Podcast Interview Transcript

Sergio Matos

In each volume of Progress in Community Health Partnerships: Research, Education, and Action, PCHP editors select one article for our Beyond the Manuscript podcast interview with the authors. Beyond the Manuscript provides authors with the opportunity to tell listeners what they would want to know about the project beyond what went into the final manuscript. Beyond the Manuscript podcasts are available for download on the journal's website (http://www.press.jhu.edu/journals/progress_in_community_health_partnerships/multimedia.html). This Beyond the Manuscript podcast features Sergio Matos, of Columbia University Mailman School of Public Health's Heilbrunn Department of Population and Family Health. Matos, also of the Community Health Worker Network of NYC, is the coauthor of "Community Health Worker Insights on Their Training and Certification." Associate editor Barbra Bates-Hopkins conducted the interview. The following is an edited transcript of the podcast.

Barbra Bates-Hopkins: Can you provide a brief summary of your project including its purpose and any results you found?

Sergio Matos: Our purpose in conducting the study was primarily to utilize community-based participatory research principles to engage community health workers and their employers in discussions on three issues of major importance to the practice. First, we wanted to develop an identity for community health workers in New York City. That identity has been lacking, and there is a lot of difference in community health worker roles and tasks depending on their setting, their employer, and their locale. We wanted to help organize an employer voice to describe what that identity might look like.

Second, we wanted to identify existing training resources and what might be additional training needs from the perspective of both practitioners and their employers. And last, we wanted to examine possibilities for credentialing and financing of the community health worker practice, again from those two different perspectives. Most important, we were very aware of constantly wanting to have the whole process informed by both practitioners and stakeholders throughout. The results we found were really interesting.

We were, in fact, able to reach all of our purposes. We developed a consensus definition that included the fundamental qualities and essential elements of the practice from the two perspectives I mentioned previously. Second, we were able to very clearly identify some unmet training needs, particularly in the area of core competencies. We found very clearly that many are trained in the health-specific content of their programs. For example, if you are working in asthma you will probably learn everything there is to know about asthma or the same holds true for HIV and AIDS or maternal child health, but you do not generally receive much training in the core competencies that have come to describe their practice and the skill sets that they need to do their work. That was clearly demonstrated in our studies. We were also able to identify a lack of appropriate pedagogy in existing training resources so that many said that they were being trained with methods that were inappropriate for them and

were not really effective in helping them develop any capacities. Last, we were also able to outline characteristics of what a credentialed process might look like and specifically one that would support and advance, rather than become an exclusionary process, as often happens with credentialing processes. This was a major concern of many practitioners of the field.

Barbra Bates-Hopkins: Yes. In the manuscript you mentioned that the partnership was established after the leadership was convinced that the project would involve shared power, participation, and leadership. Were there particular challenges to getting any of the community or the academic partners involved in this partnership?

Sergio Matos: That is the million-dollar question, and it is a very relevant and important one. We did face numerous challenges, especially in our commitment to stay true to the spirit of community-based participatory research. When we started, we quickly learned that their experience is one in which their voice is usually not requested or heard or respected, for that matter. In general, they enter a program once—much after the program has been designed and implemented. They usually arrive late, and they are mainly concerned with catching up with timelines.

They are typically told what to do and not asked how to do it, so it was very challenging to gain their trust and understanding. We really wanted and needed their understanding and ideas. It took time. In discussions with community health workers, it took a significant amount of time for them to come to believe that we welcomed and wanted to implement their ideas and suggestions. In fact, we actually had to slow our whole process down to allow for them to come around to being willing and able to inform our project design. They were very helpful in helping us develop what questions to ask and, more specifically, how to ask them in a way that would get us appropriate, genuine information and that would respect the sources of that information.

Another major challenge that we faced was limited time and resources. Community health workers generally work in the field, and they work during all hours. They work whenever their population is available. So we had to be very flexible, both in our time and our meeting processes. We had to meet them on their terms and their schedules. It also really demanded that we respect their part, the community health workers' needs and ideas.

If they were only available to meet at 10:00 at night, and we had to meet in a Starbucks, then that is what we had to do. We had to alter our own methodologies to meet their needs. That flexibility was demanded both in terms of time, in terms of location, and in terms of our research methodology. We also faced significant resistance from CHW employers, particularly at community-based organizations and health department bureaus here in the city of New York. Employers were concerned about our purpose. They were concerned: Are we organizing them? What are we doing? What are we? There was a lot of concern about their own management and control of the practitioners, and we had to work very diligently at easing those concerns.

Last, I think we met significant resistance on the point of employers to release their employees to participate in the planning, implementation, and conduct of the survey and the interviews. Community health workers carry a huge workload and are burdened and time restricted. There was some resistance from employers on that, but once the community health workers were able to participate and they went back to their jobs, employers found them to be much more enthusiastic and empowered and so became more supportive of our efforts.

