Predictors and a Framework for Fostering Community Advocacy as a Community Health Worker Core Function to Eliminate Health Disparities

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Objectives. Using a mixed-method, participatory research approach, we investigated factors related to community health worker (CHW) community advocacy that affect social determinants of health.

Methods. We used cross-sectional survey data for 371 CHWs to assess demographics, training, work environment, and leadership qualities on civic, political, and organizational advocacy. We present advocacy stories to further articulate CHW activities. The data reported are from the recently completed National Community Health Workers Advocacy Study.

Results. CHWs are involved in advocacy that is community-focused, although advocacy differs by intrinsic leadership, experience, training, and work environment. We propose a framework to conceptualize, support, and evaluate CHW advocacy and the iterative processes they engage in. These processes create opportunities for community voice and action to affect social and structural conditions that are known to have wide-ranging health effects on communities.

Conclusions. The framework presented may have utility for CHWs, their training programs, and their employers as well as funders and policymakers aiming to promote health equity. (*Am J Public Health*. Published online ahead of print May 16, 2013: e1–e7. doi:10.2105/AJPH.2012.301108)

Community health workers (CHWs) are essential to effective and comprehensive health systems throughout the world.[1,2] In the United States, CHWs have been recognized as integral to providing patient-centered care and reducing health inequalities among disenfranchised groups.[3] The workforce impact of CHWs is far-reaching in the realms of the prevention and control of chronic and infectious disease,[4–13] the reduction of health care costs,[14–16] and improved outreach, communication, and adherence,[17–20] as well as in connecting clients to existing services.[21] The recognition of the CHW model has resulted in increased integration of CHWs into the health delivery system. Although beneficial in terms of health care delivery, the institutionalization of the role of CHWs within systems of care may result in the devaluation of another CHW core function, that of building community capacity to address the social determinants of health (SDH) through advocacy and organizing.[22–24] Studies have documented the influence of CHWs on the quality of the health care delivery system[25,26] and on community-engaged strategies to address public housing[27] and decrease community violence.[28]

Balcazar et al.[21] underscore the importance of maintaining the full spectrum of CHW roles within a changing health care delivery system, which includes not only influencing how care is delivered but also addressing power relationships that underlie the SDH. The World Health Organization's Commission for Social Determinants of Health recently revised their conceptualization of SDH to include structural determinants of health, which are defined as macroeconomic and social policies related to labor, housing, and land and public policies concerning health, education, and social protection.[29] Such structural determinants have been recognized as powerful predictors of health status.[30] In responding to specific disease areas, CHWs report the need for a broad range of skills to effectively address the complex issues that they confront working with individuals and communities.[31,32]

We document the findings of a mixed quantitative–qualitative national survey investigating CHW involvement in community-level advocacy, defined as working for a cause or a change to improve the health of a community. We propose a framework to conceptualize, support, and measure the intrinsic, training, and work environment characteristics associated with CHW community advocacy. The framework also describes the iterative process in which CHWs, by creating opportunities for community voice and action, positively affect social and structural conditions that determine the health of a community.

METHODS

The National Community Health Workers Advocacy Study (NCHWAS) is a community-based participatory research project that describes the professional status of CHWs in the United States and investigates the impact of CHW advocacy on community engagement to address health disparities. Between January and September 2010, cross-sectional qualitative and quantitative data were collected through an anonymous, on-line semistructured survey. The decision to conduct an on-line survey was made in consultation with all national CHW professional organizations. Through letters, e-mails, phone calls, and meetings, the Arizona Prevention Research Center (AzPRC) distributed the survey to 4 national and 19 state CHW professional associations, and each circulated the survey among their membership. The AzPRC also promoted the survey at 1 national and 1 regional CHW conference. Additional description of the NCHWAS sampling frame and the organizations involved in the development and dissemination of the survey is available elsewhere.[32] Theoretical foundations of

mixed-methods research guided the research design.[33] Specifically, qualitative data enhanced quantitative findings. Together, these methods created an account of predictors of CHW advocacy, activities that lead to advocacy, and outcomes related to action on the SDH.[34] This account represents the direct voice of CHWs in the United States.

