primary health care case study. Also, I am a doctoral candidate for the Educational Foundations and Inquiry program in the College of Education at the University of South Carolina. I am also an instructor for the Community Health Workers (CHWs) Certification Training Program at Midlands Technical College. The purpose of this study is to gain insight into the culture of CHW programs in primary health care settings. In doing so, the study findings will assist CHWs in gaining knowledge, skills and competencies to help facilitate better health outcomes for people receiving CHWs’ services. The aims of the case study are: 1) learn the roles and responsibilities for CHWs in primary health care, 2) identify and understand the mechanisms in which CHWs provide culturally responsive services for diverse people and groups, 3) gain knowledge about CHW programs from the viewpoint of the individuals receiving services.

To better understand CHW programs, I will be conducting interview and observation sessions with individuals who are knowledgeable about CHW programs in primary health care settings. I invite you to share your experiences as a community health worker, administrator, health care team member, patient or someone who is working with or receiving services from a CHW program services. With your permission, I will observe your interactions with CHWs and others in the CHW program. Additionally, I may want to interview you individually or in a focus group. With your permission, I will tape and transcribe your interview for the accuracy of the information. For the individual and focus group interviews, I will ask you a series of questions about your experiences with working and/or receiving services from a CHW program.

You can choose not to answer any questions for any reason. Maintaining and safeguarding the rights, welfare, and confidentiality of your participation is a high priority for the study. All participants involved in the study may choose a pseudonym. I will use your pseudonym along with an identification number on all written, audio, and other materials to reference your information confidentially. I will invite you to review the transcribed interview and correct any inaccuracies.

Your participation in this study is voluntary, and you are free to refuse to participate or quit the interview and observation session at any time without fear of penalty. In such an instance, I will destroy all records related to your participation and patients will still receive the gift cards. I will report the study’s findings in an aggregate format to protect all individuals and CHW programs’ anonymity to the fullest extent possible.
There are no risks or benefits to you for participating, other than perhaps helping to improve CHW programs and services in primary health care settings. Your participation in the study will contribute rich and valuable information that will increase the knowledge and the understanding of the culture CHW programs in primary health care settings in SC from different perspectives. Thank you in advance for your interest and assistance with this research.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Print Name</th>
</tr>
</thead>
</table>


Appendix B: Field Notes

Wednesday, May 20, 2015
Site: 2 RHC

<table>
<thead>
<tr>
<th>Staff Dining Area Descriptive &amp; Background Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sabrina explained that her office was her car. I asked if I could take a picture of her car. After promising, I would not display the picture but rather use it to describe how she uses it for an office. Although she has an office in the local hospital, today she is at the RHC. She does not have an office rather she works at the end of the table in the staff lunch/break room.</td>
</tr>
</tbody>
</table>

Observations of Sabrina’s Telephone Conversation:
When I arrive, Sabrina is on the phone talking with a patient. She is reviewing the patient’s medication with her. Sabrina is letting the patient know which medication the Patients Medication Assistance (PMA) covers. As she reads each of the medications listed in the patient’s record, she states if it is covered or not covered. I noticed the medications that cost $3.99 were not covered. The patient tells Sabrina she is to see the doctor on Tuesday, May 26. Sabrina tells her she will be at the RHC to complete a Medicaid Application with her after the doctor’s appointment and to determine what medications she can receive via emergency assistance while the PMA application is pending.

She tells the patient to call Beverly in the administration to make sure she has all the information she needs. The doctor may be able to provide some samples. She reminds her to bring all of her medications with her to the physician’s office.
Appendix C: CHW Interview Protocol

Greetings
Good morning or afternoon, how are you?

Ethnographic Explanations
The focus of our interview today is to help me to understand more about community health worker programs in primary health care facilities and what it is that you do. I am very interested in learning how you work with patients, doctors, nurses and others on the health care team. I consider you to be the expert at your work, so there are no wrong answers to any of our questions. I am here to learn from you.

Project Explanations
The purpose of this study is to gain insight into CHW programs in primary health care settings. A goal of the study is to help CHWs, and other health care team members gain the knowledge, skills and competencies to help facilitate better health outcomes for individuals, families and groups receiving CHWs’ services.

Questions & Recording Explanations
During the interview and/or observation, I will be taking notes, and I may also record our interview and conversations to make sure I get everything we discuss. This information, like all information, is confidential. As you are answering my questions, or during my observations of your work, please focus on the details of how you do your work. It may be helpful for you to think about the last time you performed the task and explained it to me/us as if I/we will perform the task just as you did. Please feel free, to be honest, open and critical about your work, as well as the people, policies, and practices at ______________. Everything you tell me and we discuss is strictly confidential.

