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Insights on COVID-19 From Community Health Worker State Leaders

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Abstract: Community health workers (CHWs) leverage their trusting relationships with under-resourced populations to promote health equity and social justice in their communities. Little is known about CHWs roles in addressing COVID-19 or how the pandemic may have affected CHWs' ability to interact with and support communities experiencing disparities. A focus group with CHW leaders from 7 states revealed 8 major themes: CHW identity, CHW resiliency, self-care, unintended positives outcomes of COVID-19, technology, resources, stressors, and consequences of COVID-19. Understanding the pandemic's impact on CHWs has implications for workforce development, training, and health policies. **Key words:** *community health, community health worker, COVID-19, health equity, resiliency, workforce development*

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COMMUNITY HEALTH WORKERS (CHWs) are an important public health workforce in the United States who are defined by their trusting relationships (American Public Health Association, 2009) with communities facing economic and social disadvantage as a result of institutionalized racism. Although their job titles vary, there is agreement that their core roles include health outreach, education, cultural mediation, and advocacy, among others (Rosenthal et al., 2018).

CHWs are particularly well-known for their contributions to promoting health equity,

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including addressing social determinants of health (Kangovi et al., 2017) and improving health outcomes for chronic diseases (Brown et al., 2012). Racial disparities in rates of COVID-19 infection and deaths (Webb Hooper et al., 2020) have brought new attention to glaring health inequities in the United States, with calls for disaggregation of COVD-19 data to identify differential impacts of the virus on varied populations (Jones, 2020). These have inspired calls to involve CHWs in addressing these disparities through a range of roles including contact tracing, resource coordination, and leadership roles in nonpharmaceutical interventions (Association of State and Territorial Health Officials, 2020; Goldfield et al., 2020; Kangovi, 2020; Smith & Wennerstrom, 2020).

CHWs are generally members of underserved and underresourced populations. They may be at risk for contracting COVID-19 due to social and economic determinants of health including poverty and stress, as they often earn less than a living wage (Holgate et al., 2018). They may also be more likely than members of the general population to have suffered the loss of loved ones during the pandemic. In some cities, hundreds of CHWs are being hired to support COVID-19 response (WMAR, 2020). In contrast, there is anecdotal evidence that some CHWs may have been laid off during the pandemic (Smith & Wennerstrom, 2020), but overall, little is known about how the COVID-19 pandemic may have impacted the CHW workforce.

CHW professional networks throughout the United States at the local, tribal, state (Wilkinson et al., 2017), and, as of 2019, national levels (National Association of Community Health Workers [NACHW], 2020) generally aim to support members of the CHW workforce through advocacy and professional development. NACHW (2020) was developed in response to CHWs, Community Health Representatives, *promotores*, and other public health and social justice workforce members who increasingly sought a need for a national body to serve as their voice in policy discussions, a forum for consideration of professional standards, and as a resource for CHW leadership and professional development.

In April 2019, 20 CHWs leaders from across the United States were selected as the first cohort of NACHW state ambassadors. They are active members of both their state professional group and NACHW. They conduct outreach to other CHWs within their state to promote sharing of national updates and serve as a liaison with NACHW to their local, regional, and state networks. These individuals may have unique insights into local, state, and national workforce trends.

At the onset of the COVID-19 pandemic, NACHW began convening regular meetings with state ambassadors to provide ongoing support for CHWs and to adapt to the evolving needs and concerns of CHWs. A focus group was conducted with NACHW ambassadors to describe their lived experiences, lessons learned, strategies, and recommendations with COVID-19 for other CHWs and CHW programs. The focus group centered on how COVID-19 affected CHWs both professionally and personally.

METHODS

Sample and recruitment

Potential participants were identified from a NACHW state ambassador list. They received an e-mail describing the purpose of the study, focus group discussion date and time, and study consent form to review prior to the group discussion. The focus group took place during a monthly meeting, with time at the beginning of the meeting for NACHW state ambassador business, and an opportunity to opt out of the focus group. The facilitator and the notetaker/transcriptionist then joined the call. All potential participants were guaranteed confidentiality, the opportunity to not answer questions, and the right to withdraw from the study.

