COMMUNITY HEALTH WORKER

INTEGRATION TOOLKIT

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Community Health Workers
Help. Guide. Thrive.

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Executive Summary: CHW Integration Initiative

Objective: This toolkit is designed to support healthcare organizations, local health departments, and community-based agencies in effectively integrating Community Health Workers (CHWs) into their systems to improve health outcomes and equity across Illinois.

Program Overview: The Illinois Public Health Association's CHW Capacity Building Center led an 18-month statewide initiative, partnering with local health departments, Federally Qualified Health Centers (FQHCs), and hospital systems to assess and advance CHW integration.

This report details our findings and recommendations from our work on integrating Community Health Workers (CHWs) into health systems. We identified four key factors that influence the successful integration of CHWs: organizational capacity, support for CHWs, clarity around healthcare roles, and integration into clinical workflows. Each of these factors is explored in depth in the following sections, providing a comprehensive overview of our analysis and strategic suggestions.

Development and Implementation:

- **Initial Framework:** Developed an evidence-based CHW Integration Toolkit grounded in national best practices.
- **Refinement and Expansion:** Toolkit content was expanded and updated based on field experiences, feedback, and observed integration challenges.

Key Components:

- The toolkit outlines five essential elements for successful CHW integration.
- Includes assessment tools for readiness and tools for ongoing evaluation of CHW integration efforts.

Funding: This project was fully funded by Senate Congressional District Funding through the office of Hon. Senator Dick Durbin (D-IL).

Impact and Recommendations: This initiative will significantly contribute to strengthening health infrastructure and CHW capabilities in Illinois. Organizations are encouraged to adopt this toolkit to enhance their CHW integration efforts, benefiting from its comprehensive and adaptable resources for achieving operational success.

History of Illinois Public Health Association

Established in 1940, the Illinois Public Health Association (IPHA) is the oldest and largest public health association in the state. With a mission to enhance and support the public health system and practice, IPHA advocates for health equity and improved well-being across all Illinois communities.

As a recognized leader in public health advocacy, education, and programming, IPHA collaborates with public and private stakeholders statewide. Among its core strategic goals is building capacity and creating pathways for a diverse, well-trained public health workforce rooted in the communities it serves.

About the CHW Capacity Building Center

Launched in October 2020, IPHA's Community Health Worker (CHW) Capacity Building Center was created to strengthen and expand the CHW workforce across Illinois. Supported by HRSA initiatives and Congressional District Funding, the Center has invested over $8.5 million in CHW programming.

The Center partners with over 175 organizations, including 90 community-based organizations, 42 FQHCs, and 42 local health departments. Its mission is to dismantle historical silos by creating multi-sector partnerships and sustainable funding mechanisms to integrate CHWs into health systems and address persistent access barriers.

About the CHW Capacity Center Learning Institute (June 2023 – December 2024)

To address the growing need for sustainable, community-driven health services, the Illinois Public Health Association (IPHA) launched the *CHW Integration Readiness Assessment Tool* through its Capacity Building Center. This initiative, funded through congressionally directed spending sponsored by Senator Richard J. Durbin, was designed to help health systems across Illinois evaluate and strengthen their capacity to effectively integrate Community Health Workers (CHWs).

Developed with input from CHWs themselves, the Readiness Tool focuses on core components essential to successful integration: intentional planning, role clarity, supervision, population focus, standardized workplace policies, stakeholder engagement, comprehensive hiring and training, and ongoing evaluation. It is grounded in national best practices, including the CHW Core Competency Project and MHP Salud toolkits.

To put the tool into action, IPHA established the *CHW Learning Institute* (LI), a structured capacity-building experience that supported 11 local health departments, a six-hospital system, a rural hospital, and a Federally Qualified Health Center. Through the LI, participating organizations implemented integration strategies, shared challenges, and contributed practical insights that directly shaped the development of the *CHW Integration Toolkit*—a resource grounded in real-world application and frontline feedback.

Participants received access to monthly peer workgroups, bi-monthly one-on-one meetings with Capacity Building Center staff, site visits, and stipends to attend the IPHA CHW Summit. Digital access to a collection of templates, job descriptions, policy examples, and training tools was also made available to participants in order to streamline their integration

The CHW Learning Institute and resulting Toolkit represent critical progress in Illinois' public health workforce development. Continued investment in implementation infrastructure, reimbursement strategies, and leadership education is essential to ensuring long-term CHW integration, workforce stability, and equitable care delivery.

Despite these advances, barriers remain:

- Lack of finalized Medicaid reimbursement for CHW services continues to stall hiring.
- CHW roles often depend on short-term grants, leading to frequent retraining and turnover.
- Misunderstanding of CHW responsibilities by administrators contributes to misutilization.
- Workforce instability is exacerbated by low wages and limited career advancement pathways.
- A preference for formally educated over community-connected applicants undermines CHW effectiveness and equity goals.

The CHW Learning Institute and resulting Toolkit represent critical progress in Illinois' public health workforce development. Continued investment in implementation infrastructure, reimbursement strategies, and leadership education is essential to ensuring long-term CHW integration, workforce stability, and equitable care delivery.

Background

Community Health Workers (CHWs) have long contributed to public health systems in the United States, yet their formal recognition within healthcare teams has only emerged in recent years. Historically rooted in peer and community-based health advocacy, CHWs play a central role in prevention, chronic disease management, health promotion, and care navigation—particularly in underserved populations.

The 2010 Patient Protection and Affordable Care Act (PPACA) helped catalyze increased interest in CHWs by encouraging the development of innovative workforce models to meet the growing demand for primary care. As trusted members of the communities they serve, CHWs are uniquely positioned to bridge clinical systems and community networks. Their effectiveness lies in their ability to offer culturally and linguistically appropriate education, follow-up care, case management, and connection to both medical and social supports.

Despite growing evidence supporting CHW effectiveness—including improvements in health outcomes, care coordination, and cost reduction—their integration remains inconsistent. Structural barriers such as unstable funding, lack of standardization, limited training infrastructure, and exclusion from formal workflows contribute to underutilization. Many CHWs continue to operate on the margins of healthcare, often funded through short-term grants with limited access to supervision or professional development.

Moreover, few standardized, evidence-based frameworks exist to guide organizations on how to effectively recruit, integrate, and sustain CHWs as core members of interdisciplinary teams. Integration is often further complicated by cultural and professional gaps between CHWs and clinical staff, unclear roles, and limited opportunities for CHWs to participate in care planning or data systems.

Efforts to improve CHW integration must focus not only on clarifying their scope of practice but also on adapting hiring, training, evaluation, and workplace policies to reflect the community-rooted nature of the role. When embedded into healthcare teams with clear roles, support structures, and systemic inclusion, CHWs have demonstrated powerful potential to build trust, improve outcomes, and reduce disparities across diverse populations.

Methodology

The development of this toolkit was informed by an 18-month statewide engagement effort conducted by the Illinois Public Health Association's CHW Capacity Building Center. A mixed-methods approach was used to gather data, assess organizational readiness, and understand the landscape of CHW integration across Illinois.

Data Collection Activities

- A CHW Integration Readiness Assessment Tool—designed by CHWs—was implemented across participating health systems to evaluate preparedness in areas such as planning, supervision, role clarity, stakeholder engagement, and sustainability.
- Key informant interviews with local health department administrators, hospital and FQHC leadership, and CHWs.
- Listening sessions and focus groups to elevate frontline insights from CHWs.
- Surveys administered to CHW employers to assess integration barriers, support systems, and training infrastructure.
- Review of national toolkits and standards, including the CHW Common Indicators Study, C3 Project, NACHW Public Health Department Toolkit, MHP Salud models, and ASTHO hiring guidance.

Learning Institute (LI) Structure

Participants in the CHW Integration Learning Institute received:

- Monthly facilitated workgroups and bi-monthly one-on-one consultations with Capacity Building Center staff.
- A digital toolkit including customizable job descriptions, evaluation templates, onboarding materials, and CHW training resources
- On-site technical assistance visits
- Stipends to attend the IPHA CHW Summit

Participant Scope:

- **Local Health Departments (LHDs)**: Adams, Bureau-Putnam, Douglas, Egyptian, Greene, Henderson, Jersey, Macoupin, Madison, Sangamon/Menard
- **Hospital Systems**: Endeavor Health (6 hospitals), Red Bud Regional Hospital (1 site)

- **Federally Qualified Health Center**: Shawnee Health (4 clinics)

Key Observations:

- 3 LHDs enhanced CHW training programs using LI resources
- 2 LHDs redesigned peer roles into formal CHW positions
- 2 LHDs created new CHW roles with LI guidance
- 4 LHDs and Red Bud Hospital joined to stay informed while awaiting reimbursement mechanisms
- Endeavor Health hired 10 CHWs during LI participation
- Shawnee Health exited the LI after CHW-related funding loss

Analysis

- Qualitative data from interviews, listening sessions, and focus groups were thematically coded to identify recurring integration challenges and best practices.
- Quantitative data from readiness assessments and surveys were analyzed to identify trends in CHW utilization, recruitment, supervision, and evaluation practices.

This participatory and iterative approach directly shaped the structure of this toolkit and informed the development of assessment tools, implementation strategies, and policy recommendations.

Findings

Through statewide engagement, IPHA identified critical barriers and opportunities in CHW integration. These findings are grouped into key themes:

- **Role Clarity**: CHW responsibilities are often misunderstood, leading to underutilization and confusion within care teams.
- **Sustainable Funding**: Most programs rely on short-term, disease-specific grants, limiting CHW sustainability.
- **Position Titling and Models**: Lack of standard job titles and integration frameworks makes cross-sector collaboration difficult.
- **Training and Education**: Many CHWs lack formal training; onboarding varies widely across organizations.

- **Systemic and Structural Barriers**: Health systems often lack the flexibility or structure to support community-based, non-clinical roles.
- **Professional Recognition**: CHWs may face stigma or exclusion in hierarchical healthcare settings.
- **Coordination and Communication**: Poor alignment with healthcare teams can fragment care and reduce impact.
- **Policy and Regulation Gaps**: Absence of standard certification and workforce policies makes scaling difficult.
- **Cultural and Contextual Differences**: Local norms and expectations may clash with standardized healthcare models, complicating CHW integration.

Taken together, these challenges underscore the need for not just more CHWs, but better systems to support them. Integration is not a one-time hire—it's an organizational shift that requires structural commitment, cultural humility, and a willingness to adapt policies and practices to the realities of frontline, community-rooted care. This toolkit was developed in response to that need. Grounded in the voices of CHWs and the experiences of organizations across Illinois, it offers a practical roadmap for moving beyond pilot projects toward sustainable, embedded CHW programs that are built to last. The following sections outline how these insights were gathered and transformed into actionable tools.

Toolkit Introduction

This toolkit was developed to guide organizations through the practical and strategic steps necessary to fully integrate Community Health Workers into their health systems. Grounded in statewide engagement and refined through real-world application, the toolkit includes customizable resources that support planning, implementation, training, and sustainability efforts. Each section is designed to meet organizations where they are—whether exploring CHW hiring for the first time or seeking to strengthen an existing program—and is structured around five core components:

This toolkit is organized into five core components, each designed to support a specific phase of CHW program development. These sections include customizable templates, checklists, and worksheets to guide implementation based on organizational needs.

The Five Components of CHW Integration:

1. **Assessing Organizational Readiness**
   Tools for evaluating internal capacity, identifying champions, and conducting environmental scans.
2. **Recruitment and Onboarding**
   Templates and strategies for hiring, onboarding, and retaining CHWs, with a focus on community-aligned recruitment.
3. **Training and Support Systems**
   Guidance on CHW core competencies, structured training pathways, supervision models, and peer support.
4. **Clinical and Community Integration**
   Practical resources for embedding CHWs in care teams, building referral pathways, and integrating with EHR systems.
5. **Evaluation and Sustainability Planning**
   Tools for measuring program impact and building sustainable, long-term integration strategies.

Section 1: Organizational Readiness

Successful CHW integration begins with assessing whether an organization is structurally and culturally prepared to adopt and support this workforce. This section provides tools and strategies for evaluating internal readiness, identifying program champions, and ensuring alignment with community health goals.

Drawing from the Illinois Public Health Association's CHW Readiness Assessment Toolkit—developed through statewide implementation and funded in part by Congressional District support—this framework equips organizations to move from interest to action.

Key Readiness Activities:

- **Capacity Assessment:** Organizations are encouraged to complete a structured readiness assessment to evaluate infrastructure, staffing, funding stability, and leadership buy-in. This includes an inventory of departments or services where CHWs may be integrated (e.g., primary care, maternal health, behavioral health) and an evaluation of how CHWs might collaborate with existing care teams.
- **Environmental Scanning:** A data-informed scan of community demographics, health disparities, and social determinants is essential for targeting CHW services where they are most needed. Tables included in the toolkit guide users through identifying high-priority populations—such as rural residents, immigrants, and individuals with chronic conditions—based on public health data and stakeholder input.
- **Champion Identification:** Organizations are asked to identify internal champions—individuals with community health knowledge and leadership capacity—to lead program design and implementation. Champions are instrumental in building stakeholder support, aligning the program with strategic goals, and navigating challenges such as role clarity or funding barriers.
- **Education & Model Alignment:** For organizations new to the CHW model, the toolkit offers educational strategies (e.g., workshops, webinars, success stories) to increase staff understanding and support. Sites may also pilot CHW engagement or track utilization metrics before making long-term hiring decisions.
- **Stakeholder Engagement:** Early engagement with clinical teams, community partners, and leadership ensures shared understanding and coordinated implementation. Regular communication, staff training, and feedback loops are recommended to build internal cohesion and accountability.

Outcomes of Readiness Planning: Organizations that complete this readiness process will gain:

- A clear roadmap for CHW program development
- Insight into potential barriers and facilitators
- Stronger internal alignment and staff buy-in
- Baseline data to inform evaluation and funding decisions.

