Advancing CHW Engagement in COVID-19 Response Strategies

A Playbook for Local Health Department Strategies in the United States

The National Community-Based Workforce Alliance
September 2020

Executive Summary

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

The following playbook serves to facilitate both the conceptualization and operationalization of CHW engagement. It is intended to be used by LHD decision-makers who may wish to begin or deepen engagement with CHWs in their local COVID-19 response strategy but do not have a clear vision for what that engagement should look like or how to achieve it. **A defining feature of this playbook is the "Framework of Engagement", presented in Part 1.** This framework—built from the updated Community Health Worker Assessment and Improvement Matrix and adapted to the COVID-19 response within the United States—presents a continuum of engagement across several key areas with the goal of designing or improving programs to deliver optimal results. At the most evolved end of this continuum, **"robust engagement" envisions a state in which the organizing structure and scope of work provides CHWs the support they need to be necessary partners in the work of achieving healthy communities.** The construction of this continuum acknowledges that not all LHDs have the same capacity to achieve mature engagement with CHWs, at least not right away. To facilitate the advancement of LHDs along different stages of this continuum, **Part 2 includes a series of strategic recommendations for making discrete improvements across all areas of engagement.**

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

Background: COVID-19 and CHWs

COVID-19 has placed a spotlight on systemic racism and inequalities in US healthcare. Whereas Blacks and Hispanics represent 13% and 18% of the population, respectively, they have constituted 26% and 30% of all US COVID-19 cases.[1] Nationwide, Black people are dying at 2.5 times the rate of white people.[2] Local Health Departments (LHDs) must engage the necessary channels to center and advance racial equity across all facets of their COVID-19 response strategy (CRS).

Many have called for engagement with Community Health Workers to address emergent health inequities during the pandemic.[3,4,5,6] The term "Community Health Worker" (CHW) is an umbrella term for a variety of public health occupations which include, among other titles, promotoras de salud, community health representatives, patient navigators, care coordinators, case managers, outreach workers, direct care workers, and lay health advisors.[7] While CHWs can be found serving in nearly every sector and are representative of a wide variety of linguistic, racial, ethnic, and geographic communities throughout the United States, they are all, in the words of the American Public Health Association, "essential frontline public health workers who are trusted members of and/or have unusually close understandings of the communities they serve."[8] Because CHW identities often reflect the diversity of American communities, they have a deeper comprehension of the difficulties faced when accessing healthcare, and that shared identity helps build trust with community members. CHWs thus serve as necessary links between community members and the LHD or social support system which may have historically struggled to develop trust with the community, rending their services underutilized. While CHWs are not responsible for nor capable of completely repairing systems of mistrust, their engagement is essential throughout the healing process.

Among their many roles and capacities, CHWs ensure that community members receive healthcare information and services in a culturally accessible form.[9] For example, when a CHW was called to speak with primarily immigrant workers in a fruit packing warehouse about the fear of infection spreading within the facility, they were able to train the workers on appropriate mask wearing and physical distancing protocols.[10] They can also help community members navigate services in LHDs and nonprofits to address concerns such as food insecurity, financial challenges, transportation difficulties and emotional trauma that contribute to higher risks of disease and impede recovery. As experts in community health, CHWs are effective and essential healthcare workers in this capacity. An evaluation by the CDC found strong evidence that integrating CHWs as part of multidisciplinary teams "improved health-related outcomes" in people with chronic diseases, and a series of three randomized controlled studies over the past decade found that CHWs improved health and patient-reported quality while reducing hospitalizations by 65%.[11,12]

For the sake of advancing health equity, LHDs must engage CHWs wherever possible throughout their CRS. Activities which involve a direct interface between the LHD and community members are especially in need of engagement. These activities may include but are not limited to contact tracing and healthcare coordination, community-wide testing, vaccine