Moderator's guide

The semistructured interview guide was based on an informal national CHW COVID-19

survey (Smith & Smithwick, 2020) and input from CHW workforce researchers, NACHW board members, and experienced CHWs. Topics included experiences with COVID-19, sources of information, sources of social support, needed skills and trainings, self-care, and recommendations and strategies for the workforce. This study was approved by The University of Southern Mississippi's Institutional Review Board (Protocol 20-299).

Focus group procedures and data collection

A trained moderator conduced the 90-minute focus group accompanied by a notetaker. The moderator reviewed the risks and benefits of participation and obtained verbal consent. No incentives were offered. The session was recorded and transcribed verbatim. The notetaker also reviewed the transcripts and added information about participants' nonverbal behavior and level of engagement during the discussion.

Data analysis

Qualitative content analysis was conducted to identify major categories and substantive themes (Graneheim & Lundman, 2004). Three reviewers read the entire transcript to gain an overarching sense of the conversation and identified meaning units in the forms of phrases and sentences. These were further condensed, and codes were created and assigned to each meaning unit. Codes were further categorized, and themes were identified on the basis of the data. Several strategies were employed to enhance rigor and ensure trustworthiness of the data (Cohen & Crabtree, 2008; Pope & Mays, 1995). To reduce researcher bias, a multidisciplinary, racially diverse team of reviewers participated in the analysis. In addition, member checking (or participant or respondent validation) was conducted for respondent validation of focus group findings. Participants were asked to check for accuracy and resonance of their experiences.

RESULTS

A total of 7 CHWs, each from a different state across varied regions of the United States, participated in the focus group. All participants were women, represented regional and state CHW networks, and were NACHW state ambassadors.[1] Eight themes emerged from the data including (1) CHW identity, (2) CHW resiliency, (3) consequences of COVID-19, (4) technology, (5) resources and support, (6) stressors, (7) self-care, and (8) unexpected positive outcomes of COVID-19.

Theme 1: CHW identity

The theme of CHW identity encompassed changes to relationships, changes to services provided, and the impact of having a shared background with the communities they serve. In the subtheme of relationships, participant 1 said, "We have had to distance ourselves from our clients, which is not what we are used to. We are used to being face to face, one on one with them, to being remotely." She further noted, "Normally you can comfort someone, hug them, and say it is going to be okay. We can't do that now." In terms of changes to services, participant 2 stated, "When COVID started, I had to stop doing home visits. That was not something we were able to continue doing, none of the staff." Participant 4 verbalized, "It seems that I am doing so many Zoom meetings now instead of face to face, where I was traveling within the state to talk to CHWs." These changes initially hindered how CHWs were able to provide services and changed how information was delivered. Participant 4 noted,

> Our information was through e-mail, Facebook, and webinar . . . you name it, we sent it out, so people could read and access those things. The hope was that it was broken down in some way that CHWs who received this information were able to do all that.

Participants also mentioned that having a shared background with the communities

[1] Participants' personal information has been de-identified for reporting purposes.

they serve is a part of their identity. Participant 6 stated,

To actually be able to converse and understand where people are coming from, even if you have the same skin color, even if their culture and background are different. I think by me having the background that I had, it absolutely helps me to be more compassionate and help people in the situations that they are in and fight more for them.

Participant 3 shared,

I can definitely say that my background and culture helps me with the work that I do. Simply connecting to people of color because I have been in the same place that you have been ... it definitely helps me to connect to the patients and community that I serve.

Theme 2: CHW resiliency

CHWs described resiliency in terms of creative thinking and maintaining positivity and focus, and they noted the sources of this strength. Participant 2 observed that she was creative, especially with all of the changes that have happened during COVID-19, and she will continue to utilize this strength throughout her career. Some participants mentioned the importance of being about to "pivot" and "change things on a dime." Participant 1 explained,

Your creativity level had to go next level. There are a lot of things that you did not know you had in you, but you pressed through. Okay I can do this. Even though things were really ugly, it made me feel good that we can still make it happen in the midst of all of this. We could still make connections! We could still help even we were boohooing just as hard as our clients were. Yeah, I was having some moments. Still being able to be helpful still made me feel valued to those I was helping.

