Community-Based
Workforce Alliance

Advancing CHW Engagement in COVID-19 Response Strategies

A Playbook for Local Health Department Strategies in the United States

The National Community-Based Workforce Alliance

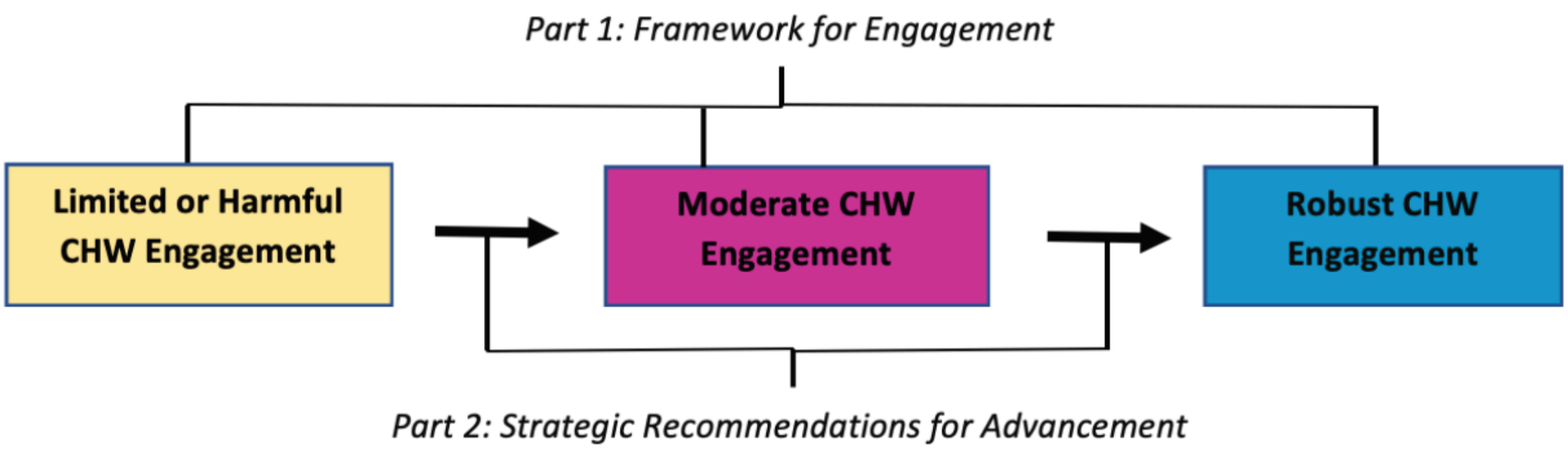
Community-Based Workforce Alliance

Executive Summary

The COVID-19 pandemic has highlighted the persistent inequities in healthcare throughout American society. Local Health Departments (LHDs) must advance health equity throughout their response and rebuild efforts. **Community Health Workers (CHWs)**, as trusted members of the community and experts in community health, are critical for this advancement. CHWs should be engaged as necessary partners throughout several key activities of the local COVID-19 response strategy, including but not limited to contact tracing, healthcare coordination, community-based testing, vaccine readiness education, and the navigation of social resources.

Grounded in HealthBegin's Community-Based Workforce Principles for Pandemic Response and Resilience, several organizations have formed the National Community-Based Workforce Alliance (CBWA) to ensure that the COVID-19 pandemic response and rebuilding efforts are equitable, effective and involve, fund, strengthen, and elevate trusted community-based workers, including CHWs. **The following playbook was developed by the CBWA to facilitate both the conceptualization and operationalization of CHW engagement for pandemic response strategies.**

A defining feature of this playbook is the **"Framework of Engagement"**, presented in Part 1. This framework—built from the updated Community Health Worker Assessment and Improvement Matrix and adapted to the COVID-19 response within the United States—presents a continuum of engagement across several key areas with the goal of designing or improving CHW-based programs to deliver optimal results. At the most evolved end of this continuum, "robust engagement" envisions a state in which the organizing structure and scope of work provides CHWs the support they need to be necessary partners in the work of achieving healthy communities. This continuum reflects the reality that not all LHDs have the same capacity to achieve robust engagement with CHWs, at least not right away. To facilitate the advancement of LHDs along different stages of this continuum, Part 2 includes a series of **strategic recommendations** for making discrete improvements across all areas of engagement.



LHDs should use this playbook to first identify where they currently exist on the continuum and where they would like to be (Part 1). They may then consider strategic options available to advance themselves appropriately (Part 2).

Background: The COVID-19 Pandemic and CHWs

The COVID-19 Pandemic has placed a spotlight on systemic racism and inequalities in US healthcare. Although Blacks and Hispanics represent 13% and 18% of the population, respectively, they have constituted 26% and 30% of all US COVID-19 cases. Nationwide, Black people are dying at 2.5 times the rate of white people (see the COVID Racial Data Tracker). Local Health Departments (LHDs) must engage the necessary channels to center and advance racial equity across all facets of their COVID-19 response strategy.