Warm-up Questions
1. How did you get the position of a community health worker at ____________?
   What was it about the position that interested you the most and why?
2. How long have you been in this position?
3. About how many people work here?
4. How do you refer to the individuals who use your health care services? (patients/clients by name)
5. How many people does the __________________ serve?
6. What services does __________________ provide?
7. How many individuals do you see on a typical day?

Ethnographic Questions
Contextual Inquiry
8. I've never been to _______________ primary health care facility nor have I worked in this type of facility. What is it like to work in a medical facility such as this? What is a typical day here for staff?
   Open Probes: You mentioned_________________. Tell me about that.

9. Tell me about the people you work with here at _______________. What are their positions? Describe the ways you work with each of them and your relationship with each of them.

Grand/Mini Tour Questions (Day in the life of a CHW)

10. While I teach the CHW training program, I have no idea what it is that CHWs do on a daily basis. Nor do I know what takes place in a CHW program in a_______ (setting).
    Could you start at the beginning of your day at ________________ and describe to me what goes on? For example, what do you do when you first arrive, then what do you do next? Walk me through your day step by step. What are some of the things you would have to do daily or most days, and then go on through your day at __________ until you walk out the door and leave at ______(time)?

    Open Probes: You mentioned________________________. Describe a specific example.
    (For each duty or activity probe for detail.)

11. Tell me what you enjoy most about your job as a CHW? Why? Describe the activities you always tackle first?

    Open Probes: Tell me more about why you do these tasks first?

12. What do you enjoy least about your job as CHW? Please explain. Describe the activities you think are a waste of your time or non-productive?

    Open Probes: Tell me more, or more specifically.

13. Tell me about the individuals you currently serve. Do not identify anyone by name; however, please tell me about the individual’s background (race, age, gender, family, living environment), and the services you provide. Describe your relationship with them.

    Open Probes: You said earlier ___________; can you tell me more about the __________? Please give me an example of ________?

14. You probably had some interesting experiences working with these individuals. Can you recall any?

    Open Probes: Could you tell me more about the individual?
    You mentioned__________. What did you mean?
Grand/Mini our Questions (Cultural Responsiveness Services)

15. Describe how you develop a relationship with the diverse individuals (race, gender, age, ethnicity, SES status, religion, backgrounds) receiving services? Tell me about their homes, families, neighborhood, and communities. What do you do when you are in their homes? When you interact with their families, friends and neighborhoods?

Open Probes: What do you think about?

16. Describe the things you do when you are with each. Describe the things you do that you consider as services and those you do not consider as services or are unsure of?

Open Probes: Can you give me an example or explain further? Tell me more about?

17. How would you refer to the individual when communicating information?

18. Describe the challenges, barriers, or issues you encounter working with each.

19. Tell me how you deal with these issues. Describe the ways in which you seek help from others (care team members, family, friends, and community resources).

Open Probes: Give me an example. Can you clarify or tell me more? What do you think about?

20. I bet you had some interesting experiences working with so many diverse individuals. Tell me about some of them?

Wrap-up Questions (Give the interviewee a big Thank You!)

21. What did you think of this interview? Anything you did not understand? Anything that made you anxious?

22. Please tell me anything you’d like to add regarding the process of working with individuals, providing services, activities, and working with a health care team within CHW programs in _________ (setting)?

23. Would you be willing to be contacted with follow-up questions?

24. Can you suggest individuals receiving services and working with you who may be willing to talk to me about the CHW program? If so, what’s the contact information and would you help me connect with the person?

25. Would you be willing to be contacted to provide feedback on my understanding of the information you shared?

26. Tell me what documents you think I should review to learn and understand the scope of the services, activities, and things you do in the CHW program
Appendix: D Patient Interview Guide

Greetings
Good morning or afternoon, how are you?

Ethnographic Explanations
The main focus of our interview, today is to help me to understand more about community health worker programs in primary health care facilities and what it is that you do. I am very interested in learning how CHWs and other health care team members (doctors, nurses and others in the healthcare team) work with patients/clients. I consider you the expert because you receive services from the CHW program, so there are no wrong answers to any of our questions. I am here to learn from you.

Project Explanations
The purpose of this study is to gain insight into CHW programs in primary health care settings. A goal of the study is to assist CHWs and healthcare team members to gain the knowledge, skills and competencies to help facilitate better health outcome for individuals, families and groups receiving CHWs’ services.

Questions & Recording Explanations
During the interview and/or observation, I will be taking notes, and I may also record our interview and conversations to make sure I get everything we discuss. This information like all information is confidential. As you are answering my questions, or during my observations of your visit with CHW, please focus on the details of how you receive services from the CHW program. Please feel free, to be honest, open and critical about the services, people, policies, and practices you receive at ____________. Everything you tell me and we discuss is strictly confidential.

