Community Health Workers in the United States: Challenges in Identifying, Surveying, and Supporting the Workforce

Community health workers (CHWs) are members of a growing profession in the United States. Studying this dynamic labor force is challenging, in part because its members have more than 100 different job titles.

The demand for timely, accurate information about CHWs is increasing as the profession gains recognition for its ability to improve health outcomes and reduce costs. Although numerous surveys of CHWs have been conducted, the field lacks well-delineated methods for gaining access to this hard-to-identify workforce.

We outline methods for surveying CHWs and promising approaches to engage the workforce and other stakeholders in conducting local, state, and national studies. We also highlight successful strategies to overcome challenges in CHW surveys and future directions for surveying the field. (*Am J Public Health.* 2017;107:1964–1969. doi: 10.2105/AJPH.2017.304096)

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Over the past decade, the community health worker (CHW) workforce has gained increased recognition and visibility in the United States, as evidenced by the creation of a US Department of Labor Standard Occupational Classification (21-094) in 2010, inclusion as a health profession in the Patient Protection and Affordable Care Act,[1] and recognition by several other prominent federal entities (http://b.my/ca). The CHW workforce has continued to gain traction and has entered the spotlight as an essential part of the public health and health care system.[2] CHWs are valuable members of health teams who play a vital role in addressing social determinants of health among underserved populations.[3,4] The workforce has also contributed to significant improvements in health outcomes by serving as a critical link between public health and human development systems and communities.[5–7]

The profession is expected to expand in coming years, creating a critical need for more information about the workforce. Currently, local, tribal, and state health departments; CHW professional organizations; and health systems often lack information to answer basic questions about CHWs in their regions. This information includes workforce demographics, job titles, scope of practice, employer types, supervision, wages, and benefits offered by employers as well as training requirements and continuing education needs.

Over the past several decades, various combinations of stakeholder groups have collaborated to locate and survey various segments of the CHW workforce. These attempts have occurred independently and have been led by diverse entities, including CHW professional organizations, employers, academics, state public health departments, payers, and policymakers. These surveys have employed a multitude of techniques and have met with varying levels of success.[8–10] For example, several state- and national-level CHW surveys have been successful in generating seminal CHW workforce data.[9,11–13] In 1998, for example, and before the use of online surveys, the landmark National Community Health Advisor Study (NCHAS) was the first to engage CHWs and their employers across the United States in defining CHW workforce core competencies (http://bit.ly/2vUzgt4).

NCHAS offered a first look at the workforce and related CHW workforce development strategies. Such information was invaluable and led to building consensus on the CHW profession's roles, skills, and competencies. In 2007, the Health Resources and Services Administration CHW Workforce Study conducted employer interviews and case studies of major CHW-employing states (http://b.my/cb). Specifically, this work and its follow-up report aimed to provide a comprehensive understanding of CHW workforce development efforts and sustainability models and provided seminal information on key demographics of the CHW workforce such as gender, ethnicity, education, and earnings. The 2010 and 2014 National CHW Advocacy Study (NCHWAS) used strategic state and national partnerships with state and local CHW professional organizations, health departments, tribal nations, health systems, and other CHW

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advocacy groups to conduct the largest online survey of CHWs to date.[13]

The lead NCHWAS surveyors engaged state and national stakeholders to develop the scope of the survey to meet local-, state-, and tribal-level data needs; created opportunities for states to include unique survey questions; and made the survey available in hard copy or online and in multiple languages. Dissemination of the survey was incentivized by making final data sets open access and by generating state and regional reports for states with fewer resources to conduct a survey on their own. Through these strategies, in 2014, NCHWAS generated information directly from 1767 CHWs from 45 states and 4 US territories and produced several downloadable state- and regional-level reports (http://b.my/cc).

Most recently, in 2016, through a highly participatory national consensus–building strategy, the CHW Core Consensus (C3) Project engaged CHWs and their allies nationwide (http://b.my/cd). The C3 Project sought to update the 1998 NCHAS and develop a contemporary list of CHW roles and skills. This process included consensus building among diverse stakeholders and included input from CHW leaders, active in state and local networks in the United States. This process was designed to improve reporting of results and help transfer ownership of the process to CHW networks. In each of these national efforts, study leads prioritized CHW voices, engaged each other, and, ultimately, built on and used previous survey work to advance understanding of the nature of the CHW profession.

Although these national surveys, as well as information gleaned from local and state surveys, in which many authors of this commentary were directly involved and have produced invaluable insights, the field lacks specific survey techniques and other methods for gaining access to this oftentimes hard-to-identify group of paid and, sometimes, volunteer professionals.[8–10,14,15] Without specific techniques for accessing the workforce and clear guidance on rigorous methodology to survey the workforce, researchers and surveyors may be replicating efforts or using ineffective strategies to answer contemporary workforce questions.

