The Nurse-Community Health Advocate Team for Urban Immigrant Primary Health Care

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Purpose: To describe: (a) development and implementation of an urban outreach health program for Latino immigrants; (b) nurse-community-health advocate (CHA) partnership roles in primary health care delivery, and (c) lessons learned from these activities over 7 years in urban community settings.

Methods: Descriptive study of a community-based health project in a large Midwestern American city. Information was gathered from participants and staff, from observing staff, and from a variety of sources to describe the program and its individual, family, and community effects.

Findings: Major findings pertain to the project team's ability to address the health promotion needs of Latino immigrant families and to successfully incorporate CHAs in planning and implementing the program. CHAs were a "bridge" between health programs and the community, promoting cultural sensitivity. CHAs and nurses provided a range of services including health education and promotion, outreach through home visits, assessment of family needs for referrals to appropriate resources, and follow-up support.

Conclusions: The nurse-CHA team was an effective strategy for promoting Latino immigrant families' access to needed health care. This framework allowed for flexibility in assisting clients of different cultural backgrounds to obtain appropriate health care.

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New immigrants to inner-city communities often live in isolation with few friends and little social support from the community. Many have little or no understanding of the health care and social service system in the United States (US), and they experience economic, linguistic, and cultural barriers to needed services. Furthermore, access to health and social services is difficult for immigrants because of adverse health policies and fragmented service delivery systems. Health and social service providers are difficult to locate, and yet they provide essential services for immigrant families. Immigrant health issues are mostly those of a young population with preventable or curable health problems if provided early detection, health education, and access to primary care and social services. The unique needs of immigrants and the structural limitations of the social service system are barriers to the health and well-being of this population.

Increased research over the past decade indicates that immigrants face several challenges in a new culture and that a combination of social and physical environmental factors (e.g., poverty, inadequate housing, racism, lack of employment opportunities, and powerlessness) are associated with poor health outcomes in these groups (Collins & Williams, 1999; Israel, Checkoway, Schulz, & Zimmerman, 1994; Israel et al., 2001; Kawachi, Kennedy, & Glass, 1999). Given that determining health among immigrants is complex and traditional prevention research projects are not effective in some circumstances, what should be done to reach these often marginalized subpopulations?

Globally, health care researchers have emphasized holistic and participatory approaches when developing, implementing, and evaluating community-based health programs in the last decade (Hatch, Moss, Saron, Presley-Cantrell, & Mallory,

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1993; Israel, Schultz, Parker, & Becker, 1998; Macaulay et al., 1999). Yet, implementing research that deviates from traditional processes poses many challenges and limitations. A large body of literature on primary health care and community-based programs indicates the challenges encountered when using approaches with increased collaboration and partnership with community residents and organizations to address community health needs (Israel et al., 1998; Roussos & Fawcett, 2000; Silka, 1999; Wallerstein, 1999). An important question is this: What kinds of strategies should be used to establish these partnerships and to engage vulnerable populations in identifying health needs and effectively enhancing health knowledge to improve overall health status?

Our approach was based on trained community health workers teamed with nurses to implement community-based health promotion programs. Several terms are used in the literature for community health workers including, "lay health advisors," "natural helpers," "village health workers," and "community health advocates." In this paper, we refer to this group as "community health advocates" (CHAs). CHAs have been incorporated into many health promotion programs in developing countries and have been used in U.S. health care delivery in the last 2 decades. These advocates' tasks vary with settings and training, but they primarily carry out activities such as home visits, health education, and outreach activities for ambulatory care sites (Swider & McElmurry, 1990). CHAs are residents of the target community who receive special training to help bring health services and health education as well as health promotion to their local communities, while also mobilizing members of the community to adopt actions that would improve their overall health and living conditions (Barnes & Fairbanks, 1997; Eng & Young, 1992; Swider & McElmurry, 1990; Watkins et al., 1994).

In the case of immigrants, those who have become acculturated to the new environment provide such critical support. In the project described here, we viewed health comprehensively, and the CHA-nurse team worked with clients and families in targeted communities to provide individual and group health promotion programs and enhance the existing social network. In this paper we (a) describe the approaches and processes used in developing and implementing an urban immigrant outreach health program using a nurse-CHA team, (b) describe the nurse-CHA partnership role in primary health care delivery, and (c) describe lessons learned from conducting these activities in urban community settings.

