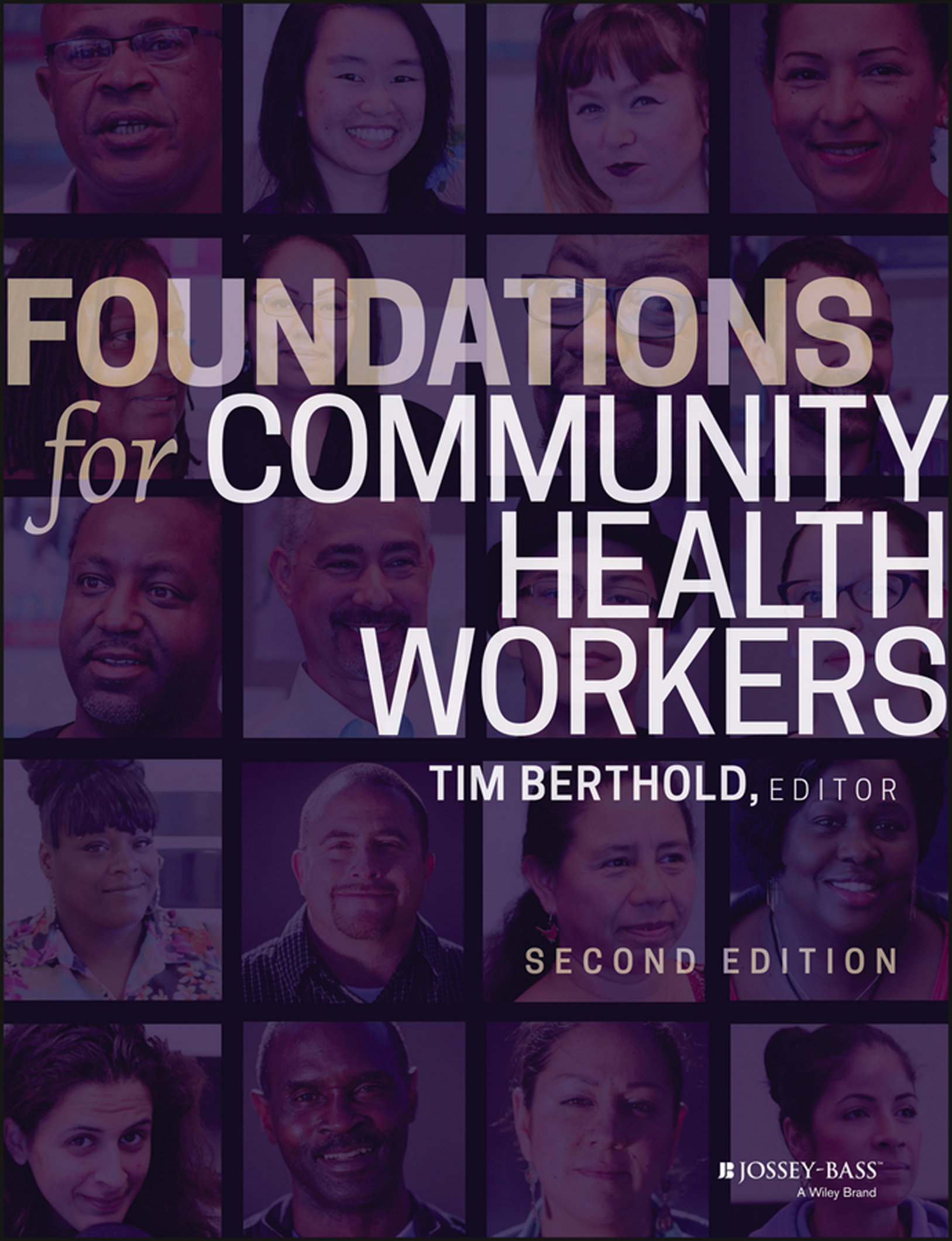

FOUNDATIONS *for* COMMUNITY HEALTH WORKERS

TIM BERTHOLD, EDITOR

SECOND EDITION

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Most importantly, this book acknowledges and is dedicated to community health workers past, present, and future.

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Introduction

1

This book is based on the Community Health Worker Certificate Program established at City College of San Francisco (CCSF) in 1992 (*www.ccsf.edu/hlthed/chw*). The program was developed by Community Health Works, a partnership between CCSF and San Francisco State University (SFSU). It was informed by research on the roles and core competencies of community health workers (CHWs) undertaken by Mary Beth Love and colleagues (*www.communityhealthworks.org*).

CHW students and faculty at City College of San Francisco.

When the CHW Certificate Program began, the faculty were unable to find an existing curriculum that addressed core roles and competencies. Over the past 20 years the faculty at CCSF have collaborated with students, internship preceptors, working CHWs, and their employers to develop, evaluate, and revise a curriculum that is responsive to the field of public health and the emerging roles of CHWs. Over time, the idea emerged to write a textbook that could be used in our classrooms. We published the first edition of this book in 2009.

Guiding principles that inform this book include a commitment to social justice, cultural humility, and client- and community-centered practice that respects the experience, wisdom, and autonomy of CHWs and the communities they serve. The book is also inspired by the ideas of popular education and the works of Paolo Freire, who believed that education should be a process of political awakening and liberation.

The book is designed for CHWs in training, and is divided into five sections as detailed in the Table of Contents:

- Part 1 provides information about the broad context that informs the work of CHWs, including an introduction to the role and history of CHWs, the discipline of public health, health inequalities, the U.S. health care system, and the public policy process.
- Part 2 addresses the core competencies or skills that most CHWs rely upon day to day, including cultural humility, ethics, how to conduct initial interviews with new clients and provide ongoing client-centered counseling or coaching and care management services, and how to conduct home visits.
- Part 3 addresses key professional skills for career success including stress management, conflict resolution, code switching, providing and receiving constructive feedback, and how to develop a resume and interview for a job.
- Part 4 applies key competencies or skills to specific health topics including working with formerly incarcerated communities, supporting clients with the management of chronic conditions, healthy eating, and active living. It also provides frameworks for supporting clients and communities in their recovery from trauma.
- Part 5 addresses competencies that CHWs use when working at the group and community levels, including how to conduct health outreach and a community diagnosis, and how to facilitate educational trainings, support groups, and community organizing and advocacy efforts.

This second edition of *Foundations* includes four new chapters in Part 4:

- Chapter 15: Promoting the Health of Formerly Incarcerated People
- Chapter 16: Chronic Conditions Management
- Chapter 17: Healthy Eating and Active Living
- Chapter 18: Understanding Trauma and Supporting the Recovery of Survivors

In this edition we have also included short educational videos (URLs or Web addresses are provided in the hard copy edition of the book, and direct links in the e-book version) highlighting key CHW concepts and skills. These videos feature interviews with CHWs, CCSF faculty, and public health experts, as well as role plays that show CHWs working with clients. The role plays are designed to demonstrate key CHW skills. We have also included "counter" role plays that highlight common mistakes or approaches that we wouldn't recommend for CHWs. We use these videos to generate discussion in our classrooms and to engage students in applying key concepts for working effectively with clients. An index to all educational videos included in this edition is provided at the end of the book.

CHW DIGITAL STORY: ROBERT'S STORY

http://youtu.be/Acaf7cKFGyo

If you wish, please watch the following two videos, which were created by students who graduated from the City College CHW Certificate Program. These are called "digital stories" and they briefly describe what motivated each video maker to become a CHW.

One book cannot possibly address all the knowledge and skills required of CHWs. Our intention is to provide an introduction to the competencies most commonly required of CHWs. This textbook does not attempt to provide information about the specific health issues that CHWs will address in the field. CHWs work in such a wide variety of settings, addressing a broad range of health issues, that it wouldn't be possible to address them satisfactorily in one book. Health knowledge also changes rapidly as new research findings are released, and

many reputable health organizations provide regularly updated information online. Instead our approach is to cover the key skills that CHWs provide in the field, and to let employers take the lead for providing additional training on any specific health topics and issues that the CHWs will focus on in the course of their work.

CHW DIGITAL STORY: LUCIANA'S STORY

http://youtu.be/FS9leOmwACk

We acknowledge that the topics addressed in each chapter (such as public health, care management or group facilitation) could form the basis of an entire book. We ask you to keep this in mind, and to remember that the process of becoming a CHW is ongoing. Your knowledge and skills will be influenced by a wide variety of factors, including your training, on-the-job experience, and guidance and support from experienced CHWs, supervisors, and other colleagues. Your own life experience, cultural identity, and personality also contribute to your development as a CHW. *Most importantly, please listen closely for the lessons that clients and communities have to teach you.*

A companion *Training Guide to Foundations for Community Health Workers* is available for free at Jossey-Bass (*http://wileyactual.com/bertholdshowcase*). The Training Guide is designed as a resource for anyone who is training CHWs and includes step-by-step lesson plans and assessment resources corresponding to each chapter of the Foundations textbook. Additional educational videos are also provided at *http://wileyactual.com/bertholdshowcase*. Additional materials such as videos, podcasts, and readings can be found at *www.josseybasspublichealth.com*. Comments about this book are invited and can be sent to *publichealth@wiley.com*.

This book was created in collaboration with many people. Some contributors have experience working as CHWs. Some have experience training CHWs in college classrooms or community-based settings. Some have experience working in public health in other ways, and others have experience conducting research and advocating with and on behalf of CHWs. *All* of us have had the privilege of working closely with CHWs. We have witnessed the passion, commitment, skills, and creativity that CHWs bring to their work. Because the contributors have different life and professional experiences, we bring different writing styles and different opinions to this book. These differences echo those that exist in the field of public health and among CHWs.

CHWs contributed to this book in a variety of ways. Some chapters were written by CHWs or former CHWs. We recruited more than twenty working CHWs who graduated from the CCSF Program to contribute quotes and photographs, and to create educational videos that appear throughout the book.

We have written this book for CHWs and for the agencies and institutions that train CHWs. We understand that CHWs are trained in a variety of ways: by the agencies they work or volunteer for, by participating in workshops or training institutes in the community, and in college settings. While this book is based on our experience training CHWs at a community college, we support programs that provide high-quality training of CHWs in any setting. We are opposed to policy efforts that would require college-based training of CHWs or certification of CHWs that would discriminate against any community, such as communities who do not speak English, English Language Learners, undocumented residents, or formerly incarcerated communities. We address these issues in greater detail in Chapters 1 and 2 of the book.

This book is rooted in a deep hope for a world characterized by social justice and equal access to the basic resources—including education, employment, food, housing, safety, health care, and human rights—that everyone needs in order to be healthy. CHWs play a vital role in helping to create such a world. They partner with clients and communities and support them to take action to bring this hope closer to reality.

We welcome your responses to this book and your suggestions for how to improve it, should we have that opportunity. Your comments may be sent to us at

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COMMUNITY HEALTH WORK: THE BIG PICTURE

PART 1

The Role of Community Health Workers

1

Darouny Somsanith and Janey Skinner

I was homeless, living in a shelter with my daughter. There was a nurse practitioner who provided prenatal care at the shelter two days a week. When a pregnant woman came in, sometimes they came in the middle of the night, so I would give them a short presentation about the prenatal services at the shelter, and tell them when the nurse practitioner lady was coming in.

I didn't know why I was doing it, I just was doing it. I got housing after three months of being at the shelter. While I was there, I was interacting with the nurse practitioner. And when I got ready to move into my housing, she asked me did I want to become a community health worker for her. I'm like, "Sure, but what is a community health worker?" I was the second CHW with her organization. She had just started this organization called the Homeless Prenatal Program, and she and a part-time social worker took me on the streets to show me what a CHW does. I learned the ropes and I used my life experience, and the part-time social worker showed me what to do in the community, and then I just took off from there. That's how I became a CHW.

—Ramona Benson, Community Health Worker Black Infant Health Program, Berkeley, California

Introduction

This chapter introduces you to the key roles and competencies of community health workers (CHWs) and addresses common qualities and values of successful CHWs. It will also introduce you to the four CHWs pictured in the photograph that appears on page 22 in this chapter. They are each graduates of the CHW Certificate Program at City College of San Francisco, on which this book is based. Their quotes and photographs appear throughout the book, providing examples of the work they do to promote community health.

You may already possess some of the qualities, knowledge, and skills common among CHWs.

- Are you a trusted member of your community?
- Have you ever assisted a family member or friend to obtain health care services?
- Are there things harming your community's health that you feel passionate about changing?
- Have you participated in efforts to advocate for social change?
- Do you hope that, in your work, you can work with your community members to become healthy, strong, and in charge of their lives?

If you answered yes to any of these questions, you have some of the characteristics of a successful CHW.

WHAT YOU WILL LEARN

By studying the information in this chapter, you will be able to:

- Describe CHWs and what they do
- Identify where CHWs work, the populations they work with, and the health issues they address
- Explain the core roles that CHWs play in the health and social services fields
- Discuss the core competencies that CHWs use to assist individuals and communities
- Describe personal qualities and attributes that are common among successful CHWs
- Discuss emerging models of care and opportunities for CHWs

WORDS TO KNOW

Advocate (noun and verb)

Capitation

Credentialing

Health Inequalities

Social Justice

1.1 Who Are CHWs and What Do They Do?

CHWs help individuals, families, and communities to enhance their health, access services, and to improve the conditions for health, especially in low-income communities. CHWs generally come from the communities they serve and are uniquely prepared to provide culturally and linguistically appropriate services (HRSA, 2007; Rosenthal, Wiggins, Brownstein, Rael, & Johnson, 1998; Rosenthal et al., 2010). They work with diverse and often disadvantaged communities at high risk of illness, disability, and death.

CHWs provide a wide range of services, including outreach, home visits, health education, and client-centered counseling and care management. They support clients in accessing high-quality health and social services programs. They facilitate support groups and workshops and support communities to organize and **advocate** (to actively speak up and support a client, community, or policy change) for social change to advance the community's health and welfare. CHWs also work with health care and social services agencies to enhance their capacity to provide culturally sensitive services that truly respect the diverse identities, strengths, and needs of the clients and communities they serve.

As a result of the work of CHWs, clients and communities learn new information and skills, increase their confidence, and enhance their ability to successfully advocate for themselves. Most important, the work that CHWs do reduces persistent **health inequalities** or differences in the rates of illness, disability, and death (or mortality) among different communities, in particular those differences that are preventable, unfair, and unjust (Hurtado et al., 2014).

The American Public Health Association adopted an official definition for CHWs during their annual meeting in 2009, a definition developed by CHWs along with researchers and advocates:

> *A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. (APHA, 2009)*

The Bureau of Labor Statistics adapted this definition to establish a standard occupational classification (SOC) for CHWs in 2010, for the first time distinguishing CHWs as a profession in standard employment statistics. Prior to this, CHWs were included in the broad category of "social and human service assistants."

The U.S. Bureau of Labor Statistics forecasts a 25 percent growth rate for CHWs over the 10-year period 2012–2022, so while official recognition of the CHW profession is recent, interest in employing CHWs is widespread. This growth rate is faster than average, when compared to other occupations (BLS, 2014). Health departments, community-based organizations, hospitals and clinics, foundations, and researchers value the important contributions of CHWs to promoting the health and well-being of low-income and at-risk communities.

You might know a CHW already. You might be one. CHWs work under a wide range of professional titles. Some of the most popular are listed in Table 1.1.

Table 1.1 Common Titles for CHWs

Case manager/Case worker	Health educator
Community health advocate	Health worker
Community health outreach worker	Lay health advisor
Community health worker	Public health aide
Community outreach worker	Patient navigator
Community liaison	Peer counselor
Community organizer	Peer educator
Enrollment specialist	Promotor/a
Health ambassador	

- *Can you think of other titles for CHWs?*

What Do YOU Think?

Please watch this video interview about becoming a CHW. The interview features two CHWs, both graduates of the City College of San Francisco CHW Certificate program.

BECOMING A CHW: CHW INTERVIEW

http://youtu.be/BASkvuq1epw

The term *community health worker* describes both volunteers who work informally to improve their community's health and those who are paid for providing these services. Regardless of compensation, they serve as "frontline" health and social service workers and are often the first contact a community member has with a health or social service agency. CHWs typically are trusted members of the community they serve, having deep knowledge of the resources, relationships, and needs of that community.

Community health workers are motivated by compassion and the desire to assist those in need, leading CHWs to work for equality and **social justice** or equal access to essential health resources such as housing, food, education, employment, health care, and civil rights. Many CHWs take on this work because they have experienced discrimination and poverty themselves and can relate to the situations of those they are working with. Others simply see a need and want to improve conditions in their communities. Regardless of how the CHW comes to the work, every CHW is an **advocate**—someone who speaks up for a cause or policy or on someone else's behalf—working to promote health and improve the conditions that support wellness in local communities.

CHW

Esther Chavez: The reason I got into community health work was because of the immediate need in my community. There was a lack of education among youth with regard to safer sex and sexually transmitted diseases. It didn't seem to be an important topic for other community-based organizations and the need was great. So my colleague and I started an organization that provided sex education and peer support around health issues for youth in our community.

Because CHWs work under so many different job titles and perform a wide variety of duties, it has been difficult to determine how many people are working in the field in the United States, and what types of jobs they hold. One recent national study attempted to do this. A study of the CHW field was completed in 2007 by the U.S. Department of Health and Human Services and the University of Texas in San Antonio. The study was called the Community Health Worker National Workforce Study (HRSA, 2007) and to date is the most accurate national estimate of the workforce. There have been more recent studies of the workforce—notably the 2010 and 2014 National Community Health Worker Advocacy Surveys (NCHWAS)—but none that estimate its total size and composition. The following data are drawn from the 2007 study, with a few additions from the 2014 NCHWAS survey or other sources (as noted).

OVERALL NUMBER, GENDER, AND ETHNICITY

- In 2000, there were approximately 86,000 CHWs working in the United States (with California and New York having the most workers) (HRSA, 2007).
- The majority of CHWs were female (82 percent) between the ages of 30 and 50. One-fourth of the workforce was younger than 30 and one-fourth was older than 50 years old (HRSA, 2007).
- CHWs were Hispanic (35 percent) or Non-Hispanic Whites (39 percent); African Americans made up 15.5 percent of the workforce, followed by Native Americans (5 percent), and Asian and Pacific Islanders (4.6 percent) (HRSA, 2007).
- The Centers for Disease Control and Prevention (CDC) more recently has estimated the CHW workforce in the United States at over 100,000 (CDC, 2014c).

