Commentary

Community Health Workers in a Post–Health Reform Era

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INTRODUCTION

Most health care spending and deaths in the United States are related to costly, debilitating chronic diseases such as obesity, diabetes, high blood pressure, heart disease, and cancer (Centers for Disease Control and Prevention [CDC], National Center for Chronic Disease Prevention and Health Promotion, 2015b). Racial and ethnic minority populations and vulnerable groups are disproportionately impacted by certain chronic conditions due to barriers caused by lack of education, socioeconomic, geographic, or other sociocultural factors (Smedley, Stith, & Nelson, 2003). As The Patient Protection and Affordable Care Act (2010) seeks to improve access to and quality of health care as well as curb health care expenditures, we are presented with a new opportunity to focus on a more interdisciplinary, holistic team approach to facing these chronic conditions—an approach that includes community health workers (CHWs). Given CHW programs have existed for decades, what additional information or changes are needed in today's evolving health environment for CHWs to live up to their promise and potential?

CHW is a standard occupational classification recognized by the U.S. Department of Labor and the World Health Organization (WHO) but in practice has been referred to under more than 150 different titles of paid and unpaid positions such as lay health advisors (LHAs), outreach workers, *promotores(as) de salud* (Spanish for "health promoters"), community health representatives, and patient navigators (Bureau of Labor Statistics, U.S. Department of Labor, 2015; California Association of Community Health Workers, 2016; Health Resources and Services Administration, 2007; WHO, 2016). A distinguishing characteristic is that CHWs are culturally responsive to the populations they serve and are trusted intermediaries between the priority populations and traditional health and social service providers (American Public Health Association, 2009, 2016). Although educational levels, job titles, and responsibilities may vary by employer, seven classical or "gold standard" CHW roles are outlined in Table 1 (Rosenthal et al., 1998).

Currently, there are 47,800 CHWs across the country, and the U.S. Department of Labor predicts that the demand for CHWs will grow faster than most other occupations by 2024 (Bureau of Labor Statistics, U.S. Department of Labor, 2015). An expanding evidence base shows that CHWs are effective across multiple health-related dimensions: behavioral (e.g., motivating or changing patient behavior, improving patient compliance with health care appointments), educational (e.g., increasing consumer knowledge, enrollment in health plans), clinical (e.g., improving lab values or physical exam findings that indicate how well a disease is controlled), psychological (e.g., depression, perceived stress), environmental (e.g.,. eliminating environmental asthma triggers from homes), and systemic (e.g., reducing emergency room

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TABLE 1
Seven Core Roles for Community Health Advisors

1.	Cultural mediating between communities and health and human services systems
2.	Assuring people get the services they need
3.	Informal counseling and social support
4.	Building individual and community capacity
5.	Providing culturally appropriate health education
6.	Providing direct services
7.	Advocating for individual and community needs

Source: Wiggins and Borbon (1998).

use, contributing to community health needs assessments through data collection; California Health Worker Alliance, 2013; CDC, National Center for Chronic Disease Prevention and Health Promotion, 2015a).

Despite the growing popularity of CHWs in the health care system, questions remain concerning CHW entry-level education, parameters for quality of instruction, recruitment and retention, reimbursement, evaluation, and other areas (Katzen & Morgan, 2014). This journal issue includes seven articles that expand the literature on CHW education and training, leadership development, community capacity building, interprofessional roles, and CHWs' promise and contributions to improving patient and community health.

Training and Development

As first articulated in the Ottawa Charter for Health Promotion some three decades ago, social determinants and community engagement are fundamental to eliminating the health gap within and between societies (WHO, 1986). In the United States, national leadership is being provided through the U.S. Department of Health & Human Services Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholder Strategy for Achieving Health Equity, coordinated by the Office of Minority Health (U.S. Department of Health & Human Services, Office of Minority Health, 2011a, 2011b). A relatively new four-part online program launched by the Office of Minority Health, *Promoting Healthy Choices and Community Changes*, instructs *promotores de salud* on how to facilitate individual-level behavior changes and how to initiate community changes to promote healthy choices (http://promotores.thinkculturalhealth.hhs.gov). The Centers for Medicare and Medicaid Services also offers online training programs for navigators and certified application counselors, as well as resources to be used by CHWs such as the From Coverage to Care toolkit (https://marketplace.cms.gov/technical-assistance-resources/c2c.html). A new associate's degree in health navigation has been introduced as one innovative avenue to attract more diverse students to the field of public health (Association of Schools and Programs in Public Health and League for Innovation in Community College, 2014; Riegelman & Wilson, 2016).

Notwithstanding these resources, the CHW movement has not adopted a standard approach to the selection and training of CHWs or national standards for their educational background or training. Most states do not require CHWs to become certified (CDC, 2015a). Some argue that certification and such professionalization remove CHWs from the populations they are intended to serve and may inadvertently disadvantage the racial/ethnic opportunities for CHW hiring and advancement. Additionally, such certification or navigation programs can be costly to implement given the need for extensive training to address the myriad barriers that vulnerable populations face in accessing the medical system. Others argue that such certification and professionalization may assure the competencies and quality of services provided by CHWs. While the authors of this article take no stance on certification, it is important to note that this is an issue of consideration in the field.

Several articles herein address CHW preparation and training and are illustrative of the differential prerequisite requirements from brief on-the-job training to formal university preparation. An analysis of 75 patient navigation (PN) efficacy studies found wide variation in the quantity and quality of training programs, with fewer than one fourth of the documented PN training programs having included education on how to assist patients in overcoming barriers to care (Ustakifkais et al., in this issue). Fewer than one third of the training programs addressed approaches to evidence-based behavior change. The authors conclude that little is known about the optimal delivery and content of PN training and call for established standards in the field.

