**Blueprint CMP Implementation Guide for Practice Facilitators**

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**Blueprint CMP Implementation Guide for Practice Facilitators**

**Adding Community Health Workers to Primary Care Practice**

## Quick Start Guide

The quick start guide offers a concise, one-page visual overview of the essential tasks required to implement CHW services within a practice. Click here for the [guide](#_Guide).

## Practice Facilitator Guide

### Purpose of This Guide

The American Diabetes Association (ADA) views community health workers (CHWs) as integral members of the diabetes care team whose involvement leads to improved health outcomes and reduced health disparities, especially in underserved communities.

The American Diabetes Association® (ADA) funded the development of this guide to assist practice facilitators and primary care providers in adding community health worker (CHW) services to their practices or enhancing these services if they already exist.

This and other ADA Blueprint Guides are designed to assist practice improvement facilitators (PFs) and primary care providers (PCPs) in implementing key care management processes and services that contribute to improved care quality and health outcomes for patients living with diabetes.

### How to Use This Guide

Practice facilitation program directors can use these guides **to develop training** to introduce PFs to key elements of CHW program design and prepare them to support PCPs through this process. PFs can use this guide **as a roadmap to guide their work with practices** to design and implement CHW services or enhance existing ones. Finally, PCPs and their quality improvement (QI) teams can **consult this guide to assist them in planning** the implementation or improvement of CHW services at their practice.

### Adding CHWs to Primary Care Practice

CHWs are frontline public health workers who are trusted members of the communities they serve, making them uniquely positioned to address social determinants of health, improve access to care, and enhance health outcomes (American Public Health Association, 2023).

The Community Preventive Services Task Force (CPSTF), an independent panel of public health and prevention experts sponsored by the CDC, recommends interventions using CHWs for diabetes prevention and management based on evidence showing improved glycemic management, weight-related outcomes, lipid management, and health care utilization (Guide to Community Preventive Services, 2017).

Common CHW program models include:

| **Model** | **Description** |
| --- | --- |
| **Promotora de Salud/Lay Health Worker** | CHWs are members of a target population with specialized training to provide health education. |
| **Member of Care Delivery Team** | CHWs work alongside medical professionals to address health issues. |
| **Care Coordinator/Manager** | CHWs help patients with complex health conditions navigate healthcare systems. |
| **Screening and Health Educator** | CHWs deliver screenings and health education to a target population. |
| **Outreach and Enrollment Agent** | CHWs provide outreach and enrollment services to a target population. |
| **Community Organizer and Capacity Builder** | CHWs promote community action and build support for new activities. |

Source: Rural Health Information Hub. (n.d.). *Promotora de Salud/Lay Health Worker Model*. Retrieved January 19, 2025, from <https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/layhealth>

In 2024, CMS introduced new payment codes in its Physician Fee Schedule, enabling Medicare to reimburse for services provided by CHWs. These services include:

* SDOH assessments,
* community health integration, and
* principal illness navigation.

This marks the first time Medicare will pay directly for services rendered by CHWs, recognizing their critical role in addressing health-related social needs and supporting people with complex health conditions.

The state tracker website at the National Academy for State Health Policy provides an up-to-date overview of CHW definitions, certification requirements, and funding options by state. Click here to search: <https://nashp.org/state-tracker/state-community-health-worker-policies/>

Incorporating CHW services into primary care can improve patient engagement, reduce hospital admissions, and improve health outcomes for patients living with chronic disease (Centers for Disease Control and Prevention, 2023). Inclusion of CHW services can also help PCPs reduce disparities in care by serving as cultural mediators and health advocates, particularly for underserved populations (Association of State and Territorial Health Officials, 2023).

In addition, CHW programs are increasingly cost-effective. A recent economic analysis of the IMPaCT program, a study of CHW interventions for high-risk patients, found a $2.47 return on each dollar invested in a CHW program (Kangovi et al., 2020).

### Benefits of Including CHW Services in Primary Care Practice

CHWs can:

* assist with the implementation of ADA Blueprint care management processes (CMPs), such as patient reminders of tests due and between-visit follow-ups by a non-clinician
* improve care gap closure
* increase detection and resolution of social health barriers that interfere with patients’ ability to manage their health
* increase access to culturally and linguistically responsive health education for patients with chronic conditions
* enhance quality of care and patient experience at the practice through incorporating the community and lived experience expertise of CHWs in the practice’s QI

### What Good Looks Like

Knowing what good looks like can help practices implement CHW services for their patients more effectively and efficiently. PFs and PCPs can learn from case examples or stories and PEARLs (tips and tricks) from PCPs who have already implemented these services, making their own efforts to implement them at their practice more efficient and effective.

One place **to view stories** and PEARLS about this CMP and **to add your own** is here:  <https://www.lanetpbrn.net/submit-case-examples>

Another way to find case studies and best practices for CHW services in primary care is to search online. Here are a few resources to start with:

**The Latino Health Access CHW model.** Source: Bracho, A., Lee, G., Giraldo, G. P., & De Prado, R. M. (2016). *Recruiting the heart, training the brain: The work of Latino Health Access*. Hesperian Health Guides.

**IMPaCT model CHW program.** The IMPaCT model is another example of a successful CHW intervention. IMPaCT is a standardized, scalable program for CHW services. It engages trusted laypeople from local communities to improve health.

See a video about the program here: <https://www.rwjf.org/en/insights/blog/2021/02/community-health-workers-walking-in-the-shoes-of-those-they-serve.html>

The model delivered CHW support to 10,000 high-risk patients in Pennsylvania. It reduced total hospital days by 65% and provided payers a $2:1 annual return on investment. It is currently being replicated by organizations in 18 states, including the Veterans Health Administration, state Medicaid programs, and Walmart’s retail health centers. For more information, go to: <https://www.impactcarehq.com/about/>

**NCQA 9 critical inputs to successful CHW programs.** The National Committee on Quality Assurance (NCQA) partnered with CHW directors and CHWs to identify elements common to high-quality CHW programs. Read the NCQA report here:

<https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs_White-Paper_Final.pdf>

## Pre-Work

### Engage leadership

A first step in implementing a new program at a practice is always to engage practice leadership to confirm their buy-in, determine their goals for the program or services, and identify resources the practice has (and will need) to implement the new program.

Meet with leadership to review these issues and identify who will be the “champion” for the program at the practice. This individual should have sufficient authority to ensure implementation of the processes at the practice and a personal interest or passion for the program or the practice’s goals for implementing it.

### Form a project team

Before embarking on this work with a practice, be sure they have identified the person or team who can make these decisions and carry out this work. This may be a special project team created by the practice to implement or enhance this program, the practice’s QI team, or, in a small practice, the office manager in consultation with the practice owner and lead physician.

Regardless of who or which group is charged with working through these tasks to implement or enhance this program, ideally, the group involved includes representatives from staff and clinicians who will be involved in the new or redesigned workflows and can provide input on their design to enhance the effectiveness of these changes.

These individuals are not always obvious, so work with the practice to ensure their voices and ideas are included in the conversations—either directly as a team member or through outreach to them for input. For example:

* The front desk clerk or whomever oversees scheduling
* MAs who may be charged with educating the patients about reminders
* The front office clerk who will be collecting intake data, updating phone numbers, and filling gaps in this information
* Community health workers (CHWs) or staff from a community-based CHW agency familiar with the patient groups and communities the practice serves

Use the worksheet below to help the practice think about and select their project team.

[Project team worksheet](#_Assessment_of_CHW)

## Key Tasks

### Task 1. Assess current state of CHW services at the practice

The National Committee for Quality Assurance (NCQA), in collaboration with CHW program leaders and CHWs, identified nine critical inputs for successful CHW programs that can be applied to program design of CHW services in primary care. These inputs can be used as informal guidelines for implementing and maintaining high-quality CHW services in a range of settings.

