CRITICAL INPUTS FOR SUCCESSFUL COMMUNITY HEALTH WORKER PROGRAMS

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EXECUTIVE SUMMARY

Overall purpose of the project: Community health workers, promotoras, and community health representatives (hereafter collectively referred to as CHWs) are essential to the COVID-19 response and long-term health equity for the communities they serve. Policymakers, including Congress and President Joe Biden, along with the Centers for Disease Control and Prevention, the Health Services and Resources Administration, and state health departments, among others, have called for increased investment in this workforce. Local, state, and federal stakeholders, including payers, policymakers, and government officials, need a way to ensure that increased investment translates into effective CHW programs, and that CHWs are supported in their work. In 2020, the National Committee for Quality Assurance (NCQA), in partnership with the Penn Center for Community Health Workers (PCCHW), set out to develop standards for recruiting, employing, and supervising CHWs that would support sustainable payment approaches for organizations that employ and partner with CHWs. This paper summarizes the work completed, describes organizational elements that can support the CHW workforce, and identifies important considerations needed for future development of standards.

Methods: To inform development of standards for CHW programs and guide our work, we convened a Steering Committee of individuals from key stakeholder groups, including CHWs, community-based organizations (CBO), and public health and health care organizations that employ or partner with CHWs. Half the members currently or previously worked as CHWs. We also hosted four public "Call for Input" Listening Sessions and conducted a targeted environmental scan to identify factors that help CHWs do their best work.

Findings: Across Listening Sessions and Steering Committee discussions, there was consensus on what organizations can do to support CHWs in their work. In all, we identified 9 overarching concepts and 27 elements within those concepts.

Nine Concepts Needed to Support CHWs

1. CHW Recruitment & Hiring
2. Training for CHWs
3. Supervision of CHWs
4. Support for CHWs
5. CHW Scope of Work
6. CHW Workforce Development
7. Health & Social Care Team Integration
8. Organizational Data Systems & Engagement
9. Program Sustainability

Among the nine concepts, the following elements were consistently emphasized and generally supported by the environmental scan: placing greater importance of candidates' lived experiences and trust-building traits (compared with education) in the hiring process; supervisors being promoted CHWs or having a deep understanding of the CHW role; a clearly defined CHW role; flexible and person-centered work practices and manageable caseloads to allow time for CHWs to build trust with clients/patients; incentivization through pay and career development; a

welcoming environment for CHWs to foster teamwork at all levels of the organization; a strong partnership between health care and social service organizations; CHW engagement in decision-making processes; and sustainable financing for CHW programs.

Discussion: There was overall agreement among Steering Committee members, Listening Session attendees, and the literature on the potential value of creating standards for organizations that employ, partner with, and contract with CHWs. Steering Committee members offered considerations for moving to a cohesive set of standards that could be equitably applied across the diverse settings where CHWs are employed, such as health care organizations, public health departments, and CBOs. A key consideration was ensuring that smaller, less-resourced organizations were not disadvantaged. For example, small and less-resourced organizations may have difficulty meeting standards that require creating promotion opportunities for CHWs or collecting and managing ongoing standardized health and social indicators.

To mitigate unintended consequences, Steering Committee members recommended that adequate and sustainable financing mechanisms be available across health and social care sectors, in addition to capacity building and technical assistance opportunities to support organizations to achieve the standards. They also recommended that future efforts to develop standards entail intentional and equitable partnership with relevant stakeholders (e.g., CHWs and CBOs) and operate in a timeline that allows meaningful collaboration and consensus building.

Conclusion: There is agreement among Steering Committee members, Listening Session attendees, and the literature about the organizational elements that can support the CHW workforce and about the potential benefits of creating standards. The guidance of the Steering Committee, along with insights from CHW stakeholders, identified important considerations needed for future efforts to develop standards. These include CHW and other stakeholder buy-in on the need for standards, the diversity of settings that employ CHWs, mechanisms for supporting less-resourced organizations like CBOs, and meaningful engagement of CHWs and other relevant stakeholders in developing and implementing standards.

INTRODUCTION

For more than 80 years, community health workers, promotoras, and community health representatives (hereafter collectively referred to as CHWs) have worked with and within a wide range of organizations—public health, community-based, and health care—to advance health equity and improve health outcomes. In the last 10–15 years, national recognition of the CHW workforce has increased, including in 2010, when the Bureau of Labor Statistics recognized CHW as an occupation and the Affordable Care Act explicitly included CHWs as contributing health professionals.[1] Interest in and recognition of the CHW workforce has recently intensified. The COVID-19 pandemic and racial justice movements of 2020 highlighted health disparities and disproportionately impacted lower income communities and communities of color.[2] The need to address these disparities accelerated interest in CHWs, given their ability to play a wide range of roles, such as advocating for social justice, addressing unmet needs of individuals and families, and providing tailored, culturally appropriate health information about COVID-19 vaccines.

A growing list of organizations, including the American Public Health Association, the Institute for Healthcare Improvement, and the NAACP, have advocated for long-term, sustainable payment for care provided by CHWs.[3,4] In March 2021, the Centers for Disease Control and Prevention announced its plan to provide $332 million to jurisdictions for CHW services to support COVID-19 prevention and control, and an additional $32 million for training, technical assistance, and evaluation.[5] In June 2021, the Health Resources and Services Administration released a Notice of Funding Opportunity: Community-Based Workforce for COVID-19 Vaccine Outreach. The program will provide up to $125,000,000 across multiple recipients to help establish, expand, and sustain a public health workforce, which includes CHWs, to prevent, prepare for, and respond to COVID-19.[6]

This unprecedented investment recognizes how the unique skills and experiences of CHWs can help address structural racism and the policy systems and environments of inequality that contribute to health disparities. This public health effort parallels calls from the Centers for Medicare & Medicaid Services, Medicaid, local and state health departments, and community-based and health care organizations for more sustainable mechanisms to employ and finance CHWs in efforts to improve health equity. However, there is wide variation in the operationalization of CHW programs—and therefore in the programs' effectiveness. National standards to guide organizations on programmatic elements, such as recruitment, employment, and supervision of CHWs, offer the opportunity to help ensure that the growing investment builds sustainable, effective CHW programs (the systems and infrastructure created by organizations that employ, partner, and contract with CHWs to provide services to a community).