EDUCATION AND WAGES

- Thirty-five percent of CHWs had high school diplomas, 20 percent had completed some type of college, and 31 percent had at least a four-year college degree, as shown in the 2007 report (HRSA). The 2014 survey showed a shift toward greater educational attainment. For example, in 2014, 33 percent of CHWs responding had completed some college, and 35 percent had a college degree (NCHWAS).
- In the 2007 HRSA study, the majority of experienced CHWs (70 percent) received an hourly wage of $13 or more, and about half received $15 or more
- In the 2014 NCHWAS survey of CHWs, almost a third of respondents made between $25,000 and $35,000 annually, while about a third made less than that and about a third made more. The most common sites of employment for CHWs were community-based organizations (37 percent), Federally Qualified Community Health Centers and other clinics (27 percent), hospitals (14 percent), and local health departments (12 percent).

POPULATIONS SERVED

- CHWs provided services to all racial and ethnic communities: Hispanic/Latino (78 percent), Black/African American (68 percent), and Non-Hispanic White (64 percent). One-third of CHWs surveyed reported services to Asian/Pacific Islander (34 percent) and American Indian/Alaska Natives (32 percent) (HRSA, 2007).
- The majority of the clients served were females and adults ages 18 to 49. Other populations served included the uninsured (71 percent), immigrants (49 percent), homeless individuals (41 percent), isolated rural and migrant workers (31 percent each), and colonial or community residents (9 percent) (HRSA, 2007).
- Programs serving immigrants, migrant workers, and the uninsured were more likely to have volunteer CHWs (HRSA, 2007).
- CHWs work primarily with low-income communities. They work with children, youth and their families, adults and seniors, men and women, and people of all sexual orientations and gender identities (HRSA, 2007).
- The 2014 NCHWAS survey had especially strong participation from CHWs working in states that border Mexico, so it is not surprising that 65 percent reported working primarily with the Latino/a population. The next most common group worked with was African Americans (41 percent), non-Hispanic White (38 percent), Native Americans (16 percent), and Asian/Pacific Islander (12 percent). Both the 2007 study and the 2014 survey demonstrate that CHWs work with a highly diverse population.

HEALTH ISSUES AND ACTIVITIES

- The top health areas that CHWs were found to work in were women's health and nutrition, child health and pregnancy/prenatal care, immunizations, and sexual behaviors (HRSA, 2007).
- The most common specific illnesses CHWs were working to address, according to the 2007 report, included HIV/AIDS (39 percent), diabetes (38 percent), high blood pressure (31 percent), cancer (27 percent), cardiovascular diseases (26 percent), and heart disease (23 percent) (HRSA, 2007). The 2014 NCHWAS survey reported the top five health issues that CHWs work on as prevention (including nutrition and/or physical activity) (36 percent), accessing health services (36 percent), diabetes (34 percent), chronic disease prevention (31 percent), and behavioral health/mental health (24 percent).
- Specific work activities highlighted in the 2007 report included culturally appropriate health promotion and education (82 percent), assistance in accessing medical and nonmedical services and programs (84 percent and 72 percent, respectively), translating (36 percent), interpreting (34 percent), counseling (31 percent), mentoring (21 percent), social support (46 percent), and transportation (36 percent) (HRSA, 2007).
- Related to the work activities listed, specific CHWs duties included case management, risk identification, patient navigation, and providing direct services such as blood pressure screening (HRSA, 2007).

Because most CHWs work within the field of public health (see Chapter 3) and primarily with low-income communities, they address a wide range of health issues, including homelessness, violence, environmental health, mental health, recovery, and civil and human rights issues, as well as more traditional health issues

(cancer prevention, asthma, HIV disease). They work with children, youth and their families, adults and seniors, men and women, and people of all sexual orientations and gender identities. CHWs are flexible, and can work with individual clients and families, with groups, and at the community level.

MODELS OF CARE

The 2007 CHW National Workforce Study further identified five "models of care" that incorporated CHWs within them. These models continue to be common in both clinical and community settings, as of the writing of this chapter:

1. ***Member of a care delivery team:*** CHWs work with other providers (for example, doctors, nurses, or social workers) to care for individual patients.
2. ***Navigator:*** CHWs are called upon to use their extensive knowledge of the complex health care system to assist individuals and patients in accessing the services they need and gaining greater confidence in interacting with their providers.
3. ***Screening and health education provider:*** CHWs administer basic health screening (for example, pregnancy tests, blood pressure checks, and rapid HIV antibody tests), and provide prevention education on basic health topics.
4. ***Outreach/enrolling/informing agent:*** CHWs go into the community to reach and inform individuals and families about the services they qualify for, and to encourage them to enroll in the programs.
5. ***Organizer:*** CHWs work with other community members to advocate for change on a specific issue or cause. Often their work aids community members to become stronger advocates for themselves.

What Do YOU Think?

- ***When did you first become aware of CHWs?***
- ***Are there CHWs working in your community?***
- ***Do some or all of these five models of care reflect your experience of how CHWs serve the community?***

CHWs AROUND THE WORLD

CHWs are working throughout the world, on every continent and in every country. Some examples of these workers are Latin American *promotoras de salud*, Bangladesh Rural Advancement Committee (BRAC) outreach workers, *accompagnateurs* in Haiti, doulas in the United States, and community health representatives in Alaska and the southwestern United States, and, a few decades ago, the "barefoot doctors" of rural China. While their roles, duties, and even titles are flexible, what is the common thread in their work is their ability to adapt to the needs of the communities they serve. This responsiveness to the needs of the communities and clients is what makes CHWs so important to the health of populations, especially for the one billion people living on less than $1.25 a day (World Bank, 2014).

Around the world, government officials and doctors are now recognizing the important role CHWs can play in providing critically needed primary care to communities living in poverty. A recent example of this was the "One Million Community Health Workers Campaign" launched in Tanzania in 2013 (see sidebar). This first of its kind conference and training workshop was part of a greater agenda to train more lay health workers and improve the health conditions of Africa's most vulnerable populations. Similarly, the Frontline Health Workers Coalition, led by noted international health organizations such as Save the Children, formed in 2012 to "urge greater and more strategic U.S. investment in frontline health workers in developing countries as a cost-effective way to save lives and foster a healthier, safer and more prosperous world" (Frontline Health Workers Coalition, n.d.).

While campaigns to expand health programs that feature CHWs demonstrate growing recognition and respect for the profession, it should come as no surprise—after all, CHWs have proven highly effective at bringing basic, life-saving care and prevention services directly to people's homes. CHWs have been a key element of global efforts that successfully reduced new cases of HIV/AIDS around the world by 33 percent and reduced new cases of malaria by 25 percent between 2000 and 2012 (Frontline Health Workers Coalition, 2014a, 2014b). How much more could be achieved, if enough CHWs were trained and employed in every community with outstanding needs?

In October 2007, a peer-reviewed journal published by the Public Library of Science asked renowned public health leaders this question: "Which single intervention would do the most to improve the health of those living on less than $1 per day?" Dr. Paul Farmer, founding director of Partners in Health and Presley Professor of Medical Anthropology, at Harvard Medical School, Boston, provided the following answer:

> Hire community health workers to serve them *[emphasis added]. In my experience in the rural reaches of Africa and Haiti, and among the urban poor too, the problem with so many funded health programs is that they never go the extra mile: resources (money, people, plans, services) get hung up in cities and towns. If we train village health workers, and make sure they're compensated, then the resources intended for the world's poorest—from vaccines, to bed nets, to prenatal care, and to care for chronic diseases like AIDS and tuberculosis—would reach the intended beneficiaries. Training and paying village health workers also creates jobs among the very poorest. (Yamey, 2007)*

One Million CHWs Campaign

In the United States and Canada, CHWs often work as part of a clinical team, alongside health care providers with a higher level of clinical training. In less-developed countries where health resources are much scarcer, CHWs are often the frontline provider of a complex set of health care services. In these settings, clinical supervision of CHWs may be available only intermittently, when a doctor, nurse, or physician's assistant visits the village or the CHW attends a regional training. CHWs in less-developed countries around the world, despite little access to medications, technology, and diagnostic tests, nonetheless have made significant positive impacts on community health. The 2014 Ebola crisis in Western Africa brought world attention to a reality that has long affected both rural village and growing urban slums in poorer parts of the world—many residents lack access to medical care, or even the most basic hygiene supplies and medications. In Liberia, for example, there is only one physician for every 100,000 people (World Bank, 2010). In this context, CHWs are of paramount importance in helping to bridge the enormous gaps in the medical system and to facilitate access to health information and services for the majority of the population.

While CHWs are already having an impact around the world, there are not enough trained CHWs available, nor do they always have the best tools and supervision possible. The One Million Community Health Worker campaign seeks to change that, with a particular focus on Sub-Saharan Africa. This campaign, launched by the UN Sustainable Development Solutions Network, seeks to recruit and train one million CHWs and link them to a network of health care providers who will provide remote supervision and supply appropriate technologies. For example, a smart phone can be used to report on medication availability, to consult with a nurse or doctor, and to submit test results for TB or HIV tests. A growing number of medical tests can be safely and accurately conducted by CHWs visiting patients in their homes or workplaces. The One Million Community Health Worker Campaign also focuses on training and engaging national and regional health systems that may not be well coordinated with CHW efforts. Where existing CHW programs are having success, the campaign seeks to expand and network these programs.

A driving motivation for the One Million CHW campaign has been the eight Millennium Development Goals (MDGs) set by the United Nations in 2000 with a target year of 2015. The MDGs sought to cut poverty worldwide in half, reduce child mortality, improve maternal health, ensure universal primary education, increase gender equality, and combat infectious diseases such as HIV/AIDS and malaria, among other things. Increasingly, both governments and nongovernmental organizations (nonprofits) recognize that the health-related MDGs will be impossible to reach by the target year of 2015 without the help of a much larger CHW workforce. For example, the Deputy Minister of Health and Social Welfare of Tanzania stated at the first international workshop sponsored by the One Million CHW Campaign, "We have to recognize that advances toward the Millennium Development Goals can be greatly accelerated by urgently expanding primary health care delivery capacity across Sub-Saharan Africa. Community Health Workers are foundational to this strategy" (One Million Community Health Workers Campaign, 2013). CHWs not only supplement health care services, they are often the main component of health care delivery and prevention efforts in low-resource settings.

1.2 CHWs and Public Health

CHWs often work within the field of public health (see Chapter 3). Unlike medicine, public health works to promote the health of entire communities and populations. Public health understands the primary causes of illness and health to be more than just access to health care, but also whether or not people have equal access to basic resources and rights, including food, housing, education, employment with safe working conditions and a living wage, transportation, clean air and water, and civil rights—understanding that people's social and physical environments play a huge role in their health and wellness. Collectively, the conditions that shape health are called the "social determinants of health."

The field of public health not only provides services to prevent illness and improve care, it also influences the social determinants of health by advocating for policies to assure basic resources and rights for all people. CHWs share in this advocacy work. For example, one of the core values listed on the website of the Community Health Worker Network of New York City (n.d.) states, "Community health workers are agents of change who pursue social justice through work with individuals and communities to improve social conditions." CHWs also play a key role in strengthening the social fabric of communities, which can enhance the health of community residents.

To achieve the goal of eliminating health disparities among racial and ethnic minorities, attention must shift to the social determinants of health. Included in the list of social determinants of health are social support, social cohesion, and universal access to medical care. Social support refers to support on the individual level when resources are provided by others, and social cohesion refers to support on a community level when the trust and respect between different sections of society result in cherishing people and their health. Community health workers (CHWs) impact these social determinants of health as they build supportive relationships with community members and community groups to promote access to resources and to health care (McCloskey, Tollestrup, & Sanders, 2011).

1.3 Roles and Competencies of CHWs

The roles of CHWs, and the competencies that are required to fulfill those roles, continue to evolve in response to changing health care delivery models and public health strategies. CHWs have proven to be an effective—as well as a cost-effective—component of programs focused on prevention, chronic condition management, healthy maternity, and health care access or enrollment (CHWA, 2013; CDC, 2011; Rosenthal et al., 2010). CHWs help to ensure that services are culturally and linguistically appropriate, especially when they are involved in designing those services. As more CHWs are employed in health care and public health, and as new mechanisms for funding and institutionalizing CHW positions emerge, the demand for greater clarity in defining CHW roles and competencies also increases. In this section we examine the CHW roles and competencies that have served as a benchmark for almost two decades, as well as noting where additional roles have been identified by efforts in several states to define CHW's scope of practice.

It should be noted that defining what a CHW does is not without controversy. Other health professionals may raise concerns when they see overlap between their profession and that of a CHW in areas such as health education, counseling, systems navigation, and case management. Even some CHWs, since they serve in so many different capacities and models of care in both volunteer and paid positions, worry that too narrow a definition of the CHW role could leave out some valuable CHW practices. Yet many CHWs and others who work with them have advocated for a clearer definition of the CHW role and scope of practice. A *scope of practice* refers to the range of services and duties that a category of worker, such as CHWs, is competent to provide. While many CHWs express mixed feelings about how formalized the field should be, all agree that the work they do deserves more recognition from government and other professionals, and increased funding.

A step towards national recognition is to be officially classified by the U.S. Department of Labor, Bureau of Labor Statistics. In 2010, the Department of Labor approved a standard occupational code—21-1094—and definition for CHWs as professionals who:

> *Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. (Bureau of Labor Statistics, 2010)*

CHWs take on many different roles and provide a wide range of services to clients and communities.

This official recognition of the CHW occupation may speed the development of more stable mechanisms for the financing of CHW services from state and federal programs such as Medicaid and Medicare. Reimbursement of CHW services under Medicaid was formally allowed under the Affordable Care Act of 2010 (the ACA, also known as "Obamacare"), and each state has the option to establish policies to do this. In fact, even before the ACA passed, states could seek a Medicaid waiver to allow "fee for service" reimbursement of certain CHW services. Minnesota was the first state to do so in 2007, and Minnesota also supports CHW services through other non-Medicaid funds (National Healthcare for the Homeless Council, 2011). Reimbursement for CHW services through large public insurance programs like Medicaid means a more sustained and stable funding stream for CHW jobs, instead of a reliance on grants that come and go. As discussed in Chapter 2, reimbursement or "fee for service" payments is just one of many mechanisms for financing the CHW profession. Formal recognition of the occupation also makes other avenues of financing CHW jobs more feasible.

What Do YOU Think?

- *What do you think of this definition of the CHW field? What does it include and what does it leave out?*
- *How would it affect your family and community if CHW services were more widely available?*

What Are Core Roles and Competencies?

Core roles are the major functions a person commonly performs on the job. For example, the core roles of a farmer include clearing fields, planting, and harvesting crops. The core roles of CHWs include providing outreach, health education, client-centered informal counselling, case management, community organizing, and advocacy.

Core competencies are the knowledge and skills a person needs in order to do his or her job well. Again, a farmer must be able to operate equipment, assess timing for planting, and prepare the soil. Core competencies for CHWs include knowledge of public health, behavior change, ethics, and community resources and the ability to provide health information, facilitate groups, resolve conflicts, and conduct an initial client interview or assessment. CHW educational programs seek to strengthen CHW competencies or skills.

A landmark study that defined CHW work was published in 1998 by the University of Arizona (Rosenthal, Wiggins, Brownstein, Rael, & Johnson, 1998). As one of the first major studies of the CHW profession, it

documented the duties that CHWs perform and identified core CHW roles and skill sets, and discussed the values or personal characteristics that many CHWs share. Identifying CHW competencies allows trainers and employers to better support CHWs in their work. In all, the study identified seven core roles and eight core competencies for a CHW (both are listed in Table 1.2 below).

The CHW Common Core Project

As we are writing this chapter, a new comprehensive review of CHW **core roles and competencies** is underway. The Community Health Worker Common Core (3C) project aims to update the 1998 study, reviewing CHW work and training in six states and consulting directly with a national panel of CHWs and those who work closely with CHWs. The results of the 3C project will be broadly available by the end of 2015. For more information about the 3C project, please see *www.chrllc.net/*.

The 1998 study of CHWs continues to be an important reference for the profession nationally. In recent years, especially as CHW coalitions and public health advocates have worked to develop mechanisms for greater employment of CHWs and reimbursement of CHW services under the ACA, different states have defined CHW roles differently. While there has been substantial overlap with the roles and competencies identified in the 1998 study, some roles have been added or defined in more detail (such as outreach and participatory research). New terms, such as system navigation and care coordination, have gained popularity, and more sophisticated methods of providing these services have been developed by CHWs and other health professionals. Table 1.2 compares roles identified in the 1998 CHW study with those from state CHW networks in Minnesota and New York (other states have already or may soon create their own definition of the CHW roles). These lists do not contradict one another and, when combined, provide a more complete picture of the many roles CHWs fulfill (Minnesota Community Health Worker Alliance, 2013; New York State Community Health Worker Initiative, 2011).

Table 1.2 Personal Qualities of Successful CHWs

1998 CHW WORKFORCE STUDY	NEW YORK STATE CHW INITIATIVE	MINNESOTA CHW ALLIANCE
Cultural mediation between community and health system	Outreach and community mobilization	Bridge the gap between communities and the health and social service systems
Informal counseling and social support	Community/cultural liaison	Navigate the health and human services system
Providing direct services and referrals	Case management and care coordination	Advocate for individual and community needs
Providing culturally appropriate health education	Home-based support	Provide direct services
Advocating for individual and community needs	Health promotion and health coaching	Build individual and community capacity
Assuring people get the services they need	System navigation	
Building individual and community capacity	Participatory research	

We provide greater detail below on the seven core roles and eight core competencies identified in the 1998 CHW study. While we address all of these roles and competencies in later chapters of this book, the book (and our curriculum at CCSF) is not structured around them explicitly. Instead, we focus most on specific skill sets, such as client-centered counseling (Chapter 9), care management (Chapter 10), outreach (Chapter 19), home visits (Chapter 11), and community organizing and advocacy (Chapter 23).

CORE CHW ROLES

1. **Cultural mediation between communities and the health and social services systems**: Intimate knowledge of the communities they work with permits CHWs to serve as cultural brokers between their clients and health and social services systems. By being a bridge that links community members to essential services, CHWs ensure that the clients receive culturally appropriate quality care.

