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Engaging Community Health Workers in Primary Care Practices:

Provider Understanding of Roles, Benefits, and Barriers

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Abstract

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Community health workers (CHWs) are increasingly addressing health disparities in primary care settings; however, there is little information about how primary care practitioners (PCPs) interact with CHWs or perceive CHW roles. We examined PCP engagement with CHWs in adult primary care settings. Overall, 55% of 1504 PCPs reported working with CHWs; involvement with CHWs differed by some PCP demographic and practice-related factors. While PCPs perceived CHWs as engaging in most nationally endorsed CHW roles, they identified several barriers to integrating CHWs into care teams. Findings can inform ongoing efforts to advance health equity through integrating CHWs into primary care practices.

Keywords

community health workers; health care teams; health equity; primary care practitioners

INTRODUCTION

Disparities in health and wellness have been documented in the United States and are due to many factors, including unequal access to care health care (Minas et al., 2020), as well as nonmedical factors that influence health outcomes (Alcaraz et al., 2020; Coughlin, 2020, 2019; Krok-Schoen et al., 2015; Chattopadhyay, 2020). Barriers to preventive services and recommended care often include fear or distrust of the medical community, lack of or inadequate health insurance coverage, financial hardship, low levels of health literacy and education, and logistical issues, such as lack of transportation (Katz et al., 2014; Rohan et al., 2016). Community health workers (CHWs), with a long history of working in communities, are increasingly working to address these challenges within health care settings (Malcarney et al., 2017). The American Public Health Association defines a CHW as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery” (American Public Health Association, 2023). CHWs may have a variety of titles, including *promotores de salud*, community health representatives, community health advisors, and peer navigators, and have long been part of the US public health system (Brownstein et al., 2011; Community Health Worker Core Consensus Project, 2013; Kangovi et al., 2015) and community-based organizations (Martinez, 2008).

Research has demonstrated that CHWs are effective in increasing screening use for breast (Guide to Community Preventive Services, 2023a; Wells et al., 2011), colorectal (Guide to Community Preventive Services, 2023b), and cervical cancers (Guide to Community Preventive Services, 2023c; Okasako-Schmucker et al., 2023), helping manage chronic conditions, such as diabetes and cardiovascular disease, and helping manage risk factors, such as high blood pressure and cholesterol (Jacob et al., 2019; Vasan et al., 2020). CHWs also promote health equity by helping individuals address social determinants of health (SDoH), such as food insecurity, housing, transportation, and childcare, as well as advocating for policies that support health equity (Enos, 2019; Gunderson et al., 2018; Kangovi et al., 2015; Katz et al., 2014; Minkler et al., 2010; Chattopadhyay, 2020; Roland

et al., 2017). The Centers for Disease Control and Prevention (CDC) has long recognized the contributions of CHWs in clinical and public health practice. Most recently, in 2021, funding for the Community Health Workers for COVID Response and Resilient Communities was provided by CDC to support hiring, training, and deployment of CHWs nationwide across 67 organizations with an investment of more than \$340 million (Centers for Disease Control and Prevention. Community Health Workers for COVID Response and Resilient Communities [CCR], 2023).

Primary care practitioners (PCPs) may also play an important role in reducing health disparities (Coughlin et al., 2019) by providing care to those with chronic conditions, offering chronic disease management counseling, encouraging patients to receive recommended screenings, and referring patients to appropriate services and interventions. Incorporating CHWs into primary care teams can improve patient outcomes (Ferrer et al., 2022); however, barriers to effectively integrating CHWs into primary care teams and programs persist (Gore et al., 2020; Greenwood-Ericksen et al., 2021; Gupta et al., 2023; Sherman et al., 2017). For example, some health care providers have reported struggling to identify CHWs and meet existing needs in clinical settings, and funding CHW positions can be challenging (Greenwood-Ericksen et al., 2021; Sherman et al., 2017). Members of multidisciplinary care teams have reported a lack of information about CHW roles, scope of practice, and clear workflows (Gore et al., 2020; Greenwood-Ericksen et al., 2021).