This report describes early efforts to gain consensus on the potential value of national standards for CHW programs. We describe findings about the potential concepts to inform future standards, considerations on development of standards that can support the variety of

organizations that employ CHWs, and methods for ensuring meaningful engagement of CHWs and community-based organizations (CBOs) in future work.

BACKGROUND

Who Are CHWs?

CHWs are frontline public health workers who are trusted members of and/or have an extraordinarily close understanding of the community they serve.[7] Trusting relationships allow CHWs to act as liaisons between health and social services and the community, facilitate access to services, and improve the quality and cultural humility of service delivery.[7] CHWs take on many roles, including coaching and social support, outreach, care coordination, and system navigation, in addition to advocating for the individuals and communities they serve.[8–10] CHWs are a reflection of their communities: 65 percent are Black or Latinx, 23 percent are White, and 10 percent are Native American.[11,12] Many have lived experiences of racism and financial hardship,[12] making them uniquely positioned to push structural transformation from the inside out.

What Impact Do CHWs Have?

A large body of evidence shows that CHWs can help improve chronic disease control[13–15] and mental health,[16] promote healthy behavior,[16,17] improve patients' perceived quality of care,[16] shrink health disparities,[17,18] and reduce emergency care use,[13,19–23] hospitalizations,[16,21–24] and health care spending.[13,21,23,25–28] CHW programs can be cost-effective and offer a positive return on investment (ROI):[13,21,23,25–28] A recent study found that for every dollar invested in a CHW intervention, Medicaid payers saw an average ROI of $2.47.[26]

Who Employs CHWs?

In 2020, the Bureau of Labor Statistics estimated that 60,000 CHWs were employed in the United States in a variety of settings; this workforce is expected to grow, increasing 15 percent by 2029.[29,30] The largest proportion of CHWs (31%) work in community-based and social service organizations: 17 percent are employed by individual or family services, and 14 percent are employed by religious, grantmaking, civic, and professional organizations. A similar proportion of CHWs are employed by government (18%) and health care organizations (16%), including hospitals and outpatient care centers. As CHWs are increasingly integrated into health care, the proportion of CHWs employed by health care organizations is rising relative to the proportion employed by community-based and social service organizations.[31] The states with the greatest number of employed CHWs are New York, California, Texas, Washington, and Massachusetts.[29]

Who Pays for CHW Programs?

Much CHW program funding is short-term, such as through philanthropic grants and upfront investment from foundations and public health agencies.[32] While short-term funding can be a good way for CHW programs to get started, programs need to establish sustainable funding arrangements with public or private entities.[33] As the desire increases for CHWs to participate in efforts to address equity and social determinants of health, states have implemented new mechanisms to support expansion of CHW programs. Nearly half the states in the U.S. (n = 24), plus Washington, D.C., have some form of Medicaid financing for CHWs, such as 1115 waivers or state plan amendments that allow CHWs to deliver preventive care, provide supports for specific populations, or include CHWs as part of Health Homes. States may also have arrangements with managed care organizations to allow them to bill for care provided by CHWs as part of administrative costs or strongly encourage them to include CHWs as part of Health Homes or care coordination services. These funding arrangements span value-based payments, fee-for-service, and bundled payments added onto capitation rates.[34,35] Additionally, some health care payers and providers have opted to internally finance CHW programs, based on an assumption or demonstration of reduced costs.[36]

What Are the Potential Benefits of CHW Program Standards?

With growing public and private investment in funding care provided by CHWs, there are varying opinions on how to structure programs that support CHWs to do their best work. Some states have focused on the roles and functions of the individual CHW; for example, as of April 2021, 15 states either define a CHW scope of practice or specify CHW roles, responsibilities, and functions for specific health conditions.[34] Many states have, or are in the process of creating, individual-level CHW trainings and certifications,[34] although one study suggests that training-based CHW certification may not lead to improved patient outcomes and could in fact "weed out" natural helpers.[37] Additional research is needed to fully understand the impact of individual CHW certification.

As the landmark *To Err is Human* report demonstrated, good outcomes depend not only on individual training, but also on the effectiveness of the systems in which individuals work.[38] To be optimally effective, CHWs depend on structures that provide oversight, resources, and support. Implementation studies in other countries have informed World Health Organization guidelines for the types of structures and systems inputs that CHWs require to do their best work,[39] but no similar guidelines exist in the U.S.

Program standards are a roadmap for program design and implementation at the organization and system levels and can clarify best practices for structuring CHW programs. Standards can specify expectations that organizations implement evidence-based infrastructure, policies, and procedures that can support high-quality programs. One example of program standards is the National Committee for Quality Assurance's (NCQA) Patient-Centered Medical Home Recognition program,[40] which has been used by states and other payers to guide system

transformation and new payment models for primary care practices. A similar approach could be applied for CHW programs.

Developing standards for CHW programs offers the potential to provide transparent expectations for organizations that employ, partner with, and contract with CHWs. Expectations would align with established definitions of CHW identity and the CHW scope of practice, and promote the infrastructure, policies, and procedures CHWs need to provide high-quality support.

NCQA, in partnership with the Penn Center for Community Health Workers (PCCHW), proposed to develop a set of national standards for recruiting, employing, and supervising CHWs that would support sustainable payment approaches for organizations that employ, partner with, and contract with CHWs. This report describes work completed on efforts to gain consensus on potential topics to inform standards, considerations for equitable implementation of such standards, and methods for ensuring meaningful engagement of CHWs in developing and implementing standards. NCQA and PCCHW formed the Project Team and executed this work in collaboration with the project's Steering Committee.

APPROACH

To identify what is needed for CHWs to be effective in their role, the Project Team solicited input by convening a multi-stakeholder Steering Committee, hosting four "Call for Input" Listening Sessions, and conducting a targeted environmental scan.

Steering Committee

We convened a multi-stakeholder Steering Committee to provide advice and expert input throughout the project. The committee included a wide range of stakeholder perspectives from CHWs, CBOs, public health, health care organizations, states, and academic researchers. When identifying candidates for this committee, we sought recommendations for individuals with expertise with CHW programs, as well as lived experiences working as CHWs. We deliberately sought candidates with diverse lived experiences, identities, and backgrounds, and we sought representation across different geographic regions in the U.S. The committee met three times as a full group between October 2020 and April 2021, and met separately in small breakout groups in March 2021. To honor CHW self-determination, at least half of the members were current or former CHWs. **Appendix A** lists Steering Committee members; **Appendix B** provides the prompting questions asked in each meeting.