Quantitative Component

A total of 371 CHWs, from 22 US states plus the District of Columbia, participated in the survey. Explanatory variables assessed included the following: sociodemographic measures of age, gender, ethnicity, family income, education level, work setting, and years of CHW work experience; CHW training experience; characteristics of CHW work environment and duties; and CHW leadership qualities. The definition of advocacy, based on our previous work[33] and partner consensus, was "to work for a cause or change that will improve the health of a community." Outcome variables specifically examined ever having talked with or written a letter to the following people or organizations about making changes in the community: school board, city council, county board of supervisors, planning and zoning commission, state representative, US representative, governor, health and social service agencies, clinic or hospital, business and law enforcement agencies, or the CHW's own agency. Findings from previous AzPRC research and input from CHWs and partner organizations guided the organization of advocacy domains into 4 major dichotomous categories (yes or no) that CHWs engaged in (1) advocacy within the CHW's own agency, (2) civic advocacy (e.g., directed to health and social service agencies, clinic or hospital, business and law enforcement agencies), (3) political advocacy (e.g., to school board, city council, county board of supervisors, planning and zoning, state representative, US representative, governor), and (4) any advocacy, meaning that the CHW engaged in at least 1 form of advocacy, be it civil, political, or within the CHW's own organization.

We assumed that missing responses were unanswered. Logistic regression assessed CHW characteristics associated with community advocacy at all levels. We used a 2-tailed α level of 0.05 to define statistical significance for statistical tests. We continuously presented quantitative analysis to the AzPRC research committee and incorporated feedback into the final data interpretation.

Qualitative Component

The NCHWAS also inquired about CHW advocacy stories and asked CHWs to describe a time when they advocated to help an individual or family, to make a change in their workplace, and to help their community to make a change. For the purposes of this article, qualitative analysis focused on workplace and community-level advocacy—termed "community advocacy," representative of advocacy that goes beyond the level of individual clients or their immediate family. We developed advocacy categories to mirror the quantitative survey questions (organizational, civic, and political domains). A team of 4 researchers with qualitative experience engaged in an iterative, face-to-face process of consensus building to (1) confirm that the data being analyzed was an example of community-level advocacy rather than individual advocacy, (2) perform content analysis to determine categories related to the types of and processes toward community advocacy, and (3) independently code advocacy stories using the agreed-upon categories. Where the investigators did not agree, which was infrequent, we engaged in face-to-face discussion to reach consensus.[35,36] Our center's research committee checked the categories' validity as well as the nuances of specific stories, the final results, and the interpretation of findings.[36]

RESULTS

Quantitative and qualitative results are described in the following sections.

Quantitative

Nearly 75% of CHW respondents engaged in some type of advocacy (Table 1). CHWs advocated for changes within their own agency (77%) and within civic (57%) and political (46%) domains. On a civic level, more than half of CHWs advocated for change within a local or state health department, and slightly fewer than half engaged various social service agencies or local businesses. More than one quarter of CHWs worked alone or as part of a group to

TABLE 1—Community Health Workers' Advocacy With Elected and Nonelected Individuals and Agencies: National Community Health Workers Advocacy Study, 2010

Target of Advocacy	CHWs, No.	CHWs Who Advocated, No. (%)
Political advocacy	332	152 (45.7)
School board	228	85 (37.3)
Planning and zoning commission	209	27 (12.9)
City council	219	57 (26.0)
County board of supervisors	215	52 (24.1)
State senator or representative	226	135 (59.7)
Governor	215	45 (21.4)
US senator or representative	224	68 (30.3)
Civic advocacy	332	188 (56.6)
Business	226	92 (40.7)
Clinics or hospitals	241	139 (57.6)
Law enforcement agencies	221	59 (26.7)
Social service agencies (HUD, DES)	229	101 (44.0)
Health department	242	132 (54.5)
CHW's own agency	265	204 (76.9)
Total (any) advocacy	332	247 (74.0)

Note. CHW = community health worker; DES = Arizona Department of Economic Security; HUD = Department of Housing and Urban Development. Missing responses were assumed to be unanswered.

engage local law enforcement agencies to create community change. Within the political domain, CHWs most often engaged their state senator or representative (60%), school board or its members (37%), and US senator or representative (30%). Approximately one quarter of CHWs advocated through the city council, county board of supervisors, or the state governor.