A summary of the nine critical inputs is available here: <https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs_White-Paper_Final.pdf>

If the practice already provides CHW services to its patients, work with them to assess those services.

If they do not currently offer CHW services to their patients or refer them out for CHW services, consider reviewing the assessment tool to help increase practice awareness of factors associated with effective CHW services so they can use this information as they design the CHW services at their practice.

Use the informal assessment tool below to help the practice assess its current CHW services or familiarize themselves with elements associated with effective CHW programs.

[Informal assessment of CHW services](#_Assessment_of_CHW_1)

### 

### Task 2. Define the practice’s goals for its CHW services

An important early step in implementing or enhancing any new program is clearly defining the practice's goals for its adoption or improvement.

Use the goal sheet below to help the practice define their goals for integrating CHW services at their practice for their patients living with diabetes, define outcome indicators, and set their timeline.

[Goal sheet](#_Goal_Sheet_for)

### Task 3. Define which patient groups will be prioritized to receive CHW services

Next, work with the practice to determine which patients they will prioritize to receive CHW services. Examples of populations that can benefit from CHW services include:

| **Patient population** | **Possible CHW services** |
| --- | --- |
| **Low-Income and Underserved Populations** | Assistance with insurance enrollment, transportation, housing, and appointment reminders. |
| **Patients with Chronic Conditions** | Support for medication adherence, health education, and disease management for conditions like diabetes and hypertension. |
| **Immigrants, Refugees, and Non-English Speakers** | Translation services, cultural interpretation, and education about the healthcare system. |
| **Maternal and Child Health Populations** | Prenatal care support, postpartum follow-ups, breastfeeding counseling, and nutrition education. |
| **Patients with Mental Health Challenges** | Peer support, emotional encouragement, and connections to mental health providers. |
| **Elderly and Homebound Individuals** | Assistance with home safety assessments, transportation, medication management, and home care coordination. |
| **Patients Facing Housing Insecurity or Homelessness** | Coordination with shelters, hygiene kit distribution, and health service connections. |
| **Patients with Substance Use Disorders** | Peer counseling, harm reduction education, and support for substance use treatment programs. |
| **Rural Communities** | Connection to telehealth services, mobile clinic coordination, and preventive care education. |
| **High Emergency Department Utilizers** | Education on primary care access, follow-up appointment scheduling, and transportation assistance. |

Use the worksheet below to help the practice select and prioritize patient groups for CHW support and then calculate the estimated number of patients in these groups.

[Patient groups prioritized for services worksheet](#_Priority_Populations_for)

#### 

### Task 4. Select approach practice will use to make CHW services available to their patients

For this step, work with the practice to help them decide how they will make the CHW services they are designing available to their patients.

**Approach 1. Direct hire**

In this approach, the primary care practice hires CHWs directly as W2 employees on payroll. A person within the practice supervises and supports the CHW staff. Funds are allocated for CHW salary, benefits, and training. This approach can make integrating the CHW onto care teams and the practice easier and makes supervision and line of report clear.

On the other hand, small and even larger primary care practices likely lack deep expertise in CHW supervision and support. They may also have difficulty assessing the knowledge and skills of applicants. There is also a greater risk of “medicalizing” the work of the CHWs when the practice directly hires them without corrective guidance from agencies that specialize in CHW services.

**Approach 2. Cross-train existing staff to serve as CHWs**

Some primary care practices are experimenting with training Medical Assistants (MAs) as CHWs. This approach can be effective but depends on MAs having excess capacity at the practice.

In these instances, consider engaging an outside agency that has expertise with CHWs to provide the training.

**Approach 3. Contract with an external CHW agency to provide CHWs to the practice**

In this approach, the primary care practice contracts an outside agency to provide trained CHWs to work at the practice.

For this approach to be successful, the PCP and community-based CHW organization should work as equal partners rather than one in service to the other which may require the PCP to adopt a new paradigm for partnering with outside organizations.

**Approach 4. Refer patients out to an external CHW agency or program for services**

In this approach, the PCP establishes agreements with external agencies to provide CHW services to their patients. This may be a community based CHW organization in the local community or CHW programs at patients’ health plans.

Use the worksheet below to help the practice think through their approach to making CHW services available to their patients.

[Approach to providing CHW services worksheet](#_Staffing_Model_and)

### Task 5. Define CHW roles and services

A. Define scope of service and roles of the CHWs. Work with the practice to determine the specific services the CHWs will provide and their roles. These should align with the needs of the patient populations prioritized for CHW support.

Examples of services and roles include:

* Create connections between vulnerable populations and healthcare providers
* Help patients navigate healthcare and social service systems
* Manage care and care transitions for vulnerable populations
* Reduce social isolation among patients
* Determine eligibility and enroll individuals in health insurance plans
* Ensure cultural competence among healthcare providers serving vulnerable populations
* Educate healthcare providers and stakeholders about community health needs
* Provide culturally appropriate health education on topics related to chronic disease prevention, physical activity, and nutrition
* Advocate for underserved individuals or communities to receive services and resources to address health needs
* Collect data and relay information to stakeholders to inform programs and policies
* Provide informal counseling, health screenings, and referrals
* Build community capacity to address health issues
* Address social determinants of health

Source: Rural Health Information Hub. (n.d.). *Roles of community health workers*. Retrieved January 19, 2025, from <https://www.ruralhealthinfo.org/toolkits/community-health-workers/1/roles>

Use the worksheet below to help the practice select and design the CHW services they will make available to the patients at their practice.

[CHW services worksheet](#_CHW_Services_Worksheet)

##### B. Identify red flags that indicate CHWs are being diverted from authentic CHW work and over “medicalized.”

The practice will need to guard against over “medicalizing” CHWs in the practice as this can significantly diminish their effectiveness. Use the checklists below to define CHW roles and to check for any “red flags” that suggest the practice may be at risk for “medicalizing” the CHWs.

Red flags include the following. CHWs are:

* Restricted to phone contacts
* Given large caseloads to manage that reduce their ability to develop robust helping relationships with each person they are seeing
* Limited to making referrals for SDOH without time for additional assessment, service navigation, and long-term follow-up around need resolution
* Having their input and ideas for communicating complex information to the people being treated dismissed as too informal
* Excluded from quality improvement work
* Not recognized or engaged as having expert knowledge of the people they see and the local community
* Not included in care team meetings to share work and insights about the people being treated
* Not provided frequent training, support, and experienced supervision that addresses their dual role as both a member and a helper of the community

Source: Houston, T. (2022). *Medicalization of community health workers: Balancing professionalism with the community's needs.* Houston Health Law. Retrieved January 19, 2025, from <https://houstonhealthlaw.scholasticahq.com/article/94072>

[CHW care team roles worksheet](#_CHW_Care_Team_1)

### Task 6. Calculate panel size for CHWs

Calculating panel size is an essential part of CHW program design. If panel sizes are too large, CHWs will not be able to deliver the needed intensity of support and services, resulting in an ineffective intervention and frustrated and over-stressed CHWs. If panel sizes are too small, existing CHW capacity is underutilized, and fewer patients than possible are supported.

The Robert Wood Johnson Foundation suggests that practices consider the following when determining CHW panel size:

* The CHW’s scope of services
* The intensity of services (low, medium, high) the CHW will be delivering to different patient groups and the time requirements for each level of service
* The location and/or modality of the service delivery (virtual or in-person)
* The efficiency of the practice’s current systems for screening, enrolling, and tracking the people being treated that CHWs will use
* The transportation available to CHWs (public, employee-owned, reimbursed, or PCP-owned) and anticipated travel time and costs
* The impact of safety protocols on CHW time (paired CHWs for home visits, etc.)