"Call for Input" Listening Sessions

We hosted four public "Call for Input" Listening Sessions in November and December 2020 to gather input from members and representatives of key stakeholder groups from across the U.S.: CHWs, CBOs, health care organizations, and researchers and government officials. Listening Sessions were advertised in advance and were open to the public. Attendees were asked what they think CHWs need in order to do their best work. They were also asked how to avoid

perpetuating inequities (e.g., standards pushing out less-resourced CBOs) and what barriers organizations might face if new standards were created for organizations that hire CHWs. A total of 209 individuals participated in the CHW session: 132 in the CBO session, 134 in the session for health care organizations and health plans, and 78 in the session for researchers and government officials. CHWs were welcome to attend any session. **Appendix B** provides information on the prompting questions asked during each session.

Environmental Scan

We conducted an environmental scan to identify relevant literature on best practices of organizations that employ CHWs, with the intent to answer two questions: "What are the characteristics of effective CHW programs?" and "What published standards, guidelines, systematic reviews, and/or best practices exist for CHW programs?" The scan included literature from peer-reviewed journals; websites of authoritative bodies in the CHW field, such as the CHW Core Consensus (C3) Project; and policy reports issued by government agencies, foundations, and nonprofit organizations. Additional references were identified through suggestions from Steering Committee members and participants of the Listening Sessions. In all, we reviewed 170 references (**Appendix C**) and included 47 in our summary (**Appendix D**). The majority of articles were excluded because they focused on CHWs rather than on CHW programs; others were excluded because they focused exclusively on CHW programs in low- and middle-income countries, or we did not have access to the full text of the articles. The 47 articles included evidence-based consensus reports and recommended guidelines, randomized clinical trials, and systematic reviews.

FINDINGS

Summary of Input

There was consensus across the three sources of input on what organizations can do to support CHWs in their work. In all, nine overarching concepts and 27 elements within those concepts were identified. The nine concepts were: 1. CHW Recruitment and Hiring; 2. Training for CHWs; 3. Supervision of CHWs; 4. Support for CHWs; 5. CHW Scope of Work; 6. CHW Workforce Development; 7. Health/Social Care Team Integration; 8. Organizational Data Systems & Engagement; 9. Program Sustainability. **Table 1** provides a brief description of each element and **Appendix D** provides detailed information and examples for each element.

In general, we observed agreement in the concepts and elements across all input sources. Themes that were consistently emphasized as important to support CHWs included:

- Recruit CHW candidates via community-based avenues and clear, inclusive job descriptions.
- Minimize traditional hiring barriers, such as checking applicants' immigration status, to recruit the right people into the CHW workforce.

- Select CHWs in the hiring process based on their lived experiences, relationship with the community, and trust-building traits, rather than on formal education.

- Promote supervisors who are CHWs or who have a deep understanding of the CHW role and can support, coach, and advocate for CHWs.

- Support CHWs' self-care and mental/emotional health.

- Define the CHW role, including building relationships, providing social and emotional support, and advocating for individuals and communities.

- Develop flexible, person-centered work practices and manageable caseloads.

- Encourage professional development within the CHW profession through pay raises that are commensurate with experience and career development opportunities.

- Create a welcoming environment for CHWs to foster teamwork at all levels of the organization and across environments (clinical settings and social service organizations).

- Form a strong partnership between health and social services organizations.

- Orient/educate organizations and non-CHW care team members to CHWs and CHW models.

- Include CHWs in leadership and engage them in the decision-making process.

- Ensure sustainable financing for CHW programs.

Table 1. Description of Summary of Concepts and Elements Needed to Support CHWs & Considerations Raised.

Concept	Elements	Brief Description	Consideration
1. CHW Recruitment & Hiring	CHW Qualities & Qualifications	Specific qualities and qualifications required for the CHW role (e.g., lived experiences similar to the community served, listening skills).	• Standards may contradict or duplicate local or federal policies and regulations. • Identifying specific qualities and qualifications could help protect the authenticity of the CHW profession.
	Recruitment Process	Approach for recruiting CHWs from the community (e.g., via community-based channels, not online job boards).	
	Hiring Process	Approach for hiring CHWs (e.g., use of behavioral scenarios for skills assessment).	
2. Training for CHWs	Initial/Pre-Service Training (& Certification)	Process for training new CHWs (e.g., adequate time for orientation to organization and role).	• States have begun creating their own training and certifications that may lead to duplication or conflict with organization-specific training. • Lesser-resourced organizations may not be able to provide continuous training and set requirements.
	Continuous CHW Training Process	Ongoing training activities for employed CHWs (e.g., knowledge updates and opportunities for further skills development).	
	General Training Methods, Content, & Evaluation	Training approach (e.g., work with CHW associations to provide comprehensive training).	
3. Supervision	Supervisor Qualities	CHW supervisors and their	• There were mixed opinions on whether CHWs

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Concept	Elements	Brief Description	Consideration
of CHWs	& Qualifications	experience (e.g., should have deep understanding of CHW role).	should be supervised by current or former CHWs or by others with appropriate training and experience.
	Supervisor Role	Expectations for supervisor role and responsibilities (e.g., support and advocate for CHW).	• Supervision requirements in health care organizations may be set by payment mechanism.
	Structure & Process of Supervision	Organizational structure and policies on CHW supervision (e.g., CHWs have regular 1:1 meetings with supervisor).	
	Training, Support, & Evaluation of Supervisor	Adequate training for CHW supervisors (e.g., on CHW role) and evaluation of quality of supervisor training and CHW supervision.	
4. Support for CHWs	Job Aids, Resources, & Supplies	Processes for providing supplies and materials that support CHWs in their work (e.g., personal protective equipment).	• Technology or tools provided (e.g., for documentation) should be easy to use in a variety of settings and avoid creating administrative burden.
	Documentation Tools	Establish systems to support CHW tracking of work with clients and patients (e.g., referral tracking system).	• Data collection systems and similar technology may not be available in all organizations that employ CHWs.
	Safety & Emergency Protocols &	Establish measures to protect CHWs from unsafe situations while on the job (e.g., documented protocols for	• Support for CHW well-being and mental health should be made available free of charge and flexible to accommodate CHW schedule.