CHWs also described being focused on the immediate needs of their priority populations, having to "dig deep" into themselves to remain positive and focused, and tap into "their levels of resiliency" to continue on. These skills were self-taught and learned through experience and trials.

Theme 3: Consequences of COVID-19

CHWs described significant consequences of COVID-19. Subthemes were sudden changes, personal challenges and sacrifices, and issues related to the political environment. COVID-19 was a sudden change and disruption to life. Participant 1 said, "It has really impacted the results of what we can do because everything connected to this pandemic has changed the way we even do our work." Participant 3 stated, "Basically anything that involved health was what we used to do, but now it is totally surrounding COVID. Our entire operation for the (organization name) is based around COVID."

This sudden change affected individual lives, and CHWs experienced significant personal challenges and sacrifices. Participant 3 noted that she was deemed an essential worker.

We have never been in quarantine, so it has been really scary for me because I have a small child. My husband and I have not been able to stay home. We have constantly been out, even with the numbers rising. It is a part of the job.

Participant 1 stated, "Now I find myself working longer hours at home than what I did when I was in the office—by an additional five hours per day—for real."

Other personal challenges and sacrifices were related to family and loved ones. Participant 4 described her experience related to her daughter's cancer treatment.

She has been going through radiation, and no one could go in with her. That was truly playing on my nerves .... That is hard when you can't do those things for your family members. That illness, people being ill, during COVID plays a hard role on their family because you can't do anything.

Participant 1 described another situation:

I had a colleague, who I had mentored as a CHW, who had gotten COVID. Right after she got diagnosed, her dad was diagnosed. She got better, but her father died. She has been blaming herself for his death saying she should have never had a birthday party. She should have never been around him. She is going through this hard guilt.

Participant 3 discussed the challenges related to changes in normal life and her child.

I don't know how to explain to my daughter what is going on. There is that stress for children of how do I just not go to school anymore? I can't go out to see friends. I can't go out to get ice cream. It was so much.

The political environment was also a noted subtheme that affected the credibility of health information. Participant 7 communicated,

Can I trust what is being told to me to share with these people? I don't want to share anything that is not correct with them. Everything is so political on both sides. It's like okay. Are you just telling me this because you don't like the red or blue side? Or is this real? This has been my hugest challenge, trying to decipher what is good advice.

Participant 4 also described how the political environment hindered building trust in the communities.

It has made it ever harder for us to build trust in people to seek any kind of services or help. As much as we know the process of connecting with one another works, it has been hard to get people to venture outside of their comfort zones or believe that is can bring change for them. Or even being equitable for them. Even using the platform of being a Black person, you try to repair stuff all of the time. All of the time. It never stops.

The political environment also contributed to the COVID-19 response and influence on behaviors. Participant 2 expressed frustration with the response of some city and state leaders, and how "CHWs are not being involved directly with contact tracing." Participant 5, however, offered that CHWs have influenced some behaviors. She expressed, "Just wearing a mask alone has an identity symbol. Identifying that it is OK to wear that because it is going to keep us safe."

Theme 4: Technology

Issues related to technology were included as a theme. Subthemes in this area include the current status of technology, developing skills, and the connections to younger generations. Participant 4 acknowledged, "Everything is on Zoom now. We have all of our meetings on Zoom." Participant 2 noted the change in the CHW training programs offered by her organization. She said, "The next step will be to probably start at the end of August and try to see if we can have a combination and do a hybrid course for the candidates." As a result, skill development for technology is key. Participant 1 observed that you need to "become a Zoom expert. You had to be a technology expert and work on computers a little bit too. Our technology game was leveled up." In addition, participant 5 remarked, "Facilitation, and virtual facilitation, is so different than when you are doing one on one than as a group—how to facilitate virtually" will be a skill. Younger generations have helped support CHWs in using technology. Participant 5 encouraged CHWs to "ask your kids who are more savvy for support in some cases." Participant 4 shared this experience:

I have a 16-year-old granddaughter. When I am attempting to do something on this darn computer that I don't know what I'm doing, I'll say come and look at this. Sometimes she gets a little aggravated and says, "Gran Gran, I already showed you this." I look at her and say, "I don't care. I need you to show it again."