Warm-up Questions
1. Tell me about yourself (background)? Questions will focus on the individual sharing background information.
2. How many people live in your household, can you describe your relationship with each?
3. How did you get connected or involve ________________?
4. What kinds of treatments have you received for health problems?
5. How did you get involved with the community health worker program at __________?
6. How long have you been receiving services?
7. How often do you see your CHW? How often do you speak with your CHW by phone or text?
8. Does anyone else in your family receive services from the CHW program or at ________________?
9. What are the services do you receive at ____________?
Ethnographic Questions
Contextual Inquiry
10. This is my first time at ________________primary health care facility. What is it like to be a patient/client at __________________________? Describe to me what happens when you walk in the door until the time you leave.

Open Probes: You mentioned_______________. Tell me about that

11. Tell me about the people you encounter receptionists, doctors, nurses, CHWs) at ______________. Describe the ways in which they treat and interact with you.

Open Probes: What ways do ______________ respond to you? For example when you ask a question. Can you describe a good and/ or bad experience you had with ____________?

12. How would you describe your health care at ____________________? What questions do you have about your health care or the ____________________?

Grand/Mini Tour Questions (Perception of CHW Program Services)
13. Describe your last office visit with your CHW. What happens when you see your CHW in the _______________health care facility? Could you start at the beginning of when you first walk in the ______________ and describe to me: what goes on? For example, how does the CHW greet you? Then what happens next? Walk me through your day step by step. What are some of the things you talk with CHW about? Why? What things you do not talk about? How long are your visits? What occurs before you leave? What is said or done? Who else is involved with you during the office visit?

Open Probes: You mentioned_________________. Describe a specific example. (For each description probe for detail)

Open Probes: What questions you have after your visit with the CHW? What do you wish your CHW would do that she/he has not done yet?

14. Tell me about the last time your CHW visited you in your home. Start at the beginning of the home visit when you first saw the CHW _______________ and describe to me what happened? For example, how did the CHW greet you, then what happened next? Walk me through your day step by step. How did she/he interact with your family or others within your home? What are some of the things you talked with your CHW about during the home visits? Why? What things do not you talk about? How long are your visits, what occurs before you leave, what is said or done?

Open Probes: Tell me more about ______________. In which environment do you prefer to see your CHW? Office or home visit? Can tell more about why you prefer________?
15. Tell me about the services you currently receive from your CHW. Describe the activities or things that you do with your CHW. What type of things do you do together? What things does your CHW do that are helpful or beneficial to you? What type of things do you think are a waste of your time or you do not do? Open Probes: You said earlier __________; can you tell me more about the __________? Please give me an example of ________?

16. You probably had some interesting experiences working with your CHW. Can you recall any?

Open Probes: Could you tell me more about time your CHW did not help you? And the time she/he did help? You mentioned, what did you mean?

17. Overall, how would describe the CHW program at ________________?

Grand/Mini Tour Questions (Ways CHWs provide cultural responsiveness services)

18. Describe your relationship with your CHW? What do you like most about your CHW, the services, and your relationship? What do you like least?

19. Think back when you first met your CHW. What were your first impressions? How did she/he go about building a rapport (relationship) with you? Describe the things the CHW did or said that made you feel comfortable or uncomfortable talking to him/her? How did it make you feel when she______________? Describe a time when a specific incident occurred, during which you felt comfortable or uncomfortable.

Open Probes: Can you me an example or explain further? Tell me more about?

20. Describe the things she/he does that let you know she/he understands you, your family and current circumstances.

Open Probes: Tell me more, or specifically can you tell me about __________?

21. Describe the ways your CHW connects with you culturally? Culture includes your race, gender, religion, beliefs, values, heritage and other things (communication) that are important to you.

Open Probe: Please clarify or give me another example.

22. Describe the challenges, barriers, or issues you encounter working with your CHW.

Open Probe: Tell me about any barriers you have heard about from other patients/clients.
23. Tell me how did she/he deal with these issues? Describe the things she/he said or did. How did you feel about the CHW afterward? What are things you said or did?

Open Probes: Give me an example. Can you clarify or tell me more? What do you think about?

24. I imagine you have had some very interesting experiences with different health care, workers/providers. Describe a time within the last ___________ (months receiving CHW services) when you felt you were treated unfairly.

Open Probes: Tell me more about the situation. What happened? What did you do?

25. Describe the successful or positive interactions or progress you have encountered or made working with your CHW.

26. Tell me how she/he helped you with problems or issues? Describe the things she/he said or did. How did you feel about the CHW afterward? What are things you said or did?

Open Probes: Give me an example. Can you clarify or tell me more? What do you think about?

27. What are the suggestions you would make to improve the CHW program at ___________ to serve client/patients better? What would they be?

Open Probes: Do you have other suggestions? If so what are they?

28. What suggestions would you make to make sure everyone regardless of their race, age, ethnicity, gender, religion or sexual orientation receives good quality health care?