CHW

Letida Sot: As a CHW, I work regularly with doctors to assist them to communicate with our Cambodian patients. Because the Cambodian community is so small, sometimes patients have to wait many hours to speak to someone at a clinic who can understand them. By me working at the clinic, the patient doesn't get lost in the system—they can easily come to me for what they need. Besides not understanding English, some of our patients don't read or write well and have a hard time understanding their medications. One of the patients I worked with suffered from hypertension, diabetes, and heart disease. She thought that she needed to finish one type of medicine first before she can start on another, even though sometimes she needed to take 15 different medications a month. Because of this, her diabetes was out of control and the doctor asked me to aid in the arrangement of her daily medication schedule. When I explained to her that she could take the medications simultaneously, she was shocked because she had been doing what she thought was right for 10 years.

2. **Informal counseling and social support:** CHWs provide client-centered counseling to support clients to live healthier and better lives. A CHW may help clients to set health-related goals and may use techniques such as motivational interviewing (see Chapter 9) to support clients in reducing health-related risk behaviors.

CHW

Tina Diep: Smoking within the Asian community, especially with men, is very integrated into the cultures. Many men know about some of the health hazards of smoking for themselves but don't really know about second-hand smoke or the other health impacts of smoking on their families. Because it is so hard for them to quit, the doctors refer them to me to get smoking cessation counselling. Of course not everyone is ready to quit or even wants to quit, but for those who are, I assist them in creating a plan to reduce or stop smoking, give them some education on the harmful effects of cigarettes, and just provide support and encouragement. In every session, I talk with them about their smoking experience and explore their ambivalence to quitting. Sometimes just talking will get those who were not ready to quit at least thinking about the possibility of it, and this can lead to another appointment and another opportunity to make a plan to quit.

3. **Providing direct services and referrals:** Some CHWs provide direct care to clients through the services they are trained and qualified to provide, such as blood pressure monitoring, reproductive health counseling or HIV-antibody test counseling. They may also provide case management services or otherwise link clients to services by knowing what services exist and referring clients appropriately.

CHW

Somnang Sin: When I can't provide the services for a patient, I refer them to services at another program or agency. It is important as a CHW to know what resources are available in the community. Part of my job is to make sure the patient gets the right care—I'll walk them to their appointment or to another agency if the patient needs me to.

4. **Providing culturally appropriate health education:** Because CHWs usually come from the communities they serve, they are familiar with the cultures of the clients they work with (for example, language, values, customs, sexual orientation, and so on) and are better prepared to provide health information in ways that the community will understand and accept. Health education can be provided one-on-one, in small groups, or through large presentations.

CHW

David Pheng: I am a CHW at a clinic in Oakland [California]. I see and give presentations to patients who are young adults ages 14 to 20. I find that during my presentations, I have to ditch lecture-based teaching and make it as entertaining as possible. But the entertainment is also speaking to the youth and relating to their everyday experiences—not from a textbook but from the radio, Internet, music, and the everyday words they use. Being culturally appropriate isn't just knowing their language but relating to them as youth, not talking down to them, and respecting their space so they feel comfortable and willing to ask questions. I find the more the youth laugh, the more they pick up on ideas and information that deal with safer sex practices and access to clinical services.

5. **Advocating for individual and community needs:** CHWs speak out with and on behalf of clients and communities. They advocate—with the community whenever possible—to make sure that clients are treated respectfully and given access to the basic resources that they need in order to live healthy lives.

CHW

Jinyoung Chun: For a couple of years now, I've taken my clients to Sacramento [California] for Immigrant Day. I think it is important that they understand how our government works and that they can have a chance to talk directly to their legislators. The clients also get to see and connect with community members from other cultures who are there for the same cause. They see that they are not alone and that people can come together and make a difference. At the legislative meetings, the clients talk about issues that impact their lives and their community while I interpret. We do a lot of preparation together before the day so they understand the process and decide what they want to say. After the meeting, they feel so empowered and heard! Many of the clients I work with now also attend and speak at local Board of Supervisors' meetings, as well as other community events on issues that they are passionate about.

6. **Assuring people get the services they need:** A CHW often is the first person many clients interact with, whether through an outreach encounter, or when a client arrives at an agency or clinic. It is the job of the CHW to ensure that these clients get the services they need. CHWs often assist clients in navigating health and social service systems, which can be confusing and overwhelming in the best of times, let alone when someone may be suffering from illness, and may or may not speak the language, read fluently, have identification, or be able to pay for services.

David Pheng: We are usually the first ones to receive questions—and complaints—from the patients. It's fun but challenging work, because the routine is never the same. Once patients come in, I find out what services they need and assist them to get these services. I try to empower the patients to seek the services themselves, but if they need it, I'll assist in guiding them through the clinical side of checking in, seeing a doctor and offering additional resources. I see what else they might need and try to find an organization in the community that can assist them, like with food or legal issues.

7. **Building individual and community capacity:** CHWs support clients and community members to develop the skills and the confidence to promote and advocate for their own health and well-being. Often this work is done with individual clients, or clients and their family members. Other times, CHWs work with groups and community networks, to build the capacity to speak out and take action in their own lives and communities.

Alvaro Morales: One of the most important ways that I know that I am doing a good job is when my clients no longer need me, or need me as much. Everything I do is based on supporting the client not to be dependent on me anymore. I want to support them to take charge of their own health, to negotiate healthy relationships, to navigate the health care system, to communicate with health care providers to get the treatment they want and deserve. And sometimes I get to work with communities and to support them to speak out for policy changes. Instead of me testifying before the Board of County Supervisors or City Council on behalf of the communities I work with, I want to support them to testify and speak out for themselves. They are the experts about what they need and want, and their voices are the voices that need to be heard.

A CHW talks with youth at a health center.

What Do YOU Think?

- *Have you ever taken on any of these CHWs' roles?*
- *What were some of the challenges that you faced in performing the role?*
- *Can you think of other roles that a CHW might play?*

EIGHT CORE COMPETENCIES FOR CHWs

Core competencies are the skills and knowledge that enable CHWs to carry out their roles. There are some core competencies that all CHWs use—communication skills, interpersonal skills, organizational skills, and a knowledge base relevant to the CHW's community and types of services provided. Other core competencies are commonly used by many CHWs, but the extent to which they are used may depend on the role that the CHW fulfills. These include skills for teaching, service coordination, capacity building, and advocacy.

The eight core competencies that are highlighted here were identified in the 1998 CHW study mentioned above. Additional tasks and skills have been identified in subsequent reviews of the CHW workforce at the state level, such as that carried out by the New York State CHW Initiative. The 3C project mentioned above will release a national review of CHW competencies in late 2015. For example, CHW tasks and skills include family engagement, problem solving, treatment adherence promotion, harm reduction, translation and interpretation, leading support groups, and documentation, among others. Many of these duties fit within the eight broad competencies discussed in this chapter (for example, documentation can be considered an organizational skill).

The eight broad competencies, as well as many more specific duties and tasks, are addressed in subsequent parts and chapters of this book. Part 1 is focused on building understanding of the broader context in which CHWs work including concepts of public health, health systems, equality, and cultural humility (part of the "knowledge base" competency listed below).

1. **Communication skills:** CHWs must be good listeners in order to learn about their clients' experiences, behaviors, strengths, and needs, and to provide health information and client-centered counseling or coaching. Group communications skills become important for leading group health education and community advocacy.
2. **Interpersonal skills:** CHWs work with diverse groups of people and must be able to develop positive relationships with clients, community members, supervisors, doctors, nurses, social workers, and policymakers. This includes the ability to provide and receive constructive feedback, and to resolve conflict.
3. **Knowledge base about the community, health issues, and available services:** CHWs often support community members to gain access to local resources. In order to do this effectively, they must spend time getting to know the communities they work with and the range of health and related services that may be available to clients. CHWs must also be knowledgeable about the health issues—such as diabetes or domestic violence—that they address day to day.

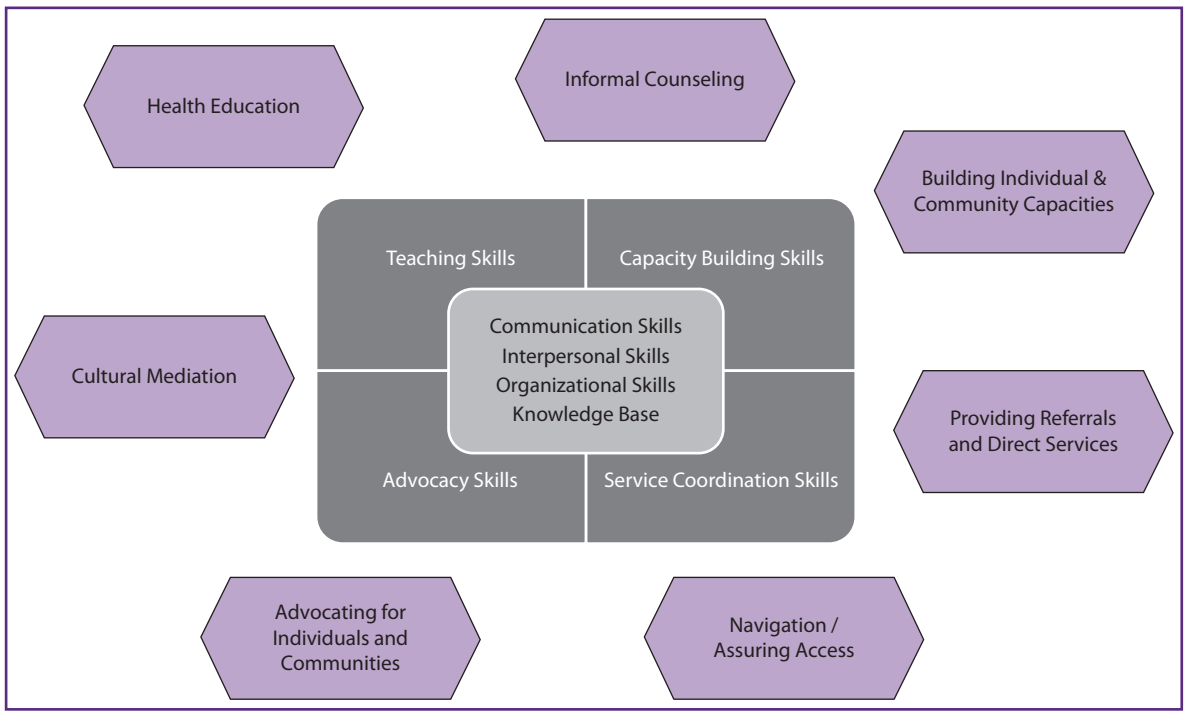

Figure 1.1 The relationship between CHW core competencies and roles

4. **Service coordination skills:** The health care and social service systems are complex, not very well integrated, and sometimes difficult to access. CHWs sometimes work as care managers and frequently work with clients to access available services and to create and follow realistic plans to improve their health, despite the complexity of the systems.
5. **Capacity-building skills:** CHWs do not want clients and communities to become dependent upon them or other service providers. They teach and support clients and communities to develop new skills and confidence to promote their own health, including, for example, communication skills, risk reduction behaviors, chronic disease management, and community organizing and advocacy skills.
6. **Advocacy skills:** CHWs sometimes speak up on behalf of their clients and their communities within their own agencies, with other service providers, and to support changes in public policies. More important, CHWs support clients and communities in raising their own voices to create meaningful changes—including changes in public policies—that influence their health and well-being.
7. **Teaching skills:** CHWs educate clients about how to prevent and manage health conditions. CHWs teach about healthy behaviors and support clients in developing healthier habits. They also teach community members how to advocate for social change.
8. **Organizational skills:** CHWs support individuals, families, and communities in getting the services they need. The work is demanding, with many details to keep track of and document, not only for oneself but also for one's clients. Being organized ensures that CHWs are able to properly follow up with clients and accurately document data for their employers.

What Do YOU Think?

- *What other skills are important for CHWs to have?*
- *Do you already have some of the skills identified?*
- *Which skills do you want to learn or improve?*

1.4 Personal Qualities and Attributes of CHWs

All of us bring unique life experiences to our work. These experiences, along with our individual personalities, shape our value systems and how we see the world around us. The work of a CHW depends upon their ability to build and maintain positive interpersonal relationships with people of diverse backgrounds and identities. Without the capacity to build relationships based on trust, CHWs cannot do their job effectively. The qualities that enable this capacity can be strengthened through practice and self-reflection. We highlight several desirable personal qualities and attributes in Table 1.3, adapted from work of the International Training and Education Center on HIV in Zimbabwe (International Training and Education Center on HIV, 2004). With these qualities and attributes, CHWs inspire confidence and trust and build positive professional relationships with clients and communities.

Table 1.3 Personal Qualities of Successful CHWs

PERSONAL QUALITIES	DEFINITIONS
1. Interpersonal warmth	The ability to listen and respond to clients and communities with compassion and kindness
2. Trustworthiness	Being honest, allowing others to confide in you, maintaining confidentiality, and upholding professional ethics
3. Open-mindedness	The willingness to embrace others' differences, including their flaws, and be nonjudgmental in your interactions with them

(continues)

Table 1.3 (*Continued*)

PERSONAL QUALITIES	DEFINITIONS
4. Objectivity	Striving to work with and view clients and their circumstances without the influence of personal prejudice or bias
5. Sensitivity	To be aware of and truly respect the experience, culture, feelings, and opinions of others
6. Competence	Developing the knowledge and skills required to provide quality services to all the clients and communities you work with
7. Commitment to social justice	The commitment and heart to fight injustice and to advocate for social changes that promote the health and well-being of clients and communities
8. Good psychological health	Having the mental and emotional capacity to perform your work professionally, without doing harm to clients, colleagues, or yourself
9. Self-awareness and understanding	Being willing and able to reflect upon and analyze your own experiences, biases, and prejudices, to ensure that they do not negatively affect your interactions with clients and colleagues

What Do YOU Think?

- ***What other personal qualities and values should CHWs have?***
- ***What personal qualities and values do you bring to this work?***
- ***What qualities do you want to build and enhance?***

The last quality in the list above has special importance: self-awareness serves as a foundation that assists CHWs to cultivate other key qualities and skills. Developing awareness of our own personal biases helps ensure that we do not harm a client or the community by judging them based on our own experiences, values, and beliefs. This is an ethical obligation for all CHWs and is essential for three key principles of CHW practice: client-centered practice, community-centered practice, and cultural humility.

Throughout this book you will find questions directed to you as a person who is training to become a CHW or to enhance your CHW skills. Some of the questions invite you to take time to reflect and to cultivate self-awareness. The questions also invite you to bring your own experience, insights, ideas, and wisdom into the conversation. Your life experience, whatever it may be, is an important foundation for the work you will do as a CHW.

The challenges of developing self-awareness and using it to inform your work as a CHW is a theme that runs throughout this book. It is addressed in greater detail in Chapters 6 and 7.

1.5 The Role of CHWs in the Management of Chronic Conditions

As CHWs become more recognized and respected, their professional role within the health and social services fields is expanding, especially in the area of primary health care and chronic disease management. Earlier in this chapter we talked about five models of care, one of which features a CHW as a "member of a care delivery team."

There is considerable interest in expanding the use of CHWs in care delivery teams, and many hospitals and clinics are already doing so. A study at the University of Utah found that CHWs were typically employed as members of a care delivery team or as part of a health care continuum, coordinating CHW services with health care providers, both nationally and within the state of Utah (McCormick, Glaubitz, McIlvenne & Mader, 2012). A report from the Urban Institute also notes that rising levels of poverty and increased immigration create an incentive for health care organizations to hire CHWs, to help bridge cultural gaps and meet the needs of communities with high levels of chronic disease (Bovbjerg, Eyster, Ormond, Anderson, & Richardson, 2013).

The ACA has provided additional incentives to employ CHWs and strategies to finance them, in particular to assist with managing chronic conditions (the ACA is discussed at greater length in Chapter 5). The ACA

promotes what's known as the "triple aim"—improve the patient's experience of health care, reduce the costs, and improve the health of individuals and populations. CHWs have a key role to play in helping health care organizations attain the triple aim. The California Health Workforce Alliance, for example, has released recommendations for scaling up the use of CHWs and *promotores de salud* (a term common in Spanish-speaking communities for community health workers who work at the grassroots, often as volunteers), specifically to help health care organizations achieve the triple aim (CHWA, 2013). The ACA not only opens up the door to Medicaid reimbursement (discussed elsewhere in this chapter and in Chapter 5, but also provides grants to eligible organizations "to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers"—an important recognition of the role CHWs play. CHWs are being embraced not only as a means to conduct outreach or enrollment, but also in promoting "positive health behaviors and discouraging risky health behaviors" (CDC, 2011).

CHRONIC DISEASE: THE DOMINANT TYPE OF ILLNESS IN THE UNITED STATES

Today, chronic conditions—such as cardiovascular disease (primarily heart disease and stroke), cancer, lung diseases and diabetes—are the most common, costly, and preventable of all health problems in the United States. Data from the CDC show that:

- About half of all adults—117 million—live with chronic illness, with one of four of these adults having two or more chronic health conditions (CDC, 2014b).
- More people die of chronic conditions in the United States than from all other causes combined. Heart disease and cancer alone account for almost half of all deaths annually in the United States (CDC, 2014b).
- The costs of medical care for people with chronic diseases account for more than 84 percent of the nation's $2.7 trillion total health care expenditures (CDC, 2014a; Robert Wood Johnson Foundation, 2010).
- Chronic diseases not only cause the majority of deaths in the United States, with many of those deaths occurring well before the patient reaches his or her full life expectancy—the prolonged illness and disability from chronic diseases such as diabetes and arthritis also result in extended pain and suffering and decreased quality of life for millions of Americans (CDC, 2014b).
- Health inequalities in chronic disease are pervasive, with higher rates of death and illness among low-income communities and among communities of color in the United States (CDC, 2013).
- Close to 40 percent of deaths from the five leading causes of death in the United States (four of which are chronic diseases—heart disease, cancer, chronic lung diseases, and stroke—plus unintentional injuries) are considered preventable (Yoon, Bastian, Anderson, Collins & Jaffe, 2014).

In March 2011, the CDC published a report about CHWs and their role in supporting patients to manage chronic disease. The report highlights

> *the unique role of CHWs as culturally competent mediators (health brokers) between providers of health services and the members of diverse communities and the effectiveness of CHWs in promoting the use of primary and follow-up care for preventing and managing disease have been extensively documented and recognized for a variety of health care concerns, including asthma, hypertension, diabetes, cancer, immunizations, maternal and child health, nutrition, tuberculosis, and HIV and AIDS. (CDC, 2011, p. 2)*

One of the ways to do this is to integrate CHWs into the health care team, discussed below. You will also read more about health care teams and chronic conditions management in Chapter 16.

