Action to Improve Social Determinants of Health: Outcomes of Leadership and Advocacy Training for Community Residents

Ashley Wennerstrom, PhD, MPH[1]
Julia Silver, MPH[2]
Miranda Pollock, MPH[1]
Jeanette Gustat, PhD, MPH[2]

Racial and ethnic disparities remain a public health problem and are largely due to social determinants of health (SDOH). Using an adapted 36-hour community health worker (CHW) curriculum, we trained 42 lay community residents in New Orleans, Louisiana, neighborhoods experiencing disparities in leadership and advocacy skills to address SDOH. Six months posttraining, 29 participants completed a follow-up survey and interview. Participants described increases in knowledge, self-efficacy, and activities related to leadership and advocacy at all levels of the social ecological model. We also found a significant increase in communicating with Louisiana state senators or representatives ($p < .0339$*). Our findings show that an adapted CHW training curriculum focused on SDOH, leadership, and advocacy can be used to train lay community residents in how to make changes in the community conditions that affect health and prompt new engagement to address SDOH at all levels of the social ecological model. Future efforts to increase lay community participation in addressing SDOH may benefit from providing ongoing support to participants such as organizing meetings with residents interested in similar topics, offering opportunities to "shadow" experienced CHWs, or hosting additional skills building workshops.*

Keywords: *social determinants of health; health disparities; training; leadership; advocacy*

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BACKGROUND

Racial and ethnic disparities in overall life expectancy and a host of chronic issues are a pressing public health problem (Centers for Disease Control and Prevention, 2013). Whites are expected to live nearly 4 years longer than Blacks (National Center for Health Statistics, 2017). The prevalence of obesity is roughly 47% for Blacks as compared to 38% of Whites (Hales et al., 2017). Similarly, the prevalence of diabetes among those groups is 12.7% and 7.4%, respectively (Centers for Disease Control and Prevention, 2017).

It is well established that racial and ethnic disparities are largely due to social determinants of health (SDOH) such as housing quality, poverty, differences in access to education, and community environments, rather than merely individual behavior or cultural factors (Braveman & Gottlieb, 2014). Criminal justice system exposure is also newly being considered as a health determinant (Davis & Evans, 2018). The social ecological model (SEM) is frequently used to illustrate how multiple, nested factors influence health (McLeroy et al., 1988). Public health practitioners and researchers increasingly

[1]*LSU Health Sciences Center—New Orleans, New Orleans, LA, USA*
[2]*Tulane University School of Public Health and Tropical Medicine in New Orleans, LA, USA*

Authors' Note: *Address correspondence to Ashley Wennerstrom, Department of Behavioral and Community Health Sciences and Center for Healthcare Value and Equity, LSU Health Sciences Center—New Orleans, 533 Bolivar Street Room 505, New Orleans, LA 70112, USA; e-mail: awenne@lsuhsc.edu; Alternate e-mail: ashwennerstrom@gmail.com.*

emphasize that SDOH must be addressed through upstream interventions focused on changing community and policy factors (Braveman & Gottlieb, 2014) represented by the two outer levels of the SEM. Jones et al. (2009) argue that promoting health equity requires specific attention to changing policies and structures that create differential access to social and economic resources. Given the enormity of the task of changing structural-level practices such as hiring and college admissions, as well as local, state, and federal policies that affect health and its determinants, there is a pressing need to involve new advocates outside of the traditional public health sphere.

Health care providers are increasingly becoming involved in addressing SDOH. For example, SDOH are being integrated into medical education (Mangold et al., 2019), and a Health Resources & Services Administration–supported National Collaborative for Education to Address the Social Determinants of Health aims to serve as a clearinghouse of resources to support medical educators in teaching nonclinical aspects of health (Northwestern University, 2019). Health professionals are also being encouraged to support policy change, with calls from nursing leaders to address SDOH through advocacy (Persaud, 2018). Similarly, some medical residency curricula now include information on contacting lawmakers (Andrews et al., 2019), and among some health professionals, there is evidence of a positive correlation between time spent on advocacy training and engaging in activities related to policy change (Lyons et al., 2015). Nonetheless, health care providers' activities generally focus on improving individual health, and their participation in advocacy to address SDOH may be insufficient to catalyze the policy changes that communities experiencing disparities desire.

