



## **Challenges & Opportunities of Community Health Workers in Buffalo, NY**

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## Abstract

*Although the United States leads the world in medical research and has the best medical technology available, vast health disparities persist. . The U.S. ranks 37<sup>th</sup> on the World Health Organization (WHO) scale in health performance, despite having the highest health care costs in the world at more than twice the average of other industrialized countries.<sup>1</sup> In addition, cities such as Buffalo, NY illustrate another troubling issue – severe racial and economic disparities in health. From diabetes to HIV/AIDS to birth outcomes, there is tremendous evidence to support the case that people of color and those living in poverty suffer disproportionately from poor health in contrast to their white and/or more socio-economically advantaged counterparts. This paper proposes that the attrition of historical roles and responsibilities of communities and families has played a major part in the creation of health disparities in the context of Buffalo. Community Health Workers (CHWs)<sup>2</sup> are a vital workforce and methodology to improve community self-sufficiency, foster meaningful use of health and social service systems, and improve health and well-being in neighborhoods with complex needs.*

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## Health Disparities in America

Social and environmental factors including housing, education, job security, neighborhood safety, and social connectivity provided by family and community, often referred to as “social capital,” can have profound effects on health. These factors are essential to the well-being of a population, and it is imperative that they be integrated into community health planning. Health and social service literature have repeatedly shown evidence that social and environmental conditions associated with high levels of poverty, such as lack of access to quality education and secure employment, domestic and community violence, and substandard housing, create disparities in health. “Disparities in health among different racial, ethnic, and socioeconomic groups in the United States are real and represent a serious threat to our future as a nation.”<sup>3</sup>

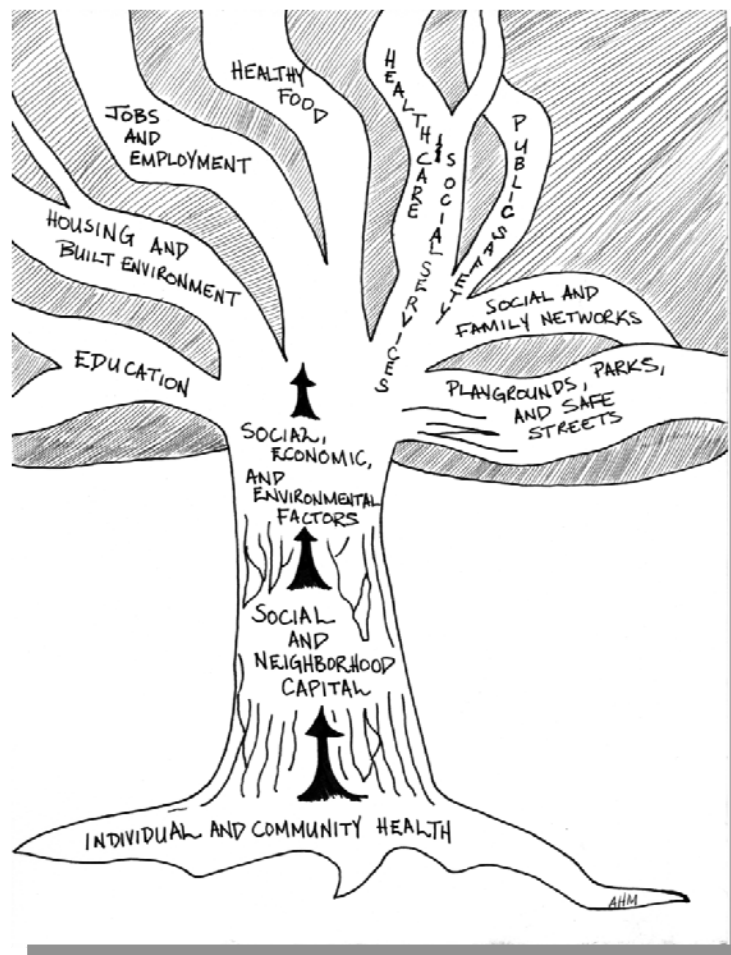
Data across the entire spectrum of health and disease highlight these disparities: Black women have a higher prevalence than White women for four related conditions: heart failure, coronary heart disease, hypertension, and stroke. Blacks experience higher incidence and mortality rates from many cancers that are amenable to early diagnosis and treatment. Hispanics have a higher incidence rate of infection-related cancers (stomach, liver, cervical cancers).<sup>4</sup> Vulnerable populations are ones that are most affected by disparities in social and environmental factors. These populations include the elderly, disabled, and pregnant women and children that live in poverty. In these populations, studies have shown increased risk for pre-term birth, low birth-weight, and related disability and illness in infancy and childhood.<sup>5</sup> There are higher rates of injury, both accidental and intentional, among children living in poverty; and life in poverty may have a detrimental effect on a child's mental health as well.<sup>6</sup> Lack of housing and economic insecurity has been shown to be associated with many poor health outcomes, including higher rates of hospitalization.<sup>7</sup>