Many have called for engagement with Community Health Workers to address COVID-19 health inequities during the pandemic. The term "Community Health Worker" (CHW) is an umbrella term for a variety of public health occupations including, among other titles, promotoras de salud, community health representatives, patient navigators, and lay health advisors. While CHWs serve nearly every sector and represent a variety of linguistic, racial, ethnic, and geographic communities throughout the United States, they are all, in the words of the American Public Health Association, "essential frontline public health workers who are trusted members of and/or have unusually close understandings of the communities they serve." **For the sake of advancing health equity, LHDs must engage CHWs wherever possible throughout their COVID-19 response**. Activities which involve a direct interface between the LHD and community members are especially in need of engagement. With unique lived experiences, trusting community relationships, and the skill to navigate siloed services and systems of care, **CHWs are well equipped to lead COVID-19 response activities.**

Among the many roles identified by the CHW Core Consensus (C3) Project, CHWs are already engaged in the following COVID-19 response activities:

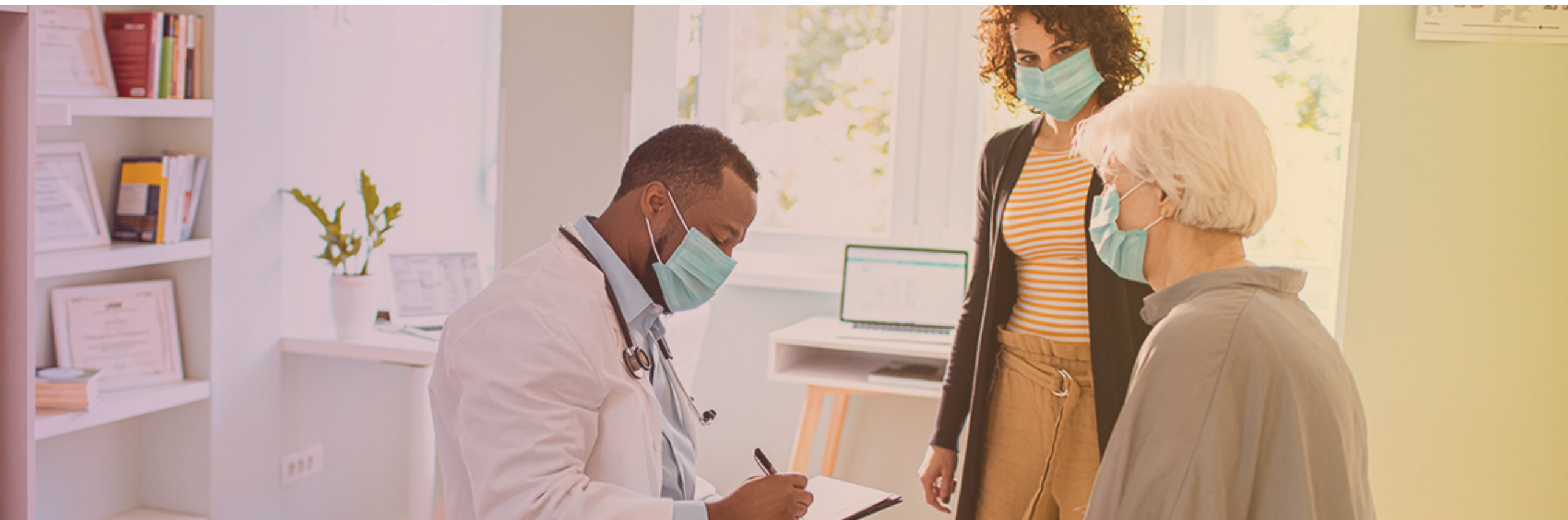
- **Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems:** CHWs build trust as necessary links between community members and the local health departments and the healthcare system, especially for communities that have been excluded from or marginalized by public health and healthcare services in the past. While CHWs are not responsible for nor capable of completely repairing systems of mistrust, their engagement is essential throughout the healing process.
- **Building Individual and Community Capacity:** CHWs bridge local institutions by working with different agencies present in a community to promote a more comprehensive COVID-19 community health response that maximizes the utility of resources present and ensures equitable distribution to prioritize the needs of the most vulnerable.
- **Providing Culturally Appropriate Health Education and Information:** Throughout American communities there is misinformation about the virus, widespread concerns about data privacy, and mistrust of traditional healthcare institutions among communities of color. There are also community concerns regarding negative consequences of providing their personal information to outsiders. A trusted messenger—such as a CHW—who meets people where they are and empowers them to act, is essential to building trust, a key component of any COVID-19 community outreach initiative. CHWs relay information to communities from LHDs and elevate the voices of the most marginalized to ensure community health responses are informed and equitable. CHWs also communicate proper COVID-19 health behavior in a culturally sensitive way. For example, when a CHW was called to speak with primarily immigrant workers in a fruit packing warehouse about the fear of infection spreading within the facility, they were able to train the workers on appropriate mask wearing and physical distancing protocols.
- **Care Coordination, Case Management, and System Navigation:** Members of vulnerable communities find it especially difficult to self-isolate—due to limited work from home opportunities, a lack of housing space to safely isolate, or difficulty establishing a secure food supply—often need tailored support to follow self-quarantine guidelines. CHWs can help these individuals navigate social resources in LHDs and nonprofits to address concerns such as food insecurity, financial challenges, transportation difficulties and emotional trauma that contribute to higher risks of disease and impede recovery. For example, CHWs in the Navajo Nation (referred to as Community Health Representatives) help find food and water resources for individuals stopped at checkpoints after locally-imposed curfews. CHWs also help navigate the healthcare system, especially for patients with comorbidities, pre-existing conditions, and chronic care needs—those who are most high-risk for COVID-19. Because CHW identities reflect the diversity of the communities they serve, they have an immediate comprehension of the difficulties distinct communities face when accessing healthcare. CHWs can also continue to strengthen and maintain the healthcare system after a crisis like COVID-19 by promoting the management of chronic conditions in vulnerable populations with continuous accompaniment. As assessed by the CDC and several randomized control trials, CHWs are effective and essential healthcare workers; they are experts in community health.

