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Community Health Work and Social Work Collaboration: Integration in Health Care and Public Health Settings

A Conceptual Framework

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Abstract: Community health worker (CHW) and social worker (SW) collaboration is crucial to illness prevention and intervention, yet systems often engage the 2 workforces in silos and miss opportunities for cross-sector alignment. In 2021, a national workgroup of over 2 dozen CHWs, SWs, and public health experts convened to improve CHW/SW collaboration and integration across the United States. The workgroup developed a conceptual framework that describes structural, systemic, and organizational factors that influence CHW/SW collaboration. Best practices include standardized training, delineated roles and scopes of practice, clear workflows, regular communication, a shared system for documentation, and ongoing support or supervision.
Key words: *collaboration, community health workers, interdisciplinary health, public health, social determinants of health, social workers*

Interprofessional collaboration has been identified as a best practice for high-quality health care delivery and meeting the quadruple aim of improving population health, controlling costs, improving quality of care, and improving the work life of health

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care providers (Bachynsky, 2020; Kaiser et al., 2022; Karam et al., 2018). Interprofessional collaboration is the process by which different health and social care professional groups work together (Reeves et al., 2017). Key components include clear team goals, role clarification, shared team identity and team commitment, interdependence, and team integration (Reeves et al., 2010). Interprofessional collaboration is particularly important given the current health care system fragmentation across settings, including health organizations and provider networks regardless of health insurance coverage (Kern et al., 2019; Matthews et al., 2017). Community health workers (CHWs) and social workers (SWs) are key health care workforces for addressing health care system fragmentation and promoting effective collaboration (Brownstein & Hirsch, 2017; Craig et al., 2020; Noel et al., 2022; Tadic et al., 2020).

Integration is the organizational framework under which health care is delivered, which is an important solution to health care system fragmentation (Strandberg et al., 2009). There are several integration frameworks, the bulk of which focus on the integration of primary care and behavioral health services (Chung et al., 2020; Heath et al., 2013; Mulvale et al., 2016; National Council for Mental Wellbeing, 2022). Historically, integration frameworks focused on 3 primary domains: shared location, shared documentation, which includes scheduling, and standardized communication. At each domain, the level of integration can be preliminary, intermediate, or advanced; therefore, integration exists across a continuum. More recently, integration frameworks included additional domains such as mental health screening, referral and follow-up, care management, multidisciplinary team-based care, and attention to social determinants of health (SDOH, Chung et al., 2020). However, the applications of these frameworks are limited beyond primary care and behavioral health settings, and they do not address collaborations among public health professionals with shared expertise in SDOH.

It has been well documented that SDOH drives health disparities, and health care systems are increasingly interested in assessing and addressing SDOH to reduce costly and preventable health care utilization (Braveman Gottlieb, 2014; National Academies of Science, Engineering and Medicine, 2019). CHWs and SWs are both SDOH experts and share core values in social justice and capacity building (Hartzler et al., 2018; National Association of Social Workers, 2017; Pérez & Martinez, 2008; Rine, 2016; Rosenthal et al., 2018; Spencer et al., 2010; Taylor et al., 2019). There is also ample evidence that SW and CHW interventions are effective at improving health (Barnett et al., 2018; Jack et al., 2017; Petruzzi et al., 2022; Ross et al., 2024) and mental health outcomes and reducing high-cost health care utilization (Barnett et al., 2018; Jack et al., 2017; Petruzzi et al., 2022; Ross et al., 2024). While CHWs and SWs often engage in collaborative practice within and across health care systems, social services, and community organizations, there is a paucity of literature on interprofessional collaboration that includes SWs and/or CHWs.