The rising burden of diseases of obesity and diabetes in this country illustrate and are inextricably linked to food access and security. In spite of social media campaigns to prevent obesity, obesity rates among our low-income children continue to rise according to recent Centers for Disease Control and Prevention (CDC) reports. The prevalence of obesity in low-income two to four year olds increased from 12.4% in 1988 to 14.5% in 2003 and continued to rise in 2008 to 14.6%. 33% of Hispanic/Latino boys are overweight, as are 35.7% of African-American boys and 51.2% of Mexican-American boys. In the population of young girls, 30.1% of Hispanic/Latino, 46.4% of African-American, and 36.7% of Mexican-American girls are overweight.<sup>8</sup> The term "food deserts" has become common among scholars and community activists to refer to urban areas where there is very little to no access to healthy, whole foods. Many residents in these neighborhoods have no supermarket or other source of fresh food in close proximity, and are forced to shop at corner stores that sell overpriced, processed foods; and to eat at fast food restaurants, which are prevalent in poor and minority communities.<sup>9</sup>

Yet another social indicator that is linked to poor population health is found in the United States prison system, which incarcerates as many as 690 persons per 100,000 citizens, putting us ahead of the Soviet Union as the number one nation in incarceration rates since 1998. This rate is six times that of our neighbor, Canada, and as much as 19 times the rate in Japan, a country that surpasses the United States in many measures of health. Disparity seeps into every aspect of

our prison system: while African Americans are estimated to constitute 13% of illicit drug users, 74% of our prisoners incarcerated for drug possession are African-Americans. It is estimated that 65% of our prisoners have not graduated high school.<sup>10</sup>

When examining disease incidence rates in the context of neighborhoods and populations, and observing the strong correlation between health outcomes and education, housing, food access, and incarceration rates, we see that public health and health care initiatives that focus merely on individual responsibility to “take charge of your health” are limited in their scope due to their lack of consideration of community context. The root causes of disease therefore must drill down to factors that are neighborhood and community-based, and which focus on “social capital.”



**Social, economic, and environmental variables, in addition to health care, have dramatic implications on individual and community health.**

## Health and Economic Disparities in Buffalo, NY

U.S. Census data from 2008 troubled the Buffalo community's consciousness with the stark reality that Buffalo ranks third in poverty among cities of its size. There are multiple sources of data that verify the observed reality in Buffalo that environments of poverty lead to disparities in health and wellness measures across entire spectrums. Buffalo's high rates of poverty, violence, disparity, segregation, and fragmentation prevent meaningful collaboration between individuals, associations, and institutions. Buffalo mirrors many of the "rustbelt" cities in the Northeast in population loss to other parts of the country. This area has been hard hit by sustained loss of the economic base in industry and the change to high technology, with a shift in the economy's needs for specialized, skilled labor. In spite of a large number of higher institutions of learning, there continues to be outward migration of the graduates from these institutions. Census data reflects a continued loss of population since 2000, at 7.8%.

Buffalo's disparate outcomes includes all fields: education, cardiovascular health, cancer rates, high rates of teenage pregnancy, late entry into care for a pregnant woman, obesity, premature births, and high rates of STDs. Poverty in the Buffalo area is concentrated in communities of color, historically the East side (African-American) and West side (Latino and refugee/new immigrant).<sup>11</sup> Many of the households living in poverty in these urban epicenters are headed by single mothers.<sup>12</sup> Residents in Buffalo living below the poverty level in 2007 were 28.7%, compared with the New York State rate of 13.7%. What is even more troubling is that Buffalo's children live in poverty at a rate that is estimated by some to be as alarmingly high as 43%. Disability and unemployment within these impoverished citizens is also striking. Disability rates in Buffalo among poor males were 33%, compared with a state rate of 18.1%. Residents of Buffalo living below the poverty rate have a much higher rate of renting, as contrasted with home ownership, which can be a more secure housing option.<sup>13</sup> Environmental hazards such as the prevalence of lead, mold, and dust in older, rented homes; and air pollution that receives a "failing" grade from the American Lung Association, creates significant health hazards that range from learning disabilities to asthma in children, and a host of chronic diseases in adults.<sup>14</sup> We know from national statistics that there is significant loss of educational advantage when our citizens are incarcerated. In Buffalo, the disparity in educational status exists even without the overlay of crime and violence. Urban Buffalo high school graduation rates were at 52% in 2009, which was actually increased from 45% in 2008. This is in stark contrast to the suburbs