- **Advocating for Individuals and Communities:** CHWs can advocate for marginalized community members with employers and landlords to facilitate safe housing options and working conditions so that community members can remain safe and do not have to assume unnecessary risk to sustain their livelihoods during COVID-19. For example, that same CHW from the fruit packing plant advocated for the employees who did not have paid sick leave and were afraid to violate mandated work hours, which eventually ensured that all workers received a COVID-19 test at the owner's expense.
- **Conducting Outreach:** While contact tracing and testing is functionally performed to track and prevent the spread of disease, the activity is fundamentally about community relationships. When a tracer conducts outreach, they represent the LHD's concern to guard the health of the community. Without serious engagement of CHWs in COVID-19-related community outreach activities, LHDs will likely fail to reduce health inequities because LHD representatives will not be trusted and largely unable to provide holistic support.

Additional CHW roles, as identified by the C3 Project, include: Providing Coaching and Social Support, Providing Direct Service, Implementing Individual and Community Assessments, and Participating in Evaluation and Research. All such roles should be engaged for the sake of COVID-19 response and rebuild efforts.

While several LHDs have already engaged CHWs in their CRS (often limited to the activity of contact tracing), including several exemplar models, most have not (see reports by FamiliesUSA and NASHP). A national poll by the National Association of Community Health Workers (NACHW) revealed that, instead of mobilizing CHWs in the first few months of the pandemic, employers in many states opted to lay them off. **As COVID-19 continues to ripple through vulnerable communities across the country, a renewed effort must engage this critical workforce**.

However, LHDs should not consider engagement with CHWs—for the sake of CRS-related activities or otherwise—as merely an effective tool or means to an end. LHDs should properly identify CHWs and CHW networks as professionals, partners, and leaders in the work of community health. These designations reflect the expert perspective CHWs have in engaging community health concerns and the essential skills they contribute to address such concerns. For at least the last several months, most LHDs have failed to recognize the critical and professional status of CHWs, which has undoubtedly weakened the US's early and ongoing response to COVID-19. LHDs must establish systems to ensure that these voices are heard and included in key decision-making processes, now more than ever.



Introduction to "The Playbook"

Several publications have been developed which justify or advocate for the engagement of CHWs in national COVID-19 response activities. This includes those developed by the National Governors Association and the Association of State and Territorial Health Officials, the National Association of County and City Health Officials and the Johns Hopkins Health Security Center also emphasize the role of CHWs. Among such documents, there is limited guidance on how LHDs should operationalize engagement with CHWs. **Properly identifying CHWs as partners in the work of community health has important implications across several areas of engagement**. Yet the capacity for LHDs to engage CHWs varies considerably and need not fit a uniform model. **Certain key features, however, must be included in any robust vision of CHW engagement—a vision in which the organizing structure and scope of work recognizes CHWs as professionals and necessary partners and leaders in the work of community health**. There thus exists a continuum of CHW engagement, characterized by the gradual implementation of those features. Establishing a vision for this continuum and the items which populate it is a critical to achieving robust engagement.

This Playbook first provides a framework for that continuum, one the draws extensively from the Community Health Worker Assessment and Improvement Matrix (CHW AIM) (Part 1). This matrix, originally created in 2011 and updated in 2018, has achieved tremendous success assisting local NGOs and national policymakers to assess the functionality of key programmatic components of any CHW-based initiative. This playbook utilizes many of the CHW AIM items, with several important adaptations to refashion this matrix to the *specific work* of COVID-19 response strategies within the *specific context* of the United States. The items presented in this Playbook are parallel and draw from guidelines developed from other CHW associations and CHW-focused CBOs, such as Visión y Compromiso and Partners in Health. **The goal of this Playbook is thus not to present entirely new ideas, but to synthesize the best of what has been considered for CHW programs and apply these considerations to the current public health crisis.**

Similar to CHW AIM's four degrees of functionality (intended to distinguish levels of effectiveness for a CHW program's design), the Playbook's framework identifies several items for LHDs to consider across three levels of an engagement continuum: Limited or Harmful Engagement, Moderate Engagement, and Robust Engagement. **At the highest level of engagement, we have emphasized the capacity for CHWs to enter into professional partnership with LHDs while both recognizing the appropriate scope of work CHWs are capable of and ensuring the individual agency to guarantee the success of that work**. More particular guidance may be provided for specific CRS-related activities (e.g. contact tracing, vaccine readiness education, etc.)—this framework is intended to establish the general program-specific features which are necessary for the success of any such activity. We hope that LHDs can use this playbook to replicate the successes that the CHW AIM matrix has achieved abroad for the United States' ongoing response to COVID-19.

