

Community Health Workers: A Guide to Developing and Implementing a CHW Program

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Second Edition September 2026



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Preface

A recent commentary entitled “The Innovation Health Care Really Needs: Help People Manage Their Own Health” provides disruptive guidance for all committed to building societal health – that of focusing energy and resources on helping individuals maintain health and self-sufficiency. It supports actively partnering with clients/patients, exploring their whole person needs and life settings, and responding proactively. The commentary cited examples, and the results were clear – better health and lower cost. (1)

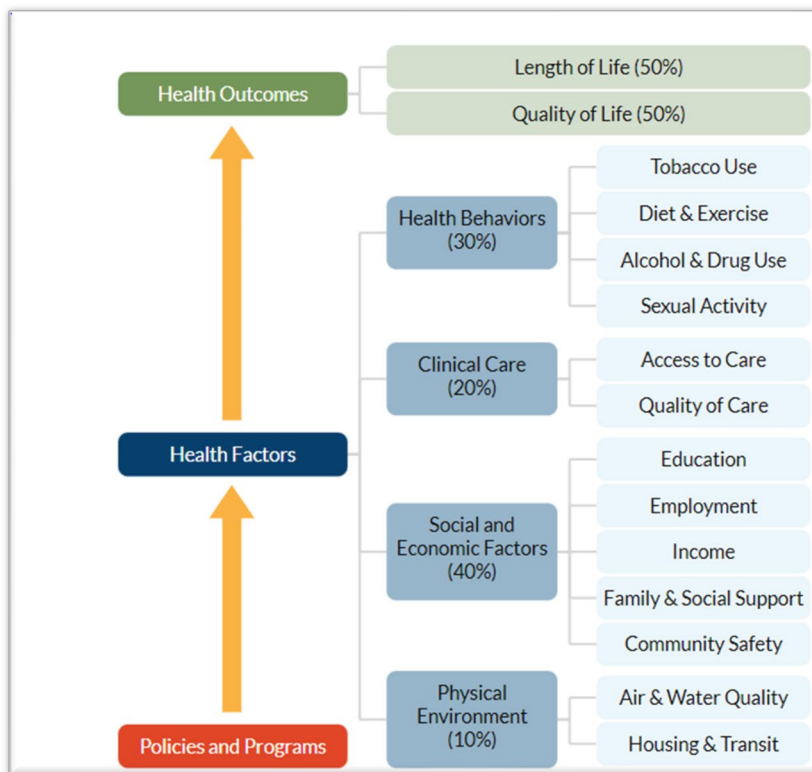
For too long, much of organized healthcare has kept its focus on the “medical model” and directed resources to maintain the status quo. This is despite the knowledge that medical care accounts for only 10-20 percent of controllable contributors to population health outcomes, while social and economic factors, physical environment, income, and modifiable health behaviors impact those outcomes at a level of 80-90%. (2)

Nowhere is the disparity between desired individual health outcomes and available health-promoting resources more apparent than in Black and Brown communities and other historically divested groups. The truth – access to healthcare services in the U.S. are not distributed evenly in the population!

“Despite spending over twice as much on healthcare resources than 11 other high-income countries, the U.S. ranks last in access, equity, and healthcare outcomes. The U.S. could make gains by investing more in preventing chronic disease. The high level of inequity in the U.S. healthcare system intensifies the problem. For the first time in decades, midlife mortality for less-educated Americans is rapidly increasing.” (3)

Increasingly, the healthcare community is focused on a new goal - impacting the health of total populations and achieving an environment of health equity. Creating the opportunity for everyone to have a fair and just opportunity to reach their maximum health potential is an extraordinarily complex goal to achieve. Health disparities (differences in health or key health determinants that adversely affect historically divested groups) must be reduced and even eliminated. Measurement of reduction in disparities provides a critical metric for assessing progress toward equity. (4)

Adverse impacts of the Social Determinants of Health (economic and social factors found where we live, work and play) lead to health disparities, and those in healthcare now understand that these factors must be addressed in order to truly improve health outcomes for the long term. The following chart, from *County Health Rankings and Roadmap*, illustrates this in graphic terms. While various factors impact our health, the Social Determinants of Health have the greatest impact on outcomes (40%). More than that, these factors often influence health behaviors (30%), and those with greater numbers of determinants are also more likely to be negatively impacted by their physical environment as well (10%). Considering these health factors together speaks to the steep hill healthcare must climb in order to reach the ultimate equity goal. (5)



County Health Rankings and Roadmap

While strategies to improve the quality of care delivery are many and varied, there is a growing body of strategies aimed outward and into communities. CHWs are a viable and important workforce that needs to be supported and needs their work expanded upon.

According to the American Public Health Association and the World Health Organization, a Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community and allows them to facilitate access to services and improve the quality and cultural competence of service delivery. In situations where the community being served is defined by race or culture, it is best practice for CHWs to be members of that race or culture to ensure the effectiveness of their role.

The presence of the CHW workforce is not new, but it has seen rapid growth nationally in recent years. And, while infrastructure to support the integration of CHWs into organizations and care teams are constantly being developed, there is more work to be done.

Introduction

Compelling evidence supports working with Community Health Workers (CHWs) to improve individual and community health. Working primarily in community-based and healthcare provider organizations, CHWs bridge gaps between individual needs and social and health services. CHWs combine lived experience, a commitment

CHWs combine lived experience, a commitment to equity, and a deep understanding of their communities to build trust and strengthen communication between individuals, systems, and service providers.

to equity, and a deep understanding of their communities to build trust and strengthen communication between individuals, systems, and service providers. In an ideal model, CHWs mirror the communities that they serve and can provide culturally and linguistically responsive services. Effective CHWs also prompt service providers to put in the work to build and reclaim trust with harmed individuals and communities that may have been long missed or unattended.

CHWs do their work under a variety of job titles and may perform focused tasks based on the priorities of their employing organizations. However, their common work activities define the profession: bridging gaps between individuals and providers; navigating health and social service systems; advocating for individual and community needs; providing direct services;

building individual and community capacity; and building organizational capacity for serving their communities in more effective ways.

The need for this common work from community to community is profound, especially where health disparities are most evident – Black and Brown communities, historically divested populations, rural communities, and vulnerable groups. These disparity fault lines were already growing, but the COVID-19 pandemic exacerbated and brought these growing disparities to light. In response, social service and healthcare organizations aggressively employed CHWs to address the complex needs of these groups. Growth of the CHW workforce promises to be greater than many other frontline healthcare professions from 2020-2030: 18.1 percent by 2026. And those projections may be underestimated. (6)

While several states – California, Texas, North Carolina, and Colorado – have a history of embracing training and supporting CHWs, widespread understanding of the CHW profession is in its infancy in many states and communities. Organizations committed to hiring CHWs rightfully have questions.

- What qualifications should candidates possess?
- What training should they have?
- How do you effectively supervise a CHW?
- How do you recruit CHWs from the communities they'll be serving?
- How do we evaluate our CHW's work? How should they be compensated?

The National Academy for State Health Policy publishes State Community Health Worker Policies at <https://nashp.org/state-tracker/state-community-health-worker-policies/>

Purpose of the Community Health Worker Implementation Guide

The purpose of this *CHW Implementation Guide* is to answer these key questions and provide a basic reference for employers and leaders in healthcare and social service organizations on CHW program development – for both new and developing CHW initiatives. It is a concise toolkit to advance the understanding of the CHW workforce and offer insight into employing and working with CHWs to advance individual and community health. While the guide references activity in Iowa, where work with the CHW workforce is generally underdeveloped, it provides an orientation to key CHW program elements for those in other states and regions. The intent of this guide is not to reinvent the wheel. There are existing resources that can also be utilized referenced throughout this guide.

The nonprofit HealthTeamWorks, previously Iowa Chronic Care Consortium (ICCC), offers this guide as a part of its deep belief in the value of CHWs to transform population health outcomes and its interest in furthering capacity among organizations in utilizing this workforce. In 2017, ICCC, now HealthTeamWorks, embarked on a learning journey with partners across Iowa to advance the understanding and use of CHWs' unique skills utilization of CHWs in a variety of organizations – public health, social service, and healthcare. Its founding of the Iowa CHW Alliance led to a first-in-Iowa training for CHWs, research on key CHW issues, a foundation-supported CHW demonstration project, a Department of Labor-approved CHW Registered Apprenticeship Program, a Community Health Navigator Training, a CHW Professional Skills Training and specialized trainings for CHWs in oral health, diabetes, health disparities, asthma, maternal health, behavioral health, community integration for those with disabilities, and COVID-19 and vaccinations promotion.

HealthTeamWorks launched a new 45-hour CHW Professional Skills Training in 2023. It includes approximately 25 hours of asynchronous training with five courses, four, 90-minute live learning sessions; continuing education credits for designated healthcare professionals; testing; selected homework; and includes full instructional compliance with the C3 Project Consensus Guidelines developed for CHW training (www.c3project.org). HealthTeamWorks believes this training to be right-sized, comprehensive, engaging, highly accessible to participants, and priced economically to prepare competent, confident CHWs to serve individuals and communities effectively.

Through work with great partners and more than 250 working CHWs who have advanced through its trainings, HealthTeamWorks has continued learning and developing a focused strategy to advance the CHW profession. This guide is part of that strategy.

Chapter 1: Understanding the Community Health Worker Role

1

Chapter 1 defines Community Health Workers (CHWs) by outlining their primary roles and competencies, identifying the healthcare professionals who benefit from CHW support, and describing the related roles that may also fall under the CHW designation.

- Defining Community Health Worker
- Exploring various position titles held by CHWs
- Understanding the roles and skills of CHWs based on organizational objectives
- Defining roles parallel to CHWs
 - Disability services
 - Substance use reduction initiatives
 - Early childhood development programs
 - Mental health care services

Community Health Worker, Defined

Community Health Workers (CHWs) are frontline health professionals purposed to advance public and population health. CHWs' specific job titles, employers, roles, responsibilities, and populations of focus vary widely. The central tenet of the role is that CHWs are trusted members of (or possess knowledge of and relationships with) the communities they serve – with this measure of trust best being determined by the community. This mutual positive regard established with the community enables outreach to individuals and families through education, navigation, informal counseling, social support, care delivery, and advocacy. CHWs foster connectivity between health/social services, community services, and individuals, especially for underserved, historically divested and vulnerable populations. CHWs provide their services wherever the community member lives, learns, works, socializes, or heals, in a culturally and linguistically affirming manner to inspire self-advocacy and achieve better health.