of Buffalo (Clarence, East Aurora, Eden, Barker, Orchard Park, and Williamsville) where graduation rates were at 90-95%. Black male joblessness rate in Buffalo is the highest of any metro area in the nation at 52%, also illustrating tremendous disparity when compared to 24% for White men.<sup>15</sup>

The racial segregation and neighborhood isolation that exists in Buffalo, remains a contributing factor to observed rates of disparities across multiple spectrums. While arguably creating a sense of cohesion, the segregation of these populations in Buffalo has caused marginalization, a sense of social bias, and made larger the racism, gender bias, and exclusion of residents from these isolated neighborhoods in civic representation and civic engagement. There is significant contribution to this ongoing, intergenerational cycle of poverty by the collective fatalism that science has recognized in segregated communities. While communities struggle, their ability to build capacity is impeded by the lack of recognition of the assets that the community may have. Generations of joblessness and poor education have not allowed for the creation of a platform to move toward asset building.

## The History and Status of Community Health Workers

Community Health Workers (CHWs) have a long history throughout time and the world. There is documentation dating back more than 300 years of particular members of communities who assumed the role of helping other community members with health related issues.<sup>16</sup> Examples include Russian *feldshers*, Chinese “barefoot doctors”, and Latino *promotores*.<sup>17</sup> In the United States, CHWs have been used primarily in the past 60 years in low-income and minority communities to address health disparities and social justice issues, with their prominence ebbing and flowing with changes in the social, economic, and political climate.<sup>18</sup> CHWs are frontline public health professionals who are trusted members of or have an unusually close understanding of the communities they serve through shared ethnicity, culture, language, and life experiences. This trusting relationship enables them to bridge social/cultural barriers between communities and health or social service systems. They help individuals navigate complicated and unfamiliar health care systems and help gather information for other health providers that might not be otherwise accessible. CHWs help build individual and community capacity through a range of activities such as outreach, health education, home visiting, community organizing, informal counseling, social support, translation/interpretation and advocacy.<sup>19</sup> There is extensive research to support CHW’s ability to improve quality and access to health systems, as well as reduce cost and address health

equity issues.<sup>20, 21, 22</sup> In addition, recent trends suggest a severe shortage of medical professionals to meet growing demand and disease burden, especially amongst primary care physicians.<sup>23</sup>

Despite evidence to support the utilization of CHWs, the workforce remains fractured and poorly organized. Several states and communities have managed to formalize a CHW workforce through training, credentialing, and reimbursement mechanisms. However, in each instance, there are major challenges to raising the profile and financial viability of a CHW workforce; while maintaining the preeminence of the qualities they possess that are difficult or impossible to regulate, or even teach; including cultural competence, empathy, respect, compassion, and an ability to be trusted by the community they serve. For example, in Minnesota, seen by most CHW advocates to be an example of a successful reimbursable CHW workforce, a credentialed and reimbursed CHW must work under the supervision of a medical professional.<sup>24</sup> This model has the potential to create bureaucracy and alter the approach that CHWs who have been working in non-health care settings (i.e., community-based and faith-based organizations) are accustomed to. Another example of how formalization can jeopardize the CHW profession is found in Texas. Here, certification requirements proved to be difficult for CHWs to meet and maintain; and language, cultural, and financial incentives were not taken into consideration. As such, over a period of six years and through 13 certified training programs, only about 500 CHWs have been credentialed, and only half of those applied for re-credentialing.<sup>25</sup> In the 15 other states that have CHW programs, they are community or disease-specific, and not statewide initiatives.<sup>26</sup>

## Community Health Workers in Buffalo

*“I was a CHW before I even knew what a CHW was and got a job that actually paid me to do this work... this is what I have been doing in my neighborhood all my life.”*