Exploring the details of how and where CHW and SW collaboration and integration occur within US health care and public health systems is beyond the scope of this article and has been documented elsewhere (Berrett-Abebe et al., 2020; Noel et al., 2022; Petruzzi et al., Under Review). However, CHWs and SWs are both involved in the assessment of social needs and the referral to health care, community, and social services to improve access to health and mental health services, improve health care and social service navigation, and improve health outcomes. Particularly in practice settings where SWs may have larger caseloads, the integration of CHWs can improve access to community resources and allow SWs to work at the top of their license by providing mental health services. Similarly, effective collaboration can allow CHWs to have more reasonable caseloads and fulfill their roles and scopes if SWs are able to address more

clinically related issues. For example, in a health care setting, SWs can focus on developing care plans with the client based on the results of a standardized assessment, while CHWs implement the care plan and focus on health education and client capacity building. Together, the CHW and SW collaborate on identifying appropriate resources and managing referrals and other support needed. This collaboration provides shared caseload management, benefiting both providers and leading to better outcomes for individuals.

Much of the existing interprofessional collaboration literature focuses on physician-nurse collaboration in primary care, which may not apply to CHW/SW collaboration in diverse health care settings (House & Havens, 2017; Hunter et al., 2017; Mulvale et al., 2016; O'Leary et al., 2020; Supper et al., 2015). Similarly, the current literature on health care integration is largely focused on integrating behavioral health services within primary care and hospital settings; however, less has been written about integrating a broader set of social care services within other US health care or public health settings (Blount, 2003; Heath et al., 2013; Karam et al., 2018; Willumsen, et al., 2012). Therefore, the purpose of this conceptual framework is to build on the current theoretical literature and empirical evidence to identify effective practice methods for CHW/SW collaboration and integration in health care and public health contexts to improve the implementation of health promotion and public health interventions.

METHODS

This conceptual framework is informed by the current theoretical literature and empirical evidence summarized above, as well as over 18 months of proceedings from over 30 key stakeholders and experts in a National CHW/SW Workgroup (Table 1). The workgroup was developed in response to interest expressed by CHWs and SWs from across the country following a presentation at the American Public Health Association's Annual Meeting in 2020. Two co-authors (J.S. and G.W.) presented opportunities to harmonize the CHW and SW relationship to promote health equity in health care and public health settings. The presentation identified shared values, areas of collaboration,

Table 1. Demographic Characteristics of CHW-SW National Workgroup Members (N = 28)

Characteristic	N (%)
Profession	
CHW	10 (36)
SW	7 (25)
CHW-SW	6 (21)
Ally (eg, physician and public health professional)	5 (18)
Gender	
Male	6 (21)
Female	22 (79)
Race/Ethnicity[a]	
White (non-Hispanic)	11 (39)
Black	7 (25)
Hispanic or Latinx	6 (21)
Asian or Pacific Islander	2 (7)
AI/AN	2 (7)
Middle Eastern or North African	1 (4)
Language	
English	24 (86)
English Spanish	4 (14)
State	
Massachusetts	9 (32)
South Carolina	6 (22)
Texas	4 (14)
New Jersey	2 (7)
Other Southern states (Arizona and North Carolina)	3 (11)
Other Western states (California and Oregon)	2 (7)
Other Midwestern states (Ohio and Minnesota)	2 (7)
Institution type	
Academic	11 (39)
Community-based organization	10 (36)
Other (eg, Public health department, national or state association of CHWs, consulting, and philanthropy)	7 (25)

Abbreviations: AI, American Indian; AN, Alaska Native; CHW, community health worker; SW, social worker.
[a]These categories are not mutually exclusive. For example, one person identified as Latinx and AI/AN.

and tensions involving power dynamics, role confusion, and health care system hierarchies (Wilkinson et al., 2020).

Subsequently, the Center for Innovation in Social Work and Health at Boston University School of Social Work and the Center for Community Health Alignment at the University of South Carolina Arnold School of Public Health created a national workgroup to gather CHWs and SWs from across the United States to discuss the current realities and challenges facing CHWs and SWs and to enhance collaboration through the identification and dissemination of best practices. The workgroup is made up of over 2 dozen CHWs and SWs, key stakeholders, and public health experts from 10 states working in health care and public health settings. Members work at academic institutions and community-based organizations, which include leadership from the National Association of Community Health Workers and the National Association of Social Workers.