On the basis of the authors' experiences and observations in conducting local, state, and national surveys, we describe current CHW surveying methods, challenges, and promising strategies to describe the CHW workforce. We highlight successful ways to overcome survey challenges and identify future directions for conducting CHW workforce studies, and we make recommendations to advance CHW workforce study techniques and, ultimately, improve the understanding and appropriate engagement of this important workforce. We offer an overview of common challenges and promising strategies to engage in CHW workforce studies in the United States (Table 1).

CHALLENGE 1: IDENTIFY THE WORKFORCE

The first methodological issue in surveying CHWs in the United States is the accurate identification of CHWs. For more than three decades, CHWs and other stakeholders have not agreed on a single workforce definition or scope of practice. National initiatives like the 1998 NCHAS and 2016 C3 Project are exemplary in their efforts to build broad-based consensus on CHW scope of practice, workforce definition, and competencies because of the more than 100 job titles that fall under the CHW umbrella title. The US Department of Labor, the US Department of Health and Human Services, and the American Public Health Association (APHA) use different definitions of CHWs. The Patient Protection and Affordable Care Act also references the CHW profession, albeit differently from any professional or governmental organization.[1] The APHA definition is the most widely vetted and accepted definition by members of the CHW workforce (http://b.my/ce).

Yet, CHW professional associations and major CHW employers have only recently begun to adopt the APHA definition, making until recently self-identification and employer recognition of a CHW a common barrier to workforce studies. In addition, developers of workforce studies may lack awareness of this issue and use a single CHW definition or title, rather than including multiple job titles. Without a common definition, other professionals, such as community-based and clinical health care providers or social workers, may mistakenly identify as a CHW and participate in CHW workforce surveys because of confusion about the distinction between CHWs' scope of practice and their own.

To overcome the methodological challenge of accurate and consistent workforce identification, we suggest using "community health worker" as an umbrella term and listing the job titles known under that term. Furthermore, to increase the likelihood of self and employer identification, study leaders should use the APHA definition of a CHW and the C3 Project 10 core CHW roles to describe CHW's roles. For example, survey respondents can be asked to review the APHA definition and C3 10 core roles and attest that they serve in a role that meets the definition before beginning the survey. Advantages to this approach include the provision of two points of identification for respondents and an opportunity for respondents to assess multiple criteria for inclusion. Disadvantages include the potential for confusion if respondents meet some but not all criteria; if brevity is required for the survey design, the roles can be simply listed with the definition. As an additional check, a question requesting a job title can be included, thus providing an opportunity to exclude answers from individuals who identify as a clinician, such as a nurse or social worker.

CHALLENGE 2: ENGAGE AND SURVEY THE WORKFORCE

Another challenge to surveying CHWs is simply reaching the workforce. We recommend collaborating with leaders of the CHW workforce, specifically through local, tribal, regional, and statewide CHW professional associations or networks, to ensure quality and validity of workforce data. Currently, there are an estimated 46 CHW professional organizations operating in 26 states (http://bit.ly/2vrLeaE). These groups are a tremendous resource, as they often maintain CHW and employer membership databases and possess important knowledge about what workforce information is

TABLE 1—Community Health Worker Workforce Survey Challenges and Recommendations: A Practical Guide

Survey Step	Potential Challenges	Recommended Questions
Challenge 1: Identifying the workforce		
1. Survey planning and design	Defining survey objectives and goals	Were CHWs and stakeholders engaged in defining survey objectives?
		Are survey objectives and goals in alignment with other CHW efforts?
		Are CHWs seen as an essential research partner?
	Establish resources (budget)	Was a budget established for this survey?
		Does the survey effort build on existing strengths and resources from the community?
	Plan the schedule	Was a flexible timeline used in planning the survey activities?
	Define the population	Was the American Public Health Association definition of a CHW used?
		Were questions written in a way that helps CHWs self-identify (e.g., use American Public Health Association definition, C3 roles and skills)?
		Was the CHW job title used as an umbrella term with job titles listed as examples?
	Estimate required sample size (relates to objectives of survey)	Was a sample size determined? Was type of CHW considered (paid vs volunteer, clinic vs community)?
	Select method of data collection (telephone, e-mail, electronic methods)	Were local, state, tribal, regional, and national CHW networks and associations consulted about the methods for data collection?
		Were community-based participatory research strategies used to engage members of CHW workforce for data collection?
	Write questions/survey	Were existing resources, materials, and data sets consulted for writing survey questions (e.g., previous surveys, survey leads, reports)?
2. Recruitment and retention	Seek input from CHWs and CHW employers on how best to recruit	Was the local CHW professional association engaged as a partner in outreach and data collection?
		Were CHWs and employers able to self-identify through the use of APHA definition, job titles, and C3 scope of practice?
		Was the survey period held open for a longer period?
Challenge 2: Engaging and surveying the workforce		
3. Data collection	Pilot survey	Was the survey pilot tested with CHWs or CHW network leadership?
	Survey launch	Was the survey launched in coordination with CHW stakeholders (e.g., local, state, and national networks)?
4. Data analysis	Determine how you will use the results and how the information will be used	Were CHWs and CHW networks engaged in determining the data analysis plan?
	Work with an analyst or methodologist for descriptive and inferential data analysis	Was an analyst or methodologist consulted for data analysis?
Challenge 3: Supporting the workforce		
5. Reporting	Decide how to best present results so that it is easy to understand and useful to your audience	Were CHWs and CHW networks engaged in the strategy for reporting results?
		Were CHWs consulted in the dissemination efforts?
		Are results reported in a variety of ways (including various audiences, health literacy levels, languages, formats, e.g., text, audio, video)?
		Were CHWs included as coauthors of reports, presentations, and manuscripts?