readiness education, and the navigation of social resources. For example, while contact tracing is functionally performed to track and prevent the spread of disease, the activity is fundamentally about community relationships. When a tracer conducts outreach, they represent the LHD's concern to guard the health of the community. And while the representation of this concern is perhaps most clear in the context of contact tracing, the dynamic would equally apply for LHDs that wish to mount a vaccine readiness campaign or establish community-based testing sites. A key component of any CRS in its own right, CHWs should not be pigeon-holed to any one activity—contact tracing or otherwise. Given the high amount of misinformation about the virus, widespread concerns about data privacy, mistrust of traditional healthcare institutions among communities of color, and concerns among concerns among some communities of potential negative consequences of providing their personal information to outsiders, a trusted messenger who meets people where they are and empowers them to act is essential for the success of all COVID-19 community outreach initiatives.[13,14,15,16,17] For instance, trust becomes even more important when community members are asked to self-quarantine as a consequence of their test status or contact history. Members of vulnerable communities who find it especially difficult to self-isolate—due to limited work from home opportunities, a lack of housing space in which to safely isolate, or difficulties in establishing a secure food supply—will likely need tailored support to follow self-quarantine guidelines. CHWs can advocate for these marginalized community members with employers and landlords, facilitate safe housing options, and locate food assistant resources so that community members can remain safe and do not have to assume unnecessary risk to sustain their livelihoods.[18,19] That same CHW from the fruit packing plant advocated for the employees who did not have paid sick leave and were afraid to violate mandated work hours, which eventually ensured that all workers received a COVID-19 test at the owner's expense.[10] Without serious engagement of CHWs in COVID-19-related community outreach activities, LHDs will likely fail to reduce health inequities because LHD representatives will not be trusted and will be largely unable to provide holistic support.[20] Many localities are failing to properly engage all community members in contact tracing and testing.[21,22] With unique lived experiences, trusting community relationships, and the skill to navigate siloed services and systems of care, CHWs are well equipped to lead all manner of CRS activities.

While several LHDs have already engaged CHWs in their CRS (though often limited to the activity of contact tracing), including several exemplar models,[23] most have not.[24,25,26] Even worse, a national poll by the National Association of Community Health Workers (NACHW) revealed that, instead of mobilizing CHWs, in the first few months of the pandemic employers in many states opted to lay them off.[27] This unfortunate practice confirms the need to further recognize the capacity of CHWs to strengthen public health response and partner with CHWs at a time when community connection and social supports are needed most.[28] As COVID-19 continues to ripple through vulnerable communities across the country, a renewed effort must engage this critical workforce.

However, LHDs should not consider engagement with CHWs—for the sake of CRS-related activities or otherwise—as merely an effective tool or means to an end. LHDs should properly identify CHWs and CHW networks as professionals, partners, and leaders in the work

of community health. These designations reflect the expert perspective CHWs have in engaging community health concerns and the essential skills they contribute to address such concerns. For at least the last several months, most LHDs have failed to recognize the critical and professional status of CHWs, which has undoubtedly weakened the US's early and ongoing response to COVID-19. LHDs must establish systems to ensure that these voices are heard and included in key decision-making processes, now more than ever.

Several publications have been developed which justify or advocate for the engagement of CHWs in national COVID-19 response activities.[20,29] This includes the "Community-Based Workforce Principles for Contact Tracing and Recovery", developed by HealthBegins, which encourages localities to "invest in trusted workers, including CHWs."[30] The "Roadmap to Recovery", developed by the National Governors Association and the Association of State and Territorial Health Officials, also recommends hiring CHWs to assist with contact tracing and connecting people with needed resources.[31] Plans developed by the National Association of County and City Health Officials and the Johns Hopkins Health Security Center also emphasize the role of CHWs.[32,33] In congress, the Health Force and Resilience Force Act of 2020, led by Sens. Kirsten Gillibrand (D-N.Y.) and Michael Bennet (D-Colo.) would allocate billions of dollars annually to fund CHWs as part of a nationally assembled "Health Force."[34] Similarly, Joe Biden's "Build Back Better" plan intends to recruit 150,000 community health workers.[35] Most recently, congressional leaders in both the House and Senate are circulating Dear Colleague letters to endorse a letter written to Health Secretary Alex Azar, encouraging him to adopt the recommendations outlined in the Penn Center for Community Health Workers' COVID response letter to CMS;[36] these recommendations include broader reimbursement for CHW services and opportunities for states to fully leverage those services.