There is little information about how PCPs, in general, interact with CHWs or perceive CHW roles. Using a nationally endorsed framework for CHW competencies and roles (Community Health Worker Core Consensus Project, 2013), we sought to better understand PCP awareness and understanding of and engagement with CHWs in adult primary care settings. Specifically, we sought to answer several research questions: (1) Are there differences in PCP involvement with CHWs based on PCP demographics, practice characteristics, and patient profiles? (2) Among PCPs who report involvement with CHWs, what is their knowledge of CHW roles, and what do they perceive as the benefits of and barriers to working with CHWs? and (3) Among PCPs who have not worked with CHWs, what could facilitate engagement with CHWs? Gaining additional insight into provider knowledge gaps can help public health practitioners facilitate better integration of CHWs into primary care settings to reduce health disparities.

METHODS

We used data from the fall 2022 DocStyles survey, a web-based survey of PCPs (internists, family practitioners, obstetricians/gynecologists [OB/GYNs], pediatricians, nurse practitioners, and physician assistants) commissioned by Porter Novelli Public Services and fielded from September 9 to November 3, 2022 (Porter Novelli Public Services, 2023). Five questions about working with CHWs were included in the survey, which contained 109 survey questions in total. Since the CHW-related questions pertained to chronic illnesses primarily seen in adults, they were not asked of pediatricians. Respondents were paid an honorarium of \$50-\$65. The data did not include identifiable information, and this activity was reviewed by CDC and was conducted in accordance with applicable federal law and CDC policy.

Survey respondents

Detailed methodological information on DocStyles can be found at <https://styles.porternovelli.com/DocStyles/>. Potential respondents were recruited from Sermo's (online platform for health care providers) verified Global Medical panel (www.sermo.com). Invitations to participate included a link to the web-based survey. Only responses from primary care clinicians who were actively practicing in the United States, working in an individual, group, or hospital practice, and had been practicing for at least 3 years were included in the final database. No individual identifiers were included in the database.

In total, 2669 health professionals were invited to participate in the survey, and 1755 completed the survey, for an overall response rate of 65.8%, with response rates ranging from 59% among OB/GYNs to 68% among both nurse practitioners and physician assistants. After excluding the pediatricians from the analytic sample, the final analytic sample included a total of 1504 respondents.

Data collection

CHW questions (Supplemental Digital Content, Appendix A, available at: <http://links.lww.com/JACM/A144>) explored respondents' interactions with CHWs in the PCP clinical setting. The questions were guided by the framework from the Community Health Worker Core Consensus (C3) Project on CHW roles and competencies (El Mp et al., 2014–2022) and drawing from a report on the impact of CHWs in Arizona Primary Care (Arizona Prevention Research Center, 2015). Survey respondents were first provided a standard definition (American Public Health Association, 2023) of a CHW and were then asked, "In what ways have you been involved with CHWs?" Response options included: (1) whether the respondent self-identified as a leader/champion that oversees the implementation of CHW staff or program, (2) worked directly with CHWs, (3) had indirect involvement (eg, "I do not work directly with CHWs, but my staff or my colleagues do and/or I receive information from those who work with CHWs"), or (4) had no involvement with CHWs.

Respondents who indicated at least some level of involvement with CHWs were asked a series of questions about their perceptions of the roles and functions of CHWs, outcomes of working with CHWs, and barriers to integrating CHWs into health care teams. For example, respondents were asked if the CHWs they worked with performed any of the 10 core roles (Greenwood-Ericksen et al., 2021). Next, survey respondents were asked, "As a result of working with CHWs, I think patients are more likely to. . ." with the following items as multiple selection response options: maintain regular care, better manage their chronic disease, have more effective communication during office visits, have better access to care, follow medical recommendations, attend scheduled appointments, and be up-to-date on preventive screenings. Finally, survey respondents with CHW involvement were asked, "What are the barriers you face in fully integrating CHWs into your health care team?" with multiple selection options related to financing, workflow, and knowledge of the CHW workforce.

Respondents indicating no involvement with CHWs were asked, "What would make you more likely to engage CHWs as part of the health care team? I would need more information

about. . .” Multiple selection response options included: the roles and functions of CHWs, the value of CHWs in improving outcomes, reimbursement for CHW services, and how CHWs link to a primary care team. Respondents also had the option to select either “not sure” or “none of the above.”