Tables 2 and 3 provide a comparison of all types of advocacy (any, own, civic, and political) by selected sociodemographic variables, CHW training experiences, work characteristics, and CHW leadership qualities. The percentage of CHWs engaged in any type of advocacy varied slightly across sociodemographic variables, although none of these differences demonstrated statistical significance (Table 2). However, CHWs with more than 5 years of CHW experience were about 3 times more likely to engage in any advocacy than were CHWs with fewer years of experience (odds ratio [OR] = 2.9; $P < .001$). CHWs working across organizational settings (community health centers, hospitals or clinics, health departments, and community-based organizations) were equally engaged in advocacy activities at all levels. Across all organizational settings, CHWs were less likely to engage in political advocacy than in other forms of advocacy. CHWs employed in non-community-based hospitals or clinics were significantly less likely to advocate at the political level (OR = 0.52; $P = .032$) compared with CHWs working in community-based organizations and clinics.

In terms of training, CHWs who reported previous leadership or advocacy training were 2 to 4 times more likely to advocate at the political, civic, and own agency levels compared with CHWs without these types of trainings (Table 3). CHWs who reported receiving advocacy training from their employer were twice as likely to advocate at the political (OR = 2.0; $P = .003$) and civic (OR = 1.91; $P = .007$) levels compared with those CHWs without such training. CHWs who reported nonemployer local (OR = 1.58; $P = .040$), state (OR = 2.69; $P < .001$), and national (OR = 2.40, $P = .016$) advocacy training were also significantly more likely to advocate within the political domain than were those without such training. CHWs who collaborated with community leaders and with other CHWs and who had the autonomy to start new projects with the community were significantly more likely to engage in political advocacy than were CHWs who lacked these characteristics. CHWs who reported community advocacy as part of their job description were significantly more likely to engage in civic, political, and own agency advocacy (OR = 2.1, 3.0, and 4.6, respectively). CHWs who reported 4 or more key leadership qualities were 6 times more likely to engage in any type of advocacy than were CHWs without these qualities (OR = 6.3; $P < .001$). CHW leadership qualities included the following: believing they represent community needs and knowing who to talk to about making changes; expressing ideas and opinions when working in groups, and feeling listened to by their organization or community leaders when representing community needs; and actively bringing people together to solve problems.

TABLE 2—Comparison of Advocacy Participation Rates, by Selected Demographic Characteristics: National Community Health Workers Advocacy Study, 2010

Variable	Advocacy Participation	
	Mean ±SD or No. (%)	OR (95% CI)
Age, y	46.3 ±0.71	1.00 (0.8, 1.2)
Gender		
Female	176/241 (73.0)	1.00 (Ref)
Male	17/19 (89.1)	3.13 (0.7, 13.9)
Race/ethnicity		
White, Non-Hispanic	21/29 (72.4)	1.00 (Ref)
Hispanic	150/196 (76.5)	1.2 (0.5, 2.9)
African American	21/31 (67.7)	0.8 (0.2, 2.4)
Other	8/12 (66.6)	. . .
Family income, $		
≤ 25 999	44/65 (67.6)	1.00 (Ref)
26 000–50 000	82/109 (75.2)	1.4 (0.7, 2.8)
≥ 50 000	35/43 (81.4)	1.5 (0.7, 3.5)
Education		
≤ high school graduate	47/70 (67.1)	1.00 (Ref)
Some college	71/90 (78.8)	1.8 (0.8, 3.7)
≤ college graduate	75/98 (73.5)	1.5 (0.8, 3.1)

Note. CI = confidence interval; OR = odds ratio. Advocacy includes having talked with or written a letter to the following people or organizations about making changes in the community: political—school board, city council, county board of supervisors, planning and zoning, state representative, US representative, governor; civic—health and social service agencies, clinic or hospital, business and law enforcement agencies; and community health worker's own agency.