Based on consensus building during one virtual retreat in May 2021, 12 national workgroup calls and ongoing planning meetings between January 2021 and September 2022, the workgroup conducted an environmental scan and developed a conceptual framework for CHW/SW collaboration and integration (Figure 1). Initial workgroup meetings focused on defining a shared vision, identifying goals and outputs, and discussing gaps in the literature through traditional consensus building (Susskind et al., 1999). Issues identified included underutilization of CHWs/SWs in health care and public health settings; a lack of clarity on respective roles and scopes of practice; limited guidance on effective implementation; and lack of sustainable funding. The workgroup also identified macro contextual factors related to the public health and health care system, professional histories, and organizations that influence effective collaboration and integration, as well as elements of effective collaboration and integration.

Each meeting was recorded, and a master's level social work student took detailed notes at each workgroup call. After each call, the recordings and chat were reviewed, and additional comments or thoughts were incorporated into the notes. These notes were then reviewed by a planning committee to identify major themes, which were reported back at the next workgroup meeting for further refinement and discussion. Between March 2022 and September 2022, 4 meetings were held to review and refine the conceptual framework through discussion and consensus-based decision-making.

CONCEPTUAL FRAMEWORK

Based on the theoretical literature and similar to other conceptual frameworks related to interprofessional collaboration in health care, structural, systemic, and organizational factors were identified as integral to understanding the CHW/SW collaboration and integration (D'amour, et al., 2005; Karam et al., 2018; Mulvale et al., 2016). Structural factors included the socio-political-cultural-historical context, which serve as the anchor of the framework as they impact the populations most affected by health inequities, as well as the systems that CHWs and SWs operate within. Systemic and organizational factors included: (1) the professional context of SWs and CHWs, (2) public health and health care systems, and (3) organizational context. Finally, we identified elements of effective CHW-SW collaboration and integration (Figure 2).

Socio-political-cultural-historical context

The conceptual framework (Figure 2) starts by recognizing environmental factors that include social, political, cultural, and historical context of the United States, which inform and shape CHW and SW practices. These environmental factors impact who has access to health care based on a variety of socio-political-cultural factors such as racism, sexism, classism, and immigration, as well as political trends and policies that criminalize health care for undocumented immigrants and trans individuals. For Indigenous Americans, eg, health inequities that have led to the risk of suicide, substance use, and mental health illnesses are

Figure 1. CHW/SW workgroup consensus process. Abbreviations: CHW, community health worker; SW, social worker.

