



**THE CENTER**  
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## Community Health Workers and Promotores in California

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### Overview and Description of the Workforce

Community health workers and promotores are public health professionals who carry out a variety of health promotion, case management, and service delivery activities at the community level. Generally speaking, they come from the communities in which they work, and act as advocates or representatives of those communities. They link individuals with needed health care by helping them understand and access an increasingly complicated health care system.<sup>1</sup> They may also offer education and information about health care issues.

Due to their close affinity with the people they serve, community health worker (CHW) and promotor/a programs have shown “remarkable effectiveness in linking individuals with the health care system, with insurance coverage, and with sources of continuous, appropriate medical care.”<sup>2</sup> From their unique position in the community, CHWs and promotores can:

- increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages to traditionally underserved communities;
- reduce costs to both providers and patients by providing preventive services, health education, screening and early detection of disease and basic emergency care; and
- improve quality of care by aiding patient-provider communication, facilitating continuity of care (by providing follow up), and by acting as

a patient navigator and advocate within the health care system.

Community health workers work under approximately 35 titles, making a clear definition of the workforce difficult.<sup>3</sup> Over the past several decades, the term “community health worker” has been used synonymously with, or to include, such terms as: community health advisors (CHA), promotores (de salud), lay health advocates, peer health educators, community health representatives, and outreach workers.

Nationally, the current term of choice is “community health worker” although “promotor/a” is increasingly common in states such as California, with large Latino populations. Generally, throughout this brief we will use the term community health worker (CHW) broadly to include CHWs, promotores de salud, and others who would fall under a broad definition of CHWs. However, we will make distinctions where appropriate.

Depending on one’s perspective, promotores de salud can be described as a subset of community health workers (primarily serving Latino communities), or as a related field that is more grounded in a social model rather than a medical model. Promotores (without “de salud”) could mean those who work in communities to provide broader social service resources, including but not limited to health care. Individuals in this field may fall anywhere along each continuum. For example, some volunteer CHWs work in clinics and some community-based promotores have considerable formal training.

The figure below helps provide a picture of the range of philosophies and characteristics of the people who are the topic of this paper.

#### **Community Health Workers and Promotores May Be:**

Socially or community focused.....	Clinically focused
Integrating health and social services.....	Focusing just on health
Responsible to community.....	Employed in health care setting
Informally trained.....	Formally trained
Volunteer.....	Paid/salaried

By definition, community health workers usually come from and are part of the communities in which they work. They understand what is important to that community, they communicate in the language of the

people they serve, and, perhaps most importantly, they recognize and incorporate cultural considerations that would usually be hindrances rather than aids when it comes to specific groups receiving care. Some of these considerations may include spiritual or religious beliefs, traditional methods of healing, effective communication (given the education and background of group), and adherence to customs.

**Examples of CHW/Promotor/a Work:**

- Provide referral services
- Work with a family to develop an economical and nutritious meal plan
- Facilitate diabetes educational groups, aimed at better self-care
- Visit crop fields to educate migrant farmers on HIV prevention
- Consult on family planning or pre/postnatal care
- Translate a medical document for a patient
- Go door-to-door to locate isolated elders to conduct health assessments and referrals

One powerful characteristic of a community health worker, or promotor/a, is the capability to act as an agent of change. Because CHWs and promotores come from the communities in which they serve and share much of the same backgrounds and beliefs of those people, they are in a good position to be trusted and to build important and dynamic relationships with the community. Many CHWs and promotores identify themselves as “born from the heart” and “willing civic participants” who work, sometimes without pay, because they believe it is their responsibility to help empower their community.<sup>4</sup> With a strong commitment to their communities and to what they do, these authentic partnerships can connect community members to larger organizations and have the potential to bring about social and political change.

