Professionalization and the Experience-Based Expert: Strengthening Partnerships Between Health Educators and Community Health Workers

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Professionalization and the Experience-Based Expert: Strengthening Partnerships Between Health Educators and Community Health Workers

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The recent inclusion of community health workers (CHWs) in the U.S. Department of Labor's 2010 Standard Occupational Classification System provides an opportunity for health educators to reflect on their relationship with CHWs. The authors discuss the ways that health educators and CHWs differ in their orientation toward professionalization and employ the concept of the "experience-based expert" to highlight what they believe to be the unique contributions of CHWs. Finally, considerations important for health educators and CHWs as they work to advance supportive and complementary practices are discussed.

Keywords: *access to health care; community organization; health education; lay health advisors; community health workers*

In January 2009, the Office of Management and Budget published a comprehensive revision to the Standard Occupational Classification (SOC) System, a job-related taxonomy used by the federal government to collect data about the national workforce. Health educators have been recognized since 1998 as a distinct occupation in the SOC, where they are grouped within "Community and Social Service Occupations," a category that also includes social workers, mental health and school counselors, religious workers, and others. With its most recent revision, effective in January 2010, the SOC has been expanded to recognize a new occupation in this division: community health workers (CHWs).

That CHWs have now been acknowledged by the federal government as a distinct occupation speaks to the growth of their practice in the ten years since the previous SOC system was published, but interestingly, the need for a unique job title for these workers was not immediately clear to those in the Department of Labor who manage the SOC system. The classification of CHWs in the 2010 SOC began in 2004 when the Department of Labor invited public input in regard to possible additions and revisions to the SOC. In response, the CHW interest group within the American Public Health Association (APHA) organized a request for the creation of a CHW classification and proposed a definition of that role, which they submitted in 2006. In early 2008, the Department of Labor issued a draft of the 2010 SOC in which, instead of receiving their own job title, CHWs were combined with health educators to create a compound classification titled "Health Educators and Community Health Workers."

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Neither health educators nor community health workers were pleased by the prospect of a shared title. Health educators argued that their occupation, which typically requires at least a bachelor's degree, is broader than that of community health workers' and encompasses not only health-related instruction but also program planning, management, and evaluation. Organized by groups, including the Society for Public Health Education (SOPHE), health educators wrote to the Department of Labor to oppose the new title and to express concerns that the compound classification would render workforce data collected about their occupation meaningless.

CHWs were equally unhappy with the shared designation. Although they too recognized shared ground with health educators, they wished to see the distinctive features of their occupation acknowledged. For example, they perceived a greater emphasis in their work on social support, service coordination and referral, and individual and grassroots advocacy. Working in concert with health educators, CHWs and their supporters also wrote letters to the Department of Labor, and the combined response constituted what was, according to one insider, the most mail the Department had ever received on a definitional issue of this kind. In the end, the appeals of health educators and community health workers were successful, and the proposed compound title was replaced with two separate job titles: Health Educators (21-1091) and Community Health Workers (21-1094; U.S. Department of Labor, 2010).

This incident, along with a number of recent commentaries about the role of community health workers, prompts us to reflect on the relationship between health educators and CHWs working in the United States. We are struck by certain similarities above and beyond each group's focus on health education. For example, both groups share an interest in facilitating relationships between health care organizations and the people those organizations are meant to serve. Both groups emphasize the importance of cultural context and the structural determinants of health as well as the need to address health disparities. Finally, both groups encompass a diverse set of practices and constituents and, in part for this reason, both groups have met challenges in gaining recognition and integration within the biomedically oriented hierarchy of the health care system.

Given these shared interests, why did a shared job title trigger such a response? As noted, health educators and CHWs do differ in terms of the duties they typically perform. Furthermore, health educators and CHWs are characterized by decidedly different relationships toward the professionalization of their practice. In this commentary, we wish to explore the nature and the implications of these differences in professionalization. We will introduce the concept of the "experience-based expert," which we feel is helpful in articulating and honoring the unique contributions of CHWs. Finally, we will note areas in which health educators and CHWs can support and complement each other's work, even as they occupy distinct job categories.

HEALTH EDUCATORS, COMMUNITY HEALTH WORKERS, AND PROFESSIONALIZATION

The concept of the profession has been variously defined in the sociological literature (see, e.g., Evetts, 2003) but has most commonly referred to an occupation that can be joined only after demonstrating the mastery of a well-defined set of knowledge and skills acquired through a rigorous and structured course of study. Based on their credentials and associations, members of a profession seek to distinguish themselves from amateurs or laypeople, and they are afforded greater autonomy, status, and often salary, based on this distinction. Given these benefits, the desire within various occupations to "professionalize" has grown over time. Whereas once reserved for a select few occupations such as medicine and law, the concept of the profession is now applied much more freely.