Use the worksheet below to help the practice calculate panel size for their CHWs based on the time CHWs have available for direct patient support and the intensity level of the services they will deliver.

[CHW panel size worksheet](#_CHW_Panel_Size_1)

### Task 7. Arrange for “supportive supervision” and training for the CHWs

For this task, work with the practice to determine how CHWs will be supervised and how continuous training will be provided.

##### A. Supportive supervision

Supportive supervision is considered a best practice for CHW services. It differs from traditional models of supervision typically used in primary care practices that focus on task completion and performance monitoring.

Work with practice leadership to ensure buy-in to using the “supportive supervision” approach with CHW staff. Practice leadership will need to understand and be supportive of using a “supportive supervision” approach with CHW staff. Supportive supervision:

* **Is scheduled and real-time:** CHWs are provided with scheduled technical supervision and real-time clinical supervision for their work with patients.
* **Is trauma-informed:** The psychosocial aspect of supportive supervision acknowledges that CHWs often encounter the same challenges they assist patients in navigating. This type of supervision must be protective due to the demanding nature of the CHW role. Since CHWs are typically members of communities deeply impacted by inequities, they may experience historical and vicarious trauma in addition to personal and individual trauma.
* **Prioritizes the safety of the CHWs:** Depending on their scope of services, safety is a critical consideration for CHWs, as they may encounter potentially hazardous situations while working in patients' homes and communities. Their work often involves supporting patients experiencing medical, psychiatric, or domestic violence crises.
* **Provides constant monitoring and coaching:** Regular monitoring and coaching are essential for CHWs performing high-acuity work. Without supportive supervision, CHWs face a higher risk of secondary trauma and burnout due to frequent exposure to traumatic situations. The lack of such support often leads to high attrition rates in clinical settings. Frequent communication with supervisors and team-building activities during staff meetings can help mitigate stress, boost motivation, and improve retention.
* **Monitors performance:** Supervisors should provide support to CHWs while also holding them accountable for achieving clearly defined performance metrics, such as patient satisfaction, goal attainment, health improvements, and reduced hospitalizations. Performance measures should be developed collaboratively with CHWs and include metrics and outcomes that include non-clinical outcomes of their work, such as the formation of health-promoting social networks, helping a child stay in school, or assisting a mother find help who is in a domestic violence situation.

Source: National Academy of Medicine. (n.d.). *Supervision strategies and community health worker effectiveness in health care settings.* Retrieved January 19, 2025, from <https://nam.edu/supervision-strategies-and-community-health-worker-effectiveness-in-health-care-settings/>

**CHWs are directly employed by the practice.** If the practice employs CHWs directly, they will need to identify someone on their staff as the CHW supervisor. They will need to ensure that this individual has the time, training, and support they need to supervise CHWs effectively.

**CHWs are provided by an outside agency.** If the practice is contracting out for services, the practice will want to meet with the agency to discuss how CHW work will be supervised and supported in their work at the practice.

The practice will want to identify a CHW supervisor at the practice who will collaborate and coordinate with the CHWs’ supervisor from the agency to guide their work at the practice and with its patients.

**Referral out to external programs for service.** If the practice is referring patients out for CHW services, they should identify an individual to oversee the referrals, monitor the quality of the CHW services provided, and monitor the status of referrals for service and patients’ receipt of services.

If the practice opts to staff the supervision position itself, they should also consider how they will select and train these individuals. Use the worksheet below to help the practice decide how they will supervise the CHWs at their practice, how they will select the supervisor, and how they will provide the supervisor with the training and support they need to support CHWs appropriately.

[CHW supervision worksheet](#_CHW_Supervision_Worksheet)

##### B. On-going training

Next, work with the practice to determine how they will provide ongoing training to CHWs.

Training for CHWs should:

* Use principles of adult education
* Meet the needs of learners with varying literacy levels
* Meet the needs of learners with limited English proficiency
* Focus on building the learner's self-efficacy to engage in the new skills and activities, not just on increasing knowledge.

Core competencies for CHWs include:

* Communication skills
* Interpersonal and relationship-building skills
* Service coordination and navigation skills
* Capacity-building skills
* Advocacy skills
* Education and facilitation skills
* Individual and community assessment skills
* Outreach skills
* Professional skills and conduct
* Evaluation and research skills
* Knowledge base
* Quality improvement skills

Source: <https://www.c3project.org/roles-competencies> and the ADA QI 101 for CHWs (Rosenthal, et al., 2022)

Specialized competencies include:

* HIPAA certification
* diabetes self-management education,
* maternal and child health,
* home blood pressure monitoring,
* violence prevention,
* medication adherence,
* mental health and substance abuse,
* health equity and social determinants of health,
* behavioral health,
* environmental health,
* geriatric health,
* oral health and others (CDC; National Association of Community Health Workers)

The practice should consider engaging an outside agency with expertise in CHWs to assist the practice with identifying CHWs with needed competencies and hiring them.

The practice can then supplement this support with online resources and materials. You can find various training curricula for CHWs by conducting an online search.

[CHW training plan checklist](#_Training_Plan_for)

### Task 8. Provide administrative resources that CHWs need for their work

Next, work with the practice to determine how they will provide the administrative resources CHWs need to do their job. These include:

* office space
* cell phone
* secure messaging or similar for real-time support from clinician or supervisor
* a place to document their work
* transportation
* health education materials
* community meeting space
* personal protective equipment (PPE)
* language translation services
* safety plans

Use the CHW resources worksheet below to help the practice identify which resources they need to prepare for their CHWs and their plan for making these available.

[CHW resources worksheet](#_CHW_Resources_Worksheet)

### ­­­­­Task 9. Review and update practice policies, procedures and insurance

Next, work with the team to assess the alignment of their planned CHW services with state requirements for CHW certification and services reimbursement

Regulations governing reimbursable CHW services vary by state. The state tracker website at the National Academy for State Health Policy and state health department websites are good starting points for is a good starting point for determining the reimbursable services CHWs can provide.

NASHP state tracker website: <https://nashp.org/state-tracker/state-community-health-worker-policies/>

The practice should also review and update their policies, procedures and coverage to include the work the CHWs will be doing. Following is a list of areas to review with the practice.

| **Element** | **Possible actions** |
| --- | --- |
| **Legal and insurance** | The practice should evaluate the need for new or expanded coverage and risk management protocols before providing CHW services. |
| **Business Associates Agreement (BAA)** | Consider whether there is a need for a BAA between your practice and any CHW vendor. |
| **Adequacy of Current Liability Coverage and Risk Management Protocols** | Discuss unique liability issues associated with new CHW services with the practice’s attorney. Identify changes needed to risk management protocols and insurance coverage. |
| **Human Resource Enhancements** | Ensure CHWs are correctly classified and implement work hours, mandatory breaks, overtime and leave policies. Provide tools like a phone app for time keeping and documenting adherence to mandatory rest and meal breaks for non-exempt employees. |
| **CHW Safety Protocols** | Develop safety protocols for CHWs working in homes and communities. Key considerations include Comprehensive training in conflict resolution, emergency response, and safety awareness. Clear guidelines on work areas, avoiding high-risk environments without support. Personal safety devices like panic buttons or GPS trackers. Regular check-ins with the base office. PPE for health-related tasks. A buddy system for added safety. |
| **Mandated Reporting Requirements** | CHWs may be mandated reporters under state laws. Work with the practice attorney to Determine state laws related to CHWs and mandatory reporting. Provide training and develop protocols aligning with state requirements. Update the practice’s risk management plan to reflect CHWs’ responsibilities. |
| **Protocols for Responding to Urgent Patient Care Situations** | Create workflows and protocols for CHWs to handle urgent or high-risk situations, such as suspected abuse, threats of harm, or medical crises, ensuring alignment with ethical, medical, and legal standards. |

[Modifications](#_Policies,_Procedures_and) checklist

### Task 10. Build staff and clinician readiness to partner with CHWs

Practices require “institutional” as well as staff and clinician readiness to onboard CHWs and implement CHW-delivered services effectively. Work with the practice to build both forms of readiness before on-boarding CHWs.