Description of the Urban Immigrant Outreach Health Program

Goals and funding sources of this immigrant outreach program changed over the years. The initial program was funded through the State Legalization Assistance Grant and became known as the "Door-to-Door project." To offset the cost of providing health care and social services to people newly legalized under the Immigration Reform Act of 1986, funding was made available through the Chicago Department of Public Health (CDPH) to community agencies, institutions, and organizations providing health and social services to immigrant populations in Chicago. In the summer of 1991, the World Health Organization (WHO) Collaborating Centre for International Development of Primary Health Care at the University of Illinois at Chicago (UIC) College of Nursing responded to a request from the CDPH for proposals to address health issues of Latino immigrants in Chicago (Park & Warren, 1999). Federal funding for the program ended in 1996, but the CDPH continued to sustain the program as its "Urban Immigrant Outreach Health Program" because of its positive effect on Chicago's ethnic communities.

In the Urban Immigrant Outreach Health Program, we identified underserved and immigrant families, assessed their health needs, and linked them to health, social, and human services. This program provided intensive outreach and follow-up in designated areas of Chicago. Services included outreach, networking, referrals, training, workshops, health fairs, health education, health promotion, screening, job placement, and KidCare (City of Chicago, Department of Public Health, Office of Hispanic Affairs, 2002).

The overall goal of this project was to assist families to gain greater control over their health and well-being through a family focused, community-based, outreach program. Specifically, the project objectives were to: (a) identify families and individuals at risk for inadequate health and social services or individuals who lacked such services through assertive outreach; (b) link families and individuals with appropriate community resources, monitor clients' outcomes, and evaluate the resolution of health issues; (c) collaborate and create a network with local clinics, hospitals, and social service agencies to promote and improve the accessibility and acceptability of these services to immigrants; and (d) enhance and strengthen existing social networks of immigrants and thus their capacity to influence health-related environments in the community.

This project served primarily Latino immigrants in four Chicago community areas: Avondale, Humboldt Park, Logan Square, and West Town. In 1990, the racial and ethnic composition of Chicago was: 38.6% Black; 37.9% White; 19.6% Latino and 3.9% other (U.S. Census Bureau, 2002). The population of Latinos in Chicago for that period was estimated at 545,852 and it increased to 753,644 by 2000, with an increase of 3.3% per year (U.S. Census Bureau, 2002). This increase in the Latino immigrant population resulted in increased demand for culturally specific health and social services.

Members of the target communities experienced many socioeconomic difficulties that were barriers to health care. For example, the percentages of people below the federal poverty level at the sites were: (a) Avondale, 17.4%; (b) Humboldt Park, 33.8%; (c) Logan Square, 26.4%; and (d) West Town, 31.9% (City of Chicago, Department of Public Health, 1999). Only 12% of the clients enrolled in the program had health insurance. The percentage of health-insured Latinos

in our project population (67%) was far below the national average insurance coverage rate for the Latino population between 1994-1997 (U.S. Census Bureau, 2002). Additionally, only 58% of our project population was employed. With the low level of employment and lack of health insurance, Latino immigrants faced difficulty accessing health and social services.

Methods

The CHA-Nurse Team

Community health nurses were specially trained to provide case management for multiple health and social problems (Bower, 1992; Grau, 1984; Mundinger, 1984). CHAs had long been considered core components of strategies for primary health care in urban communities for grassroots health education and promotion activities. The CHA-nurse team was expected to work with clients to design and implement plans for fulfilling program objectives. Project staff consisted of a part-time community health nurse and a full-time CHA who worked with over 100 families a year in their neighborhoods. The community health nurse worked closely with the CHA in identifying prevailing health problems. The team's role was primarily to link participants with service providers and in other instances to provide health information and ongoing health education to promote healthy behaviors. The nurse also guided the CHA in resolving complex tasks or making complex decisions. Health care literature has shown that a nurse-health advocate team is more effective in fostering community participation than is either working alone (Boerma, 1987; Chamberlain & Beekingham, 1987; Eng, Salmon, & Mullan, 1992).

Recruitment and Training of Community Health Advocates

An important aspect of the project was recruiting and training CHAs. Minimum requirements for a CHA were: high-school education, residence in the community, interest in community health, and English-Spanish bilingual skills. The CHA was recruited from a group of community health advocates who had all undergone training in an earlier urban primary health care project (Soares, Swider, & McElmurry, 1999). That training program was focused on the health concerns of the trainees' communities and the role of a CHA in the neighborhood. Based on the philosophy of primary health care, the training content included a broad view of health and its linkage with social issues and development. Training sessions for the CHAs were conducted over a 6-week period and included 100 content hours, with over 70 hours of field experience. Information on training of CHAs is published elsewhere (Soares et al., 1999).