## History and Background

The idea of community members as active health advocates and healers is a familiar one around the world. All of the world’s cultures have a lay health care system that is comprised of natural health aides – community members to whom neighbors turn to for health and healing advice.<sup>5</sup> The first systematic use of CHWs took place in China. After the Chinese Revolution of 1949, Mao Tse Tung instituted the Barefoot Doctor Program, a program where workers

brought basic health care to rural populations and addressed such issues as nutrition, vaccinations, and sanitation.<sup>6,7</sup>

The United States’ oldest and largest CHW program, the Community Health Representative Program, was established in 1968 to address the needs of American Indian tribes.<sup>8</sup> The role of the CHW was re-emphasized on an international level during the Alma Ata conference in 1978. The conference, which called for “health for all by the year 2000,” emphasized the role of CHWs as “one of the cornerstones of comprehensive health care.”<sup>9</sup>

## Growth of the Profession

There is currently a growing attempt in the United States to reach the increasing number of immigrants and underserved populations through CHWs. Their ability to work effectively with hard to reach populations is a cost-effective method of delivering public health care, and, more and more, health organizations of all sizes are starting to realize the unique potential of CHWs.<sup>10</sup>

In some ways, however, the lack of a clear, common definition has contributed to the relatively slow growth of the profession. “A working consensus about the roles and competencies of CHAs will help facilitate their integration into the health care system and thus enhance its ability to address the basic determinants of health.”<sup>11</sup>

In an effort to help standardize understanding about CHWs, the CDC established the first national database on the subject in 1993. Two years later, in 1995, the Annie E. Casey Foundation sponsored The Rural Health Office of the Arizona College of Public Health to conduct a comprehensive, national study on community health workers, outlining core competencies, evaluation methods, development issues, and recommendations to policymakers for the growth of CHWs in the changing health care environment. The study team worked with the CDC to collect data from programs and practitioners nationwide. The study defined community health advisors (the term used instead of “community health workers”) by clearly outlining, for the first time, seven core competencies:

1. Bridging cultural mediation between communities and the health and social service systems.
2. Providing culturally appropriate and accessible health education and information, often by using popular education methods.
3. Assuring that people get the services they need.
4. Providing informal counseling and social support.
5. Advocating for individuals and communities within the health and social service systems.
6. Providing direct clinical services, such as basic first aid, and administering health screening tests.
7. Building individual and community capacity.

In October of 2001, the American Public Health Association released a policy statement, making a formal declaration of “Recognition and Support for Community Health Workers’ Contributions to Meeting our Nation’s Health Care Needs,” urging many recommendations to policymakers, all of which would seek to more firmly establish the roles and development of CHWs and CHW educational programs.<sup>12</sup>

### **Work and Practice Patterns**

A distinction has been made between community-based CHWs and clinic-based CHWs.<sup>13</sup> This distinction indicates two broad areas defining work practices for CHWs and reflecting, to some degree, the philosophical split between serving the medical care system or the broader community. Clinic-based CHWs are more closely affiliated with health service delivery organizations and are found working in health centers, public health departments, and hospitals, with the greatest numbers of clinic-based CHWs per facility in the hospital setting.<sup>14</sup> CHWs working in clinics are more likely to perform duties focused on patient care, such as patient registration, translation, and basic health assessments.

Community-based CHW/promotores interact with the community outside of the health care delivery system, sometimes working door-to-door providing services not unlike social workers and community organizers. A 1996 survey in the San Francisco Bay

area found county health departments to be the largest employer of community health workers, followed by community-based organizations and clinics.<sup>15</sup> The same survey found 55% of community health workers’ positions were funded through ongoing federal, state, or city/county funds, and that 29% were funded by ongoing county/city funds.

Primary work activities for full-time clinic-based CHWs include: client intake, translation, health education, and information/referral, with most CHWs in the eight county San Francisco Bay Area working in HIV/AIDS and maternal and child health.<sup>16</sup> The San Francisco Public Health Department utilizes a “Health Worker” classification containing four step-grades. While the first step of this classification, Health Worker I, involves tasks typically associated with CHW’s – making appointments, routing and assisting client registration, and translation – the higher classification grades include program planning activities, supervisory tasks, staff training, and possible research activities.