Community Health Worker (CHW) is an umbrella term. Their job titles are as diverse as the communities they serve, from city, to suburb, to rural, to frontier communities. The common elements of this effective and diverse workforce are their capacity to forge connections between individuals and health/social service systems, foster trust between individuals and service providers, and improve the ability of health/social service systems to provide quality, culturally and linguistically centered care resulting in better health. (7)

Despite the common intentions for the work and service of CHWs, they are employed under a variety of diverse position titles. Examples of those commonly in use for CHWs include the following:

- Community health advisor, Promotora, Promotor de salud, public health worker, lay health worker, outreach worker, outreach specialist, community health representative (CHR), community health navigator
- Community health advocate, community health representative, community health promoter, community connector, community health outreach worker, community health advisor, community health educator, community care coordinator
- Peer educator, peer counselor, peer support worker, peer health promoter, lay health educator, lay health advisor, neighborhood health advisor
- Casework aide, health aide (or community health aide), public health aide, environmental health aide, patient navigator, family support worker, dental health, health coach, navigator, intake specialist, home care worker, care coordinator, family advocate (8)

CHW Roles and Skills

Moving beyond definitions and position titles, the roles and skills of CHWs give meaning and dimension to the work being performed, the training essential for CHWs, their practice talents, and their broad scope of work. *The Community Health Worker Core Consensus Project*, a national project engaging CHWs, stakeholders, and allies since 2014, has studied and researched the CHW workforce and practice to advance the profession. They have advanced what has become a national standard for CHW scope of practice and CHW core skills and qualities. The 10 roles outlined below offer an inclusive list of functions that CHWs may perform. The scope of practice for any given CHW program will vary based on the organization's goals and intentions for their CHW program and the needs of the community being served.

CHW Roles and Scope of Practice	CHW Competencies and Skills
1. Cultural mediation among individuals, communities, and health and social service systems 2. Providing culturally and linguistically appropriate health education and information 3. Care coordination, case management, and system navigation 4. Providing coaching and social support 5. Advocating for individuals and communities 6. Building individual and community capacity 7. Providing direct service 8. Implementing individual and community assessments 9. Conducting outreach 10. Participating in evaluation and research	1. Communication skills 2. Interpersonal and relationship-building skills 3. Service coordination and navigation skills 4. Capacity-building skills 5. Advocacy skills 6. Education and facilitation skills 7. Individual and community assessment skills 8. Outreach skills 9. Professional skills and conduct 10. Evaluation and research skills 11. Knowledge base

Greater insight into the roles and the skills outlined above are readily available at <https://www.c3council.org/>. The descriptions of the roles and skills aid in the understanding of these broader category listings and their meaning in the practice of CHWs.

Broader Opportunity for CHWs

The skills essential for competent CHWs are not unique to CHWs. There are several parallel roles that fall under the umbrella definition of CHWs, yet are not commonly thought of in the same way, generally because they work in a different service area outside of traditional healthcare or public health. There are a variety of examples in the peer support specialist arena, including:

- disability services - where family members or persons with disabilities mentor and support others;
- in substance use disorder or harm reduction services - where peer recovery coaches support those in treatment;
- in early childhood education, where home visitors support families of young children;
- in the mental health arena, where trained peers assist others with system navigation;
- and in woman's reproductive health, where doulas offer support through pregnancy, delivery, and beyond.

Professionals who benefit from the CHW skill set and meet the umbrella definition of community health worker are those providing client-facing services and support in healthcare or social services, such as:

Care coordinators, case managers, medical assistants	Those tasked with engaging clients/patients in preventive care or establishing medical homes, and linking clients/patients with services and supports to improve functioning, stability, and/or wellbeing
Home visitors	Workers who provide in-home education and support to individuals and families, such as early childhood, maternal health, homemaker and other services
Doulas	Trained professional companions who offer emotional support and assistance to clients/patients through childbirth, end of life, or other profound or traumatic experiences
Peer workers	Those providing encouragement and assistance to achieve long-term recovery in disability, substance use disorder and mental health arenas
Allied professionals	Includes direct care workers, language interpreters, patient navigators, and patient advocates

Chapter 2: The Case for CHWs

2

Keeping up with the demand for CHWs through workforce predictions and the necessity driven by evolving circumstances is vital for communities they serve. Contemporary demand for CHWs is substantiated by evidence indicating that CHWs are highly valued and essential within both medical and social institutions.

- Demand for CHWs
- Recognition and Interest from Medical Care
- Workforce Projections for CHWs
- Case Studies of Circumstantial Demands on CHWs
- Evidence Supporting the Value of CHWs Through Empirical Research
- Real-life Accounts Demonstrating the Value of CHWs in Various Situation

CHW Workforce Demand

The fact that there is little commonality in job titles among those doing CHW-like work, and that CHW roles exhibit diversity is a common source of confusion within states and nationally. While this hinders the ability of workforce analysts to provide specific predictions, evidence of the need and workforce demand is timely, apparent, and accelerating for several reasons.

- 1. Medical Care's Recognition and Interest.** In response to the needs described above, social and community service agencies are expressing the need for the type of strategies and workforce typically described as the work of CHWs. Health and medical care organizations are at the forefront in this surge in demand. As healthcare takes on increasing risk for patient outcomes as a path for payment, as some Medicare and Medicaid members are attributed to healthcare providers in Accountable Care Organizations (ACOs), and as the practice of population health becomes more missional, health and clinical systems are realizing that limited clinical gains will be achieved without addressing social needs. This breaks from a long-term provider habit – when faced with poor outcomes, simply provide more medical care. Deploying CHWs responsible to forge connections between patients, healthcare, and supportive social services has become an essential strategy. Healthcare and medical teams have thus accelerated their plans for employing CHWs.
- 2. Workforce Predictions.** CHWs are projected as one of the fastest-growing healthcare workforce occupations in the U.S., with a predicted 17 percent increase in the workforce between 2020 and 2030. This is much faster than average for other health occupations (*Bureau of Labor Statistics, US DOL*). The Health Resources and Services Administration (HRSA) also projects an increase in total demand,

Healthcare's recognition of CHWs is growing. Health systems increasingly recognize that improving health outcomes requires addressing social needs, not just providing more medical care. CHWs help bridge healthcare and community services to support better outcomes.

estimated at 11 percent between 2016-2030 (*HRSA Workforce Projections*). Compensation levels are reported with a national mean annual salary of \$49,900 for CHWs. In the State of Iowa, the mean salary was \$46,300 or \$22.26/hr (*Bureau of Labor Statistics, US DOL, May 2022*). A host of emerging Federal initiatives in the American Recovery Plan Act (ARPA) encourage and support working with CHWs. The Affordable Care Act (ACA) allows for Medicaid reimbursement based on a state's Medicaid Plan provisions.

3. **Equity Initiatives.** Creating effective equity strategies is a clear interest of public health programs and funders at the local, state, and national levels. Deploying sustainable approaches beyond point-in-time grants that align with their own program initiatives or community needs is often a complex and challenging process. This does not mean it is not worth doing. Government public health, workforce development, and Medicaid programs have policies and mutually inspired interests for advancing equity in ways that can be sustained over the long term.

By thinking broadly about the front-line, direct care professionals that fall under the CHW umbrella term, policymakers, employers, and CHW allies can lead the creation of a system of informed, trained professionals that can quickly and effectively establish relationships with those in need of connections and support.

Evidence of CHW Value

There is clear evidence of the value CHWs add when effectively deployed in both social service and healthcare organizations. The following examples affirm that effective CHW deployment and interventions lift the health status of individuals and communities and lower the cost of healthcare.

- *University of New Mexico and Molina Health* – Program in a Medicaid-managed care organization where CHWs were reimbursed for care navigation, care management, and increasing access for patients with complex medical and social needs. Against a matched control group, the return on investment (ROI) was 3:1, with substantial savings driven by reduction in healthcare utilization. (9)
- *Children's Hospital of Boston - A Community Asthma Initiative* found that the use of CHWs resulted in a 65 percent reduction in emergency department visits and an 81 percent reduction in hospitalizations. (10)
- *Wilder Research* - A study of CHWs in cancer outreach showed how benefits generated by CHWs dramatically offset the investment. Each person served by a CHW generated \$12,509 per year in net present benefits, with 54 percent of benefits resulting from increased efficiency in healthcare utilization and 46 percent of benefits accrued in value of years of life not lost. (11)
- *East Texas* - Two healthcare systems moved to employ CHWs to work with patients in their emergency department (ED). Reducing future ED visits and hospitalizations, and generally lowering healthcare utilization yielded a return on investment ranging from 3:1 to 15:1. (12)
- *Nevada CHW* - Health Plan of Nevada (HPN), a United HealthCare Services, Inc. managed care organization, conducted an ROI study with three CHWs serving an average of 37 high utilizing patients over short intervals of 60-90 days over a 14-month period. Average medical costs decreased from \$1,223 to \$983 for the CHW service periods, yielding a 1:1.81 ROI with all costs considered. (13)
- *CMMI Meta-Analysis* - The Center for Medicare and Medicaid Innovation conducted a meta-analysis of CMMI Health Care Innovation Awards (HCIA) made in 2012-2015. This investigation of 108 care delivery models revealed that only those using CHWs lowered costs at a level of \$138 per beneficiary per quarter. (14)

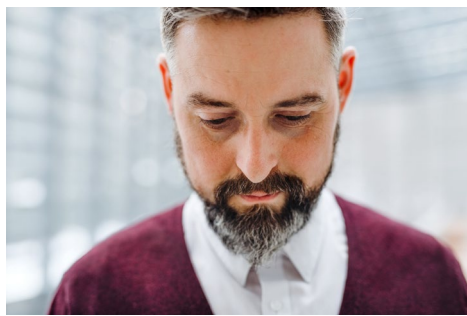
These examples offer a sample of the evidence supporting the value of CHWs in improving health and lowering healthcare costs. More than 570 studies of CHWs were conducted between 2014 and 2016, most of which report a positive impact on clinical, cost, self-sufficiency, or client/patient experience.