Community health workers (CHWs), trusted frontline public health professionals who serve as links between underserved communities and health and social services systems (American Public Health Association, 2009), have been working to promote health equity for decades. While the CHW role often initially focused on extending health care services to underserved populations, it has evolved to include community-level advocacy to address SDOH (Eng & Young, 1992; Meister et al., 1992; Perez & Martinez, 2008). As members of the communities they serve, CHWs possess an intimate knowledge of community strengths and challenges, leaving them well-positioned to take action to promote structural changes. CHWs working in a wide variety of settings (e.g., health departments, nonprofit organizations, universities, etc.) have advocated to improve delivery of health care and public health services for populations experiencing disparities (Ingram et al., 2016; Sabo et al., 2013). They have also, particularly in the context of community-based participatory research partnerships, helped change community infrastructure related to SDOH (Ingram et al., 2008; Minkler et al., 2010). CHWs who perceive themselves as leaders or who have received advocacy training are more likely to try to make community-level change (Ingram et al., 2008), and advocacy among CHWs is associated with civic participation and successful policy change (Sabo et al., 2017).

Health care systems and payers (George et al., 2020) have become increasingly interested in integrating CHWs into their practice due to CHWs' ability to improve health outcomes (Brown et al., 2012), reduce costs (Wilkinson et al., 2016), and reduce hospitalizations (Kangovi et al., 2018). As CHW practice continues to move toward health care settings and a focus on supporting individual patient health outcomes, CHWs may be less able to engage in community-level actions to improve SDOH and ensure that the voices of underresourced communities are represented in policy making. Training other community members who are similar to CHWs in advocacy and leadership skills is a potential strategy to build the capacity of communities experiencing health inequity to address SDOH.

PURPOSE

Given that CHWs are members of the underresourced communities they serve and often have limited formal education, we hypothesized that we could use an adapted CHW training curriculum focused on SDOH, leadership, and advocacy to train lay community residents in how to make changes in the community conditions that affect health. The New Orleans Leadership Education and Action on health Disparities (NOLA LEADs; Wennerstrom et al., 2020) program trained lay community residents in New Orleans, Louisiana, neighborhoods experiencing disparities in life expectancy using a 36-hour curriculum adapted from a CHW workforce development program (Wennerstrom et al., 2014). Based on Rothman's (2004) locality development model of community organizing, the course aimed to create consciousness about the underlying causes of health inequity, particularly at the community and policy levels of the SEM and, in keeping with the principle of "starting where the people are (Nyswander 1956)," (Minkler & Wallerstein, 2009, p. 27) give participants tools to address their community's most pressing concerns. Specifically, we focused on SDOH, leadership, creating coalitions, conducting strengths-based community assessments, strategies for engaging in advocacy, civic engagement, and communicating with community leaders and policy makers. We followed up with participants 6 months posttraining to

see if they reported using skills and knowledge developed through the program, and to assess whether they had significant changes in civic engagement and advocacy activities such as contacting local, state, and federal leaders.

METHOD

Between July and December 2016, our team offered a 36-hour training on SDOH, advocacy, and leadership skills to lay community residents in New Orleans, Louisiana, that has been described in detail elsewhere (Wennerstrom et al., 2020). Briefly, the course was offered in two communities experiencing health inequity, with classes being held in community-based locations (one church and one community center) on Saturdays for 6 hours, for 6 consecutive weeks. Interactive classes included activities, group discussion, and limited didactic instruction. Trainers included an experienced CHW instructor and an expert in community health interventions and research. Leaders of local nonprofit organizations focused on various SDOH, including nutrition, economic development, education, and criminal justice reform, served as weekly guest speakers.

