The Role of Community Health Workers

1

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

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

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

Introduction

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

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

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

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

WHAT YOU WILL LEARN

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

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

WORDS TO KNOW

Advocate (noun and verb)

Capitation

Credentialing

Health Inequalities

Social Justice

1.1 Who Are CHWs and What Do They Do?

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

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

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

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

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

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

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

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

Table 1.1 Common Titles for CHWs

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

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

What Do YOU Think?

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

BECOMING A CHW: CHW INTERVIEW

http://youtu.be/BASkvuq1epw

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

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

CHW

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

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

OVERALL NUMBER, GENDER, AND ETHNICITY

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

EDUCATION AND WAGES

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

POPULATIONS SERVED

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

HEALTH ISSUES AND ACTIVITIES

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

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

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

MODELS OF CARE

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

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

What Do YOU Think?

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

CHWs AROUND THE WORLD

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

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

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

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

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

One Million CHWs Campaign

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

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

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

1.2 CHWs and Public Health

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

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

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

1.3 Roles and Competencies of CHWs

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

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

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

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

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

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

What Do YOU Think?

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

What Are Core Roles and Competencies?

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

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

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

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

The CHW Common Core Project

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

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

Table 1.2 Personal Qualities of Successful CHWs

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

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

CORE CHW ROLES

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

CHW

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

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

CHW

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

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

CHW

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

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

CHW

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

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

CHW

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

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

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

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

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

A CHW talks with youth at a health center.

What Do YOU Think?

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

EIGHT CORE COMPETENCIES FOR CHWs

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

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

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

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

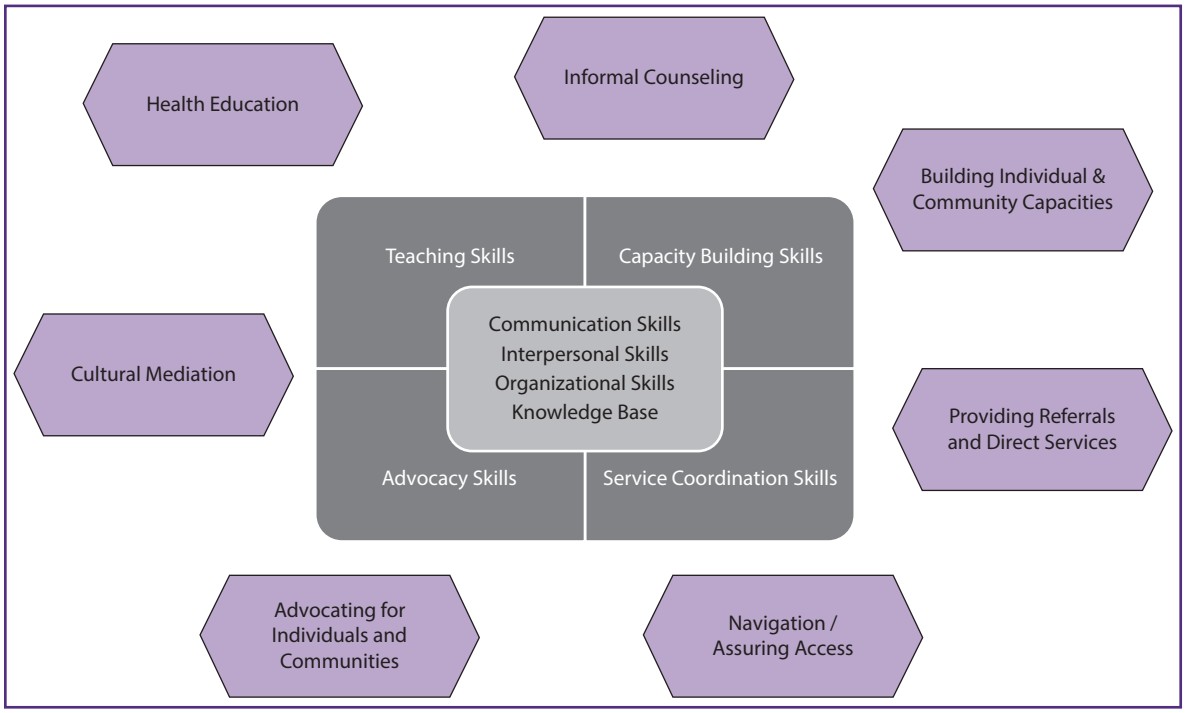

Figure 1.1 The relationship between CHW core competencies and roles

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

What Do YOU Think?

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

1.4 Personal Qualities and Attributes of CHWs

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

Table 1.3 Personal Qualities of Successful CHWs

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

(continues)

Table 1.3 (*Continued*)

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

What Do YOU Think?

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

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

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

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

1.5 The Role of CHWs in the Management of Chronic Conditions

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

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

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

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

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

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

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

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

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

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

CHWS WITHIN THE HEALTH CARE DELIVERY TEAM

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

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

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

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

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

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

THE EMERGING ROLES OF CHWs: INTERVIEW

http://youtu.be/SnaaAUKK640

Please watch this video interview with Dr. Carl Rush.

1.6 Professionalizing the CHW Field

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

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

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

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

What Do YOU Think?

An Inherent Tension

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

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

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

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

1.7 Introducing Four CHWs

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

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

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

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

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

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

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

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

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

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

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

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

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(continued)

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

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

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

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

Chapter Review

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

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CHW Network in your state or region: _____