Qualitative

Almost half (n = 161) of CHWs respondents provided a community advocacy story. Community advocacy activities fell into 2 major categories, one consisting of activities considered the building blocks of advocacy and the second of concrete advocacy actions. In the first category, respondents described activities that suggested they were on the road to a specific advocacy project. These building blocks of future advocacy came in the form of CHWs becoming aware of a community issue and responding by (1) initiating a formal or informal community assessment, (2) joining or starting a coalition or group to address that issue, or (3) initiating a corresponding activity, which could include developing and implementing a one-time communitywide event or an ongoing intervention effort. The second category consisted of concrete advocacy examples at the organizational, civic, and policy level. Most often, CHW advocacy

TABLE 3—Comparison of Advocacy Participation Rates, by Community Health Worker (CHW) Employer, Training, Work Environment, and Leadership: National Community Health Workers Advocacy Study, 2010

	Total Advocacy[a]		Political		Civic		Own Agency	
	No. (%)	OR (95% CI)	No. (%)	OR (95% CI)	No. (%)	OR (95% CI)	No. (%)	OR (95% CI)
CHW employer								
Community-based organization	84/112 (75)	1.00 (Ref)	57/112 (51)	1.00 (Ref)	63/112 (56)	1.00 (Ref)	68/89 (76)	1.00 (Ref)
Community-based clinic or community health center	42/60 (74)	0.77 (0.38, 1.56)	26/60 (43)	0.73 (0.39, 1.38)	32/60 (53)	0.88 (0.47, 1.6)	34/45 (76)	0.95 (0.41, 2.2)
Hospital or clinic (not community-based)	61/82 (74)	0.96 (0.50, 1.86)	29/82 (35)	0.52 (0.29, 0.94)	41/82 (50)	0.77 (0.43, 1.3)	50/63 (80)	1.1 (0.54, 2.5)
State or tribal health department	29/39 (76)	1.0 (0.45, 2.54)	18/38 (47)	0.86 (0.41, 1.8)	24/38 (63)	1.3 (0.62, 2.8)	23/30 (77)	1.0 (0.38, 2.6)
CHW training								
Previous leadership training	172/202 (85)	3.7 (6.9, 1.9)	112/202 (55)	2.4 (1.3, 4.4)	134/202 (66)	2.6 (1.5, 4.7)	146/180 (81)	2.9 (1.5, 5.7)
Previous advocacy training	187/225 (83)	2.1 (1.1, 3.8)	124/225 (55)	2.5 (1.4, 4.2)	142/225 (63)	1.5 (0.8, 2.5)	158/188 (84)	3.8 (2.0, 7.1)
Works with community leaders	184/216 (85)	2.2 (0.9, 5.3)	122/216 (56)	2.8 (1.2, 6.3)	153/216 (71)	3.5 (1.6, 7.6)	153/193 (79)	2.1 (0.9, 4.7)
Works on projects with other CHWs	180/217 (83)	1.9 (0.9, 3.9)	117/217 (54)	2.0 (1.0. 3.8)	139/217 (64)	1.2 (0.6, 2.3)	147/188 (78)	2.1 (1.0, 4.1)
Autonomously initiates new projects with community	191/233 (82)	1.3 (0.6, 4.3)	126/233 (54)	2.1 (1.1, 4.3)	152/233 (65)	1.0 (.50, 1.9)	155/200 (78)	1.2 (0.5, 2.6)
Job description includes community advocacy	171/191 (90)	3.09 (1.5, 6.3)	117/191 (61)	3.01 (1.6, 5.4)	138/191 (72)	2.1 (1.2, 3.8)	148/175 (85)	4.6 (2.4, 8.8)
Attends coalition meetings as part of job	125/168 (74)	1.0 (0.6, 1.9)	81/168 (48)	1.6 (0.9, 2.8)	100/168 (60)	1.4 (0.8, 2.3)	103/137 (75)	0.9 (0.4, 1.8)
CHW leadership								
Possesses all leadership qualities	126/138 (91)	6.3 (3.2, 12.2)	85/138 (62)	3.0 (1.9, 4.7)	104/138 (75)	4.0 (2.4, 6.4)	107/126 (85)	2.4 (1.3, 4.4)
Participates in any CHW professional network	111/150 (74)	0.9 (0.5, 1.5)	74/150 (49)	1.2 (0.8, 2.0)	86/150 (57)	1.0 (0.6, 1.6)	91/120 (76)	0.8 (0.5, 1.5)