Additional Related Resources

- *Community Health Workers: Evidence of Effectiveness*. Association of State and Territorial Health Officials (ASTHO) and National Association of Community Health Workers (NACHW) 2021
- *Addressing Chronic Disease through Community Health Workers: A Policy and Systems Level Approach*. Second Edition. Center For Disease Control and Prevention (CDC). April 2015
- Landers, S., & Levinson, M. Mounting Evidence of the Effectiveness and Versatility of Community Health Workers. *American Journal of Public Health*, 106(4), 591–592. 2016.
<https://doi.org/10.2105/AJPH.2016.303099>
- Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment. *Health Affairs*, 39(2), 207–213. <https://doi.org/10.1377/hlthaff.2019.00981>

Real Stories of CHW Value

The work of CHWs is often very personal. Nowhere is the sense of CHW value and impact more evident or more meaningful than through personal stories of a CHW's interventions with those they serve. The following stories are excerpted from experiences collected from CHWs participating in HealthTeamWorks' CHW Professional Skills Training program, which began in 2019 under ICCC. Participants were invited to share experiences that describe the impact they have on the individuals and families they serve, or to share lessons they learned from their work, even if the lesson is the result of a situation that did not go as well as hoped.



Middle-Aged Man

A gentleman was referred to our hospice agency with a diagnosis of throat cancer. He was a very reluctant patient, having poor experiences with hospitals and healthcare in the past. In fact, I remember my coworker working with him as an inpatient and her statement of how difficult he was to work with. With him being admitted to hospice services, our goal was to keep him comfortable through his death and ensure he had caregivers and resources to meet his needs as well.

He was pretty resistant at first. His answers to every question I asked were short and gruff. I remember I finally told him, "I am here for you, and everything I am doing is to help your situation. You can choose to accept my help or not." This was a game-changer for him, and his entire attitude shifted. He cooperated with everything I asked, which was complicated as we applied for Disability and Medicaid. He always answered my calls. We were able to establish a regular monthly income and food stamps for him. He received Medicaid funding. He utilized Medicaid-funded transportation. And the thing is, he got better. He didn't meet the goal of hospice of death with dignity. Instead, he improved his life and lived many more quality years.

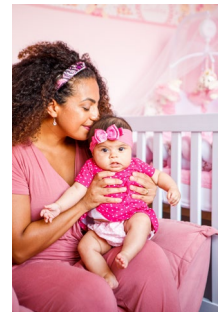
The lesson I learned is to not judge by the experience of others. Each experience is unique. I also learned that shifting the power back to the client can make things happen for everybody involved.

Eighteen Year-Old Woman with Newborn

I met a young woman when I was new to working as a hospital social worker/discharge planner. This mom and her infant had been readmitted to the hospital after discharge from delivering the baby. The baby was diagnosed with failure to thrive. The doctor managing care ordered a social services consult.

I had no idea what I was supposed to “do” for this patient. But I knew we could connect as my daughter was just a few months older than her baby.

And that’s where we started, just talking about our babies. Through conversation, I was able to assess that the mom needed guidance and teaching most of all.



We set her up with the county public health to work with parenting and weight gain for baby. We also referred her to local parenting classes. I informed the mom she could call me whenever she had questions or concerns, and I’d point her in the right direction.

That is exactly what the mom did. When the baby was younger, she would frequently drop by my office to visit and let me see the baby. This continued as she added another child to her family and as the children grew. It’s only within the last few years that the mom doesn’t stop by anymore.

I learned that you don’t have to have all the answers right away, but it is important to hear the story. You can never underestimate the difference you make to someone. I thought I’d done nothing for her, but I clearly made an impact.

Middle-Aged Oncology Patient

A woman was referred to me as staff had labeled her as “difficult”. She was at least a year out from her treatment but was still very demanding, angry, and questioning of staff. Complicating the situation is that she was also an employee at the hospital where she receives care.

I had had my own experiences with this person, so I’ll be honest that I was dreading following through with this referral. I reached out to her and encouraged her to attend A Time to Heal, the cancer rehabilitation class we offered. Surprisingly, she accepted and didn’t miss a single class. Through the lessons in class and sharing with others in the group, she was able to reframe her cancer experience and let go of a lot of the anger and bitterness she was still carrying from her experience. Her overall demeanor with me and with our clinic was improved. She appeared much happier to everyone.

This client offered a lesson in perspective. I had to understand the client’s story to help her to process the strong emotions she had related to it. This situation also showed me it’s always best to be kind to people as we don’t know what they have gone through.

Middle-Aged Woman

A client was a home health patient referred to me for a multitude of issues. This woman lived with her husband, son, daughter-in-law, and twin grandsons in a dilapidated house in a very small town. The client had recently had surgery and was needing home care during her post-op period. As nurses often say, my referral was to “fix it” (her situation).

This home was one of those visits where you really don't know where to sit or what to touch. But I made myself comfortable on the sofa next to the client anyway and figured I'd deal with whatever I might get on me. She started to tell me about her illness and surgery, and as we talked, more and more came out. The client had a laundry list of things needing addressed, and we methodically worked through them. We applied for disability as it was evident that she wasn't going to be able to go back to work. In doing this, I learned the client had been treated quite poorly at her last employer and was possibly wrongfully terminated. This brought a referral to Iowa Legal Aid to investigate. The client and family had been burning wood to heat the house but were not able to do that this year as her husband's health problems had prevented him from being able to stockpile any wood. This brought about a referral to a local community action agency, and we were able to get a new furnace installed into the home for the family. The client had a positive attitude through all of this despite the many hurdles we faced. It seemed as though we'd tackle one issue, and a new one would present itself.

The client's health continued to improve, as did her social situation. Her wrongful termination lawsuit was settled, and she was able to purchase a van for transportation (they'd previously had no transportation). She qualified for disability and was getting a monthly income. Her home was now heated. The family had seen a decrease in their level of stress.

Medication Assistance

Today, I was able to see a patient that wanted to get some questions answered about his coverage options with a disability. During the appointment, he decided to open up a little bit more with me. He gave me his background story, and how him and his son left a domestic household and became homeless. He told me about his last appointment at our facility and that his provider prescribed medications for his depression. After talking to him a bit more, he told me that he was really excited to get his mental health back on track until he tried picking up the prescription and wasn't able to afford it. After looking through his chart to find out what he may be eligible for, I saw that he was part of the Homeless Program. We took a walk down to the pharmacy, and he explained his situation. He told was by pharmacy staff that they would transfer his prescription to our facility's pharmacy and there would be no charge for the medication!!! He was trying very hard to hold back his tears, but after walking him outside, he broke down. He was so grateful for all our facility has done to get him on a better track mentally, financially, and physically.

Middle-Aged Micronesian Woman

A woman's family brought her to the clinic as she and her family were new to town. The client has diabetes and was living in a two-bedroom house with nine people. I helped her and her children get insurance (kids Medicaid/Mom marketplace). I helped her complete paperwork to assist with housing, we applied for food assistance and the Women, Infants and Children (WIC) program, and applied for financial assistance at area hospitals due to many bills.

After a while the patient did not follow through with return appointments, so healthcare and other assistance ended. Because she didn't reconcile her taxes, she lost her insurance. I continued to work on building rapport and encouraging follow-through, even though she was "difficult." I made house calls and noted there was no heat in the home, so I referred her to LIHEAP. Eventually, the patient was approved for ongoing for herself also.

She and her family were able to get a bigger home and have heat. She did complete diabetic education but is still working on her condition and choices. Two of the kids have graduated from high school, and one is working full-time.

In addition to the services we got lined up, the local school helped a lot as the kids in the home needed encouragement with attendance.

The biggest challenge with this family was the patient's very laid-back attitude, as she just didn't seem to have motivation to follow through, even though she and her kids were in very poor conditions. This case really showed me the value of relationships and persistence since the kids stood to benefit so much.

Woman from Eritrea

A pregnant woman and her two children moved to the area. Her landlord is on the organization's board and suggested she come to the organization for help. We assisted her to get Medicaid for herself and her children so they could get into school and she could get prenatal care. We helped with SNAP and financial assistance (FIP). Since she had no income for a while, we helped with section 8 housing, and she was able to move from a one-bedroom to a three-bedroom apartment. At the present time, she has used the FIP program to get a job and will be expecting a new (healthy) baby next month.

The patient speaks Tygrena, so language was a barrier. Though we have a shortage, the client needed housing, so we had to walk through the application process for funding despite her inability to read or write. She also needed help even getting around town since she was new to town.

The family moved into larger housing. The children are in school and work, and the family is in a better situation to welcome a new addition.

Referrals were made to WIC, FIP, SNAP, Medicaid. And we worked with the school to get TB testing and updated vaccinations so the children could enroll.

Our organization doesn't provide prenatal services, and it is hard to believe that pregnant women today can go without care. To see it firsthand was frightening - especially when it didn't have to be. The amount of paperwork required to get housing assistance sets some people up for failure.

Chapter 3: Designing Your CHW Program

3

Numerous models for developing CHW programs exist. **Chapter 3 presents several models along with supplementary resources and tools necessary for the initial deployment of CHWs within the organization.** It outlines the essential components for establishing a successful CHW program and concludes with methods for measuring success through the evaluation of CHW performance and data collection.

- Explore a variety of models for implementing CHW programs
- Develop tools for establishing a CHW program
- Identify essential elements required for the successful establishment of a CHW program
- Conduct evaluations of CHW programs

Models for Deploying CHW Programs

CHW programs are developed around a variety of models commonly tailored to meet the needs of the communities that they serve. Organizations engaging or employing CHWs often have a clear sense of those needs, such as improving access to care, improving education, building self-advocacy, mitigating risks, improving specific health outcomes, or advancing equity. The choice of model an organization develops typically reflects its mission, assessment of the community situation, and sometimes funding source. The models described below are organized around the six models originally identified by the Health Resources and Services Administration (HRSA) and updated by HealthTeamWorks to reflect contemporary practice. (15)

1. *Lay/Volunteer Health Worker Model* – These CHWs are usually members of the targeted population, sharing similar social, cultural, ethnic, or economic characteristics. They advance a trusting relationship with the community as an advocate, educator, mentor, translator, navigator, or outreach worker. An example is the Promotora model often used in Spanish-speaking communities.
2. *Care Delivery Team Member Model* – A rapidly growing segment of CHWs are being employed in this model where they are embedded or partner with medical professionals to address evident social determinants of health and/or provide appropriate direct care services. This may include screenings, referrals, health measurements/assessments, or other basic services. This model works most effectively when the CHW is integrated into care plan decision-making of the provider or clinic.
3. *Care Coordinator/Manager Model* – CHWs in this model often support at-risk or medically complex patients to navigate the healthcare system while attending to social determinants of health issues impinging on the desired health outcomes. CHWs may serve as a liaison with social service and community-based organizations for a healthcare provider organization, coordinating transportation, making appointments and tracking patient progress over time. They may serve to assist those being discharged from the hospital toward improved transitions. In this model, CHWs are often teamed with a medical professional and may receive disease-specific training.