Theme 5: Resources and support

CHWs cited a variety of resources that supported or hindered pandemic response including public health information, community resources, fellow CHWs, social support, and financial support. Formal sources of information came from city Web sites and health departments, the Centers for Disease Control and Prevention, and the World Health Organization. However, CHWs described having to adapt resources for their clients. For example, participant 1 shared,

First of all, the info was not user friendly. You had to break it down and dissect it, and say okay, "What would the community understand?" Then using that same thought process and turning it into a sixth-grade level for people to really get it. Then what we did was create a lot of pictures, what I'd say were infographics, to really explain the process. Then we would have really candid conversations, and say "what do you think it is?" Then

demystify it to what it really is in a way that people could understand.

She also expressed frustration in that "our team had to be sure about what we were saying because things changed a lot, moment by moment. The minute you create something to share, the next day it was different."

Community resources included medical professionals who are racial and ethnic minorities that have worked with CHWs and CHW organizations in disseminating information to vulnerable communities in innovative ways. However, CHWs faced a lack of resources to which to refer clients. As participant 7 described,

> One of the things was not having the resources that you normally would in the community with everything being shut down. Normally, I would say, "Call this person or go to this place." Being shut down caused a lot of anxiety. That was the most difficult.

Participant 6 reflected that "not having the tools or supplies you need to even meet basic needs" was extremely difficult for her community.

CHWs served as resources for one another. Participant 6 said,

> We also worked with other community health centers with the stuff that needs to be translated because we have large populations of non-English speaking groups, Marshallese, Chuukese, Samoan and Asian countries as well. We don't have the capacity or funds to develop it in-house. We reached out to our personal connections to other CHWs and said, "Hey, we need help." We were able to get what we needed. That was the only way we could do it realistically and financially.

Participant 2 mentioned,

> They (CHWs) are providing all of the resources that we need for the community and also for the workforce. I have been able to help these organizations promote the programs that they are doing and resources that they are putting in place following the CLAS standards.

CHWs also described receiving support from local, regional, and state networks and associations such as information and resource sharing (testing and pop-up centers), as well as emotional support. National-level support included webinars and online meetings to keep CHWs informed, safe spaces to debrief and discuss issues important to CHWs, platforms for discussing issues related to CHW experiences and capabilities, and keeping CHW issues in the forefront with other health and human services professionals. Employer support varied across the region depending on the nature of the organization. Some organizations, such as health department employers, included FMLA leave, paid sick time for quarantining, and mental health services. However, not all CHW participants received these types of services and packages.

Financial support also varied across regions, organization, and agencies. For some employers, CHWs are considered essential employees and have remained employed throughout the entire pandemic. However, employment varied with the nature of the position, the state affected, source of funding, and the type of agency. While most of the participants were working full-time, participant 5 noted that "we still have a lot of CHWs that did not get that support (employment)." Participant 1 explained that she was working but did experience a furlough, but participant 2 said, "I am unemployed and collecting unemployment." Some agencies have required CHWs to take personal or medical leave for childcare issues, quarantine, and sick time. When participants were asked about what support employers should provide, overwhelmingly, CHWs answered that hazard pay should be included.

Theme 6: Stressors

Participants described several topics related to stress that impacted them personally or professionally. Some described high levels of stress and anxiety due to limited resources and trying to balance the needs of clients with personal and family needs. Participant 6 said, "You are internalizing it because you are trying to take care of your family, but you have got a bigger family (the community) that is also reaching out." She also described a unique situation,

We import most of our food items, paper good items. The fear and the panic over the fact that we may not be able to import enough food, enough toilet paper, or sanitary wipes really caused a lot of stress. Then having to work with your clients who are going through the same fear. It kind of increased it.