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Concept	Elements	Brief Description	Consideration
	Resources	emergencies).	
	Peer Support	Opportunities for CHWs to support and learn from other CHWs in or outside their work teams and organization (e.g., peer-to-peer mentorship).	
	CHW Well-Being	Approach for supporting CHWs' mental and emotional health (e.g., burnout prevention measures).	
5. CHW Scope of Work	CHW Role & Responsibilities	Specification of the CHW role and job responsibilities (e.g., clearly defined tasks and responsibilities; role description based on C3 Project specifications).	• All organizations should clearly define the CHW role and responsibilities, although these may vary somewhat by organization type. • The state may define CHW roles and responsibilities.
	Flexible, Person-Centered Work Practices & Manageable Caseload	Practices for maintaining CHWs' manageable caseload to facilitate quality care delivery without burnout (e.g., CHW: client/patient ratio supports spending sufficient time with clients/patients).	• Definition of CHW role and responsibilities should help protect workforce authenticity and ensure that organizations understand the CHW role. • Important to define caseload and allow flexible work practices.
6. CHW Workforce Development	Performance Assessment	Practices for objective and fair assessment of CHW performance (e.g., involve CHWs in developing	• Assessments should go beyond the number of clients/patients seen to include client reports and other measures of CHW performance.

Table 1. Description of Summary of Concepts and Elements Needed to Support CHWs & Considerations Raised.

Concept	Elements	Brief Description	Consideration
		performance evaluation approach).	• Assessments may include improved health outcomes, but should also capture non-health outcomes, such as children enrolled in an afterschool program or patient/client moving to stable housing.
	Career Ladder	Measures that support CHW career advancement (e.g., development of career ladder for CHWs to progress to higher-responsibility positions in the CHW field).	• Organizations should have a career ladder in place so CHWs can grow in the profession, rather than being encouraged to move to other professions such as nursing or social work. • Organizations may not be able to afford pay raises associated with promotions or may lack the capacity to support CHWs in a new position, leading CHWs to leave lesser-resourced organizations in search of positions with increased responsibilities and pay.
	Pay & Incentives, Awards & Recognition	Adequate financial and (where appropriate) nonfinancial incentives and payment (e.g., market-based determination of salaries).	• CHWs should be paid a living wage; however, this varies by location. Some members noted that lesser-resourced organizations would require a threshold payment for CHW services from funders in order to afford to pay a living wage.
7. Health/Social Care Teams	Define & Recognize CHW Role with Team Members	To support positive and effective integration of CHWs with a care team, define CHW role and responsibilities relative to other care	• Important to define and recognize the CHW role on the care team and to clarify its nonclinical nature.

Table 1. Description of Summary of Concepts and Elements Needed to Support CHWs & Considerations Raised.

Concept	Elements	Brief Description	Consideration
Integration		team members; educate other care team members on the CHW role and its importance.	• CHWs' ability to work in the community and connect community and health care systems should be highlighted to the team and used to improve outcomes and engage individuals who are traditionally hard to reach.
	Organizational Commitment & Process to Link Health & Social Care	Cross-sectoral partnership between CBOs and health care organizations, collaboration with CHWs for decision making related to CHW programs.	• Collaboration between health care organizations and CBOs should be an equal partnership.
8. Organizational Data Systems & Engagement	Data Systems for Quality Improvement	Collect and report standardized data to facilitate effective program administration, quality improvement, collaboration with external partners, and CHW care delivery (e.g., collection and use of community-level needs to inform CHW care).	• Data collection for quality improvement is important but should not be burdensome for CHWs or the organizations that employ them. • Data collected should help improve client/patient and community care while demonstrating the value of CHWs and identifying areas for improvement. To help ensure this, CHWs and the community should be engaged in identifying data to collect—the idea of "nothing about us without us" is extremely important here.
	CHW Engagement	CHW leadership and engagement in organization- and program-level decision making (e.g., organizations involve CHWs in decisions that impact them and their program and/or the communities they serve).	
	Community-Centered Care & Engagement	Program design that reflects and is informed by community needs (e.g., community engagement in priority setting and problem solving).	

Table 1. Description of Summary of Concepts and Elements Needed to Support CHWs & Considerations Raised.

Concept	Elements	Brief Description	Consideration
9. Program Sustainability	Program Evaluation & Improvement	Assess program effectiveness and use evaluation findings to inform program design (e.g., evaluation of performance outputs, such as CHW competency, on client/patient outcomes).	• Stakeholders agreed that program evaluations are important and evaluation data ownership and use should be clarified in advance. • Evaluations should look beyond the number of clients/patients served to fully understand the health and social ROI CHWs can provide.
	Financial Sustainability	Payment arrangements' long-term focus incentivizes person-centered, high-value care (e.g., rather than volume).	• Financing has historically looked different for health care organizations than for CBOs. Health care organizations can work within existing systems and funders (e.g., Medicaid) for payment, while CBOs generally rely on grant funding or contracts with states or health systems. • Payment is usually provided only for health care related services. A payment mechanism is needed to pay the cost of effective CHW programs and cover social aspects of care.

Considerations for Moving Toward Standards Development

There was overall agreement among stakeholders on the potential value and utility of creating standards for organizations that employ, partner with, and contract with CHWs. However, stakeholders also noted cautions and offered guidance on how standards are developed, their content, and the fairness of requiring standards across the diverse types of organizations that employ CHWs. For example, it may be more challenging for smaller, often lesser-resourced organizations such as CBOs or local health departments to meet the same standards as larger, well-resourced organizations such as health care organizations. **Table 1** provides a description of the considerations.

Stakeholders agreed on the value of data systems collecting information for quality improvement efforts, but Steering Committee members noted that health care organizations are more likely to have data systems in place to collect and manage data. Additionally, data collection and evaluation requirements may place undue administrative burden not only on CBO staff, but also on CHWs. The Steering Committee recommended that in partnerships between CBOs and health care organizations there should be mutual agreement on data ownership, metrics used, and nonclinical outcome indicators.