Participants were adult (age 18+) residents of New Orleans with no prior formal leadership, public health, or advocacy training and with a self-reported interest in improving their community. We recruited participants through a research center's community advisory board, a CHW network email list, and community-based nonprofit organizations. Among 43 people who began the course, 42 people completed it. The majority of course participants were female (92.7%), Black (92.7%), and had attended at least some college (69.0%). Participants' median age was 61.5 years (interquartile range: 55.0–71.0 years). Roughly three quarters (73.8%) were retired or unemployed. Trainees demonstrated a significant increase in knowledge after five of the six class sessions (Wennerstrom et al., 2020).

We followed up with trainees 6 months postintervention (January–June 2017) to assess whether and how they had implemented strategies to address SDOH. We believed the follow-up period was sufficient time for trainees to engage in activities that require planning (e.g., advocacy campaigns) but short enough to recall the content and structure of the course. We reached out to participants through their preferred contact method (phone or email) to invite them to participate in a 1-hour, in-person interview. We used a 25-question semistructured interview guide that covered perceptions of the training program; participation in civic engagement and leadership activities both pre- and posttraining including volunteer work, involvement in social organizations, and leadership roles in community groups; and experiences with contacting key leaders and policy makers. We asked participants about any possible life changes since program completion and what additional skills, training, or resources they needed to improve community health. Conversations were audio-recorded and transcribed verbatim. At the time of the interview, participants also repeated a baseline survey based on previous advocacy study instruments (Ingram et al., 2008; Sabo et al., 2017). Questions addressed all levels of the SEM. They included 6-month history of experiences with individual activities, such as reading or listening to the news and expressing opinions via the internet or social media; interpersonal activities, including assisting neighbors and talking with family and friends about politics; participation in civic and religious organizations; engagement in community activities; and at the policy level, contacting businesses, policy makers, health care providers, organizations, or boards about making changes in conditions related to SDOH. Questions also assessed confidence in institutions (e.g., media, local government). Participants were offered a $40 prepaid gift card in appreciation for their time.

We employed applied thematic analysis techniques to interpret qualitative data (Guest et al., 2012). We developed an initial codebook based on the interview guide. Two researchers then independently coded 10% of all interview transcripts using Atlas.ti software Version 8 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany), and created memos to describe concepts in the text for which there were no appropriate codes. The full four-member research team then met to review all coding decisions and resolve discrepancies. The codebook was then refined to remove unnecessary codes and add others needed to categorize concepts that were not initially included. The two coders completed the remaining coding independently. They met to review coding decisions and resolved discrepancies through discussion. The full team gathered again to discuss major themes and review quotations extracted from the transcripts that best illustrated these themes. We then organized themes according to the SEM.

We calculated frequencies for all demographic characteristics. Median age and interquartile range were calculated, as the majority of participants were older. Differences in frequencies for categorical variables over time were assessed with Pearson's chi-square test, except where Fisher's exact test was indicated. To compare binary matched-pairs survey data, McNemar's chi-square test was used. Results with a p value of $<.05$ were considered statistically significant. Analyses were performed using Stata Version 15.1 (StataCorp, College Station, TX). All research procedures were approved by the Tulane

University Institutional Review Board, and all participants provided written informed consent to participate in the study.

RESULTS

Among the 42 people who completed the training program, 29 agreed to a complete a 6-month posttraining follow-up survey and interview. Twelve could not be reached and one declined to participate. Most (96%) of participants were female and Black. About three quarters were retired or unemployed, and over two thirds (69%) had an annual household income of less than $20,000. Demographic results are summarized in Table 1. Interview participants described increases in knowledge, self-efficacy, and activities related to leadership and advocacy at all levels of the SEM, which are highlighted in Figure 1 and described in greater detail below.

