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Capacity Building and Training Needs for Community Health Workers Working in Health Care Organizations

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Abstract

Members of the community health worker (CHW) workforce have new opportunities to work within the health care system. These opportunities come with questions and challenges about the roles CHWs can play and their specific capacity building and training needs. We use a mixed methods approach including a cross sectional survey of 265 CHWs and qualitative interviews with a sub-set of survey respondents (n=23) to gather perspectives from CHWs about workforce capacity building needs for CHWs working within transformative health care organizations. Eighty percent of CHWs agreed or strongly agreed that they feel well trained to carry out their duties as CHWs. CHWs ranked communication, advocacy, assurance of services, and culturally competent services as priority roles. In addition, creating a learning environment for CHWs working in health care settings is essential to support capacity building for CHWs. Understanding training needs for CHWs can help improve the relationship and understanding between CHWs and other care team members. Capacity building efforts through appropriate training and supervision of CHWs assists with CHW integration and enhances the fidelity of information CHWs deliver to patients.

Keywords: Health care; Public health; Community health

Introduction

As the health care system continues to experience growing strain on resources including limited time and access to providers, the system must consider new and creative opportunities to expand and enhance the workforce. Critical workforces such as Community Health Workers (CHWs) are one approach to simultaneously build upon community infrastructure and enhance the capacity of the health care workforce [1]. CHWs are quickly becoming an important part of the health care workforce [2-5] and these unique team members provide an opportunity for health care systems to meaningfully address disparities and create a more diverse and culturally competent workforce.

As trusted members of the community they serve, CHWs are able to address some of the most pressing needs of the country's most vulnerable populations through prevention, health education, cultural mediation, and patient advocacy [6]. The implementation of the Affordable Care Act has opened doors for CHWs by allowing them, as non-licensed providers, to provide preventive services, to become members of "Health Homes" for community members with chronic disease, and to be included in State Innovation Models for improved quality of health care [7]. Additionally, responsibilities for the health of community members are now inherent within health care systems. Some may argue that CHWs are the silver bullet to lowering costs, reducing health disparities, and solving many of the most complex issues within the U.S. health care system. However, multipronged, comprehensive approaches and actions are needed for integrating CHWs into health care systems [3,8,9].

For example, through state legislation, Minnesota has developed a statewide training curricula and professional standards for scope of practice and roles of CHWs in health care delivery systems and has found mechanisms for reimbursement [10,11]. Other states are adopting these approaches, but many policy makers and practitioners in both public health and health care systems are struggling to develop and sustain consistencies in workforce development (e.g., core skills and competency-based education, continuing education); occupational regulation (e.g., scope of practice, competency-based training standards recognized state-wide, and state-level certification); sustainable funding for employment of CHWs, and other resources (e.g., infrastructure support) for integrating CHWs into health care teams [12-14].

On one hand, CHWs are praised for their accomplishments in working with the hardest-to-reach populations and truly carrying out patient centered care; yet, CHWs as professionals who work to build capacity for individuals regarding their health largely lack the infrastructure and resource needed to build capacity among their own workforce. However, there are a growing number of state and regional CHW associations that regularly provide ongoing training at monthly or annual meetings [3]. The current CHW workforce requires suitable support for training, supervision, financing, and infrastructure because without it, CHWs can get lost in the evolving health care system. More research on the training needs of CHWs may assist in building their capacity on a national level as there are movements for more standardized training and their professional credentialing.

To address and support CHWs in their roles within the health care settings, this paper focuses on understanding internal organizational capacity that may support CHWs in health care settings, while acknowledging the array of other organizational settings CHWs may work in (e.g., community based, health system). The present assessment of CHW roles and skills may provide insight about CHW professional development needs to health care systems managers, state

health department staff, and others who are attempting to include CHWs as members of the health care team about their professional development needs.

Methods

We use a mixed methods approach including a cross sectional survey of 265 CHWs recruited through the American Public Health Association sponsored listserv. This list represented 30 CHW networks and associations from 19 states collected. We disseminated an online Survey Monkey survey, which included 56 questions and response options included multiple choice, open-ended, and Likert-scale. A subset of survey questions focused specifically on CHW training and professional development needs. Respondents were asked to rank common CHW skills and roles as beginner, intermediate, or advanced. All materials were pilot tested with four current CHWs prior to distribution and word choice and sentence constructions were asked at an eighth grade reading level. Data from the survey were imported into SPSS version 22. We ran descriptive statistics and bivariate analyses of questions targeted at understanding capacity building and training needs within health care settings. We summed training question Likert-scale responses to create a composite score and ran correlations for various demographic variables and their feelings of being well trained. The Emory IRB approved all aspects of this study.