By laying this foundation, organizations position themselves for effective, sustainable integration of CHWs who can bridge care gaps, improve health outcomes, and strengthen community trust in the healthcare system.

Organizational Readiness Domain 1: Leadership Buy-In

Why it Matters

Leadership support is the foundation of successful CHW integration. When leaders understand and endorse the CHW model, they create organizational alignment, secure resources, and reinforce the value of CHWs across teams. Without it, CHWs may be underutilized, misunderstood, or unsustainably funded.

Key Indicators of Readiness

✓ Executive leadership is familiar with the CHW model and its value
✓ A CHW program champion has been identified
✓ CHW integration aligns with the organization's mission or strategic plan
✓ Leaders support sustainable funding, supervision, and evaluation efforts
✓ CHWs are included in planning conversations alongside clinical staff

Common Leadership Buy-In Challenges

Challenge	Strategy
No designated CHW champion to lead implementation	Identify and formally appoint a respected internal leader to serve as the CHW program champion. Clearly define their role in leading planning, coordination, and communication.
Leadership unsure of ROI or impact	Provide data from peer-reviewed research and case studies (e.g., reduced ER visits, improved engagement). Share local pilot results and patient success stories to show value.
Competing priorities or staffing constraints	Tie CHW integration to existing organizational goals (e.g., value-based care, care coordination, health equity) and position it as a strategy to reduce burden on clinical staff.
CHW work viewed as a short-term pilot instead of core service	Integrate CHWs into long-term strategic planning. Use sustainability framing—such as billing options, partnerships, or grant-to-core transitions—to shift mindset from pilot to program.

Designating a CHW program champion

A CHW program champion is a key leader within an organization who drives the planning, implementation, and long-term success of Community Health Worker integration efforts. This individual serves as the primary advocate for the CHW model, ensuring that the program aligns with organizational goals, gains support across departments, and remains responsive to both staff and community needs.

A strong champion bridges the gap between leadership and frontline teams, facilitates cross-sector collaboration, and helps resolve challenges related to funding, role clarity, or workflow integration. By elevating the value of CHWs and embedding them into core operations—not just temporary projects—the champion plays a critical role in building a sustainable, equity-driven workforce.

Core Qualities of a program champion

- **Respected internally** – Someone who is trusted by both leadership and frontline staff
- **Cross-functional credibility** – Can communicate effectively across clinical, administrative, and community-facing teams
- **Committed to health equity** – Understands the CHW model's role in reducing disparities and improving access
- **Problem-solver** – Can navigate organizational challenges and advocate for resources, policy change, and sustainability
- **Collaborative mindset** – Values CHWs as part of the care team and supports inclusive planning

Ideal Roles for Champions Might Include:

- Director of Community Health or Outreach
- Population Health or Equity Officer
- Behavioral Health or Social Work Manager
- Clinical Operations Lead with a strong community lens
- Chief Nursing Officer or Director of Care Coordination
- Public Health Program Manager (in LHDs or FQHCs)

Champion Responsibilities Might Include:

- Leading CHW program design and integration strategy
- Facilitating staff training on the CHW model
- Coordinating across departments and partners
- Advocating for budget and resource allocation
- Tracking implementation milestones and evaluation metrics
- Representing the program in leadership and stakeholder meetings

Designating a CHW program champion is one of the most effective early steps an organization can take to ensure successful integration. With the right person in place, the CHW program gains a visible advocate who can navigate internal dynamics, align efforts across departments, and build momentum for long-term sustainability. Whether the champion comes from clinical leadership, community outreach, or public health administration, their ability to connect strategy with day-to-day operations is what ultimately drives success. By empowering a dedicated leader to guide implementation, organizations lay the groundwork for a CHW workforce that is not only embedded but embraced.

Capacity Assessment

Before launching or expanding a CHW program, organizations must evaluate their internal capacity. This includes infrastructure, staffing, workflow compatibility, and leadership support. A thorough capacity assessment ensures that CHW roles are positioned for success and aligned with organizational goals.

What to Assess:

Domain	Key Questions	Why It Matters
Leadership Buy-In	Do leaders understand the CHW model and support its implementation? Have champions been identified?	Leadership endorsement is essential for sustainability, staff alignment, and resourcing.
Staffing & Workflow	Are there clear opportunities to integrate CHWs within existing care teams? Will staff be open to CHW collaboration?	Ensures that CHWs are embedded in meaningful roles with defined functions.
Funding & Infrastructure	Are there financial resources available to hire, train, and support CHWs?	Stable funding allows for program planning beyond short-term pilots or grants.
Data & Evaluation Capacity	Can your organization monitor CHW activities and track outcomes?	Evaluation helps demonstrate value and informs continuous improvement.
Community Need Alignment	Do your target populations face health disparities that CHWs can address?	Aligning with community need ensures relevance and impact.

Recommended Actions:

- Convene a cross-functional team to complete the assessment collaboratively
- Use the checklist to identify strengths and gaps
- Develop a short action plan to address top-priority areas before implementation
- Reassess periodically as the program evolves

Toolkit Resources Provided:

- **Readiness Assessment Checklist** – A fillable tool to rate each domain on a scale (e.g., "Not Started" to "Well-Established")
- **Gap Analysis Worksheet** – Helps identify what additional resources or planning are needed
- **Sample Staff Survey Template** – Measures staff awareness, attitudes, and readiness for CHW integration

Readiness Assessment Checklist for CHW Integration

How to Use This Tool:

- Complete the checklist as a team (e.g., leadership, program managers, clinical leads)
- Mark your current status for each domain
- Identify and assign action steps to close readiness gaps
- Revisit this checklist regularly as the CHW program evolves

Domain	Indicators of Readiness	Status
Leadership Buy-In	☐ CHW model is understood by leadership ☐ Integration is aligned with strategic goals ☐ A program champion has been identified	☐ Not Started ☐ In Progress ☐ Well-Established
Organizational Infrastructure	☐ Roles and workflows allow for CHW integration ☐ Supervisory structure is defined ☐ Physical or digital space exists for CHWs (e.g., desk, EHR access)	☐ Not Started ☐ In Progress ☐ Well-Established
Workforce Alignment	☐ Staff understand the CHW role ☐ Existing teams are open to collaboration ☐ Cross-disciplinary communication is supported	☐ Not Started ☐ In Progress ☐ Well-Established
Funding Stability	☐ Budget exists or is being planned for CHW hiring ☐ Long-term funding strategies are under discussion ☐ Grant or billing options are being explored	☐ Not Started ☐ In Progress ☐ Well-Established
Data & Evaluation Readiness	☐ Systems are in place to track CHW activities ☐ Metrics have been identified (e.g., referrals, engagement, outcomes) ☐ Staff responsible for data reporting are identified	☐ Not Started ☐ In Progress ☐ Well-Established
Alignment with Community Needs	☐ Health disparities in the service area are documented ☐ CHW role is tailored to local priorities ☐ Community stakeholders support integration	☐ Not Started ☐ In Progress ☐ Well-Established
Scoring	**Not Started** **In Progress** **Well-Established**	**1 Point** **2 Points** **3 Points**
	Score	

Interpreting Your Score

Score Range	Readiness Level	Suggested Next Steps
6–10	Early Planning	Significant groundwork needed. Focus on leadership engagement, staff education, and resource identification before CHW implementation.
11–14	Moderate Readiness	Some core structures exist. Address key gaps—especially funding, workflows, or staff alignment—to prepare for successful CHW integration.
15–18	High Readiness	Strong foundation in place. Begin implementation planning or expansion, focusing on sustainability and evaluation strategies.

Tip: Use scores to identify specific domains where improvement is needed—not just to evaluate overall readiness. For example, even a high-scoring site may need to strengthen "Data & Evaluation Readiness" before launching.

Gap Analysis Worksheet – CHW Integration Readiness

Domain	Current Status	Identified Gaps	Recommended Action(s)	Responsible Party	Timeline
Example *Leadership Buy-In*	*Leadership is aware but not fully engaged*	*No formal champion identified; limited leadership visibility*	*Identify and appoint CHW program champion; schedule leadership briefing*	*Director of Programs*	*End of Q2*
Leadership Buy-In					
Organizational Structure					
Workforce Alignment					
Funding Stability					
Data & Evaluation Readiness					
Community Need Alignment					

- Use this sheet after completing the Readiness Checklist
- Summarize gaps and determine specific, actionable steps
- Assign clear responsibilities and set timelines
- Review progress in team meetings or check-in

Guidelines for Using the CHW Staff Education & Awareness Survey

Purpose:
This survey gauges staff understanding of the CHW role, identifies training needs, and highlights attitudes toward integration. It is used to inform internal education efforts and assess organizational readiness.

When to Use:

- Before CHW program launch
- After CHW staff training
- During readiness assessments or evaluations

Who Should Complete It:

- Clinical and non-clinical staff
- Program managers and supervisors

How to Distribute:

- Digital: Google or Microsoft Forms
- Paper: Staff meetings or onboarding
- Tip: Keep it anonymous for honest feedback

How to Analyze:

- Spot knowledge gaps and concerns (e.g., role clarity, funding)
- Sort responses by team or role to tailor training

How to Use Results:

- Plan targeted education sessions
- Share FAQs to address common concerns
- Support CHW introductions with staff to build trust

CHW Staff Education & Awareness Survey

Use this survey before launching your CHW program to assess baseline staff knowledge, attitudes, and training needs.

Part 1: Understanding of the CHW Role

1. How familiar are you with the role of a Community Health Worker (CHW)?
   ☐ Not at all familiar
   ☐ Somewhat familiar
   ☐ Very familiar

2. CHWs provide which of the following services? (Select all that apply)
   ☐ Health education and outreach
   ☐ Clinical diagnosis and treatment
   ☐ Care coordination and referrals
   ☐ Social support and advocacy
   ☐ Community needs assessments
   ☐ Not sure

3. How confident are you in explaining the CHW role to a colleague or client?
   ☐ Not confident
   ☐ Somewhat confident
   ☐ Very confident

Part 2: Attitudes Toward CHW Integration

4. I believe CHWs would add value to our care team.
   ☐ Strongly disagree
   ☐ Disagree
   ☐ Neutral
   ☐ Agree
   ☐ Strongly agree

5. I am open to collaborating with a CHW on shared patients or clients.
   ☐ Strongly disagree
   ☐ Disagree
   ☐ Neutral
   ☐ Agree
   ☐ Strongly agree

6. What potential concerns do you have about integrating CHWs into our organization? (Select all that apply)
   ☐ Role overlap/confusion
   ☐ Supervision or accountability
   ☐ Communication or workflow barriers
   ☐ Funding or sustainability
   ☐ I have no concerns
   ☐ Other: _____

Part 3: Training and Support Needs

7. What type of training would help you better understand the CHW role? (Select all that apply)
   ☐ Short in-service presentation
   ☐ Detailed workshop or training session
   ☐ Written job descriptions and workflows
   ☐ Examples from other organizations
   ☐ One-on-one Q&A with a CHW
   ☐ None needed

8. Would you be interested in attending a CHW-focused training or webinar?
   ☐ Yes
   ☐ Maybe
   ☐ No

9. What questions do you have about the CHW model or how it will be implemented here?

Organizational Readiness Domain 2: Staffing & Workflow

Why It Matters

Integrating CHWs into existing staffing structures requires intentional planning. Without clear roles, supervision, and workflow alignment, CHWs may become underutilized or isolated. Thoughtful integration ensures CHWs are positioned as valued team members with defined responsibilities and collaborative relationships across departments.

Key Indicators of Readiness

✓ Clear roles and responsibilities for CHWs have been defined
✓ Supervisory structure is established and understood
✓ CHWs are integrated into clinical or community workflows (e.g., referral processes, care team meetings)
✓ Staff understand how CHWs complement—not duplicate—their roles
✓ CHWs have access to tools and systems needed to perform their duties (e.g., EHR access, team huddles, workspace)

Common Staffing & Workflow Challenges and Strategies

Challenge	Strategy
Undefined or overlapping roles	Develop a CHW job description aligned with core competencies and community needs. Clarify responsibilities across departments.
No assigned supervisor or unclear supervision plan	Designate a CHW supervisor with relevant experience (e.g., social work, public health). Provide supervisor training specific to CHW support.
CHWs working in isolation from care teams	Include CHWs in team meetings, morning huddles, and interdisciplinary care planning. Ensure they are introduced as part of the care team.
Lack of staff awareness of CHW function	Use internal education (e.g., CHW 101 sessions) to explain the CHW scope and collaboration opportunities.
Workflow incompatibility (e.g., no referral process or data system access)	Map workflows to show where CHWs fit. Update policies to include CHWs in care coordination, referral tracking, and communication systems.

Toolkit Resources Provided

- **CHW Role Mapping Worksheet** – Helps define CHW functions, team interactions, and workflow touchpoints across departments.
- **Sample Workflow Integration Chart –** Visual tool to illustrate where CHWs fit in existing workflows such as referral pathways, care teams, or SDOH screenings.

CHW Role Mapping Worksheet

Purpose:
This worksheet helps organizations clarify the unique functions of CHWs, reduce role confusion, and identify where CHWs add value within current workflows.