Public health education is one occupation in which this trend toward professionalization is evident. Organizations such as APHA and SOPHE serve as professional homes for health educators, advancing a code of ethics, publishing peer-reviewed publications, and holding continuing education meetings, all of which are meant to inform health education research and practice. At the same time, training programs such as some bachelor's, master's, and doctoral degrees in public health and certification tests such as the Certified Health Education Specialist (CHES) exam establish credentials that health educators obtain to demonstrate a structured

body of knowledge and skill. The goal of such training and certification is the betterment of the practice (Livingood & Auld, 2001), as well as the recognition and advancement of the occupation in terms of status and salary. Compared with medicine and law, the professional requirements of health education are flexible, and health educators have sought to make their practice inclusive of various disciplines and identity groups. Nevertheless, one risk of professionalization remains the exclusion of marginalized populations who are less able to meet the financial and cultural demands that often accompany formalized education and certification.

The role of the CHW has evolved in parallel with that of the health educator but is more ambivalent toward professionalization. Although most sources describe the emergence of the CHW field beginning in the 1960s, serious attention to CHWs as a distinct workforce did not begin until the 1990s when several notable articles attempted to define the CHW role from a programmatic perspective (see Love, Gardner, & Legion, 1997; Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). From this work a picture of CHWs emerged that emphasized their function as involving: (a) the linking of communities and health services systems, (b) the support of community assessment and application of assessment findings, (c) the provision of peer-to-peer social support, and (d) advocacy for marginalized populations.

Subsequent to this work, the National Community Health Advisor Study (NCHAS) attempted to systematically define CHW roles, functions, and training requirements by casting the work in distinctly professional terms (Rosenthal, Wiggins, Brownstein, Johnson, & Meister, 1998). Citing a dictionary definition of a profession as "a calling requiring specialized knowledge and often long and intensive academic preparation," the authors note that the preparation of a CHW

> not only includes training but also life experience. [CHWs] have a core of knowledge, based on their membership in the target communities they serve, that they bring with them to the system. . . . Because practitioners bring specialized expertise, the field can indeed be looked at as a profession. (Rosenthal et al., 1998, p. 2)

More recently, the national health care reform bill (PPACA) classified CHWs as "primary care professionals" under the purview of the National Health Care Workforce Commission (sec. 5101(i)(1)).

The desire to professionalize the CHW role is also apparent in various efforts to standardize their training and credentialing. For example, several states have established standards for CHW certification, including Texas and Ohio where certification systems cover all paid CHWs as well as Indiana and Alaska where certification programs apply to CHWs employed in specific settings. Minnesota has established training standards for CHWs whose services are reimbursable under Medicaid, and discussions are underway concerning the potential for certification of CHWs in a number of other states, including Massachusetts, New York, Michigan, Illinois, New Mexico, and California.

Despite these trends, it would be a mistake to interpret the progression of the CHW field as a linear evolution toward professionalization. For example, although some organizations have succeeded in uniting CHWs at the state level, efforts to create a national association of CHWs have had limited success. Furthermore, despite the aforementioned state-level certification programs, many CHWs continue to be viewed as ad hoc or casual hires who receive site-specific training and whose positions are often supported by short-term special project grants. Although some CHWs receive wages, others work as volunteers.

The incomplete professionalization of CHWs has been explained in at least two ways. Noting that CHWs are often members of the marginalized communities they seek to represent, some observers have noted that they are vulnerable to exploitation by health care systems in search of cheap labor (Maes, Kohrt, & Closser, 2010). Racial/ethnic minority status, gender inequality in the workplace, and CHWs' lack of traditional credentials are factors that can limit CHWs' ability to negotiate higher salaries and to raise the recognition of their practice among other service providers.

However, a second reason that CHWs have not been further professionalized may be internal resistance to this trend. Although the attitudes of CHWs toward professionalization have not to our knowledge been systematically assessed, our experience suggests that some CHWs are suspicious of such efforts. Recognizing that the social function of professionalization is, in part, the separation of members from "lay" others, some CHWs perceive such efforts to be in conflict with their mission to be advocates for their communities. As one CHW we know observed, "In many low-income and minority communities, there is the perception that 'the professionals' have repeatedly failed us. So why would we

[as CHWs] want to be like them?" In addition to the issues of representation and loyalty, some nonpaid CHWs have noted that they appreciate the flexibility and freedom that a volunteer position affords them. Such preferences have prompted some leaders in the field to encourage the conceptualization of the CHW role as a spectrum ranging from volunteers devoted to community advocacy and mobilization on one end to paid staff trained to work more directly and consistently with the health care system on the other (Cherrington et al., 2010). Thus, although CHWs as a group have established certain aspects of professional practice, the traditional model of professionalization seems conceptually inadequate to serve practitioners who value the emic perspective derived by their closeness to, rather than distinction from, lay populations.