–Yaritza Osorio, Community Health Worker, Northwest Buffalo Community Health Care Center

In 2008, a group of community advocates based in urban Buffalo working in health care, public health, and community development began to coalesce around issues of health equity and a desire to address this issue from the perspective of root causes and with a bottom-up approach. Community Health



Workers were identified as a strategy to address social determinants of health in a practical, hands-on way. The Buffalo CHW advocates connected with the CHW Network of New York City, housed at Columbia University's Mailman School of Public Health, who had recently received a grant from the New York State Health Foundation to pursue training, credentialing, and reimbursement of CHWs through a statewide coordinated effort. Bolstered by the ability to utilize this training program as an educational and organizing tool, the Buffalo CHW advocates began to engage CHWs 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 poor health outcomes and were low on the scale of social determinants of health.

Many of these CHWs were functioning in isolation both within their organizations and within the community, and most had never met each other previously. 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 received training of 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 Community Health Foundation of Western and Central New York that provided support for a project director 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.

## Key Findings Surrounding Community Health Workers in Buffalo

Through a literature review of CHW history, best practices, challenges, and opportunities, and through the community planning process conducted in Buffalo, we aimed to look at the CHW paradigm from as many perspectives as possible. We were motivated by a desire to clarify a message and strategy that would support a local and statewide effort to bolster CHWs and community-



based health equity initiatives. We intuitively understood that we had a communication challenge between the theoretical grounding of CHWs and the qualitative and quantitative case for CHW implementation; and how this was translated to the reality of CHW recognition, leadership, and financial viability. There is a wealth of information making a case **for** CHWs; and so we focused on why it was not happening, the resistance and/or confusion surrounding the concept of CHWs, and possible new messages about CHWs that may resonate more deeply with stakeholders and build public support around CHWs.

### ***The Language and Framing of Social Determinants of Health and Community Health Workers is a Challenge***

Through conversations and working sessions with CHWs, CHW advocates, and CHW stakeholders throughout Buffalo and New York State,<sup>27</sup> it became clear that although there was a working definition of “social determinants of health” and “Community Health Worker,” there was a gap between the language and understanding by the vast majority of people we spoke with. This finding is supported by other research that states that while issues of health equity are well-established in academic circles, the concept is not easily translated in a way that makes sense on the ground.<sup>28</sup> Additionally, in Buffalo, very few organizations were utilizing Community Health Workers, or even had an understanding of what a CHW was. We found that there were many individuals working in community and faith-based organizations and in health care settings that did indeed fit the definition of a CHW, but that only about 15% were identifying as such. There were also organizations that were purporting to use CHWs who did **not** fit the definition. For example, organizations using telephonic outreach and identifying this as CHW work arguably did not reach the communities isolated by poverty, cultural bias, and fear of the larger systems that keep these populations away from needed care. Even CHWs themselves who identified as such and were leaders in their movement often could not respond to “what is a CHW?” in a way that was clear, consistent, and memorable. Lastly, CHWs are most often viewed as health care workers and much of the research speaks to their impact on health care and chronic disease management versus population and community health.

### ***Community Health Workers as a Workforce AND as a Set of Principles and Values***

In our attempts to sort through how to talk about social determinants of health and CHWs, we tested various messages in various ways. Because our theoretical framework and the practice of CHWs are non-linear, they did not translate well

