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Community Health Worker Professional Advocacy

Voices of Action from the 2014 National Community Health Worker Advocacy Survey

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Abstract: This mixed-methods study explores community health worker (CHW) engagement in professional advocacy. Data from the National Community Health Worker Advocacy Survey (n = 1661) assessed the relationship between CHW professional advocacy and CHW demographics, and work characteristics. Qualitative data articulated the quality of professional advocacy efforts. Approximately, 30% of CHW respondents advocated for professional advancement or collaborated with other CHWs to advance the workforce. Advocacy was more prevalent among CHWs affiliated with a professional network. CHW advocacy targeted recognition of the field, appropriate training and compensation, and sustainable funding. CHW professional advocacy is imperative to advancement of the field. **Key words:** *advocacy, community health workers, policy, professional development, workforce develop*

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SINCE THE 1960s, community health workers (CHWs) throughout the world have been characterized as community leaders who share the language, socioeconomic status, and life experiences of the community members they serve (Rosenthal et al., 2011). Community health workers have been recognized as a promising strategy to address glaring health inequities among marginalized populations (Nelson, 2003). Yet, inconsistent funding streams and shifting public health priorities have stymied development of a coordinated workforce (Dower et al., 2006).

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Nonetheless, evidence suggests that CHW roles are converging, and are considered a distinct health profession, rather than merely complements to public health interventions (Ingram et al., 2012). In 2010, CHWs were recognized by the Bureau of Labor (Statistics, 2010) and in 2013 CHWs were included in the Affordable Care Act as distinct members of the health care team (Patient Protection and Affordable Care Act, 2010). Furthermore, the Centers for Medicaid and Medicare services recently issued new guidance that allows for reimbursement of preventive services offered by unlicensed professionals such as CHWs if states opt in (Services, 2013). These developments have tremendous implications for how the workforce will continue to evolve, particularly with regard to possible creation of statewide training and credentialing standards.

Members of emerging professions are generally expected to pave the path for their own workforce advancement (Evets, 2003). It is possible that CHWs—who are typically members of marginalized populations and low-wage earners—may face difficulty in leading workforce development efforts in other areas of the country as well (Bureau of Health Professions, 2007). Case studies from a few states highlight successful collaborations between CHWs and other stakeholders to make decisions about CHW training and credentialing (Matos et al., 2011), and to pass legislation to support CHWs (Mason et al., 2011; Rosenthal et al., 2010). The aim of this article is to characterize CHW professional advocacy defined as the frequency and ways in which CHWs promote CHW professional identity and sustainability through the education, inter- and intraprofessional collaboration, and promotion of legislative or policy initiatives. We apply a mixed-methods, sequenced analysis approach to first quantitatively assess the prevalence and correlates of CHW professional advocacy and qualitatively describe the various forms and impact of such advocacy on the field (Creswell & Plano Clark, 2007).

METHODS

The National Community Health Workers Advocacy Study (NCHWAS), conducted by the University of Arizona, Arizona Prevention Research Center (AzPRC), assesses the professional status of CHWs in the United States and investigates the impact of CHW advocacy on community engagement to address health disparities. Between February and May 2014, cross-sectional qualitative and quantitative data were collected through an anonymous, online survey. The NCHWAS was distributed through a comprehensive e-mail list of local, state, and national CHW professional associations and networks, CHW programs located in local and state health departments, federally qualified community health centers, and private and not-for-profit organizations. AzPRC researchers followed up by e-mail, phone call, and face-to-face meetings with over 75 representatives of CHW state associations and programs. The NCHWAS was also promoted at various regional and national conferences. The survey was available in English, Spanish, and Korean languages.