The 1996 survey<sup>17</sup> found that part-time CHW’s had similar work profiles but spent a larger proportion of their time in specific topic areas such as immunization, perinatal care, family planning, HIV/AIDS/STDs, and asthma. This may indicate CHWs were hired to assist with a focused, perhaps short-term, program in the community or clinic and therefore are not engaged in more general community building activities.

The number of community-based programs in California utilizing CHW/promotores is difficult to calculate; there may be dozens or hundreds. Generalizing about work duties and procedures for community-based CHW/promotores is also difficult as they will be defined by the needs of the community and the mandates of the employer or grant project. Community-based CHWs are more likely to engage in “community building” activities than their clinic-based counterparts, and to work irregular hours in varied job settings.

### **Community Partnerships In Action: Latino Health Access**

Established in 1993 in Santa Ana, CA, Latino Health Access uses promotores to provide better health services for their community of 65,000, predominately Latino, residents. Latino Health Access boasts an 1500-hour training program for its own employees, as well as for outside participants. Through outreach and education in the neighborhoods, the small non-profit becomes aware of emerging issues and develops nearly all of their health programs based on the requests and needs of the community. The promotores are instrumental in this process as collectors of information, community educators, and, perhaps most importantly, as role models who share the same culture and language as the community from which they come and in which they serve. Latino Health Access could be seen as a model program for other groups wishing to incorporate promotores into their workforce.

### **Wages**

A 1998 multi-state survey of eight programs utilizing community health workers found the annual costs for the position (including salary, benefits, supervision, administration and overhead) ranged from \$9,104 to \$64,866.<sup>18</sup>

A 1996 survey of health providers in the eight counties of the San Francisco Bay Area found that 44% of the community health workers earned \$20,000-\$25,000 annually, with 30% earning more than \$25,001.<sup>19</sup>

In 2003, a Health Worker I in San Francisco's Department of Public Health, performing tasks such as registering and routing patients, language interpretation, and making appointments, earned \$31,152 or approximately \$16.22 an hour.<sup>20</sup> The San Diego Area Health Education Center (AHEC) and Latino Health Access both employ promotores, earning an average of \$11 an hour with health benefits.<sup>21,22</sup>

Community health workers, and promotores in particular, come from a strong tradition of community service. Some advocates, in fact, feel that working as a volunteer is essential to the authenticity of a CHW/promotor.<sup>23</sup> There could be CHW/promotores working for little or no monetary compensation in California.

### **Demographic Characteristics**

The difficulty in defining who is working in the capacity of a community health worker under various job titles makes collection of statewide demographic information very difficult. The San Diego AHEC reports between 400-500 promotores/community health workers in the San Diego area, with the majority being Latino females.<sup>24</sup> The 1996 San Francisco Bay Area survey found 66% of the workers were female, 77% were non-white, and that 58% had a high school diploma or less.<sup>25</sup>

### **Education and Training**

Training for CHW positions ranges from minimal on-the-job training to formal community college academic programs which grant a certificate or even an associate's degree. Typically, community health workers have been trained on the job. A 1992 survey of health facilities utilizing community health workers found that 39% primarily trained CHWs internally, 42% utilized both in-house and external training of their CHWs, and 47% would send their workers to a certificate program.<sup>26</sup> A focus group of community health workers found that ongoing education tended to be sporadic and, while the on-the-job training was valuable, workers wanted more formal training.<sup>27</sup>

In the community-based organizations utilizing CHWs, and particularly those promoting a promotor/a model of outreach, training is likely to be more dependent on community specific culture and/or project specific materials and procedures. On-the-job training, specific to the community needs is associated with the community-based model that underlies many programs utilizing CHWs. Some advocates of the promotor model view standardized training for CHW/promotores, like that being offered at community colleges, as a threat to the authenticity and effectiveness of the CHW. Instead of motivated members of the community working in their community, CHW's will be defined by having a specific skill set that may have little to do with the real needs of the community.

Membership in the community, fluency in the native language, and a desire to serve, have been the only qualifications required of many community health workers. Formal training programs will add

prerequisites which could make entry into the field more difficult. While two of the existing community college programs seek to enroll employed community health workers for further education, each requires a high school diploma or GED for entry.