4. *Health Educator Model* – CHWs in this model often focus their health education and related work on populations with specific conditions or broadly on those with chronic conditions providing screenings, coaching toward healthy behaviors, provider follow-up, nutrition guidance, navigation of health system and referrals to needed community resources. CHWs in these roles are most effective when they provide this work in a culturally appropriate way.
5. *Outreach and Enrollment Model* – This model has similarities to the Health Educator Model, with added outreach and enrollment tasks that may take the CHW into the community and individual homes. There they may provide home or environmental assessments, promote child and maternal health, conduct disease-specific assessments, offer advice, and enroll individuals into specialized social service programs.
6. *Community Organizer/Capacity Builder Model* – The community organizing/capacity building CHW may have direct contact with patients or clients, yet often plays a larger role in promoting new programs, advancing evidence of priority community needs, building coalitions, or developing policy proposals. Much of their work centers on building relationships with government, education, grassroots organizations, faith-based communities, and others to shape a coordinated approach to addressing the needs and disparities of the community. Requirements for CHWs in this model include networking, presentation, and leadership skills, along with a thorough awareness of the problems they seek to solve.

Additional Related Resources

- *Community Health Worker Programs: A Case Study Compendium*. Advisory Board. Population Health Advisors. 2018
- *Promoting the Health of the Community: Community Health Workers Describing Their Roles, Competencies, and Practice*. J. St. John, S. Mayfield-Johnson, W. Hernandez-Johnson. Springer 2021

Developing a CHW Program

Organizations considering the deployment of CHWs for the first time or the installation of a CHW program are well served by some good basic planning. Hiring a CHW without the context of program expectations limits the potential of the new CHW and of the CHW program experiencing success and desired impact. Thoughtful steps such, as those outlined below, pay dividends and add to the promise of a CHW program as a valuable intervention.

- Identify program intention through community assessments or defined community needs that warrant response – consider the above-referenced *Models for Deploying CHW Programs*.
- Consider funding at hand and reimbursement or payment options to make the CHW program sustainable over longer periods of time.
- Explore and study CHW culture and understand how to effectively support and engage this workforce authentically.
- Evaluate how the organization or community currently documents and measures health-related social needs – for the organization and for clients/patients.
- Set program goals. Is the focus on addressing health-related social needs, advancing community engagement, improving client/patient activation, increasing the use of preventative care, providing nutrition coaching, or enrolling at-risk populations in key programs?
- Consider intended program outcomes. Start with the end in mind and create a strategy with measurable goals.
- Determine how the organization will measure success. Can a return on investment be demonstrated?

- Plan for bi-directional feedback – create a path for CHWs to share what they have learned from the community so the healthcare ecosystem/organization can be more responsive to community needs.
- Consider equity for the CHW, as they fill the essential gaps left by the system, are often the experts on what is needed to improve health outcomes, and yet are often compensated at lower levels within the organization.
- Specify how CHWs will be trained, managed, supported, and involved in CHW program quality improvement.

Elements of Successful CHW Programs

A practical checklist for CHW program development and operation has been developed in a report developed by Community Health Works. This original checklist touches on a variety of key considerations for building a successful approach. It has been adapted for use in this Guide by HealthTeamWorks. (16)

Completion	Task	Description
	Recruitment	How and from where a community health worker is identified, selected, and assigned to a community.
	CHW role	The role's alignment, design, and clarity from community, CHW, and health system perspectives. Clarity of role is pivotal and essential.
	Initial training	Training is provided to the CHW to prepare for their organizational role and ensure that they have the necessary skills to provide safe and quality services. Identify in-person, virtual, and hybrid opportunities; explore language needs.
	Continuing training	Ongoing training is provided to update CHWs on new skills, reinforce initial training, and ensure they are practicing skills learned.
	Equipment and supplies	The requisite equipment and supplies are available when needed to deliver expected services, including computers or tablets, access to the Internet for work in the field, printers, transportation and office space when needed.
	Supervision	Supportive supervision is carried out regularly to provide feedback, coaching, problem-solving, skill development, and data review. Supervision, especially if not by a seasoned CHW, can stifle creative solutions and impose harmful hierarchies.
	Individual performance evaluation	Evaluation to fairly assess work during a set period of time, and specifically what is being assessed.
	Incentives	A balanced incentive package includes financial incentives (such as salary, tuition reimbursement, and bonuses) along with non-financial incentives (such as training, professional development, conferences, recognition, certification, uniforms, and other items appropriate to the job expectations).
	Community involvement	The role that the community plays in supporting a CHW. Selecting a CHW directly from the community, having the community participate in selection, and ensuring opportunities for CHW engagement in community activities are features of community involvement.
	Referral system	A process for determining when a referral is needed, a logistics plan in place for transport and funds when required, and a process to track and document referrals.
	Opportunity for advancement	The possibility for growth and advancement for a CHW – a defined pathway for upward mobility within the organization – is supported by professional development opportunities such as conferences, fellowships, speaking engagements, and community activity participation.

	Documentation and information management	How CHWs document visits, how data flows to the health system and back to the community, and how data is used for service improvement.
	Linkages to health systems	How the CHWs and communities are linked to the larger health system through involvement in recruitment, training, incentives, supervision, evaluation, equipment and supplies, use of data, and referrals.
	Program performance evaluation	General program evaluation of performance against targets, overall program objectives, and indicators carried out on a regular basis.

Evaluating CHW Programs

Whether one is developing a new CHW program or assessing the merit of their current program, evaluation is essential. Affirming the value of a CHW program internally is a first-level requirement, and proving the value externally for funders, partners, and community members provides the evidence necessary for program sustainability. With many team members often contributing to the “gold standard” of health outcomes, measuring cost-effectiveness or ROI for a CHW program may be challenging, yet worth the effort when possible.

Documentation of CHW interactions, group sessions, clinical reports, referrals, case management touches, and education delivered should be data points planned and collected from the outset for all CHWs. In clinical settings, additional patient data can be utilized ideally both pre and post-intervention, or as matched control in comparing those receiving the intervention versus those who did not.

Goals of the CHW program often inform the type and extent of the evaluation metrics and data to be collected. Lessons from successful CHW programs, many of which have operated for decades, offer practical ideas by category.

- **Client/patient demographic data** – gender, age, race, health status, chronic conditions, access/source of healthcare or dental care, access/type of health or dental insurance, physical activity, SDOH assessments
- **Process measures** – number receiving education, number of education programs offered, number of interactions, number screened, number of referrals, number enrolled in programs, number receiving coaching, number of community presentations
- **Consumer behaviors** – interaction reason/problem, patient/client source of contact, type of service offered/referred, self-management/compliance issues
- **Outcomes of CHW interventions** – health outcomes (BP, blood glucose, etc.), healthcare utilization (ED, inpatient, physician office, scripts, etc.), client/patient experience, SDOH improvements, improvement in self-skill/knowledge, cost savings (ED, inpatient, scripts, etc.)
- **Improvements for program sponsor** – changes made by the sponsoring organization to serve clients more effectively or efficiently based on CHW feedback and observations

Additional Related Resources

- *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings*. Sinai Urban Health Institute 2014
- *CDC Evaluation Coffee Break: Evaluating Community Health Worker Programs*. Centers for Disease Control and Prevention 2012

- Cuvelier, M. *How to evaluate your community health worker training program*. Community Health Worker Training. 2014. <https://chwtraining.org/training-points-you-should-be-evaluating/>
- *Evaluation Toolkit for Promotor(a) De Salud Programs*. MHP Salud 2016
- Stevens, K. *Community Health Worker Evaluation Tool Kit - Resource*. Better Evaluation 2022. <https://www.betterevaluation.org/tools-resources/community-health-worker-evaluation-tool-kit>

Chapter 4: Building and Sustaining Your Workforce

4

Chapter 4 thoroughly examines the processes involved in selecting, recruiting, and supporting CHWs within the organization. It is essential to regularly evaluate the tools and skills of CHWs, which are mentioned briefly within this section.

- Requirements for CHW candidates
- Personal Qualities and Soft Skills for the Ideal CHW Candidate
- Reliable Support Systems and Supervision for CHWs
- Strategies for Maintaining CHW Retention
- Promoting and Supporting the Self-Care of CHWs
- Assessment of the Proficiency of CHWs Women's reproductive health care services
- Identifying healthcare beneficiaries of CHW assistance.

Selecting, Hiring, and Supporting CHWs

Once an organization has envisioned or developed a CHW program strategy, attention often turns to employing a Community Health Worker. While attributes of effective CHWs vary, research and field experience have shown that recruiting and selecting individuals from the community the organization seeks to serve, especially those who mirror the community they serve, can foster program success. Trusted, community-connected individuals can create and convey desired messages, more quickly establish trust, and achieve support from the community and stakeholders.

Many effective CHWs come from non-healthcare-related employment or situations. They may be community volunteers, interpreters, active club or organizational leaders, or respected members of the community. Depending on the goals of the CHW program and requirements posited by an individual state for certification, being 18 years of age, possessing a high school diploma or equivalent, and having community-lived experience may be qualifications for employment. Several states, including North Carolina, advocate and offer an experiential track for certification that honors CHWs for their lived experience. CHW training is recommended for CHWs – a bonus if already completed, but predictably valuable for most new hires. This is outside of a more standard onboarding process that all organizations offer to new employees.

Many healthcare provider organizations, and some public health and community-based organizations, have established qualification standards, especially as they relate to prior educational attainment, that would prohibit or eliminate the most promising CHW candidates from consideration. In short, many “standard” qualifications set by such organizations are contraindicated, given the role and expectations for the CHW.