CHWS WITHIN THE HEALTH CARE DELIVERY TEAM

Many clinics and hospitals now employ CHWs as members of a care delivery team for patients with chronic diseases. Typically in the team model, CHWs work with a medical provider (a doctor, a nurse practitioner or physician's assistant), a nurse, a medical assistant, and sometimes other health professionals (such as a social worker or a respiratory therapist). The team works together consistently to manage the care of patients. The health care delivery team may combine social support (provided by CHWs) and clinical care (provided by doctors and nurses) to assist patients to more effectively manage and control their illnesses. Team-based care developed as a strategy to improve quality, access, and patient centeredness; reduce health care costs for high-cost patients; and strengthen health care delivery teams. Within this model, CHWs are trained to educate, counsel, and work with patients to improve their health through one-on-one and group sessions. CHWs may also

provide home visits. Some of the chronic conditions that CHWs address in their work include diabetes, high blood pressure, HIV/AIDS, and cancer (Bodenheimer & Laing, 2007; Martinez, Ro, Villa, Powell, & Knickman, 2011).

The financing of health care under the ACA creates new incentives for health care teams, and rewards clinics and hospitals for achieving positive health outcomes. One of the important ways the ACA does this is through capitation. **Capitation** means that the health care organization receives a set amount of funding to serve each patient, instead of reimbursement for each appointment, test, or treatment provided. This creates a financial incentive to keep all people in that group as healthy as possible—so they won't need more frequent or more expensive treatment. CHWs, because of their strong links to communities, can help clients get into care early, access the appropriate level of care (for example, a primary care clinic instead of the emergency department at a hospital), overcome barriers to chronic conditions management, and help the rest of the health care team understand the patients' needs and resources more completely. This can translate into lower health care costs. Under capitation, there is the potential for some of those health care savings to be redirected to create permanent jobs for CHWs as members of the health care team.

Community health workers can play a vital role in helping clinics and hospitals attain the Triple Aim, in a variety of ways (Bodenheimer, 2015; CHWA, 2013; Findley, Matos, Hicks, Chang & Reich, 2014; Martinez et al., 2011). Some of benefits of hiring CHWs as part of a care delivery team include:

- Improve health outcomes for individuals and populations
  - Improving access to health care and insurance is a key component of improving health outcomes. If people cannot access affordable primary care, screening tests, and prevention services, they are more likely to show up for care with advanced diseases that are much more difficult and expensive to treat. CHWs play an important role in expanding access to care. They have signed up thousands of people for health insurance. They conduct outreach and build community awareness of services. They identify cases (people with a disease or at high risk) and help them to access the appropriate services.
  - Beyond access, CHWs help patients stay in treatment and achieve better health outcomes by providing health education and peer counseling, health coaching, systems navigation, and advocacy. These services have been shown to have a real impact on health outcomes, for example, reducing the need for hospitalization (CDC, 2011).
- Reduce health care costs
  - CHWs provide clients with the health education, social support, and follow-up required to manage their chronic health conditions. Successful self-management of the condition will mean fewer complications, thereby decreasing the chances of a patient ending up in the emergency room or hospitalized, where care is more expensive.
  - The contributions of CHWs may free doctors, nurses, and other clinicians to invest their time providing the services that only they can provide. CHWs reinforce the work of doctors, nurses, and others—for example, by reviewing the doctor's instructions with the client, or by making the medical provider aware of the patient's concerns.
- Improve patient-centeredness and the patient's experience of health care
  - CHWs speak the languages of their patients and can connect them to culturally appropriate health and social services resources. By being a cultural bridge between their community and the service providers, CHWs ensure that clients receive better care.
  - CHWs can also help other members of the health care team to understand the patient's perspective and adapt to the patient's needs.

As our society grows and diversifies, and as poorly treated chronic conditions become an increasing strain on the health care system, employing CHWs is a cost effective and culturally appropriate solution to improving the health and wellness of all community members. Not incidentally, this approach also has a strong potential to reduce health inequalities.

THE EMERGING ROLES OF CHWs: INTERVIEW

http://youtu.be/SnaaAUKK640

Please watch this video interview with Dr. Carl Rush.

1.6 Professionalizing the CHW Field

The CHW field is growing and transforming. You will learn more about this in Chapter 2. There are disagreements among CHWs, CHW supporters, researchers, educators, employers, and other health professions about how best to professionalize the field. Some people advocate for **credentialing** (CHWs would need certification from an educational institution, professional association, or employer in order to work—see Chapter 2 for more details) and greater integration into the health care field. As of 2012, 15 states and the District of Columbia had issued one law or regulation regarding CHWs, and at least five states (Massachusetts, Minnesota, Ohio, Oregon, and Texas) have developed credentialing procedures (Miller, Bates, & Katzen, 2014). Others worry that credentialing may harm or diminish the connection that CHWs have to local communities and their commitment to social justice. Everyone, however, seems to agree that the field deserves greater recognition, respect, and funding.

Strategies that are being used to advance the CHW field include:

- Conducting research about the field to further clarify what CHWs do and how effective they are
- Founding national and regional CHW organizations as a way for CHWs to have a collective voice in determining the development of their profession, and to advocate on behalf of the communities they serve
- Developing appropriate ways to credential or certify the work of CHWs
- Developing training programs and materials that teach the core competencies required for success as a CHWs
- Advocating for policy changes that will result in more stable funding for CHWs
- Developing regulations and procedures to take advantage of the funding opportunities in the ACA

- ***What do you see as the key opportunities and challenges for CHWs as the field becomes more professionalized?***

What Do YOU Think?

An Inherent Tension

Sergio Matos, longtime CHW and current (2015) Chair of the Education and Capacitación Committee of the CHW Section of the American Public Health Association, discusses issues that arise as the role of CHWs within the health and social services systems expands.

"There is tension between our community's needs and desires, and the programs that pay CHWs—they often have conflicting goals and objectives. There is a big risk that CHWs will just get co-opted by the service industry. It's attractive—it provides salaries, it provides benefits, it provides a lot of stuff. But it betrays much of our tradition and history.

"Our society has become a service economy and in order to keep it going you need clients to sell your service to. We often don't even think about it, but we continuously label people in a way that oppresses them so that they are dependent on our services. So, for example, people are no longer people but they're diabetics, or they are handicapped or disabled, they're homeless, they're poverty stricken, or underprivileged. All these labels that we put on people—and once we get you to accept that label we say, 'Oh, but fear not, we have a service for you!'

"The work of CHWs is directly opposed to that—directly and fundamentally opposed to that. A CHW is successful when the person they work with no longer needs us. That's our true measure of success—when we've helped somebody develop self-sufficiency and independence so that they no longer need us or our services."

1.7 Introducing Four CHWs

Throughout this book, you will find quotes from CHWs who have firsthand knowledge, experience, and information to share. Quotes and photographs from four CHWs appear frequently throughout the entire book. The CHWs are **Ramona Benson**, **Phuong An Doan-Billings**, **Lee Jackson**, and **Alvaro Morales**. They each

graduated from the CHW Certificate Program at City College of San Francisco and contributed to the development of this book by participating in extensive interviews and taking photographs that represent their work. In this section, each of them is introduced. Through the rest of the book, you'll see an icon every time we include a quote from a CHW.

Ramona Benson journeyed from being a client at a San Francisco homeless shelter to becoming a CHW with the Homeless Prenatal Program in San Francisco in 1990. She completed her CHW certificate from City College of San Francisco in 1994 and trained CHWs at the Homeless Prenatal Program until 2000. She was the supervisor of supportive services at San Francisco' s Tenderloin Housing Clinic from 2000 to 2001, when she became the CHW at the Black Infant Health Program in Berkeley, California. In 2008, she became the coordinator of the Black Infant Health program at Berkeley's Department of Public Health. She completed her Bachelor's degree in Liberal Studies with a minor in Health Education, and is considering applying for a Master's program.

Ramona Benson: You have to have a variety of skills to be effective as a CHW. There are going to be some long hours that you're not going to get paid for. You have to be committed and passionate and you have to be a team player: we can't do it all by ourselves. My reward is seeing my community become healthy, becoming empowered. That's how I measure my success, by watching those who I've worked with overcome barriers. They may have had 10 barriers and they overcame two of them—but that's success, for me.

In my career, I've worked as both a CHW and a supervisor. I'm a coordinator now, but I'm still doing CHW work because it's in me. When I was at Homeless Prenatal and Tenderloin Housing, as rewarding as it was to be promoted as a supervisor, being in that role for a good amount of time, I began missing providing services hands on. I wanted to get back into a CHW role because that's where my passion is. I came to Black Infant Health as their first CHW. Now as a coordinator there, I wear multiple hats. I do the CHW work as well as the coordinator work and supervision.

Four graduates of the CCSF CHW training program. From top clockwise: Lee Jackson, Alvaro Morales, Ramona Benson, Phuong An Doan-Billings.

Born in Vietnam, Phuong An Doan-Billings holds a BA degree in English from Saigon University (1979). She taught French and English in Vietnam until she came to the United States in 1990. She started working for Asian Health Services (AHS) in Oakland in 1992 as a health care interpreter and CHW. In 2005, Phuong An became the supervisor of the AHS Community Liaison Unit, which reaches out to Asian communities for health education services and health care advocacy. She also contributes her in-depth language skills to the AHS Language Culture Access Program, which provides training for hundreds of health care interpreters in the Bay Area. Since 2012 she has been the Healthy Nail Salon Program Coordinator.

Phuong An Doan-Billings: A lot of what I do with the Healthy Nail Salon program is coordinating the members, the nail salon workers and owners, organizing, holding them together. We just graduated our second group of core leaders. We train them in public speaking and outreach, so they can take the role of advocacy for their own industry. We build awareness of the hazards of the products they use that are notoriously toxic. Advocacy requires a little public speaking, something that Vietnamese women are definitely not trained for over the generations. It's a very big challenge for them. I know the culture, the community. I use my own personality so people get involved. In our culture, we appeal to personal relationships. When they see you are committed to helping, they trust you. It's like what I did in the clinic, before. It's holding the relationship with them, facilitating their participation in programs, educating and motivating them.

Lee Jackson has seven certificates from City College of San Francisco, including Drug and Alcohol Studies, HIV/STI Outreach, Case Management, Group Facilitation, Infectious Disease Prevention in Priority Populations, Diversity and Social Justice, and Community Health Worker and Post-Prison Health Worker; he completed the CHW certificate in 2004. Originally from Texas, Lee moved to Los Angeles in 1979 and San Francisco in 1987. He has worked as a CHW at several nonprofits including the South Beach Resource Center, Walden House, and PlaneTree, and currently works for San Francisco Department of Public Health's Early Intervention Program at Southeast Health Center. Lee works with clients who are HIV positive, multiply diagnosed, or struggling with substance abuse. Lee has completed an A.S. degree in Health Education.

Lee Jackson: As a CHW, you have to work from the heart and give your all to do what's best for your client. Some of my clients are really sick and I go wherever I have to find them. I visit them on the streets and in their apartments, in detox and residential drug recovery programs, in jail and at the General Hospital. I even accompany them to court when they have legal problems. In this work, you have to learn how to take care of yourself, too. I'm really into jazz, so I listen to music a lot. What keeps me going is my strong lease on my spirituality. The only way you are going to remain relevant in this changing field is to stay up-to-date, so it's important to me to take classes, get these certificates and attend conferences, workshops and seminars.

Alvaro Morales: I am originally from Guatemala, where I got an accounting degree. I started out working here in the United States as a cook for a big hotel in San Francisco. But that isn't what I wanted to do. I started volunteering for an AIDS hotline, answering questions, talking to people over the phone. Someone told me about the CHW training program at City College. I started the program, and for my internship I went to a community health center and worked with their outreach worker. We went out on the streets, to the parks, and to different agencies, talking to people about HIV, passing out condoms, telling people about the health center and about how to get tested for HIV. It was a great training because I learned to work with all kinds of people, to talk with people about all kinds of topics, including things like relationships and sex and drug use and to work in both Spanish and English. When the outreach worker quit, they offered me the job.

Then I started doing HIV antibody test counselling at the clinic. It was a great chance to learn how to do client-centered counselling, how to assist people to reduce their risks for HIV, and how to work with people

(continues)

(continued)

that were HIV positive to stay healthy. I listened a lot, and provided emotional support and a safe place for people to talk about things that are private, or that they were scared of. I had great supervisors who really taught me a lot about this work.

Since then, I worked all around the [San Francisco] Bay Area. I managed a mobile HIV testing project for a local health department. I did Healthy Families (SCHIP) outreach and enrollment, assisting low-income families in getting health insurance and primary health care for their children. I worked at a drop-in center for the homeless. I worked for the San Francisco Department of Public Health, doing environmental health work for day laborers and restaurant workers.

I have benefited from every experience working as a CHW and everyone I ever worked with. I think, as a CHW, you learn a lot from your colleagues, but you learn the most from your clients. I try to keep them in mind, to remember the things they have taught me, and to put that to use in the work I am doing today. But I also know that I don't know it all. I'm a person who likes to keep learning. Not just for my job, but for myself, too, and my family.

About 10 years after I finished the CHW certificate at City College, I went back to school. In December 2007, I completed my BA in Humanities with an emphasis on Social Change and Activism. In 2010, I completed a master's degree program in public health at San Francisco State University. I always wanted to work in Alameda County, and I found a job as a clinic manager at a school-based health center. From there, I was hired in 2014 as Director of Administrative Affairs and Outreach/Eligibility Assistance for the Alameda County Public Health Nursing Unit, and I'm really happy there. Among other things, I get to work with our eight outreach workers, providing training, also involving them not only in program implementation but in the ideas, the evaluation. I am taking the same approach I have taken in other positions—equal participation and team decision-making approach. I feel fortunate to have been given the opportunity to share my experiences and to work with CHWs, and together we will be planning, developing, implementing, and evaluating effective strategies to better serve the residents of Alameda County. We just got started, stay tuned!

Chapter Review

1. Which communities or populations do CHWs most commonly work with? What experiences (if any) have you had with CHWs in your own community?
2. If you were to tell someone how you got interested in community health work, like Ramona Benson's story at the start of this chapter, what would you say?
3. What health issues do CHWs commonly address in their work? Which health issues most motivate you as you train to work as a CHW?
4. How would you explain the relationship between roles and competencies? Review the quotes from the four CHWs profiled in the preceding section. What examples of the core CHW roles do you see in their biographies?
5. Which of the seven core roles are you most comfortable fulfilling? Which do you know the least about?
6. Explain the eight core competencies of CHWs, and provide an example of each. Have you had the opportunity to develop and practice any of these skills? Which of these skills are you currently least prepared to put into practice?
7. Describe personal qualities and attributes that are common among successful CHWs. Which of these qualities will you bring to the work? What additional qualities, attributes, or values will you bring?
8. Think about a chronic condition that you or a family member lives with. How could you imagine a CHW supporting you or your family in managing this chronic condition, as part of a clinical team?
9. As the profession grows, what are some of the challenges you see CHWs encountering? What new opportunities or recognition would you like to see CHWs gain?

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CHW Network in your state or region: _____

The Evolution of the Community Health Worker Field in the United States

2

The Shoulders We Stand On

E. Lee Rosenthal and J. Nell Brownstein

> A great river always begins somewhere. Often it starts as a tiny spring bubbling up from a crack in the soil, just like the little stream in my family's land (in Ihithe), which starts where the roots of the fig tree broke though the rocks beneath the ground. But for the stream to grow into a river, it must meet other tributaries and join them as it heads for a lake or the sea . . .
>
> *—Wangari Maathai, Unbowed: A Memoir (2006)*

Introduction

There are many Community Health Workers (CHWs) throughout the United States and the world. In all communities, we see natural helping and aid-giving networks that may include CHWs; however, formal CHW programs and services, including both paid and volunteer CHWs, are not found in all the communities. In the United States, CHWs are not yet a routine part of health and human service systems, but they are becoming increasingly common, often being added to service systems in both clinical and community settings. CHWs are seen by many as invaluable members of the safety net for communities, and they can be an important force for improving the health of individuals, families, and communities.

The focus of this chapter is the growth and development of CHWs in the United States, including ongoing efforts to define CHW roles or "scope of practice" (what CHWs are allowed to do). As a part of looking at the documented history of CHWs, we will look at the early origins of the field in the United States and various trends that affect the CHW field, including developments in evaluation and research and education and capacity building. We also look briefly at polices aimed at sustaining CHW programs as presented in five phases of CHW policy development (see Phases 1–4 in the online supplement). The chapter also presents an overview of CHW local and national network building in the United States and shares reflections by two prominent CHW leaders looking back on the short life of the American Association of CHWs. You will also find the story of a CHW whose life's work as a CHW and CHW organizer and advocate spanned more than 40 years. In addition to CHWs in the United States, be sure to learn more about CHWs around the world. Look at the overview of CHWs in international settings and see profiles of CHWs in Canada, Mexico, Brazil, Vietnam, and South Africa.

Additional Online Resources

Please note that supplemental materials for this chapter will be posted on the publisher's website. These materials include additional information about the work of CHWs around the world, and interviews with CHW leaders, and a history of key policy decisions that have influenced the CHW profession. (*http://wileyactual.com/bertholdshowcase*).

CHWs have a long history of promoting the health of vulnerable communities.

The history of the CHW field in the United States includes the contributions of many individuals and organizations working together to establish culturally tailored and community-specific ways to promote the health of our most vulnerable communities. CHWs and their allies understand that CHWs support families and communities by enabling them to take greater control over their own lives and health and to better access and use formal health care systems.

As we begin this review of the CHW journey in the United States, take a moment to ask yourself, "Where have I made my contributions?" If you are new to CHW work, ask yourself, "Where will I fit into this history?" Think about your role in assisting people, such as your neighbors and friends, one by one, and any role you have played in making your community healthier. You already have, or one day will have, an important story to tell about your contributions as a CHW.

WHAT YOU WILL LEARN

By studying the material presented in this chapter, you will be able to:

- Describe the contributions of CHWs in promoting the health of individuals and communities in the United States and around the world
- Identify and discuss major trends and debates that have impacted the development of the CHW field in the United States
- Discuss the role that CHWs have played in advocating for greater recognition and respect for their field
- Consider what place you want to have in the CHW field

WORDS TO KNOW

Natural Helping System

Self-Determination

Author's Note to the Second Edition

E. Lee Rosenthal, PhD, MS, MPH: At the time of this writing (2015) the CHW workforce in the United States appears to be making a shift. CHWs are becoming increasingly recognized and valued in medical care settings, especially as they find their place on health care home teams. CHWs also continue to make a difference in community development and play a pivotal role in addressing social determinants of health and promoting health equity. In this light, it is interesting to update the history chapter of this ground-breaking textbook. Our perspective on the past changes more than I first realized when I agreed to revise this short chapter.