TABLE 1
Demographic Characteristics of NOLA LEADs Community Health Training Participants Who Completed 6-Month Follow-Up (*N* = 29)

Characteristics	n	%
Sex (*n* = 28)		
Female	27	96.43
Male	1	3.57
Ethnicity (*n* = 28)		
Black	27	96.43
White	1	3.57
Education (*n* = 28)		
High school or GED	7	25.00
Some college	10	35.71
Bachelor's degree	6	21.43
Graduate degree	5	17.86
Annual household income (*n* = 29), $		
<10,000	8	27.59
10,000–19,999	12	41.38
20,000–29,999	3	10.34
30,000–39,999	2	6.90
40,000–49,999	2	6.90
≥50,000	2	6.90
Occupational type (*n* = 29)		
Works full-time	5	17.24
Works part-time	2	6.90
Retired	15	51.72
Unemployed	7	24.14
Age in years		
Median (IQR)	63 (55–72)	
Range	29–78	

Note. NOLA LEADs = New Orleans Leadership Education and Action on health Disparities; IQR = interquartile range.

Individual Level

At the individual level, 22 interviewees (75.8%) described some changes in their personal health behaviors or an increase in knowledge of community resources. For example, one person mentioned, "I did start my own garden." As one participant explained, "I found out the different places I can go when I do have a problem that's concerning the neighborhood or the community." "I feel more comfortable advocating," was also a common theme. Interviewees mentioned that the training program prompted them to obtain new employment and embark on new educational pursuits. One participant described joining another leadership program, "where I work with 53 other people across eight different states . . . and we discuss different policy issues, infrastructure, transportation, health care, education, tourism, policy, governance. That's something that I've started since NOLA LEADs." Completing the course was described as a motivator for beginning new volunteer or leadership activities in churches, schools, community-based organizations, coalitions, and community gardens.

Interpersonal Level

In terms of interpersonal interactions, 22 (75.8%) interview participants reported sharing community resources they learned about during the training with friends, family, and neighbors. One participant stated,

> I had a lady yesterday that came in for food assistance, but she was also saying that she was homeless and . . . I put her in touch with someone who's a social worker who could help her to get what she needed.

Participants also reported a new desire to support civic engagement among other community members, particularly youth. For example, one trainee mentioned,

> I've never been involved in anything with voting, but it was after the class that I realized that I needed to talk to the younger generation to tell them how important it is for them to register and to participate in voting.

FIGURE 1 Trainee-Reported Efforts to Address SDOH at All Levels of the Social Ecological Model
Note. SDOH = social determinants of health.

Organizational Level

Just over half (51.7%) of interviewees reported changes in their involvement in community-based organizations. Some discussed taking on new leadership positions within organizations with which they were involved prior to the course. For example, an interviewee explained, "I joined the [health education program] peer leaders . . . Now, I was already a member with them, but then after going through the leadership classes I decided to become a peer leader." Others mentioned beginning new activities such as "volunteering at the food bank" or supporting an animal welfare organization. A common theme that participants described was joining coalitions that address SDOH. Many of the coalitions mentioned were those that participants learned about during the course. One person described starting a new nonprofit organization after completing the program.

Community Level

Just under half of participants (48.3%) mentioned changes related to the community level of the SEM. One major theme was increased knowledge about health disparities and the social issues that cause them. Participants expressed a desire to address disparities through conducting community health education classes on nutrition or starting new programs such as support groups or walking clubs. They described recent activities to organize community events related to SDOH. For example, an interviewee explained,

> We had [a community anti-violence event] by our house . . . We set it all up and we went around, gave out flyers. Invited all the neighbors. And a lot of them came out who didn't know each other.

They also made efforts to gather community support and information about municipal plans for zoning and enforcing rules on the use of short-term rental properties.

Policy Level

A total of 15 (51.7%) interviewees mentioned engaging at the policy level. A consistent theme was that they had learned how to contact elected officials. One participant stated, "I actually did use some of the information they gave me in class to go on the internet and find out where different legislators are." They reported an increase in reaching out to local, state, and federal policy

makers via letters, emails, and phone calls. One interviewee said, "I ended up writing letters and contacting this lady in city hall, even started meeting with her." Participants also described their desire to participate in policy-making processes.