Personal qualities and soft skills of CHW position candidates warrant attention and assessment in the selection process. Evidence of such qualities and skills can be acquired through observation, references, and the interview process. Extending the recruitment into the community the CHW program is serving, employing non-traditional

interviewing techniques such as case scenarios, and focusing on the shared experiences that a CHW candidate has with the community are all strategies to consider. The following table offers examples of qualities often associated with successful CHWs.

Personal Qualities	Soft Skills
Willingness to learn	Being constructive in interpersonal relationships
Compassion, caring about others	Being friendly, outgoing, sociable, culturally competent, patient, open-minded, nonjudgmental
Communication skills	Knowing about health issues and the healthcare system
Cultural and linguistic competence	Understanding the importance of sharing knowledge with family, friends, community
Professional experience	Speaking, listening, writing, teaching skills
Commitment to community	Ability to identify and utilize resources
Respected by peers	Possessing initiative, being self-directed, possessing capacity to work independently
Shared values/experience with those being served	Being adept at resolving conflicts
Good health practices and attitudes	Being respectful and honest
Sense of self-esteem	
Ability to grow, change, learn	
Trusted community member	

Supporting and Supervising the CHW

CHWs need regular and reliable support to fulfill their organizational roles and to be successful in their work. CHWs' work settings and activities often differ from others on staff. This is particularly evident in healthcare settings. CHWs may have different work hours. Their work may take place out of the office in client homes, client/patient work settings, in community facilities, or in public settings. Travel and travel time may be a feature of their work. Being responsive to urgent or emergency situations as they arise can play havoc with normal work hours. The nature of CHW activities and their focus on advocating for and providing support to their clients is often demanding and stressful. Creating an environment of support, recognition, and understanding of the challenges CHWs face is facilitated by adhering to several essential best practices:

- Create a CHW position description that clearly outlines the expectations of the CHW and reflects the goals of the CHW program – consider community members or current CHWs when developing.
- Provide regular and reliable supervision with ongoing feedback, ideally by someone who has experience as a CHW or is trained in CHW supervision. It is essential that the supervisor knows and understands the community being served by the CHW.
- Integrate the CHW into the team's work to provide regular feedback on clients/patients
- Seek feedback from the CHW on the most common and most pressing client/patient needs that may warrant organizational or community response.
- Provide space and opportunity to hear CHW feedback on organizational processes, practices, and procedures.
- Provide tools for the CHW to work effectively in the community, such as a cell phone, computer or tablet, Internet access, printer, transportation, and a colleague to accompany them when needed.
- Incorporate expectations and support for community involvement into the CHW role and job description so the CHW can serve as a community voice in coalitions and work groups.
- Evaluate the CHW on the alignment of their work with the expectations of the CHW program.

- Explore how the organization can support the CHW to enable them to be effective by enhancing their skill set in their work role.
- Offer opportunities for ongoing CHW education and networking with other CHWs through local, state and national CHW professional associations and conferences.
- With the CHW, examine opportunities for career path progression and advancement, and support their advancement when appropriate.

CHW Retention and Self-Care

Retaining qualified and capable employees is essential for virtually all positions within an organization. Retaining effective CHWs is especially valuable and worth concerted effort. The principal reason is tied to the trusting relationships that CHWs build with the communities they serve. This familiarity and mutual positive regard between CHW and the community often requires time to develop. Turnover in CHWs can erode the bridge between the CHW program and the community being served.

Several actions that mitigate turnover and promote retention are outlined in the section on *Supporting and Supervising the CHW* above. However, special attention to unique CHW issues is vital to ensure retention as well as maintain an effective CHW workforce.

1. *Supervisor Role.* Supervisors should be able to closely identify with or be able to relate to the work of CHWs, have an understanding of expected CHW roles and tasks, and advocate for the work of the CHW, both within and outside the organization. Especially in cases when the CHW supervisor has no previous experience as a CHW, available CHW supervisor training is encouraged along with active mentoring, frequent check-ins and feedback, and exploration/management of CHW caseload experience. Supervisors also need to be readily available to the CHW due to complex ethical dilemmas and family dynamics CHWs can be faced with. Supervisors are pivotal in work satisfaction and retention.
2. *High Stress Job.* The work of CHWs often involves high-touch interactions with clients/patients in vulnerable communities, which can lead to high stress. Supervisors and team members are encouraged to learn about the work and potentially stressful encounters common to CHW work so they can both recognize and respond to the CHW at appropriate points of experience.
3. *Compassion Fatigue.* Burnout in the form of compassion fatigue is common to those devoting their work lives to serving clients/patients experiencing emotional, physical, social, or financial distress. CHWs often encounter such clients/patients who demonstrate complex needs in one or more of these areas. It is important to recognize compassion fatigue and to provide strategies to mitigate and address it when it occurs.
4. *Flexibility.* The CHW's work settings, often in homes and the community (with added travel time), contrast dramatically with the protective environment of an office or clinic position. Work often includes evenings and weekends. CHW programs and CHW supervisors can offer schedule flexibility to CHWs to ensure adequate time for rest and relaxation from the demands of others, along with time for self-care – mental, physical, and spiritual.
5. *Self-Care.* Self-care is the practice of caring for one's physical, emotional, and psychological well-being, and mental health is often a part of the mix. The nature of CHWs' often stressful work prompts CHW programs, teams, and supervisors to ensure attention, adequate time, and specific policies for self-care for CHWs. (17)
 - Increased self-awareness
 - Creating a healthy relationship with self

- Improves relationships with others
- Creates work/life balance
- Increases motivation
- Reduces stress
- Boosts personal confidence, esteem, contentment
- Increase ability to control emotions
- Improves general health

Assessing CHW Proficiency

The value of conducting regular CHW assessments is significant for the CHW organization and the CHW. First, the value of the organization's CHW program is at stake. The CHW is often the primary facilitator of the CHW program's goals. How well their work and service align with organizational interests is a primary focus of the CHW assessment. Second, how effectively is the CHW delivering the service and interventions in support of the CHW program plan? What can the CHW and/or the organization do to improve the effectiveness of the entire organizational team? How can the organization best support or enhance the work of the CHW? Third, individuals in CHW roles often require time to build active connections and useful knowledge of the communities they serve, and fostering trusting relationships requires time and a consistent presence. Turnover is distracting for any organizational personnel; for CHWs, turnover imposes an extraordinary negative impact on CHW program goals/intentions. Effective assessment and ongoing feedback reduce the probability of turnover.

How to assess the CHW and their role will vary based on organizational processes and the work expectations for the CHW. However, several sources of feedback for CHW assessments constitute best practice: 1) utilize a CHW self-assessment; 2) collect feedback from other members of the organizational team; 3) observe the CHW in client situations; and 4) collect client/patient feedback. Tools and surveys enabling the design of such feedback are widely available from a variety of resources and can be adapted to your organization and CHW program.

Additional Related Resources

- *Community Health Worker Assessment Toolkit: A Framework for Assessing Skills Proficiency and Fostering Professional Development.* The Community Health Worker Core Consensus Project. Texas Tech University Health Sciences Center. El Paso, TX. 2018 www.C3Project.org
- *Training and Supporting Community Health Workers and Promotores: Lessons for California and Other States.* Center for Health Care Strategies, Inc. August 2020.
- *Building a Community Health Worker Program: The Key to Better Care, Better Outcomes & Lower Costs.* Brooks, B.A., Davis, S., et al. Community Health Works. Chicago. July 2018

Chapter 5: Assessing and Addressing Social Needs

5

CHWs use evidence-based assessments to determine appropriate services, medical needs, and care requirements of individuals. **Chapter 5 discusses Social Determinants of Health (SDOH) assessments and the community outreach and resource utilization strategies employed by CHWs to support communities and foster positive outcomes.**

- Define Social Determinants of Health Assessments
- List the uses of (SDOH) Assessments
- Explore SDOH Assessments as a tool for CHW programs

Social Determinants of Health (SDOH) Assessments and Use

Assessing barriers to an individual's or family's optimal health that arise from non-medical sources, such as the physical environment in which people live, historical and generational trauma, language barriers, health inequities, transportation, housing, and safety; social and economic factors including marital status and relationships, income, education; and health behaviors including diet, access to healthy and affordable food, eating habits, substance misuse, hygiene, smoking, self-care - is pivotal to CHWs' roles. Addressing or mitigating SDOH influences is often essential to accessing/utilizing medical care and benefiting from the value of its provision.

Addressing or mitigating SDOH influences is often essential to accessing/utilizing medical care and benefiting from the value of its provision.

Healthcare organizations now understand that addressing SDOH factors can improve outcomes and reduce costs, especially for individuals with or at risk of chronic conditions. Understanding SDOH information and acting on its insights is a more complex task. CHWs who are fully supported and effectively integrated into their healthcare teams can play supporting roles, working with clients/patients in exploring identified SDOH barriers and mitigating the effects.

It is incumbent on healthcare organizations and community health efforts to follow a path of identification, stratification, focused mitigation, and data collection as a best practice approach. It is essential to assess SDOH data for all clients comprising their panels or patient populations. This assessment is appropriate for clinical organizations and community-based organizations that may be directing their efforts toward specific chronic conditions or unique populations.

Along with the strategy of addressing and caring for individuals most at risk, the next step is merging clinical or condition data of those at greatest risk with SDOH data. For some organizations, this may be accomplished by using existing Health Risk Scores for clinical data and matching it with independently developed SDOH assessment data to stratify the population. This allows for more focused efforts toward those most at risk with the most movable SDOH barriers. For more sophisticated, data-rich providers, the capacity to utilize proven predictive models which integrate clinical risk data with SDOH data to produce merged risk stratification may be possible.

While many healthcare organizations are committed to addressing SDOH barriers through use of their own or partnering organizations' CHWs, there are practical limitations to workforce and financial resources needed to address all such barriers. There are clear differences between focusing on medication management for those without financial resources, providing special assistance for patients transitioning home without available support of family or friends, and ensuring that at-risk clients/patients without housing or transportation have such barriers removed. Hence, it is prudent for organizations to focus SDOH initiatives for at-risk clients/patients around the community's needs and movable SDOH barriers, especially as a CHW program is initiated. Examining SDOH barriers that are most easily impacted for a community and barriers that have the greatest impact on health outcomes if mitigated, and matching that against CHW program capacity and resources is a foundational approach used by the most successful programs.