To facilitate the operationalization of items mentioned within the framework, **this Playbook next identifies realistic policy recommendations to advance LHDs along the continuum (Part 2)**. For each evolution (e.g. from moderate engagement to robust engagement), recommendations are provided across all ten areas of engagement. These recommendations should be considered suggestive but not exhaustive.

With both parts applied in combination, we encourage LHDs to use this Playbook to first identify where they currently exist on the continuum and where they would like to be (Part 1). They may then consider strategic options to advance themselves appropriately (Part 2).

PART 1: FRAMEWORK FOR ENGAGEMENT

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Increasing Intensity of Engagement →			
Area of Engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Robust Engagement**
Role Definition	● No mention of CHWs within any CRS documentation, or a brief mention of CHWs are provided but without further guidance. ● CHWs are not relied upon to design roles and expectations of CHWs within the contact tracing strategy.	● CHWs are mentioned within some features of the CRS but there is not a clear role for them or acknowledgement of expertise. ● Without being explicit, the CHW role reflects several of the recognized roles and competencies of CHWs as outlined by the CHW Core Consensus Project.	● The roles and capacities of CHWs are explicitly recognized by other members of the CRS. ● The role of CHWs includes all items from the CHW Core Consensus Project, including those specific to COVID-19. Explicit recognition is given that CHWs can execute all such roles and competencies. ● There is an explicit emphasis on a holistic conception of the CHW role, which prioritizes their ability to know their clients as people. ● The role of CHWs, as formally articulated, is flexible enough to provide tailored support across a range of services depending on individual client needs, including those which address upstream determinants of health. ● The role of CHWs is designed using evidence-based work practices and direct input from participating CHWs.
Recruitment	● Using non-CHWs to fulfill CHW roles or otherwise hiring non-CHWs but classifying them as such. ● External recruiting agencies (if existing) have limited knowledge of CHW-associated qualities to consider.	● Members of the community or experienced CHWs/CHW associations are engaged to assist with the recruitment process. ● Recruitment is of authentic CHWs (i.e. from communities disproportionately affected by COVID-19 who have demonstrated trust building traits).	● Recruitment is grassroots and is designed to maximize diverse racial/gender participation, prioritize shared life experience, and to match the diversity of the communities CHWs come from. ● Barriers to entry (e.g. requiring more than a high school diploma, disqualifying people who have touched the criminal justice system) are reduced as much as possible. ● CHWs themselves are involved in the selection process. ● The number of CHWs recruited is done with attention to case-load capacity, which is considered with respect to the CHW role, the geographic reach of the CHW and the complexity of client needs.

Increasing Intensity of Engagement →			
Area of Engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Robust Engagement**
Training and Professional Development	● Minimal, one-time online training is provided to CHWs. ● Training is not guided by published accounts of CHWs roles and capacities in the United States.	● Initial training is provided to all CHWs (experienced or new) but training is not ongoing throughout the course of the COVID-19 response ● Experienced CHWs or CHW associations assist training design. ● Partner organizations/NGOs provide ad hoc workshops on topics that are narrowly epidemiological or biomedical (e.g. the specifics of contact tracing or COVID-19 disease natural history) ● Training is provided for free or at a much-reduced cost.	● Initial training meets state standards for CHW accreditation if such standards exist. ● Training is strongly guided by published accounts of CHW roles and capacities within the United States ● Training ensures proficiency across all of the core competencies as outlined within the CHW Core Consensus Project ● CHW training includes extensive practicum time ● Continuous capacity development is provided by employer to reinforce initial training, teach CHWs new skills that could be used to further their professional growth, and to help ensure quality. ● CHWs are actively trained to use any COVID-related technology (e.g. contact tracing mobile applications) ● Training establishes proficiency across all 11 core competencies as outlined within the CHW Core Consensus Project and is designed to fit all CHW roles
Safety and Supplies	● CHWs are expected to provide their own supplies and safety measures including PPE. ● No safety standards are established for CHW safety.	● Occasionally CHWs are stocked with the appropriate supplies and PPEs, but this stock often does not last for the duration necessary. ● Minimal standards are established to ensure CHW safety ● CHWs are responsible for self-supplying other supplies (e.g. telephones, tablet, vehicle to conduct door-to-door visits)	● All necessary supplies and protective equipment are consistently available throughout CHW engagement. ● Written procedures/protocols exist to ensure the safety of CHWs when working with patients/clients ● Safety/support metrics for self-care and mental health of CHWs (not just physical health with PPE) are included.