THE CONCEPT OF THE EXPERIENCE-BASED EXPERT

In reflecting on this phenomenon and its implications for the relationship between health educators and CHWs, it seems that a different way of conceptualizing CHW practice is needed, one that captures the unique contributions CHWs make to the health care system. One widely acknowledged strength of CHWs is their ability to offer a different viewpoint on the problem of illness and the challenge of health promotion. From the perspective of science studies, CHWs can be understood to hold "local" (Geertz, 1983) or "situated" (Haraway, 1988) forms of knowledge, which are typically acquired through experience, rather than certification, and which reflect a particular social position in terms of race, gender, and social class. Thus, whereas health educators are expected to be knowledgeable about the etiology and epidemiology of a particular disease, CHWs are assumed to know the same disease in a different, socially contextualized way. For example, they may know how members of their community experience the pain of that disease or how they attempt to negotiate the power differentials inherent in the medical encounter. For CHWs who have a close, representative knowledge of their community vis-à-vis a health issue, this knowledge can be thought of as a form of expertise, making them what Collins and Evans (2002) would call "experience-based experts."

We believe that conceptualizing CHWs as experience-based experts holds several advantages over forcing the practice into the traditional professionalization model. First, invoking the term "expert" acknowledges that CHWs possess specialized knowledge and skills that are worthy of compensation and that can be built on through training and, where appropriate, credentialing. Second, using "experience-based" rather than the designations of "lay" or "professional" better articulates the basis of CHWs' expertise while at the same time avoiding terms, such as *paraprofessional* that some CHWs find inaccurate or even demeaning. Finally, in using "experience-based expert," we can better conceptualize how CHWs and health educators, who might be considered "credential-based experts," can best complement and support each other.

DEVELOPING COMPLEMENTARY PRACTICES

Continuing to think in terms of "experience-based" and "credential-based" expertise, we return to the Department of Labor's definitional misstep. Clearly, health educators and CHWs *do* occupy different jobs, so how might they best coordinate their efforts to achieve their shared goal of eliminating health disparities in health care settings? Answering this question will likely require attention to the articulation of occupational boundaries, and such a project is best accomplished through collaborative discussion between leaders in each camp. To prime such discussions, we wish to note contributions that health educators and CHWs make toward establishing a complementary practice.

As credential-based experts, health educators are able to contribute a set of specialized knowledge and skills to CHW programs that can improve their effectiveness. By bringing their knowledge of health behavior theory, literature review, program planning, and evaluation to CHW programs, health educators help CHWs maximize and demonstrate their impact on health-related outreach and counseling. Similarly, health educators play a role in pursuing research agendas aimed at establishing best practices in the field.

In addition to contributing to the development of CHW programs, health educators can support CHW practice by extending some of the benefits of professionalization to their CHW colleagues. For example, APHA has long served a role in organizing CHWs at the national level, and organizations such as SOPHE

can continue to encourage the participation of CHWs in professional meetings and publications. Similarly, academic degree programs in public health can serve as one opportunity for advancement in the "career lattice" for those CHWs who wish to pursue more professionalized practice (Love et al., 2004). More generally, because they may be more likely than CHWs to hold institutional affiliations, health educators can help connect CHWs with health professionals and academics as well as with institutional resources such as libraries and meeting spaces.

Of course, CHWs are well positioned to make contributions to health educators' practice as well. As experience-based experts, CHWs play a role in tailoring generic health education efforts to meet the needs of local audiences in terms of cultural competence, health literacy, and outreach. At the same time CHWs are an important, though often underused, source of evaluation for existing programs and can provide information about how people experience health care services. Finally, CHWs are a source of grassroots advocacy and as such can help connect health educators to community stakeholders and marshal the political influence needed to achieve shared goals.

CONCLUSION

The shared interests of health educators and CHWs position them as partners in health promotion. Given the recent attention to the articulation of the CHW role, the time is ripe for focused discussion between CHWs and health educators about ways of maximizing this partnership. By working to understand occupational boundaries and establishing formalized channels of communication, health educators and CHWs may be better able to coordinate their "experience-based" and "credential-based" expertise.

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