Quantitative analysis

To assess correlates of CHW professional advocacy, the NCHWAS data set was restricted to self-identified CHWs currently employed and compensated as a CHW. Unadjusted and adjusted logistic regression was used to model CHW advocacy, which was measured using the question: "Have you ever advocated for yourself as a community health worker or with other community health worker professionals?" Our primary interest was in assessing the effects of 8 variables measuring CHW leadership and advocacy job description. Other potential explanatory variables included sociodemographic measures of age, sex, ethnicity, individual income, education level, and years of CHW work experience; workplace characteristics, such as type of employer, professional benefits, and opportunities for growth; and other CHW-related policy environment characteristics including living in a state with CHW legislation, a credentialing system or an established statewide professional association. Variable selection for the adjusted models was based on the methods described by Hosmer and Lemeshow (Hosmer & Lemeshow, 2013). Briefly, the base model consisted of all variables determined to be significant through

univariate variable selection with the exception of the 8 leadership and advocacy job questions. These questions were regressed with the base model covariates as a separate model to ensure the association between each question and the outcome would not be obscured by the correlation among the questions (Harrell, 2001). Because of substantial missing data, sensitivity analysis was performed utilizing multiple imputation by chained equations (Azur et al., 2011), as implemented in the statistical software SAS version 9.2. The data set was imputed 20 times, and the resulting data sets were used to assess robustness of findings from the initial model.

Qualitative analysis

Upon completion of the quantitative analysis, an inductive content analysis was performed on 970 short CHW narratives responding to the question, "Describe a time when you advocated for yourself as a CHW or with other CHWs on behalf of your profession." Three academic researchers with qualitative research expertise independently coded CHW narratives using Nvivo 10 for qualitative analysis. The lead author organized all codes into a coding memo, which included the definition of the code and several illustrative quotes (Patton, 2002). Through a process of consensus building, academic researchers and 2 senior CHWs, with research experience and currently serving as leaders of 2 different state CHW professional networks, interpreted the coding memos and ascribed meaning and significance to CHW narratives of professional advocacy.

RESULTS

A total of 1767 CHWs from 47 US states and 4 US territories participated in the NCHWAS, making it the largest survey of CHWs conducted to date. Quantitative and qualitative results are described in the following sections.

Quantitative component

Of the 1661 subjects that fit the inclusion criteria, 961 (58%) of the observations had complete information on the variables of interest. Approximately one third of the CHW participants have engaged in CHW professional advocacy (Table 1). The strongest correlate of advocacy was membership in a CHW association (Table 2). Community health workers affiliated with a professional network were 4 times as likely to advocate on behalf of their profession compared with nonmembers. Community health workers whose job description included advocacy, working with community leaders, and/or with other CHW s were significantly more likely to engage in CHW professional advocacy compared with those CHWs who did not report such job characteristics. Although no less than one third of the CHWs employed in states with supportive CHW policy characteristics, such as existing CHW legislation, a CHW credentialing process or a statewide CHW professional network engaged in professional advocacy, these characteristics were not significantly associated with CHW professional advocacy.

Qualitative component

A total of 970 CHWs offered qualitative descriptions of advocacy work. We stratified results by CHWs affiliated ($n = 638$) and unaffiliated ($n = 332$) with a CHW professional association or network to elucidate differences between the 2 groups (Table 3). The domains of CHW advocacy outlined in Table 3 are sequential, moving from lower to higher forms of professional advocacy. Affiliated CHWs more often reported engaging in professional advocacy and at higher policy levels compared with unaffiliated CHWs. Unaffiliated CHWs also tended to use the word "I" versus "we" when describing CHW professional advocacy. The use of I by CHWs not connected to a CHW network may be indicative of the lack of a connection to a collective network from which to work with and through. It also speaks to how affiliated CHWs may be working in isolation of other CHWs, which may limit their ability to engage in higher forms of advocacy and effect broader impact. The remaining sections describe the major themes encountered in CHW narratives.

Table 1. Descriptive Statistics and Comparison of CHW Professional Advocacy by Selected Demographics: National CHW Advocacy Survey, 2014 (N = 1661)