Some participants also discussed issues related to media and their perspectives on elected officials. Although our interview guide did not include questions about these issues, several people spontaneously brought them up while responding to other questions. Four (13.8%) participants reported less engagement with news media, due to its distressing nature. Specifically, witnessing violence on the news and learning about systemic issues affecting children, such as decreases in funding for school lunch programs, were reasons for abstaining from media consumption. One participant explained, "I try not to turn the news on, because it's depressing." Four (13.8%) trainees expressed disappointment in elected leaders, including a perceived lack of compassion. One participant described, ". . . to me, Donald Trump just doesn't have a heart. He was just born without a heart. It's just sad." Three (10.3%) people mentioned frustration with federal policy makers' recent decisions on specific issues including federal nutrition programs, immigration, and changes to the Affordable Care Act.

These results, along with additional illustrative quotes are summarized in Table 2.

References to Training

Finally, interviewees cited specific aspects of the training that they perceived to be useful in promoting community change. They mentioned the value of community mapping activities, having materials to review at home, guest speakers, and role-playing a legislative visit. One participant described that hearing from guest speakers was "very useful. [They] exposed me to a lot of new information, and also ways to create change. I really liked seeing and hearing about what they actually do to bring about change." Participants shared that the course created a nonjudgmental space to discuss concerns openly. As one person noted, "I felt the comfort. I felt I could ask anything without being pushed back or anything." Participants also highlighted neighborhood diversity among the class attendees. One participant elaborated,

> The class was made up of people from all different areas of the city. I got to meet people that I didn't know. I got to meet people who live in different areas of the city and find out what they're doing.

When asked about any possible barriers to becoming more involved in advocacy or community development activities, participants primarily mentioned that they needed more knowledge, time, and confidence in their abilities. They believed additional financial resources and additional training, particularly in the areas of technology use and data analysis, would be helpful.

Quantitative Results

There were no significant changes at the individual (e.g., consumption of news, using the internet/social media to express opinions) or interpersonal level (e.g., talking with neighbors, discussing politics with family or friends) of the SEM. The only significant change at the organizational level (e.g., participating in neighborhood, religious, or civic groups) was a significant decrease of 92.9% to 67.9% in volunteering ($\chi^2 = 5.44$, $p < .0196$). At the community and policy levels, among questions about whether participants had contacted local, state, and federal policy makers about making change, the only significant increase was in communicating with Louisiana state senators or representatives ($\chi^2 = 4.50$, $p < .0339$), while contacting the city planning commission approached significance ($\chi^2 = 3.00$, $p < .0833$). Among five questions about perceptions of institutions (e.g., various levels of government, corporations, and media), the only significant change was with the media, which slightly increased from 70.4% to 85.2% expressing some to definite confidence ($\chi^2 = 4.00$, $p < .0455$; data not shown).

DISCUSSION

This article describes 6-month postintervention outcomes for a leadership development and advocacy training program that used an adapted CHW curriculum to teach lay community residents skills for addressing SDOH within their own communities. Those who participated in a follow-up interview (29 of 42 training participants) described new knowledge and activities at all levels of the SEM, and they demonstrated a significant increase in contacting members of the state legislature, an increase in confidence in the media, and decreased volunteerism.

Although the program primarily aimed to prepare participants to address community- and policy-level influences on health, community organizing theories (Minkler & Wallerstein, 2009) suggest that course participation may have prompted trainees to consider aspects of overall health that were within their immediate control. Adopting new health behaviors may also be an important first step in developing confidence to advocate for community health. Trainees' new educational

TABLE 2
Changes in Knowledge, Self-Efficacy, and Activities at All Levels of the Social Ecological Model