##### A. Assess and build institutional readiness

Work with the project team and practice leadership to evaluate the “readiness” level of the practice and create plans to increase it if needed. Latino Health Access, a 25-year-old CHW-based community organization located in Santa Ana, California, identifies the factors below as key to effective support of CHWs and programs:

* a commitment to CHW inclusion,
* respect for CHW’s cultural and community knowledge and recognition of them as experts in these areas
* clear role definitions for CHWs
* integration of CHWs onto care teams
* investment in ongoing training and supervision for CHWs
* adequate compensation and career pathways for CHWs
* inclusion of CHW voices in decision-making
* creation of feedback loops for CHWs to inform their clinical and administrative teammates about what is working and not working in community and patient engagement and services
* use of program evaluation methods that capture the impacts of CHW work beyond basic medical indicators.

Source: Bracho, A., Lee, G., Giraldo, G. P., & De Prado, R. M. (2016). *Recruiting the heart, training the brain: The work of Latino Health Access*. Hesperian Health Guides.

##### B. Build clinician and staff readiness to work effectively with CHWs

Work with the project team to develop presentations and hold discussions with practice staff to build their knowledge and readiness to work with their new CHW team members.

There are existing training resources for clinicians and staff available online that you can find by conducting an online search.

Look here for an example of these types of resources

<https://mhpsalud.org/portfolio-items/making-the-case-for-community-health-workers-on-clinical-care-teams-a-toolkit/>

Use the practice readiness worksheet below with the practice to help them assess their readiness to implement CHW services at their practice and create a plan for increasing this.

[Practice readiness worksheet](#_Medicalizing_CHWs_Checklist)

### Task 11. Redesign workflows to incorporate CHWs as expert team members

Work with the practice toidentify where CHWs will be incorporated into care team processes and practice administrative processes.

Start by having the team list the specific workflows that will include CHWs based on the definition of their roles and job tasks earlier in this guide. Examples include:

* Conduct social determinants of health (SDOH) screening.
* Connect patients to eligibility programs (e.g., Medicaid, insurance enrollment).
* Conduct after-visit outreach calls
* Conduct outreach calls to remind patients of preventive services due and navigate to help them navigate to services.
* Collaborate with clinicians to develop patient-centered care plans.
* Attend huddles and provide input on patient experience
* Conduct home visits or community check-ins to support care plans
* Provide health education on diabetes self-management
* Monitor and report patient progress to the care team.
* Identify barriers to care, such as housing, food insecurity, or transportation.

Then, work with the project team to design or re-design those workflows to include authentic CHW participation.

Use the worksheet below to help the practice think through key workflows involving the CHWs.

[Key CHW workflows worksheet](#_Key_Workflows_Worksheet)

### Task 12. Prepare patients to work with CHWs

Don’t assume patients at the practice will be ready or even open to work with your new CHWs. Patients may be unfamiliar with CHWs and their work, uncomfortable talking with a non-clinician about health or social needs, or uncomfortable with someone coming to meet with them at their home.

Work with the practice to create a plan for educating patients about CHWs, their work, and the benefits they can provide related to helping them improve their health and well-being.

The practice may decide to educate patients about CHWs in a variety of different ways: educational flyers in the waiting room, educational messages sent to patient portals, via SMS or via letter announcing the addition of CHWs to the care team, and even one-to-one education by their clinician when a referral is made.

Some patients may be hesitant about receiving services in their homes. The practice can let them know about the safety, confidentiality, and benefits of home-based services while also offering alternatives. Patients should be informed that they can choose to meet with CHWs at the practice rather than in their homes if preferred. This flexibility makes people feel more in control and comfortable with the arrangement.

Use the worksheet below to help the practice plan its patient education strategy.

[Patient education on CHWs worksheet](#_Patient_Education_on)

### Task 13. Onboard CHWs and integrate into the practice

Next, work with the practice to plan how to introduce the new CHWs to staff and clinicians and integrate them into workflows and care teams.

The CHW supervisor should help lead the development of this session in collaboration with the project team and HR staff.

**Introductions.** Include informal introductions and a relaxed and celebratory approach to help the CHWs feel welcome and valued in the practice.

Include listening sessions during the orientation where CHWs can share their experiences working with people being treated and in primary care—either as a patient, CHW, or both.

Review their roles, tasks, and key workflows. Include job aids to use when training the CHWs on the key workflows.

Introduce the CHWs to the clinician and staff members they will be working with during this session.

**Co-design sessions.** Facilitate co-design sessions with the CHW supervisor, the CHWs, and their care team members regarding key CHW workflows once the CHWs are oriented and have begun work.

In all trainings, consider the literacy levels and language fluency of the CHWs and provide supports such as providing translation services if needed.

You can find helpful resources on onboarding and integrating CHWs onto care teams and in practices by conducting an online search. Examples of some of these resources include:

Rural Health Information Hub. (n.d.). *Introduction to community health workers.* Retrieved January 19, 2025, from <https://www.ruralhealthinfo.org/toolkits/community-health-workers/1/introduction>

Center for Health Care Strategies. (2014). *Integrating community health workers into care teams: Lessons from the field.* Retrieved January 19, 2025, from <https://www.chcs.org/integrating-community-health-workers-care-teams-lessons-field/>

[Onboarding and integrating CHWs into the practice worksheet](#_Onboarding_and_Integrating_1)

### Task 14. Consider billing options for CHW services

Next, work with the practice to determine if and how the CHW services will billed. Some helpful resources include:

The National Academy of State Health Policy’s (NASHP’s) CHW policy [website](https://nashp.org/state-tracker/state-community-health-worker-policies) provides information about each state’s reimbursement policies, billable codes, and other funding sources for CHW services. Click here to access it: <https://nashp.org/state-tracker/state-community-health-worker-policies>

Healthcare Common Procedure Coding System (HCPCS) is available on the CMS website [here](https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0) and [here](https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule).

The state Medicaid website will also have helpful information on reimbursable services for CHWs and billing codes. Here is one example of allowable services for CHWs by the [California Department of Health Care Services](https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/31781_01).

[Billing worksheet](#_Billing_Worksheet)

### Task 15. Add CHW services to the practice’s QI program and policies and procedures

##### A. Add metrics to the QI program

In this final step, work with the practice to add the CHW services to the practice’s quality improvement program.

Beyond basic service hours delivered and number of patients supported, when developing measures for assessing the services delivered by CHWs, it is important to track and capture elements that align with the work the CHW is doing and the outcomes of that work that may fail to be captured by traditional medical and quality outcome metrics.

Have the practice collaborate with their CHWs or the CHW agency they are partnering with to select measures to include in the practice’s quality improvement (QI) plan.

Use the worksheet below to outline recommended additions to QI

[Recommendations to the QI team worksheet](#_Recommendations_to_QI_1)

##### B. Add information to the practice’s policies and procedures

Include a summary of the CHW services and program, calculations of panel sizes, supervisor requirements, training, and other resources into the practice’s policies and procedures manual.

Be sure to adjust employee evaluations to include one for the CHWs and expand or include performance evaluation for the person providing supervision and training for the CHWs at the practice.