Note. CI = confidence interval; OR = odds ratio. Missing responses were assumed to be unanswered. Except for "CHW employer," reference category for each item is absence of listed attribute.
[a]Total advocacy includes having talked with or written a letter to the following people or organizations about making changes in the community: political—school board, city council, county board of supervisors, planning and zoning, state representative, US representative, governor; civic—health and social service agencies, clinic or hospital, business and law enforcement agencies; and community health worker's own agency.

activities were nonlinear, but iterative. CHWs described moving in and out of both activities (building blocks and concrete advocacy). Examples of community advocacy at the organizational, civic, and political levels follow.

Organizational advocacy activities. Accounts of successful CHW advocacy efforts within their home agency ranged from raising awareness and status of the role and value of CHWs to obtaining the resources needed by CHWs, such as work space, computers, cell phones, and training. The following CHW statement illustrates CHWs' advocacy on their own behalf:

> In the workplace, we worked hard for the last 5 years to prove the community health worker concept and the benefits of having them in a clinical setting. In a clinical setting we advocate for those who are underserved and uninsured. We are well received now, and are counted as part of the care delivery team.

CHWs also described talking with their supervisors about improving cultural and linguistic resources for clients, and making resources and services more accessible. The following quote from a clinic-based CHW exemplifies client-centered CHW advocacy initiatives:

> Our clinic's signage was awful and not literacy appropriate. I was able to get management to see the need to improve its signage. I consulted with health promotion department who got 2 public health students to do their internship. . . . This project motivated other management to relook at clinic paperwork (registration, sliding scale discount, etc.). Similar projects are happening across programs to improve the way info is presented using health literacy as guideline.

On some occasions, CHWs identified and corrected opportunities to reach monolingual clients diagnosed with diabetes. One example includes a CHW who recognized the need to adapt English-only diabetes prevention and management classes to meet the needs of non-English speakers. The CHW approached clinic supervision to propose the idea and began adapting materials and promoting the classes.

Civic advocacy activities. CHWs reported engaging civic leaders or civic bodies to advocate for improved community infrastructure, health, and social service policy. CHWs working in rural areas and in states along the US–Mexico border were successful in advocating for connecting homes to potable water and sewage lines and for cleaning and paving streets. In urban communities, CHWs were successful in advocating for improved and newly constructed community parks and better community lighting, neighborhood recreation centers, increased and improved modular housing for low-income families, computers for youth groups, and improved healthy options in supermarkets, corner stores, and restaurants. The following quote demonstrates how CHWs from community-based organizations were successful in responding to community concerns about neighborhood safety and housing:

> In Boston there is a lot of gang violence. One of my residents asked the question why there was no lighting in the park that has a lot of shootings. I asked her to assist me with getting names on a petition. We received more than 100 names of residents from this community. We then sent this petition to our state officials. Two weeks later, the lights were on in the stadium.
> I participated in a large campaign to stop demolition of housing projects after Hurricane Katrina, motivated by personal experiences of displacement and by the literature linking

> community destruction to a wide range of physical, mental, and social problems. While we did not save the projects, we did force a promise from the private development company that demolished the housing development to provide for rehousing [for] all former residents in the same neighborhood, and provide housing choice vouchers for all pre-Katrina leaseholders.

Political advocacy activities. CHWs contacted various elected officials or elected governing bodies and described taking classes or internships to learn how to communicate effectively with elected officials and to organize groups of people. They described sharing advocacy skills with clients and neighbors. CHWs invited clients and neighbors to attend city council or public meetings, where they demonstrated how to give public testimony to elected officials. They described collecting signatures and conducting community focus groups, and visiting representatives' offices alone and with others to inform politicians of community issues. Specifically, CHWs talked with representatives about disparities in infant mortality, improved lead screening for children, and increased access to health care for the uninsured. One CHW employed in a community health center described encouraging elected officials to be more involved in community health. Another hospital-based CHW described her work on welfare reform. Finally, a community health center–based CHW discussed the development of a community center:

> I have contacted our City Council members regarding health and wellness in our communities and the need for their visible and vocal support to encourage our areas to take action to live healthier lifestyles.