Increasing Intensity of Engagement →			
Area of Engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Robust Engagement**
Supervision	● CHWs are not supervised by anyone with experience overseeing CHW-led activities or who understands CHW roles and competencies. ● Supervisors don't have the optimal background (e.g. heavy clinical background, lack of familiarity with community-engaged work).	● Supervision of CHWs mainly operates to collect data for record keeping (e.g. tracking the number of cases identified through contact tracing). ● Dedicated supervisors conduct regular updates that include reviewing reports and providing problem-solving support to the CHW. ● Supervision is conducted with close reference to published accounts of CHW roles and capacities, according to the "Building a Community Health Worker Program Report" (pg. 25).	● Supervisor is dedicated exclusively to CHWs and receives training on effectively supporting CHWs. ● Community Health Nurses may supervise CHWs and accompany them into the field, which adds credibility for community members and allows supervisors to better understand challenges faced by the CHWs ● Supervisors are experienced CHWs or have a passion for CHW role and understand the significance to both CHWs and their patients/clients. ● Supervisors have the capacity to both meet regularly with CHWs for one on one reviews of cases and convene team meetings which consist solely of CHWs. ● Supervisors ensure recognition, collaboration, and support between CHWs and other members of the response effort (i.e. this should be included as part of their job description) ● Supervisors have a system for assessing performance and supporting any needed improvement on an ongoing basis. ● In addition to CHW supervisor, the LHD recruits a program coordinator who manages infrastructure issues (data and reporting, communication about cases between CHWs and others on a contact tracing team, new information coming about test sites, resources, etc.) ● Supervisors receive effective supervision and support from a local/ regional director

Increasing Intensity of Engagement →			
Area of Engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Robust Engagement**
Compensation	● No financial or non-financial incentives are provided; CHWs are volunteers.	● Limited financial incentives are provided but there is no salary or benefits. ● Payment is ensured for the duration of their time within the CRS. ● Some non-financial incentives are offered such as training certificates or class credit. ● Compensation is also provided during the training process.	● Full-time CHWs are compensated financially at a competitive rate relative to the respective market and salaries are consistently paid on-time. ● CHWs are paid at an hourly rate which amounts to a living wage relative to the community they work within. ● CHWs are offered non-financial incentives such as health-insurance and paid time-off. ● CHWs are compensated for the entire range of services they provide, not simply those related to contact tracing work. ● CHWs are ensured employee benefits and can negotiate benefit contents.
Healthcare Integration	● Any work of CHWs within the CRS is not directly linked to the work of other health professionals.	● The role of the CHW is loosely linked to the work of other health professionals but this linkage is not formally advocated for and managed by supervisors. ● CHWs are recognized as a formal part of the health system or local health departments effort to curb COVID-19. ● CRS organizers uniquely market the role of CHWs and ensure community-wide recognition for their work	● Individuals from the formal healthcare system are encouraged to serve as "champions" for the work of CHW during the COVID-19 response. ● CHWs create linkages between patients/clients and primary care settings, to address issues with contacts outside of COVID-19. ● For the work of contact tracing, there is a coordinated process for CHWs to refer contacts to the appropriate health professionals, within the contact tracing team or otherwise. CHWs are constantly updated on the progress of their patients who have been contacted and referred to other members of the contact tracing team. ● There is a clear communication strategy between the state or other local health department and CHWs regarding COVID-19 progress. ● Integration of CHWs within the CRS advances the core principles of Community-Centered Health Homes

Increasing Intensity of Engagement →			
Area of Engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Robust Engagement**
Community Partnerships	● Additional community institutions are not considered within the CRS.	● Community institutions are weakly involved with the CRS strategy. ● CHWs know where referrals should be made but have no formal referral process, logistics, or forms. ● The CRS works closely with state-wide CHW associations if such associations exist.	● Community members and CHWs play a key role in the design and implementation of the CRS. ● The community is clearly made aware of privacy issues around data collection (e.g. during contact tracing and testing) and CHWs are engaged as trusted members of the community to transmit this information. ● Support is given on behalf of the CRS to encourage CHWs to engage existing multisectoral community structures (e.g. health committees, community meetings). ● CHWs are preferentially placed within CBOs or other community health institutions such as FQHCs (as opposed to strictly being placed at the health dept office itself, which can be a barrier to some who may not be able to access health department services or may mistrust the department).
Career Investment	● There is no long-term career vision for the CHW workforce after COVID-19.	● Limited guidance and additional training are given to CHWs to advance similar careers after COVID-19 contracts are over.	● Employment for CHWs is guaranteed after the COVID-19 contract has expired. ● Career ladder exists to move CHWs from COVID-specific activities to other tasks for post-COVID employment. ● Guidance is given to facilitate connections with longer-term career opportunities