	CHW Professional Advocacy Participation	
Variable	**Median (Range) or n (%)**	**Unadjusted OR (95% CI)**
Age, y	46 (20-77)	*1.02 (1.00-1.03)*[a]
Experience as a CHW, y	4 (0-45)	*1.05 (1.03-1.07)*
Sex		
Male	66/116 (56.9)	*1.58 (1.05-2.37)*
Female	437/935 (46.7)	1.0 (Ref)
Ethnicity		
American Indian/Alaska Native	50/89 (56.2)	*1.72 (1.03-2.87)*
Asian/Pacific Islander	7/18 (38.9)	0.9 (0.33-2.44)
Black/African American	114/195 (58.5)	*1.9 (1.27-2.83)*
Hispanic/Latino	184/443 (41.53)	0.94 (0.67-1.31)
Non-Hispanic white	100/229 (43.7)	1.0 (Ref)
Other race/ethnicity or more than one race/ethnicity	43/70 (61.4)	*1.87 (1.06-3.3)*
Education level		
High school, GED, or less than high school	51/131 (38.9)	1.0 (Ref)
Some college	170/348 (48.9)	1.4 (0.9-2.17)
College degree	188/373 (50.4)	1.5 (0.97-2.31)
Graduate degree	61/138 (44.2)	1.11 (0.66-1.87)
Other	33/65 (50.8)	1.54 (0.82-2.88)
Income level		
<$25 000	154/337 (45.7)	1.0 (Ref)
$25 000-$35 000	171/363 (47.1)	1.09 (0.8-1.49)
$35 000-$50 000	121/246 (49.2)	1.22 (0.87-1.72)
≥$50 000	56/100 (56.0)	1.46 (0.92-2.33)
CHW leadership		
Community-based organization	152/386 (39.3)	1.0 (Ref)
Federally qualified community health center	66/174 (37.9)	0.77 (0.5-1.17)
Hospital	56/159 (35.2)	0.72 (0.46-1.14)
Tribal health program	48/107 (44.9)	1.42 (0.83-2.41)
Local health department	53/157 (33.8)	0.66 (0.43-1.01)
University/education program	31/98 (31.6)	0.68 (0.4-1.16)
CHW workplace characteristics		
Employer offers health insurance	406/853 (47.6)	0.86 (0.62-1.19)
Opportunities for better pay within the CHW organization	129/215 (60.0)	*1.53 (1.07-2.2)*
CHW state policy environment		
Employed in State with CHW legislation	201/587 (34.2)	0.84 (0.65-1.09)
Employed in State CHW credentialing process	151/456 (33.1)	0.78 (0.59-1.02)
Employed in State with a statewide CHW association	443/1166 (38)	1.23 (0.87-1.75)
CHW professional advocacy		
CHW has engaged in CHW professional advocacy	518/1661 (31.1)	NA

Abbreviations: CHW, community health worker; CI, confidence interval; GED, General Educational Development; OR, odds ratio; NA, not available.

[a]Italicized are significant at the .05 level.

Table 2. Correlates of CHW Professional Advocacy by Selected CHW Leadership and Advocacy Job Description Characteristics, National CHW Advocacy Survey, 2014 (N = 1661)

CHW Leadership and Advocacy Job Description	n (%)	Unadjusted OR (95% CI)	Adjusted[a] OR (95% CI)	Sensitivity Analysis OR (95% CI)
CHW is a member of a CHW professional association	284/426 (66.7)	3.61 (2.74-4.74)	4.03 (2.99-5.43)	3.53 (2.32-5.39)
Works with other organizations	490/1167 (42.0)	1.2 (0.68-2.13)	1.28 (0.67-2.44)	1.27 (0.7-2.3)
Works with community leaders	460/1054 (43.6)	1.92 (1.32-2.79)	1.72 (1.13-2.61)	1.77 (1.17-2.67)
Works on a project with other CHWs	452/1021 (44.3)	1.87 (1.31-2.68)	1.53 (1.03-2.27)	1.53 (0.99-2.37)
Works with a coalition, or group, trying to improve the community	465/1081 (43.0)	1.62 (1.08-2.43)	1.55 (0.98-2.44)	1.36 (0.84-2.2)
Makes independent decisions about the best way to serve individuals, groups, or communities	405/951 (42.6)	1.15 (0.85-1.57)	1.07 (0.76-1.51)	1.07 (0.78-1.47)
Advocates with or for a community	485/1136 (42.7)	2.2 (1.3-3.75)	2.00 (1.11-3.61)	1.61 (0.9-2.88)
Job description includes community advocacy	448/1019 (44.0)	1.91 (1.36-2.7)	1.91 (1.31-2.8)	1.77 (1.2-2.61)

Abbreviations: CHW, community health worker; CI, confidence interval; OR, odds ratio.
[a]Adjusted for age, years of experience, ethnicity, CHW membership, and CHW employer
[b]Results of 24 logistic regressions on the outcome of CHW advocacy.