Introduction to the Playbook

Among the several advocacy documents that have been produced, there is limited guidance on how LHDs should operationalize engagement with CHWs. Within the context of any CRS, properly identifying CHWs as professionals, partners, and leaders in the work of community health has important implications across several areas of engagement—everything from training this workforce to properly compensating the work they perform. LHDs may benefit from technical materials to guide effective CHW partnership efforts. To be successful, such materials must be flexible to various resource settings. The capacity for LHDs to engage CHWs varies considerably and need not fit a uniform model, yet certain key features must be included in any robust vision of CHW engagement—a vision in which the organizing structure and scope of work recognizes CHWs as professionals and necessary partners and leaders in the work of community health. There thus exists a continuum of CHW engagement, characterized by the gradual implementation of those features. Establishing a vision for this continuum and the items which populate it is a critical first step toward achieving robust engagement.

This playbook first provides a framework for that continuum, one the draws extensively from the Community Health Worker Assessment and Improvement Matrix (CHW AIM) (Part 1).[37] This matrix, originally created in 2011 and updated in 2018, has achieved tremendous

success assisting local NGOs and national policymakers to assess the functionality of key programmatic components of any CHW-based initiative.[38,39] This playbook utilizes many of the CHW AIM items, but includes several important adaptations have been made to refashion this matrix to the *specific work* of COVID-19 response strategies within the *specific context* of the United States. These adaptations include, among other changes, a rearrangement of the original 10 key programmatic components into 9 key areas of engagement:

1. Role Definition
2. Recruitment
3. Training and Professional Development
4. Safety and Supplies
5. Supervision
6. Compensation
7. Multisector Integration
8. Career Investment
9. Program Evaluation

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

To facilitate the operationalization of items mentioned within the framework, this playbook next identifies realistic policy recommendations to advance LHDs along the continuum (Part 2). For each transition (e.g. from moderate engagement to mature engagement), at least one recommendation is provided across all nine areas of engagement. These recommendations should be considered suggestive but not exhaustive. We have also limited our recommendations to be intended for LHD decision-makers and therefore do not comment on any federal policy which could advance CHW engagement in this work.

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

Part 1:
Framework for Engagement

Part 1: Framework for Engagement				
	→ Increasing Intensity of Engagement →			
Area of engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Mature Engagement**	**Robust Engagement**
Role Definition	• No mention of CHWs within any CRS documentation, or a brief mention of CHWs are provided but without further guidance.	• CHWs are not relied upon to design roles and expectations of CHWs within the contact tracing strategy. • CHWs are mentioned within some feature of the CRS but there is not a clear role for them or acknowledgement of expertise.	• The CHW role is clearly defined and reflects at least half of the recognized roles and competencies of CHWs as outlined by the CHW Core Consensus Project.	• The roles and capacities of CHWs are explicitly recognized by other members of the CRS. • The role of CHWs includes all items from the CHW Core Consensus Project, including those specific to COVID-19. Explicit recognition is given that CHWs can execute all such roles and competencies. • There is an explicit emphasis on a holistic conception of the CHW role, which prioritizes their ability to know their clients as people. • The role of CHWs, as formally articulated, is flexible enough to provide tailored support across a range of services depending on individual client needs, including those which address upstream determinants of health. • The role of CHWs is designed using evidence-based work practices and direct input from participating CHWs.
Recruitment	• Using non-CHWs to fulfill CHW roles or otherwise hiring non-CHWs but classifying them as such.	• External recruiting agencies (if existing) have limited knowledge of CHW-associated qualities to consider.	• Members of the community or experienced CHWs/CHW associations are engaged to assist with the recruitment process. • Recruitment is of authentic CHWs (i.e. from communities disproportionately affected by COVID-19 who have demonstrated trust building traits).	• Recruitment is grassroots and is designed to maximize diverse racial/gender participation, prioritize shared life experience, and to match the diversity of the communities CHWs come from. • Barriers to entry (e.g. requiring more than a high school diploma, disqualifying people who have touched the criminal justice system) are reduced as much as possible. • CHWs themselves are involved in the selections process. • The number of CHWs recruited is done with attention to case-load capacity, which is considered with respect to the CHW role, the geographic reach of the CHW and the complexity of client needs.
Training and Professional Development	• Minimal, one-time online training is provided to CHWs. • Training is not guided by published accounts of CHWs roles and capacities in the United States.	• Initial training is provided to all CHWs (experienced or new) but training is not ongoing throughout the course of the COVID-19 response • Partner organizations/NGOs provide ad hoc workshops on topics that are narrowly epidemiological or biomedical (e.g. the specifics of contact tracing or COVID-19 disease natural history) • Training is provided for free or at a much-reduced cost.	• Training is strongly guided by published accounts of CHW roles and capacities within the United States • Experienced CHWs or CHW associations assist training design. • Ongoing training is provided throughout the duration of their contract • Competencies are tested and CHWs must meet a minimum standard prior to practicing • Training ensures proficiency across at least half of the core competencies as outlined within the CHW Core Consensus Project	• Initial training meets state standards for CHW accreditation if such standards exist. • CHW training includes extensive practicum time • Continuous capacity development is provided by employer to reinforce initial training, teach CHWs new skills that could be used to further their professional growth, and to help ensure quality. • CHWs are actively trained to use any COVID-related technology (e.g. contact tracing mobile applications) • Training establishes proficiency across all 11 core competencies as outlined within the CHW Core Consensus Project and is designed to fit all CHW roles