In 2002, 15 academic programs, most leading to certification, were identified in 10 states.<sup>28</sup> Five California community college campuses provide a community health worker training program that offers certification.<sup>29</sup> Since programs of less than 21 units do not come under the scrutiny of the community college chancellor's office, there may be campus programs that are not listed in the system-wide databases. The San Francisco Interior Bay Regional Health Occupations Resource Center (RHORC) indicates at least three colleges considering implementing the community health worker program developed at City College of San Francisco.<sup>30</sup>

California community college CHW programs offer certification programs ranging from 17 to 30 unit credits with most allowing certificate units to be applied toward an associate's degree. Two programs provide an associate's degree. Most of these programs provide electives beyond the core CHW courses that allow specialization in training. These electives include: aging, HIV/AIDS, asthma, diabetes, nutrition, and maternal and child health.

Community colleges provide both a responsiveness to community needs for health workers as well as the ability to design training programs offering specific knowledge and skills needed in local communities. The college programs reflect the needs and resources of local employers and health departments. For example, one community college has focused on training community health workers to work with the disabled. This was in response to the needs of one local agency. One community college program has no enrollees, reflecting the downturn in the local economy according to the program director.<sup>31</sup>

Increased academic training and certification of CHW trainees is viewed with mixed reactions in the field. While acceptance into academia could promote measurable performance standards and may increase employment opportunities for CHW trainees and Medicare reimbursement for CHW's, some feel that this removes the primary qualification for a

community health worker – membership and participation in their community, coupled with a real sense of service. Where culture, language, and a desire to serve the community, have been the primary qualifications for CHW's, the increased reliance on formal academic training may mean more obstacles for those wishing to work in the community.

## Credentialing

Employers, insurers, and members of the public often ask about the credentials of health care workers. For community health workers, credentials vary considerably and training is often tailored to a particular clinic, agency, or community's needs. There are no requirements issued by state or local government, no national- or state-based professional association to which everyone looks for a standard credential, and no standard credentials established by third-party insurers. Credentials may be based on formal education or training (often at community colleges as described above), program-specific training, or may be based on competence, role in the community, and less formal experience. While educational institutions may offer certificates of completion of programs for community health workers, such certification has not been standardized, leading to some flexibility and variation among the programs and the qualifications of their graduates. Some of the community colleges in California that offer CHW programs are discussing standards but these have not been implemented.

## Certification

Nationally, there have been some calls for standardization of CHW credentials. For example, the report of the National Community Health Advisor Study included the following recommendation, which was presented as the first component needed to improve working conditions and future opportunities for CHAs:

### ***Establish a National CHA Certification.***

Develop a CHA certification based on refined CHA core roles and competences; link to other certifications such as those being explored by front-line human services professionals.<sup>32</sup>

Texas has been the first state to mandate credentialing for CHWs seeking compensation,<sup>33</sup> and

other states may be considering similar moves. Although there are clear benefits to programs with this type of law, commentators have noted that the move might also have worsened the problem of how to define CHWs:

As more employers discover the value of the skills and aptitudes of CHWs, the question arises whether all workers with such training are “true” CHWs. This uncertainty may be exacerbated rather than reduced by the growth of credentialing and formal college-based training for CHWs.<sup>34</sup>

There is probably even more variation among subsets of CHWs such as promotores, who may participate in any one of hundreds of different programs estimated to be operating in California. Some of these programs require considerable training (the promotores at Latino Health Access in Orange County have had 800 hours of training) but others require minimal training that is tailored to the needs of the program, or no formal training at all. California AB 1963 (Salinas, 2004) would define promotores as trained community health workers but does not spell out training components. Although individual perspectives may vary, generally the organized advocates for promotores do not support mandating credentials because of the perceived negative impacts on the members of the workforce who have minimal formal education (and may even lack legal residency status in the U.S.) but are extremely valued and respected within the community.