Finally, data should be collected and continuously reviewed. Tracking at-risk clients/patients, possibly those with a particular condition such as diabetes or heart failure, along with moveable SDOH data and interventions by CHWs, allows improved tailoring of both healthcare services and CHW interventions. Thoughtfully constructed analysis of such data also provides evidence of CHW program value and impact.

Additional Resources

- *Social Determinants of Health (SDOH) Toolkit*. Iowa Healthcare Collaborative. 2019
<https://www.ihconline.org/initiatives/community/community-resources>
- Feedback from clients and community forums

SDOH Assessment Tools

Recognizing how important SDOH assessments are to a CHW program, many organizations struggle with determining the type and nature of assessments to utilize. Some are comparatively detailed and provide levels of SDOH risk that can be measured over time. Some are relatively comprehensive yet easy to utilize. Others focus on assessing the limited number/type of SDOH barriers that the organization or CHW program has elected to address. Further still, payers or funders sometimes require use of a specific tool tailored to their needs or goals. Below is an annotated description of three examples of SDOH assessments, along with additional resources for CHW programs to explore and consider in developing an approach suited to their situation.

Health Leads Screening Toolkit - <https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/>

This toolkit includes a comparatively simple SDOH assessment that covers key health and social needs. It is offered in both English and Spanish. The toolkit also describes utilization of SDOH data and describes other SDOH assessment tools for possible use.

Arizona Self-Sufficiency Matrix - <http://www.selfsufficiencymatrix.org/>

This extensively researched and validated SDOH assessment addresses 21 social determinant domains. Each domain provides a scaling of measure of need – crisis, vulnerability, stable self-sufficiency, and thriving. This allows for assessing/measuring of domain status changes over time. This is among the more detailed and sophisticated SDOH assessments.

PRAPARE - <http://www.nachc.org/research-and-data/prapare/toolkit/>

Emerging from a national initiative to develop a standard SDOH assessment, the *Protocol for Responding to and Assisting Patients, Assets, Risks and Experiences* is widely used by federally qualified health centers and a host of other providers. It is practically sized and detailed for use.

Community Outreach and Resource Utilization

The work of CHWs is purposed to advance public and population health. This work is often accomplished by working directly with individuals and families to connect them with health, social, and community resources. CHW interactions may occur through education, navigation, informal counseling, social support, care delivery, and advocacy. Fulfillment of these important connections utilizes three companion talents – effective community outreach, extensive knowledge of available resources, and referral and follow-up.

Community health outreach aims to identify, contact, connect, and establish trusting positive relationships with individuals and families of the community being served. It typically revolves around the organization's intentions and interest in addressing priority SDOH needs.

Outreach encounters can occur at individual, group, institutional, population, venue, or street levels.

Community health outreach aims to identify, contact, connect, and establish trusting positive relationships with individuals and families of the community being served. It typically revolves around the organization's intentions and interest in addressing priority SDOH needs. This may involve CHW presentations or education around a critical population health need such as hypertension or mammogram screenings. It may be establishing links between community organizations such as a service club and a hospital stroke prevention program. It could include drawing in community members to help advise the design of a new health service or program. In public health settings, the CHW may focus outreach around a found priority community need such as housing, isolation, or transportation. Outreach encounters can occur at individual, group, institutional, population, venue, or street levels.

The companion CHW talent to community health outreach is effective resource utilization. An array of personal and SDOH needs often exists as barriers to achieving optimal health, especially among vulnerable or disenfranchised populations. It is paramount that CHWs are aware of resources that can be accessed or those to which clients/patients can be referred for assistance and support. The first step is gaining knowledge of available resources, their eligibility guidelines, service areas, and other factors impacting access. Resources may be local, regional, or national. The step beyond awareness of these resources is developing relationships with individuals associated with those resources. Fostering relationships that enable rapid, reliable contact with the "right" staff of health and social service organizations allows valuable and prompt responses to individual and family SDOH issues that are critical or urgent. Additionally, since resources are ever-evolving, CHWs should keep abreast of new or different programs and their capacity as they emerge and change.

A practical approach for new CHW programs or CHWs to establish high-functioning resource relationships is to develop a resource inventory or matrix for your organization. Targeting frequently-referred programs the CHW can keep at their fingertips will facilitate smooth and efficient referral processes. Keeping the resource directory manageable and limited to the commonly referred programs will help ensure it is regularly updated.

Developing a community resource inventory designed for a new CHW program allows tailoring to its community needs and program goals. Looking at each of the primary domains of social determinants of health (SDOH), identifying the need or barrier, cataloging available resources or services available to address that need, and

specifying contact information or a method of connecting with that resource is a worthwhile endeavor for all CHW programs. This resource inventory can be updated over time and shared with other members of the team and organization for use, feedback, and further development.

In the *Resources* section of this guide, a template to guide identification of community resources for the development of CHW programs is found in the *CHW Community Resource/Referral Template*.

There are times, however, when unusual or less frequent needs arise. There is no way a CHW – or anyone for that matter – can keep abreast of all available services, their programs, eligibility guidelines, the presence of waiting list or other capacity issues, or key contacts at the organizations. There are some useful resources that can assist the CHWs when needs are presented for which the CHW doesn't have a resource or program readily in mind. There is a growing list of these types of information and referral services, and the CHW's employer may have a contract or preferred relationship with one. A few examples of those tools include *FindHelp*, free and priced packages of support and tools, 211, an online listing of resources, and *NowPow*, an organization that has partnered with healthcare and community-based organizations to categorize resources and facilitate referrals. Still, more resource-facilitating organizations are likely to emerge in the coming years and are powerful tools when paired with the skills of CHWs.

Additional Resources

- *Best Practices from the Field: Using Social Determinants of Health Resource and Referral Data to Increase Equitable Access and Connection Rates to Essential Resources*. Health Leads. 2021
www.healthleadsusa.org

Chapter 6: Preparing for and Sustaining the Program

6

Chapter 6 emphasizes the importance of thorough preparation of CHWs through training to promote the program's sustainability. It includes an example of a CHW training course outline and examines strategies for financing and supporting the program.

- Learn about the significance and advantages of training to cultivate high-performing CHWs
- View an example of a professional CHW training course outline
- Explore sources for financing and supporting CHW activities and services

CHW Training

Formal CHW training is a particularly significant cornerstone for cultivating an effective CHW and a robust CHW program. As CHW programs often seek candidates from the communities they serve, especially individuals with strong connections to their community, they may have lacked opportunity for formal education. In addition, as CHW programs may elect to move currently employed individuals in other positions to a CHW role, the formal education that they possess is often quite different than the CHW skills and competencies outlined by the C3 Project and common to practicing, high-performing CHWs.

What constitutes effective training for CHWs? While 36 states have some form of approved CHW training, are developing training, or have approved competencies, Iowa and several other states do not. Twenty-two states require state certification (voluntary or required) or are studying certification. Iowa and many other states do not have requirements that include guidelines or prescriptions regarding training content.

As the Iowa CHW Alliance began its work in 2017, CHW training was noted as a priority strategy to advance the development and utilization of a CHW workforce in the state. In response, the Iowa Chronic Care Consortium (ICCC), now HealthTeamWorks, with state and private foundation support, commenced the study of CHW trainings across the U.S. to assess training content and features that would serve Iowa's growing number of CHWs. This resulted in the creation, development, and approval of a US Department of Labor-approved Community Health Worker Registered Apprenticeship. Key features of the CHW Registered Apprenticeship include 2,200 hours of on-the-job learning experience as a CHW with a cooperating employer paired with about 147 hours of related instruction – roughly 35 hours of live virtual learning sessions and 112 hours of study, homework and practice. Successful participants in this robust training receive a

Key features of the CHW Registered Apprenticeship include 2,200 hours of on-the-job learning experience as a CHW with a cooperating employer paired with about 147 hours of related instruction – roughly 35 hours of live virtual learning sessions and 112 hours of study, homework and practice.

National Certification as a qualified Community Health Worker from the US Department of Labor.

As CHWs in training moved through that program, it became apparent that the demand for a professional CHW training was high both in Iowa and in other states. Responding to this demand, ICCC embarked on developing a companion CHW Professional Skills Training program. This program utilizes much of the curriculum for related instruction in the CHW Registered Apprenticeship Program, engages CHW experienced faculty and other community resources to provide instruction, and offers the training for each of Iowa's 16 community colleges which provide a non-credit certification for CHW Professional Skills Training. More than 100 aspiring or working CHWs have enrolled in this training program to date.

The CHW Professional Skills Training Program content focuses on building the skills and capacity of this workforce to optimize effectiveness. Content includes communication skills and strategies; fundamentals such as confidentiality, implicit bias, ethics, and boundaries; practical information on working in a professional setting; strategies for safety and personal well-being; cultural humility and understanding trauma; understanding public health; and conducting outreach. Teaching and learning is built around the national C3 Project roles and competencies and utilizes *Foundations of Community Health Workers, Second Edition* by Tim Berthold, Editor, as a textbook and reference.

CHW Professional Skills Training - Course Outline

Course 1: Introduction to Community Health Work: The Big Picture • The role of Community Health Workers • The Evolution of the Community Health Worker • Introduction to Public health • Healthcare and Health Policy • Health for All: Promoting Health Equity
Course 2: Core Competencies for Providing Direct Services • Practicing Cultural Humility • Guiding Principles • Conducting Initial Client Interviews
Course 3: Enhancing Client Interactions • Client-Centered Counseling for Behavior Change • Care management / care coordination • Home Visiting
Course 4: Enhancing Professional Skills • Stress Management and Self-Care • Conflict Resolution Skills • Professional Skills
Course 5: Applying Core Competencies to Key Health Issues • Chronic Conditions Management • Promoting Healthy Eating and Active Living • Understanding Trauma and Supporting the Recovery of Survivors • Health Outreach and Navigating Community Services • COVID-19 Response and Recovery • Evaluation and Research

Financing CHW Work and Service

Developing reliable, sustainable funding for CHWs has been a significant barrier to their widespread deployment in most states and at the national level. As the profession develops, the evidence of value is repeatedly validated, and medical care recognizes the essential contribution CHWs make to population health outcomes, the outlook for ongoing budgeted financial support for CHWs has and will continue to improve.