Participant 1 articulated,

It created a lot of anxiety, even then, not having what you needed to do your work effectively from home or do your work period. It caught us off-guard, and I think as CHWs, we like to pride ourselves on being ready. We weren't ready for this. To be blindsided to this capacity was a lot of anxiety, stress, and worry. Again, it wasn't just about our clients. It was about us, too. Trying to separate the two was difficult and just not being ready and not having what you need to do any kind of job effectively. Having to scramble to try and have some semblance of normalcy. It was hard.

Financial stress was also an issue. Participant 3 explained,

For me having to continue to work, there was a financial stress for me with having to pay for daycare for my daughter. That is not something I am usually having to do. If I am paying for an afterschool program, then it is usually for a couple of hours. Now we are talking about from 7 until 7 because I am having to work longer days. . . . I am still making the same amount of money.

CHWs mentioned physical and mental health consequences of dealing with COVID-19. Participant 6 shared, "The stress level was huge. In fact, I got put on blood pressure medication." Participant 1 described that she "cried a lot. I had to keep myself from going into this state of depression because I was really sad. It made me really sad . . . . It made me really emotional. I almost thought that I needed some medication to help me because I was stressing so bad." Participant 3 revealed, "It was super stressful for me, and I felt I had a responsibility that I could not manage." She noted that "I'm stressed out. I am sad. I am crying and like "what is going on?"

Theme 7: Self-care

CHWs employed a variety of self-care methods to deal with stress during the pandemic. Activities for participant 2 include "going to the beach as much as I can. I sit by the chaise and just get the fresh air. I look at the beautiful view." Participant 4 shared, "I like to cook. It is more cooking than I normally cook. I tell the children that I have a drive through at the garage. I will pack your food. Just drive to the garage, and I will hand it over." Participant 1 identified that she loves to "photograph the sky and flowers because they make me so happy. I have been getting the pictures printed and use it as my resilience book." Participant 7 stated that activities included walking with her husband and children on a walking trail or the neighborhood.

"Wine," "scotch," or "a little tequila" were noted as modes for self-care. In addition, some spoke about using humor. Participant 5 said she enjoyed, " . . . joking YouTube videos about COVID-19 and other jokes in a positive way." Finally, getting away and disconnecting with "bubble baths," "turning off the television," and "unplugging from all this constant bombarding of social media and the media itself" were sources of self-care.

Theme 8: Unexpected positive outcomes of COVID-19

Finally, CHWs described some unexpected positive outcomes of COVID-19, including using technology to support their work, gaining access to new resources, development of skills, and personal change. Participant 7 provided these comments about technology, "I cannot imagine this happening twenty, thirty years ago without the Internet and being able to do Zoom meetings and such. The positive is learning the technology and being able to use it at such a high level." Participant 2 conveyed that "I had to start a course in college to be able to properly give my trainings online and learn about everything. It has really been such an eye-opening experience." CHWs explained that some trainings were previously costly and required in-person attendance, but the pandemic necessitated sharing of information, tools, and skills to help facilitate response and recovery. For example, participant 5 provided this insight, "We are able to then go into other organizations that are able

to provide trainings through technology that we have now. Being able to get that information into my toolbox has been very beneficial." Participant 3 shared that she was able to "acquire a new skillset in my department. That was an absolute positive for me. I also showed my leadership abilities where I would not have been able to in my regular job setting." Participant 5 said, "Virtual facilitation is so different than when you are doing one on one than as a group. That has been an increased skill on my end. How to facilitate virtually." Finally, participant 3 identified personal change. She said, "I also learned that I can be a teacher because I have been a teacher for a few months, so that was another thing that was positive for me. I get to see how our educators feel on a daily basis."

DISCUSSION

A qualitative study of CHW state ambassadors was conducted to gain insight into how the COVID-19 pandemic has affected CHWs personally and professionally. Content analysis not only identified themes related to the uniqueness and relational aspect of CHWs in the scope of their services but also highlighted the challenges CHWs now face in engaging community members during this pandemic and the anxiety and stressors associated with such work. There are several important implications for supporting CHWs through the remainder of this pandemic and in the future.