Theme	*Illustrative quote*
Individual	
Changes in health behavior	"I did start my own garden."
	". . . that helped me try to live a better life, a healthy life . . . get my body where it should be at, where I could get off some medication."
Increased knowledge of community resources	"I found out the different places I can go when I do have a problem that's concerning the neighborhood or the community. I never did really know exactly who to go to, but with the program here, I found out where to go."
Confidence to advocate	"What I learned from that experience [NOLA LEADs] is that you've got to be an advocate for yourself. You can't be afraid to ask questions."
	"I feel more comfortable advocating, and I use it for my job often. I think I understand more mechanisms for bringing change."
New employment	"I am working part-time at (city organization) as a lifeguard and the reason I considered it also was to give back to the community."
New educational pursuits	"I've been studying for a couple of months now, actually right after NOLA LEADs . . . I got into this program."
Leadership program participation	"I am a part of this program . . . where I work with 53 other people across eight different states . . . and we discuss different policy issues, infrastructure, transportation, healthcare, education, tourism, policy, governance. That's something that I've started since NOLA LEADS."
Interpersonal	
Engaging others in community and civic activities	"I also get the neighborhood and the community to . . . to make flyers with contact stuff and things like that."
	"I've never been involved in anything with voting, but it was after the class that I realized that I needed to talk to the younger generation to tell them how important it is for them to register and to participate in voting."
Sharing community resources	"In the little small interactions I've had with people in my community, I've been able to just make them more aware of resources that are available to them."
	"I had a lady yesterday that came in for food assistance, but she was also saying that she was homeless and . . . I don't know exactly how to deal with that, but I put her in touch with someone who's a social worker who could help her to get what she needed."
Organizational	
Taking on new leadership roles	". . . And I realized since I been to the class, I've moved up a little notch in leadership, so that's going to help me."
	"I joined the [health education program] peer leaders . . . Now, I was already a member with them, but then after going through the leadership classes I decided to become a peer leader."
New volunteer activities	"I volunteer with my local seniors, and a little at the school."
	"Volunteering at the food bank has been since the classes."
	"I also recently signed up for [animal rescue organization]."
Participation in new coalitions	"I'm a member of the [coalition] group . . . so I'm constantly looking for new avenues to get involved with, you know to keep the city moving."
	"I did get involved in something else. It's [organization]. We're doing a special thing and it was trying to figure out what's happening in neighborhoods. We're doing a group meeting. Right now, we are doing it once a month."

(continued)

TABLE 2 (CONTINUED)

Theme	*Illustrative quote*
Starting a nonprofit organization	"In fact, we got started right after I left this particular program and we're licensed with the state, we have an occupational license with the city, we have a 501(c)3, we're members of the chamber of commerce and now we begin to network with other nonprofit groups. It's really rolling along."
Community	
Increased knowledge of health disparities	"The map [activity from class] in terms of the food deserts and the disparity between two zip codes that were less than five miles apart from each other and the 20-year disparity in terms of life expectancy, that was a really powerful visual there, and I've used that in several conversations since."
Offering health education to improve disparities	"I wanted to create support groups for breastfeeding women of color. Teach them the importance of breastfeeding to a minimum of six months. Incentivize them with money to attend peer support groups. This [idea] all started after the classes."
	"Well, the change I would say I made is dealing with nutrition, educating people about their health and eating properly and doing the things to stay healthy and stay fit."
Organizing community events	"We had [a community anti-violence event] by our house. . . . We set it all up and we went around, gave out flyers. Invited all the neighbors. And a lot of them came out who didn't know each other."
Actions to address social determinants of health	"One of my other neighbors on the next street is legally blind and they wanted to connect the two subdivisions for the traffic . . . So I went around, and I spoke with my neighbors about the concern."
	"The only thing in housing, that I can say I've been concerned about, is in these neighborhoods, they were starting these (short term rentals) . . . I called on that, to see what the specifications for these people having them . . . to find out, did they have the proper credentials."
Policy	
Increased knowledge of resources to find legislators	"It enlightened me more with the legislature and how to contact your different legislators, because I actually did use some of the information they gave me in class to go on the internet and find out where different legislators are."
Contacting policy makers	"I ended up writing letters and contacting this lady in city hall, even started meeting with her."
	"Recently I sent . . . emails to different state legislators when they were doing votes for criminal reform."
	". . . the ICE, the immigration type of stuff that's going on right now, I've made phone calls as it relates to people that have been picked up . . . ."
Desire to develop policy	"Let's build a coalition. I would love to do that. Let's build it, and let's make it happen. I would love to write policies and write laws and legislation. . ."