Writing in this issue, Ingram et al. also call for a standardized framework for CHW training and the need to integrate broad leadership competencies that could supplement more traditional CHW instruction on a specific disease, health condition or setting. The Women's Health Leadership Institute curriculum and training program was designed and implemented over 3 years to help CHWs develop their leadership skills in reducing health disparities. The program used CHWs with master's degrees to increase trainees' leadership competencies and the application of the competencies in the community.

Interprofessional Roles

More research is needed on the effective integration of CHWs into interprofessional teams in the post–health care reform environment. In California, one of the states

with the largest number of CHWs, health care providers lack awareness of CHWs' unique knowledge and skills compared with other health professions (California Health Worker Alliance, 2013). The complementary roles and capacities of health education specialists (HESs) and CHWs are often unclear to other health professionals, despite distinct standard occupational classification definitions. As outlined in the supplementary materials for this article (available online at http://hpp.sagepub.com/supplemental), HESs share many of the core foundational values of CHWs such as community engagement but at a minimum have a bachelor's degree and a well-established set of competencies and subcompetencies (Eng, Parker, & Harlan, 1997; Israel, 1985; Society for Public Health Education, 2013). HESs often develop evidence-based interventions delivered by CHWs, coordinate CHW recruitment and training, and oversee population management and quality improvement of programs employing CHWs (American Public Health Association, 2016; Society for Public Health Education, 2014).

As with other effective working relationships, trust is a key factor in the integration of CHWs into interprofessional teams. De la Riva et al. describe in this issue that health providers, after initial resistance, valued CHWs in terms of strengthening community partnerships and programs, enhancing their overall teamwork and effective communication, and dealing with a large case load of patients accessing the medical system for the first time. Although it took months for clinical providers in the DuPage Patient Navigation Collaborative to increase their trust of and reliance on navigators, they eventually became enthusiastic about expanding navigation to other health conditions.

Building Capacity Through CBPR

CHWs play a valuable role by building capacity in underserved populations, particularly through community-based participatory research (CBPR). In this research paradigm, the community plays a central role in identifying a priority research topic, which is the goal of improving health and eliminating health disparities (Wallerstein & Duran, 2006). Several CHW articles herein use CBPR to engage diverse and underserved populations to improve health knowledge and capacity in both African American and Hispanic populations, applying the health belief model as the theoretical construct. In this issue, Vines et al. describe using LHAs in a community coalition to address prostate health among African Americans in rural North Carolina. After a 2-day training program, LHAs achieved improvements in knowledge of prostate health and confidence in teaching. The authors recommend providing interactive training over multiple days, with regular hands-on activities and teach-back sessions.

In a related article, Mojica et al. describe their efforts using CHWs to deliver evidence-based cancer education based on the health belief model and PN to influence screening rates and knowledge of screening guidelines and early detection among low-income rarely or never-screened Latino women. CHWs were trained over 2 weeks on study protocols, followed by monthly meetings and yearly booster sessions. Positive changes were found in participants' cancer screening behavior and knowledge of screening guidelines and belief in early detection.

In a unique approach described herein, Documet et al. examined the feasibility of training and retaining male Latino LHAs, which is significant given that this male population views LHAs as unpaid or low-paid positions more apropos for women. The *de la Mano con la Salud* program aimed to enhance participants' social support, community connections, and health care access. LHAs were provided five 4-hour training sessions that addressed workplace safety, U.S. health system, case management, emotional health and recreation, values, nutrition, and diabetes. In true CBPR fashion, the researchers found they needed to provide additional training to LHAs, who were called on to first address broader social determinant needs of the population such as housing and immigration before addressing health care issues.

Broadening the Lens

Although many CHW studies focus on *promotores de salud* as means to improve knowledge and navigation of cancer prevention and screening, an article in this issue by Balcazar et al. describes using CBPR to address cardiovascular disease prevention among Mexican Americans in El Paso, Texas. The intervention organized physical activity and nutrition programming at parks and recreational facilities and provided free YWCA memberships to address the environmental factors that influence healthy behaviors. On average, more than 16 physical activity sessions and 5 nutrition sessions were attended by study participants over a 4-month period. The authors stress the importance of developing partnerships between community organizations to increase access to available resources.

CONCLUSION

Opportunities and challenges presented in the post–health reform era require an upstream focus on prevention and management of chronic conditions. A multidisciplinary team, including CHWs, HESs, and clinical staff, demonstrates promise to improve health outcomes, patient satisfaction, and decreased cost. Although innovative practices are evolving rapidly, there is much to be learned through qualitative and quantitative research concerning (1) education of providers about the unique value and

roles of CHWs and how to successfully integrate them into health care teams; (2) how CHWs' backgrounds, educational levels, and other factors influence successful health outcomes; (3) optimal length, methodologies, instructors, and evaluation of CHW formal and on-the-job training; (4) best practices in CHW recruitment and retention, including preventing burnout; (5) innovative and sustainable CHW reimbursement models and payment systems; and (6) strengthening the role of CHWs in CBPR and building community capacity. In this era of post–health care reform, integrating CHWs as a vital member of the health team shows exciting promise to address issues of health care quality, access, and cost and to contribute to the overarching goal of reducing health disparities.

SUPPLEMENTAL MATERIAL

The supplementary materials are available at http://hpp.sagepub.com/supplemental.

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