Step 1: Define CHW Functions in Your Setting

Core Function	Will CHWs Perform This?	Notes / Clarifications
Health education and outreach	☐ Yes ☐ No	e.g., diabetes prevention workshops
Care coordination & referrals	☐ Yes ☐ No	e.g., SDOH needs, transportation assistance
Navigation of health & social services	☐ Yes ☐ No	e.g., help with Medicaid, food banks
Informal counseling & support	☐ Yes ☐ No	e.g., pregnancy support, chronic illness
Community engagement	☐ Yes ☐ No	e.g., attending neighborhood events
Home visits / field-based work	☐ Yes ☐ No	e.g., postpartum support at home
Data collection / documentation	☐ Yes ☐ No	e.g., referral outcomes, client goals

Step 2: Map Team Collaboration

Team Member	Interaction with CHWs	Notes / Communication Channels
Nurses	e.g., CHWs reinforce care plans	Team huddles, shared case notes
Social Workers	e.g., CHWs identify non-clinical needs	Warm handoffs, care conferences
Providers	e.g., CHWs prepare clients for visits	Referral workflows
Program Managers	e.g., Supervise CHWs	Weekly check-ins, data review
Front Desk / Intake	e.g., CHW referrals after SDOH screening	Internal messaging or referral form

Step 3: Integration Points in Workflow

- **CHW Referral Triggered By:**
  ☐ Intake Screening
  ☐ Provider Referral
  ☐ SDOH Assessment
  ☐ Community Outreach
- **CHW Documenting In:**
  ☐ EHR
  ☐ Separate tracking system
  ☐ Paper forms
  ☐ Not yet determined
- **CHW Included In:**
  ☐ Care Team Meetings
  ☐ Case Conferences
  ☐ Community Advisory Boards

CHW Supervision Planning Guide

Purpose:
This guide helps organizations define a supervision structure that supports Community Health Workers (CHWs) through mentorship, performance oversight, and professional development while recognizing the unique nature of their role.

Step 1: Identify the Right Supervisor

Ideal Supervisors May Include:

- Behavioral Health or Social Work Manager
- Public Health Nurse or Program Coordinator
- Experienced CHW or CHW Team Lead (if internal career pathways exist)
- Population Health or Care Coordination Manager

Note: CHWs should not be supervised solely by clinicians unfamiliar with community-based work.

Step 2: Define Supervision Responsibilities

Function	Supervisor Role	Frequency
Performance Feedback	One-on-one check-ins, review of referrals and documentation	Weekly or Bi-weekly
Case Consultation	Support on complex client needs or boundary issues	As needed
Professional Development	Identify training needs, support certification, or advancement	Monthly
Emotional Support	Provide space for debriefing, stress management, and reflection	Regular, trauma-informed approach
Workflow Support	Ensure CHWs have what they need to do their job effectively	Ongoing

Step 3: Create a Supervision Plan

Planning Area	Your Notes
Who will supervise the CHW(s)?	
How often will individual supervision occur?	
What group/team supports will be in place (e.g., peer supervision, team meetings)?	
What documentation or evaluation tools will be used?	
How will supervisors be trained in CHW role, scope, and support needs?	

Tips for Effective CHW Supervision

- Center relationship-based supervision, not productivity-only checklists
- Provide ongoing coaching, not just administrative oversight
- Use reflective practices and trauma-informed principles
- Ensure role clarity across teams to avoid CHWs being asked to perform or be evaluated on duties outside their scope and the unique qualities of the CHW profession.

Sample Workflow Integration Chart

CHW Integration Across the Client Journey

Toolkit Tip:

- Use this as a starting point for creating your own internal flowcharts.
- Include custom roles (e.g., Peer Support Specialist, Health Navigator) if applicable.
- Don't forget to train all staff on how CHWs fit into each step.

Workflow Step	Staff Involved	CHW Role	Touchpoints / Notes
1. Intake / Registration	Front Desk, Intake Coordinator	Review SDOH screeners, flag unmet needs, initiate warm handoff if needed	CHW may be co-located or on-call
2. Initial Assessment	Nurse, Case Manager, Provider	Provide support in gathering social history or barriers to care	May sit in on appointment or meet client immediately after
3. Referral Triggered	Provider, Social Worker	CHW receives referral via EHR, paper form, or verbal communication	Ensure referral process is documented and trackable
4. CHW Engagement	CHW	Meet with client (in person, phone, or home visit), complete needs assessment, offer support and education	Document contact in EHR or tracker
5. Resource Navigation	CHW, Social Worker	Assist with housing, transportation, insurance, food, etc.	Coordinate with internal or external partners
6. Team Communication	CHW, Care Team	Share updates during huddles or meetings; escalate complex needs	Ensure CHW insights are valued and included
7. Follow-Up & Closure	CHW	Confirm referral completion, client satisfaction, and linkage to ongoing care	Close case or continue support based on need

Organizational Readiness Domain 3: Funding & Infrastructure

Why It Matters

Sustainable funding and operational infrastructure are essential for long-term CHW integration. Without secure financial support, CHW positions often depend on short-term grants, leading to instability, high turnover, and interrupted care. Infrastructure—such as HR systems, technology access, and operational policies—ensures CHWs are not just hired but supported effectively.

Key Indicators of Readiness

✓ CHW positions are included in the organizational budget
✓ Potential billing/reimbursement pathways have been explored
✓ HR systems can onboard and track CHWs as a distinct staff category
✓ CHWs have access to technology, workspaces, and operational supports
✓ Long-term funding plans are in development (e.g., value-based care, braided funding)

Common Funding & Infrastructure Challenges and Strategies

Challenge	Recommended Strategy
CHW roles are funded only through short-term grants	Start planning early for long-term sustainability. Explore blended/braided funding, Medicaid reimbursement, or aligning CHWs with value-based care initiatives.
CHW positions not included in the core operating budget	Incorporate CHW staffing into annual budgeting cycles and strategic plans to avoid dependency on temporary funds.
No billing or reimbursement model in place	Explore available Medicaid or managed care billing pathways in your state. Engage finance teams and external partners, such as billing hubs or partnerships.
Lack of infrastructure (desk, computer, phone, data access)	Ensure CHWs have workspace, equipment, and secure systems access. Include CHWs in IT, facilities, and HR onboarding workflows.
HR systems don't track or differentiate CHWs	Create a distinct job title or classification. This supports evaluation, funding proposals, and career development tracking.

Toolkit Resources Provided

- **CHW Budget Planning Worksheet** – Helps identify personnel and operational costs, funding sources, and sustainability gaps
- **Infrastructure Readiness Checklist** – Covers workspace, equipment, systems access, and onboarding needs

CHW Budget Planning Worksheet

Planning for Sustainable CHW Program Funding

Step 1: Estimate Personnel Costs

Category	Estimated Cost	Notes
CHW Salary (per FTE)	$_____	Base salary or hourly rate × expected FTE
Benefits (health, retirement, PTO)	$_____	Estimated at ~25–30% of salary
Supervisor/Manager (portion related to CHW oversight)	$_____	May be shared across programs
Peer Mentorship or Team Lead Support	$_____	Optional, if applicable
Staff Training & Onboarding	$_____	CHW core training, orientation, cultural humility, etc.

Step 2: Estimate Operational & Infrastructure Costs

Category	Estimated Cost	Notes
Equipment (laptop, phone, hotspot)	$_____	One-time or replacement every 2–3 years
Workspace / Desk / Supplies	$_____	May be field-based or co-located
EHR Access / Software Licensing	$_____	For documentation and coordination
Travel / Mileage / Field Visit Costs	$_____	Especially for community- or home-based roles
Program Evaluation / Data Tracking	$_____	Surveys, dashboards, outcome tracking tools

Step 3: Identify Funding Sources

Funding Source	Amount or % of Budget	Status
Federal or State Grants	$_____	☐ Confirmed ☐ Pending ☐ Needs Research
Local Funding / Health Department	$_____	☐ Confirmed ☐ Pending ☐ Needs Research
Medicaid Reimbursement / MCO Partnership	$_____	☐ Available ☐ Not yet explored
General Operating Funds	$_____	☐ Confirmed ☐ Needs Leadership Approval
Philanthropy or Foundation Support	$_____	☐ Confirmed ☐ Needs Application

Step 4: Funding Gaps & Action Items

What costs are currently unfunded?

What short-term solutions can cover gaps?

What is needed for long-term sustainability (e.g., billing readiness, advocacy, partner support)?

Use this worksheet annually or during grant development, budgeting cycles, or CHW program planning meetings.

CHW Infrastructure Readiness Checklist

Ensuring CHWs Have the Tools and Access to Work Effectively

Use this checklist to assess whether your organization is equipped to onboard and support CHWs in their daily responsibilities. It can be completed by HR, program leads, or supervisors during program planning or hiring.

Workspace & Physical Environment

Item	Status	Notes
Dedicated workspace (desk, workstation, or shared office)	☐ Yes ☐ No	
Access to shared meeting space for client or team interactions	☐ Yes ☐ No	
Field-based workers equipped with mobile tools (e.g., laptop/tablet)	☐ Yes ☐ No	

Technology & Systems Access

Item	Status	Notes
Computer or tablet issued to CHW	☐ Yes ☐ No	
Work phone or secure phone access for client communication	☐ Yes ☐ No	
Organization email account set up	☐ Yes ☐ No	
EHR access (if applicable)	☐ Yes ☐ No	
CHW-specific login credentials to necessary platforms (e.g., SDOH tools, trackers)	☐ Yes ☐ No	

Operational Tools & Supplies

Item	Status	Notes
Office supplies or digital materials for client engagement	☐ Yes ☐ No	
CHW resource directory (physical or digital)	☐ Yes ☐ No	
Documentation forms or care coordination templates	☐ Yes ☐ No	

Onboarding & Integration Support

Item	Status	Notes
CHW included in standard staff onboarding	☐ Yes ☐ No	
CHW-specific onboarding plan in place (e.g., shadowing, introductions)	☐ Yes ☐ No	
Introduced to care teams, supervisors, and support staff	☐ Yes ☐ No	
Participating in team meetings or huddles	☐ Yes ☐ No	
Orientation includes review of role expectations and workflows	☐ Yes ☐ No	

Toolkit Tip: Complete this checklist before the CHW's first day to avoid delays in engagement and client care.

Organizational Readiness Domain 4: Data & Evaluation Capacity

Why It Matters

CHW programs must be able to demonstrate their impact to justify continued funding, improve service delivery, and support workforce sustainability. Data and evaluation systems allow organizations to track referrals, outreach efforts, client outcomes, and overall program effectiveness. Without proper tracking and evaluation, CHW contributions may remain invisible, undervalued, or disconnected from organizational goals.

Key Indicators of Readiness

✓ Systems exist to document CHW activities (referrals, screenings, education, outreach)
✓ Key performance indicators (KPIs) are defined and aligned with program goals
✓ CHWs are trained on how to document their work accurately and consistently
✓ Supervisors and evaluation staff regularly review data for program improvement
✓ Evaluation metrics are tied to funding requirements and/or quality initiatives

Common Data & Evaluation Challenges and Strategies

Challenge	Recommended Strategy
No system in place to track CHW activities	Develop simple, structured tracking tools (e.g., spreadsheets, case logs) or add CHW fields to existing HER systems. Start small and scale up.
Unclear or inconsistent documentation practices	Train CHWs on what to document, how, and why. Use role-specific examples and reinforce through supervision.
No defined outcomes or performance measures	Work with leadership to identify key indicators tied to organizational priorities (e.g., reduced no-shows, improved linkage to care, SDOH resolution).
CHW data siloed from clinical data	Integrate CHW data into shared systems or create regular communication loops (e.g., huddles, shared dashboards) to align care.
Evaluation not tied to sustainability	Use data to build the case for continued investment. Share metrics with funders, leadership, and partners to demonstrate value.

Toolkit Resources Provided

- **CHW Activity Log Template** – Simple tracking sheet to document outreach, referrals, and follow-ups
- **Key Indicators Menu** – Sample metrics aligned with common CHW goals (e.g., referral success, engagement, health access)
- **Data Integration Planning Tool** – Helps identify how CHW data fits into existing systems (EHR, dashboards, case management)
- **CHW Documentation Best Practices Tip Sheet** – Guidance on real-world documentation that balances detail with feasibility

CHW Activity Log Template

Daily/Weekly Tracking of CHW Activities

Use this tool to document CHW interactions with clients and the community. It supports supervision, evaluation, and reporting for funders or internal stakeholders.

CHW Name: _____

Date Range: _____

Organization / Program: _____

Date	Client Initials or ID	Type of Activity	Topic / Focus	Referral Made?	Follow-Up Needed?	Notes
4/11/25	JD	Outreach	SNAP/food access	Yes (WIC)	Yes – call in 1 week	Client missed benefits appt.
4/11/25	RS	Health education	Diabetes prevention	No	No	Group workshop – gave resource guide
4/12/25	AC	Care coordination	Behavioral health	Yes (counseling)	Yes – check status	Waiting for call back from provider
4/12/25	--	Community event	COVID vaccines	N/A	No	Attended church health fair – 45 people reached

Legend:

- **Type of Activity:**
  ☐ Outreach
  ☐ Health Education
  ☐ Referral Support
  ☐ Follow-Up
  ☐ Navigation
  ☐ Community Event
- **Topic / Focus Examples:**
  Housing, Food Access, Chronic Illness, Maternal Health, Mental Health, Transportation, Insurance, Substance Use, etc.

Key Indicators Menu

Sample Metrics for Evaluating CHW Program Impact

Use this menu to select key performance indicators (KPIs) that align with your CHW program's goals. These metrics support internal evaluation, grant reporting, and demonstrating value to funders and stakeholders.

