A Case Study of
The Community Health Worker Network of Buffalo, Buffalo, NY

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Introduction

The Community Health Worker Network of Buffalo (CHWNB) is a unique network that approaches the development of Community Health Workers (CHW's) using a combination of Popular Education, Asset-Based Community Development (ABCD), and Community-Based Participatory Research (CBPR). The following paragraphs describe the development of the network, its approach and practices, obstacles encountered, and efforts to build appropriate success measures.

Buffalo At Crossroads—Needs and Opportunities

Buffalo, NY is a community which has consistently been labeled as troubled, economically depressed, and segregated. The Buffalo-Niagara region is home to some of the worst racial and economic inequities in the nation, with the seventh worst racial segregation of the 362 major metropolitan areas in the nation, and 81.4% of African-Americans living in high-poverty neighborhoods.[i] Almost half of the city's children live in poverty, which is concentrated and inter-generational in the inner-city of the East and West Sides. Buffalo Public School graduation rates have been in the 50% range for decades, with rates for the most vulnerable, such as black males and refugees, in the 20% range. New York leads the nation in health care spending ($180 billion per year), but its rate of death as a result of chronic disease is the highest in the country.[ii] Erie County, where Buffalo is located, ranks 56 out of New York's 62 counties in health outcomes.[iii]

Education and health indicators are closely connected to poverty and to each other. In Buffalo, as in the rest of the country, major investments have been made to improve poor and disparate outcomes. The extremely high costs per capita for education and healthcare in Buffalo in comparison to other cities reflects the same trends as the United States in comparison to other countries. In both cases these investments yield little to no positive change on a systemic level in terms of cost, quality of care, and population health outcomes.

In 2008, looking at these statistics and considering their personal experience, Buffalo residents were alarmed at the reality that their children were set up to live shorter, sicker, less successful lives than their parents. Institutional-based initiatives and large scale investments were not seeming to create the much needed change required to move Buffalo ahead. In the shadow of multi-million dollar, institutional-based investments in a large Buffalo-Niagara Medical campus and a major overhaul and reconstruction of all Buffalo Public Schools buildings, residents felt that there should also be investment in "bottom up" strategies to improve community health and education in their city. To this end, an association of concerned and diverse citizens—representing various sectors, residents and professionals; and across neighborhoods, races, and cultures—and coalesced under the name of the Community Health Worker

Network of Buffalo (CHWNB). This network developed as frontline workers and stakeholders came together in the areas of health care, public health, housing, education, environment, food access, and social services; with the intent to empower community members to define their own challenges and opportunities and take action to self-determine their future.

A Network Based on Assets

In developing a name and framework for their identity, this grassroots network convened around the concept of Community Health Workers (CHWs). Community Health Workers go by many names, including outreach workers, patient navigators, peer health educators, and lay health advocates. Traditionally, CHWs (Russian feldshers, Chinese barefoot doctors, and Latino promotores) have helped people overcome obstacles by accompanying them through treatment, monitoring needs for food and housing, leading education campaigns and empowering community members to take charge of their own health. As members of the communities they serve, CHWs establish relationships of trust with those they serve, bridging the gap between institutions and community.[iv] Community Health Workers embrace a holistic conception of health, working not only in health care, but also with the social determinants of health such as poverty, education, and housing.

The Buffalo CHW advocates connected with the CHW Network of New York City, housed at Columbia University's Mailman School of Public Health, which had received a grant from the New York State Health Foundation to pursue training, credentialing, and reimbursement of CHWs through a statewide coordinated effort. With this support, the CHW Network of New York City provided an initial training on CHW "Core Competencies" for Buffalo CHWs and a small number of other stakeholders (a physician, nurse, executive director of an HIV/AIDS community-based organization) who represented a diverse cross-section of urban Buffalo (by race, ethnicity, gender, age, target population, etc.). The CHWs worked mostly in community-based organization settings with clients who were experiencing outcomes related to social determinants of health.