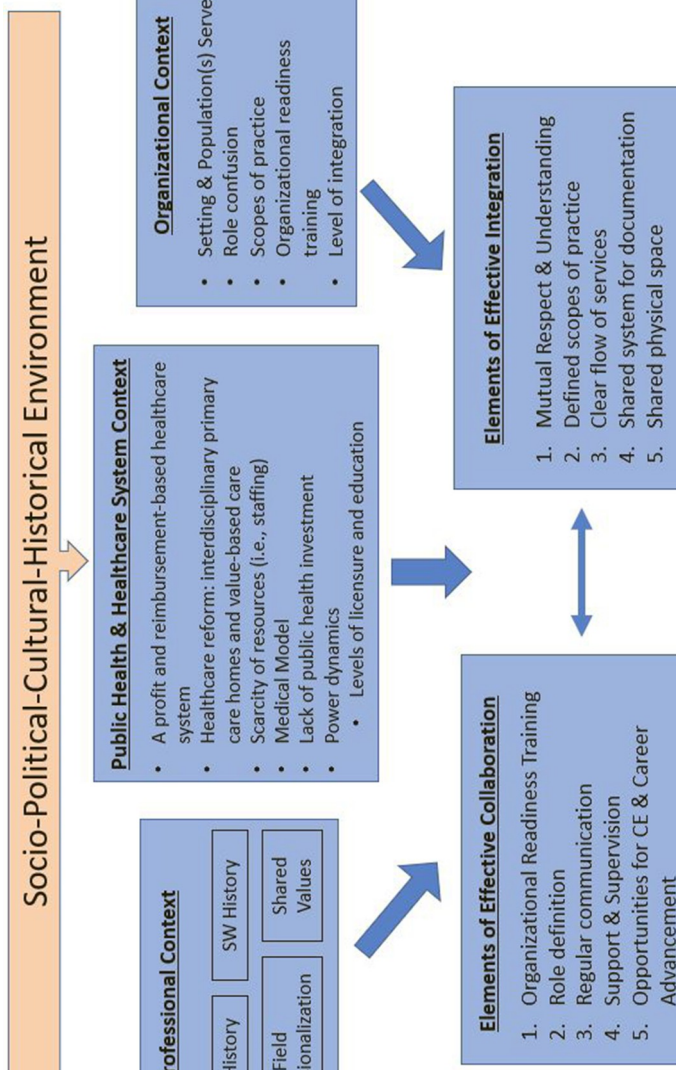

Figure 2. Socio-political-cultural-historical environment.

deeply rooted in historical trauma from displacement from ancestral territory, genocide, and colonialism (Indian Health Service, 2023). For other racial and ethnic minoritized or immigrant populations such as the Latinx community, acculturation can affect psychosocial well-being in the United States (Choy et al., 2021; Ward Geeraert, 2016). Therefore, advancing health equity among these populations requires an understanding of the impact of the sociopolitical contexts and the community impacts of generational trauma. A coordinated approach across systems whereby SWs and CHWs (including Community Health Representatives [CHRs] and promoters) collaborate effectively with culturally tailored approaches can help address the unique cultural needs of diverse populations including acculturation, immigration stress, and language. These environmental factors also influence how population health inequities are defined and understood. Individual-level risk factors such as unhealthy eating or lack of exercise are often treated as the root cause of medical conditions, while SDOH such as poverty, mass incarceration, immigration policy, food deserts, or redlining are overlooked or underemphasized. This leads to the devaluing of SW and CHW professions, particularly in the public health and health care fields, where SDOH have historically been considered "outside" of the health domain.

Moreover, recognizing the historical context is essential to addressing barriers to health care and public health services. For example, during the COVID-19 pandemic, there was widespread recognition that the history of how Black, Indigenous, and People of Color (BIPOC) communities have been exploited or harmed by health care systems led to vaccine hesitancy and medical mistrust (Thompson et al., 2021). CHWs played a crucial role in bridging this gap by providing culturally relevant health education and addressing misinformation to improve vaccination efforts. However, as the COVID-19 pandemic subsided, so did grant funds to sustain the CHW workforce in public health.

Professional context: history and shared values

The varied SW and CHW professional contexts are also important to consider. For example, the field of social work was established in the mid-1800s by affluent, white women within the charity movement through the establishment of settlement houses for immigrants and low-income communities (Moniz Gorin, 2003). Social work expanded into child welfare and hospital settings in the early 1900s and was integrated into the Public Health Service by the 1920s (Beder, 2006; Ruth Marshall, 2017). The National Association of Social Workers was founded in 1955 and the Association of Social Work Boards was established in 1979, which led to professionalization and licensure (Dyeson, 2004).

In contrast, the CHW field started in global health as a grassroots movement of "barefoot doctors" or trained community members (American Public Health Association, 2021; Pérez Martinez, 2008). In the 1950s, promoters became a powerful public health workforce in Latin America, born out of liberation theology movements that sought to empower those living in poverty and to address an unequal distribution of health resources (Pérez Martinez, 2008). CHWs were not introduced to the United States' health care system until the 1960s, although the roots of the profession started in the healing and mutual support traditions of BIPOC communities. In 1968, the US Congress established the CHR Program in response to the expressed needs of the American Indian and Alaska Native communities (Indian Health Service, 2024). CHRs were the first, federally funded CHWs, and the CHR program is the longest-standing CHW program in the country (Sabo et al., 2021). In 1999, Texas was the first state to offer certification for CHWs, and in 2007, the first CHW code of ethics was published (Nichols et al., 2005; Scott Dunning, 2008). The National Association of Community Health Workers was formally established in 2019 and certification expansion varies by state (Centers for Disease