1. Client Engagement & Reach

Indicator	Definition	Why It Matters
Clients Served	Total number of unique individuals engaged by CHWs	Demonstrates program reach and workload
Repeat Contacts	Average number of follow-ups per client	Shows depth of engagement and trust-building
Community Events Held	Number of events or outreach efforts conducted	Captures visibility and community presence
Educational Sessions Delivered	Number of 1:1 or group health education sessions	Tracks prevention and empowerment efforts

2. Referral & Navigation Outcomes

Indicator	Definition	Why It Matters
Referrals Made	Number of referrals to services (e.g., housing, food, mental health)	Indicates CHW connection to local resources
Referral Completion Rate	% of referrals successfully accessed by clients	Measures effectiveness of follow-through support
Barriers Identified	Common social determinants recorded (e.g., transportation, food insecurity)	Informs policy and programmatic priorities

3. Health Access & Care Coordination

Indicator	Definition	Why It Matters
Clients Linked to Primary Care	Number of clients connected to a PCP or clinic	Supports continuity of care and preventive access
Preventive Services Accessed	Vaccinations, screenings, or wellness visits completed	Demonstrates role in improving care utilization
Missed Appointment Reduction	Change in no-show rates for clients with CHW support	Tied to cost savings and care plan adherence

4. Program Sustainability & Workforce

Indicator	Definition	Why It Matters
CHW Retention Rate	% of CHWs retained over 12 months	Reflects workplace support and program stability
Supervisor Feedback	Regular assessments of CHW integration by managers	Guides quality improvement
Stakeholder Satisfaction	Feedback from partners or departments working with CHWs	Captures value perception across teams

Toolkit Tip: Choose **3–5 indicators** that match your CHW model and capacity. Start simple and scale over time with input from CHWs and program staff.

Data Integration Planning Tool

Aligning CHW Documentation with Existing Systems

Use this tool during planning meetings with supervisors, IT, evaluation staff, or leadership to define how CHW data will be collected, shared, and used—without creating silos or duplicative work.

Step 1: Define What CHWs Will Document

CHW Activities to Track	Will It Be Tracked?	Format / Method
Client encounters / outreach	☐ Yes ☐ No	[e.g., EHR notes, Google Form, Excel]
Referrals made	☐ Yes ☐ No	
Referral outcomes (completed or not)	☐ Yes ☐ No	
Education topics covered	☐ Yes ☐ No	
SDOH needs identified	☐ Yes ☐ No	
Client goals / follow-ups	☐ Yes ☐ No	
Group event participation	☐ Yes ☐ No	

Step 2: Identify Where CHW Data Will Be Entered

System or Platform	CHWs Have Access?	Notes / Integration Needs
Electronic Health Record (EHR)	☐ Yes ☐ No	e.g., EPIC, eClinicalWorks
Case management system	☐ Yes ☐ No	e.g., Salesforce, Apricot, Athena
CHW-specific platform	☐ Yes ☐ No	e.g., CareMessage, RedCap
Shared tracking spreadsheet	☐ Yes ☐ No	e.g., Excel, Google Sheets
State/funder data portal	☐ Yes ☐ No	e.g., Medicaid dashboard, grant system

Step 3: Plan for Access, Training, and Privacy

Integration Area	Notes / Action Items
Who grants CHWs access to required systems?	
What training is needed for documentation tools?	
How will data be reviewed and used for improvement?	
Are there any HIPAA or confidentiality concerns?	
Will CHWs participate in team data huddles or reviews?	

Toolkit Tip: If CHWs do not have EHR access, develop a secure handoff or referral log system that connects their data to the broader care team. Even basic integration strengthens visibility and continuity.

CHW Documentation Best Practices Tip Sheet

Helping CHWs Document Effectively and Sustainably

Documentation should reflect the value of CHW work—without overburdening frontline staff or requiring unnecessary detail. Documentation formats should take into consideration a range of literacy levels and writing experience. This tip sheet helps strike that balance.

What Should Be Documented?

CHWs should document interactions that reflect:

- Client contact and support (who, when, and why)
- Services or education provided
- Referrals made and their outcomes
- Needs identified (e.g., food, housing, transportation)
- Follow-up actions or client progress
- Significant barriers, safety concerns, or care coordination issues

Documentation Do's

Do This	Why It Helps
Use clear, plain language	Supports shared understanding with providers and supervisors
Be concise but specific	"Provided transportation support to food pantry" > "Helped client"
Use checkboxes/templates when available	Reduces burden and improves consistency
Include context only when relevant	e.g., "Client unable to attend appointment due to lack of childcare"
Document in real-time or end of day	Improves accuracy and reduces backlog
Flag urgent concerns immediately	Use your organization's escalation protocol

Documentation Don’ts

Avoid This	Why It’s a Problem
Writing long narratives for every contact	Time-consuming and often unnecessary
Documenting sensitive personal info without relevance	Breaches trust and confidentiality
Using slang, judgmental, or clinical language (if not licensed to do so)	Can misrepresent the CHW’s role or confuse others
Skipping documentation entirely	Undermines visibility, funding, and team coordination

Tips for Supervisors and Program Leads

- Make expectations realistic (e.g., prioritize key fields over full case notes)
- Ensure CHWs are trained on documentation systems and privacy guidelines
- Allow time during shifts for data entry—don’t treat it as “extra”
- Use CHW documentation in team meetings, grant reports, and success stories

Organizational Readiness Domain 5: Community Need Alignment

Why It Matters

CHWs are most effective when their work is directly aligned with the health needs, lived experiences, and priorities of the communities they serve. A mismatch between CHW deployment and actual community conditions can lead to underutilization, duplication of services, or erosion of trust. Assessing local health disparities, demographic data, and social determinants ensures that CHW roles are responsive, strategic, and equity-driven.

Key Indicators of Readiness

✓ CHW focus areas align with documented health disparities and community priorities
✓ The organization has reviewed local public health and SDOH data
✓ Community members or advisory groups inform CHW program design
✓ CHWs are recruited from or have strong ties to the target population
✓ Programs are tailored to high-need groups (e.g., rural residents, immigrants, low-income families)

Common Community Alignment Challenges and Strategies

Challenge	Recommended Strategy
No data-driven process to prioritize community needs	Conduct a simple environmental scan using public health data, SDOH reports, and stakeholder input. Use toolkit templates to guide the process.
CHW activities not aligned with local gaps	Review service area data and redesign CHW responsibilities to focus on highest-need issues (e.g., chronic disease, maternal health, housing).
No community voice in CHW planning	Establish feedback loops through listening sessions, surveys, or advisory groups. Involve community partners early.
CHWs not representative of the community served	Recruit directly from within the population served and remove barriers that privilege formal education over lived experience.
Services duplicated or disconnected from local providers	Map existing community resources and integrate CHWs into cross-sector referral networks or collaborative efforts.

Effective CHW integration begins with the community—not the clinic. Programs that are informed by real needs and shaped by local voices are more likely to earn trust, achieve measurable impact, and promote equity. Community alignment is not a one-time step; it is an ongoing process that keeps CHWs rooted in purpose and practice.

Toolkit Resources Provided

- **Community Scan Worksheet** – Guides organizations in assessing local demographic, health, and SDOH indicators
- **Population Prioritization Matrix** – Helps teams decide where CHWs can have the most impact
- **Stakeholder Engagement Planning Tool** – Outlines how to involve community members and partners in CHW program design

Community Scan Worksheet

Assessing Demographic, Health, and SDOH Indicators to Guide CHW Focus

Use this worksheet during planning meetings, grant writing, or readiness assessments to determine where and how CHWs can make the most impact.

Step 1: Define Your Service Area

- Counties, ZIP codes, or neighborhoods served:

- Primary population groups (e.g., racial/ethnic, linguistic, age-based):

- Partners or agencies already serving this area:

Step 2: Demographic Snapshot

Indicator	Your Data / Notes	Source Used
Total population		
% Living below poverty line		
% Uninsured or underinsured		
% Non-English speaking or limited English proficiency		
% Rural or transportation-limited		
Age distribution (youth, older adults)		

Step 3: Health Disparities & Access

Health Factor	What the Data Shows	Notes
Chronic disease prevalence (e.g., diabetes, hypertension)		
Maternal/infant health outcomes		
Mental health/substance use concerns		
Emergency room overuse / avoidable hospitalizations		
Preventive care access (e.g., screenings, vaccines)		

Step 4: Social Determinants of Health (SDOH)

Need Area	Local Challenges Identified	Existing Resources?
Housing		☐ Yes ☐ No
Food security		☐ Yes ☐ No
Transportation		☐ Yes ☐ No
Employment / job readiness		☐ Yes ☐ No
Legal/immigration support		☐ Yes ☐ No
Digital access / broadband		☐ Yes ☐ No

Step 5: Implications for CHW Focus

- What **health or social gaps** could CHWs address directly?

- Which populations are **most underserved** in your region?

- Where are the **opportunities for CHWs to connect clients** to care or resources?

Toolkit Tip: Pair this worksheet with the **Population Prioritization Matrix** to turn data into action when designing CHW roles.

Population Prioritization Matrix

A Tool to Help Determine Where CHWs Can Do the Most Good

Use this matrix to compare population groups based on key factors like health disparities, service gaps, and CHW fit. It's best completed with a small team including program staff, CHWs (if available), and community partners.

Step 1: Identify Populations to Consider

List specific groups or communities in your service area that may benefit from CHW support (e.g., rural seniors, Spanish-speaking immigrants, low-income parents, unhoused individuals, youth exiting foster care, etc.)

Step 2: Rate Each Group Across Five Criteria

Rate from 1 (low) to 5 (high). Add notes if needed.

Population Group	Health Disparities	Access Barriers	Existing Services	CHW Alignment	Community Demand	Total Score (out of 25)
Example: Rural seniors	5	5	2	4	4	20
Example: Spanish-speaking immigrants	4	5	3	5	5	22

Rating Criteria:

- **Health Disparities:** How significant are the preventable or unmanaged health issues in this population?
- **Access Barriers:** Does this group face structural or geographic challenges to getting care?
- **Existing Services:** Are other programs already serving this population? (Lower score = more coverage)
- **CHW Alignment:** Does the CHW workforce reflect or relate well to this group?
- **Community Demand:** Have stakeholders or community members identified this group as high-priority?

Step 3: Interpret Your Results

- Focus CHW deployment on populations with **high total scores**
- Use results to inform recruitment, training, and outreach strategies
- Revisit regularly as population needs and services evolve

Toolkit Tip: Pair this matrix with your **Community Scan Worksheet** to ground your decisions in both data and local insight.

Stakeholder Engagement Planning Tool

Building Inclusive Input Into CHW Program Design

Use this tool to map out who should be at the table, how they'll contribute, and how feedback will inform decisions. Meaningful engagement builds stronger programs and greater community trust.

Step 1: Identify Stakeholders to Engage

Stakeholder Group	Why They Matter	Current Relationship	Engagement Approach
CHWs (current or former)	Bring frontline expertise	☐ Strong ☐ Moderate ☐ None	☐ Listening session ☐ Focus group ☐ Advisory role
Community members	Voice of lived experience	☐ Strong ☐ Moderate ☐ None	☐ Survey ☐ Town hall ☐ Partner via CBO
Community-Based Orgs (CBOs)	Serve overlapping populations	☐ Strong ☐ Moderate ☐ None	☐ MOU ☐ Joint planning mtg ☐ Resource sharing
Clinical or care team staff	Key collaborators with CHWs	☐ Strong ☐ Moderate ☐ None	☐ Cross-training ☐ Integration planning
Public health / FQHC leadership	Policy, funding, and oversight	☐ Strong ☐ Moderate ☐ None	☐ Briefing ☐ Roundtable ☐ Strategic alignment
Faith-based, cultural, or local leaders	Community gatekeepers	☐ Strong ☐ Moderate ☐ None	☐ Invitation to advisory group ☐ One-on-one outreach

Step 2: Define Engagement Methods and Timeline

Activity	Format	Goal	Timeline	Lead Contact
CHW design input session	Virtual focus group	Identify role clarity & training gaps	Aug 10	Program Coordinator
Community feedback survey	Online + paper	Capture care barriers & needs	Sept 1–15	Outreach Team
Advisory group formation	Recurring meetings	Guide program alignment long-term	Ongoing	Director of Equity

Step 3: Plan for Feedback Integration

What Will You Do With the Input?	Who's Responsible?	How Will Stakeholders Be Informed of Outcomes?
Incorporate CHW suggestions into job descriptions and workflows	Program Manager	Email summary + final drafts shared
Use community survey results to set CHW focus areas (e.g., food, housing)	Data Team	Community update newsletter
Bring advisory recommendations to leadership for policy change	ED or Admin Lead	Report back during next meeting

Toolkit Tip: Stakeholder engagement is not one-and-done. Build feedback loops that ensure partners feel heard—and see how their input shapes outcomes.

Section 2: Recruitment & Onboarding

Recruiting and onboarding Community Health Workers (CHWs) is more than filling a role—it's about finding the right people with the lived experience, trust, and cultural alignment to connect with the community and deliver meaningful support. This section provides strategies and tools to help organizations attract, select, and onboard CHWs in ways that are inclusive, practical, and community-centered.

Effective recruitment focuses on hiring individuals from within the populations served, prioritizing real-world knowledge and community connection over formal credentials. CHW onboarding must go beyond standard HR procedures, introducing new hires to the mission, values, and expectations of the role, while equipping them with tools to thrive on day one.

This section also addresses screening practices that honor both lived experience and transferable skills, as well as early-stage supports that build retention—including supervision, mentorship, and structured team introductions. When done thoughtfully, recruitment and onboarding lay the groundwork for CHWs to feel empowered, supported, and embedded within the organization's care structure from the very beginning.

Community-Aligned Recruitment

Why It Matters

The strength of a CHW program begins with who you hire. CHWs are most effective when they share lived experience, language, culture, or history with the communities they serve. Recruiting from within the population ensures CHWs are not only trusted by clients but can engage meaningfully and navigate systems on their behalf with credibility. **Overemphasis on credentials, disconnected job ads, or rigid HR processes often filters out the very people best suited for the role.**

Key Strategies for Community-Aligned Hiring

Strategy	Action Steps
Recruit from the population served	Post jobs through community-based organizations, churches, mutual aid networks, and trusted local spaces—not just large platforms.
Value lived experience equally to education	Make clear in the job description that community knowledge, informal leadership, or personal experience with health systems is valued.
Remove unnecessary credential barriers	Eliminate degree requirements unless required by funders. Instead, focus on communication skills, reliability, and community trust.
Use inclusive and plain-language job postings	Avoid jargon. Say what the job actually involves using accessible language and real-world examples.
Involve community partners in outreach	Let trusted organizations refer candidates. Consider CHW info sessions or informal application support.
Reflect equity in compensation	Ensure CHW pay is competitive and reflective of the value they bring—don't assume the role can be filled by unpaid labor or volunteers.