The Buffalo CHW's and community health advocates were introduced to the rich history of CHW's, as well as the teaching and learning pedagogy of Popular Education (also known as anti-oppressive education) and the strengths-based orientation way of working. They also learned that this was an approach and way of educating, working, and organizing that was being utilized in many other parts of the country and world. So many frontline workers and community advocates had been trained to diagnose what was wrong and deficient in a person and/or a community. Critical to the group's core values was understanding the process and pedagogy by which a CHW works in partnership with an individual, family, and/or community to help identify strengths from which to build on. While recognizing the importance of needs assessments and identification of individual and community level problems and diseases, the Buffalo CHWs and advocates started to see that this was only one way to think about and describe the people, families, and neighborhoods they worked with. Critical to the group's core values was an evolving understanding of the process and pedagogy by which a CHW works in partnership with an individual, family, and/or community to help identify strengths from which to build.

Many of these CHWs were functioning in isolation both within their organizations and within the community, and most had never previously met each other. Many reported after the training that it had

"changed their lives" by giving them a construct to work within and through, and a learning community through which to understand their practice. In a period of six months, 25 CHWs and CHW advocates received the five-day training Core Competencies for Community Health Workers, and four were trained as trainers so that Buffalo could have the ability to develop and implement a local training team. A CHW community forum was conducted and attended by 70 people, and a stakeholder CHW learning day was held, attended by 40 people identified as key decision makers in Buffalo (funders, non-profit executives, leaders in health care, and academia, etc.) A small grant was secured from the Health Foundation for Western and Central New York that provided support for a project director (a resident/founder of the CHWNB) to facilitate a three month planning process that included the formation of a CHW advisory board, data collection and key informant interviews, community forums, continued work with the New York City based training, credentialing and reimbursement initiative, fund and program planning, and the production of a white paper.

As the CHWNB began to develop, evidence of transactional and transformational change began to bubble up. CHWs, often the lowest person in their organizational hierarchy, were empowered to see their critical role in understanding and building capacity in the most vulnerable patients, clients, and residents. They saw how they were uniquely positioned to be a bridge between different job roles within their organization, sectors of work in the community, and residents on opposite sides of the city. These CHWs brought a new perspective into the institutions, organizations, and neighborhoods they were serving. Additionally, a community-based social and professional network began to form. CHWs working in clinics focused on disease management began to form a knowledge base of contacts within the housing, mental health, and nutrition sectors. Community organizers, outreach workers, parent facilitators, peer counselors, church and block club members began to see themselves as more similar than different through the construct of "Community Health Workers," and a learning community through which to understand their work and practice was established.

Through research associated with the strengths-based way of working of CHW's, the CHWNB discovered Asset Based Community Development (ABCD). This was very much in line with the network's recognition that it is not enough to deliver health services to a community; instead, the residents of a community must become the co-producers of community health, building from the community's existing assets to address root causes of poor health. Although the CHWNB was working intuitively and organically without "naming" their categories of work, they were developing three foundational pillars of how they were identifying themselves, educating, and organizing:

The CHWNB was made up of people who were Community Health Workers (natural helpers, who were people of and from the community they serve), and CHW allies and advocates.

Teaching and learning happened in a way that is based in Popular Education principles and practices. Education—in trainings, workshops, and meetings—was facilitated in a pedagogy developed by Brazilian educator Paulo Freire where everyone teaches and everyone learns (including the facilitator) and the goal is a just, equal, and truly democratic society. Popular education is highly participatory and aims to create a learning environment that uses principles and practices that are accessible to all people, including those with limited formal education and low levels of literacy.

The community was being organized through the CHWNB based on Asset-Based Community Development (ABCD). This grassroots, resident-driven, locally focused, engagement-oriented framework employed asset mapping and asset mobilizing in both formal and informal ways to empower individuals and communities.