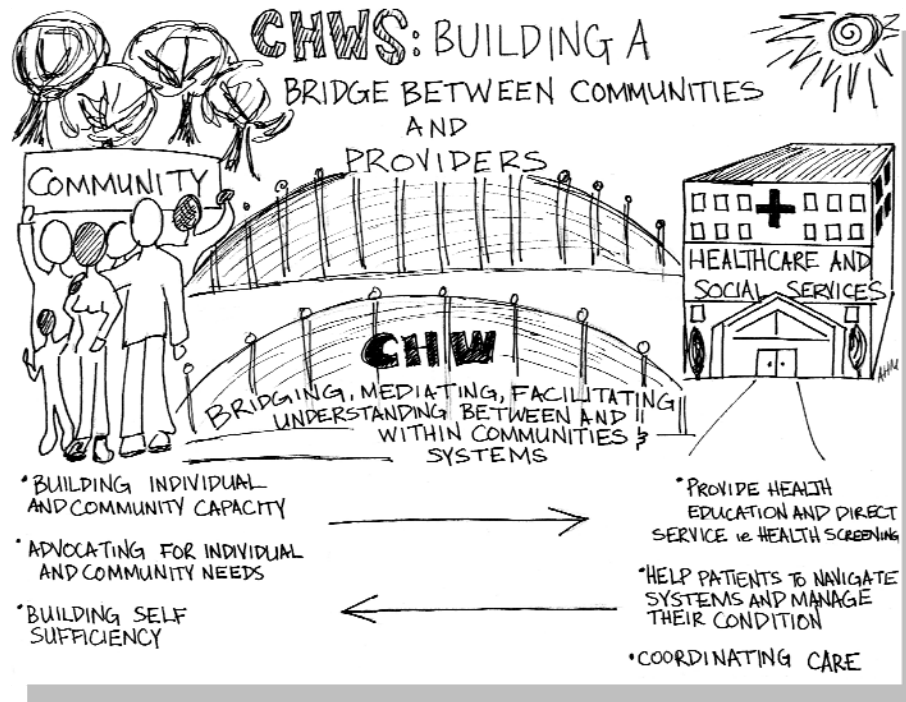
into a concrete message or description. For stakeholders, one-on-one conversation that allowed for dialogue seemed to produce “buy in” more than reports or PowerPoint presentations. But the most impactful way to illustrate our concept was to have CHWs tell their stories through dramatic presentation (i.e., acting out a “docudrama” of the history of CHWs), visual presentation (i.e., a picture showing a “typical” family that a CHW might interact with), and testimonials (stories from CHWs about the communities they serve and their daily experience). Throughout the course of the community planning process, it became clear that CHWs could not merely be defined as a workforce—although there was significant energy around this concept—but also as a set of principles and values that emphasized trust, understanding, empathy, shared experience, an asset-based approach, and putting people and community issues in a holistic context. There has been significant energy around the organizing of a CHW scope of practice into a credentialed and reimbursable workforce on both a statewide and local level, but there is also a commitment amongst CHWs and CHW advocates to ensure that a formal regulatory process should not sacrifice CHW principles and values.

***Community Health Workers Are Connectors Between and Within Neighborhoods and Institutions***

*“I had a client who was newly diagnosed with HIV and she was so depressed and scared that she couldn't leave the house. She and her one-year-old were facing eviction, and I knew I needed to do whatever it took to be her advocate. We worked together on the paperwork required to prevent her eviction the evening before Thanksgiving. I went over to social services as soon as they opened up after the holiday ....the social services worker asked me why I was there, knowing most agencies were closed, including mine, on Thanksgiving holiday. I told her, ‘I can't do anything to help the turkey, but I can help this woman’! She pushed my paperwork through and my client was prevented from becoming homeless.”*

– Kenneth Gaston, Substance Abuse Counselor, GROUP Ministries

In Buffalo, we found that CHWs are working in diverse settings. We have identified those in health care systems, multi-sector community-based organizations (CBOs) and faith-based organizations (FBOs) that all address one or more “social determinant of health;” and we even began to explore how teachers, police, court liaisons, etc. might be functioning in CHW-type roles. There is a large informal network of CHWs working in neighborhoods and functioning as trusted sources in their communities. They work as both paid employees and volunteers in churches, block clubs, and schools. Much of the work that these CHWs do is about “connecting” – helping families to work together, introducing them to their neighbors or resources within their community, and assisting them in navigating health and social services systems. Complementary to this, institutions are realizing they need to garner community buy-in, increase access, and assist in meaningful use of their institution from a quality and cost standpoint. However, larger systems often do not have the necessary relationships or trust with the individuals they serve; to effectively engage the community. Because CHWs are often not defining themselves as such and frequently work in isolation (versus being connected to others in similar roles in other organizations, sectors, or neighborhoods), their impact is not as great as it could be if there was a hub through which to organize and advocate through. In addition, systems that either built in a CHW role internally or else had a strong CBO/FBO partnership where CHWs were a part of the partnership seemed to be more effective and trusted by the community and their clients/patients.