Control and Prevention, 2015; Jones et al., 2021; National Association of Community Health Workers, 2023). It is also worth noting that while CHWs are being integrated into health care and public health systems more regularly, there are many CHWs who are employed by community-based or nongovernmental organizations or work voluntarily within the community. Further, there is considerable tension within the CHW workforce regarding whether and how CHWs should be formally certified and/or integrated into systems (Kissinger et al., 2022).

CHWs and SWs share values in self-determination, cultural humility, social justice, and policy advocacy (National Association of Social Workers, 2017; Scott Dunning, 2008). These values are enacted through social care services and interventions that support the underserved, remove barriers to health and social systems, and address SDOH to improve health outcomes. However, it is important to consider the power dynamics between CHW and SW professions due to community perception, educational requirements, pay disparities, and the racial, ethnic, and class differences between the 2 workforces (Smithwick et al., 2023; Wilkinson et al., 2017, 2020). CHWs and SWs often operate within systems that are hierarchical in nature and can reinforce power dynamics, thus impacting effective collaboration.

Public health and health care system context

There are several public health and health care system contextual factors to consider. First, the current health care system assigns value to professions based on reimbursable rates, and both CHWs and SWs have struggled to receive adequate reimbursement rates. Limited access to sustainable funding streams for case management and social care interventions through public or private insurance directly impacts where and how CHWs and SWs can work and collaborate and which positions are deemed more essential or sustainable (Crook et al., 2021). This creates inconsistencies and scarcity in funding, which can lead to anxiety, burnout, and high turnover, as well as unnecessary competition for limited grant funds.

Although there are some health care system challenges related to potential collaboration, there are also promising practices within health care reform that provide opportunities for enhanced collaboration. For example, value-based care payment models and bundled care payments are becoming more common in an effort for health plans and states to create payment flexibility that in turn enhances the opportunity for more interdisciplinary collaboration (Crowley et al., 2020; Park et al., 2019). However, standardized reimbursement structures are needed at the federal and state levels to ensure equitable compensation for CHW and SW services. While the Centers for Medicare and Medicaid Services recently updated the 2024 Physician Fee Schedule to include some reimbursement for SDOH via Medicare, it only reimburses for CHW services, not SW services (Centers for Medicare Medicaid Services, 2023; National Association of Social Workers, 2024). Further, Medicaid reimbursement for CHW and/or SDOH services varies widely by state (Hinton, 2023).

Second, inadequate federal and state investment in public health infrastructure, community-based organizations, and SW and CHW workforces makes it challenging to implement services and interventions at the appropriate staffing levels and collect meaningful outcomes and workforce data. There has been a general disinvestment in public health systems and workforces over the past several decades that has unfortunately impacted our ability to fund CHW and SW interventions and address SDOH. Moreover, many CHW and SW collaborations exist outside of reimbursement-based health care settings in public health or community-based organizations. CHW and SW programs are often focused on community members with complex social and medical needs, with limited staffing to address the level of client complexity.

Lastly, it is important to recognize the power dynamics among various health professionals, particularly in relation to disparate educational backgrounds, licensure, certification, and policies (Okpala, 2021). Similar to other health professions, these power dynamics can create unintended tensions between SWs and CHWs in terms of disparate levels of role familiarity, different levels of respect from health care leaders and administrators or other care team members, and pay inequities (Center for Health and Social Integration at Rush, 2022).