Part 1: Framework for Engagement *(continued . . .)*				
	→ Increasing Intensity of Engagement →			
Area of engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Mature Engagement**	**Robust Engagement**
Safety and Supplies	• CHWs are expected to provide their own supplies and safety measures including PPE. • No safety standards are established for CHW safety.	• Occasionally CHWs are stocked with the appropriate supplies and PPEs, but this stock often does not last for the duration necessary. • Minimal standards are established to ensure CHW safety	• Most protective equipment is continuously provided to CHWs • CHWs are responsible for self-suppling several other supplies (e.g. telephones, tablet, vehicle to conduct door-to-door visits)	• All necessary supplies and protective equipment are consistently available throughout CHW engagement. • Written procedures/protocols exist to ensure the safety of CHWs when working with patients/clients • Safety/support metrics for self-care and mental health of CHWs (not just physical health with PPE) are included.
Supervision	• CHWs are not supervised by anyone with experience overseeing CHW-led activities or who understands CHW roles and competencies.	• Supervision of CHWs mainly operates to collect data for record keeping (e.g. tracking the number of cases identified through contact tracing). • Supervisors don't have the optimal background (e.g. heavy clinical background, lack of familiarity with community-engaged work).	• Dedicated supervisors conduct regular updates that include reviewing reports and providing problem-solving support to the CHW. • Supervision is conducted with close reference to published accounts of CHW roles and capacities, according to the "Building a Community Health Worker Program Report" (pg. 25).	• Supervisor is dedicated exclusively to CHWs and receives training on effectively supporting CHWs. • Supervisors are experienced CHWs or have a passion for CHW role and understanding of its significance to both CHWs and their patients/clients. • Supervisors have the capacity to both meet regularly with CHWs for one on one reviews of cases *and* convene team meetings which consist solely of CHWs. • Supervisors ensure recognition, collaboration, and support between CHWs and other members of the response effort (i.e. this should be included as part of their job description) • Supervisors have a system for assessing performance and supporting any needed improvement on an ongoing basis. • In addition to CHW supervisor, the LHD recruits a program coordinator who manages infrastructure issues (data and reporting, communication about cases between CHWs and others on a contact tracing team, new information coming about test sites, resources, etc.) • Supervisors receive effective supervision and support from a local/regional director
Compensation	• No financial or non-financial incentives are provided; CHWs are volunteers.	• Limited financial incentives are provided but there is no salary or benefits. • Some non-financial incentives are offered such as training certificates or class credit.	• CHWs are paid at an hourly rate which amounts to a living wage relative to the community they work within. • Payment is ensured for the duration of their time within the CRS. • Compensation is also provided during the training process. • CHWs are offered non-financial incentives such as health-insurance and paid time-off.	• Full-time CHWs are compensated financially at a competitive rate relative to the respective market and salaries are consistently paid on-time. • CHWs are compensated for the entire range of services they provide, not simply those related to contact tracing work. • CHWs are ensured employee benefits and can negotiate benefit contents.