Barbra Bates-Hopkins:	Were there incentives that you offered them to participate?
Sergio Matos:	No, we did not pay participants to participate in the development of the survey or to conduct the survey. They did that on their own interests and volition. We did supply refreshments at meetings and planning meetings and design meetings.
Barbra Bates-Hopkins:	Would you talk a little about how your partnership acknowledged and worked through any issues of cultural competence and cultural sensitivity? I do not think you really touched on that too much.
Sergio Matos:	Let me talk about cultural sensitivity because I am not sure what cultural competence means or even if it is a thing.
Barbra Bates-Hopkins:	Right.
Sergio Matos:	But I can tell you, though, that we did not experience challenges in the implementation of our study. I certainly acknowledge that cultural sensitivity and respect are critical to any CBPR effort. However, I think that the process that we followed of involving CHWs and their employers in the design of the interviews and the surveys actually helped us to develop questions and methods that were both informative and culturally sensitive. Our methodologies foresaw those kinds of challenges, and we faced them upfront. For example, we considered some questions that people did think would be off-putting or would shut people down to contributing to the study, particularly questions around immigration status or country of origin. So, the community health workers really helped us to develop those questions in a way that was respectful and dignified. Involving them at the very beginning and respecting their ideas and suggestions really went a long way to avoiding these challenges. Although I have to tell you, they are important, and thank you for bringing them up.
Barbra Bates-Hopkins:	You mentioned plans for a more extensive survey in the next phase of your research. What are the next steps that are being taken or have been taken based on this work that you have done?
Sergio Matos:	We are continuing to circulate our findings to major stakeholders, including CHWs themselves, but also their employers, training institutions, policymakers, and state regulators. Of course, publication in your journal goes a long way toward broadcasting these findings. We are also very involved in getting input from these stakeholders on the appropriateness and applicability of our findings. So, having established these partnerships that we did to conduct the CBPR study, we continued to evolve those relationships by sharing information and continuing to get their input. We are also now reaching out to a broader sampling of CHWs and their employers. There were some sectors of the CHW practice that we were not able to reach given the limited time and scope of our earlier work, and so now we are reaching out to those segments that we were not able to reach previously. In a few months, we are going to extend our survey to other parts of New York State. A recent publication by the HRSA documented that there are about 8,000 community health workers in New York State. We are going to reach beyond the city limits here to try to reach out to some of those community health workers and start collecting their voices, especially community health workers that are working in the Native American nations in the New York State region.
Barbra Bates-Hopkins:	Can you describe in more detail your efforts to use your findings to influence policy or practice as it relates to the CHW training and certification?

Sergio Matos: This is also a central question and one of really significant importance for the development and stabilization of the community health worker field. Until very recently there was no labor category, no standard occupational category for community health workers in the United States. Their utility in improving outcomes, reducing costs, and adding value has been documented in the literature. But because of a lack of unified description or labor category, community health workers were hired by whoever wanted to hire them and put to do whatever the employer wanted, so there was no standardization. There were no standards for the practice, and there was no standard description.

In January of this year, the Department of Labor created a unique standard occupational category for CHWs. This was a huge accomplishment and the result of a national campaign led by community health worker organizations both locally and nationally. But as a result of this, now we do actually have a standard occupational category for CHWs, and it is unique to them. We plan to use our work to help describe this new occupational category and to start developing a community health worker identity and scope of practice that will go along with that occupational classification.

We are also using the results of our work to help inform regulators and policy makers at both the state and municipal levels on what might be potential strategies for creating a community health worker credentialing process that would both support the field and help develop it. We continue to work with employers and regulators to develop financing strategies and schemes that would help stabilize and support the field. As it stands, the field is mostly supported by soft money, grants, philanthropies, foundations, and contracts. The whole paradigm needs to change to create more stable financing strategies and we are using our work toward that end.

Barbra Bates-Hopkins: Are there any last comments that you want to share with our listeners about other aspects of the study that were not captured in the manuscript?

Sergio Matos: My main point was that community-based participatory research was really uniquely adaptable for this research, which addressed the growing interest in CHWs and their practice. The practice itself is quickly evolving as the health care system's interest and application of the model grows. And this work documents really the importance of CHW leadership of all policy and practice issues relevant to the field and the critical importance of local and regional CHW organizations in informing employers and regulators, funders, and other stakeholders, including policy makers, that might be interested in supporting the model. CBPR has afforded a way of collecting the voice of practitioners and to help that voice come to describe the practice. This is really important because regulatory efforts in other states have failed to embrace regulations that emerge without their voice. By using this process and being faithful to its principles, we have been able to faithfully collect some accurate and genuine information.