Continued

TABLE 1—*Continued*

Survey Step	Potential Challenges	Recommended Questions
6. Dissemination of results	Allow the audience to take action on the results	Do dissemination strategies include publicly available and accessible reports (e.g., interactive Web site, infographics)? Were creative dissemination opportunities considered (e.g., data workshops and presentations with CHW stakeholders, social media)?
7. Advocacy and policy	Encourage data-driven policy decisions	Were specific workforce policy and advocacy implications included? Are the contributions of your research clear for those working in CHW workforce advocacy and policy? Was a CHW policy champion consulted pre- and postsurvey (e.g., policymaker, chief executive officer, grassroots organization)?

Note. CHW = community health worker. The following resources are a nonexhaustive list of examples of excellent planning and design; instrumentation; recruitment and retention; data collection, analysis, and reporting; dissemination of results; and advocacy and policy: (1) Community Health Worker National Workforce Study: http://b.my/cd; (2) The National Community Health Worker Advocacy Survey: http://b.my/cg; (3) The National Community Health Advisor Study: http://bit.ly/2vUzgt4; (4) The Michigan Community Health Worker Alliance CHW Employer Surveys: http://b.my/ch; (5) Paving a Path to Advance Community Health Worker Workforce in New York State: http://bit.ly/2vs946b; (6) United Voices Community Health Worker Census: http://bit.ly/2vs4sgk; (7) Massachusetts CHW Certification Evaluation: http://bit.ly/2uuvM06; (8) Texas Department of State Health Services Certification Evaluation: http://bit.ly/2hQQhOI; and (9) National Common Indicator Project http://bit.ly/2hP6sc2.

needed and what policy issues are at stake. CHW associations can offer insight into which workforce surveys have occurred, how they were conducted, who conducted them, and what lessons were learned; these insights can help avoid duplication of efforts and subsequent survey burnout.

CHW survey distribution requires a decision about whether the survey should be disseminated online, in-person, or in combination. Some CHWs may have limited access to technology, making it difficult to complete surveys online. Consulting and pilot testing with CHWs will enable the use of the most reliable methods for distribution. CHW professional networks may be the best source of distribution in one area, and distribution through employers may be better in another. Furthermore, understanding some of the perceptions of different organizations among the CHWs surveyed can benefit the design and implementation of workforce studies. These considerations are important because they may affect who answers the survey and how they answer the survey. Language must also be considered. Many CHWs speak English as a second language and may be more comfortable completing a survey in their primary language. Face-to-face surveys may allow CHWs to become data collectors and survey distributors. Wisconsin and New York are exemplary states in promoting a shared identity among diverse and multilingual CHW workforce and in engaging CHWs in survey design, recruitment, and data collection efforts (http://b.my/ci).[14]

Finally, state and local studies are common among CHW stakeholders. Such studies are highly variable and depend on the policy environment related to the local CHW workforce, which may include issues related to financing, certification, training, and, oftentimes, the needs of the survey's funder. Thus, it is important to define the intended audience for information generated by a CHW workforce study, as there may be multiple competing audiences including health plans, community health centers, policymakers, the health care industry, community-based organizations, and local and state health departments.

Although it may initially seem appealing to attempt to serve multiple target audiences, limiting a survey's purpose and scope is preferable to avoid long, onerous surveys that go largely uncompleted because of participant lack of knowledge on specific workforce topics. Surveys may focus on workforce tracking, similar to national CHW workforce studies, but they frequently extend beyond the workforce itself and aim to understand CHW workforce impact, workforce needs, and demands from non-CHW perspectives and stakeholders (e.g., employer perceptions or health care and public health provider perceptions about CHWs' impact on health care teams, roles in chronic disease self-management, or promoting access and enrollment in health care).