Given the challenges of the task and the opportunity, I am excited that in this updated version of the history chapter I have had the opportunity to work with a number of esteemed colleagues. I am happy that Carl H. Rush, Sergio Matos, and Durrell Fox each accepted the invitation to contribute to this chapter by writing brief pieces on health policy and national association development among CHWs. I am also pleased to have had Noelle Wiggins update her piece on CHWs in international settings. In addition to Dr. Wiggins's viewpoint on CHWs around the globe, I am excited to share short pieces on CHWs in different countries led by my colleagues Sara Torres (Canada), Hector Balcazar (United States/Mexico), Rosemary Blake (South Africa), Nguyen Thi Thanh Ha (Vietnam), and Estelle Dutra Prado (Brazil). Finally, I am truly grateful and pleased to have my longtime colleague Dr. J. Nell Brownstein join me as a coauthor of the chapter.

It takes many voices to tell the Community Health Worker story. We cannot capture all the history that has gone before but I hope together we have begun to unravel the cloth so we can see each thread and its rich color, which together make a whole and strong tapestry.

Why Study History?

Some say the past predicts the future or creates the present, so looking at history helps us to understand the world we live in today. As you study and work as a CHW you are becoming part of something bigger—a world shared with your peers—other CHWs known by many names including *promotores*, Community Health Representatives, and peer health educators. At times CHWs and their allies would describe this field as part of a movement—one dedicated to health equity, social justice, and to economic development. Learning about how the CHW field has grown in the United States since the 1950s can give you insights into your work today, the people you serve, and about the relationships CHWs have with others working throughout the nation to promote health and deliver medical care.

A Note on Writing Down Histories

E. Lee Rosenthal: Sometimes, when people met my mother, Betty Clark Rosenthal, she would tell them about her life and the work she did, and they would say, "You should write down your story." And she would say, "I am too busy living my life and doing my work to stop and write it down." Just because something is published in a book or article does not mean that it is the only story or the best story. Research can tell us only about what has been documented in some way, especially in the articles published in scientific journals. These research articles are a valuable source of history. Yet our experiences are also valuable sources of information. As someone who has played a role in the U.S. CHW field for many years, I have been honored to contribute to its history. I am pleased to have a chance to share some of what I have witnessed and learned. I also understand that, even with the literature to help me, I am able to shed light on only a small piece of the much bigger and richer CHW story.

Please reflect on your own story as a CHW and the story of the communities you come from.

What Do YOU Think?

- *When did you start working or volunteering as a CHW?*
- *How has your work as a CHW impacted individual clients or families?*
- *How has your work as a CHW impacted the communities you serve?*
- *How have you helped to build the CHW field (or how would you like to help develop the CHW field)?*

2.1 Neighbor Assisting Neighbor

The history of CHWs began when neighbors first aided each other to take care of their health. Over time those seeking to promote wellness saw the promise of building on these *natural* helping systems to establish more formal approaches. The many programs and CHW services we see today include both paid CHWs and volunteer "lay" aid programs and networks. The informal assistance-giving tradition still continues today; CHWs extend that tradition.

What Is a "Natural Helping System"?

A **natural helping system** is a naturally occurring community network through which family, friends, neighbors, and others, connected by shared experience (in the same geographic setting or shared experience), watch out for one another and reach out with assistance on a regular basis and in times of crisis.

What natural helping networks do you rely on?

2.2 CHW Names, Definitions, and Scope of Practice

MANY NAMES FOR CHWs

As the CHW field has evolved, no one definition for a CHW has been adopted. In this textbook we use the term *community health worker* to include the volunteer and paid health practitioners known nationally and internationally by many different names or titles. The National Community Health Advisor Study (NCHAS) identified more than 60 titles for CHWs, including lay health advocate, *promotor,* outreach educator, Community Health Representative, peer health promoter, and of course, CHW (Rosenthal et al., 1998); other sources state that more than 100 names for CHWs have been identified (CHW Initiative of Sonoma County, n.d.). This last term, CHW, is used by the World Health Organization and is the title most commonly used in international settings. It is also used by the American Public Health Association CHW Section.

Having many titles reflects the diversity of the field but it can make it hard for CHWs to identify one another and find the support they need for training, improving practice, and their own professional development.

Durrel Fox: During a series of meetings in the mid 1990s of diverse leaders in the CHW movement in the United States, it was decided that we needed a unifying, umbrella term for the many titles under which CHWs fall. CHW was the agreed-upon, common, unifying term to help the movement for sustainability of our CHW workforce to progress, especially to help inform policy development.

—Durrell Fox served on the Executive Board of American Public Health Association from 2011–2015

DEFINING CHWs

Because CHWs work in so many communities, under a wide variety of titles, and provide such a wide variety of services, the field and the occupation have not been well defined. As part of a movement for greater recognition and respect for the work that CHWs do, several groups have been advocating for a formal definition of CHW. In the early 2000s, a newly formed Policy Committee for the American Public Health Association (APHA) CHW Special Interest Group (SPIG, later a Section of APHA) took the lead in developing such a definition. As a part of this effort, the Center for Sustainable Health Outreach (CSHO) collected definitions from CHWs and CHW networks across the United States and from other sources.

In 2006, the APHA CHW SPIG submitted a definition of CHWs to the U.S. Department of Labor and Statistics (DOL) for consideration. Other groups have also submitted definitions for consideration. In March of 2009, the U.S. Department of Labor (DOL) approved a separate occupational (work-related) category—21-1094—for CHWs (U.S. Bureau of Labor Statistics, 2009). The Department of Labor's new definition was used in collecting U.S. Census data in 2010, but given the newness of the established definition, counts in this first federal census are not widely cited. In 2014, CHWs and their supporters, with leadership once again from the Policy Committee of the CHW Section of APHA, have advocated for an updated definition that better reflects the community-based nature of CHWs.

In the past several years, many local and state CHW networks have adopted the APHA CHW definition as a part of campaign to create greater unity in the field. The updated (2009) definition is:

> *A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. (APHA, 2009)*

The APHA CHW Section and many others are urging the DOL to update its definition to be more in alignment with the APHA definition and to ensure the definition includes reference to CHWs having close affiliation to the communities they serve; something the current definition lacks.

At the time of this writing, the DOL has just finished a review period in which they were accepting public comments and feedback on the CHW occupational category.

CHWs conducting outreach.

What Is a "Scope of Practice"?

A Federation of State Medical Boards (2005) report defined scope of practice as the "Definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a defined field. Such practice is also governed by requirements for continuing education and professional accountability."

Within the CHW field we use the term *scope of practice* more broadly (outside the context of granting a license to CHWs) to talk about the breadth and depth of CHW roles or functions that allow you to do your work. A scope of practice for CHWs may be found in various places, including CHW job descriptions or within state legislation.

The concept of scope of practice is described in greater detail in Chapter 7.

IDENTIFYING WHAT CHWs DO: CHW ROLES AND COMPETENCIES

There is no official agreement about the definition of CHWs, likewise there is no official agreement about core CHW roles or competencies. This is in part due to the lack of leadership from any single independent national CHW network or association (see the discussion of CHW networks later in this chapter and in Chapter 1). In the absence of official roles and competencies, many have looked to the National Community Health Advisor Study conducted from 1994–1998 NCHAS, 1998). Notably, roles and competencies identified in the Study (Wiggins and Borbón, 1998) were not formally endorsed by the field, but they were adopted in 2000 by the American Public Health Association. Though not formally identified as standards, the NCHAS roles and competencies have

influenced many CHW job descriptions, training curricula, and state-level guidance on roles and scope of practice and training standards.

Given the continual use of the NCHAS roles and competencies and the absence of national standards, beginning in 2014, a team of researchers including CHWs and CHW allies joined together in a 2014–2015 study known as the CHW Core Consensus (C3) Project. The aim of the study is to revisit the roles and competencies identified in the 1994–1998 NCHAS and compare them with more current role and competency documents that reflect current scope of practice and CHW competencies.

In summer 2015, at the time of this writing, the C3 project team is releasing its findings to U.S. CHW network leaders. These networks are invited to review the findings and to give input on them to create a field-driven list of roles and competencies. Following the network's review, the C3 project team will release the findings more widely. The short-term goal of the project is to build national awareness of CHW roles and competencies and the long-term goal is the use and endorsement of the identified roles and competencies by local, state, and national organizations seeking to initiate and/or support existing CHW education, practice, and policies.

AN EMERGING WORKFORCE

Generally, health professions have become recognized by defining themselves and helping others to understand what they do to improve health. At times, health professionals have faced conflicts with other competing professions, and have had to struggle for respect and legitimacy. This has been true for many health professions groups such as nurse practitioners, midwives, home health aides, and CHWs (Rosenthal, 2003). For the past few decades, U.S. CHWs are actively organizing on local, state, and national levels to ensure that their knowledge, skills, and contributions are valued, respected, and integrated into health and public health systems.

SELF-DETERMINATION BY CHWs ABOUT CHW PRACTICE

With the many elements of the CHW field being defined and refined, one key is to place CHWs themselves in charge of that process. CHWs' self-determination about their practice and the policies that impact it is actively promoted by many CHWs and CHW allies. In 2014, the APHA passed a resolution entitled "Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing" that called CHWs to be 50 percent of participants in all efforts aimed at defining or regulating CHWs (APHA, 2014). Two of the four action steps of the resolution directly reference this important topic:

1. Urges state governments and other entities considering creating policies regarding CHW training standards and credentialing to engage in collaborative CHW-led efforts with local CHWs and/or CHW professional groups. If CHWs and other entities partner in order to pursue policy development on these topics, a working group comprised of at least 50 percent self-identified CHWs should be established.
2. Encourages state governments and any other entity drafting new policy regarding CHW training standards and credentialing to include in the policy the creation of a governing board comprised of at least half CHWs. This board should, to the extent possible, minimize barriers to participation and ensure a representation of CHWs that is diverse in terms of language preference, disability status volunteer versus paid status, past source of training received, and CHW roles.

2.3 The International Roots of CHWs

CHWs throughout History and around the World

As a CHW you are part of a worldwide community with historical roots that go back hundreds of years. In this section of the chapter, I explain three of the historical roots that produced CHW programs outside the United States.

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CHWs throughout History and around the World

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In nearly all human communities, people have been recognized for their skill in preserving and restoring health. These informal healers have gone by many names: *curanderos*, shamans, elders, and *sobadores,* among others. At a certain point in history, these informal healers began to be seen as different from the more formal healers who practiced health care as a profession. But in many places around the world, especially in rural areas, there were not enough formal healers to go around, and community members were trained to fill the gap. For example, in seventeenth-century Russia, laypeople called *feldshers* were trained for one year so that they could care for the health of civilians and soldiers. *Feldshers* are still part of the health care system in many parts of the Russian-speaking world. Three centuries later, Chinese leader Mao Tse-Tung promised that he would increase access to health care in the rural areas. Initially, he sent doctors from the cities to serve rural communities. But the urban doctors didn't want to stay, so the Chinese government began to train villagers to treat common illnesses, promote sanitation, and give immunizations. They were called "barefoot doctors" because many were so poor they could not afford shoes. Similarly, in the 1960s and 1970s, newly independent Tanzania in East Africa and Zimbabwe in southern Africa developed programs of community health promoters. People with some formal education were trained for a relatively brief time—six months was common—to improve access to health services. These early programs were staffed by locally supported volunteers or, in the case of China, as part of the revolutionary division of labor.

Another important factor that led to the creation of CHW programs was the desire to create more just and equitable societies. In many colonial societies, and among colonized communities of color in the United States, health care and education had been systematically denied to keep people under control.

Popular movements for social justice throughout the world influenced or supported the development of CHW programs. For example, CHWs or *promotores de salud* throughout Latin America became active in promoting the health of poor communities, often supporting these communities to organize and advocate for greater access to basic rights and resources. In many parts of Latin America, such as El Salvador, CHWs were targeted for intimidation, violence, and death by right-wing governments and affiliated paramilitary groups and death squads simply because they worked with and on behalf of poor communities or were associated with organizations, including the Catholic Church, that had been labeled "subversive."

The final root of CHW programs outside the United States is the effort to provide primary health care for all. In 1978, at a conference in Alma Ata, Russia, the World Health Organization adopted the concept of primary health care (PHC) as its main strategy for achieving "health for all by the year 2000." An important part of this strategy was "community participation in health," which meant involving community members to identify health problems and participate in their solution. The WHO said that "village health workers" (VHWs) were the best strategy for achieving community participation in health. This formal recognition and support led in the 1970s and 1980s to large-scale government-sponsored CHW programs in developing countries such as Indonesia, Costa Rica, and Colombia.

A variety of historical situations have produced CHW programs in many parts of the world. However, none of these programs could have been created if community members were not motivated to aid other community members achieve more control over their lives and their health. This is, in the final analysis, the most important root of CHW programs.

Additional information from Noelle Wiggins about the international roots of CHWs, including a participatory Radio Play, has been posted on the *Foundations* for CHWs site (*http://wileyactual.com/bertholdshowcase*).

Source: Noelle Wiggins, MSPH, founder and manager, Community Capacitación Center, Multnomah County Health Department, Oregon.

PROFILES OF CHWS ACROSS THE GLOBE

CHWs are found across the world. Their important contributions to health systems have been widely documented and recognized by the World Health Organization (Lehmann, Friedman, & Sanders, 2004). In each country CHW services reflect the system and health needs of their country. CHWs educational and employment needs change and evolve just as individual, family, and environmental health issues change. Health system reforms also impact the organization of CHW services. In this next section, CHW allies share a brief snapshot of the history and work of CHWs in their countries.

The following profiles highlight the work of CHWs in Brazil, Canada, Mexico, South Africa, and Vietnam. We have included a brief excerpt of each country profile here, with additional information posted on the *Foundations* website (*http://wileyactual.com/bertholdshowcase*).

Community Health Workers in Canada

Sara Torres—L'Université de Montréal:

In Canada, CHWs are primarily involved in health education and health promotion projects that include: prevention and management of chronic illnesses (diabetes, cancer) and infectious diseases (HIV/Aids, gonorrhea); prenatal and postnatal support; and access to health and social services. Generally, CHWs come from the communities they serve; they have developed close relationships with these communities, and share similar experiences to members of those communities (Torres, Labonté, Spitzer, Andrew, & Amaratunga, 2014). While many CHWs are selected through formal hiring processes, some are recruited because employers know of their work in the community. CHWs require many skills, but a key one is their ability to advocate with and/or for communities regarding access to health services, and social programs, such as housing, childcare, and food security. Many CHWs establish collaboration between communities and local systems and work to build community capacity by giving voice to clients (potential patients) and citizens who otherwise have no voice.

Community Health Workers—*Promotores* in Mexico

Hector G. Balcazar Ana Bertha Perez Lizaur, Ericka Escalante Izeta, Maria Angeles Villanueva—Universidad Ibero Americana:

The Health Promotion Operational Model developed in 2006 provides a platform from which the CHW model can be best examined in contemporary Mexico. Mexico, a country like many in the Americas, is burdened with an increase of chronic diseases such as obesity, diabetes, and cardiovascular disease. Mexico is responding to these challenges with strategies in public health, and medical care, and community outreach mobilization aimed at all levels of health promotion and disease prevention. The CHW model in Mexico has seen key developments, especially along the Mexico–U.S. border. Also, community-based participatory research which involves community members and CHWs is popular.

Brazil's Agentes Comunitários de Saúde

Estelle Regina Dutra Prado, MS—Seção de Assistência Nutricional/Coordenadoria de Saúde Ocupacional e Prevenção/Secretaria de Serviços Integrados de Saúde/Superior Tribunal de Justiça:

Lay health workers had been providing health education and basic care to poor communities in the Amazon and the Northeast of Brazil since the 1950s. In the 1980s, they carried out a Catholic Church–based program that taught basic hygiene and nutrition to poor women with children, thus contributing to a successful decrease in Brazilian infant mortality rate. But it was the need to reform a medical- and hospital-centered health model that led the Brazilian government to create the *Programa de Agentes Comunitários de Saúde* (*PACS*, Community Health Workers Program) in 1991. This federally funded program was incorporated to the *Estratégia de Saúde da Família* (*ESF*, Family Health Strategy) in 1994 (Morosini, Corbo, & Guimarães, 2007; Santos, Pierantoni, & Silva, 2010) and deploys CHWs to provide much-needed health education and social services to local households in communities throughout the country.

Village Health Workers in the Vietnam Health Care System

Nguyen Thi Thanh Ha, Institute of Population, Health, and Development, Vietnam:

It is reported that approximately 70 percent of Commune Health Stations (CHS) in Vietnam have a doctor and almost 80 percent are reported to have volunteer Village Health Workers (VHWs) (World Health Organization and Ministry of Health, 2012). Village Health Workers volunteers are members of the community who receive training from the provincial health service, often at the district level, to cope with the most common medical needs of the members of the village. During the past few years, the government has revived and promoted the Village Health Worker strategy of providing a minimum of health care to the people living in more remote areas. Village Health Workers are supposed to assist with immunizations, antenatal care, and family planning programs, advise about clean water and sanitation, and offer simple treatments to people in remote villages.

South Africa

Rosemary Blake, PhD Candidate—Department of Social Anthropology, University of Cape Town:

During apartheid the public health system in South Africa reflected the racist ideology of its government. When the African National Congress (ANC), led by Nelson Mandela, became the first democratically elected government in 1994, it inherited a health care system characterized by deep fragmentation and stark inequalities in health care access and the distribution of resources (Coovadia, Jewkes, Sanders, & McIntyre, 2009). On the new government's agenda was a plan to radically reform the health system, and

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to this end they shifted the health system away from an emphasis on hospital-based, curative medicine that was accessible to only a minority toward a system focused on primary and preventative health care and accessible to all South Africans (through the decentralization of many services). Initially, CHWs were excluded from the new system. It was only in 2003, prompted by a severe human resource shortage, and in the grips of a massive HIV/AIDS and TB epidemic, that the Department of Health began to officially support CHW programs. In the mid-1990s there were only 5,600 CHWs working in South Africa, but by 2011 this number had risen dramatically to 72,839 (Malan, 2014). CHWs now provide a variety of services within the health system, but the vast majority of their work responds to the high burden of communicable diseases in South Africa, particularly HIV/AIDS and TB. They deliver essential services through their work as home-based caregiver lay counselors, antiretroviral (ART) adherence counselors, and directly observed therapy (DOT) supporters for patients with tuberculosis.