Stakeholders generally agreed that specifying desired qualities and qualifications and roles and responsibilities for CHWs is important, but opinions differed about how these elements should be defined if they are included as standards. Some stakeholders found value in defining the qualities and qualifications of CHWs, to ensure that lived experiences are a key qualification for entering the CHW workforce but cautioned that the definition must be broad enough to apply across the diverse organizations hiring CHWs. Similarly, there was agreement that defining the roles and responsibilities of CHWs could help preserve the authentic CHW role without overmedicalizing it. Some stakeholders cautioned that too narrow a definition of qualifications and roles might limit CHWs' autonomy to deliver personalized, tailored support to meet client/ patient needs.

Stakeholders believed that topics like *Pay & Incentives, Awards & Recognition,* and *Career Ladder* are important, but cautioned about a single set of requirements for all organizations. They noted that wages are influenced by many factors beyond the control of a CHW program, including state or local minimum-wage laws. Although promoting professional development and career advancement in the CHW profession is considered important, stakeholders noted that smaller organizations may not have the infrastructure to offer opportunities for CHWs to advance into managerial positions.

DISCUSSION

Overall, we heard support from Listening Session attendees and Steering Committee members on the potential value of standards for organizations that employ, partner with, and contract with CHWs. Steering Committee members appreciated our efforts to respect CHW self-determination

by collecting input from a wide range of stakeholders early on in the project via Listening Sessions, and for our willingness to refine our process throughout the project based on stakeholder feedback. Committee members also expressed concerns about potential unintended consequences of standards for CBOs and CHWs and offered suggestions for the standards development process.

The most common concern was that standards could have the unintended consequence of perpetuating inequalities between different types of organizations that employ CHWs. Standards could create a barrier to entry for less-resourced organizations, unless accompanied by resources to build the capacity to support and strengthen disadvantaged organizations as trusted service providers for their communities. For example, if a state includes the standards in Medicaid Managed Care Organization contracting requirements, organizations that lack the resources or capacity to demonstrate that they meet the standards would be excluded. Similarly, standards included as requirements for value-based payment arrangements would drive financing opportunities.

Organizations will need adequate and sustainable financing to support CHWs to do their best work and to demonstrate that they meet program standards. An analysis published in 2020 found that in order to achieve a $2.47 return on investment for Medicaid, theper patient cost was $1,700 for six months of intensive CHW support. This cost is fully loaded, and incorporates the cost of many program elements described above including CHW hiring, training, supervision, flexible work practice, defined caseloads, equipment and professional development .[26] Funding for CHW programs and services is often far less, which could compromise the quality of services provided and diminish the return on investment. Also, unless payment for CHW programs flows across the health and social services sectors, rather than being kept within health care, CHW programs in health care settings will be favored which risks overmedicalizing the CHW care delivery model.

Standards should encourage meaningful collaboration among public health and health and social service organizations to meet the health and social needs of communities. These cross-sector collaborations should emphasize mutual autonomy and respect and should not burden less-resourced CBOs with excessive administrative requirements. CBOs should be valued as equal partners that have extensive grassroots experience and established trust with the communities they serve.

Stakeholders also discussed the importance of having the right process in place to develop standards. Although NCQA has a typical standards development process for the health sector, stakeholders emphasized that the timeline to develop standards for CHW programs should allow intentional and meaningful engagement among stakeholders. Despite increased state funding and political urgency to create standards, it is critical to uphold a participatory, grassroots process that gives stakeholders—CHWs in particular—time to provide input and reach consensus. Multiple stakeholders also noted that urgency is a tool of White supremacy and that communities

need CHW support in light of oppressive systems. In advancing the CHW workforce, we must be cautious about perpetuating the same oppressive systems by not allowing full and meaningful stakeholder engagement.

This project was designed to purposefully engage stakeholders in forming a multistakeholder Steering Committee and conducting Listening Sessions. Future efforts should engage CHWs, state and local CHW associations, and organizations such as CBOs and health departments, which will be asked to implement standards at the leadership level and promote buy-in and ownership. Future project leaders should also ensure that potential power imbalances, especially between CHWs and non-CHWs, are acknowledged and addressed in stakeholder meetings and discussions.

To avoid misapplication of the standards, future project teams should work with stakeholders to ensure they have a clear understanding of what the standards are, how they are used, and their intention and purpose. In addition, stakeholders must have sufficient opportunity for feedback; for example, through breakout meetings, "Call for Input" Listening Sessions, informational webinars, and collaboration with national, state, and local CHW organizations.

CONCLUSION

This white paper describes the first step in developing CHW program standards: getting input on what CHWs need in order to do their best work from a triangulation of sources including experts, stakeholders, and the literature. Through this effort, we captured the concepts and elements that can help organizations best support CHWs and can help inform future development of CHW program standards. Future work will need to continue the conversation with stakeholders from diverse settings, geographies, experiences, and areas of expertise. Such conversation can help ensure consensus about the need for CHW program standards, improve our understanding about the potential impact of standards across different settings, and support efforts to identify ways for equitable implementation such as creating capacity-building opportunities and encouraging intentional partnerships. Stakeholder engagement must use a timeline that allows meaningful participation and consensus building, to ensure that future CHW program standards will be equitable.

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Appendix A. Steering Committee Contributor Acknowledgments

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Appendix B. Prompting Questions Asked at Listening Sessions and Steering Committee Meetings

Date	Meeting	# Participants	Prompting Questions Asked to Meeting Participants
10/29/21	First Steering Committee Meeting	11	• What inputs are needed to help CHWs do their best work? • How can we make sure that CBOs do not get pushed out?
11/17/20	"Call for Input" Listening Session for Community Health Workers	209	• What helps CHWs do their best work? • How do we avoid perpetuating inequities with these new CHW program standards? How do we make sure that this effort does not lead to the medical sector pushing out CBOs? • What are some unintended consequences of these standards? What might organizations need to meet these standards?
11/20/20	"Call for Input" Listening Session for Community-based Organizations	132	• What do you as supervisors need to do to support community health workers and implement effective CHW programs? • How does your organization keep track of the caseloads and schedules of CHWs? How good is this system? • How does your organization demonstrate and report the effectiveness of your CHW programs to external stakeholders? What are your challenges? • What are the challenges that supervisors and CBOs will face in trying to meet the standards? • How can we avoid perpetuating inequities by pushing out organizations with fewer resources, like CBOs? • What do CBOs need in order to achieve standards?
12/1/20	"Call for Input" Listening Session for Health Care Organizations	134	• How can organizations support CHWs to do their best work? • How can we ensure that the standards do not push CBOs and small public health departments out of this space? • How can we support and integrate CHWs without overmedicalizing their roles or co-opting their grassroot, community-based identity?