## Regulation

Like the vast majority of states, California does not regulate community health workers. In other words, there are no governmental requirements for entering into this profession and no regulatory recourse for members of the public who might have a complaint about a community health worker (there is no “license” that can be suspended or revoked should something go wrong). The lack of regulation may be due to the fact that, compared to doctors, pharmacists, dentists and other health care professionals, CHWs pose extremely low risk to members of the public; the higher the potential risk to consumers, the more likely the state legislature is to regulate a profession. Alternatively, the lack of regulation to date may be due to the newness and relative size of the profession. Generally, as health professional workforces expand in numbers and

evolve in their education and training, members of the professions often seek to obtain regulatory recognition for purposes of reimbursement and professionalization.

## Critical Issues and Policy Concerns

Several policy issues will likely frame the debates regarding the future of community health workers in California.

### *California Assembly Bill 1963*

The future of community health workers, including promotores, in California, will depend in part on expanded recognition and use of these workers in various settings. The California legislature is considering a bill that would encourage the use specifically of promotores in rural and agricultural settings to address health concerns. AB 1963 (Salinas, 2004) also offers for the first time a California legislative definition of promotor/a programs and legislative description of the services promotores offer. Under the legislation:

“Promotores de salud” means community-based programs which utilize trained community members who provide linguistically and culturally appropriate outreach, education, and access to services intended to improve health outcomes, particularly, but not exclusively, for agricultural workers in rural areas of the state.

To date, the bill has not raised much controversy and several organizations, including the American Federation of State, County, and Municipal Employees (AFSCME), the California Primary Care Association, and the California Nurses Association have registered support (no opposition is on file). The legislation, if passed, might considerably advance the use and recognition of promotores in California.

### *Mandating Credentials*

As noted above, Texas recently passed legislation requiring mandatory training and certification of CHWs/promotores who are compensated for providing a variety of community services. This move has been viewed as a positive and promising

one by some and a frightening precursor by others. The legislation will make it easier for employers, including public health agencies, and the public to know more exactly what credentials a CHW or promotor/a holds in Texas. However, the new certification requirements may result in limiting the number of CHWs/promotores who qualify and are able to continue to offer needed services in many communities. Other states are watching closely to track what impact the Texas legislation will have on community health care.

### *Funding*

An ongoing source of concern for CHWs and those who employ them or work with them is funding. Securing funding for CHW positions may be challenging, particularly in times of budget cuts and economic downturns. When funding sources are found, it is not unusual for them to be tied to specific diseases or conditions, unreasonably limiting or restricting the CHW's work. Even within the profession, there are splits regarding whether and how much CHWs should be paid. Some feel more comfortable with a volunteer model in which a CHW or promotor/a fulfills a civic or social responsibility to his or her community through service free of charge while others see the work as an important, community-based effort, but one which is still a job for which one should be compensated.

### *Integrating into Mainstream Healthcare*

While many CHWs and those who train or employ them would like to see better and more integration of CHWs into mainstream healthcare to realize the potential contributions CHWs may make to health outcomes in the US, there are also many questions and concerns about how best to integrate without compromising the core values and heart of community health work. Without better recognition and integration, CHWs risk being seen as marginalized workers providing a 2<sup>nd</sup> tier of health care to underserved communities. As noted by a advocate:

Individual CHWs have expressed their frustration at both a lack of respect from other health professionals and having “nothing to show” for their experience and training.<sup>35</sup>

However, becoming a part of mainstream medicine in itself might take away that critical and primary responsibility to the community. As discussed in one of the major reports on this field:

It is clear that the CHA field must be defined and standards articulated in order to pave the way to better integration of CHA roles into health systems. However, we caution against taking these fundamental issues too far from the hands of CHAs themselves.<sup>36</sup>

The issue of integration may put additional pressure on existing divisions within the CHW field as to definitions, goals, and purposes of the work.

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### California HealthCare Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, its goal is to ensure that all Californians have access to affordable, quality health care. For more information, visit us online at [www.chcf.org](http://www.chcf.org).



### The California Endowment

The California Endowment, a private, statewide health foundation, was established to expand access to affordable, quality health care for underserved individuals and communities. The Endowment provides grants to organizations and institutions that directly benefit the health and well-being of the people of California.

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