Data analysis

We conducted chi square tests to compare respondents who reported involvement with CHWs to respondents who did not interact with CHWs, comparing provider- and practice-based characteristics such as age, sex, race and ethnicity, medical specialty, number of years in practice, geographic region of the United States, geographic location type (urban, metro, and rural), type of practice, type of clinical setting, average number of patients seen per week, and average household income of patients. Respondents could select multiple types of medical practice settings to best describe their practice type; however, we created a mutually exclusive variable giving priority to more specific, but less frequently selected, categories (eg, Federally Qualified Health Centers [FQHCs], Urban Indian Health Clinics/Indian Health Service or Tribal Clinic or Hospital) to better understand CHW involvement in those specific settings. Our threshold for statistical significance was set at $P \leq .05$, and all P values were corrected for the false discovery rate (Benjamini Hochberg, 1995; Glickman et al., 2014). Among respondents who reported CHW involvement, we calculated descriptive statistics for perception of CHW roles, perceived patient benefits from interacting with CHWs, and perceived barriers to engaging CHWs in primary care. Finally, among respondents who did not report engagement with CHWs, we calculated the percentages of respondents indicating each type of activity that may be needed to incorporate CHWs into their work. We used SAS 9.4 and Microsoft Excel to conduct analyses.

RESULTS

Among 1504 survey respondents, 55% ($n = 829$) reported engagement with CHWs, either directly or indirectly, and 45% ($n = 675$) reported no involvement with CHWs (Table 1). Most survey respondents were under age 50 (63%), male (57%), and identified as non-Hispanic White (61%). Survey respondents were primarily internists (36%) or family practitioners (30%), who more often reported having been in practice for less than 20 years (64%). Most respondents worked in a group outpatient setting or clinic (65%) and practiced in a suburban setting (51%).

Respondents who reported higher levels of involvement with CHWs relative to the respective comparison groups were under age 40 (59%; $P = .05$), were nurse practitioners (65%; $P = .05$), and practiced in urban areas (60%; $P = .03$) (Table 1). Involvement with CHWs was highest for respondents working in urban American Indian/Alaska Native or tribal health clinic settings (100%), FQHCs (79%), and community health centers (71%) ($P < .0001$). Involvement with CHWs was also higher among respondents seeing 125 or more patients per week (62%; $P < .01$) and respondents who more frequently saw patients with household incomes below \$25 000 - per year (68%; $P = .05$). Involvement with CHWs was

less frequently reported among respondents practicing for 30 or more years (47%; $P = .05$) or who had an individual outpatient practice (48%; $P = .05$).

Perceived community health worker roles

Respondents who worked with CHWs most often reported that CHW colleagues performed care coordination/case management/system navigation (80%), advocated for the needs of individuals and communities (79%), provided coaching and social support (74%), provided culturally appropriate health education and information (74%), conducted outreach (68%), provided a bridge/cultural mediation (66%), and implemented individual or community assessments (65%) (Figure 1).

Perceived patient benefits of receiving community health worker services

Respondents who worked with CHWs reported the following patient benefits resulting from CHW participation in health care delivery teams: improved access to care (71%), maintaining regular care (66%), better managing their chronic disease (63%), following medical recommendations (61%), and attending scheduled appointments (59%) (Figure 2).

Perceived barriers to engaging community health workers in primary care

Respondents who worked with CHWs identified the following as barriers to collaborating with CHWs: concerns about lack of reimbursement/inability to bill insurers for CHW services (45%), difficulty recruiting CHWs (40%), and lack of clarity about how they function as members of the care team or link to primary care (33%, Figure 3). Additionally, respondents who did not report engaging with CHWs also indicated it would be beneficial to have more information on the roles and functions of CHWs (40%), how CHWs link to the primary care team (36%), and the value of CHWs in improving outcomes (36%, Figure 4).