> I talked to the representative of the area about a recreational center for the betterment of our community and use by adults and children. We have been in talks for 6 years, to make this possible. I just received the news that the center will open in June.

DISCUSSION

Our research suggests that CHWs are actively engaged in community-level advocacy to address structural and social determinants of health.[29] Intrinsic leadership, experience, advocacy, and leadership training and the work environment contribute to CHW community advocacy. Work environments that foster CHW autonomy and collaboration with peers and leaders are associated with community advocacy. The CHW advocacy stories describe a variety of advocacy efforts and their outcomes. For example, CHWs learned and shared methods to effectively communicate with elected officials and civic bodies about making environmental change. They also made significant gains in addressing indicators of social cohesion and the built environment, such as safe lighting and housing, potable water, healthy food choices, and public recreational spaces, all of which have been shown to have long-term health implications.[17,34–36] Overall, CHWs were more likely to describe successful advocacy outcomes in the organizational and civic domains than in the political domain. This may be an indication of CHW social capital at the immediate neighborhood, city, and county level.[28]

Community Health Worker Community Advocacy Framework

CHWs recognized by their communities, employers, and community leaders as trusted members of community opinion can be supported in a variety of ways.[21] On the basis of our quantitative and qualitative findings, we present a framework to conceptualize, support, and evaluate community-level advocacy among CHWs (Figure 1). Our framework links the significant personal, training, and work environment factors related to CHW

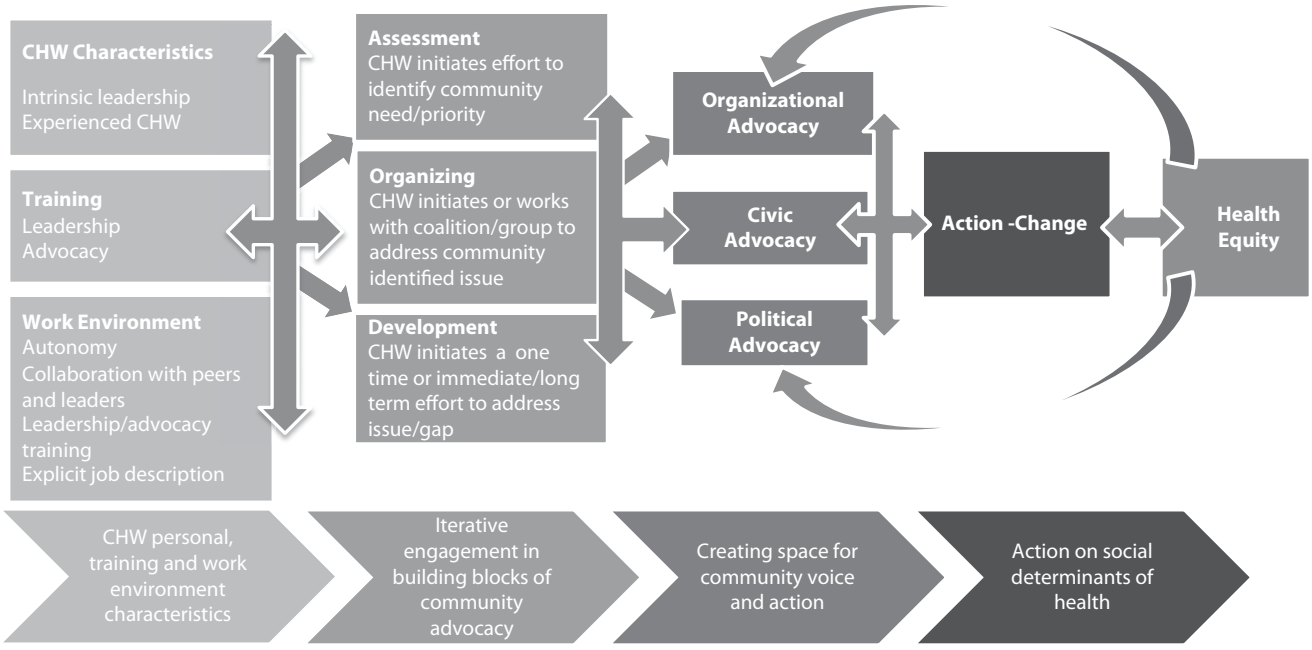

FIGURE 1—Community health worker (CHW) advocacy framework: National Community Health Workers Advocacy Study, 2010.