Role, recognition, and expansion of CHW services

A common advocacy theme was explaining the roles, competencies, and impact of CHWs and the ways in which CHWs can add value to existing services or programs. Community health workers raised awareness of the scientific evidence associated with their profession, including CHW impact on population health. Community health workers described promoting their profession in staff meetings, with supervisors, community members, and broader coalition meetings. Community health workers discussed making appointments or taking the initiative to speak up at meetings with local agencies to explain the role of CHWs. Community health workers also presented formally on the role and impact at public health conferences and in some cases were invited by state and federal agencies to present on the activities and impact of CHWs. Many CHWs employed within the health care setting described engaging in an ongoing process of educating clinic managers, administrators, and medical providers. Many CHWs believed these health professionals did to not fully understand the role and impact of CHWs in a clinical setting and as a member of the health care team. Community health workers also advocated for the expansion of CHW services and the integration of CHWs into systems that had not traditionally used a CHW approach.

Table 3. Summary of CHW Professional Advocacy Themes

	Illustrative Quote	
	CHWs Affiliated with a CHW Organization	**CHWs Not Affiliated with a CHW Organization**
Role, recognition, and expansion of CHW services		
Explain CHW role to other health professionals	*I recently had to advocate for myself as my position changed to working with a multidisciplinary team and some people in the team didn't clearly understood my role as a CHW and wanted my time to be spent doing their administrative work.*	*Every day that I interact with clinic staff is a day I have to advocate. Regularly medically trained professionals do not recognize the importance of CHWs nor understand our role. I constantly have to tell people what I do and why it's important.*
Demonstrate value of CHW services	*I am the only CHW in our clinic system. My supervisor and physician and I are working to show the value of CHWs and incorporate then system wide.*	*During a planning meeting myself and other CHWs collaborated with our data analyst to come up with a better way to capture and record the work that we do.*
CHW compensation, work environments, and professional development		
Living wage	*. . . 90% of my work is advocating for CHW of all job descriptions paid and unpaid. Most of us are women not receiving a living wage for the work we do and thus many are functioning below the poverty line often invisible to the health system we serve!*	*I presented at a conference and made the case why CHW need to be compensated for their work. Many organizations are seeing the benefits but are slow to compensate the work.*
Pay commensurate with workload or position	*My roles and responsibilities changed, increasing my work load. . . I spoke with my supervisor and my position is undergoing reclassification for a higher pay rate.*	*I advocate for myself, other CHWs that are doing the same job as other CHWs, they get better pay and services than us.*
Training and continuing education	*. . . more education or continued education, as well as education done by a CHW that knows what it is like to be in the field and not someone who has never done what we do.*	*We are currently working . . . to identify certification programs for CHW's which will further substantiate the viability and importance of the role of the CHW in the community and as a part of the Medical Service Providers network.*

(*continued*)

Table 3. Summary of CHW Professional Advocacy Themes (*Continued*)

	Illustrative Quote	
Role, recognition, and expansion of CHW services	**CHWs Affiliated with a CHW Organization**	**CHWs Not Affiliated with a CHW Organization**
Professional network engagement		
Network formation	*[I have been involved in] planning process to bring together all CHW… to know each other, share one common goal, resources, information, and bridging the generational/services gap.*	*We are working on developing a collaborative to look for policies that support our work. Reimbursement, funding, sustainability, credentials and certification, etc.*
Workforce development and policy		
Administrators and funders	*In 2010 a group of CHWs were invited to speak and train with HRSA about success and barriers CHW face.*	
State-level	*Each year, we go to the State House to remind Sate reps… of the vital roles Community Health Workers play in improving health outcomes for the entire community.… part of a committee that created a legislative bill and spoke to local elected officials at a delegates meeting.*	
State-board service	*I served on the Oregon Health Authority steering Committee as a CHW and Doula and helped to form polices around certification and training for CHW, peer wellness specialists, doulas and patient navigators.*	

Abbreviation: CHW, community health worker.

