Co-designing education with and for community health workers: creating a bridge to care

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Abstract

Community Health Workers (CHWs) are essential elements in the healthcare system in Canada and around the world. Many CHWs live and work in their communities. Their connection and proximity to their communities affords them with a unique approach to care. CHWs leverage their in-depth knowledge of their communities to address health and social needs, and tackle barriers to care. Therefore, education and training for the CHW workforce offers a unique proposition: it can be used to improve community health outcomes and health equity. However, limited education and training opportunities exist that truly reflect CHWs status and position as healthcare providers. These gaps inspired the **Bridge to Care Initiative** in 2024 which aimed to address workforce integration gaps experienced by CHWs in Ontario. Its goal was to co-design an Advanced Certificate program with and for CHWs in Ontario in collaboration with other key interest holders. This paper outlines how Appreciative Inquiry was used over a span of six months culminating in the creation of the **Community Health and Social Medicine (CHASM) Care Worker Program**, now offered by the **Michener Institute of Education** at the **University Health Network**.

Keywords: Appreciative Inquiry, Co-design, Community Health Worker (CHW), Education, Participatory, Equity, Community

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Engagement of Community Health Workers (CHWs) has been promoted globally as an opportunity to address healthcare gaps in underserved communities where CHWs may also reside.[1] CHWs are unregulated care providers (UCPs) that work to support and address the health and social care needs of members of their community.[1,2] They are an essential part of the healthcare system representing a diverse care workforce that is deeply rooted and connected to their communities.[1] In contrast to their colleagues in regulated health professions, CHWs frequently work in an interstitial space that exists between health and social care systems and their respective communities.[1,3] This positionality offers CHWs with the opportunities to enact care that is attentive to the needs of the people that they work with.[1,4] Often, CHWs share lived and cultural experiences with the people with whom they work, enabling them to offer a holistic approach to care that accounts for various facets, determinants and barriers to care impacting health.[1,2] These shared experiences with the people that they work with, also help to build trust and bridge formal systems, especially for groups who have been historically excluded or harmed. Therefore, educating and training this care workforce offers a unique proposition as it can be used to improve community health outcomes and create a more inclusive system of care that adequately reflects and includes communities.

However, healthcare education and training opportunities, while increasingly aiming for diverse recruitment of learners, can (ironically) distance

individuals from their communities, devaluing their positionality and conforming them to a mold of "health professional" in the process.[5] Moreover, since CHWs are an unregulated workforce, the levels of education and training may vary amongst this workforce.[2] Most CHWs are trained on-the-job in accordance with the needs of their employers.[1,2] Curriculum design for many healthcare training programs has relied on competency-based or standards-driven frameworks, developed by oversight of institutions or professional groups external to the workforce itself. [5] Such approaches risk underrepresenting the relational and community-embedded expertise central to CHW practice.[2,6] While participatory and co-design approaches may address this limitation, many remain problem-focused. Appreciative Inquiry (ApinQ) offers a strengths-based curriculum design alternative that foregrounds existing values and capabilities for program development.[7]

These gaps inspired the Bridge to Care Initiative with the aim of addressing workforce integration gaps with an education program that values and preserves connections to the community. Bridge to Care is a novel CHW education co-design initiative that involved a collaboration between The Institute for Education Research (TIER), the Collaborative Advocacy & Partnered Education (CAPE), the Michener Institute of Education at the University Health Network (UHN) and CHWs across the province of Ontario**,** Canada. The co-design process was informed by ApinQ, a strengths-based approach inviting CHWs to share their core values, peak experiences, unique skills and aspirations for the future of the workforce.[7] Integrating this approach to co-design enabled us to focus on this "positive core", since "the study of organizations operating at their best builds knowledge, wisdom, and replicable capacity about how to bring out the best in the organizations". [7] Thus, the utilization of ApinQ was crucial to building a CHW program that was centered on CHW visions for change for their workforce, who are in many cases an under-recognized and marginalized workforce in healthcare.[1,3,6]

