Lay Health Educators' Roles in Improving Patient Education

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There is an urgent need to transform our health care system to improve the quality of and access to care, more efficiently use limited resources, and be more cost effective. The convergence of trends, many studied by the North Carolina Institute of Medicine, driving this need for transformation include the alarming increase in chronic diseases across the lifespan, persistent shortages of health care professionals and interpreters, the increasing uninsured population, and limitations of our health care safety net to meet growing demands. Demographic changes, environmental health risks, and health literacy issues further compound these problems. All these factors contribute to health disparities and underscore the need for culturally relevant and linguistically appropriate health education and care. A key to health care transformation is the shift from a traditional hierarchical, clinician-centered approach to a patient or relationship-centered approach in interpersonal communication and service delivery strategies.

Given the current milieu, it is time to take a fresh look at the role lay health educators (LHEs), also known as lay health advisors, community health workers, or *promotoras*, can play in improving communication, increasing access to quality care, and reducing costs. Research in health literacy has heightened awareness that it is not enough, from a practical or ethical standpoint, to simply disseminate health information. It is problematic when the information is laden with medical jargon and technical terms and written at too high a reading level. For effective disease treatment and prevention and behavior modification, individuals must be motivated and able to access, understand, and use health information in the context of their daily lives. Lay health educators are respected and trusted members of a community who know most of the residents they educate. They help translate health information into culturally meaningful, understandable messages that their neighbors can critically think about and act on. The LHE model was first endorsed by the federal government in the 1960s as a way to expand access to care for underserved populations. These natural helpers build bridges between systems of government, educational institutions, and medical and social services that might otherwise be out of reach to individuals and their communities. Acting in a spirit of collaboration and mutuality, their work and use of "living room" language embody the principles and best practices of health literacy and relationship-centered care.

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Although currently an underutilized service delivery strategy, the versatility and effectiveness of LHE programs make them an attractive and vital option in today's health care environment. Lay health educator programs are typically used to accomplish 3 interrelated goals: (1) strengthen the therapeutic alliance between health care professionals and community members; (2) improve appropriate health care utilization; and (3) reduce health risks.[1] Diverse program structures and roles and responsibilities of lay health educators reflect the uniqueness of communities and their resources. Amidst this diversity, common program components exist. For example, many programs include outreach to underserved communities through activities such as networking with neighbors, providing simple health screening, and staffing mobile units. Lay health educators often help develop or select health materials for their peers based on their knowledge of language as well as local cultural beliefs and practices. Many LEH models have roots in Paolo Freire's work in adult literacy and seek to empower community members to identify their own needs and then develop and implement a plan that is right for them.[2] Health advocacy, home visits, health promotion, support for lifestyle changes, and the provision of transportation are other program components that are often part of LHE outreach efforts.

Lay health educators' primary allegiance is to their communities and social networks. This is a critical element and must be both respected and maintained by programs. The degree to which LHE programs are integrated within the health system varies. On one end, LHEs are fully integrated into the health care team as paid employees. On the other end, LHEs work autonomously in their community with no connection to the health care community and no compensation. Within these extremes lie a wide variety of partnerships and structures. The level of formal and informal linkages between LHEs and health care providers should be balanced based on the program's focus. In some cases, strong ties with health care providers assist LHEs in their work and health promotion efforts. In other cases, particularly when reaching more isolated and difficult to access communities (such as those with HIV/AIDS), strong links to providers might create a sense of distrust within communities and undermine a LHE's effectiveness. In other circumstances, activities that are integrated with a health center's clinical operations may facilitate better access to comprehensive services.[3] For example, consistent contact between physicians, case managers, and LHE home visitors can help ensure appropriate referrals and more effective follow up. Lay health educator programs must consider ways to respect the contribution of time and expertise of LHEs as well as ways to keep them engaged over time. Cash compensation is one obvious incentive. Increased access to services, training opportunities, respect from their peers, and a deep sense of knowing they have helped their community are other ways that LHEs benefit from their labors.

Programs that actively work with LHEs can build capacity at individual and system levels. Lay health educators commonly report an increased level of self-confidence, assertiveness, and ability to speak their minds as a result of their role. Their increase in knowledge and enhanced health and science literacy skills help increase the capacity of the entire community to take action on behalf of their members. Individuals and communities are empowered to get involved and stay connected with outside systems, a crucial function in times of health crises and natural disasters. Identifying motivated individuals in communities through LHE training can foster opportunities to recruit new talent from underserved communities for possible careers in health care.

With appropriate training and supervision, LHEs can benefit health care systems by providing a cost effective way to address cultural and language differences and more effectively meet the needs of an increasingly diverse patient population. One example of potential system efficiency is to use LHEs with groups of mothers to provide prenatal education as a complement to short physician visits. This can expand and heighten the cultural sensitivity of health care information received by women. The pregnant mothers would also receive greater social support, which has been shown to improve birth outcomes.[4] In addition, sharing the educational responsibilities with LHEs would allow health professionals and clinic interpreters an opportunity to use their time more effectively. In fact, nurse-supervised LHEs provided group prenatal education to high-risk Latinas in a recent study to improve quality of care and reduce health disparities among Medicaid managed care enrollees. They used *photonovellas* (or "photo-stories") and the Teach-With-Stories Method. This innovative approach, developed in North Carolina, is an internationally recognized best practice model for addressing prenatal care, empowerment, and health literacy needs of women. Latinas who received the Teach-With-Stories intervention had higher rates of optimal prenatal care (90.5% vs 64.7%) than the overall prenatal population at Neighborhood Health Plan of Rhode Island, the statewide health maintenance organization conducting the study.[5]

Lay educators have been used successfully with diverse populations to address specific health problems such as cancer, HIV/AIDs, diet and nutrition, prenatal care, environmental health issues, and health disparities within all these issues. The lack of standardization in the program structures, roles, and responsibilities described above as well as differences between community and research cultures pose evaluation challenges. While more research is needed, there are additional studies that demonstrate that LHE interventions can improve access to care, increase client knowledge, and facilitate behavior changes.[5,6,7] Research has also shown that LHEs can improve the health status of individuals with chronic diseases such as diabetes and high blood pressure.[8] The studies available that evaluate the financial impact of LHE programs provide evidence that they are economically sustainable.[9] One study, designed to assess the return on investment of LHEs working with underserved men, examined service utilization, charges, and reimbursements. Primary and specialty care visits increased while urgent care and inpatient and outpatient behavioral health care utilization decreased. Consequently, uncompensated costs decreased; the return on investment was $2.28 for every $1.00 in costs.[9]

Meaningful dialog and greater insight into the strengths and needs of communities are needed to improve health literacy, increase access to quality health care, and use limited resources more efficiently. This cannot be accomplished in isolation. Lay health educators offer a unique opportunity to strengthen the relationships between health professionals and patients through more culturally sensitive communication. They are able to adapt and discuss health information with their neighbors in a way that is understandable and encourages improved health promotion and risk reduction. With appropriate training and supervision, these natural helpers can also give community members practical support to navigate systems and make changes in their lives. Despite mounting evidence of their efficacy and cost-effectiveness, barriers exist to the use of LHEs and the sustainability of such programs. For example, while grant funds may be available to start community-based programs, innovative ways to fund LHEs and maintain a program's infrastructure are needed. Also, data systems must be improved to allow better tracking and assessment of LHE programs. Working together, health professionals, community members, researchers, and policy makers can make better use of lay health educators in North Carolina to the benefit of all. **NCMJ**

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