To overcome these challenges and others presented throughout this commentary, we recommend a community-based participatory research approach that includes CHWs in all phases of the work, including survey design, dissemination, and policy change. Community-based participatory research is a research paradigm that engages nonacademic partners who are ultimate beneficiaries and stakeholders of the research findings and support making results relevant to policy, practice, advocacy, or everyday life.[16] Most importantly, tenants of community-based participatory research that involve CHWs and professional associations are methodologically and ethically sound because they increase the likelihood of effective and appropriate survey design, participant recruitment, survey comprehension, and action in response to findings.[17]

CHALLENGE 3: SUPPORT THE WORKFORCE

Ultimately, supporting the workforce through wide dissemination of survey results to

inform workforce development and policy is particularly challenging. Beyond issues of computer, e-mail, and Internet access predominately used to share survey results, CHW participation in workforce development activities that promote continuous dialogue and action is a major barrier.[13] For example, most health professionals have the autonomy and support from their employer to affiliate with their professional network. As health professionals, we attend our annual conference and often serve as board and committee members to advance our profession. This is not the case for the CHW profession, which continues to fight for recognition as a health profession and the autonomy and employer support to actively participate in workforce sustainability efforts.[18] Because of this challenge, we recommend working carefully with local CHW associations and employers to determine the best format to communicate and elicit CHW perspectives (e.g., participation in analysis, interpretation, presentations and writing of reports, and advocacy). Such engagement enables CHWs to identify pieces of data salient to their daily work and broader workforce policy issues, whereas other stakeholders may elevate other results in their review.

Effective data dissemination and meaningful dialogue with CHWs also depends on the use of creative ways to share and promote dialogue about results. One step is to not limit results to academic journals and national conferences but, instead, consider sharing the work through multiple and interactive distribution channels. Modes of dissemination and dialogue could include interactive face-to-face presentations and workshops at local association and employer staff meetings and the use of CHW network and employer listservs and postal mailing lists. When possible, engage graphic designers or open source info graphics to distill and communicate key findings in plain language. As in the case of NCHWAS, stakeholder-specific or geographic-specific reports may be generated. Often workforce policy is the goal; engaging CHW policy champions early and often can help us identify important information to collect and highlight as well the mechanisms for fully engaging the workforce in data-driven policy and advocacy. Several highly successful state and CHW association strategies for engagement, dissemination, and action are included in Table 1.

OTHER ISSUES AND GAPS

Ultimately, the state-to-state variance in CHW regulations and the shifting public health and health care policy landscape create challenges to answer CHW workforce policy–related questions. Without specific techniques for accessing the field and clear guidance on rigorous methodology to survey the field, researchers may be replicating efforts or using out-of-date techniques to answer current questions. Ideally, data from multiple vantage points are combined to ensure a comprehensive picture of the issue at hand. For example, several states have made strategic decisions to survey providers, employers, and policymakers to understand trends and opportunities available to the CHW workforce. Working collaboratively with CHW professional associations enables ongoing discussions for priority and targeted research to occur.

One such emerging priority area is understanding the role of the CHW in the clinical care team. There is a lack of documentation on the role the CHW plays on the care team and how that role contributes to integrated care and health outcomes. Although studies have largely supported the idea that the presence of CHWs adds value to the clinical setting, surveys present an opportunity to quantify CHW contributions, especially in light of the rapidly changing health care environment. A deeper understanding of the value of the CHW role and its contribution to the care team may provide valuable insight into role delineation within integrated care as care systems move toward value-based payment. Such a gap in understanding CHW-specific tasks and service delivery, specifically in the clinical setting, provides an incentive for stakeholders and allies to support standardized, participatory surveys of the CHW workforce. The National Common Indicator Project is one attempt to identify and develop standardized process and outcome measures to enable the collection of standardized data on CHW activities within and across public health and health care systems highly dependent on policy shifts (http://b.my/cj).

CONCLUSIONS

CHW workforce studies pose unique opportunities and reflect the challenges the workforce experiences on a broader level, including clarifying definitions and role delineation, promoting self-identification of the workforce, addressing language and literacy opportunities, and working with diverse stakeholders. Understanding and addressing the current state of the art and science and the challenges and barriers that exist in CHW workforce studies provides tangible benefits to the field. When we better understand the CHW workforce, we better understand the who of the workforce, gain clarity on where they are, and allow a regular way to gather CHW input on workforce development and sustainability. AJPH

CONTRIBUTORS

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