At the end of the survey, participants were asked if they would like to be part of an interview to learn more about their work as CHWs. We conducted 23 semi-structured phone interviews with CHWs from 17 states and the District of Columbia. The principal investigator received informed verbal consent prior to the interview and permission to record it. The interviews were then transcribed verbatim. Examples of questions about training include: 1) On a scale of 1-5 with 1 being not skilled and 5 being completely skilled, how would you rate your skills and knowledge that you need to be a CHW? 2) What training have you received as a CHW? 3) To what extent would you say that you have the knowledge and skills you need to provide high blood pressure self-management services to your patients or clients? and 4) What additional skills or knowledge would be helpful?

A codebook was developed and adapted upon completion of a consensus review between the two primary coders (CA and AS). The codes were compiled in MAXQDA version 11 and retrieved individually. Researchers used inductive thematic analysis for qualitative analysis [15]. Finally, qualitative and quantitative data were compiled by research question and combined through triangulation techniques [16].

Results

Roles and skills: A point in time reflection by participating CHWs

To help build the workforce's capacity and provide training for CHWs, we first need to understand their perspectives on these topics as members of the health care team. The survey sample included CHWs with an average age of 43.1 (SD=12.8). The majority of the sample identified as Hispanic (45.4%), Black/African American (25.7%), and non-Hispanic white (25.0%). The majority of CHWs were female, had achieved at least a high school/GED, and almost half of the CHWs worked in a health care setting (clinic, FQHC, hospital) (45.6%). CHWs had spent an average of 7.2 years as a CHW (SD=7.5) and 6.1 years (SD=6.4) at their current organization. The average number of CHWs in an organization was 9.6 (SD=10.6). Racial demographics of the CHWs closely matched the racial demographics of those clients CHWs serve. CHWs were asked to identify the roles they played and the skills they had or needed based on a compilation of well-known/cited roles and skills from the field [17]. They were also asked to rank the level of priority (Table 1) for each of these roles and skills and level of difficulty in carrying out each of the roles and skills (Table 2).

	Low	Medium	High
Communication skills	2 (1.3%)	19 (12.7%)	129 (86.0%)
Advocating for individual and community needs	5 (3.3%)	20 (13.2%)	127 (83.6%)
Assuring that people get the services they need	4 (2.6%)	22 (14.4%)	127 (83.0%)
Providing culturally appropriate health education	4 (2.6%)	26 (17.0%)	123 (80.4%)
Broad knowledge base about community and health issues	4 (2.7%)	27 (18.0%)	119 (79.3%)
Advocacy skills	3 (2.0%)	30 (20.1%)	116 (77.9%)
Organizational skills	2 (1.4%)	37 (25.2%)	108 (73.5%)
Teaching skills	5 (3.4%)	35 (23.5%)	109 (73.2%)
Providing direct services	7 (4.6%)	35 (23.2%)	109 (72.2%)
Interpersonal skills	3 (2.0%)	40 (26.7%)	107 (71.3%)
Cultural mediation between communities and health and human service systems	6 (3.9%)	39 (25.7%)	107 (70.4%)
Service coordination skills	3 (2.0%)	43 (29.1%)	102 (68.9%)
Building individual and community capacity	5 (3.4%)	44 (29.5%)	100 (67.1%)

Capacity building skills	4 (2.7%)	49 (33.1%)	95 (64.2%)
Informal counseling and social support	9 (6.0%)	46 (30.5%)	96 (63.6%)
Note: Results are presented in rank order.			

Table 1: CHW roles and skills ranked by level of priority.

Eight in ten CHWs ranked communication skills, advocating for individuals and community needs, assuring that people get services they need, and providing culturally correct health education as high priority (Table 1). Over 70% of CHWs ranked broad knowledge base about community and health issues, advocacy skills, organizational skills, teaching skills, ability to provide direct services, interpersonal skills, and cultural mediation between communities and health and human services as high priorities for their work.