			• What challenges would prevent health care organizations or health plans from accepting or meeting the new standards?
12/2/20	"Call for Input" Listening Session for Researchers and Government Officials	78	• How can organizations support CHWs to do their best work? • What are some additional things that we should think about when we think about these standards? • When we say the word "supervision," what does that mean? How are organizations doing it? What are the best practices? • What barriers prevent organizations from hiring the right folks? • Are there special considerations to keep in mind to support CHWs to continue to work with the community while they can't be there in person? • What can an organization do to demonstrate that, that they are valuing their CHWs? • What challenges and unintended consequences might the standards impose, despite our best intentions? • How do we avoid perpetuating inequalities i.e. by ensuring the standards do not push out community-based organizations and small, public health departments?
1/29/21	Second Steering Committee Meeting	11	*Questions about summary of input:* • Do you have any feedback about these concepts and themes? • Do you see anything missing? *Questions about proposed draft standards (CHW qualities and qualifications; pay and incentives):* • Do you agree with the drafted standard? • Do you think this is something that every CHW program should and could do? • Are there specific examples of existing best practices we should reference? • Are there additional enabling policies we should call out?
4/15/21	Third Steering	10	• How could standards for CHW programs be

	Committee Meeting		used? • How might standards be helpful? • How might standards be harmful?

3/11/21 – 3/19/21	Steering Committee Breakout Meetings	11	• Do you have any questions or feedback about the purpose of the project or our process to date?
			• Do you support the summary of input?
			  o What are the two concepts that you think are most important for us to discuss as a group?
			  o What else are we missing?
			  o Is there any re-wording needed?
			• Do you have any recommendations for next steps?
			  o How do we produce a white paper that is still useful to the various stakeholders?
			  o Should NCQA publish just the input summary and general recommendations on best practices and policy concerns? Should we create value-based payment standards for healthcare organizations?

Appendix C. Master Reference List Reviewed for Environmental Scan

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Appendix D. Summary of Concepts and Elements Needed to Support CHWs, with Examples

Concept	Element	Examples			
1. CHW Recruitment and Hiring	CHW Qualities & Qualifications	Members of/ relationship with/ knowledge of community served; understanding of community experience, language, culture, and socioeconomic needs; shared values and experiences (1a,1b,2,3,4,5)	Willing to learn, compassionate, empathetic, strong listening skills, good interpersonal skills, culturally competent, committed to serving, trust-building (1a,1b,2,3,4,6); creative problem-solving skills, natural helpers/leaders (1a,1b,3,4), emotional intelligence (1a,1b,5)		
	Recruitment Process	Base recruitment of CHWs on population density, type, or needs (e.g., chronic and primary care needs), coverage area; recruit CHWs based on role expectation (1a,1b)	Unconventional channels to recruit candidates (e.g., block captains associations, food pantries) (1a,1b,3,6); community-based recruitment and CHW community networks for recruitment (1a,1b,2,3,4); intentional CHW recruitment to meet community needs	Written description on job accountabilities, qualifications, role/ statement of work (SOW) and expectations; clear selection criteria but should be inclusive, not restrictive (1a,1b,4,5,6)	Work with HR to understand ideal candidate qualifications to identify/hire CHWs (2)

Concept	Element	Examples		
		(1a,1b,4,6)		
	Hiring Process	Structured hiring processes: pre-hiring training to assess trainees, face-to-face interviews; CHWs involved in selection process (1a,1b,5)	Link interview to competence and skills required; use behavioral scenarios to assess traits like listening, empathy; hiring rubric with essential qualities for the role (1a,1b)	Maximize diversity; minimize barriers to not weed out "authentic" CHWs (education requirements, citizenship, English proficiency, criminal record); background, personality, lived experiences > education (1a,1b,2,3,4,5,6).

Concept	Element	Examples			
2. Training for CHWs	Initial / Pre-Service Training (& Certification)	Paid training upon/ before hiring; demonstrate proficiency in core competencies before practicing (1a,1b)	CHW certification requirement: competencies tested before practicing; retest permitted; recertify at regular intervals (1a,1b)	Adequate time for orientation to the organization (1a,1b); not a "crash course" (6)	
	Continuous CHW Training Process	Adhere training to accepted guidelines; involve CHW in developing training; have training plan and routinely track training (1a,1b)	Knowledge- and skills-based, ongoing field-based mentoring; continuous capacity development to reinforce initial training, update new knowledge, address challenges, further skills refinement (1a,1b)	Training linked to increased CHW self-efficacy, mastery of tasks, professional development pathway (1a,1b)	Content: Organizational goals, appointment scheduling, patient goal setting, case/ records documentation, disease/health issues and social determinants of health (SDOH), health inequities, communication/care coordination; (1,4) navigate/identify/ access community resources (2,4) computer app skills (3,4,6)

Concept	Element	Examples			
	General Training Methods, Content, & Evaluation	Methods: interactive, hands-on, participatory, classroom, computer-based, 1:1 experiential mentoring, extensive practicum time, core competencies (from C3 project) (1a,1b,6)	Work with CHW associations, local colleges/vocational training programs to provide training that meets existing accreditation standards to develop CHW workforce (1a, ,1b,4)	Evaluation: Number of CHWs trained, topics covered, quality of training, effectiveness, application of new skills (1a,1b)	Content: Active listening, motivational interviewing, goal setting, trauma-informed care, social injustice, recognizing unmet social needs, psychosocial support, mental health emergencies, care coordination, navigation, health coaching, health promotion (1,3,6)
3. Supervision for CHWs	Supervisor Qualities & Qualifications	Promoted CHWs or social workers, or have deep understanding of CHW role and grassroots approach; understand lived experiences of community (1a,1b,2,3,4,5,6)	Caring/supportive, trust/ respect CHW autonomy (2,5); not controlling (2,3); understand trauma-informed/strength-based supervision and care (3,6)		