### Quick Start Guide

8. [Provide for administrative resources that CHWs need for work](#_Task_8._Provide)

1. [Assess current state of CHW services](#_Task_1:_Identify)

9. [Review and update practice policies, procedures and insurance](#_Task_9._Review)

[15. Add CHW services to the practice’s QI program and P&P](#_Task_15._Add)

[14. Consider billing options for CHW services](#_Task_14._Consider)

7. [Arrange for “supportive supervision” & continuous training for CHWs](#_Task_7._Arrange)

6. [Calculate panel size for CHWs](#_Task_6._Calculate)

13. [Onboard CHWs to the practice](#_Task_13._Onboard)

12. [Prepare patients to work with CHWs](#_Task_12._Prepare)

5. [Define CHW roles and services](#_Task_5._Define_1)

4. [Select the approach the practice will use to make CHW services available to patients](#_Task_2:_Determine)

11[. Redesign workflows to incorporate CHWs as expert team members](#_Task_11._Redesign)

10. [Build staff and clinician readiness to partner with CHWs](#_Task_10._Build)

2. [Define practice’s goals for its CHW services](#_Task_2._Define)

3. [Define which patient groups will be prioritized for CHW services](#_Task_3._Define)

## Guide

A diagram of a work flow

Description automatically generated

## 

## Worksheets

### Project Team Formation Worksheet

[(return)](#_Form_a_project)

**Practice:**

**Date:**

**Participating:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Role in Practice** | **Contact Information** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |

1. Is there someone with experience in this area at the practice who should be included on this team?
2. Whose workflow will be impacted by patient reminders? Do we have a representative from each position/role that will be involved in this process on the team?
3. Do we know any PCPs with excellent or “exemplary” CHW services that we can learn from?

Summary and Decisions

To dos:

1.

2.

3.

### 

### Goal Sheet

[(return)](#_Task_2._Define)

**Practice:**

**Date:**

**Participating:**

1. What do we hope to accomplish or change or improve by implementing CHW services for our patients?
2. The specific outcomes we hope to achieve are:

*Ex: To increase completion of annual eye exams by 50% over the next year*

A.

B.

C.

1. Our specific objectives are:

|  |  |
| --- | --- |
| Objective | Timeline |
| *Ex: Hire 2 CHWs fluent in Spanish and English and trained in DSME* | *By 3rd quarter* |
| A. |  |
| B. |  |
| C. |  |

1. How does implementing CHW services align with or compete with our top three practice priorities?

### Assessment of CHW Services at a PCP

Based on NCQA’s nine critical inputs for successful CHW programs

[(return)](#_Task_3._Assess)

**Practice:**

**Date:**

**Participating:**

**Our practice:**

* Has existing CHW services (complete this assessment to identify possible areas to improve)
* Is implementing CHW services for the first time and reviewing this assessment to guide the design they are currently creating

|  |  |  |
| --- | --- | --- |
| **Our practice’s approach to recruiting and hiring CHWs** | **RATE**  **0 = not present in our program to 4 = strongly present** | **For elements rated 0-3: ideas for aligning our current program to these elements** |
| **Clinician and staff readiness** |  |  |
| 1) We orient staff and care team members on the non-clinical nature of the CHWs' work to create readiness to integrated and work with CHWs as team members. Specifically, we educate them on their area of expertise, and how their knowledge, experience and services support clinical care outcomes |  |  |
| **Staffing model** |  |  |
| 2) To staff our CHW program, we selected the approach that enabled us to best support our CHWs in ways that align with best practices in the field. |  |  |
| 3) We developed job descriptions for CHWs and minimized red tape in hiring/contracting with CHWs/CHW agencies and to ensure our ability to hire and engage “natural helpers.” |  |  |
| 4) We know the official roles and scope of work our state allows for CHWs and reimbursable services as appropriate. |  |  |
| **Roles, services, and caseload** |  |  |
| 5) When designing CHW roles, we protect authentic CHW work and avoid delegating menial work. |  |  |
| 6) We clearly define CHWs’ roles and how they are distinct from:   * medical assistants, * social work, * health educators, and * other related roles   to reduce conflict and role confusion. |  |  |
| 7) We engaged CHWs and/or members of the outside CHW agency we are using as partners in designing our CHW services. |  |  |
| 8) We calculated a manageable caseload for our CHWs by considering:   * The need level of the people they will serve * Evidence on the intensity of services that will be needed to produce the desired outcomes for each person being treated * The amount of time needed to travel in the community, perform administrative tasks, and train for and supervise their work * The impact of safety protocols on productivity |  |  |
| **Onboarding and employee structure and support** | |  |
| 9) We provide onboarding training to CHWs to orient them to their role at our practice. |  |  |
| 10) We ensure ongoing (weekly) training and support for CHWs to:   * Build their knowledge and skill in the work they are doing * Support CHWs in managing the challenges created by the dual role they play being both peers/from the community and delivering support to the community |  |  |
| 11) We provide content-specific training for CHWs on roles that:   * Is designed based on the principles of adult learning * Is appropriate for low-literacy learners * Is available in the CHWs’ preferred language * Is sufficient for the CHW to build self-efficacy in delivering the content or skill |  |  |
| 12) We ensure our CHWs are supervised by a person who:   * Is clearly identified, provided protected time, and receives job incentives for the role of CHW supervisor * Receives special training on supervising CHWs from experts on CHW supervision * Has worked as a CHW in the past or is deeply familiar with the work and role of CHWs and their unique role as “natural helpers” * Has the access needed to advocate for CHWs within our practice to ensure their work and workflows align with the nine critical inputs for successful CHW programs |  |  |
| 13) We provide job aids for the CHWs to assist them in their work designed for their literacy levels and language. |  |  |
| 14) We have performance assessments for the CHWs that align with their scope of work and the unique contributions that CHWs make to patient care and community engagement. These outcomes include things outside the purview of primary care, like:   * enrolling children in afterschool programming, * helping a person being treated find stable housing, * other |  |  |
| 15) We involve CHWs/or the CHW agency in the design of these performance evaluations |  |  |
| 16) We provide a professional career ladder for the CHWs in our organization that allows them to advance within their profession—not just move to another discipline like social work. |  |  |
| 17) We pay a fair and living wage to our CHWs.  We offer the same benefits, incentives, awards, and recognition as other employees of our practice |  |  |
| 18) We offer opportunities for continuous professional development for CHWs, such as:   * completing new certifications in diabetes education * asthma management * QI * community programming, and * attending professional conferences and meetings |  |  |
| **Documentation methods and work resources** |  |  |
| 19) We provide methods for CHWs to document their work that do not require entry into electronic health records designed for medical staff and prevent “medicalization” of the CHWs’ work. |  |  |
| 20) We provide resources the CHWs need for the work they do in the office and the community:   * cell phone * bus passes * desk * office space * ADA website for CHWs * Education materials |  |  |
| **Safety protocols** |  |  |
| 21) We implement policies, procedures, and training to ensure the CHWs’ safety when they are working in the community:   * buddy system * cell phones * policies * time of day * location of visit |  |  |
| **Legal and insurance** | |  |
| 22) We reviewed and updated legal and insurance policies for the practice to cover additional risks associated with community-based work |  |  |
| **Integration on care teams** | |  |
| 23) We establish mechanisms for CHWs to communicate regularly with the care team about:   * the needs of each person being treated, observations about their care processes, * observations about the community, and * to request real-time supervision and support. |  |  |
| 24) Care teams redesign workflows in collaboration with the CHWs to incorporate them as a clear member of the care team, and there are maps of these redesigned workflows that the team and CHW can refer to, assess, and continually improve |  |  |
| **Inclusion in QI** | |  |
| 25) We include CHWs as part of our practice’s QI team as experts on the experience of the person being treated and the community |  |  |
| 26) We use methods like:   * partnering the CHW with a practice facilitator, * providing simultaneous translation * inviting input from them directly * other   to increase their comfort and ability to participate as an equal member of the group. |  |  |
| 27) We include a standing item on the agenda for CHWs to contribute their recommendations for improving the patient's outcomes and experience. |  |  |
| 28) We have identified and included quality metrics for our CHW services on our QI dashboard and are working to improve the service continuously. |  |  |
| 29) We include CHWs on the QI team, regularly request their input on program successes and improvement areas, and partner with them in continually improving. |  |  |
| 30) With research partners, we continuously improve by evaluating and documenting CHWs’ impact on patient outcomes and share our findings with funders to justify their services. |  |  |
| **Creating patient readiness to work with CHWs** |  |  |
| 31) We do not assume patient readiness to work with CHWs. We build patient readiness to work with CHWs:   * through education, * warm hand-offs and * other methods: |  |  |
| **Billing and financial model** | |  |
| 32) We understand certification requirements, Medicaid reimbursement for CHWs, and additional funding sources. |  |  |
| 33) Our staff and billing team are familiar with the codes that can be used in our state for reimbursement of CHW services |  |  |
| 34)We have developed a sustainable financial model for our CHW services or are actively working to do this. |  |  |