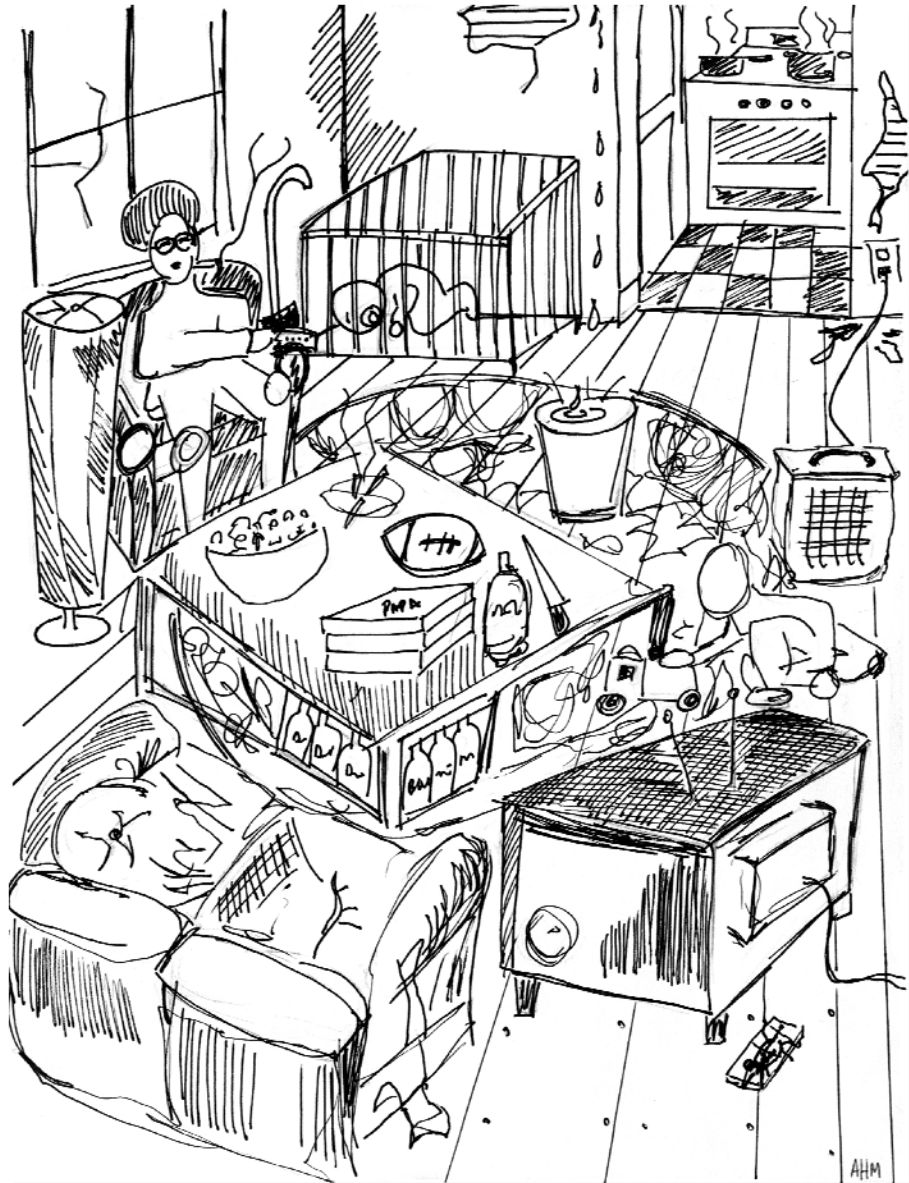


Community Health Workers can be envisioned as a “bridge” between communities and health care/social services. CHWs play critical roles on both sides to build capacity and foster better health outcomes.

**Community Health Workers Possess an Asset and Strength-Based Orientation**

*“One of my first clients was a teenage mother who had a newborn baby ... she was sleeping on a friend’s couch. She had nothing for the baby and he was sleeping in a cardboard box. Still, she was keeping him safe and close to her, and she seemed to desperately want to do better for herself and him. I helped the mother get diapers, clothes, and a bassinet. She told me that I had given her something bigger than the ‘stuff- I had given her **hope.**”*

–Nadia Pizzaro, Outreach Worker/Housing Coordinator, American Red Cross, Greater Buffalo Chapter



**This is a typical home setting that a CHW may typically enter. What do you see here? What are your perceptions about this family? (Discussion continues on page 14)**

An important paradigm that has not been prolific in the CHW literature, but is a part of CHW training and philosophy, is an asset based orientation. Conventional wisdom and funding streams support a needs-based, problem specific, reactive approach. Needs assessments are primary tools in determining resources allocation, and in turn shapes the orientation for the work that is funded. As such, health care and social service systems see “helping” as “fixing,” focusing on problems that need to be addressed by professionals within the system. Conversely, in “helping,” CHWs look for what they can work

with and foster within an individual or community, by identifying what is right versus what is wrong. Our research reflects that CHWs are already acting as implementers of asset building and the reclaiming of communities, albeit in an informal and intuitive way. There are many programs and initiatives across the United States that are adopting asset - and strength-based approaches.