Toolkit Resources Provided

- **CHW Job Description Template** – Adaptable postings that emphasize lived experience, flexibility, and core responsibilities
- **CHW–Community Fit Checklist** – Helps assess alignment between applicants and target populations
- **Recruitment Strategy Checklist** – Planning tool to ensure equitable, community-rooted hiring practices
- **Sample CHW Interview Questions**– Plain-language discussion points that consciously evaluate lived experience, trust, and community-connection

Community Health Worker (CHW) Job Description Template

Job Title: Community Health Worker (CHW)
Reports to: [Program Manager / Director of Community Health / Clinical Supervisor]
Employment Status: [Full-time / Part-time / Contract]
Location: [Organization Name / Service Area]

Position Summary:

The Community Health Worker (CHW) serves as a bridge between the community and the healthcare, social service, or public health system. This role focuses on supporting individuals in navigating resources, improving health outcomes, and addressing social determinants of health through outreach, education, and care coordination.

Essential Duties & Responsibilities:

- Conduct outreach to individuals and families in the target community
- Provide culturally appropriate health education and informal counseling
- Assist clients in navigating healthcare systems and accessing services (e.g., medical, behavioral health, housing, food)
- Conduct screenings for social determinants of health and make referrals as needed
- Support clients in care coordination, follow-up, and appointment scheduling
- Facilitate communication between clients, families, providers, and community organizations
- Maintain accurate documentation of encounters, referrals, and outcomes
- Participate in case reviews, staff meetings, and community events
- Collaborate with healthcare teams, social workers, and community agencies
- Uphold confidentiality and ethical standards at all times

Qualifications:

- Lived experience or strong ties to the community being served

- High school diploma or equivalent (some positions may prefer CHW certification or additional education)
- Strong interpersonal and communication skills
- Ability to work independently and as part of a team
- Basic computer/data entry skills and willingness to learn electronic systems
- Bilingual (preferred but not required, depending on service area)

Who We're Looking For: (Optional Descriptions)

You do not need a college degree to apply. We are looking for someone who:

- Has strong ties to the community or population being served
- Is a good communicator, listener, and problem solver
- Has compassion, patience, and the ability to build trust
- Is organized and willing to learn new things
- Can work well with people from different backgrounds
- Speaks [insert language(s)] (if relevant to the population served)

Work Environment / Travel:

- Based in [clinic, community setting]
- May require local travel to homes, schools, community sites, or partner agencies
- Flexible hours may be required, including evenings or weekends

CHW–Community Fit Checklist

Assessing Alignment Between CHW Background and Community Needs

Use this checklist during hiring, program design, or re-alignment planning to ensure CHWs are positioned to build trust, bridge gaps, and connect meaningfully with the populations they serve.

Step 1: Define the Target Population

- Community served (e.g., ZIP codes, neighborhoods): _____
- Priority population group(s): _____
  (e.g., Latinx immigrant families, unhoused individuals, rural seniors, etc.)

Step 2: Assess Fit Between CHWs and the Community

Fit Area	Key Questions	Current Status	Notes or Action Items
Lived Experience	Do CHWs share lived experience (e.g., housing insecurity, caregiving, recovery)?	☐ Yes ☐ Some ☐ No	
Cultural / Linguistic Alignment	Do CHWs speak the language(s) and understand the cultural norms of the population served?	☐ Yes ☐ Somewhat ☐ No	
Community Connection	Do CHWs live in or have strong ties to the community?	☐ Yes ☐ Some ☐ No	
Trust / Reputation	Are CHWs known and trusted in the community (or introduced well)?	☐ Yes ☐ Building ☐ Unknown	
Role Relevance	Are CHWs addressing needs that matter to the community (e.g., food, housing, stress)?	☐ Yes ☐ Partially ☐ Misaligned	

Step 3: Use Findings to Improve Fit

- **If fit is strong:**
  Maintain and elevate community voice in hiring, training, and program design.
- **If fit is partial or low:**
  - Revisit recruitment practices to prioritize lived experience and cultural relevance
  - Offer additional training or pairing with trusted community members
  - Engage local stakeholders or advisory groups in onboarding and role refinement

Toolkit Tip: A strong CHW–community fit is often more valuable than formal education. Prioritize shared experience, trust, and communication over credentials.

Recruitment Strategy Checklist

Ensuring Equitable, Community-Aligned CHW Hiring

Use this checklist before launching your hiring process to ensure it is accessible, inclusive, and tailored to recruit CHWs with lived experience and strong community connection.

1. Define the Role Clearly

Task	Completed?	Notes
CHW job description emphasizes lived experience, trust, and cultural relevance	☐	
Core functions reflect actual program needs (e.g., outreach, navigation, education)	☐	
Unnecessary credential or degree requirements removed	☐	
Position is classified appropriately in HR system	☐	

2. Plan for Community-Aligned Outreach

Task	Completed?	Notes
Job posted on platforms relevant to the population (e.g., local FB groups, churches, libraries, workforce centers)	☐	
Community-based partners asked to share or co-promote the posting	☐	
Materials available in plain language and multiple languages (if needed)	☐	
CHW info session or informal Q&A offered before application deadline	☐	

3. Build an Inclusive Screening Process

Task	Completed?	Notes
Interview questions assess alignment with CHW values and community connection—not just work history	☐	
Community stakeholders, CHWs, or peer staff included in the interview or review panel	☐	
Reference checks include community-based or informal leaders (when appropriate)	☐	
Process accommodates alternative formats (e.g., phone interviews, verbal applications if needed)	☐	

4. Set Up for Retention From the Start

Task	Completed?	Notes
Pay is competitive and reflects the value of the CHW role	☐	
Job includes access to training, supervision, and team support	☐	
Role has a clear pathway to permanency or advancement (if possible)	☐	

Toolkit Tip: Use this checklist collaboratively with HR, program leadership, and CHW staff. Revisit after each hiring round to assess what worked—and what needs to change.

Sample CHW Interview Questions

Emphasizing Lived Experience, Trust, and Community Connection

These questions are designed for interviews with CHW candidates from diverse backgrounds. They prioritize interpersonal skills, personal insight, and alignment with the role's mission—rather than technical knowledge alone.

Community Connection & Lived Experience

1. Tell us about the community you're most connected to. What makes you feel part of it?
2. Have you ever helped someone in your family or community find services or support? What did you do?
3. What are some challenges people in your community face when trying to get healthcare, food, or housing?
4. What does being a "trusted person" in your community mean to you?

Values, Communication, and Support Approach

5. How do you build trust with someone who may feel nervous, frustrated, or unsure about getting help?
6. Give an example of a time when someone came to you for help. How did you handle it?
7. CHWs often listen to people who are going through tough times. How do you take care of yourself while helping others?
8. What does "meeting people where they are" mean to you in your own words?

Teamwork & Growth

9. Have you worked as part of a team before? What helped you work well with others?
10. Is there something you've learned from personal experience that you think would help others if you became a CHW?
11. Are you open to learning new things, like how to use simple tools to track your work or learning about health topics?

Optional Skills-Based or Scenario Questions

12. **Scenario:** A client tells you they don't want to go to their doctor appointment because they don't trust providers. What would you say or do?
13. **Scenario:** You're working with someone who doesn't have a phone or transportation. How would you help them stay connected to services?

Toolkit Tip: Consider letting candidates respond in writing, verbally, or through informal interviews. Invite community members or CHWs to join your interview panel when possible.

Onboarding Essentials

Why It Matters

CHW onboarding must go beyond the standard HR packet. A thoughtful, structured onboarding process helps new CHWs feel welcomed, respected, and confident in their role from the start. It also reduces early attrition, clarifies boundaries, and fosters trust between CHWs and their teams. Onboarding should reinforce both the technical expectations of the position and the community-rooted nature of CHW work.

Key Elements of CHW Onboarding

Focus Area	Best Practices
Orientation to Mission & Role	Provide a CHW-specific overview, including the purpose of the role, how it fits within the organization, and expectations for confidentiality, boundaries, and relationship-building.
Connection to Team	Introduce CHWs to care team members, community partners, supervisors, and admin staff. Include them in team huddles, walkthroughs, and informal meet-and-greets.
Training on Core Competencies	Cover communication, motivational interviewing, SDOH navigation, documentation, and safety. Reinforce the CHW scope and clarify what *not* to do.
Shadowing & Real-World Practice	Pair new CHWs with experienced CHWs or trusted staff for observation, debriefing, and gradual handoff of responsibilities.
Technology & Tools Setup	Provide logins, phones, laptops, tracking systems, and space to work. Include time for training on any documentation tools.
Wellness & Support Culture	Emphasize self-care, support structures, and supervision early on. Let CHWs know they're not alone—and that debriefing is encouraged.

Toolkit Resources Provided

- **First Week Checklist** – Covers workspace setup, team introductions, technology access, and required trainings
- **CHW Welcome Packet Outline** – Suggested documents and handouts to include on Day 1
- **Peer Shadowing Plan Template** – Structure for matching new CHWs with experienced staff for guided field learning

First Week Checklist: CHW Onboarding

Covers Logistics, Team Connection, and Early Training

Use this checklist to guide supervisors or onboarding staff during a CHW's first week. This ensures a smooth start and helps prevent common oversights that lead to early disengagement.

Workspace & Technology Setup

Task	Completed?	Notes
CHW assigned a workspace, desk, or shared station	☐	
Laptop/tablet issued and login credentials provided	☐	
Work phone or access to communication device	☐	
Email and calendar account activated	☐	
Access granted to EHR or documentation system	☐	
Orientation to any scheduling, mileage, or data tracking tools	☐	

Organizational Orientation

Task	Completed?	Notes
Welcome from supervisor or leadership	☐	
Review of mission, vision, and values	☐	
HR paperwork completed and benefits reviewed	☐	

Policies and procedures reviewed (confidentiality, safety, documentation, PTO)	☐	
Program overview and CHW role clarified	☐	
Provided CHW Welcome Packet (org chart, key contacts, resource guide)	☐	

Team Introductions & Relationship Building

Task	Completed?	Notes
Introduced to care team (e.g., nurses, social workers, BH staff)	☐	
Connected with CHW peers or mentors	☐	
Attended first team huddle or staff meeting	☐	
Introduced to community partners (if applicable)	☐	

Early Training Activities

Task	Completed?	Notes
CHW Role & Scope of Practice Orientation	☐	
Motivational Interviewing or Communication Basics	☐	
Overview of local resources and referral systems	☐	

Documentation / Data Entry Practice	☐	
Shadowing schedule created	☐	

Toolkit Tip: Review this checklist with the CHW at the end of Week 1 to address gaps and reinforce support.

CHW Welcome Packet Outline

Suggested Documents and Handouts for Day 1 Onboarding

The CHW Welcome Packet should be clear, culturally responsive, and accessible. Avoid jargon where possible, and emphasize tools that support the CHW's role, identity, and confidence.

1. Organizational Orientation Materials

- Welcome letter from leadership or program manager
- Mission, vision, and values of the organization
- Overview of programs and services
- Organizational chart (with key contacts highlighted)
- Staff directory or team contact list
- FAQ or Who-to-Call guide for internal processes

2. CHW Role & Program Information

- CHW job description and scope of practice overview
- Role clarification chart (what CHWs do and don't do)
- Overview of core competencies and expectations
- List of populations served and key community priorities
- CHW program goals and how impact will be measured
- Sample day-in-the-life schedule or activity log example

3. Resource & Referral Tools

- Local resource directory (e.g., housing, food, mental health, legal aid)
- SDOH screening tool(s) or referral form templates
- Emergency protocols or escalation pathways
- List of common referral partners and contact info
- Quick reference handouts for transportation, insurance enrollment, etc.

4. Administrative & Logistics Info

- Office or site map, access instructions, parking info
- Timesheet or payroll instructions
- Technology logins and system overview (email, EHR, trackers)
- Mileage reimbursement form or fieldwork protocol (if applicable)
- Training calendar or schedule of shadowing activities

5. Support & Professional Development

- Supervisor introduction and check-in schedule
- Peer mentor contact (if applicable)
- CHW support group or community of practice info
- Upcoming training dates, webinars, or certification opportunities
- Self-care and mental wellness resources

Toolkit Tip: Use a simple folder or binder with tabs—or go paperless with a shared drive or tablet setup. CHWs should be given time during onboarding to explore and ask questions about the packet contents.

Peer Shadowing Plan Template

Guided Field Learning for New CHWs

Use this template to plan and track shadowing activities during a CHW's onboarding period. Peer shadowing promotes confidence, relationship-building, and applied learning rooted in trust and community knowledge.

Shadowing Goals

Goal Area	Description
Orientation to fieldwork	Observe how CHWs engage clients in homes, clinics, or community spaces
Learn documentation practices	Watch how referrals, encounters, and follow-ups are recorded
Understand communication approaches	See how CHWs build trust and navigate sensitive topics
Experience systems navigation	Follow how CHWs support access to care, benefits, or resources
Normalize support culture	Reinforce debriefing, emotional regulation, and peer mentorship

Pairing Plan

Item	Details
New CHW Name:	
Peer Mentor CHW:	
Supervisor Contact:	
Shadowing Start Date:	

Sample Shadowing Schedule

Day	Activity / Setting	Focus Area	Debrief Notes
Day 1	Home visit with client	Client communication	
Day 2	Community outreach event	Navigation + education	
Day 3	Clinic-based care team meeting	Role integration	
Day 4	Referral follow-up calls	Documentation + barriers	
Day 5	Open time + Q&A	Peer connection	

End-of-Shadowing Reflection

Question	New CHW Response
What did you learn from observing your peer?	
What surprised you or stood out most?	
What do you still feel unsure about?	
What support would help you next?	