Organizational context

Finally, organizational context can influence CHW/SW collaboration and integration including the setting, population served, and scopes of practice. These 3 factors can dictate where interventions are conducted, how long they last, and how CHWs and SWs collaborate. For example, in primary care settings such as Federally Qualified Health Centers, SWs may be limited to behavioral health interventions such as counseling, while CHWs may focus on social needs. This can significantly reduce role confusion between SWs and CHWs among clinic staff and create a clear division of roles. However, under this type of organizational context, CHWs can experience an undue burden to address the complex and varied social needs of a marginalized population, limiting collaboration with SWs who are also trained to deal with social needs as a part of behavioral health care planning. In comparison, community-based settings may approach SW and CHW collaboration with more flexibility, which can allow for seamless integration and ability to partner in service provision. However, it can also lead to some role confusion. Therefore, it is critical that program goals be clear and that members of both professions are included in program design, role delineation, referral processes, and overall decision-making. Further, without adequate organizational readiness training for staff on interdisciplinary collaboration and role delineation, there can be role confusion or conflict in the team, ultimately affecting the quality of care (Lee et al., 2019). Therefore, it is essential for organizations that integrate CHWs and SWs to better understand the elements of effective collaboration and integration discussed below.

Elements of effective collaboration

Interprofessional collaboration is defined as "multiple health workers from different professional backgrounds who provide comprehensive services by working together with patients, families, carers, and communities to deliver the highest quality of care" (World Health Organization, 2010). Through a consensus building process outlined in Figure 1, we identified 5 elements of effective collaboration including standardized training, role delineation, regular communication, support, and supervision, as well as opportunities for continued education and career advancement. "Standardized training" for all organizational and/or team members on program goals and interprofessional collaboration is the first step to building a collaborative team and building the foundation for respect, trust, and understanding among care team members. Training provides clarity about the services provided and delineated roles and scopes of practice, as well as expectations around communication, documentation, and other crucial components of collaboration (Brashers et al., 2020). "Role delineation" is particularly important for setting feasible expectations for patients/clients, community members, care team members, and outside organizations (Karam et al., 2018). If roles and scopes of practice are unclear among team members, it will be even harder for community members or outside organizations to understand how CHWs and SWs complement one another. For example, creating a document that outlines the roles and scopes of practice for CHWs and SWs as well as other care team members can be beneficial for clarity, training, and supervision.

"Regular communication" among team members is documented in the literature as

a core component of interdisciplinary collaboration (Karam et al., 2018; Reeves et al., 2010). While the frequency of communication is important, communication quality is also important. Open and reciprocal communication ensures that both CHWs and SWs feel comfortable, valued, and heard so they can discuss issues or challenges that arise. Regular communication is particularly important if role delineation is less clear. While regular communication can look different depending on the setting or team, some possibilities are weekly case meetings, daily huddles, email, phone, or "chat" communication on a case-by-case basis. Additionally, CHWs and SWs should define communication plans for crisis situations (ie, safety concerns such as suicidality).

"Support and supervision" are critical components of effective collaboration, which includes supervision by trained professionals from their respective fields. For example, SWs or CHWs are frequently supervised by other health care professionals (ie, registered nurses). While this may be standard practice within certain health settings, it should not be the only support provided. CHWs and SWs have field-specific values, competencies, and expectations in terms of professional licensure or certification. Therefore, CHWs and SWs should be provided with supervision and guidance from experienced professionals in their respective fields. Further, SWs are sometimes asked to manage CHWs, which can create tension or unproductive power dynamics if the collaboration is inequitable, if the SW does not have community-based experience or experience having worked with CHWs. One possible solution would be group supervision, in which CHWs and SWs engage in reciprocal supervision or support, thus providing a safe space to address challenges or issues arising in the team.

Lastly, "opportunities for continuing education (CE) and career advancement" are important for effective collaboration. SWs may not be familiar with CHW competencies or scopes of practice and vice versa due to limited opportunities for interprofessional education. While there has been growing interest in interprofessional collaboration within health care and hospital settings for medical, nursing, pharmacy, and/or social work students, CHWs to date have been largely excluded from these efforts (Schot et al., 2020; Spaulding et al., 2021). CHWs and SWs can benefit greatly from continual learning opportunities as it may be required to complete continuing education (CE) for certification or licensure. It also provides an opportunity for team building and trust building among CHWs and SWs to learn more from each other based on their areas of expertise. Moreover, it is important for SWs and CHWs to be considered for career advancement and leadership opportunities within organizations, particularly within areas of program design, research, or policy to improve overall CHW and SW collaboration within the organization or system (Pecukonis et al., 2019; Sugarman et al., 2021). Both SWs and CHWs often have a good understanding of health care and social service systems, and value individual and community health outcomes, yet can be overlooked for leadership opportunities.