Increasing Intensity of Engagement →			
Area of Engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Robust Engagement**
Program Evaluation	●No defined process for documentation or information management is in place to uniquely demonstrate the value of CHWs in the CRS. ●Limited data collection and documentation processes exist to evaluate CHWs, and this data is never shared with CHWs.	●Data collection is strongly informed by published CHW assessment guides and with the assistance of experienced CHWs or CHW associations. ●CHWs are involved in a limited number of phases of the evaluation.	●Strong efforts are established at the beginning of the CRS to collect data on CHW-specific activities for the sake of demonstrating value, as suggested by the "Building a Community Health Worker Program Report." ●Patients/clients, community-engaged scientists, and CHWs are involved in all phases of the evaluation of the CRS, including design, data collection, analysis and interpretation. ●Evaluation findings are honored in adaptations of CHW employment. ●Program evaluation is scientifically designed and reports are prepared for the express purpose of informing future CHW-related policies and funding streams (such as future Medicaid managed care contracts or for State Plan Amendments). ●To promote multisector integration, performance metrics are shared transparently with other community and public sector partners

PART 2: STRATEGIC RECOMMENDATIONS FOR ADVANCEMENT

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Area of Engagement	Limited or Harmful to Moderate Engagement	Moderate to Robust Engagement
Role Definition	● No mention of CHWs within any CRS documentation, or a brief mention of CHWs are provided but without further guidance. ● CHWs are not relied upon to design roles and expectations of CHWs within the contact tracing strategy.	● Make clear to all members within the CRS that CHWs are expected to execute any and all roles and competencies identified by the CHW Core Consensus Project. We also recommend LHDs to consult this resource put out by ASTHO on CHW Training and Core Competencies across different states. ● Require that all CHW hiring decisions be made only after approval by peer CHWs or organizations that work in that community or neighboring ones, for purposes of ensuring that the diversity of hired CHWs reflects the diversity of the communities they are serving. ● Provide scripts, interview guides, and a documentation platform that support CHWs in getting to know and supporting their patients in a holistic way.
Recruitment	● Using non-CHWs to fulfill CHW roles or otherwise hiring non-CHWs but classifying them as such. ● External recruiting agencies (if existing) have limited knowledge of CHW-associated qualities to consider.	● Contract with CHW associations and community leaders to advertise and host community meetings in order to identify individuals from communities and encourage them to apply for the position (especially communities disproportionately affected by COVID-19). ● We recommend LHDs refer to the Contact Tracing Workforce Estimator, developed by The Fitzhugh Mullan Institute for Health Workforce Equity in partnership with ASTHO and NACCHO, to estimate the amount of CHWs potentially needed.
Role Definition	● No mention of CHWs within any CRS documentation, or a brief mention of CHWs are provided but without further guidance. ● CHWs are not relied upon to design roles and expectations of CHWs within the contact tracing strategy.	● Make clear to all members within the CRS that CHWs are expected to execute any and all roles and competencies identified by the CHW Core Consensus Project. We also recommend LHDs to consult this resource put out by ASTHO on CHW Training and Core Competencies across different states. ● Require that all CHW hiring decisions be made only after approval by peer CHWs or organizations that work in that community or neighboring ones, for purposes of ensuring that the diversity of hired CHWs reflects the diversity of the communities they are serving. ● Provide scripts, interview guides, and a documentation platform that support CHWs in getting to know and supporting their patients in a holistic way.

Area of Engagement	Limited or Harmful to Moderate Engagement	Moderate to Robust Engagement
Recruitment	● Using non-CHWs to fulfill CHW roles or otherwise hiring non-CHWs but classifying them as such. ● External recruiting agencies (if existing) have limited knowledge of CHW-associated qualities to consider.	● Contract with CHW associations and community leaders to advertise and host community meetings in order to identify individuals from communities and encourage them to apply for the position (especially communities disproportionately affected by COVID-19). ● We recommend LHDs refer to the Contact Tracing Workforce Estimator, developed by The Fitzhugh Mullan Institute for Health Workforce Equity in partnership with ASTHO and NACCHO, to estimate the amount of CHWs potentially needed.
Training and Professional Development	● Require all CHWs to participate in a training course and allow opportunities for continuous learning. ● Contract with experienced CHW training programs to train and test CHWs on their knowledge and competencies before their participation within the CRS.	● Continue to provide supplemental trainings for hired CHWs to learn new skills, including the use of new technology (e.g. mobile applications for contact tracing, technology for vaccine distribution) ● LHDs should work with CHWs, CHW associations, and if possible local community colleges with a history of providing CHW training to identify training curricula that meets any existing standards for CHW accreditation and includes an extensive practicum component of the curriculum.
Safety and Supplies	● Consult safety guidelines such as those developed by OSHA or IDSA to develop basic criteria for workplace safety among CHWs. ● Establish contracts with local medical equipment supply centers to develop a consistent supply line for PPE materials such as hand sanitizer, medical masks and/or face masks, and non-sterile gloves, and continue to provide supplies throughout all CRS efforts	● Regularly consult with CHWs to assess equipment and supplies needed to perform their roles. ● Provide support for CHWs to practice self-care and receive free or low-cost mental health services ● Regularly check-in with CHWs to ensure that all supplies have been received and develop a well-monitored complaint line for CHWs to express concerns about the PPE they've received or the lack thereof.
Compensation	● Use funding dedicated to COVID-19 related activities (e.g. contact tracing, vaccine dissemination) to make financial and non-financial incentives available to CHWs who participate in those activities. ● Use funding dedicated to the CRS to cover the costs associated with training programs such that CHWs do not incur any costs due training. ● When developing a budget for the CRS, LHDs should allocate sufficient funding to compensate CHWs with a living wage, as can be estimated using the MIT Living Wage Calculator, and full benefits for the duration of their time within the CRS.	● Take advantage of a variety of funding sources (such as those available through the CDC, Medicaid and HRSA) to ensure that CHWs are compensated as full-time, salaried employees for their full scope of work that includes both contact tracing and support services. Contracts with CHWs should allow for negotiation of benefits and collective bargaining. ● Consider resources put out by ASTHO, NACHW, and Families USA on sustainably financing CHWs. We also encourage LHDs to support current advocacy efforts in this space, such as the Call to Action developed by the Penn Center for CHWs. ● Advocate for the allocation of more short-term COVID-19 federal relief money to be invested in CHWs, such as is presented in the Health Force Bill, first introduced in April 2020 by Sens. Kirsten Gillibrand (D-N.Y.) and Michael Bennet (D-Colo.).