2.4 CHWs in the United States

CHWs have an important role to play in the United States that is increasingly being recognized. In both health care and in community-based settings, CHWs work in partnerships with community members and other health and human services providers with the goal of improving health and access to systems of care. CHWs carry out many or all of the roles described at the start of this chapter (and textbook) to do this work. For example, in their role of cultural mediator, they can help make health and social service systems more culturally competent. Often the communities they represent have traditional healing systems that were developed long before Western medicine developed. Now the two systems coexist, with individuals and families integrating what they consider the best from both systems to maintain or improve their health. These systems take many forms. For example, in American Indian communities, traditional healers such as medicine men were and are an important part of health networks (Mohatt & Eagle Elk, 2000). In Latino communities, *curanderos* assist in promoting health in the community (Brown & Fee, 2002; Gonzalez and Ortiz, 2004; Reyes-Ortiz, Rodriguez, & Markides, 2009; Rothpletz-Puglia, Jones, Storm, Parrott, & O'Brien, 2013). CHWs help to bridge these worlds. They help to increase the two-way flow of information so that both providers and those they serve can identify ways to best support health gains and use formal medical and social prevention and treatment services. CHWs do the same to increase understanding of other social, political, and economic issues. This bridging role of CHWs is just one of the many ways CHWs help those whom they serve and ultimately help address health equity and improve health.

Many different groups recognize the potential and importance of CHWs in health promotion and disease prevention. Public health and other health professionals recruit and partner with individuals who are connected to the natural helping networks in their communities (Eng & Young, 1992; Gilkey, Garcia, & Rush, 2011) supporting them in developing skills as a formal CHW. CHWs address many health and social issues, sometimes prioritized by community members themselves, as well as issues identified by those serving communities. Health care systems and community-based agencies are increasingly hiring and integrating CHWs to serve within teams in public health departments, hospitals, community clinics, or other sites. Other CHWs contribute on a volunteer basis in these settings and in community centers and social and faith-based organizations. In these cases, programs often provide incentives such as educational credits or modest financial stipends to CHWs to support their participation. About one-third of formal CHW programs are volunteer based, while the rest are paid CHW programs (Rosenthal et al., 1998; U.S. Department of Health and Human Services, Human Resources and Services Administration, 2007).

CHWs' FORMAL EARLY HISTORY IN THE UNITED STATES: 1950–2000

In the 1950 and 1960s, the first documented volunteer and paid CHW programs established in the United States emerged. During this period, Native American tribes and migrant farmworkers became the best-known programs (Giblin, 1989; Gould & Lomax, 1993; Hoff, 1969; Meister, Warrick, de Zapien, & Wood, 1992). Strong CHW programs still serve these communities today.

The Federal Migrant Act of 1962 required federally qualified migrant clinics to conduct outreach in migrant labor camps. CHWs were hired to provide this outreach, a move that established many CHW programs. This outreach built on the *promotor(a)* tradition common in Mexico and throughout Latin America, where many farmworkers were raised or have family ties (Mahler, 1978).

The largest program of that period (and still the largest today) got its official start in the late 1960s; the Community Health Representative (CHR) Program. It was established by the Indian Health Services (IHS) with support from the Office of Economic Opportunity in collaboration with American Indian tribes (Indian Health Service, n.d.; Indian Health Service, 2006; Satterfield & Burd, 2002). The CHR program has stood the test of time, and there have been more than 1,600 CHRs serving more than 250 tribes for nearly 50 years. It is estimated that there are still over 1,400 CHRs serving today. Since the program began, many tribes have taken over their federal healthcare funding from I.H.S., and they now oversee and manage their tribe's health programs. In doing this they have also made decisions about whether to keep their CHR programs and then manage them directly. Like all CHWs, CHRs address many health issues including maternal and child health, asthma, diabetes, and other chronic disease management. In all CHR programs, tribal leaders select the issues they will prioritize and the roles CHRs will play. Due to great distances in rural reservation communities, CHRs also often assist families with transportation to health care providers.

In the 1960s and 1970s, new CHW programs continued to develop throughout U.S. rural and urban communities. CHW programs addressed important public health issues, and at the same time they were often credited with creating valuable employment opportunities for people who had a hard time entering the paid workforce (Domke & Coffey, 1966). The Office of Economic Opportunity invested in CHWs in many urban areas (Meister, 1997). CHWs and other community-based workers were seen as critical to the reorganization of the human services system (Pearl & Reissman, 1965). CHWs were recognized for their connection to the community and their unique insight into the individuals they served (Withorn, 1984).

In this period, opportunities for paid and volunteer CHWs and *promotores* increased and were hailed as contributing to the reorganization of health and human services delivery systems (Pynoos, Hade-Kaplan, & Fleisher, 1984; Service & Salber, 1977). CHWs were paid to work across a range of health projects and programs targeting different issues and populations (Hoff, 1969; Potts & Miller, 1964; Wilkinson, 1992). In this era, groups like the Black Panther Party and the Young Lords advocated for the government to provide free health care, including prevention services, and accessible services to treat drug addiction for African American, Latino, and all oppressed peoples. The Black Panthers also created free breakfast programs for schoolchildren and free medical clinics for their communities (Black Panther Party Research Project, 2009; Brand & Burt, 2006).

CHWs were an important part of the early years of Community Health Centers (CHC) (Northwest Regional Primary Care Association, 2015) beginning in the mid 1960s, helping to first establish these clinics and tie them to communities. Today, many CHCs integrate CHWs into their health promotion and other community programming where they help to assure that CHC achieve their mission of delivery culturally competent and community-centered services (NACHC, 2010; Spiro, Marable, & Collins, 2012).

In the 1970s, Service and Salber (1977) started to use the term "lay health advisors" (LHAs) and called attention to the important community roles of LHAs, such as health promotion, social support, mediation (helping two sides reach an agreement), and community empowerment (Salber, 1979).

In the 1980s, funding for job creation programs slowed, and the number of paid CHWs participating in forums such as the American Public Health Association declined. At the same time, a number of CHW programs expanded their roles. Programs for migrants grew with funding from private and government sources (Booker, Grube-Robinson, Kay, Najjera, & Stewart, 2004; Harlan, Eng, & Watkins, 1992; Meister, Warrick, de Zapien, & Wood, 1992). The number of CHWs making home visits to aid mothers and infants increased (Julnes, Konefal, Pindur, & Kim, 1994; Larson, McGuire, Watkins, & Mountain, 1992; McFarlane & Fehir, 1994; Poland, Giblin, Waller, & Hankin, 1992). The federal Healthy Start program began to rely on outreach workers to address inequalities in infant mortality rates, especially in cities among African Americans mothers and infants. CHWs also started supporting community members at risk for chronic conditions or diseases (for example, high blood pressure, cancer, diabetes) to maintain better control, keep appointments with and talk to their doctors, check their blood pressure and blood sugar levels, and know the signs of serious illness (Brandeis University, 2003; Brownstein et al., 2005; Norris, Chowdhury, & Van Le, 2006).

In this same period the emergency of HIV-AIDS challenged and motivated activists to organize and advocate for civil rights protections and investment in community health outreach, education, and testing programs, research into treatments, and access to quality health care. Perhaps the best-known activist organization was the AIDS Coalition to Unleash Power (ACT UP), founded in 1987. ACT UP built on the protest traditions that came out of the civil rights movement and opposition to the Vietnam War (Klitzman, 1997). Activists were successful in building strategic alliances with health and public health professionals, in drawing public attention to HIV/AIDS, in advocating for changes to public policies and the creation of new public health programs and research on treatments for HIV disease. As a result, local health departments and community-based organizations began to hire CHWs to conduct outreach and provide client-centered education, counseling, and HIV-antibody-testing services. CHWs conducted home and hospital visits, facilitated support groups, trained physicians and other providers in providing culturally competent care, initiated syringe exchange programs, and much more. With the development of the AIDS epidemic in the United States "a disease [became] the basis of a political movement" (Klitzman, 1997). The success of CHWs in aiding to address the HIV epidemic in turn influenced the development of the CHW field.

In the 1990s, CHWs gained increased recognition for their important contributions to health and job creation (Rosenthal et al., 1998; Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). Jobs creation was pushed by Welfare Reform, which brought with it renewed federal attention and resources. Welfare-to-work programs explored CHW jobs as an important option for individuals newly entering or re-entering the paid workforce. CHW program coordinators reminded all involved of the importance of looking for individuals who were already known to be natural aides in their communities when recruiting CHWs (Aguirre & Palacio-Waters, 1997).

From 2000 on, workforce studies, articles, and reports about CHWs became more common (Love et al., 2004; Proulx, 2000a, 2000b; Matos, Findley, Hicks, Legendre, & Do Canto, 2011). At the same time, public and private grant funding for CHW programs continued to grow, focusing on assisting individuals in managing health conditions such as HIV disease, diabetes (Norris, Chowdhury, & Van Le, 2006; Tang et al., 2014) high blood pressure (Allen, Dennison, Himmelfarb, Szanton, & Frick, 2013; Brownstein et al., 2007; CDC, 2015a), cancer, and asthma (Margellos-Anast et al., 2012; Prezio, Pagán, Shuval, & Culica, 2014) and other health areas (Guide to Community Preventive Services, 2015).

During this period, we began to learn more about the work of CHWs and the evidence base grew. A colorectal cancer navigation program designed for Hispanic men showed an increase in life expectancy by six months for participant as compared to nonparticipants with a health care savings of $1,148 per program participant (Wilson, Villareal, Stimpson, & Pagan, 2015). Interventions incorporating CHWs have been found to be effective for improving knowledge about cancer screening, as well as screening outcomes for both cervical and breast cancer (Viswanathan et al., 2007). Integrating CHWs into multidisciplinary health teams has emerged as an effective strategy for improving the control of asthma, diabetes, and high blood pressure among high-risk populations, along with cost savings (CDC, 2015a). With this growing evidence base showing the impact that CHWs make, interest in developing the CHW workforce has continued to grow.

2.5 Interview with CHW Yvonne Lacey

FROM THE FRONT DOOR TO THE HEAD OF THE TABLE

After nearly 40 years of formal service as a CHW beginning in the 1970s, Yvonne Lacey retired as coordinator of the City of Berkeley, California, Black Infant Health Program in 2007. She played a key role in the development of the CHW Certificate Program at City College of San Francisco where she was a frequent guest lecturer and trainer during the first two years of the program. She served as the CHW cochair of the National Community Health Advisor study from 1994–1998 and led a group of CHWs and their allies within the American Public Health Association at the turn of the century. From 2004–2006 she again cochaired a national project with CHW Durrell Fox that looked at key considerations for CHW education in community colleges (chw-nec.org).

It was a pleasure to work with Yvonne in these last three roles, supporting her in helping to increase understanding and recognition of the CHW field. The following is an excerpt from an interview with Yvonne conducted in the spring 2008; thanks to CCSF staffer Mickey Ellinger for making this possible (www.ccsf.edu).

"I've Been Doing This Work All My Life"

Yvonne Lacey: As I think back over my history, I realize that I've been doing this work all my life. I live by this old song I heard in church as a child: "If I can help somebody as I pass along, then my living shall not be in vain."

Back when I was a dressmaker, friends would come to my shop so I could help fix a zipper or a hem, and we'd end up talking about daily problems and relationships and all that. There wasn't a week that went by that I didn't have women in there helping each other get through our daily lives.

In October 1970, I was sewing out of my home. A friend called and said, "I saw the perfect job for you!" I finally went down to the City of Berkeley's Department of Public Health and got hired as a CHW for maternal and child health. My life has never been the same.

The Maternity and Infant Care Program provided prenatal care to low-income women. It was one of the most comprehensive programs that I have ever seen up to today. There was a social worker, two CHWs, a public health nurse, a nurse practitioner, and doctors who took rotation in our clinics. That's where I learned the team concept of delivering health services. That's when I began to love this community health work. I began to really see what we could do in the community to make a difference.

Although I began the work knowing my community, I gained years of experience and training on the streets of Berkeley. I also got an education from a cherished mentor public health nurse in the department—although we fought constantly.

In the early 1990s, City College of San Francisco was planning a course for CHWs and they recruited CHWs to be on the planning committee. We were planning the curriculum and trying to see the benefits of having a course, and what CHWs would get from it. In 1993, I contributed as a guest lecturer and trainer for the first groups of CHW students. I did that for two years.

After that experience I really got involved with building the CHW profession. Many of us worked so hard to get more recognition for CHWs (through the American Public Health Association. When I first started attending APHA meetings in 1996, CHWs were called the "New Professionals." In 2000, we convinced APHA to change the group's name to the CHW Special Primary Interest Group (SPIG). I chaired that group for three years. It is my opinion that the chair of any CHW group has to be a CHW, not an advocate for CHWs.

From 1994 to 1998, we worked on the National Community Health Advisor Study. I was the cochair of the 36-member advisory committee that included a large group of experienced CHWs. We are the only ones who really know the work that we do. With our voices we can make sure that the value of the work is known and recognized and with our voices we can lead the way to more investment in our communities.

In 2004, I was asked to cochair the CHW National Education Collaborative (CHW NEC; Proulx, Rosenthal, Fox, & Lacey, 2008). C). It was trying to bring community colleges together to have a standard competency-based training that covers the basic things that all CHWs need to know. We also helped colleges understand that CHWs have to be at the table at every stage of developing our profession. CHWs have to help plan the trainings and be involved in the teaching. Maybe having a mentorship program built into that training. I wouldn't want CHWs to lose touch with their own communities, or lose the fire and passion they have just because they earn a degree. Also, we want these colleges to understand they are training CHW leaders.

It was such rewarding work—the work I did in my 37 years at the Berkeley Health Department and at the national level. You don't always see the results of the work right away. But I've gone to get gas and somebody's come up to me and said, "You're Miss Lacey, aren't you? You helped me during such and such." Or, "If it hadn't been for you I wouldn't have gone back to school." Or, "I only had that one baby, Miss Lacey, because you told me . . . " And sometime around the country I have had that same kind of confirmation from CHWs that somehow, I have touched their lives. That has made it all worthwhile. "I did touch somebody's life here." And to me that has been worth the whole thing.

2.6 Trends in the CHW Field: Growing Strong in the New Millennium

The CHW field has been increasingly recognized in the United States as evidenced by the development of public policy related to CHWs in numerous states (CDC, 2013; State Reform, 2015), activities in federal agencies in support of CHWs (CDC, 2014; Office of Minority Health, 2015), and attention to CHWs in peer review literature, in the press, and on social media (Goldfield, Rosenthal, & Macinko, 2011). With the nation's focus in health care on the often-cited "triple aim" of improved health outcomes, improved experience of care, and efficiency related to costs, interest in CHWs is not surprising. CHW services have sought to address all three aims with promising impacts documented (Findley et al., 2014). The Patient Protection and Affordable Care Act passed by the Obama Administration in 2010 also brings increased attention to CHWs and the roles they have in improving access to care and in the delivery of prevention services. Related new regulations has begun to open up more opportunities for the sustainability of CHW services (Witgert et al., 2014).

With this promising horizon in place for CHWs, let's explore what trends are influencing development in the field in this period.

RESEARCH: BUILDING THE EVIDENCE BASE ABOUT THE WORK OF CHWs

Through the 1990s, researchers conducted a number of regional and national studies of CHWs. Together, these studies demonstrated the power, value, and importance of the work that CHWs have been doing in the United States in a form that could be understood by the fields of public health and medicine.

As noted earlier, the NCHAS (Rosenthal et al., 1998) was carried out in collaboration with many partners including CHWs. The NCHAS was a participatory research project, meaning the group being studied participated in designing the study, and in analyzing and interpreting findings. CHWs comprised the majority of the NCHAS advisory council members, and the council alone was responsible for making recommendations based on the data for the field. Many of the actions recommended by the 36 council members are now being implemented throughout the United States. These include increased access to CHW educational programs that offer college credit, and the controversial recommendation to credential CHWs.

In addition to identifying the core roles and competencies of CHWs, the study also identified the many community and clinical settings where CHWs work, including homes, schools, clinics, and hospitals. The settings in which CHWs work clearly influence the activities of CHWs. According to the California Workforce Initiative, CHWs working in clinics are more likely to perform duties focused on traditional patient care, whereas CHWs working door to door act more in the roles associated with social workers and community organizers (Keane, Nielsen, & Dower, 2004).

Early workforce studies in the San Francisco Bay Area (Love, Gardener, & Legion, 1997) inspired other regions and states to conduct similar assessments to determine the extent and roles of CHWs in local labor markets. The Annie E. Casey Foundation funded another study of the CHW workforce, looking at the potential of worker-owned CHW cooperatives (Rico, 1997). More recently, the federal government funded and coordinated the CHW National Workforce Study (HRSA, 2007). The study explored the roles and functions of CHWs in different settings and estimated that there were 120,000 CHWs throughout the United States in 2005.

In 1995, a commentary entitled "Community Health Workers: Integral Members of the Health Care Work Force" appeared in the *American Journal of Public Health* (Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). The article's title alone stimulated attention to the field. The Institute of Medicine's landmark book, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* talked about the importance of CHWs in reducing health inequalities (Smedley, Stith, & Nelson, 2002). A study funded by the Centers for Medicare and Medicaid Services (CMS) on approaches to cancer prevention among elders of color found that CHWs were the "primary mechanism for cultural tailoring" (Brandeis University, 2003).

Over the years, research has continued to document the evidence of the effectiveness of CHWs in promoting health outcomes (Giblin, 1989; HRSA, 2007; Nemcek & Sabatier, 2003; Swider, 2002). In 2007, CHWs, researchers, and other stakeholders met to develop a CHW Research Agenda by and for the field (Rosenthal, De Heer,

Rush, & Holderby, 2008). At this two-day conference led by Carl Rush, conference participants identified the most important areas for additional research (complete findings may be accessed online at www.famhealth.org/researchagenda.htm):

- CHW cost-effectiveness or return on investment
- CHW impact on health status
- Building CHW capacity and sustaining CHWs on the job
- Funding options
- CHWs as capacity builders
- CHWs promoting real access to care

Practitioners, policy makers, and researchers continue to examine the workforce. Minnesota and Massachusetts have taken comprehensive approaches to the development of policy regarding CHWs and conducted studies of their workforce to guide their thinking. The accomplishments of these two states in implementing systems changes to build capacity for an integrated and sustainable CHW workforce serve as models for the nation (Rosenthal et al., 2011).