Toolkit Tip: Use this template alongside the onboarding schedule. Debriefs can be peer-led or supervised, depending on the comfort and capacity of the staff involved.

Retention Strategies

Why It Matters

Recruiting CHWs is only half the battle—keeping them requires investment, support, and a workplace culture that values their lived experience. Too often, CHWs leave programs because they feel isolated, underpaid, misunderstood, or burned out. Retention isn't just about salaries (though those matter); it's about community, connection, and growth.

High retention leads to deeper trust with clients, less turnover-related training costs, and stronger program outcomes. Creating a culture of support, peer connection, and recognition is essential to building a CHW workforce that's not only present, but thriving.

Key Retention Practices

Focus Area	Best Practices
Supportive Supervision	CHWs need supervisors who understand their role, check in regularly, and create space for reflection—not just productivity.
Peer Connection & Mentorship	Establish regular peer check-ins, CHW learning circles, or assign peer mentors to reduce isolation.
Recognition & Celebration	Celebrate CHW wins—big or small—publicly and consistently. Value impact, not just numbers.
Professional Growth	Offer training stipends, conference access, or certification support. Create internal pathways for advancement when possible.
Feedback Loops	Ask CHWs what's working, what isn't, and what they need. Use anonymous surveys and safe spaces to collect feedback. Act on it.
Work-Life Balance & Flexibility	Honor the emotional toll of the role. Offer mental health resources, flexible scheduling, and wellness culture.

Toolkit Resources Provided

- **Peer Support Planning Tool** – Helps structure regular check-ins, group learning, or mentorship pairings
- **Retention Feedback Survey** – Sample questions to understand CHW satisfaction, burnout risk, and areas for improvement

Peer Support Planning Tool

Building a Framework for CHW Connection, Reflection, and Retention

Peer support isn't just "nice to have"—it's a key factor in retention and emotional sustainability. Use this tool to develop or strengthen your CHW peer support model.

Step 1: Define Peer Support Structure

Support Format	Will You Implement This?	Notes / Plan
Regular peer check-ins (1:1 or small group)	☐ Yes ☐ No	e.g., weekly or biweekly Zooms, field-based meetups
CHW peer mentoring (new paired with experienced)	☐ Yes ☐ No	Can be formal (assigned) or informal (opt-in)
Peer learning circles or case debriefs	☐ Yes ☐ No	Shared learning around tough cases or field stress
Monthly CHW-only space	☐ Yes ☐ No	For unfiltered discussion without supervisor present
Anonymous feedback mechanism	☐ Yes ☐ No	Anonymous suggestion box or regular pulse survey

Step 2: Identify Roles & Logistics

Component	Plan
Who will facilitate or coordinate peer support activities?	
Where will peer meetings take place (virtual/in-person)?	
How often will peer support sessions occur?	
Will CHWs be compensated or scheduled during peer time?	
How will participation be encouraged but not forced?	

Step 3: Set Purpose & Boundaries

Element	Guiding Principles
Purpose of peer space	Support, reflection, not performance evaluation
What is *not* included	No disciplinary conversations, required documentation
How challenges are escalated (if needed)	CHWs know when to bring issues to supervisor or team lead
How feedback will be used	Voluntary, non-punitive, used to improve program quality

Example Peer Support Activities

- CHW wins & shout-outs
- Role play and motivational interviewing practice
- Field safety discussion
- Burnout check-ins / emotional debriefing
- Guest speaker from another CHW program
- Resource swap: what's working in your area?

Toolkit Tip: Even a monthly 45-minute CHW-only space can dramatically reduce isolation and improve morale. Build it into schedules from Day 1.

Retention Feedback Survey

Supporting CHW Retention Through Honest Feedback

This survey can be used anonymously or during 1:1 check-ins. Aim to administer it quarterly or bi-annually. Feedback should be used to improve support, not punish performance.

Section 1: Role Clarity & Job Satisfaction

1. **I have a clear understanding of my role as a CHW.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree
2. **I feel that my work as a CHW is valued by the organization.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree
3. **I have the tools and resources I need to do my job effectively.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

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Section 2: Support & Supervision

4. **I feel supported by my supervisor or program manager.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree
5. **I receive regular check-ins or supervision that help me grow.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree
6. **I know where to go if I need help or have concerns.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

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Section 3: Connection & Well-Being

7. **I feel connected to other CHWs or staff doing similar work.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree
8. **I have opportunities to give feedback about my experience.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree
9. **I feel emotionally supported in this role.**
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

Section 4: Open-Ended Feedback

10. What's going well for you in this role right now?

11. What would help you feel more supported or successful?

12. Anything else you'd like to share about your experience as a CHW?

Toolkit Tip: Summarize responses and revisit common themes in team meetings or supervisory sessions. Make changes where possible—and communicate when you can't (yet).

Section 3: Training and Support Systems

As Illinois and other states advance standardized training and certification pathways for Community Health Workers (CHWs), organizations must be prepared not to deliver training themselves—but to support CHWs in completing required training within a structured, supportive environment. This includes allocating paid time, providing flexible schedules, and reinforcing what's learned through supervision, reflection, and practice.

CHW training isn't just a checkbox. It's a foundational part of workforce development—and it's most effective when organizations build internal systems that respect the learning process and reinforce skill development on the job.

Key Organizational Responsibilities

Area	Best Practices
Time Allocation	Ensure CHWs have paid time to complete required trainings during the workday—particularly for longer multi-week programs.
Communication	Clearly explain how external training requirements (state certification, continuing education) fit into CHW onboarding and development.
Logistical Support	Help CHWs with registration, navigating online platforms, or arranging transportation if training is off-site.
On-the-Job Reinforcement	Use team huddles, peer mentorship, or supervision to reflect on how training applies to real-world situations.
Flexibility	Recognize that CHWs come from diverse educational backgrounds and may need additional support to complete online or technical components.
Policy Alignment	Stay informed about state-level requirements and avoid duplicating or deviating from recognized training standards.

Toolkit Resources Provided

- **Support Strategies Menu –** Quick-reference list of ways to support CHWs before, during, and after training

Support Strategies Menu

Practical Ways to Support CHWs Through Required Training and Certification

Use these tables to identify specific strategies to support CHWs before, during, and after training. Select what fits your team's structure and resources.

Before Training

Strategy	Description
Paid Training Time	CHWs complete training during paid hours—not on their own time.
Clear Expectations	Provide a one-pager outlining training goals, structure, and relevance to their role.
Technology Prep	Ensure CHWs have internet, devices, and logins before training begins.
Flexible Scheduling	Adjust workload or shifts so CHWs can focus on training without burnout.
Early Q&A Space	Hold a casual session before training to address concerns or logistics.

During Training

Strategy	Description
Regular Check-Ins	Supervisors or mentors meet weekly for reflection and emotional support.
Applied Practice	CHWs apply training topics in real-world scenarios (e.g., shadowing, referrals).
Normalize the Learning Curve	Reassure CHWs that it's okay to need help and take time to learn.
Peer Support Loop	Create buddy systems, group chats, or informal learning cohorts.

After Training

Strategy	Description
Structured Debrief	Meet to discuss key takeaways and how to apply learning in the field.
Documentation Practice	Provide real-world practice and feedback on referral tracking or client notes.
Update Role Expectations	Adjust workflows or responsibilities to reflect new competencies.
Celebrate Completion	Publicly recognize achievement with a certificate, shoutout, or team acknowledgment.
Plan for Ongoing Growth	Encourage CEUs, webinars, or future specializations to support continued development.

Reflective Supervision & Growth

Why It Matters

Community Health Workers (CHWs) operate at the intersection of community need, emotional labor, and complex systems. Traditional top-down performance evaluations don't meet the unique demands of this role. CHWs need supervision that is **relational, supportive, and reflective**—centered not just on outcomes, but on wellbeing, growth, and navigating the complexities of community-based work.

Reflective supervision gives CHWs a safe space to process their work, celebrate wins, and explore challenges without fear of judgment. When combined with clear check-ins, growth planning, and trauma-informed practices, it builds trust, reduces burnout, and increases retention.

Key Elements of Reflective Supervision

Focus Area	Best Practices
Regular, Scheduled Check-Ins	Hold 1:1s at least biweekly—focused on both logistics and emotional reflection. Keep them consistent.
Strengths-Based Feedback	Celebrate what's working before diving into what needs improvement. Use CHW observations to improve systems.
Collaborative Problem-Solving	Invite CHWs to bring real client situations or systemic barriers to explore together.
Confidentiality & Emotional Safety	Make it clear what stays in supervision unless there's a legal or safety concern. Normalize reflection as part of professional practice.
Goal-Setting & Growth Planning	Ask CHWs where they want to grow—and help them identify realistic next steps. Use those insights to build individualized development plans.
Field Debriefing Space	Offer time to process emotionally heavy work. This is especially critical for CHWs navigating trauma, crisis, or grief in their communities.

Toolkit Resources Provided

- **Reflective Prompts for Supervision** – Questions to help deepen trust and shared insight
- **Supervisor Quick Guide** – One-pager for CHW supervisors on best practices and what to avoid

Reflective Prompts for Supervision

Building Connection, Insight, and Trust in CHW 1:1s

Use these prompts to guide supportive conversations. You don't need to ask them all—choose 1–3 per session based on the moment, the CHW's needs, and your relationship.

Emotional Check-In & Wellbeing

- What's something that stuck with you this week—good or bad?
- Has anything been sitting with you after a client interaction?
- Where have you felt stretched or emotionally tired lately?
- What part of this work feels most rewarding for you right now?

Fieldwork & Role Reflection

- Were there any moments where you weren't sure what to do?
- What's a challenge you faced in the field that we could troubleshoot together?
- Have you had to set a boundary recently? How did it feel?
- Is anything about your role feeling unclear or heavier than expected?

System & Team Navigation

- Is there anything you're seeing on the ground that others on the team may not be aware of?
- What's something you wish your colleagues or leadership better understood about your work?
- Have you experienced any friction or disconnects in team communication lately?
- Are there voices or needs from the community you think we're not responding to?

Growth & Development

- What's something you've learned about yourself in this role?
- Is there an area of the work you want to go deeper in or feel more confident with?
- How would you like to grow in the next 6 months?
- What would support look like for you right now—not just training, but space, structure, or care?

Supervisor Quick Guide

Core Principles

Do	Why It Matters
Center relationship-based supervision	CHWs thrive on trust and open communication, not top-down directives
Check in regularly (at least biweekly)	Prevents burnout and builds consistency
Ask for input—not just updates	CHWs have valuable insight into community needs and system barriers
Normalize emotional reflection	CHWs carry community stress—debriefing should be part of the job
Protect role clarity	CHWs are not nurses, case managers, or social workers—they are connectors and advocates
Offer feedback with context	Tie feedback to values, not just metrics (e.g., "You helped that client feel safe")

Common Pitfalls to Avoid

Don't	Why It Harms the Program
Expect CHWs to "do it all"	Leads to task shifting and burnout
Over-focus on clinical metrics	Can overlook the relational and trust-building work CHWs do
Leave CHWs out of care teams	Undermines integration and causes role confusion
Delay support until there's a problem	Proactive supervision = fewer crises later
Assume quiet = fine	CHWs may hesitate to share stress—create regular space for reflection

Key Reminders

- CHWs are often navigating the same systems and struggles as the communities they serve
- Supervision should focus on **support and development**, not control
- A good question to start any 1:1 is: *"What's going well for you this week?"*

Section 4: Clinical and Community Integration

Why It Matters

CHWs are most effective when they're not working in silos—but fully integrated into the care and support systems surrounding the individuals and communities they serve. Whether based in a clinic, public health department, or community-based organization, CHWs need access to the right people, processes, and platforms to make meaningful connections and close care gaps.

Integration is more than co-location. It means CHWs are part of care team conversations, have access to referral pathways, and can share information in ways that improve coordination while maintaining trust. It also means building relationships with external partners, ensuring CHWs are looped into broader systems of care—especially when addressing social determinants of health.

This section provides strategies and tools to help organizations embed CHWs across clinical and community settings. The goal is not just to place CHWs into a system, but to position them for collaboration, contribution, and long-term impact.

CHW Care Team Integration

Why It Matters

For CHWs to be effective, they must be recognized as **core members of the care or support team**, not outsiders or temporary staff. When CHWs are integrated into team meetings, communication loops, and decision-making spaces, they can share critical insights, reinforce care plans, and improve outcomes through trust-based relationships with clients. Without integration, CHWs may be left out of key conversations, duplicate others' work, or struggle to advocate effectively for clients.

True integration also supports retention. CHWs who feel included, heard, and respected are more likely to remain in their roles and grow within the organization.

Key Practices for Team Integration

Practice	Implementation Tips
Include CHWs in team meetings or huddles	Invite CHWs to attend staff huddles, case reviews, and interdisciplinary meetings where care coordination happens.
Assign clear team roles	Clarify CHW contributions (e.g., follow-up after discharge, SDOH screening, system navigation) and how they differ from other roles like nurses or social workers.
Facilitate warm introductions	Supervisors or care team leads should introduce CHWs to clients as trusted members of the team—not "extras."
Create feedback loops	Build systems for CHWs to share field observations with care teams or leadership (e.g., team updates, case notes, reflective summaries).
Ensure mutual understanding	Offer CHW 101 sessions to care teams and consider joint training with nurses, case managers, or behavioral health staff.
Design workflows that include CHWs	Identify points in the client journey (intake, discharge, follow-up) where CHW intervention is most useful and define it in policy or SOPs.