DISCUSSION

Our examination yielded several differences regarding PCP engagement with CHWs in adult primary care settings, including their perceptions of CHW roles, perceived benefits to patients receiving CHW services, and perceived barriers to engagement with CHWs. Among the 55% of PCPs who reported working with CHWs, involvement differed somewhat by PCP demographic and practice-related factors. The finding that younger and less experienced providers are more likely to work with CHWs could be because medical education and residency programs are newly beginning to emphasize the role of CHWs and SDoH in shaping health outcomes (Kangovi et al., 2018). Continuing medical education courses on the role of CHWs and the value of integrating them into health care practices may be helpful for the 45% of providers who do not interact with CHWs, particularly those who are more seasoned. Because providers working in rural areas are less likely to work with CHWs, there may be a need for workforce development to support CHWs in rural communities, particularly given evidence that CHWs improve access to care in rural settings (Berini et al., 2022). Our findings that PCPs affiliated with urban American Indian/Alaska Native or tribal health clinic settings, FQHCs and CHCs, nurse practitioners, PCPs seeing a high volume of patients per week, and PCPs seeing patients with lower household incomes reported higher involvement with CHWs were not unexpected, given that many FQHCs

have a long history of robust CHW programming (Gore et al., 2020; Greenwood-Ericksen et al., 2021; Roland et al., 2017) and that CHWs generally work with under-resourced communities (Fingerhood, 2018; Viswanathan et al., 2010).

As with a previous study of PCPs in Arizona (Arizona Prevention Research Center, 2015), our findings demonstrate that providers perceive CHWs to be engaging in most nationally endorsed CHW roles (Community Health Worker Core Consensus Project, 2013). Provider understanding of what CHWs do is essential to successful integration of CHWs into the health and public health workforce, since prior studies have shown that limited knowledge of CHWs scope of practice within an organization presents a major challenge to CHW effectiveness (Sherman et al., 2017; Wennerstrom et al., 2015). Providers in this sample generally appear to understand CHW roles, particularly those that are tied to promoting health equity and addressing SDoH (eg, individual and community advocacy, providing culturally appropriate health education, and assessing individual and community needs), in addition to those that are more clearly connected to promoting health care access (eg, service coordination). This is promising, since there is evidence that CHWs working in well-integrated health care teams routinely address health disparities (James et al., 2019; Johnston et al., 2019; Mobula et al., 2015; Paulson et al., 2021) and empower patients to advocate for themselves more effectively with PCPs (Paulson et al., 2021). As well, participants' perceptions of how CHWs benefit patients (eg, by increasing access to care, better managing chronic health conditions, following medical recommendations, having more effective communication with office visits, and being up-to-date on preventive screenings) are consistent with evidence that CHWs do, indeed, contribute to such outcomes (Berini et al., 2022; Guide to Community Preventive Services, 2023a, 2023b, 2023c; Jacob et al., 2019; Vasan et al., 2020). These findings also suggest that PCPs familiar with CHWs value their professional contributions.

Our finding that PCPs perceive that funding is a barrier to fully integrating CHWs into health care teams is consistent with other studies (Arizona Prevention Research Center, 2015; Wennerstrom et al., 2015). CHW positions are largely grant-funded, and, despite numerous (Guide to Community Preventive Services, 2023c) efforts to establish sustainable financing approaches for CHW services over the last decade, significant challenges remain. For example, Medicaid State Plan Amendments (SPAs) have been granted in several states to allow for payment of some CHW service. Reimbursement for CHW services may help to incentivize provider groups to recruit and retain CHWs. SPAs generally support a fee-for-service (FFS) reimbursement model, which may lack clarity in state CHW reimbursement policies and billing codes and processes (Gunter et al., 2023). Moreover, Medicaid FFS models are unlikely to support CHWs in enacting roles that are not directly related to patient care (eg, advocacy and social support), and they cannot serve uninsured populations (Centers for Disease Control and Prevention. Community Health Workers for COVID Response and Resilient Communities (CCR), 2023).

Strengths and limitations

This study has several strengths. To our knowledge, this is the first study using a nationally derived sample of PCPs to describe their involvement with CHWs and their perception

of the CHW role. This study also has a relatively large sample size and had a high response rate. Limitations include that self-reported data can be participant to recall bias and social desirability bias. Another limitation is that we did not conduct cognitive interviews to test survey questions; however, the questions were reviewed and approved by Porter Novelli survey experts. Furthermore, it is worth noting that percentage of providers working in FQHCs and tribal settings was relatively low, even though both are known to have well-developed CHWs programs so it is possible that the perspectives of some providers very familiar with CHWs were not included. The survey respondents are not necessarily representative of other providers in their fields of medicine, so the findings may not be generalizable to all PCPs.