Summary and Decisions

Tasks

1.

2.

3.

### Patients prioritized for CHW services worksheet

[(return)](#_Task_3._Define)

**Practice:**

**Date:**

**Participating:**

Check the groups that our practice will prioritize to receive CHW supports and the estimated number of those patients

|  |  |  |  |
| --- | --- | --- | --- |
| **Prioritized for CHW services (Y/N)** | **Patient populations** | **Approximate # of patients in this group** | **Area/gap to be addressed by CHW services** |
|  | People with chronic conditions: |  |  |
|  | * Diabetes |  |  |
|  | * Hypertension |  |  |
|  | * Chronic obstructive pulmonary disease (COPD)/Asthma |  |  |
|  | * Heart disease |  |  |
|  | * Other: |  |  |
|  | People with behavioral health needs, such as: |  |  |
|  | * Mental health disorders |  |  |
|  | * Substance use disorders |  |  |
|  | * Other: |  |  |
|  | People with high health care utilization, including ED utilization, such as: |  |  |
|  | * Frequent emergency department users |  |  |
|  | * Hospital readmissions |  |  |
|  | * High-risk pregnancy |  |  |
|  | * Other: |  |  |
|  | People with SDOH challenges, such as: |  |  |
|  | * Low socioeconomic status |  |  |
|  | * Housing insecurity or homelessness |  |  |
|  | * Transportation barriers |  |  |
|  | * Language and cultural barriers |  |  |
|  | * Other: |  |  |
|  | Elderly and frail people |  |  |
|  | * Other: |  |  |
|  | Maternal and child health, such as: |  |  |
|  | * Pregnant women |  |  |
|  | * New mothers |  |  |
|  | * Children with special needs |  |  |
|  | * Other: |  |  |
|  | People with low health literacy and limited education |  |  |
|  | * Other: |  |  |
|  | Medically complex people, such as: |  |  |
|  | * Multiple comorbidities |  |  |
|  | * Polypharmacy |  |  |
|  | * Other: |  |  |
|  | Transitioning populations, such as: |  |  |
|  | * Post-discharge patients |  |  |
|  | * People transitioning from pediatric to adult care |  |  |
|  | * Other: |  |  |
|  | People with preventive care gaps, such as: |  |  |
|  | * + Missed preventive screenings |  |  |
|  | * + Unmet preventive care needs |  |  |
|  | * + Other: |  |  |
|  | People eligible for CHW support through state initiatives/programs |  |  |
|  | * Name of program: * Other: |  |  |
|  | People with low health equity, such as: |  |  |
|  | * Underserved populations |  |  |
|  | * Geographically isolated people |  |  |
|  | * LGBTQ+ people |  |  |
|  | * People with disabilities |  |  |
|  | * People with limited English proficiency * Other: |  |  |
|  | Other: |  |  |

Summary and decisions

Tasks

1.

2.

3.

### CHW Services Worksheet

[(return)](#_Task_5._Define_1)

**Practice:**

**Date:**

**Participating:**

| **Include in our program (Yes/No)** | **Header** | **General Description** | **Describe for our program** |
| --- | --- | --- | --- |
|  | Health education | Providing information on various health topics like nutrition, exercise, preventive care, maternal and child health, and managing chronic conditions. |  |
|  | Outreach and engagement | Reaching out to community members to encourage preventive care, identify health needs, and promote healthcare utilization. |  |
|  | Screening and assessment | Conducting basic health screenings like blood pressure checks, BMI calculations, and depression screening. |  |
|  | Health navigation | Assisting patients in understanding the healthcare system, scheduling appointments, navigating insurance complexities, helping with transportation, and finding necessary services. |  |
|  | Individual support and advocacy | Providing one-on-one support to patients, addressing their concerns, and advocating for their needs with care team and providers. |  |
|  | Behavioral health | Providing one-on-one behavioral health education and support around topics including substance use disorder, loneliness, and depression. |  |
|  | Social determinants of health | Screening patients for social health needs and linking patients to social services like food assistance, housing support, transportation, and mental health services. |  |
|  | Chronic disease management | Supporting patients with chronic conditions like diabetes, hypertension, and Asthma by providing education, medication reminders, and self-management techniques. |  |
|  | Translation services | Acting as interpreters to facilitate communication between patients and healthcare providers. |  |
|  | Community engagement | Organizing community events, workshops, and health fairs to raise awareness about important health issues. |  |
|  | Cultural competency | Bridging cultural gaps by understanding the unique needs and beliefs of patients conveying these to care teams and QI teams to increase responsiveness of services. |  |
|  | Collaboration with healthcare team | Work as member of care teams to coordinate patient care and provide their expertise on the lived experience, barriers/facilitators of health, and care plan implementation of patients. |  |
|  | Quality improvement | Participation on QI teams to improve patient experience, accessibility, equity, and cultural responsiveness of services. |  |
|  | Public health emergencies | Disseminating information, coordinating resources, and distributing essential supplies. |  |
|  | Other: |  |  |

Summary and decisions

Tasks

1.

2.

3.

### CHW Roles Worksheet

[(return)](#_Task_5._Define)

**Practice:**

**Date:**

**Participants:**

Complete the table below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Role/task | CHW | MAs | Care coordinator | Other: |
| Ex: Screen for SDOH needs | X | X |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |

**Medicalization Red Flags:**

Use this checklist to identify Indicators that CHWs are at risk of being underutilized or medicalized in your practice. If any of these are present, create a plan to remove that element.

* Restricted to phone contacts
* Given large caseloads to manage that reduce their ability to develop robust helping relationships with each person they are seeing
* Limited to making referrals for SDOH without time for additional assessment, service navigation, and long-term follow-up around need resolution
* Having their input and ideas for communicating complex information to the people being treated dismissed as too informal
* Excluded from quality improvement work
* Not recognized or engaged as having expert knowledge of the people they see and the local community
* Not included in care team meetings to share work and insights about the people being treated
* Not provided frequent training, support, and experienced supervision that addresses their dual role as both a member and a helper of the community

Summary and decisions

Tasks

1.

2.

3.