Client Service Plan

Families were eligible to participate in the program if they had health or social service needs that the primary health care (PHC) team could address. Clients were recruited for the program through a case-finding approach, including agency referral, outreach, self-referral, and word-of-mouth. However, assertive outreach was the preferred mode of case finding, such as placing information where immigrants were likely to gather: adult education centers, churches, day-care centers, and community centers. The client service plan included the following components or processes: (a) case finding, (b) initial assessment, (c) risk assessment and planning, (d) service arrangements, monitoring, and reassessment, (e) evaluation, and (f) case closing. Readers interested in understanding the in-depth explanations of the client service plans are encouraged to read Park and Warren (1999).

Program Implementation Strategies

The staff believed that a PHC approach combined with case management would be most effective, particularly for isolated people with weak ties to the community. We defined case management as a combination or sequence of services that were planned, coordinated, and facilitated to provide access to services, information on programs and health services, and follow-up. Our PHC model for case management was focused on client and community participation. Clients were provided with information, health education, and the skills necessary to promote self-care and self-reliance. The nurse-CHA team provided feedback to agencies about clients and their families. In this way isolated families were exposed to diverse resources in the community and they were introduced into a system where they could receive service.

System-level interventions. As contacts between immigrant families, local organizations, and community agencies increase, stronger ties between families and local systems are established, thus enhancing the effectiveness of the program. System-level interventions can enhance the informal social network's support function, and enhanced social networks and support can lead to mobilization of potential community resources and participation. Examples of strategies that we used to strengthen support for immigrant families include the establishment of "immigrant support groups" and expansion of "volunteerism." Volunteers were trained to answer the telephone as well as to monitor clients, provide general information on local resources, and assist with special health-related events. Over time, volunteers became effective as natural helpers in informal social networks.

Developing a corps of volunteers is a strategy to promote sustainability of a program. Even after the program's termination, trained volunteers remain a health resource, able to provide information and link families with community health and social services. Their experience and knowledge often leads to employment at one of the agencies or clinics affiliated with the project.

Community-based agency collaboration and interagency coordination. Limited health service availability in a community can be addressed by increasing interagency coordination among service providers without an actual increase in the physical capacity of the system (Bloxham, 1997; Polivka, 1995; Schermerhorn, 1995). By increasing interagency coordination, our program improved access to

health and social services. For example, our project team coordinated community health fairs by mobilizing local health and social service providers to increase awareness of health issues and to inform the community about health services available. Health fairs are a cost-effective way to provide health screenings, explore health care services, and educate community residents in a neighborhood setting that is easily accessible and familiar (Malott, 1996). Through health fairs, families become aware of available resources in the community, while local agencies have an opportunity to reach people most at risk.

Results

Six important factors were evident in this project: (a) effect on individuals and families; (b) effect on local clinics and agencies; (c) effect on target communities; (d) issues of sustainability; (e) role of the nurse and community health advocate; and (f) issues of data quality and documentation.

Effect on individuals and families. An analysis of program data indicated that families in this PHC program had improved social skills and became knowledgeable about health and social services. Former clients reported that barriers to access were reduced significantly by activities such as assistance with transportation, accompaniment to secure health services, interpretation and translation of health information, advocacy, information about local resources and how to use them, and education about health and self-care. Reducing barriers to community resources has contributed to the long-term health and overall well-being of participants in the program. The **Table** shows the types of services provided over a 39-month period from 1994-1997.

Table. Services Provided to Latino Immigrants by Service Categories and Number of Encounters

Category & type of service	Number of encounters	Category & type of service	Number of encounters
Health promotion	**1,841**	**Mental & social health**	**67**
Pregnancy	414	Depression	35
Infant care	102	Domestic violence	15
WIC program	182	Child behavior	8
Immunization	44	Alcohol abuse	6
Physical exam	288	Victim of crime	1
School exam	43	Chronic mental impairment	2
Family planning	48		
HIV/STD	36	**Human & economic**	**793**
Risk assessment	380	Social Security	38
Cholesterol	12	Public Aid	409
Hypertension	3	Dept. Health/Human Services	15
Diabetes	18	Food	4
Pap smear	46	Housing/shelter	26
Mammogram	46	Employment	7
Exercise	2	Legal	283
Lead poison	45	Transportation	6
Tuberculosis	11	Other	5
Dental	22		
Housing hazards	7		
Occupation/work	4	**Total services provided**	**2,701**
Child safety	7		
Percentage of services by service category			
Health promotion/maintenance	69%	Human & economic services	29%
Mental & social health services	2%		