Open Probes: Can you give me an example or tell me more?

**Wrap-up Questions (Give the interviewee a big Thank You!)

29. What did you think of this interview? Is there anything you did not understand or made you uncomfortable or you would like to set the record straight about?

30. Would you like to add anything else about receiving services or activities from individuals on the health care team at ____________, or your CHW programs in __________ (setting)?

31. Would you be willing to be contacted with follow-up questions?

32. Can you suggest individuals receiving services and working with you who may be willing to talk to me about the CHW program? If so, what’s the contact information and would you help me connect with the person?
33. Would you be willing to be contacted to provide feedback on my understanding the information you shared?
34. Can you tell or show me documents or objects you think would help me to learn and understand about the services, activities, and things you do with the CHW program?

** Note not all of the above questions or probes will be used; rather this is a guide to generate dialogue for the interview.
Appendix E: Health Care Team Members Interview Questions

Introductions
1. What is your name and position on the health care team?
2. Tell me about where, when, and how you utilize the CHW?
3. What factors do you consider when making a referral to the CHW?
4. Who are other members of the patients’ health care team? Describe the ways the CHW interacts with the members of the health care team?
5. In what ways do the CHW’s duties and responsibilities differ from other health care team members?
6. What are the ways in which you have observed the CHW connecting with patients culturally?
7. What do the patients tell you about the CHW and services?
8. What are the competencies that the CHW needs to demonstrate on a regular basis?
9. What other competencies are needed?
10. What are your thoughts about the CHW programs in primary health care?
11. What are the strengths of the CHW programs in primary health care?
12. What are the barriers/challenges the CHW encounters in primary health care?
13. If you could change any aspect or add any services, what would they be?
14. What else would you like to say about CHW in primary health care?
## Appendix F: Sample of Documents Collected

<table>
<thead>
<tr>
<th>Documents</th>
<th>Patient-centered</th>
<th>Medicaid</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Action Plan</td>
<td>Identifies what, how, when and comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CHW Intake Form</td>
<td>Initial form gathered information on the client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. CHW Phone Call Questionnaire</td>
<td>Documents phone call comments, complaints, referrals, patient in the ER Demographics</td>
<td>Non-billable</td>
<td>Required by the practice, physicians may request CHW</td>
</tr>
<tr>
<td>4. Guidelines for Billing CHW Services</td>
<td></td>
<td>CHW develop the form to ensure compliance with Medicaid</td>
<td></td>
</tr>
<tr>
<td>5. Comprehensive List of Discount Medications at Local Retail Pharmacies, Jan., 2014</td>
<td></td>
<td></td>
<td>List of Medications by name, generic or brand with retail prices. Family Practice has a Pharmacy</td>
</tr>
<tr>
<td>6. CHW Behavior Change Follow-Up</td>
<td>Behavioral Plan</td>
<td></td>
<td>A brochure about the Family Medicine Services</td>
</tr>
<tr>
<td>7. Bubble Chart</td>
<td>Behavioral change Model</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Target for Diabetes Self-Management</td>
<td>Documents Blood Glucose Targets</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. <strong>Monthly Managed Weight Loss Attempts</strong></td>
<td>Identifies goals targets for weight loss/ with an exercise plan. Calorie Count</td>
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<td>---</td>
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<tr>
<td></td>
<td>10. <strong>CHW Checklist</strong></td>
<td>Used to ensure all areas are discussed with patients</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G: CHW Checklist

- Verbal & Written Informed Consent
- Introduction of CHW
- Reason for appointment
  (Order specific)
- Medication Reconciliation
- Health and Wellness Education
  (Client Specific)

Or

- Vital Signs (Weight, blood pressure, blood sugar)
- Scheduling of Appointments
- Summary of Visit with follow-up instructions
- Documentation of visit

**Diabetic Visits**

- Steps 1-2 of CHW Checklist
- In step 3 discuss patients’ type of Diabetes (utilizing patient diabetes handout and other aides)
- Step 4 of CHW Checklist
- Step 5, define carbohydrate nutrition steps (follow-up visits will consist of a meal, log tabulation of carbohydrate intake)

**Asthma/COPD/Inhaler Visits**

- Steps 1-2 of CHW Checklist
- Step 3 Define and discuss diagnosis
  - Children in situations of respiratory distress must establish their relationship with their medical home provider to direct and reiterate their approach to the child’s asthma care
  - Confirm child is taking asthma medication routinely and correctly
  - Update asthma action plan (copies at home and school) and all district-specific forms for managing asthma at school; renew prescriptions and devices needed in emergency situations
Housing/Community Resource/Education Visits

- Steps 1-2 of CHW Checklist
- Step 3 Clarify barrier or need
- Steps 6-8 CHW checklist