Elements of effective integration

While collaboration concerns how effectively care team members work together within a team, integration concerns how effectively teams are embedded and coordinated within particular health care, public health, or other organizational systems and settings. Effective integration includes defined scopes of practice, a clear flow of services, a shared system for documentation, shared physical space, and mutual respect and understanding. Similar to the importance of clear role delineation on care teams, it is essential to have clearly defined "scopes of practice." While scopes of practice are well defined by national workforce bodies, they may not be well understood by health care leadership or clearly delineated at the organizational level (National Association of Social Workers [NASW], 2016; Rosenthal et al., 2018). SW and CHW

scopes of work span across the individual, community, and systems levels and include macro work such as community organizing, advocacy, and policy practice. Therefore, these system-level scopes represent additional opportunities for alignment between the 2 professions, particularly NASW and National Association of Community Health Workers (NACHW), in advancing health equity and aligning health care or public health services with community needs.

In order for organizational and programmatic design to align with scopes of practice, a deeper understanding of both CHW and SW fields, beyond the current setting or intervention, such as the process of certification or licensure, is required. For example, one way in which SWs are differentiated from other mental health providers such as psychiatrists is their inability to prescribe medications. Similarly, for CHWs, clinical counseling or therapy is beyond their scope of practice. However, CHWs can provide informal mental health support and use techniques such as motivational interviewing or behavioral activation to improve mental health. These differentiations are crucial to ensure that SWs and CHWs practice "at the top of their license or certification," in line with the ethical standards of their respective fields.

A clear scope of practice is also helpful in establishing the best "flow of services" between the SW and the CHW. Does each team member conduct their own assessment? And if so, are there areas of overlap? Do all patients or community members receive SW and CHW services or are there certain criteria for receiving services from one care team member vs the other? The flow of services may also depend on the setting and whether other care team members are involved, such as a primary care physician, midwife, or school counselor. These details are essential to maintaining a strong rapport with stakeholders across health care systems, reducing the duplication of services through coordinated care and maintaining high patient/client satisfaction and community trust.

The next 2 recommendations, "a shared system of documentation" and "a shared physical space," are key components to health care integration more broadly. Integration is a spectrum that is defined by 3 primary components: level of coordination, co-location, and systems integration (Heath et al., 2013). Integrated care with full collaboration is a completely merged practice where behavioral health and primary care providers work within the same system, so they share medical records and billing and are recognized by patients as being part of a fully integrated team (Blount, 2003). While this framework is typically used for ambulatory and primary care settings, it can be expanded to support CHW and SW integration. Shared documentation can help ensure that SWs and CHWs stay current on shared care plans, while shared physical space fosters close coordination and regular communication.

The final recommendation for effective integration is a consistent demonstration of "mutual respect and understanding." CHWs function as cultural brokers and are necessary for developing and/or rebuilding community trust, particularly among marginalized communities that have been actively harmed by the health care system (Schaaf et al., 2020). While traditional health care systems value the number of years of education received and compensate people accordingly, it is crucial for lived experiences to be recognized as just as valuable. This is critical for the prevention of burnout and the retention of CHWs. It is also essential for SWs to value CHWs beyond how they can promote social work or lighten the SW workload and recognize CHWs for their unique and essential contributions in alignment with the social work value of cultural humility (Spencer et al., 2010; Stanhope et al., 2015). Moreover, mutual respect and understanding of CHWs and SWs within the health care, public health, or community-based organization is also essential for employee satisfaction and retention. Organizational or system leaders and other care team members such as physicians, nurses, and program managers need to

understand and value CHW and SW roles and be able to differentiate between the 2 professions in order for CHWs and SWs to be effectively integrated into health care and public health systems.