### CHW Panel Size Calculation Worksheet

[(return)](#_Task_3:_Determine)

**Practice:**

**Date:**

**Participants:**

|  |  |  |
| --- | --- | --- |
| **Section** | **Details** | **Calculations/Values** |
| **CHW time allocation** | The average number of hours worked per month by a CHW |  |
|  | Percentage of time in direct patient care (%/n) |  |
|  | Percentage time in documentation, care team meetings, etc. (%/n) |  |
|  | Percentage time in training/supervision (%/n) |  |
|  | Percentage time in QI and other activities (%/n) |  |
|  | Direct patient care hours available per 1 FTE per month |  |

| **Section** | **Details** | **Calculations/Values** |
| --- | --- | --- |
| **CHW intervention intensity levels** | Time requirements of direct patient care services |  |
|  | Time requirements of Low-Intensity direct patient care intervention |  |
|  | # of contacts per month |  |
|  | Average time spent per visit/call |  |
|  | Total time per low-intensity patient per month |  |
|  | Time requirements of medium-intensity services |  |
|  | # of contacts per month |  |
|  | Average time spent per visit/call |  |
|  | Total time per medium-intensity patient per month |  |
|  | Time requirements of high-intensity services |  |
|  | # of contacts per month |  |
|  | Average time spent per visit/call |  |
|  | Total time per medium-intensity patient per month |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CHW panel size (1 FTE)** |  | | | | |  |
|  | Total number of direct patient care hours available per month per 1 FTE | | | | |  |
| CHW name: | % FTE : | | | | |  |
|  | Total available hours of CHW: | | | | |  |
|  | Panel composition: | | | | |  |
| Low-intensity patients | # patients |  | # hours per pt/month | |  | Total hours: |
| Medium intensity patients | # patients |  | # hours per pt/month | |  | Total hours: |
| High-intensity patients | # patients |  | # hours per pt/month | |  | Total hours: |
|  | Total patients/panel size: | | | Total hours required: | | Total available hours of CHW: |

Summary and decisions

Tasks

1.

2.

3.

### Approach for Making CHW Services Available Worksheet

[(return)](#_Task_4._Select)

**Practice:**

**Date:**

**Participants:**

Use the table below to analyze each approach's pros and cons and select the most feasible for the practice.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Use? (Y/N)** | **Approach** | **Pros** | **Cons** | **Fit with our practice** |
|  | Hire directly |  |  |  |
|  | Re-train existing staff as CHWs |  |  |  |
|  | Contract with/ an external agency to provide CHWs to our practice |  |  |  |
|  | Refer patients out to external CHW programs for services |  |  |  |
|  | Other: |  |  |  |

Summary and decisions

Tasks

1.

2.

3.

### CHW Supervision Worksheet

[(return)](#_Task_5:_Select)

**Practice:**

**Date:**

**Participants:**

**1. Source of supervision for CHWs**

* Supervisor/s from practice
  + Clinical. Name:
  + Technical. Name:
* Supervisor from external CHW agency partner. Name of agency:
* For referrals to external CHW services only. Referrals manager. Name:

**2. Supervisor credentials (check all that apply)**

Name of supervisor/s:

Credentials:

☐ Has experience working as a CHW or a deep understanding of CHW work.

☐ Understands factors that can negatively impact CHW service delivery.

☐ Completed formal training in supervising CHWs.

☐ Updates supervision training at least yearly.

☐ Provides emotional support and understands CHW challenges.

☐ Supports CHWs in balancing their dual roles within the community.

☐ Understands and respects the cultural backgrounds of CHWs and the communities they serve.

☐ Supports CHWs in delivering culturally appropriate care.

☐ Demonstrates strong communication skills.

☐ Provides constructive feedback and conveys expectations clearly.

☐ Encourages open, two-way communication with CHWs.

☐ Has a background in clinical practice to navigate healthcare environments.

☐ Can provide guidance on clinical-related issues encountered by CHWs.

☐ Demonstrates strong leadership skills and inspires CHWs.

☐ Advocates for CHWs within the practice to ensure integration and adequate resources.

☐ Supports CHWs in delivering non-clinical support and prevents over-medicalization.

☐ Supports ongoing learning and skill-building for both the team and themselves.

☐ Provides regular opportunities for training, idea-sharing, and development.

**4. Supervision availability**

* Weekly scheduled sessions
* Real-time supervision via:
  + Phone
  + Secure messaging
  + Other:
* Based on the schedule/model of our external CHW agency partner

1. **Supervisor training/support**

* Formal training course on CHW supervision. Source:
* CHW supervision learning community. Source:
* By our external CHW agency partner
* Other:

Summary and decisions

Tasks

1.

2.

3.

### Training Plan for CHWs

[(return)](#_B._Regular_training)

**Practice:**

**Date:**

**Participants:**

1. Core competencies CHWs will need:

2. Specialized training CHWs will need for services at our practice include:

* None
* HIPAA certification
* diabetes self-management education,
* maternal and child health,
* home blood pressure monitoring,
* violence prevention,
* medication adherence,
* mental health and substance abuse,
* health equity and social determinants of health,
* behavioral health,
* environmental health,
* geriatric health,
* oral health and others (CDC; National Association of Community Health Workers)
* other:

3. Additional certification and training requirements in our state

Check:

A.

B.

C.

D.

Describe:

Summary and decisions

Tasks

1.

2.

3.

### Administrative and Supportive Resources for CHWs Checklist

[(return)](#_Task_8._Provide)

**Practice:**

**Date:**

**Participants:**

Complete the table.

|  |  |  |
| --- | --- | --- |
| **Resource** | **Provide? Y/N** | **Plan** |
| Weekly supervision sessions |  |  |
| Real-time supervision access |  |  |
| Method for real-time supervision access |  |  |
| Weekly training |  |  |
| Professional development trainings |  |  |
| Peer support meetings |  |  |
| Documentation platform for CHW work |  |  |
| Office space |  |  |
| Cell phone |  |  |
| Community/group activity space |  |  |
| Health education materials |  |  |
| Translation services |  |  |
| Transportation support for patients |  |  |
| Transportation support for CHW |  |  |
| ADA CHW membership and access to the website |  |  |
| Other: |  |  |

Tasks

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3.

### Modifications Checklist

[(return)](#_Task_8:_Review)

**Practice:**

**Date:**

**Participants:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Legal and Insurance** | **Have** | **Need** | **Plan** |
| * Engage practice attorney, HR service provider, and/or insurance broker. |  |  |  |
| * Evaluate the need for new or expanded coverage and risk management protocols. |  |  |  |
| **State-Specific Regulations** |  |  |  |
| * Ensure the CHW program aligns with state regulations. |  |  |  |
| * Define CHW's scope of practice and certification requirements. |  |  |  |
| **Privacy and Confidentiality** |  |  |  |
| * Ensure CHWs complete HIPAA certification. |  |  |  |
| * Verify data handling practices comply with privacy laws (e.g., HIPAA). |  |  |  |
| **Business Associates Agreement (BAA)** |  |  |  |
| * Determine if a BAA is needed between the practice and the CHW vendor. |  |  |  |
| **Liability Coverage and Risk Management** |  |  |  |
| * Assess liability issues and insurance needs with practice attorney. |  |  |  |
| * Update risk management protocols as necessary. |  |  |  |
| **Human Resource Enhancements** |  |  |  |
| * Verify CHW employment classification and work-hour policies. |  |  |  |
| * Implement a system (e.g., phone app) for CHWs to document rest/meal breaks. |  |  |  |
| **CHW Safety Protocols** |  |  |  |
| * Develop training on conflict resolution, emergency response, and safety. |  |  |  |
| * Establish work area guidelines and high-risk area policies. |  |  |  |
| * Provide personal safety devices (e.g., panic buttons, GPS tracking). |  |  |  |
| * Implement regular check-in communication protocols. |  |  |  |
| * Equip CHWs with appropriate PPE. |  |  |  |
| * Consider a buddy system for additional safety. |  |  |  |
| **Mandated Reporting Requirements** |  |  |  |
| * Identify state laws on CHWs and mandatory reporting. |  |  |  |
| * Provide training and protocols for mandatory reporting. |  |  |  |
| * Update the risk management plan to include CHW-specific considerations. |  |  |  |
| **Urgent Patient Care Protocols** |  |  |  |
| * Create protocols for responding to abuse, threats of harm, and medical crises. |  |  |  |
| * Align workflows with ethical, medical, and legal requirements. |  |  |  |
| **Other** |  |  |  |
|  |  |  |  |
|  |  |  |  |

Summary and decisions

Tasks

1.