In 2010, an influential report by the Massachusetts Department of Public Health was released entitled the "Community Health Workers in Massachusetts: Improving Health Care and Public Health" (Massachusetts Department of Public Health, 2009). The report presented strong evidence that the state's nearly 3,000 CHWs have improved access to health care as well as the quality of that care. It also presented 34 recommendations for further integrating CHWs into health care and public health services in the state. It suggested that state policy changes—including workforce development and training, occupational regulation, guidelines for research and evaluation, and sustainable financing—are needed to promote and sustain CHWs services. CHWs have also been included in the State CHW Certification Act of 2010, and a regulatory process for certifying individual CHWs and approving CHW training programs is being developed at the state's Department of Public Health. CHWs are part of a priority program strategy in Massachusetts for strengthening clinical-community linkages to improve chronic disease outcomes (Mason et al., 2011).

Minnesota initiated studies to better understand their CHW workforce (Willaert, 2005). Support from the Minnesota Community Health Worker Alliance, coupled with widespread recognition of the cost-effective care provided by CHWs, resulted in the development of state legislation in 2008 that authorizes hourly reimbursement for CHWs. As a result, CHWs who have graduated from the standardized curriculum and received a certificate are eligible to enroll under the Minnesota Health Care Plans and can provide services—supervised by a physician, advanced practice nurse, dentist, or public health nurse—that are billable to Medicaid. Mental health providers have also been added to this list.

In 2013, the U.S. Centers for Disease Control and Prevention identified 15 states and the District of Columbia that had laws addressing CHW infrastructure, professional identity, workforce development, and financing (CDC, 2013). Of these 15 states, six had advisory boards working to investigate the impact of CHWs on health care savings and health disparities, eight had created a CHW scope of practice, seven had laws authorizing Medicaid payments for some CHW services, and seven had created laws that encouraged the integration of CHWs into team-based care models for select health care organizations and services. Alaska, Minnesota, and, most recently, New Mexico, support CHW services with Medicaid financing.

Additionally, states and organizations (e.g., CHW Network of New York, California, Virginia, Community Health Foundations, Foundations for Health Generations, American Association of Diabetes Educators) have developed reports on a variety of CHW issues such as scope of practice, training, financing, and cost effectiveness. These and other states continue to explore options for supporting CHW integration and sustainability. New research studies on workforce issues help inform those who are trying to integrate CHWs into health care teams and sustain their employment (O'Brien, 2009; Volkman & Castanares, 2011).

A new 2014 ruling by the Center for Medicare & Medicaid Services (CMS) allows states to develop payment systems for preventive services by unlicensed individuals such as CHWs. The new ruling helps improve people's access to preventive services, aids the partnerships between health care providers and advocates for CHWs, increases access to CHWs, reduces program costs, and has the potential for CHWs to be reimbursed under

Medicaid. States must include a summary of the qualifications of CHWs, their required training, education, experience, and credentialing or registration. Credentialing of CHWs is not required by CMS (CDC, 2015b, 2015c).

The Centers for Medicare and Medicaid Services Innovation Center (CMMI) funded projects from 2013–2016 to work on models that reduce costs, improve care for populations with special needs, test approaches to transform clinic models, and improve the health of populations by focusing, for example, on diabetes or hypertension prevention programs that go beyond clinics. Many of the funded projects center on CHWs. For example, Oregon was given a grant to test the effects of its Coordinated Care Organizations (CCOs) and new payment model on health outcomes and costs. All of the CCOs have integrated CHWs into their care teams (Foundation for Health Generation, 2013).

Research on the work of CHWs is key to making the case for bringing more resources to the field. Furthermore, an emerging role for CHWs is to participate in conducting research, for, with, and about the communities they serve. Durrell Fox observes that CHWs have an important role to play in conducting research; he observed that that CHWs have already informed research and public health theories and science for decades (Rosenthal, De Heer, Rush, & Holderby, 2008) and will continue to do so.

A Look at How Research Can Influence Policy

J. Nell Brownstein

Taking a close look a the evolution of research on a single health topic: A snapshot about CHWs helping people control high blood pressure.

During my work at the Centers for Disease Control and Prevention (CDC), I learned of several research studies focused on CHWs' efforts in helping people control high blood pressure (also called hypertension). Uncontrolled high blood pressure is a major risk factor for stroke and heart and kidney disease. Most of the existing studies were carried out by researchers at Johns Hopkins University. I invited those researchers to join me in writing a paper (Brownstein et al., 2005) in which we gave a summary of the research involving CHW work and made recommendations for future research and practice. We recommended that CHWs be included in health care teams and in community-based research to allow CHWs to play an important role in helping to reduce disparities in heart disease and stroke. We noted that what was needed was sustainable funding and reimbursement for CHW services, better use of CHW skills, improved CHW supervision, training and career development, policy changes, ongoing education, and a reporting of CHW program costs. Since then, other researchers, agencies, program developers, evaluators, practitioners, and other CHW stakeholders have addressed these issues through meetings, reports, and new studies. A new tool from CDC can help inform people about the strengths and limitations of the CHW policies. www.cdc.gov/dhdsp/pubs/docs/chw_evidence_assessment_report.pdf

In 2007, I was the lead author of a team that conducted a systematic literature review of the effectiveness of CHWs in the care of persons with high blood pressure. Our review showed that most of the patients had significant improvements in blood pressure because CHWs helped people keep medical appointments and stay on their prescribed medicines.

This paper influenced the 2010 Institute of the Medicine Report (A Population-Based Approach to Prevent and Control Hypertension) that recommended that the CDC work with state partners to bring about policy and systems changes that result in trained CHWs ". . . deployed in high-risk communities to help support health living strategies that include a focus on hypertension."

In 2013, the CDC gave states the opportunity to work on (a) integrating CHWs into health care teams to support self-management and ongoing support for adults with high blood pressure and diabetes, (b) having

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A Look at How Research Can Influence Policy

(continued)

CHWs lead or support diabetes self-management classes, and (c) having CHWs promote linkages between health systems and community resources for adults with high blood pressure and diabetes.

In 2015, the CDC's Community Preventive Task Force released the results of its systematic review of 23 CHW hypertension studies. It recommends "interventions that engage community health workers to prevent cardiovascular disease (CVD). There is strong evidence of effectiveness for interventions that engage community health workers in a team-based care model to improve blood pressure and cholesterol in patients at increased risk for CVD. There is sufficient evidence of effectiveness for interventions that engage community health workers for health education, and as outreach, enrollment, and information agents to increase self-reported health behaviors (physical activity, healthful eating habits, smoking cessation) in patients at increased risk for CVD."

I have developed and supported others to develop resources to support CHWs, including technical assistance and a heart disease and stroke prevention training, and *fotonovelas* about blood pressure and sodium and cholesterol in English and Spanish (www.cdc.gov/dhdsp/pubs/chw-toolkit.htm). Additional trainings can be found at www.nhlbi.nih.gov/health/healthdisp/aa.htm.

2.7 Capacity Building and Education

Capacity building refers to strengthening the knowledge, skills, and confidence of individuals—like CHWs—or communities. CHWs learn from many sources and in many settings, and these keep changing over time.

CHW TRAINING GUIDES AND CURRICULA

Many training guides and educational curricula have been developed for CHWs. Some educational resources are shared freely, while other training materials are proprietary and are not made available by the individuals and organizations that developed them. Publicly and privately developed curricula address specific health issues, such as diabetes, heart health, cancer, HIV/AIDS, and prenatal health. In the early 1990s, the National Commission for Infant Mortality developed a curriculum for maternal and child CHW programs that included a training manual, a CHW pocket manual, and even a community guide to starting CHW programs. Though issue specific curricula are still very common, there appears to be a shift to curriculum that develops core or foundational CHWs skills. In Minnesota, a core curriculum on CHWs was developed collaboratively by educators, employers, and CHWs in that state (Willaert, 2005); that curriculum was designated as a required curriculum for CHWs seeking reimbursement by the state. As states have begun to formalize regulations for CHWs, some have considered the option of a single curriculum but more have chosen to identify core competencies and play a role in approving a range of curricula (Miller, Bates, & Katzen, 2014) to address these areas. As of 2015, no single CHW curriculum, book, or textbook for CHWs has been adopted throughout the United States, but some resources have been widely used. *Helping Health Workers Learn*, developed by the Hesperian Foundation, has been popular, especially in international settings (Werner & Bower, 1982). The City College of San Francisco developed the textbook you are now using. This is the first textbook specifically developed for use by CHWs in classroom settings. It was first released in 2009 and now this second edition is being updated in 2014–2015. *The book itself is of historic significance, especially for the U.S. CHW field.*

ON-THE-JOB LEARNING

On-the-job learning (also known as on-the-job training) has been a mainstay of CHW education (HRSA, 2007). In the early days of the field in the U.S., CHW program coordinators often developed CHW trainings in their own organizations (Rosenthal et al., 1998). These trainings were accessible to working CHWs, and employers covered

the costs. It meant that CHWs could be selected directly from communities due to the qualities that would make them good CHWs versus their prior formal learning (Jennings, 1990). This meant high access to the field for CHW candidates. At the same time, training on the job requires significant resources from each employer. CHWs also reported that on-the-job training was a barrier to career development, because it is not recognized when they moved from one job to another (Rosenthal et al., 1998). Additionally, some CHWs and administrators reported that on-the-job training was too limited and even off-base (Love et al., 2004).

Today it appears to be increasingly common for CHWs to come into a paid CHW position having completed their core training from a community college or in a CHW training center or program (Rosenthal et al., 2011). In this way, employers are largely freed from covering CHW educational costs. In some cases, however, employers sponsor their CHWs to go through these educational programs. Also, many employers take responsibility for CHW continuing education, scheduling trainings and covering the time and costs associated with participation for their staff or volunteers. In the state of Massachusetts, organizations receiving public funds for CHW services are required to support ongoing training and CHW networking opportunities.

APPRENTICESHIPS FOR CHWs, IN THE CLASSROOM AND ON THE JOB

On-the-job learning is closely related to the skills development approaches that are found in professions where training is based on an apprenticeship model, in which a professional called a "journeyman" (or woman) mentors an apprentice. In the United States, the Department of Labor runs a formal system of Registered Apprenticeships (http://www.dol.gov/apprenticeship/). The apprenticeship model has certain standards and blends a required classroom component with a significant on-the-job learning component. It also requires that apprentices be paid and provides an incentive for increased pay during the apprenticeship training period. Due to collaborative efforts in the state of Texas, in 2011, the Department of Labor officially accepted the CHWs workforce as eligible for apprenticeship opportunities. Find out more through the Department of Labor (n.d.). Texas did a pilot test of the model with a small number of apprentices in rural Texas under the coordination of the Coastal AHEC. At the time of this writing, several states including Wisconsin and Rhode Island are actively exploring developing CHW apprenticeship programs.

CENTER-BASED AND COLLEGE-BASED CHW EDUCATIONAL APPROACHES

In the 1990s, there was a move toward center-based trainings (rather than on-the-job training), as well as college-supported educational programs for CHWs. An early example of center-based training comes from Boston's Community Health Education Center, developed by the City of Boston to respond to a citywide need for CHW capacity building. Since the 1990s, the center has provided core initial training to CHWs. It has also been a resource center for training and other materials and has served as a gathering place for CHWs, hosting activities like job-sharing luncheons.

Early in their history, efforts were made in some areas to assist CHWs to gain access to academic pathways and credit within college programs. Early reports of CHWs in academic settings showed that there were challenges in the college setting; some CHWs felt their competence gained through life experience and experience on the job were undervalued (Sainer, Ruiz, & Wilder, 1975).

City College of San Francisco started a CHW Certificate Program in the early 1990s. The program, designed to address some of these challenges and barriers, offered the first full-scale college credit-earning educational opportunity for CHWs (Love et al., 2004). Building on this model and other emerging programs, Project Jump Start at the University of Arizona (1998–2002) focused on creating credit-bearing training for CHWs through four Arizona community colleges predominately serving rural communities (Proulx, 2000b). During 2004–2008, CHWs, allies, and representatives of 22 CHW college-based educational programs formed the CHW National Education Collaborative (CHW NEC) to advise college-based CHW programs about best practices for such programs (Proulx, Rosenthal, Fox, Lacey, & CHW NEC, 2008). The project saw CHW leadership as imperative, and its majority CHW Advisory Council and cochairs Lacey and Fox were important to the project. I (Lee Rosenthal) served as the project's codirector along with Director Don Proulx and Coordinator Nancy Collyer. In 2008, as the CHW NEC project came to an end, we generated a guidebook for the field, looking at ways colleges and other institutions can start and strengthen CHW educational and capacity-building programs.

HOW DOES THE ORGANIZATION OF CHW TRAINING AND EDUCATION IMPACT THE FIELD?

Many of the skills and personal qualities needed to excel as a CHW can be learned on the job and through life experience. The skills that lead to success in higher education do not, in themselves, translate into job effectiveness as a CHW. Veteran CHWs have often been suspicious of college-based training programs: the typical college classroom is not an avenue that is open to all community people. In addition, it is common in the health workforce that higher education credentials are set as a requirement for employment. This can limit access to employment for CHWs who are highly skilled but lack formal education. Specifically, *requirements* for college-based programs may present barriers to and adversely affect the very communities with the greatest potential to be outstanding CHWs, including low-income communities, communities of color, undocumented immigrant communities, and English language learners. At the same time, college credit and education are closely linked to employment outcomes, career advancement, and higher income. Well-designed educational programs that are accessible and that offer college credit to CHWs can provide these students with valuable opportunities for professional growth and advancement.

Many in the CHW field believe it is important to maintain multiple approaches to CHW education and training and to develop ways to recognize and credit the value of life and job experience. To the extent that college-based training becomes more widespread, it is important to ensure that these programs are accessible to CHWs financially and in their preferred teaching and learning approaches. See www.chw-nec.org to learn about "Key Considerations" for starting or strengthening CHW educational programs (Proulx, Rosenthal, Fox, Lacey, & CHW NEC, 2008). It is also important to make sure that employers continue to support and fund CHW training and education, which historically has been an important ingredient for success in the field, maintaining access to many CHWs who are, and who continue to become outstanding CHWs.

THE USE OF TECHNOLOGY AND ONLINE EDUCATION

The CHW field has some curricula and training resources that are offering online CHW education, both in real time and self-paced. Resources in the online environment come from both public and private sources. Some are offered at no cost, while others have associated fees and, in some cases, credits. No matter what the cost, online or distance education training means that there are more resources available for CHW learning that may be especially valuable for CHWs in geographically isolated communities. In using online training curricula it is important to consider how this high-tech approach may impact what we could call the "high touch" role of CHWs. Generating a hybrid plan for face-to-face learning time and online education still seems the best fit for CHWs.

CHW CREDENTIALING

Many health occupations use credentialing in some form, including certification and licensure, in an effort to assure that workers have the knowledge and skills necessary to do their jobs. Credentials may be administered by a public entity, such as a state health department, or by a free-standing organization led by members of the occupation itself, or by another interested organization. Credentialing may directly certify individuals (nurses, social workers, or CHWs) or may credential programs (agencies, clinics, training programs, institutions) and training curriculum. Trainers may also be certified. In some cases all of these strategies are used.

Credentialing has been a controversial issue in the CHW field (Keane, Nielsen, & Dower, 2004; National Human Services Assembly, 2006; Rosenthal et al., 1998). Some feel that credentialing will support the ongoing effort to increase recognition and respect for CHWs, and to create stable sources of funding for CHW positions. Others question or oppose credentialing because they feel that it may make the field too bureaucratic and weaken the strong ties and allegiance that CHWs have to the community. Others are concerned that it may keep people from becoming CHWs who would otherwise have the necessary commitment, knowledge, and skills. For example, many CHWs have had an experience, such as felony drug convictions, that would disqualify them from receiving a credential if the process is modeled after those of other professions. At the same time, individuals with this background may be the best fit for working with marginalized communities that could fall through the cracks without CHWs whose life experience provides a meaningful connection. There are also concerns that credentialing is driven by the norms of other health care professionals rather than a genuine understanding of CHW work and a desire to strengthen the field.

In spite of these concerns, it is increasingly common for states to pursue approaches to formally certify CHWs and/or the agencies where they work. Funds from the CDC for managing chronic diseases (CDC, 2015a) provide

A CHW earns her certificate from City College of San Francisco.

states with the opportunity to address issues related to integrating CHWs into health care teams, having CHWs lead diabetes self-management courses, and having CHWs become critical links between health care systems and community resources. The first state to formally establish a CHW credentialing programs was Texas, in 2001. The credential is coordinated by the Department of Health Services with a committee that includes certified CHWs (Nichols, Berrios, & Samar, 2005). In 2003, Ohio adopted a credentialing program regulated by the state Board of Nursing. Groups in other states are considering credentialing at various levels, including credentialing individual CHWs, their trainers and/or curricula, and CHW programs.

Numerous other states have started or begun planning for ways to monitor CHWs. In some states, like Florida, a network of CHWs has taken the lead in creating and administering CHW certification, diminishing the role of the state in this process. Other states like Massachusetts are choosing voluntary certification in recognition that certification, in some cases, may prevent able CHWs from serving as CHWs. To learn more about what states are doing to establish credentialing and related processes see the following interactive maps:

National Academy for State Health Policy:

www.nashp.org/state-community-health-worker-models/

Association of State and Territorial State Health Officials:

www.astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards/

2.8 CHW Policy Initiatives and Sustainability

Numerous policy changes over the past several decades have helped to shape the CHW field. To better understand these changes, CHW advocate Carl Rush has divided the history of CHW policy into five phases. See a description of the most recent phase below. To learn about the first four phases, please link to our online supplement.

Carl Rush has worked for and with community health workers for close to 20 years. He serves as a core team member of the Project on CHW Policy and Practice at the University of Texas' Institute for Health Policy, and has supported numerous state and national studies on CHW employment policy.

EXPLOSION OF STATE AND FEDERAL INTEREST (PHASE 5: 2007–PRESENT)

The publication by the U.S. Health Resources and Services Administration (HRSA) of the CHW National Workforce Study launched a period of rapid growth in policy activity in the CHW field. During this period, several trends helped to stimulate interest in policies favorable to CHWs. These include a new emphasis on increasing health equity (or reducing health disparities), an appreciation of the importance of "social determinants of health," and renewed efforts for health care reform or transformation at the national level, including the establishment of the Patient Protection and Affordable Care Act (ACA). The period also has seen more concerted efforts to integrate CHW positions into ongoing financing of public health and health care, to move away from short-term grants and contracts to finance paid CHW positions.