Short-term grants build programs. Sustainable funding builds a workforce. Long-term financing allows CHWs to develop trusted community relationships, retain experienced staff, and deliver lasting impact.

As a recent brief from the *National Association of Community Health Workers* highlighted, CHWs have often been supported in projects or programs that are often short-term, supported by appropriations or philanthropic interests, and commonly focused on specific goals such as job training, reducing infant mortality, or raising immunizations. Such “funding does not afford CHWs or CHW programs latitude to apply the full range of CHW capabilities to community needs,” according to the report’s authors. (18)

Sustainable funding will offer CHW programs the reliability of long term financial support, rather than the current situation, which typically offers only episodic support. Community relationships and patterns of trusting service take time to develop and mature. Veteran CHWs often ascribe their success, in part, to the longevity of built relationships with service providers along with the trusted relationship with their communities that have evolved based on continuous engagement over time.

The most promising sustainable resources are already emerging, although unevenly, from state to state and by various organizations. Medicaid reimbursement shows especially high potential. The Affordable Care Act (ACA) set the stage for Medicaid funding of CHWs authorized through Medicaid 1115 waivers. As a result, 20 states currently have Medicaid or Medicaid Managed Care Organization (MCO) payment or reimbursement for CHWs. In addition, MCOs in several states have voluntarily supported, CHWs through a variety of methods, in light of the value they add to managing the populations that they serve. CHWs have long demonstrated being especially effective in meeting the needs of minority, low-income and marginalized populations – communities often served through Medicaid.

Healthcare reform under the ACA has created a series of alternative payment models versus traditional fee-for-service (FFS) reimbursement. In most of these models, healthcare provider organizations assume some level of risk for outcomes. In an increasing number of these programs, CHWs have proven their value in working with high need populations. As those models continue in play, CHW funding and support is accommodated/included in the recurring budgeting process. As healthcare provider systems assume more risk for patient outcomes as measuring of payment; as those payments shift from volume (FFS) to payment for value (outcomes); and as more Medicare, Medicaid, and commercial payers attribute patients to provider systems for care; engaging CHWs promises to emerge as a very pragmatic and cost-effective strategy.

Federally qualified health centers (FQHCs) are supported through Prospective Payment Systems. There are provisions that allow CHW’s cost inclusion into total cost proposals negotiated with Medicare and Medicaid. Additionally, CHW compensation and expenses can be included as a part of “enabling services” supported by HRSA 330 grant funding.

CHW programs and their champions, whether they are based in healthcare or community-based organizations, can help shape the future sustainable funding for CHWs. They can advocate for inclusion of CHWs through Medicaid reimbursement at state and federal levels, they can create demonstrations that prove the business case for CHWs in their own communities, and they can create blended or braided funding (multiple sourced) for CHWs that can be counted on year after year, including foundation support.

Additional Resources

- *Recognizing and Sustaining the Value of Community Health Workers and Promotores*. Center for Health Care Strategies 2020 www.chcs.org
- *Community Health Worker Sustainability Initiative*. Families USA. (2022, August 29). <https://familiesusa.org/our-work/c-h-w/>

References

1. *The Innovation Health Care Really Needs: Help People Manage Their Own Health*. C. Christensen, A Waldeck, R. Fogg. Harvard Business Review. October 6, 2017/November 6, 2017.
2. *Health and Social Services Expenditures: Associations with Health Outcomes*. E. Bradley, B. Elkins, J. Herrin, B. Elbel. BMJ Quality and Safety in Health Care 20(10):826-831, 2011.2
3. *County Health Rankings: Relationships Between Determinant Factors and Health Outcomes*. C. Hood, K. Gennuso, G. Swain, B. Catlin, *American Journal of Preventive Medicine* 50(2):129-135, 2016.3.
4. *What is Health Equity and What Difference Does a Definition Make?* Executive Summary, University of California San Francisco. Robert Wood Johnson Foundation. May 2017
5. <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model> Accessed November 2021
6. *Community Health Worker/Peer Workforce: Recruiting and Hiring for Social Determinants of Health Screening: Best Practices Guide and Findings from COVID-19 Pandemic*. National Health Care for Homeless Council, MHP Salud, CSH. 2021
7. *Making Community Health Workers (CHWs) Fundamental: New Research Strengthens the Case for State Policy Makers to Include CHWs in Care Delivery Teams*. Families USA. Fact Sheet. December 2019
8. *Community Health Worker (CHW) Environmental Scan*. Final Report to Iowa Department of Public Health. University of Iowa. R. Afifi, L. Walkner, W. Appelgate, D. Kazmerzak, A Sursely. June 30, 2021
9. *Community Health Workers and Medicaid Managed Care in New Mexico*. D. Johnson; P. Saavedra; E. Sun; et al. 2012 *Journal of Community Health*, Volume 37:563-71
10. https://www.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf Children's Hospital Boston. Accessed November 2021
11. *Social Return on Investment: Community Health Workers in Cancer Outreach*. Wilder Cancer. J. Diaz. Wilder Research. June 2012
12. *Rush C. Return on Investment from Employment of Community Health Workers*. C. Rush. *Journal of Ambulatory Care Management*. 2012; 35(2): 133-137
13. *Community Health Worker Return on Investment Study*. Final Report. E. Christiansen, K. Morning. Center for Program Evaluation School of Community Health Sciences University of Nevada Reno. May 31, 2017
14. *Health Care Innovation Awards (HICA) Meta-Analysis*. CMMI Meta Analysis and Evaluators Collaborative, Third Annual Report. T. Day. RTI International. February 2018
15. *Community Health Workers Evidence-Based Models Toolbox*. Office of Rural Health Policy, U.S. Department of Health and Human Services, Health Resources and Services Administration. August 2011

16. *Building a Community Health Worker Program: The Key to Better Care, Better Outcomes & Lower Costs.* Brooks, B.A., Davis, S., et al. CommunityHealth Works. Chicago. July 2018
17. *Self-Care for Community Health Workers.* National Research Center for Refugees, Immigrants and Migrants (NRC-RIM). October 2021 <https://nrcrim.org/self-care-community-health-workers>
18. *Sustainable Financing of Community Health Worker Employment.* C. Rush. National Association of Community Health Workers. 2020

Appendix

Model Community Health Worker Position Description

This model CHW position description provides a template, intended as a starting point, for developing a job description for the role in a variety of CHW programs. It should be adapted to the intention, setting and goals of the CHW program and adjusted to outline the expectations of the CHW to support that program. It may also be modified based on the training and qualifications created for the role. With these items defined, the resulting CHW position description may serve as a basis for assessing the work and service of the CHW.

Job Title: Community Health Worker

Job Code:

Position Name: Community Health Worker

Position Code:

Department Name: Primary Care Clinic

Manager/Supervisor Name: Sally Smith

Job Summary: The Community Health Worker will function as an integral part of the care team that provides patient and family support to aid patients in maintaining healthy lives and achieving positive health outcomes through health outreach, advancing healthcare access, facilitation of health improvement, health promotion, disease prevention, health program development, and coordination/referral with community partners and resources.

Essential Duties and Tasks:

- Provide and facilitate client/patient referrals to appropriate healthcare and community services in collaboration with care team recommendations or protocols.
- Support clients/patients in completing required forms, applications and requests to receive needed services, resources or assistance from community or national organizations.
- Assist clients/patients in obtaining information and education related to their health and social service needs.
- Advocate for clients/patients needs and interests to support their self-advocacy.
- Communicate with diverse populations about health and social service programs in a culturally affirming and competent manner.
- Maintain data and information for client/patient records as well as CHW program reporting.
- Provide education and coaching for client/patient disease and conditions with intent of building self-management skills and behaviors in individuals, families, groups.
- Teach community groups and organizations on topics to promote healthy living and self-management.
- Advise organizations and systems on how they can better respond to client and community needs.
- Advise when organizational values are in conflict with community values.
- Interpret community culture and value back to the organization to improve its service and advocacy.
- Assist with health and SDOH screenings and assessments.
- Facilitate client/patient healthcare and community organization navigation and access.
- Perform other tasks as may be assigned.

Required Education/Experience: Minimum 18 years of age. High school diploma or equivalent. Education, certification as a Community Health Worker or its achievement within six months of employment. Two years of healthcare or community service experience or equivalent healthcare or social service education. Relationships with individuals and organizations in the community to be served. Demonstrated computer skills or experience in working with electronic platforms or devices. Language capacity appropriate to community being served strongly preferred.

Working Environment: Primary function in a healthcare or clinic setting, work on a computer or other data systems, collaboration with healthcare team members, outreach and interaction with clients/patients and their families (in person, by phone, electronically), work in community settings including homes of clients/patients, and travel (primarily service area) to accomplish work roles.

Beginning Salary/Wage Range: \$32-42,000/yr. or \$15.40-20.20/hr. Salaries should be competitive and commensurate with their experience and expertise in understanding and interpreting community structure, culture and value.

CHW Program Development and Operation Checklist

Completion	Task	Description
	Recruitment	How and from where a community health worker is identified, selected, and assigned to a community.
	CHW role	The role's alignment, design, and clarity from community, CHW, and health system perspectives. Clarity of role is pivotal and essential.
	Initial training	Training is provided to the CHW to prepare for their organizational role and ensure that they have the necessary skills to provide safe and quality services. Identify in-person, virtual, and hybrid opportunities; explore language needs.
	Continuing training	Ongoing training is provided to update CHWs on new skills, reinforce initial training, and ensure they are practicing skills learned.
	Equipment and supplies	The requisite equipment and supplies are available when needed to deliver expected services, including computers or tablets, access to the Internet for work in the field, printers, transportation and office space when needed.
	Supervision	Supportive supervision is carried out regularly to provide feedback, coaching, problem-solving, skill development, and data review. Supervision, especially if not by a seasoned CHW, can stifle creative solutions and impose harmful hierarchies.
	Individual performance evaluation	Evaluation to fairly assess work during a set period of time, and specifically what is being assessed.
	Incentives	A balanced incentive package includes financial incentives (such as salary, tuition reimbursement, and bonuses) along with non-financial incentives (such as training, professional development, conferences, recognition, certification, uniforms, and other items appropriate to the job expectations).
	Community involvement	The role that the community plays in supporting a CHW. Selecting a CHW directly from the community, having the community participate in selection, and ensuring opportunities for CHW engagement in community activities are features of community involvement.
	Referral system	A process for determining when a referral is needed, a logistics plan in place for transport and funds when required, and a process to track and document referrals.
	Opportunity for advancement	The possibility for growth and advancement for a CHW – a defined pathway for upward mobility within the organization – is supported by professional development opportunities such as conferences, fellowships, speaking engagements, and community activity participation.
	Documentation and information management	How CHWs document visits, how data flows to the health system and back to the community, and how data is used for service improvement.
	Linkages to health systems	How the CHWs and communities are linked to the larger health system through involvement in recruitment, training, incentives, supervision, evaluation, equipment and supplies, use of data, and referrals.
	Program performance evaluation	General program evaluation of performance against targets, overall program objectives, and indicators carried out on a regular basis.