Information about the significance of the program included clients' perceived barriers to accessing health and social services. The variable was measured by using a random sample from two groups—clients and nonclients—in the target communities. Averages of total access-barrier scores from clients (n=33) and nonclients (those not enrolled in the program but with similar characteristics: n=31) were compared. Results of the two group t test (t=2.44; p=.018) indicated that clients perceived significantly fewer barriers in access to health and social services. Further, clients used more health and other services than did nonclients. This success rate can be attributed to the team approach of the nurse and the community health advocate in linking clients with needed services. For instance, clients working with the case management team had greater completion rates for referrals (92.1%) than did clients referred by traditional methods (79.5%).

Effect on local clinics and agencies. A decreased demand was placed on local clinics, particularly those that charged sliding scale fees and where long waits for appointments and services were common. In many of these clinics, clients' demands exceeded capacity. Although our policy was to refer clients to resources in the neighborhood, the case management team recognized the need to look outside the community for access to health service providers. Considerations for linking clients with alternative resources included accessibility of public transportation, safety, and acceptability of services. For example, a clinic in a neighboring community that served an African American population was not fully utilized until the case management team negotiated with their director to provide care for underserved Latino clients. Five years later, one third of the clientele were Latino, and bilingual staff and primary care providers had been hired to serve them. By adding this clinic to the referral list, the burden on neighborhood clinics operating above their service capacity was decreased and access to medical and prenatal care was improved.

Effect on target communities. Another aspect of evaluation was the project's social value to the community. A sample of selected clients was asked to indicate the total value of the program by the "contingency valuation method" (Park, 1997). Clients said that the program exceeded its costs, thus showing the desirability of the program in social context. Moreover, the estimated benefit of the program can be an indicator of the extent of program sustainability.

Self-reliance and self-sustainability. Five years of data indicated that 19% of clients stayed more than 1 year and 15% stayed more than 2 years. For this group, the marginal rate at which clients left the program (case closing) did not decline, an indication that clients stayed for as long as they had problems to be resolved. Analysis also indicated that clients with more than 1 year in the program used more program service time than did clients who stayed less than 1 year.

Whether recipients become reliant upon programs is a sensitive issue in sustaining government welfare programs. This project was not designed to address this issue, nor did we restrict services offered to clients after a specified length of time.

Providing free service might also create disincentives for the community members or families who might otherwise handle some problems by themselves using their resources. Although we recognize this possible drawback, our team's practice of encouraging clients to become volunteer workers, particularly when they did not have financial resources to donate, was an effective strategy for personal growth and enhanced social support functions.

The role of nurse and community health advocates. The daily issues faced by the nurse in this project differed from what many nurses might have learned in public health and nursing programs in regard to community health problems. As a member of the nurse-CHA team, the nurse had many program management activities and encountered inter-organizational issues within the community as the team worked to mobilize resources and develop system-level interventions.

The CHAs worked closely with the nurses to ensure program implementation. CHAs experienced role conflict when the expectations of clients differed from the expectations of the professionals with whom they worked. Clients often view CHAs as they would family members who share their unique cultural background (Fuller, 1995). Yet, CHAs were asked to bridge differences between clients and health professionals such as nurses. Two factors important for our project were selecting from the communities they served and training them (Norr, McElmurry, & Misner, 1999; Swider, 2002).

As CHAs became more experienced, the extent of their services expanded. Some policy makers and program planners have proposed "CHA Only" programs as an alternative to reduce program costs. However, this type of program would limit the CHA to mechanical service delivery activities. Without professional backing, CHAs would have difficulty facilitating system-level intervention (mediation) to resolve complex service delivery issues. The nurse's role was critical for a comprehensive community program implementation strategy as used in this program. The CHA's role did not substitute for the professional's role even when the CHA gained skills through training, education, and field experiences (Bird, Otero-Sabogal, Ha, & McPhee, 1996; Swider, 2002).

The necessity for ongoing supervision, staff development, monitoring, and evaluation of CHAs has been repeatedly emphasized. The qualification of a lay CHA is that of a helper with additional training. The sustainability of a program is based on the qualification, recruitment, and selection of CHAs. Finding the right type of people is related to the effectiveness of the program and the long-term effect on the target community. Ongoing program evaluation is important and enhances the relevance and effectiveness of community-based programs (Schultz & Hatcha, 1997; Swider, 2002; Walt & Gibson, 1990). Additionally, participatory action research for an ongoing program is necessary to continuously monitor the program and to assess outcomes, enabling effective revision of the service delivery system. Consistency and integrity in documenting factors is required, and the CHAs' attention to recording this evidence is critical.