Note. NOLA LEADs = New Orleans Leadership Education and Action on health Disparities.

pursuits and leadership involvement indicate that the course increased self-efficacy and promoted personal development. Similarly, descriptions of posttraining communication with friends, family, and neighbors suggest that even though the frequency of trainees' social interactions did not change, the course developed useful knowledge and the confidence to discuss health and social issues.

Participants' descriptions of their new involvement in addressing a host of issues including nutrition, criminal justice, housing affordability, animal welfare, neighborhood traffic patterns, and immigration issues suggest that the program clearly conveyed the relationship between myriad social issues and community health. Hearing directly from local community organization and coalition leaders during the course about concrete actions

they have taken to improve SDOH likely inspired participants' reported involvement in these groups and may even explain their unexpected significant decrease in volunteerism. Participants who previously volunteered for direct service projects may have begun to engage in new community development activities (e.g., participating in coalitions, organizing community events) posttraining that they did not consider to be "volunteer" efforts, even though such efforts brought about benefits to the community.

We did not anticipate the finding that participants would have a significant increase in contacting state officials without similar increases in attempting to reach local or federal lawmakers. However, participants may have contacted the Louisiana legislature because many social issues discussed during the training program are largely driven by state policy. For example, Medicaid had not yet been expanded in Louisiana when the course took place. In contrast, participants may have aimed to address local issues through collaboration with neighborhood or community groups, rather than the city council or the mayor, due to recent history of local political corruption (Robertson, 2014). Donald Trump's inauguration, which was largely unpopular with members of our participants' demographic (e.g., Black women; Newport, 2019), occurred during the time between our intervention and follow-up and may have discouraged political participation at the federal level.

Some participants' qualitative reports of less engagement with the news due to its perceived upsetting nature was surprising, given the overall significant increase in trust in the media. It is possible that participants primarily engaged with news sources critical of policies or politicians they disliked, bolstering their perception of the trustworthiness of such institutions. Alternatively, participants may have begun to notice more new stories that confirmed concepts presented throughout the course, making the news media seem more reliable.

Although qualitative findings suggest that our training curriculum was well-received and promoted new involvement in addressing SDOH, additional follow-up support is likely necessary to achieve significant changes in multiple types of advocacy and civic engagement. Examples could include organizing meetings for trainees interested in addressing similar SDOH, facilitating connections to existing community organizations and coalitions, providing opportunities to "shadow" experienced CHWs and other health advocates, offering additional posttraining skills building workshops, and providing monetary support to implement interventions or community organizing activities.

This study is limited in that it took place in only one community. Most changes in quantitative measures were not significant. Qualitative findings may not be generalizable to other communities, particularly given that our sample was older and largely retired or unemployed. Additionally, the time frame of the follow-up may not have been sufficient to capture the extent of the impact the training program may have had. Follow-up interviews were conducted over the summer and may not have been the ideal time to show participation in a political campaign or other civic activism.

IMPLICATIONS FOR PRACTIVE AND/OR POLICY AND RESEARCH

Building on the success of the CHW model in addressing SDOH among vulnerable populations, an adapted CHW training curriculum focused on SDOH, leadership, and advocacy was used to train lay community residents from underresourced neighborhoods. The program was well-received, increased knowledge and self-efficacy, prompted new activities to address SDOH at all levels of the SEM, and increased engagement with state lawmakers and confidence in the media. Other areas of civic and political engagement remained unchanged, while volunteerism decreased. Future community training programs focused on increasing grassroots participation in addressing SDOH should include additional, ongoing support for participants to ensure they have the skills, tools, and connections to put knowledge into practice.

ORCID iD

Ashley Wennerstrom https://orcid.org/0000-0003-1888-0432

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