Community Health Worker Resource/Referral Template

This template is meant to be developed as ready resource for CHWs in their current role, or an anticipated role they may have in the future. Referral networks are essential as a Community Health Workers. When developed, this document is a valuable resource and intended to be updated as CHWs expand their network. Additional lines can be added for more resources as a CHW builds this document.

A common intent of CHW programs is their impact upon social determinants of health and improving health outcomes of the people being served. This template is categorized by the five domains of social determinants of health. While completing this template, consider how social determinants of health relate to the types of services your CHW program or CHW connects, or could connect, with your clients.

Directions: Using the resources you are aware of, 211 or other trusted sources, begin completing the template. If you are not sure which domain to list your resource under, it doesn't matter. Some resources are appropriate in more than one domain. The important thing is to create a robust list of resources that can be used when the need or situation of a client/patient arises, and that you can keep updated and refer to as you perform your job responsibilities.

Social Determinant of Health Domain	Services	Contact Method (name, number, email, etc.)
Neighborhood and Built Environment (quality of housing, access to transportation, availability of healthy foods, air and water quality, and neighborhood crime and violence)	<i>Home repairs</i>	<i>Rebuilding Together</i>
Economic Stability (poverty, employment, food security, and housing stability)	<i>Food Security</i>	<i>Women's Infants and Children (WIC), statewide</i>
Education Access and Quality (graduating from high school, enrollment in higher education, education attainment in general, language and literacy, and early childhood education and development)		
Social and Community Context (cohesion within a community, civic participation, discrimination, conditions in the workplace, and incarceration)		
Health and Health Care		

(healthcare, access to primary care, health insurance coverage, and health literacy)		

Additional Training and Skill Development for Community Health Workers

This document provides added links or other information for learning about community health navigation, community health workers, and other additional training opportunities.

Opportunities to Learn More About Specific Health Conditions	
<i>Midwest Public Health Training Center (MPHTC)</i>	View recorded webinars created for Community Health Workers on the following topics: • Opioid Misuse • Obesity • Diabetes • Depression http://www.mphtc.org/chw-webinar/
<i>HealthTeamWorks</i>	Oral Health Training for Community Health Workers The Iowa Chronic Care Consortium (ICCC), now HealthTeamWorks, developed a training program for front-line workers focused on oral health. This training is available on demand and is estimated to take about one and one-half hours to complete. Successful completion will result in a certificate of Basic Oral Health Knowledge. https://communityhealthworker.org/additional-chw-training/healthteamworks-trainings/oral-health-training/
Skill Development	
<i>Community Health Worker Professional Skills Training Program</i>	This training utilizes the Foundations textbook provided to training participants and offers a robust training for community health workers and other front-line workers. Learn more at this link: www.communityhealthworker.org or contact contact HealthTeamWorks at solutions@healthteamworks.org.
<i>Clinical Health Coach Training</i>	Primary training is 26-hour on demand online learning experience with four added tele-classes. Advanced skills trainings are offered both online and live onsite. Custom programs also available. This is an opportunity to go deep to advance communication skills and strategies to truly engage patients/clients in their own healthcare and self-sufficiency. Visit https://clinicalhealthcoach.com or contact HealthTeamWorks at solutions@healthteamworks.org.
Learn More about CHWs and Other Front-line Workers	
<i>National Association of Community Health Workers (NACHW)</i>	NACHW is a great resource for information about CHW programs, activities at state and national levels, and more. Visit the website at: https://nachw.org. NACHW also has an extensive document resource center: https://nachw.org/chw-document-resource-center/.

*National Academy
of State Health
Policy*

Learn what other states are doing to support community health workers.

<https://www.nashp.org/state-community-health-worker-models/>

Featured Resources for Community Health Workers

1. *Resources for Community Health Workers, Community Health Representatives, and Promotores*
<https://go.usa.gov/x6bRW>
Information on how CHWs can safely serve their communities during the COVID-19 pandemic.
2. *Community Health Worker Resources*
<https://go.usa.gov/x6bRZ>
List programs across the Centers for Disease Control and Prevention (CDC) that offer resources relevant to the work of CHWs.
3. *Community Health Worker Toolkit*
<https://go.usa.gov/x6bRK>
Offers online training, lessons learned, and best practices to train and build the capacity of CHWs in their communities.
4. *National Association of Community Health Workers (NACHW)/CDC CHW Document Resource Center*
<https://bit.ly/3pk4lKe>
Provides CHW leaders, current and potential employers, and payers a searchable collection of documents on state-level CHW policies.
5. *Engaging Community Health Workers in the Development of a Statewide Infrastructure for Sustainability*
<https://go.usa.gov/x6bRX>
Presents a summary report and job aid from a CDC forum that explored issues related to developing statewide infrastructure to promote long-term sustainability and financing of CHWs.

Source: Centers for Disease Control and Prevention (CDC)

Implementation Guide Author Biographies

William Appelgate, PhD, CPC

William Appelgate is the founder and former CEO of the Iowa Chronic Care Consortium, a non-profit population health capacity building organization established in 2002 with clients and trainees in 45 states and several foreign countries. ICCC has received national recognition for its particular skill in achieving dramatic clinical and cost outcomes through health behavior change with at-risk populations.

He believes deeply that supporting and inspiring improved personal health behaviors is *the change-the-world strategy* required for the future of healthcare in America.

His professional work has included service as a director of a university research center (Illinois), college academic dean (Nebraska), college foundation director (California), college president (Iowa), CEO of comprehensive, innovative healthcare systems (Wisconsin and Iowa), as well as Vice President and Clinical Professor at Des Moines University, a graduate health sciences university and medical school (Iowa).

He is the founder of the Clinical Health Coach® Training and the Community Health Worker Professional Skills Training – national trainings which have prepared more than 5,000 community healthcare professionals with client enabling skills to improve health outcomes.

He speaks nationally on the topics of disease management, population health and health coaching -- addressing organizations such as the American Telemedicine Association, National Rural Health Association, Population Health Alliance, Center for Telehealth and E-Health Law, National Medical Home Summit, Healthcare Financial Management Association and Institute of Medicine.

He earned a B.S. from Iowa State University, an M.A. from Loyola University of Chicago and a Ph.D. from Southern Illinois University. He is a Vietnam Era Veteran and a Certified Professional Coach.

Hakima Tafunzi Payne, MSN, RN

Hakima Tafunzi Payne is the founder and Executive Director of Uzazi Village, a nonprofit organization dedicated to eliminating health outcome disparities in maternal and infant health in African-American Communities.

She holds a Bachelor's in Nursing and a Master's in Nursing Education. She is the creator of the Village Doula Program (a community-based home visiting community health worker program for pregnant individuals), Chocolate Milk Cafe (a breastfeeding support group for Black families), the Village Circle (an Afro-centric group prenatal care model, and Culturally Congruent Care (an anti-racist medical education curriculum). She sits on her local Fetal Infant Mortality Review Board (FIMR) to address Black infant mortality and has been appointed by her city's mayor to serve as a Health Commissioner.

She is a certified trainer for Community Health Workers and has created a specialty curriculum for Maternal and Infant Community Health Workers. She speaks nationally on the topics of Black maternal and infant health. Ms. Payne works tirelessly to make birth safer, the village healthier, and to promote anti-racist care models for African-American families. She is the subject of an upcoming documentary, "Sister Doula". Ms. Payne resides in Kansas City, Missouri.

Honey Yang Estrada, MPH, CHW

Honey Yang Estrada is the President of the North Carolina Community Health Worker Association. She was born in Fresno, California and moved to North Carolina when she was 11 years old. The eldest daughter of Hmong refugees who came to the United States during times of war, Honey understands the struggles families face in navigating various societal systems and the existing barriers that inhibits them from achieving positive outcomes.

A proud Community Health Worker, Honey has worked in healthcare and public health for over 20 years. Her experience is rooted in community health and advocacy. Throughout her career, Honey continues to serve as a catalyst for change where she champions racial and health equity.

She currently lives in Newton, NC with her family, teaches Zumba at the local library and holds a Masters in Public Health.

Stephanie Salazar-Rodriguez, MPH, MNM

Stephanie Salazar-Rodriguez is a second generation native Denverite from a mixed Latino and Native American familial background and is bilingual. She possesses over 25 years' experience working in high needs and under-resourced communities to effectively address social and economic barriers to health, education, and health equity. Stephanie holds a Master's in Public Health from the University of Colorado, Anschutz and a Master's in Nonprofit Management from Regis University. She also has extensive experience as a Training and Technical assistance provider in the areas of Community Health Workers/Promotores de Salud, executive leadership coaching, capacity building and strategic planning.

Stephanie is the Founder/Lead Trainer of Blazing Cloud Consulting, LLC, where she works to improve health outcomes and educational attainment in the Latino and Native American communities in Colorado. Most recently Stephanie was very active in addressing the disproportionate impact of COVID-19 on communities of color.

Stephanie was the former Director of Community Engagement/Regional Health Connector at the Mile High Health Alliance. She also previously held the position of Program Manager for the Promotores de Salud Program at Planned Parenthood, addressing reproductive health and was a Promotora serving personas mayores (elders) at Sisters of Color, United for Education.

Stephanie is active in the local community to promote authentic community engagement and health equity. Her commitment is demonstrated through work as a member of the Steering Committee, HRSA-CU School of Public Health, Community Health Worker Grant, the Colorado Blueprint to End Hunger, and as a presenter and panelist for the National Network for Public Health Institute.