Methods & Results

In 2024, we engaged over 100 CHWs, employers, and interest holders to co-design an Advanced Certificate program with CHWs in Ontario. Throughout ApinQ's 4-D phases (e.g., Discovery, Dream, Design and Destiny), we remained committed to centering participants' strengths, visions, and aspirations for change, for CHWs in Ontario, as a crucial part of education innovation and transformation for members of this workforce. ApinQ guided the co-design progress, including the curriculum design contributions generated at each of the four phases, as summarized in Table 1.[8] In the first phase of the education co-design process, the Discovery phase, we explored core factors that contributed to CHW peak moments. Recognizing the diversity of this workforce and the variance in determinants and experiences throughout communities and regions in Ontario, we adopted a provincial scope and reached out to hundreds of CHWs to ensure that the unique positionalities and experiences of CHWs were fully captured.

Through 20 initial interviews and seven storytelling sessions, CHWs in Ontario were asked about their experiences of a time when they felt that they did an exceptional job providing service to members of their community, and to highlight what it is about their 'being' and 'doing' that created these positive experiences. In total, 51 stories were gathered in this phase, which were further analyzed for themes by the core research team, members of the Gattuso Centre for Social Medicine and their Lived Experience Advisory Council in a meaning-making session. The themes were used to identify 18 representative stories across participants' narratives.

These representative stories were then shared at the Storytelling Summit in April of 2024, as part of the next stage of the co-design process, the Dream phase. Both CHWs who participated in the initial interviews and storytelling sessions, and CHWs included in the initial outreach, as well as employers and stakeholders, were invited to participate in this summit. Attendees at the summit were asked to read the stories and reflect upon their own peak experience to collectively identify themes around CHW strengths and their highest hopes. This summit also asked participants to envision what the Advanced Certificate program would look like if it was running and exceeding all expectations. Participants were then asked to select the design elements and descriptors for the certificate program, and to consider key voices and perspectives that were missing from this summit. Key outputs of this phase included a list of CHWs´ highest hopes and perspectives on important design elements, and descriptors identified by the participants for the CHASM Care Worker Program.

In the Design phase, we focused on building the program with participants at the Rapid Prototyping Summit in June, 2024. Participants from the Storytelling Summit were invited to participate again in this summit, alongside other new participants identified by participants at the previous summit as missing voices (as key voices that should be included in the co-design process). This summit focused on brainstorming ideas in collaboration with the participants to actualize design elements for the program. Participants were also provided with insight into different education format options (e.g., CE Badge, CE Certificate, Ontario

Certificate, Ontario Diploma, 2+ 2 Degree Partnership). This discussion was crucial as it provided a basis of understanding of the different formats available for CHWs´ and participants´ preferences and values regarding education format and design. In particular, this phase focused on co-designing with CHWs and other key stakeholders to co-develop community-based experiential learning placements and inform the program's structure, content, funding model, and marketing strategy (for more information on the Bridge to Care co-design process, please go to: https://chasmcareworkers.ca/).

The following phase, the Destiny phase, is the phase of development in which we currently exist. With the inaugural launch of the CHASM Care Worker Program, our team has now entered the phase where we engage in continued learning with participants, core team, and collaborators to continually improve the program to meet and address students' needs. With the first semester completed, we are now embarking on evaluation of this preliminary term to assess and check in with students regarding their learning and future opportunities to build on existing educational frameworks and design. Please see Table 1 below for an overview of the co-design process and key outputs.