- In 2007, the State of Minnesota submitted a Medicaid State Plan Amendment to authorize reimbursement for CHW "self-management education" services to Medicaid recipients. The State specified completion of a standard training curriculum as a requirement for CHWs to be Medicaid "providers."
- In 2009, the Office of Management and Budget published a series of changes to the Standard Occupational Classification, used to classify employment data from employers and the Census. Effective in 2010, the system now includes "community health worker" as a distinct occupation (SOC 21-1094). The revision produced record numbers of comments, many from CHWs.
- Licensing was ruled out in three states as a means of credentialing CHWs. Licensing boards in New York, Massachusetts, and Virginia all declined to consider licensing of CHWs, finding that there is minimal risk of harm to the public from the work of CHWs.
- During this period, the Centers for Disease Control and Prevention (CDC) dramatically increased their emphasis on the role of CHWs in chronic disease prevention and treatment, funding numerous demonstration projects and the creation of specialty training curricula for CHWs in fields like diabetes and heart disease. The CDC's National Center for Chronic Disease Prevention and Health Promotion included in their strategic priorities encouraging policy and system change to increase employment of CHWs, and published several policy briefs and reports related to evidence-based policy.
- State legislation calling for task forces to recommend CHW policies was passed in Massachusetts in 2010 (creating a CHW Board of Certification), and rapidly passed in early 2014 in New Mexico, Illinois, and Maryland. Many other states created CHW policy initiatives during the period, most of these with active sponsorship and/or participation by state government officials. By mid-2015 almost all states had some form of CHW policy initiative underway.
- Several states have created new policy initiatives involving CHWs, such as Oregon's "Coordinated Care Organizations" and a pilot of Medicaid funding of CHWs in 14 primary care practices in South Carolina.
- Federal interest in CHWs led to the development of numerous committees and work groups:
  - The Office of Minority Health convened a committee in 2010 to examine the role of CHWs or *promotores* among Hispanic residents of the United States; the U.S.-Mexico Border Health Commission helped to convene that group.
  - The Centers for Disease Control and Prevention established a CHW Work Group in 2011 (CDC, 2014).
  - In 2011, the U.S. Department of Health and Human Services (HHS) Office of Minority Health convened staff to support the National Promotores Initiative by promoting *promotores de salud* and recognizing their efforts in strengthening underserved Hispanic communities. A *promotores de salud* steering committee (with 15 *promotores* members) was to provide feedback and guidance on support for *promotores*. This work group and its steering committee are still active.
  - The HHS Interagency CHW Work Group grew out of the *promotores* workgroup in 2014. HHS staff share information and resources to keep Work Group members informed about CHW programs, projects, and trends so they can better serve states, grantees, and others. Work Group members helped plan and presented at the 2014 Unity Meeting.
- This period has been capped (2014) by a Medicaid rule change allowing payment for preventive services by "nonlicensed" individuals. At this writing many states are considering how to use this provision to authorize more sustainable employment for CHWs under Medicaid.

To see more CHW Policy History (Phases 1–4) adapted from the CHW National Workforce Study (2007), see the online supplements to the *Foundations for CHWs* textbook at http://wileyactual.com/bertholdshowcase.

2.9 Convening CHWs: Networks and Conferences

CHWs have organized local, state, and national networks out of the belief that they must have a strong voice in shaping the field as it evolves and to provide mutual support, mentoring, and peer learning.

Durrell Fox, Founder of the Massachusetts Association of CHWs

In 2001 there was a crisis in public health funding in my state [Massachusetts] that deeply impacted CHWs. We had emergency budget cuts. Our state had new and long-standing outreach and prevention programs with evidence of effectiveness. Some programs that had a full year of funding were notified that funding was cut in half. Some programs were notified on a Wednesday that by Friday they would have no more funding. They had to close and lay off staff, including CHWs. We began to see a pattern where CHWs were the first to go and last to know.

Since some CHWs were already connected through training and networking we got together and said, "We've got to do something." We created the Massachusetts Association of CHWs (MACHW) to build strength, support, independence, and sustainability for CHWs. At the time, CHWs were not paid well, were disenfranchised and disconnected. We had maternal child health outreach workers, HIV outreach workers funded by different agencies and not communicating with each other. You could be in a housing development stepping over other outreach workers who might be dealing with some of the same families yet have no communication or coordination with them. This was crazy and inefficient. We didn't have enough resources to have six CHWs serving one family. So MACHW brought CHWs together to learn about what each other was doing and what communities they served. We began to do strategic planning to help CHWs be more efficient and effective.

MACHW linked up with a couple of training programs, one in Boston (CHEC) and in Worcester (Outreach Worker Training Institute [OWTI] in Worcester), and that's where we developed a way to have CHWs coming together from across the state to network, support, and learn from each other.

NATIONAL AND REGIONAL NETWORKS

There are many national groups in the United States that assist in regularly convening CHWs. The names of the groups, and their size and capacity, have varied with funding over the years, but each group works to provide leadership and opportunities for CHW networking and sharing.

The APHA CHW Special Primary Interest Group (CHW SPIG)

In 1970, 500 CHWs and their supporters joined together within the American Public Health Association in what was then called the New Professionals Special Primary Interest Group (SPIG). The name, the "New Professionals," was chosen in protest against the many terms used to describe them, including *nonprofessional, subprofessional, aide, auxiliary,* and *paraprofessional* (Bellin, Killen, & Mazeika, 1967; D'Onofrio, 1970; Murphy, 1972). In the year of their formation, the New Professionals wrote:

> *For too long, non-degreed health workers have been left out of the mainstream of planning for the delivery of health services and [have] gone without recognition and reward. . . . It is our hope that the National New Professional Health Workers will be able to change the status of workers across the country and thereby improve the health of the nation. (American Public Health Association, 1970)*

In the 1980s, membership and activity in the SPIG declined. In the 1990s, the SPIG membership was small, and it was held together by long-time CHW member and SPIG leader Ruth Scarborough. At that stage, those working in the field across the country were looking for a way to stay connected, and in the early 1990s we began to rebuild the SPIG. Many CHWs and allies played a role in this effort in the 1990s, and the group grew strong

once again. We worked together to create a visible niche within APHA for CHWs. Many CHW allies (including the authors of this chapter) and CHWs worked together to build the SPIG. Yvonne Lacye, a CHW leader in the late 1990s, pushed for the New Professional SPIG to become the CHW SPIG. A few years later, with another push under the leadership of Sergio Matos and Lisa Renee Holderby Fox, the CHW SPIG became the CHW Section, which meant we now had a greater number of members and were a bigger part of APHA.

Moving forward since the new millennium, the CHW SPIG once again grew and as of early 2015, we are few hundred short of 1,000 members. With growth of the Section its committees have become stronger and taken on important tasks of working on issues impacting CHWs both inside and outside APHA.

The National Association of Community Health Representatives

The National Association of Community Health Representatives (NACHR and pronounced "nature") is a network of CHRs and CHR coordinators across the country. It was established in the 1970s to be the voice of what is now more than 1,700 CHRs serving their tribal communities. This association has twelve service areas. Their leadership structure includes having lead representatives from each of these 12 health service regions. They coordinate the activities of NACHR in collaboration with the Indian Health Service. For many years NACHR held its national meetings once every three years, when more than 1,000 CHRs gathered to learn about other health issues and programs as well as to honor leadership and longevity in the CHR program. Currently, meetings are less frequent, but NACHR regional leaders work together to connect CHRs across the country, and national meetings are still being held. Some of the 12 regional CHR networks meet regularly to explore issues in their area. Find out more at www.nachr.net.

The Center for Sustainable Health Outreach and the Unity Conference

Beginning in 2000, CHWs began meeting under the auspices of the National Center for Sustainable Health Outreach (CSHO), a partnership between Southern Mississippi University ("CSHO south") and Georgetown University Law School in Washington, D.C. ("CSHO north"). After nearly a decade of collaboration, the CSHO partnership ended, but the Unity Conference lives on bringing together CHWs every one to two years in various cities across the U.S. Dr. Susan Mayfield Johnson continues to coordinate the meetings with funding from various sources.

In the past, several other CHW groups were active, including the following:

The National Association of Hispanic CHWs

The National Association of Hispanic CHWs grew out of the CHW National Network Association, based in Yuma, Arizona, at the regional Western Area Health Education Center. The association was established in Arizona for the southwestern states in 1992; it grew to include people from other regions, including the Midwest and New England, eventually becoming a national network. The annual conference was held primarily in Spanish along with simultaneous translation of selected sessions. In 2007, the organization announced that it would officially focus on Hispanic promoters while maintaining its interest in all CHWs. At the time of this writing it is no longer active, but its legacy lives on with many *promotores* actively networking at the state level and participating in national meetings on behalf of CHWs.

The American Association of CHWs

CHWs and allies came together in 2006 to explore development of a national CHW leadership organization. The CSHO (noted above) staff team played an important role in supporting this strategic network development meeting and Unity meetings provided an important networking forum. The meeting led to the development the American Association of Community Health Workers (AACHWs). Though the network's efforts were not sustained long term, many important lessons can be learned from its efforts and can inform any future efforts to develop or restart other regional and national networks. The group left the legacy of a Code of Ethics that it established (referenced in Chapter 7). Over its few years of collaboration the association focused on organizing issues generally and around providing support for regional and national efforts to promote CHW sustainability.

To learn more about AACHW, read the thoughts of two CHWs, Durrell Fox and Sergio Matos, that follow. Both were among the group of committed CHWs who were active in AACHW when it was active.

A Look Back at the Rise and Decline of the American Association of Community Health Workers (AACHW)

Durrell Fox and Sergio Matos:

In honor of the *Foundation for Community Health Workers* textbook, two well-known leaders of the U.S. CHW field, Durrell Fox and Sergio Matos, share their reflections on the rise and decline of the first broad-based multicultural national association for and by CHWs. Their reflections were written in response to a series of questions about the strengths and challenges that AACHW faced during its several years of active development. The majority of their response can be found in the online supplement to the Foundations for CHWs textbook. Below you will find comments by Fox and Matos to give you an understanding of AACHW.

To put these critical reflections in context, Durrell Fox, who led AACHW for several years and who helped found the Massachusetts Association of CHWs, shares a brief overview of the early hopes of those involved in the creation of the CHWs' association.

Durrell Fox, Responding to the Question: What Was the AACHW?

The American Association of Community Health Workers (AACHW) is currently dormant but not forgotten, and there is a possibility to revisit what it stood for to make sure it fits today's climate. AACHW was a concept and a hope, some might say a dream that grew out of over six years of CHW-led dialogs and organizing meetings during a range of national meetings, including the Unity Conference (for CHWs) and American Public Health Association (APHA) as well as during some local and statewide CHW meetings. Over those six years, approximately 200 CHWs alongside approximately 50 allies and partners, talked about the need for a unified CHW-led national association that could lead national CHW workforce development and sustainability efforts, while connecting the many state and local CHWs networks and associations to advance national advocacy and policy development in an equitable way. One of the driving forces behind developing a CHW-led national association was a belief in the importance of CHW self-determination. This need was identified in a time when some cities and states were moving forward with CHW workforce development and credentialing without CHW participation or leadership in decision making.

For many years, I was honored to coordinate and facilitate some of the CHW national organizing meetings. Other CHW leaders volunteered their time as well since we had no funding support, but we did receive some in-kind contributed support from several agencies in the form of meeting space. Extensive notes were taken during the meetings and shared widely across the country. These notes included consensus agreements on proposed structure, leadership, and governance for a diverse, independent, CHW-led national association.

In 2006 the Harrison Institute for Public Law at the Georgetown University Law Center and the Center for Sustainable Health in Mississippi were able to use some of the information from the CHW national organizing meetings to successfully apply for Foundation funding to support staff who could dedicate time to advance efforts to develop a CHW national association. The inaugural meeting of AACHW was convened in September 2006 in Potomac, Maryland. Over 50 CHWs, allies, and partners from more than one dozen states developed a steering committee, an interim leadership structure, proposed governance structure, and plans to appoint and advisory board. A decision was made to move forward with a CHW steering committee made up entirely of CHWs and plan to activate an advisory board. Within a few months of the meeting, there was drop-off in participation for various reasons, including participants losing employment, leaving the field, and being busy working on critical local and statewide CHW organizing and workforce development issues. One year after the inaugural AACHW meeting, less than 50 percent of the original steering committee members were still fully engaged and active.

(continues)

A Look Back at the Rise and Decline of the American Association of Community Health Workers (AACHW)

(continued)

Participation continued to dwindle in AACHW over a few years and allies would check in but after several years it became clear that AACHW was not able to survive as an organization at that time. Given that, we look back now at lessons learned from AACHW, some of which may serve the CHW field today.

Reflections on AACHW from Sergio Matos, Active in the AACHW Leadership and a Lead in the New York City CHW Association, on the Road Ahead:

The climate for advancing the CHW workforce is much different today from what it was in 2006 and 2007. Early local and regional organizing has progressed in the absence of a national AACHW. Numerous states have developed and implemented workforce standards and regulatory processes—often in the absence of CHW leadership. The Affordable Care Act and its mandates for improved outcomes at lower cost have piqued interest in the CHW workforce. The recent ruling by the Centers for Medicare and Medicaid Services (CMS) to allow reimbursement for preventive services delivered by nonlicensed staff has also driven much activity at the state level to establish workforce standards for the CHW practice. Increasing attention to the importance of addressing the social determinants of health, especially in emerging health reform innovations such as Patient-Centered Medical Homes, health homes, and Accountable Care Organizations, has also fueled interest in the CHW workforce. In short, the issues of importance today are different from what they were in 2006. Today we are more concerned with regulatory oversight of our practice and preserving the integrity of our work. As health care and state systems gain interest in our work, they also venture to define and govern our practice. Although this is a completely unprofessional approach, it is not uncommon for people and organizations in power. In addition to being unprofessional, it is quite illogical for the very systems that have failed to achieve the triple aim to govern our practice and its integration with inter-professional health care teams. A small number of states in which CHWs have, in fact, surrendered their self-determination provide valuable lessons learned and strategies to avoid.

Fortunately, CHWs have been able to advance a policy agenda and continue the battle for self-determination through activities at the APHA CHW Section. We have gained consensus on a national definition and issued policy statement with APHA supporting that definition. We have gained our own unique standard occupational classification with the U.S. Department of Labor. We have issued numerous policy positions though APHA in support of the CHW workforce and CHW self-governance. The scientific evidence supporting our work has exploded over the past five years. Much more evidence exists supporting our scope of practice, our impact on improved outcomes, and the business case for CHW interventions.

In spite of these advances, the need for an independent professional association is greater now than it has ever been. Forces beyond our control stand poised to co-opt our practice for their own purposes. Our principal challenge in the coming years will be to preserve the integrity of our work. Only a self-governing association can accomplish that goal.

REGIONAL AND STATE NETWORKS

There are numerous CHW regional, state, and city-level CHW networks throughout the United States.

One group that has focused at the state level has recently seen itself as providing networking activities at the regional level. That group is *Vision y Compromiso,* a California-based network. The network works to bring together *promotores* and networks of *promotores* for annual conferences, assuring language access in Spanish at those meetings. Their annual conference is well attended. Additionally, within California they work with regional partners to develop a well-connected network. At their 2014 annual conference, four state networks of *promotores* and Community Health Workers explored some ways in which their networks can come together. The participating networks represent large communities of *promotores* and Community Health Workers; working or volunteers, affiliated with or independents with local, regional, and state organizations that support

Spanish-speaking families in rural and urban communities. They currently represent the states of Washington, Nevada, Arizona, and Colorado. *Vision y Compromiso* plans to support these networks with leadership, training, and advocacy activities.

As noted in the discussion of national networks, tribal Community Health Representatives are part of regional networks across 12 Indian Health Service regions. Some regions are more active than others and all connect back to their larger national association, NACHR. Working at the regional level, tribes can exchange insights about more local issues and examine how they are participating in their various states in other CHW organizing activities. For example in the New Mexico/outer Colorado region CHRs are sharing about CHRs' role in New Mexico's state policy developments and can see how that may impact their practice and anticipate such activities in Colorado through their exchange.

Much of the networking activity in the CHW field takes place in state-level networks. The first statewide network of U.S. CHWs was formed in the early 1990s in New Mexico as the New Mexico Community Health Worker Association. About the same time, the Oregon Public Health Association formed a committee on CHWs that was chaired by CHWs. This committee provided leadership at the state level and nationally by working as a part of the Oregon Public Health Association.

Over several decades CHW networks have formed in many states including Arizona, California, Florida, Maryland, Massachusetts, Minnesota, Mississippi, New York, Texas, and Virginia, to name a few. In some states, regional and issue-specific networks have been established so a number of states have more than one network, with Texas currently having eleven small regional networks.

Some cites also have networks of CHWs such as the CHW Network of NYC. At the time of this writing there are close to 50 state and regional CHW networks in the United States. In 2015, discussion about again forming a national association made up of those networks is again underway (see the Fox and Matos reflections on the rise and decline of the American Association of CHWs that formally began its launch in 2006). Networks clearly have a role to play in helping the field develop.

THE VALUE OF CHW NETWORKS

By joining together in regional, state, and national networks and associations, CHWs are taking leadership in the development of the field, defining their roles, establishing new standards, research priorities, educational and training models, and advocating for greater recognition and increased funding to support the valuable contributions of CHWs. Visit the website of the American Public Health Association Community Health Worker Section to help you find local, regional, and national contacts: www.apha.org/apha-communities/member-sections/community-health-workers.

If you cannot find a contact at the website, reach out to other colleagues to be sure there is not a newly forming group or a longstanding one in need of your energy and input.

If there really is not a network of CHWs in your area, maybe it is time for you to start one!

Chapter Review

1. Why is it so hard to develop a common definition of CHWs and CHW roles and competencies?
2. How could a common definition of roles and competencies benefit the CHW field?
3. What has been the role of CHW leaders in defining and developing the CHW field?
4. Why is academic research about CHWs important to developing the CHW field? What are research priorities for the CHW field?
5. How are developments in CHW training, education, and credentialing shaping the CHW field? Why are these developments controversial?
6. How do CHW networks develop and why are they important to the future of CHWs in the United States?
7. Are there CHW networks in your city, county, or state? How can you get involved?

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