DISCUSSION

As evidenced by a recent National Academies of Science, Engineering and Medicine (2019) report, addressing social needs is essential for improving health equity. CHWs and SWs are experts at addressing social needs through standardized assessment, community resource referrals, and care coordination. While both have an increased presence in health care and public health systems, there is still a lack of understanding of their unique and overlapping roles and scopes of practice, as well as their varied professional histories. Further, there is a dearth of studies that assess interprofessional collaboration among CHWs and SWs, and they typically do not provide details regarding the process of collaboration, such as training or role differentiation, or level of integration such as shared physical space, documentation, or frequency of communication (Noel et al., 2022). This hinders their ability to effectively collaborate with or integrate into interdisciplinary care teams.

Our conceptual framework was informed by the interprofessional collaboration literature that identified the importance of having a common interest in collaboration, shared decision-making, mutual respect, and communication (House Havens, 2017; Supper et al., 2015). These themes highlight the importance of interprofessional education and training to improve role clarification and mutual respect across disciplines and at the organizational level. Similarly, Smith et al. (2018) identified 5 principles of high-performing teams to reduce clinician burnout: shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes. However, our group expanded what has been previously written about interprofessional collaboration by identifying organizational and health care systems factors that uniquely impact CHW and SW collaboration. We also incorporated historical, social, cultural, and political contexts so this framework could be more adaptable to the varied places and contexts that integrate CHWs and SWs into health care or public health settings.

Recommendations and next steps

There are some key takeaways from the conceptual framework. First, it is essential for health organizations or programs that are already integrating SWs and CHWs to better understand the various factors that influence effective collaboration and integration. For example, having a clear understanding of CHW and SW scopes of practice during the planning stage is crucial for successful implementation. Second, standardized organizational training on roles and scope is crucial, not just for CHWs and SWs but also for other team members or staff. This enhances a shared understanding of the program's goal and fosters mutual respect. Third, organizations need to create a clear workflow with user-friendly and shared documentation and communication systems to support effective collaboration. Lastly, providing adequate opportunities for SW and CHW CE and career advancement is essential for increased understanding of CHW and SW roles, competencies, and scopes of practice and improves workforce development and retention. Career ladders that provide growth and advancement opportunities will ensure that program directors and leadership decisions are more familiar with CHW and SW workforces and improve overall CHW and SW collaboration and integration.

As previously described, this was a part of a larger initiative to improve CHW and SW collaboration and integration in health care and public health settings. This study was co-designed and analyzed through a consensus process (refer to Figure 1) to ensure that the findings are relevant and

translatable for both professions. In terms of our next steps as a national workgroup of CHWs and SWs, we are conducting a mixed method study with CHWs and SWs across the United States to validate our conceptual framework in varied public health and health care settings.

Limitations

This conceptual framework was developed based on the current research literature, as well as the expertise of a diverse, national workgroup with CHWs, SWs, and public health and health care allies. However, the framework still needs to be validated with a larger, nationally representative sample of CHWs and SWs. Additionally, there may be cultural, linguistic, and place-based needs that are not fully encompassed or addressed in the current conceptual framework. While our workgroup is diverse in terms of race, ethnicity, and state context, additional data need to be collected from a larger and more diverse sample, considering multilingual, rural, and other state contexts.

CONCLUSIONS

SWs and CHWs offer expertise in health interventions, SDOH, community engagement, and systems thinking that have the potential to reduce health inequities. CHW/SW collaboration is crucial to the improvement of population health and quality of care, yet systems often engage the 2 workforces in silos and miss opportunities for cross-sector alignment in both individual and community health services. The conceptual framework that we developed is a step forward to enhancing the understanding of CHW and SW roles and scopes of practice in health care and public health settings and improving the integration of social care interventions across a variety of settings to promote health equity.

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