Toolkit Resources Provided

- **CHW Integration Mapping Template** – Visual tool for identifying where CHWs fit within client workflows and team processes
- **Team Roles & Scope Clarity Guide** – Helps distinguish CHW roles from other team members in shared settings
- **CHW Introduction Script Examples** – Sample language care teams can use to introduce CHWs to clients
- **Joint Team Meeting Agenda Template** – Sample structure that includes CHW updates in interdisciplinary conversations

CHW Integration Mapping Template

Identify Where CHWs Fit Within Care Teams and Workflows

Use this template to work with supervisors, care teams, and CHWs to clarify the *when, where, and how* of CHW involvement in client care and team communication.

Step 1: Identify Integration Points Across the Client Journey

Stage of Care / Service	Is a CHW Involved?	CHW Role	Team Interaction Point
Intake / Registration	☐ Yes ☐ No	Review SDOH screeners, explain CHW support role	Warm handoff from front desk or intake staff
Initial Visit / Assessment	☐ Yes ☐ No	Gather contextual info, identify barriers	Debrief with provider or care manager
Ongoing Case Management	☐ Yes ☐ No	Provide support with referrals, follow-ups	Monthly team case review or 1:1 updates
Discharge / Transition	☐ Yes ☐ No	Ensure connection to community supports	Joint discharge planning with social worker
Follow-Up & Outreach	☐ Yes ☐ No	Conduct home visits, calls, or field check-ins	Note shared in EHR or manual tracking log

Step 2: Map CHW's Relationship to the Team

Team Member / Role	Interaction with CHW	Communication Channel
Nurse Case Manager	Shares discharge notes and care plans	Shared EHR notes or secure messaging
Social Worker	Coordinates on SDOH needs	Weekly check-in call
Behavioral Health Provider	Warm handoffs for clients needing support	Referral form + in-person debrief
Program Manager / Supervisor	Reviews CHW logs, offers field support	Biweekly 1:1 supervision
Community Partner (e.g., food pantry)	Accepts CHW referrals, confirms service access	Referral log + networking or quarterly check-ins

Step 3: Identify Gaps or Barriers to Integration

- **Are there stages where CHWs *should* be involved but currently are not?**

- **Are communication systems set up for CHWs to share updates effectively?**

- **Are there team members unsure of what CHWs do?**

Toolkit Tip: Repeat this exercise every 6–12 months with CHWs and care teams to refine workflows and improve collaboration.

Team Roles & Scope Clarity Guide

Defining CHW Functions Within Interdisciplinary Teams

Use this guide to prevent role confusion, reduce task-shifting, and support mutual respect between CHWs and other team members.

CHW Core Functions

Function	What It Looks Like in Practice
Health Education	Providing basic health info using plain language in community settings or 1:1 conversations
Care Navigation	Helping clients make appointments, understand referrals, and access public benefits
Outreach & Engagement	Connecting with clients in homes, community events, or informal settings
Follow-Up Support	Checking in after appointments or missed visits, helping with next steps
Referral Support	Identifying needs and linking clients to housing, food, behavioral health, etc.
Advocacy & Trust-Building	Helping clients speak up for their needs and building bridges with systems they may distrust

What CHWs Do Not Do (Unless Specifically Trained & Authorized)

Clinical Tasks	Why It's Outside CHW Scope
Conduct medical assessments or diagnoses	Requires licensure (nurse, physician, etc.)
Make treatment decisions or adjust medications	Outside of CHW training and legal scope
Provide clinical mental health therapy	Reserved for licensed mental health professionals
Serve as substitute for case managers or social workers	CHWs support—not replace—these roles

How CHWs Complement Other Roles

Team Member	CHW Complementary Role
Nurse	Reinforces care plan, follows up on barriers, explains instructions in plain language
Social Worker	Supports navigation and follow-up after referrals (e.g., housing or benefits)
Behavioral Health Provider	Provides warm handoffs and trust-building before and after sessions
Case Manager	Serves as extra support in high-barrier cases, especially between appointments

Toolkit Tip: Review this guide as a team when onboarding new staff. Consider co-developing a workflow map to show where each role fits.

Referral Pathways

Why It Matters

Referrals are one of the most common—and powerful—functions CHWs perform. But without clear workflows, CHWs can get stuck between systems, unsure of how to initiate, track, or follow up on a referral. Worse, clients may fall through the cracks.

Effective referral systems must be **clear, repeatable, and two-way**. CHWs should know how to make internal and external referrals, who to notify, and how to follow up. Equally important, CHWs must receive feedback on whether the referral was successful—so they can support the client accordingly.

CHWs also play a vital role in expanding referral capacity by identifying and building relationships with community partners who aren't yet part of formal systems.

Building a Functional CHW Referral Pathway

Key Element	Best Practices
Standardized Referral Process	Use simple forms or digital tools that CHWs and team members understand. Include fields for service type, urgency, and follow-up plan.
Defined Referral Points	Clarify which needs (e.g., housing, mental health, transportation) CHWs are responsible for addressing—and when a referral should be made.
Designated Contacts	Maintain a go-to list of internal and external partners for each referral type. Relationships matter—don't refer into a void.
Feedback Loop	CHWs should know whether a referral was accepted, completed, or declined. Build this into your tracking system or communication workflow.
Client Follow-Up	CHWs follow up directly with clients to confirm whether the referral worked, answer questions, or offer additional support.
CBO Relationship Building	CHWs are well-positioned to establish or strengthen referral partnerships with trusted, grassroots service providers.

Toolkit Resources Provided

- **Referral Pathway Builder Template** – A visual tool to map how referrals flow from CHW to service partner and back
- **Internal Referral Form Template** – Customizable form for common in-house referrals (e.g., behavioral health, food, nurse case management)

Referral Pathway Builder Template

Visualize How Referrals Move From CHW to Partner and Back

Use this template during team planning or workflow sessions to clarify who does what, when, and how. A clear referral pathway prevents delays, duplication, and client frustration.

Step 1: Define the Referral Type

Referral Type	Internal or External?	Common Triggers	CHW Role
e.g., Housing	External (CBO)	Client lacks stable housing, at risk of eviction	Identify need, complete referral form, follow-up

Step 2: Map the Referral Process

Step	Person Responsible	Tool / Method Used	Expected Timeframe
1. Identify client need	CHW	Verbal screening or SDOH tool	In real-time
2. Complete referral	CHW	Paper form, EHR, or online system	Within 24 hours
3. Send to partner / program	CHW or front desk	Fax, email, direct entry, shared system	Same day
4. Confirm referral received	CHW or program assistant	Phone call, message, portal	Within 48 hours
5. Receive outcome update	Referral partner	Call, form, secure message	Within 5–7 days
6. CHW follows up with client	CHW	Phone call, visit, message	Ongoing until resolved

Step 3: Notes & Barriers

Referral Partner	Notes (Delays, Barriers, Solutions)
e.g., Food Pantry A	No email access; prefers phone referrals. Staff turnover causes delays.

Toolkit Tip: Build a separate pathway for each high-volume referral type (e.g., food, housing, behavioral health) and update regularly as partners or systems change.

Internal Referral Form Template

Streamlined Form for In-House Referrals to CHWs or Support Services

Use this form when staff refer clients to CHWs—or when CHWs refer internally to behavioral health, case management, or other in-house services. Can be adapted for digital or paper use.

Section 1: Client Information

Field	Details
Client Name:	
Date of Birth:	
Phone Number / Preferred Contact Method:	
Language Preference:	
Preferred Time to Contact:	☐ Morning ☐ Afternoon ☐ Evening ☐ Any

Section 2: Referral Details

Field	Details
Referred By:	
Date of Referral:	
Referral Type:	☐ CHW Services ☐ Case Management ☐ Resource Navigation ☐ Other:
Reason for Referral (Check all that apply):	**Details**
☐ Housing instability	
☐ Food insecurity	
☐ Transportation barriers	
☐ Missed appointments	
☐ Medication access	

☐ Social/emotional support	
☐ Health education	
☐ Insurance navigation	
☐ Other:	

Section 3: Additional Notes (Optional)

Please describe the concern, current plan, or relevant context:

Section 4: Staff Use Only

Field	Details
Received By:	
Referral Accepted?	☐ Yes ☐ No
Initial Contact Attempted On:	
Notes or Follow-Up Needed:	

Toolkit Tip: Store completed forms in a shared folder, tracking log, or EHR upload location if applicable. Add a checkbox for whether client consent was obtained if required by your organization.

Community Partner Integration

Why It Matters

CHWs are uniquely positioned to build and maintain meaningful partnerships with community-based organizations (CBOs), faith-based groups, housing programs, harm reduction services, and other grassroots supports. These partnerships extend the reach of the organization beyond the clinical setting, helping clients access care that is culturally relevant, nonjudgmental, and embedded in the neighborhoods they trust.

Too often, partnerships exist on paper but not in practice. For CHWs to function as effective connectors, organizations must create space for relationship-building, cross-training, and shared accountability with community partners. This also supports more effective referrals, warmer handoffs, and fewer gaps in care.

Strengthening CHW-Led Community Partnerships

Strategy	Implementation Tips
Support CHWs in building relationships	Allow time in CHW schedules for site visits, introductions, or attending partner events—not just client-facing work.
Maintain an active resource directory	Keep a shared list of reliable, CHW-vetted community partners with contact info, eligibility criteria, and referral processes.
Develop cross-sector agreements	Use MOUs or informal workflows to clarify expectations for referrals, communication, and follow-up.
Facilitate introductions	Supervisors or leadership should personally introduce CHWs to external partners to establish trust.
Create shared training opportunities	Co-host sessions or webinars with community partners to build mutual understanding and collaboration.
Track partnership strength	Monitor which organizations reliably respond to referrals and which need more relationship-building.

Toolkit Resources Provided

- **Sample MOU / Referral Agreement Template** – Customizable agreement to define shared expectations
- **Resource Directory Template** – Spreadsheet-style tool to document community orgs, services, contact info, and notes

Sample MOU Letter

Subject: Memorandum of Understanding for CHW Referral Partnership

[Partner Organization Name]
[Partner Organization Address]
[City, State, ZIP]

[Date]

Dear [Partner Contact Name],

We are writing to formalize a mutual understanding between [Your Organization Name] and [Partner Organization Name] regarding the referral and coordination of services for individuals served by our Community Health Worker (CHW) program.

The goal of this partnership is to support seamless, client-centered access to resources by establishing a clear and respectful referral process between our teams. CHWs at [Your Organization Name] regularly identify individuals in need of [insert service types—e.g., food support, housing assistance, behavioral health care, etc.], and we view your organization as a trusted resource in addressing those needs.

Our mutual understanding includes the following:

- **Referral Process:** CHWs will refer clients to your organization using [phone/email/form/portal] and include relevant (non-clinical) information with client consent.
- **Confirmation & Feedback:** When possible, your team will confirm referral receipt and provide basic updates (e.g., appointment scheduled, not eligible) to help CHWs support follow-through.
- **Communication:** Either party may reach out with questions, updates, or concerns about the referral process. Regular check-ins are welcomed but not required.
- **Confidentiality:** We will uphold strict client confidentiality and ensure referrals are made only with appropriate verbal or written consent.
- **Duration:** This letter reflects an informal understanding and may be updated or discontinued by either party at any time.

We appreciate your continued partnership and commitment to serving our shared communities. If you agree with the terms outlined above, please sign and return a copy of this letter for our records.

Sincerely,
[Your Name]
[Your Title]
[Your Organization Name]
[Your Contact Info]

Acknowledged by:
[Partner Contact Name]
[Title]
[Partner Organization Name]

Signature: _____
Date: _____

Toolkit Tip: This letter works well with small CBOs, mutual aid groups, or programs that prefer relationship-based collaboration over formal contracts.

Resource Directory Template

Track Local Partners, Services, and Referral Notes

Use this table to maintain an up-to-date, CHW-friendly list of community resources. You can build this into Excel, Google Sheets, or a shared drive for team use.

Organization Name	Service Type(s)	Contact Person	Phone / Email	Referral Method	Eligibility Requirements	Languages Available	Notes / CHW Feedback
e.g., Hope House	Housing, shelter	Maria Lopez	(555) 123-4567 maria@hopehouse.org	Call or fax referral form	Adults 18+ experiencing homelessness	English, Spanish	Reliable response within 48 hours; limited beds during winter
e.g., Food First Pantry	Food access	N/A (walk-in)	(555) 555-1212	Walk-in only	No ID required	English only	Friendly, but sometimes long wait lines on Mondays

Suggested Categories for Filtering or Sorting:

- Region / ZIP code
- Priority population (e.g., youth, reentry, immigrants)
- Service availability (e.g., evenings, weekends)
- CHW-vetted (Y/N)

Toolkit Tip: Ask CHWs to regularly update this based on lived field experience—what actually works, not just what looks good on paper.

Section 5: Evaluation and Sustainability Planning

Why It Matters

CHW programs cannot survive on mission alone—they need evidence. Whether you're seeking continued funding, demonstrating value to leadership, or making the case for integration into long-term strategy, you must be able to show what CHWs are doing, what's changing because of their work, and why it matters.

Evaluation doesn't have to be complicated or data-heavy. The key is to track what's meaningful: referrals completed, barriers addressed, client trust built, and system gaps closed. Paired with stories and feedback, even simple metrics can build a compelling case for sustaining and expanding your CHW program.

This section offers tools to help organizations measure CHW impact, collect both numbers and narratives, and plan for long-term sustainability—whether through braided funding, policy alignment, or integrating CHWs into value-based care models. The goal isn't just to fund a program—it's to **build something that lasts.**

CHW Program Evaluation

Why It Matters

If you can't measure it, you can't fund it—and you may not be able to protect it. But CHW evaluation shouldn't look like traditional clinical performance review. It must reflect the unique nature of CHW work: relationship-building, trust, access, and community connection.

CHW programs are often evaluated using process and outcome measures: how many people were reached, how many referrals were completed, what barriers were addressed, and what changed over time. But numbers alone aren't enough. CHW stories, client feedback, and staff reflection are equally important in showing what success really looks like.