CONCLUSION

The findings of this study can inform ongoing efforts to advance health equity through the integration of CHWs into primary care practices. The need for PCPs to have a clear understanding of the roles, skills, and qualities of CHWs is especially important now, due to recent national-level policy developments that have the potential to change the landscape of how CHWs are engaged and funded in clinical health care. Specifically, the 2024 Physician Fee Schedule final rule (Centers for Medicare Medicaid Services, 2023) issued by the Centers for Medicare and Medicaid Services (CMS) includes the availability of separate Medicare payments for collection of SDOH information from patients, an activity that could be performed by CHWs. Additionally, the CMS rule created new codes to enable billing for community health integration services to address health-related social needs, another area where CHWs have expertise. CHWs, along with their allies such as public health practitioners who authentically engage CHWs (ie, include CHWs in decision-making and leadership roles), are uniquely positioned to educate health care providers and practices about the roles of CHWs. In particular, CHWs and allies could collaborate to develop continuing education modules on CHW roles and activities for practicing physicians, as well as curricula for medical schools and residency programs. They may also support integration of CHWs into primary care practices so that CHWs can contribute to providing patient-centered care, including recognizing and addressing social needs at the individual, family, and community levels. We hope this initial study provides a foundation for future studies to more fully understand the barriers to integrating CHWs into primary care settings, which could support the development of resources needed to more effectively integrate CHWs into primary care settings.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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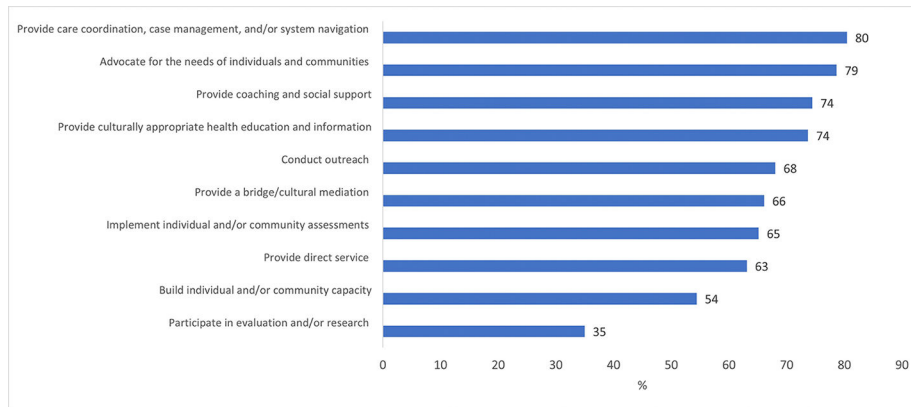


Figure 1.

PCP perceptions of CHW roles, among providers with CHW involvement n = 829. Figure represents the percent of providers indicating “yes” to each role. Respondents with “not sure” answers were included in the denominator. CHW, community health worker; PCP, primary care practitioner

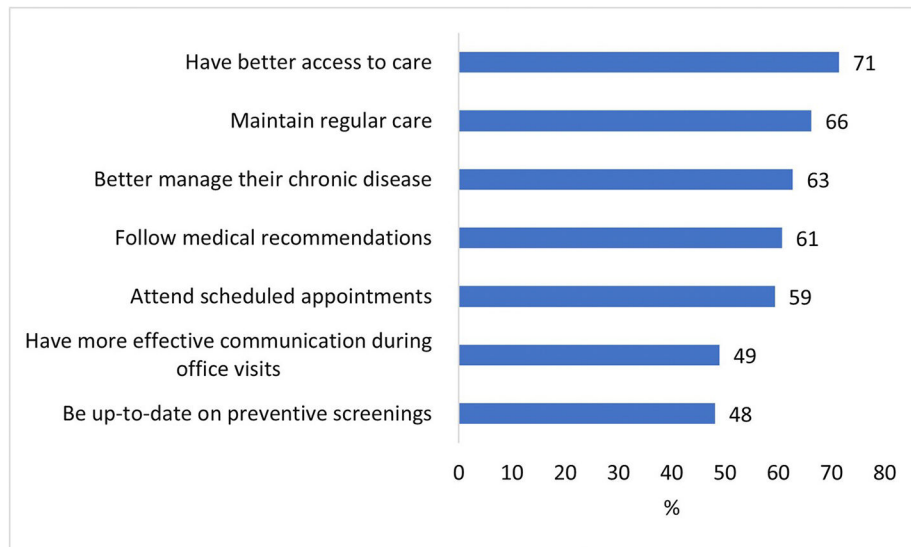


Figure 2.