Examples include:

- *Asset Based Community Development (ABCD) Institute* at Northwestern University
- *The Search Institute* (where the framework of “developmental assets” was developed)
- *Family Development Center of University of Connecticut* (which trains family workers how to coach families to set and reach their goals for healthy self-reliance)
- *Full Frame Initiative* (which addresses the ways in which mainstream social service systems have failed, and proposes new interventions to shift outcome orientations)
- *Harlem Children’s Zone* (that has established a “do whatever it takes” approach to support children from birth to college through broad community collaboration in Harlem, NY).<sup>29</sup>

The picture on the previous page illustrates this concept. The average person may look at this home and perceive the adult in the room as lazy, irresponsible, and unhealthy. We may focus on the knife on the table, the leaky ceiling and cracked paint, cigarettes, pizza, what appear to be alcohol bottles, etc. The CHW, operating from an asset-based paradigm, would view the adult and the home very differently. While recognizing that there may be real problems that need to be addressed, the CHW will try to refrain from judgment and find what is right, i.e. the mother has her children in view, there are utilities on in the home and there is furniture and ample food. In this frame of mind, we may view the adult presiding over this home as strong, caring, and working with limited means to make ends meet. Recognizing our bias, we may consider the possibility that those bottles in the picture are not alcohol but water, that the television may not be turned on, that one child is sleeping peacefully and the other is playing with a toy, and that a healthy meal is cooking on the stove. Helping community members to build on what they are doing right, and assisting service providers to develop an asset based approach, can foster a paradigm shift that creates empowerment and mutual respect.



## Recommendations

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### **Develop and build capacity for an independent Community Health Worker organization in Buffalo:**

*“I just don't see how an individual who is not empowered can go on a crusade to empower others. I have to be in a position where I can be a CHW and not have too many restrictions, or be in a position where I will be taught skills that will help me not just survive but thrive, so that I can help others.”*

-- Malik\*, Community Health Worker (name has been changed)

A CHW organization should work collaboratively with health care institutions, social services, government agencies, CBOs and FBOs, academia and businesses. However, it should not be affiliated with any one organization, neighborhood, or population in particular in order to maintain autonomy and prevent perceived or actual conflict of interest. This organization should be formed and governed by a diverse engagement of multi-sector stakeholders and **with a strong contingent of CHWs themselves** as part of planning process and leadership team. It cannot be overstated that community members and CHWs must drive this process in partnership with stakeholders in order for it to be successful and sustainable.

**Formalize a process to train and credential CHWs:** In order to increase visibility, legitimacy, and earning power –both of individual CHWs and as a workforce –there should be a standardized set of core competencies and an agreed upon scope of practice, as well as a statewide training and certification process. The Buffalo-based CHW organization should work in partnership with the CHW Network of New York City to build on the training that they have developed in partnership with Columbia University’s Mailman School of Public Health. Local training hubs in academic, health care, and community-based organizations should be established in Buffalo and tailored to the specific challenges and opportunities present in Buffalo. Training and credentialing moves CHWs towards achieving third party reimbursement, and will likely expand public and private job opportunities and increase CHW salaries.



**Implement neighborhood-based projects that use CHWs as organizers that build community capacity and inform institutional knowledge of the communities they serve:**

The most effective way to foster community empowerment is to allow individuals, families, associations, and institutions already established in that community to develop their own agenda concerning what is important to them. CHWs are uniquely poised to serve as facilitators in this process because they possess personal and professional qualities and shared experiences that allow them to be trusted and to understand the communities they serve from an “insider” perspective. Health care (and other institutions) and CBO/FBO partnerships can improve access, quality, and meaningful use; as well as reduce cost and improve health indicators.

**Utilize an asset and strengths-based versus deficit and needs-based approach when working in and with communities:**

People want to be valued as humans—not labeled as problems that need to be fixed. An asset based approach that respects individuals, families, and communities as a resource for themselves and each other fosters a sense of responsibility, ownership, and competency. This will ultimately foster sustainability and stability because the success of a neighborhood based initiative relies more on the internal resources of a community versus outside professionals or resources.