CHW compensation, work environments, and professional development

Several CHWs reported engaging their supervisor or employer in conversations regarding matching CHW skills with increased and or just wages. Some CHWs described advocating for a certification or credentialing process as a mechanism for increased pay and fair wages. Others were concerned and advocated for a reclassification of their current position to attain the higher pay grade. Some respondents requested the development of a career ladder in which salaries were commensurate with experience and responsibility. Many CHWs advocated for access to training and professional development opportunities. In other cases, CHWs advocated for appropriate supervision and reasonable expectations from their employers.

CHW professional network engagement

CHW engagement in their professional network ranged from basic membership within an association and attending meetings, to holding leadership positions within the associations, which required leadership and organizing CHWs throughout their region or state. As part of the network, CHWs were involved in developing and implementing statewide CHW trainings and workshops. Community health workers submitted abstracts or were invited to make formal presentations at CHW conferences to share CHW network activities and advancements. CHW network engagement also resulted in direct forms of advocacy, including, in at least one state, establishment of a CHW Day at the Capital, as a mechanism for CHWs to talk directly with policy makers about the role and impact of CHWs.

CHW workforce policy development

Community health workers were actively engaged in advocating for legislation and systems change that promoted the recognition and sustainability of the CHW workforce. This came in form of involvement in legislative processes or systems change initiatives to officially recognize CHWs through credentialing or certification. Such activities were often accompanied by education of administrative agencies, state policy makers, and state boards that regulate health professions. Community health workers described forming coalitions of CHWs and stakeholders, working through their own CHW networks to educate policy makers about the impact of the CHW workforce on health outcomes and health disparities. Much of the workforce policy efforts mentioned by CHWs were related specifically to establishing a certification or credentialing system for CHWs, whereas others described the development of policy amendments to secure recognition of CHWs and support reimbursement for CHW activities.

DISCUSSION

In 2014, in direct response to the lack of CHW leadership in determining workforce standards for training and credentialing, the American Public Health Association (APHA) adopted a policy with broad-based support requiring any governing body or advisory board making decisions on behalf of the CHW workforce to be constituted by no less than 51% of CHWs (Wennerstrom et al., 2015). According to this APHA policy, "CHWs are capable of, and best suited for, leading collaborative efforts to determine their scope of practice, developing standards for training, and advocating for policies regarding credentialing" (Wennerstrom et al., 2015). These statements and recommendations are consistent with findings from our 2014 National CHW Advocacy Survey, which clearly demonstrates CHWs engagement in several critical forms of professional advocacy, including promoting professional identity, increasing the public image of CHW roles and skills, development and engagement of inter- and intraprofessional collaboration. Most importantly, we found CHWs to be actively involved in the promotion of workforce-related legislative and policy initiatives to advance and sustain the workforce.

Fundamental to CHW professional advocacy was CHW participation in a professional network. Although participation in a

professional network is an expectation for many health professionals, there are several characteristics of the CHW workforce that require intentional steps on the part of employers, state and federal entities, funders, and allies to fully operationalize active CHW network participation. Foremost, CHWs are effective because of their unusually close connection to the experiences of the communities they serve. These experiences often include socioeconomic, racial and ethnic inequality, and political exclusion. Such structural inequality not only limits educational and career advancement opportunities among populations but also serves as the same barriers that restrict social and professional mobility among CHWs. In one eloquent quote, Mary, a CHW from Oregon, illustrates the structural inequalities faced by many CHW professionals, "My family earns below poverty level, I am a part of the priority population so my work is always very real to me and my lived experiences." Community health workers in the United States are more likely to be middle-aged women of color, with moderate educational attainment who often go without increases in their wages proportional to their education, work experience, or job tenure (HRSA, 2007). Although shifting, health and retirement benefits were also not historically a component of a CHW's employment package as compared with other health professionals (HRSA, 2007). Therefore, the ability for a CHW to actively participate in a professional network and thus achieve professional equity is highly dependent on work environments and policies that provide the protected time in which to do so (Farrar et al., 2011).