Table 2 demonstrates CHWs' views on level of difficulty of each of these roles and skills. Interestingly, there is a parallel match between more advanced roles and skills and the CHWs sense of the importance of the skill. For example, communication skills are ranked as advanced and high priority. The central theme is that their roles are dictated by the needs of the community members they are serving.

Role or Competencies	Beginner	Intermediate	Advanced
Communication skills	8 (5.2%)	47 (30.7%)	98 (64.1%)
Interpersonal skills	11 (7.2%)	45 (29.6%)	96 (62.2%)
Advocating for individual and community needs	12 (7.9%)	49 (32.2%)	91 (59.9%)
Organizational skills	11 (7.2%)	54 (35.5%)	87 (57.2%)
Assuring that people get the services they need	13 (8.6%)	54 (35.5%)	85 (55.9%)
Service coordination skills	17(11.2%)	52 (34.2%)	83 (54.6%)
Advocacy skills	15 (9.9%)	55 (36.4%)	81 (53.6%)
Broad knowledge base about community and health issues	17(11.0%)	57 (37.0%)	80 (51.9%)
Providing direct services	21(13.7%)	59 (38.6%)	73 (47.7%)
Teaching skills	15 (9.8%)	65 (42.5%)	73 (47.7%)
Providing culturally appropriate health education	23(15.1%)	58 (38.2%)	71 (46.7%)
Informal counseling and social support	28(18.3%)	60 (39.2%)	65 (42.5%)
Capacity building skills	18(11.7%)	71 (46.1%)	65 (42.2%)
Building individual and community capacity	24(15.9%)	66 (43.7%)	61 (40.4%)
Cultural mediation between communities and health and human service systems	24(15.9%)	73 (48.3%)	54 (35.8%)
Note: Results are presented in rank order.			

Table 2: CHW roles and skills ranked by level of difficulty.

Learning needs and capacity building

Overall, CHWs described feeling well-trained to do their work. Over 80% (n=67) agreed or strongly agreed that they feel well trained to carry out their duties as a CHW, indicating that they feel well prepared to work as generalists within health care settings. However, qualitatively CHWs detailed some of the nuances of training and preparedness. Specifically, in early stages of integration, CHWs felt that they needed more support. One CHW stated, "…that was something that I had trouble with, you know, at the beginning was feeling as if I was kind of just pushed in and I guess expected to learn it on the fly." Examples of support during early stages of integration include managerial support and leadership buy-in, which requires upper-level management being visible in the clinical setting and interacting with all employees, including CHWs, and healthcare providers being open and respectful to CHWs as new members of their care teams. Such support allowed team members to leverage CHWs' community based expertise and strengths.

The need for on-going learning opportunities and capacity building were also relevant themes from the qualitative interviews. Often CHWs described a desire to continue learning because it was beneficial to their patients or clients. For example, "I went through [continuing education] strictly because I wanted more education and I just felt that it would be beneficial to our patients." CHWs felt that continuing education helps them keep up with new information, builds their

skills, and is important as they gain experience on the job. Furthermore, having the opportunity to share what they have learned while working in communities through networking with other CHWs and onsite supervision are essential components of feeling well equipped to carry out their roles. For example, when describing her supervisor, one CHW stated, "[She] is very knowledgeable, having been an emergency room social worker for many years, and there's just a number of staff that are very knowledgeable with community resources. We also support each other if there's going to be a challenging home visit or a new client […] we are both working for the good of the patient."

Eight in ten (79.2%) of CHWs in the survey stated that they feel well trained to carry out their duties. In addition, we ran correlations of various demographic and organizational characteristics of the CHWs and the training composite score. No significant correlation exists between the training composite score and number of CHWs in the organization, number of patients CHWs serve, number of patients the organization serves, number of years as a CHW, or number of CHWs in the organization. The number of years at the organization, however, was positively correlated with the statement "I feel well trained to carry out my duties as a CHW" (ρ=0.177, p=0.037, R2=0.006, n=170). No significant correlation existed for any CHW specific demographic including age, race, or gender.

Overall, CHWs, in our study, actively sought on-going training and continuing education combined with an outlet for sharing on the job experiences as a CHW. Training needs were primarily focused at the organizational level (as compared to receiving state or national training). Non-organizational level training facilitators include networking with other CHWs (77.9%), recognition of the role of CHWs in the state or region (59.1%), training or support from the state health department (54.4%), and being a member of a CHW alliance and/or association (49.7%).