Concept	Element	Examples			
	Supervisor Role	Full-time, dedicated to CHWs; mentor and support CHWs so they can perform as expected (1a,1b,3)	Supportive: flexible with scheduling, manage workload, help solve problems, address burnout, provide feedback, track performance, coach, foster skills development and professional growth, quality improvement, and help achieve goals (1a,1b,2,3,5,6)	Help improve care delivery: observe CHW service, track CHW metrics, track supplies (e.g., personal protective equipment [PPE]), support referrals, help with higher-level care, track community feedback (1a,1b);	Advocate for CHW role, autonomy, value; advocate for CHW care model (2,3,5); create welcoming spaces for CHWs (2,3); translate CHW work to other clinicians (3); recognize challenges to work (e.g., COVID) (6)
	Structure & Process of Supervision	Supportive, humanized supervision; adequate CHW: supervisor ratio to ensure quality supervision (e.g., 6:1); regular feedback; regular 1:1 (e.g., weekly/biweekly) and team meetings (1a,1b,3,4)	Monthly supervision visit: 1:1 observation of CHWs, review data, provide problem-solving support, perform quality assurance (1a,1b)	Clear supervisory structure with a defined CHW supervisor (1a,1b,5)	CHWs working in clinical settings have a clinical supervisor (e.g., licensed health workers) (1a,1b) and a nonclinical/ community-based supervisor (4)
	Training, Support, & Evaluation of Supervisor	Management support for strong supervision (1a,1b,6); reasonable workload (1a,1b)	Training: CHW roles/ needs, supportive supervision, care delivery observations, basic	Quality of supervision evaluated, prioritize improvement (1a,1b); include CHW	Lack of agreement on core competency requirements for supervisors (6)

Concept	Element	Examples			
			supervision checklists/ tools, use CHW performance data to improve care (1a,1b,4,5)	feedback on supervision methods (3,4)	
4. Support for CHWs	Job Aids, Resources, & Supplies	Standardized job aids (outreach tools, checklists, flowcharts, education materials, data collection forms, interview guides with patients, documentation platforms, etc.) (1a,1b,4,6)	Supply chain management practices: regularly monitor and restock supplies, have buffer stock available, verify quality/inventory of all supplies (1a,1b)	Order supplies based on CHW needs (1a,1b); tools for communication (e.g., printer, scanner, mailbox) (3,1b); administrative/IT support and telehealth devices (1a,1b,4)	Flexible, easy-to-use tools to allow CHW to provide tailored, holistic care (1a,1b,2,4); computer equipment for working virtually during COVID (6)
	Documentation Tools	Standardized documentation/ information management: workflow and supported holistic notes (life story and person-centered goals) (1a,1b); track number and duration of visits, services, supervisor review, data flow between community and care systems	Referral tracking system: standardized referral forms and procedures; referrals given/services used and needs met; closed-loop information back to CHWs (1a,1b,4)	Involve CHW in data system design; involve CHWs in using data in problem solving (1a,1b,2); make digital data systems accessible, manageable, user friendly and useful for CHWs (1a,1b,2,6)	

Concept	Element	Examples			
		(1a,1b,4)			
	Safety & Emergency Protocols & Resources	Written safety protocols for CHWs in emergency situations (e.g., domestic/ neighborhood violence, clinical emergencies, use of buddy system) (1a,1b, 2)	Equipment for routine care (e.g., PPEs against infections) for CHWs and patients (1a,1b, 2,6)	Liability insurance for CHWs to travel and see patients in their homes (3)	
	Peer Support	Peer-to-peer support (1a,1b) for CHWs with shared experiences (5)	Establish CHW coalitions for trauma-informed peer support, pollical capital, peer networking, resource sharing, peer mentoring, professional development (3,4,5)	CBO-health care organization collaborative can provide peer support for both organization types (5)	Peer-to-peer mentorship (1a,1b); an experienced team member should support CHW by attending the first home visit; COVID made peer support difficult (6)
	CHW Wellbeing	Support for CHW self-care and mental/ emotional health (1a,1b	Motivate CHW, increase job satisfaction, decrease absenteeism and attrition	Access to group or individual group	Clinical supervision may prevent CHW

Concept	Element	Examples			
		2,3,4); prevent burnout (1a,1b,2)	(1a,1b); feeling isolated (5)	therapy for CHWs (4)	burnout (5)
5. CHW Scope of Work	CHW Role & Responsibilities	Defined CHW role, flexible work practices; supported by organization policies; clear expectations (workload, maximum distance), measurable activities (e.g., provide food supplements); role updated routinely (1a,1b,4,5)	Patient-center care approach: all items from C3 project; flexible to provide tailored, holistic support; role designed with evidence-based practices (1a,1b,4); build trust with patients and advocate for clients/ patients; "relationship specialist" on behalf of the team (1a,1b,2,5,6)	Tasks: Build trust with patients, provide tailored support, empower patients, prevention efforts, psychosocial intervention, care coordination (navigate, advocate, referral, follow-up), collect/record data (1a,1b,2,3,4,6); flexible, tailored SOW based on SDOH and social needs (1a,1b,2,3), close health care disparities (1a,1b,5); contact tracing, health/public health education (1)	Link patients to health and community resources; promote trust, provide information about data privacy; promote community awareness/use of affordable care; translate community needs to health systems (social justice/health disparities); hold services accountable to the communities served (1a,1b,3,4,5,6); advocate for policy change for community (1a,1b,3); work with the community to identify solutions (1a,1b,5)

Concept	Element	Examples			
	Flexible, Person-Centered Work Practices & Manageable Caseload	CHW-to-client/patient ratio allows empathy and wide range of work (social support, advocacy, community work); flexible schedule/ workload to build trust and respond to clients/ patients in creative ways with extended patient interaction/ home visits (1a,1b,3,4, 5,6) and with community at large (4)	Manageable workload should factor in care intensity, number of tasks, office meeting, administrative tasks, catchment area (1a,1b,3,4,6)	Catchment area based on frequency of contact required, nature of patient needs and care provided, time commitment, distance to client, safety (1a,1b)	
6. CHW Workforce Development	Performance Assessment	Assess knowledge and actual performance; quantity and quality (timeliness, care experience) of services, community feedback, identify achievements and areas for growth (1a,1b,2)	Fair, structured, objective performance assessment at a set time: yearly, documented, evaluate care delivery and coverage (1a,1b,2) beyond supervisor's opinion (1a,1b,2)	Involve CHWs in developing performance evaluation approach (1a,1b)	