Balancing complex and competing interests

The CHWNB had formalized by 2010 and secured a larger grant from the local community health foundation to support their work, which was administered by a community center on Buffalo's West Side as the network worked to incorporate and apply for non-profit status. The Board of the CHWNB worked diligently, through a community-based process, of defining and beginning to actualize their mission of: "We provide opportunities for the residents of vulnerable neighborhoods to realize their full potential for health and well-being. We achieve this through empowerment and asset-building strategies for individuals and communities, developed and delivered by a diverse collaboration of Community Health Workers, community members, advocates and other stakeholder groups." Organization vision and values centered around seeking to build effective, trusting, respectful relationships with the community and its members and to do whatever it takes to help the community leverage their assets. There was also a strong emphasis on collaboration, and bringing people together in a way to emphasize a common set of values, inclusiveness and diversity.

The emerging CHWNB found ABCD to be a compelling approach, because it aligned with their core values, and the belief that even in under-resourced neighborhoods, all sorts of assets can be found and mobilized toward health improvement. Working from an asset- or strength-based foundation resonated with the idea that CHWs could be instrumental in mobilizing residents to be powerful agents of change, for improving their community and thereby improving opportunities for health.

The network began to work to develop a structure that could create legitimacy for the CHWs it would help train and mobilize, yet enable them to maintain a grassroots approach to their work. The network began to offer training, professional development, and networking opportunities to increasing numbers of residents, CHW's, and other frontline workers and stakeholders through a variety of activities such as an intensive 4 day core competencies training, monthly lunch meetings, quarterly community forums, and other learning opportunities; and explored innovative opportunities for CHWs by conducting research on frontline health workers in a framework of asset-based community development. Part of their initial grant was an initiative that would fund three mini-grants/pilot projects where CHWs were focused on the social determinants of health in an ABCD context, including education (community empowerment teams in four schools designated as "persistently low achieving" by the U.S. Department of Education), nutrition/food access (a farmers' market across from the Erie County Medical Center, in an economically depressed area of Buffalo), and family/social networks (organizing refugee women to share their experiences with the health care system via the development and performance of a play at a local theater). In these bottom-up, asset-driven health improvement projects, CHWs acted as agents of social change to create healthier and more empowered communities and individuals. Project leaders and participants reported increased efficacy and self-sufficiency, and tangible opportunities were created that were leading to parents creating policy change in the Buffalo Schools, fresh fruits and vegetables being provided to residents in a food desert, and refugee women were gaining visibility and forming their own networks of support in Buffalo.

Additionally, the CHWNB believed it to be imperative that as they served individuals, families, and communities, they also addressed systemic and root cause issues that could help or hinder a healthy, educated, thriving population. The CHWNB began to research and advocate for policy and systems change in areas such as making Buffalo Public Schools healthier and safer and universal (single payer) healthcare. The network hosted community forums, brought in national experts, and worked with local academics to generate and share best practices around research, policy change, and tool-kits for advocacy. CHWNB leaders were instrumental in writing and securing passage of a Buffalo Schools Wellness Policy, pushed to get recess reinstituted, advocated for a comprehensive health education curriculum in the schools, and filed a complaint against the school district with the New York State Education Department on their lack of compliance with state regulation on physical education. They also started a chapter of Physicians for a National Health program and became leaders in New York State around "healthcare of all" advocacy when most healthcare reform advocates were focused on Medicaid Redesign and the Affordable Care Act. Through their efforts, the CHWNB became increasingly effective utilizing the media as a platform for awareness, education, and community change.