PCP perceived benefits for patients who receive CHW services, among providers with CHW involvement n = 829. 1.7% of survey respondents answered “not sure” to this series of questions, and 1.2% reported “none of the above.” CHW, community health worker; PCP, primary care practitioner.

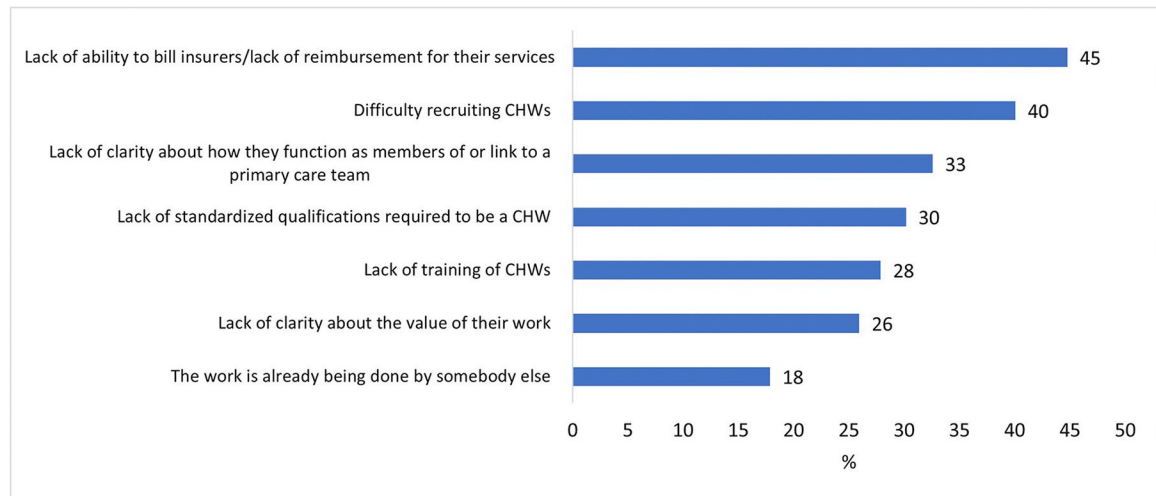


Figure 3.

PCP perceived barriers to integrating CHWs into health care teams among providers with CHW involvement, n = 829. 5.8% of survey respondents answered “not sure” to this series of questions, and 6.4% reported “none of the above.” CHW, community health worker; PCP, primary care practitioner.

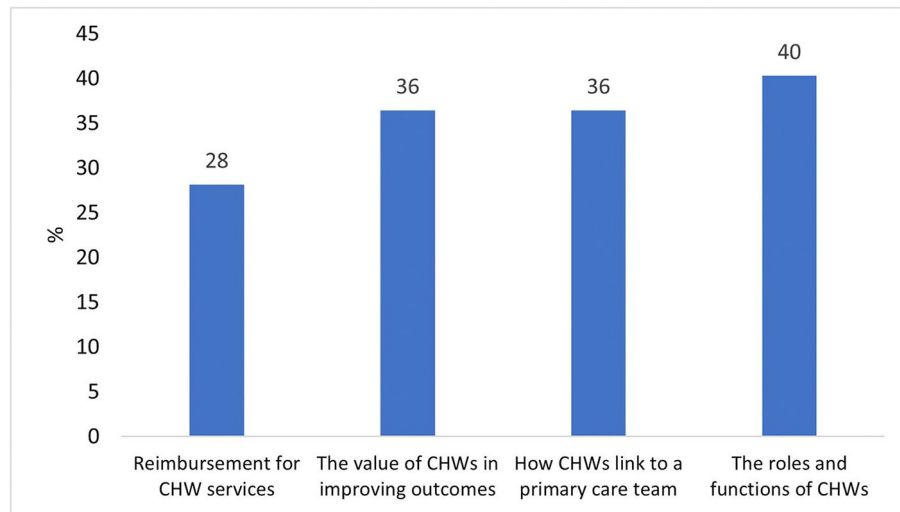


Figure 4.