Concept	Element	Examples			
	Career Ladder	Invest in professional development (training in new skills, certification), increased responsibilities, different levels within CHW profession, supervisory promotion opportunities, attend conferences and professional networks (1a,1b,3,4,6)	Value CHWs with a formal career path (1a,1b) in the CHW profession (2,4,6); minimize attrition to other fields (4,6)	Advancement for CHWs performing well based on fair evaluation and those expressing interest (1a,1b)	Job security for CHWs hired in direct response to COVID (1); job security is not contingent on the volume of clients/ patients seen (3)
	Pay & Incentives, Awards & Recognition	Financial incentives (salary, bonuses, travel reimbursement); non-financial incentives (e.g., certification, recognition, uniforms); involve community in recognition (1a,1b,6)	Financial/non-financial incentives increase over time, are commensurate with job role/expectations (SOW, workload, job demands, hours, roles, administrative/clinical services provided, complexity); tied to performance (work quality, quantity) (1a,1b,4,5); lived/work experiences (1b,5,6)	Adequate salary, compensation, reimbursement, and benefits; competitive rates relative to market; livable salary allows full-time work (1a,1b,3,4,6); value and retain CHWs with livable, reliable wages (2,5,6)	CHW program administrators work with HR to understand pay/nonmonetary incentives for CHWs (2)

Concept	Element	Examples			
7. Health & Social Care Teams Integration	Define & Recognize CHW Role with Team Members	Educate/orient all staff about CHW program and professional history, unique role, lived experiences, core competencies, and fit in the team; defined roles and work relationships of CHWs and other team members (1a,1b,2,3,4,5,6)	Integrate CHWs into full care team: participate in care planning; emphasize unique nonclinical role to support treatment; value community insights; document CHW services in EHR to foster information sharing; include health workers in CHW training (1a,1b,6); respect CHW grassroots approach to addressing social injustice and SDOH needs; have clinical champion to help buy-in with CHW role/ translate CHW work in care continuum (1a,1b,2,3,4,5)	Clear communication of CHW role to gain recognition/respect from all care team members; promote acceptance and welcoming teamwork environment with CHWs at all levels of the organization (1a,1b,2,3,4,6); multidisciplinary teamwork between CHWs and others allow each to focus on what they do best and support each other (1a,1b,5)	Not co-opting CHWs in health system or overmedicalizing CHW roles (2,3)

Concept	Element	Examples			
	Organizational Commitment and Process to Link Health & Social Care	Strong partnership among CHWs, health care organizations, CBOs and communities; learn from CBOs and leverage their resources, expertise, and connections with communities (1a,1b,2,3,4,5,6)	Joint involvement/mutual support with CBOs in CHW recruitment, training, incentives, supervision, evaluation, equipment, data sharing, identifying community needs, referrals, care delivery, meeting SDOH needs (1a,1b,4,5,6)	Frequent staff communication, improve workflow (timing of visits, patient hand-offs); closed-loop referrals (information flows back to CHWs) (1a,1b); build channels to break down power dynamics and build trust with CBOs (4)	Get organization ready before launching CHW program; design people-centered program by putting client/patient first (vs. disease-specific); adapt program to support CHWs and their care approach (2,3,6); apply social justice lens to care delivery (3); diversity, equity, inclusion/ antiracism committee to create better workplace (5); understanding of community needs/ resources (6)

Concept	Element	Examples			
8. Organizational Data Systems & Engagement	Data Systems for Quality Improvement	Data feedback loop: collect/report standardized indicators (e.g., care processes, health and social needs met) and data evaluated to inform CHW performance and program-level process improvement (1a,1b,5)	Minimize reporting burden; harmonize data requirements; ensure confidentiality and security of data (1a,1b)	Collect data to address community-level needs and improve CHW/ program-level performance; digitalize data systems to improve care quality, speed, or equity (1a,1b); collect social returns on investment (ROI) outcomes besides readmissions/ cost savings (6)	
	CHW Engagement	Engage CHWs in decision-making process, leadership positions, program/ process improvement, hiring, training, work practices, and care delivery issues (1a,1b,2,4,5,6); "nothing about us without us" philosophy	Have a CHW champion to help promote understanding and value of CHW role (1a,1b,2)	CHW role in driving racial and social justice focus, respecting their lived experiences (3)	

Concept	Element	Examples		
		(6)		
	Community Centered Care & Engagement	Reflect community health/social needs in program design; engage community in health education and other meetings; outcomes monitoring and evaluation (e.g., community scorecard) (1a,1b,3)	Engage communities in operations: priority setting, training, problem solving, performance feedback, awards/appreciation (1a,1b,3)	Program success depends on community trust in CBOs and CHW engagement in the community (2,3); exchange information between organizations and community (6)

Concept	Element	Examples			
9. Program Sustainability	Program Evaluation and Improvement	Regular evaluation of program outcomes, ideally with a comparator group (1a,1b)	Evaluate programmatic progress (supervision and support, CHW workforce development); performance outputs (CHW competency and well-being, access/use and quality of community services, experience with care); economic evaluation (cost-effectiveness and cost-benefit); health equity; patient and community health outcomes aligned with Triple Aim (1a,1b)	Findings inform process improvement and program support, are provided to CHWs and care team, designed for informing future CHW-related policies and funding streams (e.g., Medicaid managed care contracts) (1a,1b)	Many aspects of CHW work cannot be measured through numbers (or volume of services) (3); focus on/ create new metrics on social ROI measures and equity/health disparities (4,5); collect comprehensive qualitative data to support quantitative data on outcomes (4)

Concept	Element	Examples			
	Financial Sustainability	Payment should promote tailored, person-driven care and reward improved outcomes (e.g., emotional health); funding should reward addressing population's SDOH and social needs and be adjusted based on these (1a,1b,2,3)	Move away from volume or focus on list of clinical processes (e.g., get a mammogram) (1a,1b,2,3), demands on proving ROI of CHW model, disease-specific programs (rather than whole-person care) (2,3), and funding health care (not grassroots) organizations (5)	Medicaid agencies could formally support CHW workforce by requiring CHWs to play an established role in the care continuum in managed care plans (2,6); may need clear definition of SOW for billable services; more funding for effectiveness research to show importance of CHW work (5)	Reliable, sustainable, adequate financing needed for less-resourced CBOs to retain CHWs and promote career ladder; flexible funding to bill time needed to build trust (2,3,4,5,6) and provide creative CHW care approaches; funding for IT may distract funding from supporting CHWs and their services (2)