While the CHWNB and those who participated in the ABCD/CHW pilot projects found them to be enormously empowering, the outcomes were largely short-term and qualitative. And as the CHWNB become more vocal and effective as community organizers, most funders and institutions were not interested in supporting their policy work (this even became a liability for the network as they were seen as "adversarial" when they were advocating for change in an assertive way that challenged the status quo). It was difficult to create a case for ongoing support, and the CHWNB's primary funder was focused in large part on the health care sector versus the larger context of the social determinants of health. The CHWNB was facing increasing pressure to formalize CHW's and fit them into the healthcare delivery system. Another local foundation provided support for a feasibility study to explore if a Community Health Worker (CHW) training and development center in Buffalo and/or Western New York would be logistically feasible and fiscally sound. Through a six month, comprehensive process that utilized an overview of literature on this topic, interviews with 46 stakeholders, and surveys/focus groups; it was determined that such a center for the geographic area was not feasible. The study highlighted the deep disconnections that existed between communities most impacted by health and education disparities and the systems that serve them, as well as between various community sectors. Such a collaborative endeavor would have been difficult given this environment.

The phase of the CHWNB and the findings that came out of the feasibility study painted a picture of institutions and organizations that wanted to do better, that saw opportunities, and that were curious about a new approach. However, these same stakeholders also reflected a distrust of ways of working that are indeed different, i.e. we want innovation, but we also want best practices, standards and a data-driven business model. The CHWNB found it challenging to incorporate these competing needs as the network valued innovation, which meant that "best practices" needed to be considered in the context of the assets of a specific place and in an environment of change, and that such best practices could also become quickly outdated. Additionally, there was a strong divide between perceptions in regard to CHW roles, responsibilities, and the scope of practice between CHWs/community representatives and non-CHW's/institutional representatives. The CHW language and way of working of neighborhoods was different than healthcare or academic institutions, and each neighborhood and institution had its own

culture as well. Stakeholders interviewed for this study seemed to want the community to be empowered and take care of itself. However, institutional decision-makers generally did not feel comfortable giving grassroots organizations—of and from the communities they serve—significant resources to develop the knowledge and tools they need, because they were perceived to lack capacity to manage large-scale resources or initiatives. While this was a valid concern, there did not seem to be an interest in supporting communities to build capacity in order to develop their own infrastructure for self-sufficiency.

A CHW workforce development survey was also conducted in order to assess the impact of the CHWNB training on CHW effectiveness in the job market. CHW's generally reported extremely high rates of satisfaction and feelings of empowerment immediately post-training, but continued to struggle with implementing strength-based practices in their workplace and working with clients/patients where needs assessments/deficit models were often employed. They also experienced high rates of job turnover as most CHW jobs were funded by time-limited grants, and they had difficulty finding a CHW-type job.

Embracing the difficult and messy work of ABCD

After starting out extremely grassroots, and then spending significant time and resources on formalizing and working to gain legitimacy, the CHWNB is now working to find a middle path and to find new ways to measure the value of their work and create a business plan for the sustainability of the organization as well as CHW's in various sectors.

The CHWNB is developing the organization as a capacity builder, community trainer, and convener. Their community-based training and technical assistance services are delivered by a diverse training team of CHW's as well as a physician, academic, and public health professional. The CHWNB is promoting a framework of core competencies skills (one of which is ABCD) that promote effective and high-impact engagement with the populations that both frontline workers and organizations/institutions they serve. Core competencies provide meaningful knowledge, skills, and practices that empower neighborhood residents, community associations and organizations, and other groups to organize and plan around their assets in a framework of strengths-based approaches and asset-based community development. Instead of being absorbed into organizations and institutions, the CHWNB and CHW's are working to develop community-based engagement strategies that promote positive outcomes in the hardest to reach and most at-risk populations that organizations and institutions serve.