Table 1: Appreciative Inquiry phases and corresponding curriculum design outputs

Phase	Purpose*	Activities	Outputs
Discovery Phase	Understanding and appreciating the best of what already is.	We explored the strengths of CHWs and the core factors that contributed to CHW peak experiences (Feb. – March 2024)	51 participant stories, which were thematically analyzed to identify 18 core representative stories capturing strengths, values and forms of expertise.
Dream Phase	Envisioning what might be.	Participants were asked to envision what an advanced certificate program for CHWs could look like at a Storytelling Summit held in April, 2024	A shared set of CHW aspirations and design principles guiding curriculum goals, structure and learner experience.
Design Phase	Co-construct the ideal future and how to get there.	Using Rapid Prototyping, we co-designed elements of the program at a Summit held in June 2024.	Co-designed curriculum structure, content areas, funding model and marketing/recruitment strategy.
Destiny Phase	Finding ways to sustain what was co-created through ongoing learning and adaptation	We are currently engaged in collecting data from program participants and staff to help inform the ongoing iteration of the program.	Preliminary evaluation data highlighting student experiences to inform iterative curriculum refinement and future program development.

The co-design team has continuously engaged in reflexivity and brought their unique strengths in community health, education, research, and equity to the forefront throughout all points of the process. While we drew from our collective expertise as we moved through the phases of the co-design process, we considered the limitations of our knowledge and experiences. We aimed to continually question our assumptions and power relations, and to consider whose perspectives were emphasized and whose were missing. When possible, we aimed to address assumptions, power relations, or gaps in perspective.[9]

This reflexive process was crucial to adequately reflect the social realities of CHWs in Ontario. In practice, this required an extensive recruitment process and debriefing sessions with the team as we continually revisited our own beliefs and assumptions to make space for other ways of knowing and doing—through an iterative process of inquiry and community dialogue. Additionally, we reconsidered our own understandings of CHWs (from various vantage points to examine the many ways in which CHWs were socially constructed across the system—in healthcare, in community, academia and so forth). Thus, the solutions put forth in this co-design process reflect these considerations facilitated through dialogue with our team and broader system as we worked to center CHWs visions of change for their workforce. The goal was to build an education program that truly leveraged their skills and unique positionality in the healthcare system.

Discussion

This work demonstrates how ApinQ can be used as a structural curriculum design approach for CHWs. CHWs' voices directly shaped the CHASM Care Worker Program, now offered by the Michener Institute of Education at the UHN. Throughout the co-design process, we remained committed to the central tenets of ApinQ, which required that we pay attention to and make spaces for the voices that often go unheard or unnoticed, such as underserved communities and future students, to ensure that our co-design reaches members of these communities and incorporates their visions.

Since CHWs are often members of the communities that they work with, we recognized the importance of ensuring that recruitment for this initiative was accessible to underserved communities. Our outreach process required careful mitigation of barriers that may prevent CHWs from participating (i.e., language, geography, financial, etc.). Through continuous reflexivity and community dialogue, our team fostered a more inclusive co-design process. This approach may be particularly valuable in contexts where workforces are heterogeneous or historically marginalized, and where conventional competency-driven curriculum development risks de-valuing lived expertise.

In just six months, our team was able to engage a large and diverse group of participants, moving from an idea to a complete program prototype. Grounding the process in personal stories and community reflection brought out the essence of being a CHW. This process highlighted collective strengths and a vision for CHWs as an antidote to the "distancing" from community that can occur with further professionalization. Education, when rooted in lived experience and community-led reflection, can serve as a powerful tool for system transformation.

This research also demonstrated the implications of undertaking a community-oriented approach to co-design for CHW education and training in Canada. This approach is a significant departure from attempts at CHW education rooted in established standards and competencies that may universalize CHWs experiences as a whole, or those solely developed by others outside of the CHW workforce (such as other medical professionals or employers).

Rather, this project showcases the benefits of working with communities using strengths-based approaches to curriculum design as they provide opportunities for meaningful dialogue and inclusivity in the process of curriculum development. Curriculum development is rooted in CHWs´ perspectives, visions and experiences, providing a more expansive lens rather than the limited scope of a problem-oriented approach. Approaches used in this project can be used in combination with more traditional approaches to curriculum design with ApinQ informing early needs analysis, design principles and curriculum priorities, while established institutional models support implementation and evaluation. This approach offers a cohesive picture of CHWs´ needs, whilst also being grounded in the creative possibilities that emerge from CHWs´ community expertise and knowledge.

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