2.

3.

### Practice Readiness Worksheet

[(return)](#_Task_10._Build)

**Practice:**

**Date:**

**Participating:**

*Use this rating sheet to help a practice evaluate its “readiness” to work effectively with CHWs and to implement or enhance CHW services at their practice.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Readiness Element** | **Not present** | **Emerging** | **Solidly present** |
| 1. Leadership supports inclusion of CHWs on care teams and as service providers at our practice |  |  |  |
| 1. Our practice is ready to allocate financial, human, and physical resources suggested by best practices to implementing or enhancing CHW services at our practice. |  |  |  |
| 1. We have an organizational culture that values the lived experience and wisdom of promotores. |  |  |  |
| 1. Our practice supports CHWs having a meaningful influence in care planning, community outreach, and education efforts, and we will design this into our program and services. |  |  |  |
| 1. We are willing to provide sufficient ongoing supervision and training on health issues and advocacy, fostering connections with their communities, and addressing burnout. |  |  |  |
| 1. We are committed to providing fair compensation and a career pathway for CHWs. |  |  |  |
| 1. We view CHWs at our practice as co-creators, teammates, and not subordinates. |  |  |  |
| 1. We include data collection tools and methods that capture the contributions of CHWs that extend beyond traditional medical outcome measures. |  |  |  |
| 1. We orient staff and care team members on the non-clinical nature of the CHWs' work, their area of expertise, and how their expertise and services supports clinical care outcomes to create readiness to add CHWs to care teams |  |  |  |

Adapted from: **Bracho, A., Lee, G., Giraldo, G. P., & De Prado, R. M.** (2016). *Recruiting the heart, training the brain: The work of Latino Health Access*. Hesperian Health Guides.

Summary and decisions

Tasks:

1.

2.

3.

### Key Workflows Worksheet

[(return)](#_Task_12._Redesign)

**Practice:**

**Date:**

**Participating:**

1. Key CHW-involved workflows

|  |  |
| --- | --- |
| **Role/Service** | **Workflow** |
| *Ex: Health education* | *Ex: One-to-one meeting with patients to provide self-management education* |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

2. Steps in workflows

*Ex: Workflow #1 - Name: One to one education*

*Step 1. MA does warm-handoff to CHW*

*Step 2. CHW reviews PCP instructions re: education in patient records in EHR*

*Step 3. CHW provides 1st education session*

*Step 4. CHW gathers feedback from the patient and schedules the next education session with the patient*

*Step 4. CHW documents session in Pear Suite platform for CHWs*

Workflow #1 - Name:

Step 1.

Step 2.

Step 3.

Step 4.

Workflow #2 - Name:

Staff:

Step 1.

Step 2.

Step 3.

Step 4.

Workflow #3 - Name:

Staff:

Step 1.

Step 2.

Step 3.

Step 4.

Workflow #4 - Name:

Staff:

Step 1.

Step 2.

Step 3.

Step 4.

Summary and Decisions:

To do:

1.

2.

3.

### Onboarding and Integrating CHWs into Practice

[(return)](#_Task_14._Onboard)

**Practice:**

**Date:**

**Participants:**

| **Section** | **Prompts and Planning Notes** | **Plan** |
| --- | --- | --- |
| **CHW Onboarding and Orientation** | How will the CHW orientation session be structured to build readiness and foster a welcoming environment? |  |
|  | Who will lead the session (CHW supervisor, HR, etc.)? |  |
|  | How will CHWs be introduced to clinicians and staff? |  |
|  | Will listening sessions be included so CHWs can share their experiences? |  |
| **Staff and Clinician Kick-off Training** | What topics will be covered (CHW role, non-clinical nature of work, communication protocols)? |  |
|  | How will the differences between CHWs and other roles (e.g., MAs care coordinators) be clarified? |  |
|  | What materials and methods (slides, handouts, interactive sessions) will be used? |  |
| **Cultural Humility Training** | How will the practice incorporate cultural humility training for staff? |  |
|  | What external resources (e.g., "Think Cultural Health") will be utilized for training? |  |
| **Workflow Redesign for CHW Integration** | What workflows will be mapped (e.g., pre-visit calls, post-visit follow-ups, SDOH screenings)? |  |
|  | How will process maps and swim lane diagrams be created and shared? |  |
|  | What key roles and responsibilities will be assigned (check-in, health education, huddles, etc.)? |  |
| **Communication Protocols** | What communication methods will CHWs use to collaborate with the care team (secure messaging, EHR tasks, huddles)? |  |
|  | How will communication approaches account for CHW literacy and language proficiency? |  |
|  | Will translation services or agenda items for CHWs at meetings be provided? |  |
| **Supervision of CHWs** | How will the supervisor for the CHWs be trained and supported by the practice? |  |
|  | How will supervisors support CHWs in expanding their roles and services? |  |
| **Documentation Requirements** | How and where will CHWs document their work? |  |
|  | How will documentation requirements avoid diminishing CHWs’ relational work and community focus? |  |

Summary and decisions

Tasks

1.

2.

3.

### 

### Patient Education on CHWs

[(return)](#_Task_12._Prepare)

**Practice:**

**Date:**

**Participants:**

| **Element** | **Prompts/Details** | **Notes/Plans** |
| --- | --- | --- |
| Goals for Patient Education | What are the key messages we want to convey about CHWs? |  |
|  | Key message 1: |  |
|  | Key message 2: |  |
|  | Key message 3: |  |
| Methods of Communication | Communication Methods We will Use |  |
|  | * Educational Flyers |  |
|  | * Patient Portal Messages |  |
|  | * SMS Messages |  |
|  | * Letters |  |
|  | * Clinician Referral (One-to-One) |  |
|  | * Other: |  |
| Addressing Patient Concerns | How will the practice address concerns about working with CHWs (e.g., unfamiliarity, non-clinician status, privacy concerns)? |  |
|  | What messages will be shared about the safety and confidentiality of home-based visits? |  |
|  | How will the practice communicate options for meeting locations (e.g., at home or at the practice)? |  |

Summary and decisions

Tasks

1.

2.

3.

### Billing Worksheet

[(return)](#_Task_15._Consider)

**Practice:**

**Date:**

**Participants:**

Use the table below to organize the billing strategies and reimbursement information for CHW services in your practice.

| **Resource** | **Key Information** | **Codes** |
| --- | --- | --- |
| NASHP CHW Policy Website |  |  |
| HCPCS Codes |  |  |
| State Medicaid Website |  |  |
| Other: |  |  |

**Plan Next Steps**

* Who will lead the review of these resources?
* What internal meetings or consultations are required to finalize the billing process?
* Identify key tasks to integrate any new billing codes for CHW services into the practice’s workflows.

### Recommendations to QI Team

[(Return)](#_A._Add_metrics)

**Practice name:**

**Date:**

**Participating:**

To the Quality Improvement (QI) Team/Lead: We recommend adding the following metrics to the practice's QI program and dashboard for monthly monitoring and continuous improvement.

Start Date of CHW Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHW Program Champion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suggested measures**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Will use | Metric Name | Description | Data Source | Target |
|  | *Ex: # patients enrolled for CHW services with a completed SDOH screener in past 12 months* |  | *Social history section of EHR* | *80%* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Summary and decisions:

Task list:

1.

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3.

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