**Measure key indicators of success based on individual, family, and neighborhood self-sufficiency, stability and safety and meaningful use:**

Outcomes that are one dimensional and not placed in context of the physical, mental, emotional, spiritual, and social well-being of individuals and communities often prove to be unsustainable. Looking at various and multi-faceted indicators such as numbers of people employed, youth graduating from high school, venues to access fresh and healthy foods, incarceration/re-entry rates, emergency room admissions, etc., allows for a deeper analysis as to whether an initiative is affecting health and well-being.

**Community-based participatory research (CBPR) should be adopted as the primary research and evaluation mechanism:**

Traditional research and evaluation methodology, such as randomized controlled trials, ignores the importance of external influences, participant choice, qualitative research methods, and the complexity of human behavior and social interactions.<sup>30</sup> In contrast, CBPR is a joint effort that involves researchers and community representatives in all phases of the research process. The joint effort engages community members, employs local knowledge in the understanding of health

problems and the design of interventions, and invests community members in the processes and products of research.<sup>31</sup>

**Messaging Matters:** Because the construct we are proposing is non-traditional and has many complex, interdependent elements; it is important to develop clear and easy to understand messages and consistent marketing. In addition, because a successful community-based project that meets the criteria we are recommending requires investment from multiple stakeholder communities, it is important to tailor messages to different stakeholders in ways that speak in the language of their industry, community, and/or worldview.

## Conclusion

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Health is produced through an array of interrelated individual and community level factors. For communities who are experiencing health disparities, the context of the social, economic, and environmental factors in which they live, work, go to school, recreate and shop are critically important to consider when designing health care and public health strategies. The health care delivery system alone will not be able to create and ensure community health. Only communities that are empowered and invested in their own well-being, working to engage and foster improvements and meaningful use of health care and social services, can create the impetus for that change. Community Health Workers are a critical workforce and methodology that have the ability to facilitate asset-based partnerships within and between vulnerable individuals and neighborhoods; and a shift towards better quality, cost, and access in our systems that provide services to these populations.

## Endnotes

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- <sup>1</sup> World Health Report, WHO, 2000.
- <sup>2</sup> For the purpose of this paper, CHWs will generally be defined as frontline workers who address health in a holistic context, and are of or from the communities they serve. Further definition and explanation will be provided in this paper.
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- <sup>6</sup> Id.
- <sup>7</sup> Id.
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- <sup>19</sup> Definition by the Community Health Worker Section of the American Public Health Association, 2010.
- <sup>20</sup> Lewin, S., Dick, J., Pond, P., et al. "Lay Community Health Workers in Primary and Community Health Care," *Cochrane Database of Systematic Reviews* 1, (2005): CD004015.
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- <sup>23</sup> Sataline S., Wang S., "Medical Schools Can't Keep Up," *Wall Street Journal*, April 2010.
- <sup>24</sup> Minnesota Statute, MS 256B.0625, Subdivision 49.
- <sup>25</sup> Findley S., Martinez J., Matos S., et al. "The New York State Community Health Worker Initiative," Columbia University, September 2010.
- <sup>26</sup> Id.
- <sup>27</sup> New York State partners currently part of an emerging statewide initiative include: the Community Health Worker Network of New York City and the Community Health Worker Association of Rochester (CHWAR), as well as the Community Health Worker Network of Buffalo.
- <sup>28</sup> Isaacs Lowe, J. "Why We Need a Better Way to Talk About Social Determinants of Health," Robert Wood Johnson Foundation, *A New Way to Talk About Social Determinants of Health*, 2010: iii.
- <sup>29</sup> See [www.abcdinstitute.org](http://www.abcdinstitute.org), [www.search-institute.org](http://www.search-institute.org), [www.familydevelopmentcredential.org](http://www.familydevelopmentcredential.org), [www.fullframeinitiative.org](http://www.fullframeinitiative.org), [www.hcz.org](http://www.hcz.org). Retrieved December 2010.
- <sup>30</sup> Oakley A. "Who's afraid of the randomized trial? Some dilemmas of the scientific method and "good" research practice," *Women's Health Counts*, London: Routledge; 1990.
- <sup>31</sup> This definition of CBPR was adopted by the Prevention Research Centers network of the Center for Disease Control and Prevention in 2007.

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