Furthermore, CHWs were interested learning more about chronic and other diseases as part of on-going training, in addition to conflict management, and training and use of electronic health records. CHWs realize the necessity of on-going training and supervision as important to ensuring the fidelity of information delivered and evidence-based practices.

Discussion

The present study reports on the perspectives of CHWs about the roles and skills they feel are of highest priority and their training needs. CHWs who were part of this sample identified personal relationships both with the patient and the organization as critical components of their training. Additionally, CHWs identified a need for training in "common CHW practices" such as advocacy and patient needs assessment and resolution. Future training and professional development should focus first on these areas of "common CHW practices" and skills that are noted as "Advanced;" continuing professional development in these areas would ensure a more competent CHW workforce beyond their initial orientation and training. The high number of roles and skills selected as "Advanced" demonstrate the importance of on-going education beyond initial training or on boarding.

Further specialized training may include "disease-specific education" on the health issue, treatment of disease, and provider/system interaction for various types of diseases. While there are common roles and practices for CHW training, there are also opportunities for specialized, disease specific topics relevant to CHW practice. The Center for Disease Control and Prevention highlights CHWs working in various health issues throughout the country [3]. A repository of health topic specific training materials could be developed to address the need for more specialized trainings. More recent roles identified in the literature include patient navigation and patient self-management behaviours beyond just medication adherence or symptom management [3,18]. For example, other self-management roles include reminding people about appointments and using home monitors to regularly measure blood pressure or check blood glucose. New roles and opportunities for CHWs will also continue to emerge as CHWs become more integrated into the health care system in the U.S. In addition, a handful of states have begun certifying and credentialing the workforce and these efforts and lessons learned may inform on-going efforts for training and continuing education [12,19].

Well-articulated training needs and CHW roles can help improve the relationship and understanding of non-CHWs in the care team and give non-CHW team members an understanding of how to support and work with CHWs [20]. Training, both in the beginning and throughout the lifespan of the CHWs time at an organization, helps to further CHWs' competency and allows CHWs to feel supported in providing services while also ensuring fidelity of evidence-based service delivery. Without well-defined roles and clearly articulated training needs, the workforce may not be meeting the needs of its clients and may not have a recognized role and skillset in the healthcare delivery system.

Learning from other newer or emerging professions can help the field to better develop training standards and capacity building efforts, a critical step in the recognition of a competent workforce for health promotion and reimbursement of CHW services through medical systems and government programs. For example, health educators have a well-recognized credentialing system through the National Commission for Health Education Credentialing, Inc (NCHEC) [21]. NCHEC outlines seven areas of responsibility and endorses a code of ethics for health education specialists; it administers a competency-based examination for individuals to become Certified Health Education Specialist (CHES), which was created from a Health Educator Job Analysis Study. NCHEC also administers the Master Certified Health Education Specialist credential (MCHES), which reflects more advanced-level skills and experience. NCHEC regularly conducts job analysis to validate and confirm areas of responsibility to improve certification and continuing education. While national standardization for CHWs may not be appropriate or necessary, borrowing ideas and lessons learned from well-established professions including health educators, social workers, medical assistants, among others can provide valuable insight into the process required to clearly define a new profession and gain credibility from multiple stakeholders [22,23].

The present study is limited in its sample size and geographic representation; thus, the results may not be applicable to all CHWs in the U.S. In addition, the study focuses primarily on CHWs' perspectives and does not include perspectives of non-CHW team members (e.g., providers, patients, supervisors). Future studies may include multiple team members are their perceptions about integration, capacity building, and training needs.

Future areas of study such as on-going training needs assessments with CHW input can inform CHW training and professional development. Other types of capacity building such as organizational

(e.g., creating sustainable organizations that can respond to community needs) and system level (e.g., functions and structures that support programs and activities that cut across organizations and government units) may assist in addressing workforce needs. As CHWs continue to gain recognition in health are settings, opportunities will continue to emerge and require clearly defined roles and skills for CHWs working in care teams. Well-established roles and skills, training and capacity building needs will allow CHWs to contribute their strengths to improve patient centred care.

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