First, CHWs are generally resilient and often self-reliant and may hesitate to ask for help. These traits may not serve them well in a time of burgeoning workload, redistribution in scope of services, intense stress, and dealing with a disease or content area—in this case COVID-19—they have not previously encountered. Although these sources of anxiety may not affect every CHW, they can weaken the confidence of CHWs in themselves and the health care delivery system, precisely when their ability to stay calm and reassure the public is most needed. Having conversations with frontline caregivers, such as CHWs, may help reduce anxiety (Adams & Walls, 2020). Recognizing the sources of anxiety allows employers, institutions, and organizations to develop targeted approaches to address these concerns and provide specific support to their CHW workforce (Shanafelt et al., 2020). Focusing on addressing CHWs' sources of anxiety and fear specifically, rather than teaching generic approaches to stress reduction or resilience, should be the primary focus of support efforts. The best way to understand what CHWs are most concerned about is to ask, provide safe spaces for them to express their concerns, and then collaborate to develop responsive strategies.

While all members of the public health workforce will be stressed by the challenges of a prolonged response to COVID-19, organizational leaders must emphasize the importance of self-care, particularly for CHWs (Adams & Walls, 2020). It is critical for leaders to allow CHWs the flexibility to tend to personal needs such as caring for children or ill family members. They must also ensure a living wage and paid time off. Such benefits allow CHWs to feel supported, both as public health professionals and as individuals, and will build their confidence to carry out their vital roles.

Another important lesson is that organizational leaders must encourage CHW team members to ask for help and encourage CHWs to rely on and support each other. CHWs are uniquely poised to collaborate on developing innovative health communication strategies when traditional channels (eg, community outreach and in-person meetings) are unavailable. Employers should also provide protected, paid time for CHWs to participate in meetings, informational webinars, trainings, or other offerings provided by local, state, regional, and national CHW associations. Such activities may help ensure that CHWs have access to the latest science, develop new skills, gain knowledge about ever-evolving community resources, and receive emotional support.

In addition, engaging CHWs in the planning, implementation, and evaluation of COVID-19 strategies for communities at the forefront is essential in moving forward during this and future pandemics. CHWs have

"grassroots information" that is critical to medical initiatives and policies related to health disparities, and they are distinctly suited to current and prospective roles in pandemic preparedness and response (Boyce & Katz, 2019). For example, CHWs have promoted pandemic preparedness by increasing access to health services and products within communities, communicating health concepts in a culturally appropriate fashion, and reducing the burdens felt by formal health care systems. During various international epidemics, CHWs engaged in pandemic preparedness by acting as community-level educators and mobilizers, contributing to surveillance systems, and filling needed health services gaps (Boyce & Katz, 2019). Health providers, CHW supervisors, and other public health professionals need education about the roles CHWs can play in pandemic response and how these complement, rather than compete with, other health providers' activities. Understanding and acknowledging the success CHWs have had in these roles and in previous interventions can support CHWs in becoming engaged in pandemic preparedness roles in the future and, ultimately, promote community resilience.

LIMITATIONS

These study findings are limited in that only NACHW state ambassadors participated. It is possible that the full range of all CHWs' experiences in addressing COVID-19 was not represented. Another limitation was that only English-speaking CHWs participated in the research. While some NACHW state ambassadors were bilingual, the study did not include CHWs whose primary language was something other than English. It is possible that the perspectives of CHWs working with non–English-speaking communities differ from focus group participants.

Despite these limitations, this research provides insight into the activities in which CHWs are engaging to address COVID-19. These findings may be useful for employers including state health departments that may be adapting CHW models to address the pandemic. Local, state, and national CHW professional associations may also tailor their usual offerings to better address the needs of CHWs working on COVID-19 response.

CONCLUSION

CHWs have been on the front lines and serving as essential workers during this pandemic. They have faced great risk to exposure, extreme workloads, and lack of culturally appropriate information and services to provide to their communities. Identifying and understanding the impact COVID-19 has on CHWs, and subsequently their communities, have implications for workforce development, training, and health policies for both the CHW labor force and the public health profession.

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