Area of Engagement	Limited or Harmful to Moderate Engagement	Moderate to Robust Engagement
Healthcare Integration	● Establish regular check-in periods for CHWs to be updated on both the status of CRS efforts in the state and the status of individual contacts that they have referred outside the CRS (perhaps by giving CHWs access to local electronic medical record systems).	● For CHWs that work directly within a clinical system, we recommend LHDs to consider the multiple strategies for clinical integration that the Penn Center for CHWs IMPaCT model advances. ● Develop personal contacts between CHWs and individual members of local health systems (e.g. primary care doctors) to build trust and acknowledgement of CHW-related work during the COVID-19 response.
Community Partnerships	● Develop a detailed information guide for CHWs to consult when making referrals, whether to social support services or other members of the local health system (e.g. primary care doctors). ● Identify leadership from state-wide CHW associations with whom to partner	● Work with CHWs to identify community institutions which should be involved in the CRS and develop formal means of communication between members of the CRS and these institutions.
Career Investment	● Work with local hiring agencies to identify career opportunities that CHWs could transition to and ensure that CHWs receive training to develop the skills needed for those opportunities. ● Establish a career guidance officer or workforce development board within the CRS initiative that personally works with CHWs to identify and obtain employment opportunities after COVID-19 (e.g. through resume assistance, interview coaching, accessing interview clothing if needed, etc.).	● Include within CHW contracts that employment will be guaranteed once COVID-19 activities are over. ● Develop a pipeline for CHWs to have careers in the health and social services sectors. ● Identify CBOs, community health centers or hospitals that would be willing to employ CHWs after COVID-19 activities are over.
Program Evaluation	● Conduct a scoping review of the literature on CHW evaluations ● Ensure that CHWs are being evaluated as a distinct member of the contact tracing strategy ● To develop an evaluation guide for CHWs, refer to or borrow from well-tested evaluation frameworks such as the National Community Health Advisor Study (NCHAS), the University of Arizona CHW Evaluation Toolkit, or the Sinai Institute's report on "Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings."	● Use a data system that supports – not subverts – CHW work. ● Develop an evaluation committee which consists of community-engaged scientists, CHWs, as well as other members from the community. ● Hire an experienced third-party organization with experience in community-engaged research to lead a rigorous evaluation of CHW engagement in the CRS. ● Speak with community members, funders, and local lawmakers to understand what matters most to individuals/communities and are most important for advancing the recognition of CHW activities within state policy. Work backward from these conversations to inform the components of an evaluation guide. ● LHDs are strongly encouraged to consider evaluation criteria identified by the Common Indicators Project or outcomes included in several CHW evaluation studies conducted by the Penn Center for CHWs.

Enabling Environments and the Road to Health Equity

This playbook was developed to assist local health departments to both identify areas of engagement for CHWs in CRS activities and to advance along a continuum of engagement within all such areas. The vision at the end of this continuum—"robust engagement"—is of a CHW workforce that is an essential, professional, and autonomous partner for LHDs in the work of community health during the COVID-19 pandemic.

The COVID-19 pandemic has rightfully spotlighted the essential role of CHWs in response efforts. However, these efforts cannot fall on the shoulders of just CHWs. Cross-sectoral collaboration is essential—including involvement from health Insurance and prescription drugs companies, community based organizations, private and non-profit health systems, and government institutions at all levels. Achieving health equity is the responsibility of all players within the healthcare and public health landscape, especially those with the power to significantly alter systems of medical care and prevention. We also cannot return to the relegated status of CHWs before the pandemic began. This workforce is not dispensable, despite what many of the short-term mobilizations of CHWs for the sake of CRSs may suggest. The current "Rapid Response" of CHWs must transform into sustainable "Emergence Response" strategies where CHWs are properly situated as one of many essential responders to future emergencies and where CHWs have received the proper training and tools to facilitate that response. Our current crisis is an opportunity to initiate that transformation.