Factors that could support engagement of CHWs as part of the health care team, among providers with no CHW involvement n = 675. 21.5% of survey respondents answered “not sure” to this series of questions, and 11.1% reported “none of the above.” CHW, community health worker.

Table 1.

Provider and Medical Practice Characteristics of Primary Care Practitioners Overall and by Their Reported Involvement^a With Community Health Workers (N = 1504)

Characteristics	Total		Reported Involvement With CHWs (n = 829)		P value ^b
	n	Col %	n	Row %	
Total	1504		829	55.1	
Provider characteristics					
Age group, y					
<40	511	34.0	300	58.7	.05
40–49	430	28.6	243	56.5	
50–64	444	29.5	230	51.8	
65+	119	7.9	56	47.1	
Sex					
Female	630	41.9	331	52.5	.05
Male	861	57.3	487	56.6	
Prefer to self-identify	13	0.9	11	84.6	
Race and ethnicity					
American Indian/Alaska Native/other/multiracial (non-Hispanic)	97	6.5	57	58.8	.12
Asian/Pacific Islander, non-Hispanic	340	22.6	200	58.8	
Black/African American, non-Hispanic	52	3.5	30	57.7	
Hispanic/Latino	99	6.6	62	62.6	
White, non-Hispanic	916	60.9	480	52.4	
Medical specialty					
Family practitioner	457	30.4	259	56.7	.05
Internist	545	36.2	303	55.6	
Nurse practitioner	123	8.2	80	65.0	
Obstetrician/Gynecologist	251	16.7	127	50.6	
Physician assistant	128	8.5	60	46.9	
Years in practice					
3–9	462	30.7	263	56.9	.05
10–19	503	33.4	293	58.3	

Characteristics	Total			Reported Involvement With CHWs (n = 829)			P value ^b
	n	Col %	n	Row %			
20–29	352	23.4	185	52.6			
30+	187	12.4	88	47.1			
Medical practice characteristics							
Practice type							
Community Health Center (not FQHC)	17	1.1	12	70.6			<.0001
FQHC	67	4.5	53	79.1			
Group practice	833	55.4	448	53.8			
Hospital-based practice	338	22.5	195	57.7			
Indian Health Service or Tribal Clinic/Hospital/Urban Indian Health Clinic ^c	5	0.3	5	100			
Managed care organization	36	2.4	24	66.7			
Solo practice	200	13.3	90	45.0			
Other	8	0.5	2	25.0			
Main work setting							
Group outpatient practice or clinic	982	65.3	546	55.6			.05
Individual outpatient practice	231	15.4	111	48.1			
Inpatient practice/hospital	291	19.4	172	59.1			
Region							
Midwest	321	21.3	179	55.8			.82
Northeast	346	23.0	188	54.3			
South	504	33.5	272	54.0			
West	333	22.1	190	57.1			
Geographic area							
Rural	159	10.6	84	52.8			.03
Suburban	772	51.3	400	51.8			
Urban	573	38.1	345	60.2 ^c			
Average number of patients seen per week							
<75 patients/week	430	28.6	205	47.8			<.01
75–99 patients/week	280	18.6	153	54.6			
100–124 patients/week	445	29.6	256	57.5			

Characteristics	Total		Reported Involvement With CHWs (n = 829)		P value ^b
	n	Col %	n	Row %	
125+ patients/week	349	23.2	215	61.6	.05
Annual household income of patients					
Less than \$25 000	100	6.7	68	68.0	
\$25 000–\$49 999	377	25.1	219	58.1	
\$50 000–\$99 999	608	40.4	314	51.6	
\$100 000–\$249 999	282	18.8	158	56.0	
\$250 000 or more	137	9.1	70	51.1	

Abbreviations: CHW, community health worker; FQHC, Federally Qualified Health Center.
All *P* values were adjusted for the false discovery rate.

^a Among all survey respondents, 34% reported indirect involvement with CHWs, and 18% reported direct involvement, with included overseeing a CHW program or serving as a program champion (6% of all respondents).

^b Comparing no CHW involvement to any CHW involvement.

^c Response options “Urban Indian Health Clinic” and “Indian Health Service or Tribal Clinic/Hospital” were combined to protect privacy due to the small number of survey respondents who reported working in either setting.