Through the difficult, messy, and extremely time-consuming work of relationship building, the CHWNB is uniquely positioned within the community to serve in multiple roles. It has earned the trust of CHWs and many community-based organizations, and is seen as a champion of underserved individuals and communities. The CHWNB is ideally placed to educate the public about CHW roles and responsibilities and address awareness challenges, (i.e., healthcare organizations accepting and validating CHWs as a legitimate workforce and non-healthcare organizations accepting CHWs skills standards for existing workers); serve as a liaison and conduit between CHWs and community training program(s); develop the business case for the utilization of CHWs; and serve as a contributing partner both in the development and implementation of a CHW training curriculum. The CHWNB is slowly gaining legitimacy as a group who can provide training and technical assistance to both CHW's/frontline workers, as well as organizations, institutions, and professionals who may need assistance in understanding the need and

assets of the community. One large contract (NYSDOH) and several small contracts have been secured in the past year. An additional grant has been secured from a local foundation for a collaboration with two of the groups who were part of the initial ABCD/CHW projects two years previous (the District Parent Coordinating Council of Buffalo Public Schools and Ujima Theater Company) to support collaboration between education, arts/culture, and health.

Measuring Impact and Building Capacity

Integral to the identity, work, and organizing of the Community Health Worker Network of Buffalo is the fact that the network is made up of natural helpers of and from the community being served. These Community Health Workers are teaching and educating through Popular Education, and organizing through Asset-Based Community Development. As an organization and movement, the CHWNB has been able to demonstrate pockets of success and positive outcomes through its training and community building work. Much of the evidence for this success is qualitative and process-oriented. Additionally, because the CHWNB works across the social determinants of health and the nature of its work is collaborative, it is difficult to isolate the impact the CHWNB is having in the community.

Successes of the CHWNB include:

- The training and mobilization of several hundred CHWs and CHW stakeholders in various organizations and initiatives working in the social determinants of health.
- Raising the profile and creating a movement and/or workforce of CHW's who were previously unorganized and unidentified, and an increase in reported efficacy of CHW's based on job satisfaction and level of community engagement.
- The development of a training curriculum including core competencies for CHW's, popular education, ABCD, and examples/pilot projects for developing ABCD-centered community initiatives that has been increasingly utilized by organizations.
- The creation of two major policy platforms around national health insurance (including the formation of a local chapter of Physicians for a National Health Program) and Coordinated School Health in Buffalo Public Schools (which lead to the creation of a Wellness Policy in the schools, and major strides in the areas of physical activity, nutrition, and health education); as well as many other smaller scale policy and advocacy initiatives.

Challenges associated with the CHWNB approach include:

- Positioning CHW's as natural helpers with a high degree of autonomy vs. credentialed CHW has created a diverse continuum which makes it difficult to identify and measure progress in the CHW movement and workforce.
- Lack of clarity, or at times less-than-positive feedback, from systems regarding the CHWNB.
- The common view of institutions and funders of residents as patients, clients, and/or recipients rather than actors on behalf of their own health and well-being.

- Contemporary emphasis on "results based accountability" and quantitative, predictive outcomes; which makes a qualitative, interdisciplinary approach more difficult to garner support for.

Conclusion

The CHWNB and CHW's present a promising framework for improving population health and empowering communities. There is a need to balance legitimization of CHW's with the recognition that the true CHW model may be deconstructed/manipulated if appropriated by medical systems in the United States, which have a poor track record in creating health. Emerging research shows that communities that are connected and acting together are more resilient and more likely to do well than those that are simply being served. An integrated approach in which institutions have their appropriate place (and are seen as an asset), and communities have their appropriate place (and are seen as an asset) needs to be explored through collaborative work and an investment of resources to build community capacity. ABCD gives us a framework of principles and practices that allow all people, places, organizations, and institutions to play a role in building a healthier, more equitable and robust America.

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[i] *Share of Population Living in High Poverty Neighborhoods by Race/Ethnicity*, DIVERSITYDATA.ORG (2000 Census Data), http://diversitydata.sph.harvard.edu

[ii] Jacqueline Martinez and James Knickman, "Community Health Workers: a Critical Link in Improving Health Outcomes and Promoting Cost-Effective Care in the Era of Health Reform." NYS Health Foundation (October 2010).

[iii] County Health Rankings and Roadmaps, 2013 Report; University of Wisconsin, Population Health

[iv] Partners in Health, 2012, www.pih.org.