Employers are a first critical link to CHW participation in professional meetings and broader workforce development activities, such as educating policy makers about the roles and impact of CHWs, which have directly resulted in increased resources and infrastructure (Mason et al., 2011; Sabo et al., 2013). As with other health professions, supervisors and employers should consider CHW professional networking as CHW professional development with the potential for direct benefits to the organizational mission of retaining high-quality employees. Such intentional work environments that foster CHW autonomy, leadership, and connection to peers and community leaders have been found to contribute to CHW community-level advocacy to reduce health disparities through policy and systems change (Sabo et al., 2013). As is the expectations of most health professionals, CHW employers should incentivize CHWs to attend face-to-face and phone network meetings, nominate and accept leadership positions within the network, and leverage organizational resources to promote high-quality CHW training, supervision, financing, and career advancement.

States have also benefited from CHW professional advocacy efforts and play a major role in prioritizing CHW involvement in workforce issues. CHW affiliation with a professional network have resulted in policy change at state and federal levels that directly benefit organizations through broad-based mechanisms for CHW reimbursement, opportunities for training and capacity building (Balcazar et al., 2011; Mason et al., 2011). In those states successful in developing broad-based support for CHW policy initiatives, all have included substantial participation of CHWs, with employers playing pivotal roles in passing legislation (Mason et al., 2011; Matos et al., 2011; Wiggins et al., 2013). In New York, CHWs lead broad-based stakeholder research efforts to establish a state-wide scope of practice and training curriculum (Findley et al., 2012). In Minnesota, CHWs developed a state certification system attainable through the community college system (Rosenthal et al., 2010). In Massachusetts, New Mexico, and Oregon among other states, CHWs were critical in the establishment of state credentialing and certification boards. In Arizona, CHWs met with policy makers to explain the role and impact of CHWs on birth outcomes—crucial in establishing a state budget line to support a statewide CHW prenatal home visiting program (Meister et al., 1992). All of these forms of CHW professional advocacy contribute to innovative mechanisms for reimbursement,

career and educational advancement, and ultimately the ability for states to reduce health disparities. State and federal agencies considering drafting policy regarding CHW training standards and credentialing should head the APHA policy on CHW self-determination and establish a governing board composed of at least half of the CHWs (Wennerstrom et al., 2015). State and federal entities should reach out to CHW state networks and CHW employers to ensure the full and meaningful participation of CHW governing board members.

Although here we are focused on the power of the CHW employers, state and federal agencies to advance CHWs role in attaining professional equity and representation in the policy arena, there are other broader coalitions with skin in this game. Advocacy groups focused on advancing the issues of low-wage health care workers, women, immigrant communities, and people of color—all play a role in advancing the issues of CHWs. Such networks are often stronger, and strategically connected to allies that can support CHW networks to pursue collective advancement of marginalized communities and the elimination of health disparities in the United States.

Limitations

We recognize several limitations including the nonrandomized sample that includes a disproportional number of Hispanic and female respondents, which may not be representative of the US CHW profession. The online nature of our survey and method of survey dissemination through CHW associations may also overrepresent CHWs affiliated with a CHW professional organization and/or with access to a computer with Internet connectivity. Furthermore, we estimate that 15% to 38% of the data had missing values for the correlates of interest. However, the results from sensitivity analyses were largely consistent with the main results.

CONCLUSION

Community health workers are highly effective in the professional networking and advocacy required to advance the CHW workforce in the United States. Employers, states, federal agencies and funders stand to benefit from CHW professional advocacy efforts and play a major role in prioritizing CHW involvement in workforce issues. CHW professional advocacy have resulted in policy change at state and federal levels that directly benefit organizational missions to reduce health disparities through broad-based mechanisms for CHW reimbursement, training, and capacity building (Balcazar et al., 2011; Mason et al., 2011). To ensure the sustainability of this workforce, CHW networks, employers, state and federal entities, and allies should be intentional in creating opportunities for CHWs to promote professional identity, increase the public image of CHW roles and skills, develop professional collaboration, and promote workforce-related legislative and policy initiatives to advance and sustain the workforce. Mechanisms for promoting active CHW participation in CHW networks and involvement in workforce policy efforts include, prioritizing professional participation in CHW job descriptions, provision of protected time to participate and engage as leaders in network meetings. More broadly, CHWs should make up at least 51% of any governing board making decision regarding the workforce.

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