Part 1: Framework for Engagement *(continued . . .)*				
	→ Increasing Intensity of Engagement →			
Area of engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Mature Engagement**	**Robust Engagement**
Multisector Integration	• Additional community institutions are not considered within the CRS. • Any work of CHWs within the CRS is not directly linked to the work of other health professionals.	• Community institutions are weakly involved with the CRS strategy. • The role of the CHW is loosely linked to the work of other health professionals but this linkage is not formally advocated for and managed by supervisors. • CHWs know where referrals should be made but have no formal referral process, logistics, or forms.	• The CRS strategy works to align referrals and CHW activities with existing community institutions and leaders. • CRS organizers uniquely market the role of CHWs and ensure community-wide recognition for their work • CHWs are recognized as a formal part of the health system or local health departments effort to curb COVID-19. • For the work of contact tracing, there is a coordinated process for CHWs to refer contacts to the appropriate health professionals, within the contact tracing team or otherwise. CHWs are constantly updated on the progress of their patients who have been contacted and referred to other members of the contact tracing team. • There is a clear communication strategy between the state or other local health department and CHWs regarding COVID-19 progress. • The CRS works closely with state-wide CHW associations if such associations exist.	• Community members and CHWs play a key role in the design and implementation of the CRS. • The community is clearly made aware of privacy issues around data collection (e.g. during contact tracing and testing) and CHWs are engaged as trusted members of the community to transmit this information. • Support is given on behalf of the CRS to encourage CHWs to engage existing multisectoral community structures (e.g. health committees, community meetings). • Individuals from the formal healthcare system are encouraged to serve as "champions" for the work of CHW during the COVID-19 response. • CHWs create linkages between patients/clients and primary care settings, to address issues with contacts outside of COVID-19. • CHWs are preferentially placed within CBOs or other community health institutions such as FQHCs (as opposed to strictly being placed at the health dept office itself, which can be a barrier to some who may not be able to access health department services or may mistrust the department).

Part 1: Framework for Engagement *(continued . . .)*				
	→ Increasing Intensity of Engagement →			
Area of engagement	**Limited or Harmful Engagement**	**Moderate Engagement**	**Mature Engagement**	**Robust Engagement**
Career Investment	• There is no long-term career vision for the CHW workforce after COVID-19.	• Limited guidance and additional training are given to CHWs to advance similar careers after COVID-19 contracts are over.	• Career guidance is provided to help CHWs secure jobs in related fields after COVID-19. • Guidance is given to facilitate connections with longer-term career opportunities.	• Employment for CHWs is guaranteed after the COVID-19 contract has expired. • Career ladder exists to move CHWs from COVID-specific activities to other tasks for post-COVID employment.
Program Evaluation	• No defined process for documentation or information management is in place to uniquely demonstrate the value of CHWs in the CRS.	• Limited data collection and documentation processes exist to evaluate CHWs, but this data is never shared with CHWs. • Collection, analysis and interpretation of data is not informed by any scientific principles • Nothing about the evaluation plan is conducted in partnership with CHWs.	• Strong efforts are established at the beginning of the CRS to collect data on CHW-specific activities for the sake of demonstrating value, as suggested by the "Building a Community Health Worker Program Report." • Data collection is strongly informed by published CHW assessment guides and with the assistance of experienced CHWs or CHW associations. • CHWs are involved in a limited number of phases of the evaluation. • Community-engaged scientists are informally consulted to assist with the evaluation.	• Patients/clients, community-engaged scientists, and CHWs are involved in all phases of the evaluation of the CRS, including design, data collection, analysis and interpretation. • Evaluation findings are honored in adaptations of CHW employment. • Program evaluation is scientifically designed and reports are prepared for the express purpose of informing future CHW-related policies and funding streams (such as future Medicaid managed care contracts or for State Plan Amendments).