Moreover, a renewed effort must be taken to develop the "enabling environment" to ensure that CHWs have the necessary tools and support to achieve success when they are called upon—in moments of both calm and crisis. Without this environment, CHW engagement will fall flat and, even worse, lead to even more CHWs becoming burnt out from the immense difficulties—emotional and physical—of their work. To the extent this environment is built, the damages incurred throughout the pandemic—especially among historically marginalized communities—will be minimized and those communities will be more capable of building back to a healthier future. The capacity to build this environment depends upon an entirely new focus for the public health workforce and a deepened commitment to community-centered public health. CHWs will not have the training, supplies, and funding to sustain this work without the necessary institutions that prioritize their role within the post-COVID-19 public health infrastructure. Happily, the items which characterize "robust engagement" are also the items which best facilitate the construction of this enabling environment. When CHWs are finally recognized as essential, professional, and autonomous partners with LHDs, they will more likely have the capacity to secure sustainable financing, train new generations of CHWs, and serve as community health advocates for all manner of community health needs which have accumulated as COVID-19 has dominated our attention.

LHDs that robustly engage CHWs must be the future of public health. COVID-19 has taught us this. **We are left with a question: Community health workers are ready to lead the United States on the road to health equity, but is the United States ready for them?"**

THE NATIONAL COMMUNITY-BASED WORKFORCE ALLIANCE

This playbook is published on behalf of the National Community-Based Workforce Alliance—an alliance of organizations with the mission to ensure that COVID-19 response and rebuild efforts are equitable, effective, and involve, fund, strengthen and elevate trusted community-based workers.

For more information, please visit communitybasedworkforce.org/

Appendix A: Summary Version

Community Health Worker (CHWs includes promotores de salud and community health representatives) engagement is critical for Local Health Departments (LHDs) and other healthcare or public health institutions that wish to advance health and racial equity in their COVID-19 Response Strategies (CRS). As trusted members of the community and experts in community health, CHWs build relationships with community members and bridges to medical, health department and social support systems with historic structural barriers. During the pandemic, more practical guidance is needed on how LHDs and others can integrate CHWs into CRS. Inspired by HealthBegins' Community-Based Workforce Principles for Pandemic Response and Resilience, and the National Community-Based Workforce Alliance have developed an extensive playbook to articulate strategic recommendations across a continuum of CHW engagement that amplify the roles of CHWs and draw from CHW best practices and workforce policies. This one-page document provides summary highlights from this document.

Area of Engagement	Items Necessary for Engagement	Strategies to Advance Engagement
1. Role Definition	The role of CHWs is broadly defined and includes the range of activities (social support, advocacy, navigation, etc.) from the CHW Core Consensus Project.	Consult nationally recognized CHW Core Consensus Project roles, qualities, skills and competencies. Align with state recognized credentialing, certification or training standards.
2. Recruitment	Recruitment is grassroots, draws from communities to be served, limits barriers to entry, and involves CHW in the selection process.	Ensure hiring rubrics prioritize qualities essential for the role (e.g. trust-building traits, empathy, problem-solving skills, knowledge of the local community).
3. Training and Professional Development	Training includes extensive practicum time and ongoing professional development. Training is co-created/co-led by CHWs.	Work with local and state CHWs, CHW associations, and organizations with a history of providing CHW training to identify the best available training curricula.
4. Safety and Supplies	Necessary supplies/protective equipment are provided; self-care, mental health, and the prevention of burn-out is prioritized.	Consult regularly with CHWs to assess equipment and supplies needed to ensure safety and provide the best care. Ensure compliance with OSHA workplace guidelines for COVID-19.
5. Supervision	Supervisors are experienced CHWs or have a background in community/social services and meet with CHWs in individual and team settings.	Screen supervisors using criteria such as: understanding and importance of the CHW role, familiarity with the communities CHWs will be working in, and the lived experience of community members
6. Compensation	CHWs are compensated at a competitive rate for all work they do and are given employee benefits which they can negotiate	Guarantee CHWs a living wage, using the MIT Living Wage Calculator. Advocate for moving from fee-for-service to value-based payment and integration of CHWs into operating budget.
7. Healthcare Integration	Healthcare professionals champion CHW involvement	Develop personal contacts between CHWs and individual members of local health and social services systems
8. Community Partnerships	CHWs engage existing multisectoral community structures such as CBOs, departments of social services, and faith-based institutions	Develop personal contacts between CHWs and individual members of CBOs and other community institutions. Work with local and state CHW associations to identify these institutions.
9. Career Investment	Employment for CHWs is guaranteed after the COVID-19 contract has expired. CHW Professional development opportunities are provided for career advancement.	Identify CBOs, community health centers or hospitals that can employ CHWs to respond to other health issues after COVID-19 activities are over; identify additional funding through the LHD or SHD to sustain program activities.
10. Program Evaluation	Patients/clients, community members, scientists, and CHWs are involved in all phases of the evaluation of the CRS, including design, data collection, analysis and interpretation.	Develop an evaluation committee which consists of community-engaged scientists, CHWs, and community members; include social return-on-investment and equity outcomes as key metrics within the evaluation.
Community Wisdom: CHWs are positioned to deliver the wisdom of the communities being served to the health system, not only health services to unreached communities.		