Data quality and documentation. More study is needed to understand how much of the nurses' time needs to be allocated for monitoring and evaluating activities germane to maintaining the overall quality of services. Caseload bears a direct relationship to the quality of documentation. When caseloads become too heavy, less time is spent on regular documentation. Given the differences in educational and literacy levels of CHAs and nurses (or other health professionals), determining appropriate methods of documentation is a continuous challenge. Much work is required to resolve differences between current documentation procedures and innovative methods that would correctly describe activities and outcomes. Some strategies we used to help CHAs document data accurately were providing a laptop computer and formatting all records for online recording. In addition, time was set aside for periodic record reviews by the nurse-CHA team.

Discussion

Our findings indicated that the nurse-CHA model was valid for reaching immigrant populations in this inner-city setting. With the PHC nurse-CHA framework, we provided health promotion and maintenance, mental and social health services, and human and economic services to 2,701 Latino immigrants. One great success was the reduction in perceived barriers to health and social services and an increased awareness of and use of such services by clients and families in the target communities.

The nurse-CHA framework differs from traditional approaches for implementing many community-based programs. Traditionally, many health promotion and prevention programs rely on health care professionals (e.g., nurse or public health professional) to implement such programs. In such top-down academic approaches, little or no feedback is obtained from those who benefit from the programs. From working in this PHC program over the last decade, we became convinced of the importance of grassroots participation. Other researchers also have advocated use of CHAs in community-based programs. CHAs are clearly recognized in many developing countries where they are the frontline for health education and health promotion for many preventable conditions. CHAs have excellent potential for working with nurses and other health care providers in several disease prevention and social welfare areas, and research indicates their potential in the U.S. health care system for reaching vulnerable populations in urban communities.

Collaboration between the university and local agencies. The health problems faced by many urban communities today are multiple and often require renewed collaboration among all stakeholders. The university's role in this project was focused on training, service, and research. University faculty

and staff increasingly collaborate with community participants to promote health (World Health Organization, 1984).

Collaboration with community agencies and community groups provided opportunities for graduate students to conduct research on different aspects of the program and, as a result, they participated as observers and evaluators. Their research yielded valuable information and ideas that helped the program's stakeholders better understand how to apply PHC principles and improve effectiveness of the project (Barron, 1994; Buck, 1994; Keeney, 1993). Overall, our strategy was to focus attention on the complex nature of immigrant health situations in local communities with an integrated, comprehensive approach to maximize program effectiveness.

Academic personnel can take leading roles in working with communities to improve health. One of the missions of the University of Illinois at Chicago is to help improve the health status of residents in Chicago and around the state. This process is accomplished through training health and human resource personnel and implementing health projects. The WHO Collaborating Center for Primary Health Care Development has an established history of working with several local community agencies and other stakeholders to provide health to vulnerable populations (Swider & McElmurry, 1990; McElmurry, Tyska, et al., 1999; McElmurry, Buseh, et al., 1999). Academic public health professionals in the city of Detroit have used similar approaches with great success (Lantz, Viruell-Fuentes, Israel, Softley, & Guzman, 2001). Despite the many challenges, an important conclusion drawn from this approach is that a community-based participatory process allows universities and communities to establish partnerships and create learning opportunities where faculty, students, and staff gain real-world experience in health care delivery.

Conclusions and Recommendations

These findings indicated that the nurse-CHA model was effective in the Latino immigrant communities. The role of the CHA complemented and strengthened that of the community health nurse.

This nurse-advocate framework allowed for flexibility in helping clients of different cultural backgrounds to obtain health care appropriate to clients' needs. The nurse-CHA teams were willing and able to respond to the diverse needs of the clients they served, illustrating Schorr's (1997) point that effective responses to community development are interactive responses between technical assistance and community residents, rather than traditional "bottom up" or "top down" processes.

Previous studies have indicated that what works in community-based health care is noncategorical, comprehensive, and integrated family-focused strategies for expanding access, reducing costs, and improving quality of health care (Feetham, 1997; Schorr, 1997). CHAs teamed with nurses can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems. If properly recruited and trained, CHAs reduce costs by providing health education, health screening, and increased quality of care. At the same time, they are also contributing to patient-provider communication, continuity, and consumer protection. The nurse-CHA framework is one way to improve the health of people.

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