community advocacy evidenced in the quantitative data to the qualitative processes that CHWs described in advocating at the organizational, civic, and political levels. CHW activities, which are referred to as building blocks of CHW community advocacy in our model, include assessment, organization, and development. These blocks are iterative and mutually reinforced by personal, training, and work environment factors. Building blocks are CHW initiated and respond to immediate and long-term community issues. Ranges of activities include conducting formal and informal community assessments, participating in collaborative organizing with associations or institutions, responding to a community-wide issue by working alone or with a group to develop events, and recognizing the need for a longer-term solution in the form of an intervention or policy change. Through the building blocks of advocacy, CHWs create opportunities or space for community voice and action.

We contend that the opportunities created by CHWs through the proposed building blocks and concrete advocacy efforts at different levels contribute to action on elements of the SDH. We conclude that action by decision-makers on CHW- and community-identified SDH may increase health equity within the affected community. The framework also posits a feedback loop in which the experience of successful advocacy efforts may contribute to sustained civic engagement among community members on new challenges to be affected through CHW assessment, organization, and development.

The framework may be a tool for CHW employers, professional organizations, funders, and policymakers concerned with civic engagement and environmental change to address the SDH.[37] It suggests a means to identify specific training needs and institutional support roles that foster advocacy as a core CHW function, even in those organizations where individual- and organizational-level advocacy takes priority over broader community-level change. Stakeholders can support CHW community advocacy by explicitly including community advocacy as central to the CHW job description. Employers may also delineate specific advocacy activities, in line with institutional mission and project goals, and identify and provide skill-building opportunities that prepare CHWs for organizing and advocating effectively.

Limitations

We recognize several limitations connected with this study that we hope to address in future collaborative efforts. The NCHWAS is a nonrandomized sample that includes a disproportional number of Hispanic and female respondents and may not be representative to the CHW profession in the United States. CHW respondents may also be different from those CHWs not affiliated with a CHW professional organization. Furthermore, our survey distribution strategy might have missed CHWs not affiliated with a professional CHW organization. CHWs involved in this study may therefore be more likely to advocate than other CHWs. However, it should be noted that within the NCHWAS, CHW advocacy rates among those CHWs affiliated with a CHW professional association were consistent with those of previous findings.[33] Additional details on the limitations regarding the NCHWAS primary on-line sampling strategy are also published elsewhere.[32]

Conclusions

The findings show that CHWs are involved in advocacy activities within several domains and that CHWs address complex issues, often tangentially related to a specific illness of their clients. Systematic efforts, such as a CWH training model that includes the SDH, may add important continuity in empowering CHWs to reflect community concerns. Such efforts are also consistent with the fundamental community-centric origins that make these workers effective, and they may promote collegiality among CHWs from various settings. This issue is also of importance within larger professional societies that represent their collective interests and obligations. Specifically, we can identify a number of training and environmental characteristics that may contribute to CHW engagement in community advocacy; these include employer-based leadership and advocacy training, job descriptions that outline a role for community advocacy, and autonomy for CHWs to start new projects and to be involved in collaborative leadership within their own agencies and among community leaders and coalitions. The broader implications of our data-informed framework are that it serves as a useful heuristic to guide CHWs' training, program evaluation, and institutionalization, and also guides policymakers and funders in targeting their resources to address the social determinants of health. ■

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Contributors

S. Sabo conceptualized the study, analyzed the data, and led the writing and model development. M. Ingram assisted in the conceptualization of the study and the writing and editing of the article. K. M. Reinschmidt, K. Schachter, L. Jacobs, and J. G. de Zapien were involved in survey design and edited the article. L. Robinson provided community perspective in the editing process. S. Carvajal supervised the statistical analysis and final editing of the article.

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Human Participant Protection

This study was approved by the University of Arizona Institutional Review Board for the Protection of Human Subjects.

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