Part 2:

Strategic Recommendations for Advancement

Part 2: Strategic Recommendations for Advancement			
Area of engagement	**Limited or Harmful → Moderate Engagement**	**Moderate → Mature Engagement**	**Mature → Robust Engagement**
Role Definition	• Consider how CHWs have been engaged in other programs within the health department, neighboring health departments, or local health systems.	• Consult items from the CHW Core Consensus Project.	• Require that all CHW hiring decisions be made only after approval by peer CHWs or organizations that work in that community or neighboring ones, for purposes of ensuring that the diversity of hired CHWs reflects the diversity of the communities they are serving. • Make clear to all members within the CRS that CHWs are expected to execute any and all roles and competencies identified by the CHW Core Consensus Project. We also recommend LHDs to consult this resource put out by ASTHO on CHW Training and Core Competencies across different states. • Provide scripts, interview guides, and a documentation platform that support CHWs in getting to know and supporting their patients in a holistic way.
Recruitment	• Include recruitment of CHWs as a component of the CRS staffing plan.	• Contract with CHW associations and community leaders to advertise and host community meetings in order to identify individuals from communities and encourage them to apply for the position (especially communities disproportionately affected by COVID-19).	• We recommend LHDs refer to the Contact Tracing Workforce Estimator, developed by The Fitzhugh Mullan Institute for Health Workforce Equity in partnership with ASTHO and NACCHO, to estimate the amount of CHWs potentially needed. • Ensuring hiring rubrics prioritize qualities essential for the role (e.g. trust-building traits, empathy, problem-solving skills, knowledge of local community.
Training and Professional Development	• Require all CHWs to participate in a training course and allow opportunities for continuous learning.	• Contract with experienced CHW training programs to train and test CHWs on their knowledge and competencies before their participation within the CRS.	• LHDs should work with CHWs, CHW associations, and if possible local community colleges with a history of providing CHW training to identify training curricula that meets any existing standards for CHW accreditation and includes an extensive practicum component of the curriculum. • Continue to provide supplemental trainings for hired CHWs to learn new skills, including the use of new technology (e.g. mobile applications for contact tracing, technology for vaccine distribution)
Safety and Supplies	• Consult safety guidelines such as those developed by OSHA or IDSA to develop basic criteria for workplace safety among CHWs.	• Establish contracts with local medical equipment supply centers to develop a consistent supply line for PPE materials such as hand sanitizer, medical masks and/or face masks, and non-sterile gloves, and continue to provide supplies throughout all CRS efforts • Regularly check-in with CHWs to ensure that *all* supplies have been received and develop a well-monitored complaint line for CHWs to express concerns about the PPE they've received or the lack thereof.	• Collect data and develop strategies to optimize the use of PPE (as suggested by the CDC) so as to ensure no CHW is left unprotected. • Regularly consult with CHWs to assess equipment and supplies needed to perform their roles. • Provide support for CHWs to practice self-care and receive free or low-cost mental health services

Part 2: Strategic Recommendations for Advancement *(continued . . .)*			
Area of engagement	**Limited or Harmful → Moderate Engagement**	**Moderate → Mature Engagement**	**Mature → Robust Engagement**
Supervision	• Require CHWs to use data management and reporting systems to record their CRS activities and have other members of the CRS team verify those reports.	• As part of the staffing plan, recruit dedicated supervisors for the CRS who are familiar with CHWs' core roles competencies and can provide problem-solving support accordingly	• Screen and select supervisors using criteria that include: strong understanding of CHW role and their importance in communities, familiarity with the communities CHWs will be working in, and understanding of the lived experience of lower-income individuals and people of color (e.g. licensed clinical social workers) • Require supervisors to ensure recognition, collaboration, and support between CHWs and other members of the CRS (i.e. this should be included as part of their job description) • Develop digital data systems to track ongoing evaluation metrics and present these metrics in easy displays for supervisors to refer to
Compensation	• Use funding dedicated to contact tracing to make financial and non-financial incentives available to CHWs who participate in contact tracing. • Use funding dedicated to the CRS to cover the costs associated with training programs such that CHWs do not incur any costs due training.	• When developing a budget for the CRS, LHDs should allocate sufficient funding to compensate CHWs with a living wage, as can be estimated using the MIT Living Wage Calculator, and full benefits for the duration of their time within the CRS.	• Take advantage of a variety of funding sources (such as those available through the CDC as well as Medicaid and HRSA) to ensure that CHWs are compensated as full-time, salaried employees for their full scope of work that includes both contact tracing and support services. Contracts with CHWs should allow for negotiation of benefits and collective bargaining. • We encourage LHDs to consider resources put out by ASTHO on sustainably financing CHWs. • Advocate for sustainable financing of CHWs.
Multisector Integration	• Develop a detailed information guide for CHWs to consult when making referrals, whether to social support services or other members of the local health system (e.g. primary care doctors).	• Develop a guide which outlines the flow of communication among CHWs and other members of the CRS team and/or local health system. • Establish regular check-in periods for CHWs to be updated on both the status of CRS efforts in the state and the status of individual contacts that they have referred outside the CRS (perhaps by giving CHWs access to local electronic medical record systems).	• Work with CHWs to identify community institutions which should be involved in the CRS and develop formal means of communication between members of the CRS and these institutions. • Develop personal contacts between CHWs and individual members of local health system (e.g. primary care doctors) to build trust and acknowledgement of CHW-related work during the COVID-19 response. • For CHWs that work directly within a clinical system, we recommend LHDs to consider the multiple strategies for clinical integration that the Penn Center for CHW IMPaCT model advances.