The goal isn't to prove that CHWs do everything. It's to show that what they do **matters.**

Practical Evaluation Strategies

Focus Area	Recommended Approaches
Process Measures	Track CHW activities: clients served, referrals made, education provided, barriers identified
Outcome Measures	Monitor changes: improved access, referral follow-through, reduced missed appointments, increased trust
Qualitative Data	Collect stories, quotes, or field notes that show impact in ways numbers can't
Client Feedback	Use simple surveys or interviews to gather client experience with CHWs
Team Reflection	Hold quarterly reviews with CHWs and supervisors to reflect on what's working and what needs adjustment
Equity Indicators	Evaluate if services are reaching the populations facing the greatest barriers—and if those barriers are being addressed

Toolkit Resources Provided

- **CHW Evaluation Planning Worksheet** – Helps select meaningful measures and align with organizational goals
- **Key Metrics & Indicators Menu** – List of practical, non-clinical indicators commonly used in CHW program evaluation
- **Client Feedback Form Template** – Simple tool for collecting input from clients served by CHWs

CHW Evaluation Planning Worksheet

Design a Right-Sized, Purposeful Evaluation Strategy for Your CHW Program

Use this worksheet with your program team, evaluation staff, or CHWs themselves to co-design an approach that reflects both impact and equity.

Step 1: Clarify the Purpose of Your Evaluation

What are you trying to show or learn?	Primary Audience	How will results be used?
e.g., Demonstrate impact to funders	Grantor / Funder	Support renewal application
e.g., Improve team workflows	CHW Team / Supervisors	Adjust training & supervision
e.g., Show how CHWs improve access	Leadership	Make case for adding FTEs

Step 2: Choose What to Measure

Type of Measure	Example Metrics	Will You Track This?
Activity	# of clients served, referrals made, follow-ups completed	☐ Yes ☐ No
Outcomes	Referral completion rate, access to services, reduced no-shows	☐ Yes ☐ No
Qualitative	Stories of success or barrier resolution	☐ Yes ☐ No
Client Feedback	Satisfaction with CHW support, sense of trust or empowerment	☐ Yes ☐ No
Equity	Are we reaching priority populations? Are gaps closing?	☐ Yes ☐ No

Step 3: Data Collection Plan

Data Source	Collection Method	Frequency	Responsible Staff
CHW activity logs	Digital form or spreadsheet	Weekly	CHWs / Program Assistant
Client feedback forms	Paper or mobile survey	At program exit or quarterly	Outreach Team
Referral outcomes	Follow-up with partners	Monthly	CHW Supervisor
CHW reflections	Journal prompts or team discussion notes	Quarterly	CHWs or Peer Leads

Step 4: Sharing and Learning

Audience	How Will Results Be Shared?	Timeline
CHW team	Quarterly team huddle + visuals	Every 3 months
Funders / stakeholders	Short impact report with data + stories	Annually
Leadership	Dashboard update or end-of-year report	Year-end

Toolkit Tip: Don't overbuild. Start with **3–5 meaningful indicators** and build from there. And don't forget: stories are data too.

Key Metrics & Indicators Menu

Sample Measures to Evaluate CHW Program Activity, Outcomes, and Equity

Use this menu to select **3–5 indicators** that reflect your CHW program's purpose and capacity. Mix quantitative and qualitative measures to tell a fuller story.

Process & Activity Indicators (What CHWs *Do*)

Indicator	What It Shows
# of clients served	CHW reach and caseload
# of referrals made	Breadth of support across service types
# of follow-ups completed	Persistence of support, relationship-building
# of outreach events attended or led	Visibility and community presence
# of SDOH needs identified	Community-level trends and system gaps
# of partner organizations referred to	Network strength and breadth

Outcome Indicators (What *Changed* Because of CHW Work)

Indicator	What It Shows
Referral completion rate	Follow-through and navigation effectiveness
% of clients linked to care	Improved access to services
Missed appointment reduction	Improved engagement and continuity of care
% of clients reporting increased knowledge/confidence	Empowerment and health literacy
Client-reported trust in system/provider	System navigation + equity impact

Qualitative Indicators (What the Data *Feels Like*)

Indicator	What It Shows
Client quotes or stories	Context, trust, barriers, and breakthrough moments
CHW field notes or reflections	Emerging trends, system barriers, real-time challenges
Partner feedback	Strength of CHW-community collaboration

Equity & Access Indicators

Indicator	What It Shows
Demographics of clients reached	Who is being served—and who is not
% of high-barrier clients supported	Impact on populations facing the most challenges
Geographic or ZIP code spread	Where services are happening—or lacking

Toolkit Tip: Pair these metrics with your **Evaluation Planning Worksheet** to make sure you're measuring what actually matters to your community and funders.

Client Feedback Form Template

Gather Feedback from Clients on CHW Services

Use this form at program exit, during periodic check-ins, or after specific service encounters. Can be adapted for paper, phone, or digital use (Google Forms, SMS, etc.).

Part 1: About Your Experience

1. **Did a Community Health Worker (CHW) help you during your time with us?**
   ☐ Yes
   ☐ No
   ☐ Not sure
2. **How helpful was the CHW in supporting your needs?**
   ☐ Very helpful
   ☐ Somewhat helpful
   ☐ Not helpful
3. **What types of help did the CHW provide?** *(Check all that apply)*
   ☐ Helped me get services (housing, food, mental health, etc.)
   ☐ Helped me understand my health or care plan
   ☐ Helped me feel less overwhelmed
   ☐ Listened to my concerns
   ☐ Other: _____
4. **Did the CHW treat you with respect and listen to you?**
   ☐ Yes
   ☐ Somewhat
   ☐ No
5. **Did you feel more connected to care or services after working with a CHW?**
   ☐ Yes
   ☐ No
   ☐ Not sure

Part 2: Your Feedback

6. **What did the CHW do that was most helpful to you?**

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7. **Is there anything you wish the CHW or program had done differently?**

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8. **Is there anything else you'd like us to know?**

🛠️ *Toolkit Tip:* Make this form available in multiple languages. If possible, have someone **other than the CHW** administer it to avoid power dynamics.

Sustainability Planning

Why It Matters

Without a long-term funding strategy, CHW programs are at constant risk of losing staff, restarting services, or collapsing when grants end. Sustainability doesn't just mean "finding another grant"—it means embedding CHWs into your organization's structure, priorities, and budget for the long haul.

Sustainable CHW programs align with strategic plans, leverage multiple funding streams, and use evaluation data to make the case for continued investment. It's not about proving CHWs do everything—it's about proving that what they do is irreplaceable.

Key Sustainability Strategies

Strategy	Implementation Ideas
Integrate CHWs into strategic goals	Ensure CHW work aligns with organizational focus areas (e.g., health equity, care coordination, maternal health)
Use blended or braided funding	Combine short-term grants, general operating funds, Medicaid billing, and partnerships to stabilize positions
Map to reimbursement pathways	Identify which CHW services may be billable through Medicaid, managed care, or value-based care models
Leverage evaluation data	Use simple metrics and client stories to demonstrate ROI and justify continued investment
Engage leadership early and often	Keep leadership updated on CHW impact—make them champions, not just signers
Document systems and roles	Create onboarding tools, job descriptions, and workflows so the program doesn't vanish with staff turnover
Build partner investment	Encourage health systems, funders, or CBOs to co-fund or contract CHW services in shared populations

Toolkit Resources Provided

- **CHW Sustainability Planning Worksheet** – Tool to assess current funding, identify risks, and set long-term sustainability goals
- **Braided Funding Strategy Map** – Visual guide to blending grants, core funding, billing, and partnerships
- **Sustainability Scenario Planning Template** – Helps prepare for different funding outcomes (e.g., funding ends, expands, or shifts)

CHW Sustainability Planning Worksheet

Assess Your Program's Funding Stability and Map Next Steps

Use this worksheet with your leadership team, fiscal staff, or program leads. It can be revisited annually or whenever funding conditions change.

Step 1: Funding Inventory

Current Funding Source	Amount / % of CHW Budget	Expiration Date	Renewal Plan
e.g., State Grant (Maternal Health)	65%	June 2025	Renewal pending – results report due April
e.g., MCO Partnership Funds	25%	Ongoing	Review annual impact report in Q4
e.g., General Operating Funds	10%	Continuous	Advocate for increase in next budget cycle

Step 2: Risk Assessment

Risk Area	Current Concern	Planned Mitigation
Overreliance on a single grant	Primary funding ends in 6 months	Begin proposal for alternate grant + leadership advocacy for base funding
No internal budget line for CHWs	CHWs seen as "grant-funded only"	Draft language to include CHWs in strategic plan + next FY budget
Lack of reimbursement pathway	No billing yet for CHW services	Connect with Medicaid policy lead to explore options

Step 3: Long-Term Goals

Sustainability Goal	Target Date	Responsible Lead	First Action Step
Secure 50% of CHW budget from core ops	FY 2026	Director of Programs	Present impact summary to CFO
Bill for at least one CHW service area	2025	Billing/Compliance Lead	Schedule Medicaid policy meeting
Create CHW position in org chart	Q4 2024	HR + Program Lead	Draft permanent CHW job classification

Braided Funding Strategy Map

Blend Grants, Operations, Billing, and Partnerships to Sustain CHWs

Use this as a planning tool during budget discussions, leadership meetings, or grant development. The goal is to reduce reliance on any single source while maximizing flexibility and stability.

Core Funding Streams for CHW Sustainability

Funding Source	Role in Sustainability	Examples
Grants	Launch or expand CHW services; pilot new models	State innovation grants, CDC or HRSA funding, local foundations
General Operating Funds	Backbone funding for positions and benefits	Core budget lines for CHW salaries, supervision, onboarding
Medicaid / Reimbursement	Formalize CHWs into care delivery + secure recurring income	Fee-for-service, value-based care, managed care contracts
Partnership Agreements	Cost-sharing with external partners or funders	Hospitals, MCOs, school districts, CBOs co-fund embedded CHWs
Community Investment or Public Health Funds	Fund CHWs to meet population health, SDOH, or prevention goals	Community Foundations, Workforce Development Funding

Example: Braided Funding Structure for a CHW Program

Funding Source	Purpose / Use
Grant (50%)	Initial funding for CHW program launch, training, and early implementation
Core Operating Funds (20%)	Ongoing support for salaries, administration, supervision, and evaluation
Medicaid Billing (20%)	Reimbursement for CHW services such as outreach, navigation, or care coordination
Partner Contributions (10%)	Shared funding from schools, MCOs, or hospitals for CHWs embedded in shared settings

Toolkit Tip: **You can adjust percentages or add rows as needed for your own funding mix. This structure helps demonstrate diversification to funders and leadership.**

Sustainability Scenario Planning Template

Prepare for Funding Changes Before They Happen

Use this tool with leadership, program, or finance staff to identify what actions your organization would take under different funding outcomes.

Step 1: Define Key Funding Source(s)

Current Funding Source	% of CHW Budget	End / Renewal Date
e.g., State CHW Pilot Grant	60%	June 2025
e.g., Hospital Partner Contribution	15%	Annual agreement – renewed each July

Step 2: Plan for Three Likely Scenarios

Scenario	What This Means	Planned Actions
Scenario A: Funding Continues as Expected	No major change to funding in next 12 months	Maintain current staffing and services. Continue impact reporting and leadership engagement to secure future funding.
Scenario B: Funding Decreases or Ends	Loss of major grant or delayed renewal	Identify essential roles to preserve. Develop interim funding plan. Notify leadership and begin alternative funding proposals. Scale down outreach if needed.
Scenario C: Funding Expands	New grant, contract, or partner funds become available	Expand CHW staffing, outreach, or service area. Revisit onboarding/supervision needs. Update evaluation plan and budget. Consider long-term retention strategy.

Step 3: Internal Prep & Communication

Topic	Plan / Notes
Who needs to be informed early (e.g., HR, finance, CHWs)?	
What non-funding supports (e.g., MOUs, supervision, space) might need to adjust?	
What messaging will you use for staff or clients if funding changes?	
What funding alternatives are already identified (e.g., internal funds, new grant, partner contributions)?	

Toolkit Tip: Revisit this tool 2–3 times per year—especially before grant renewals, legislative sessions, or fiscal planning cycles.

Closing Reflections

Community Health Worker (CHW) integration is more than a staffing decision—it's a commitment to building systems that center trust, equity, and lived experience. CHWs bring critical insight into the realities faced by marginalized communities, often serving as the only link between individuals and the care, services, or support they need. As this toolkit demonstrates, successful integration requires more than hiring—it takes structural alignment, shared understanding, and sustained investment.

We encourage organizations to start where they are. For some, that may mean completing the Readiness Assessment Checklist and identifying a program champion. For others, it may involve refining onboarding practices, strengthening CHW supervision, or creating a sustainable funding plan. Wherever you begin, let this toolkit be your guide—not as a prescription, but as a flexible framework built from the realities of Illinois communities.

If you're not sure where to start, begin with Section 1 to assess your current capacity and gaps. Already have CHWs on staff? Skip ahead to Sections 3 and 4 to improve training, supervision, and care team integration. The tools, templates, and planning guides provided are meant to be adapted and shared. Even incremental progress, when rooted in intentionality and community alignment, can have a lasting impact.

This resource was developed with deep gratitude to the CHWs, program managers, public health leaders, and partner organizations who shared their experiences, challenges, and insights. Their stories and strategies—gathered through the CHW Learning Institute and statewide engagement—are reflected throughout this toolkit. We thank them for their leadership, honesty, and commitment to doing this work in ways that are both strategic and human.

For continued support, the IPHA CHW Capacity Building Center is available to provide technical assistance, customized training, and consultation for organizations at any stage of CHW program development. To learn more or request support, contact [insert contact info]. Most importantly, we invite you to stay connected to the growing CHW community across Illinois—because sustaining this work will take all of us.

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