Part 2: Strategic Recommendations for Advancement *(continued . . .)*			
Area of engagement	**Limited or Harmful → Moderate Engagement**	**Moderate → Mature Engagement**	**Mature → Robust Engagement**
Career Investment	• Work with local hiring agencies to identify career opportunities that CHWs could transition to and ensure that CHWs receive training to develop the skills needed for those opportunities.	• Establish a career guidance officer or workforce development board within the CRS initiative that personally works with CHWs to identify and attain employment opportunities after COVID-19 (e.g. through resume assistance, interview coaching, accessing interview clothing if needed, etc.).	• Include within CHW contracts that employment will be guaranteed once COVID-19 activities are over. • Develop a pipeline for CHWs to have careers in the health and social services sectors. • Identify CBOs, community health centers or hospitals that would be willing to employ CHWs after COVID-19 activities are over. • Use a data system that supports – not subverts – CHW work.
Program Evaluation	• Conduct a scoping review of the literature on CHW evaluations • Ensure that CHWs are being evaluated as a distinct member of the contact tracing strategy	• Consult the literature on "community based participatory research" (CBPR) to consider aspects of the evaluation which may feasibly be conducted through a CBPR lens. • To develop an evaluation guide for CHWs, refer to or borrow from well-tested evaluation frameworks such as the National Community Health Advisor Study (NCHAS), the University of Arizona CHW Evaluation Toolkit, or the Sinai Institute's report on "Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings." • LHDs are strongly encouraged to consider evaluation criteria identified by the Common Indicators Project or outcomes included in several CHW evaluation studies conducted by the Penn Center for CHWs.	• Develop an evaluation committee which consists of community-engaged scientists, CHWs, as well as other members from the community. • Hire an experienced third-party organization with experience in community-engaged research to lead a rigorous evaluation of CHW engagement in the CRS. • Speak with community members, funders, and local lawmakers to understand what matters most to individuals/communities and are most important for advancing the recognition of CHW activities within state policy. Work backward from these conversations to inform the components of an evaluation guide.

Looking Ahead

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

To the extent this vision is satisfied, the damages incurred throughout the pandemic—especially among historically marginalized communities—will be minimized and those communities will be more capable of building back to a healthier future. Yet the capacity needed to sustain this vision depends upon an entirely new focus for the public health workforce. CHWs will not have the training, supplies, and funding to sustain this work without the necessary institutions that prioritize their role within the post-COVID-19 public health infrastructure. Happily, the items which characterize "robust engagement" are also the items which best facilitate the construction of this infrastructure. When CHWs are finally recognized as essential, professional, and autonomous partners with LHDs, they will more likely have the capacity to secure sustainable financing, train new generations of CHWs, and serve as community health advocates for all manner of community health needs which have accumulated as COVID-19 has dominated our attention.[40] LHDs that robustly engage CHWs must be the future of public health. COVID-19 has taught us this.

The National Community-Based Workforce Alliance

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

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Alliance member organizations

References

[1] "Racial and Ethnic Breakdown of COVID-19 Cases/Deaths and Gaps in Data Reporting," June 8, 2020. https://www.ama-assn.org/system/files/2020-06/covid-health-equity-data.pdf.
[2] "The COVID Racial Data Tracker." COVID Tracking Project. The Atlantic Monthly Group. Accessed July 22, 2020. https://covidtracking.com/race.
[3] "Three Workforce Strategies To Help COVID Affected Communities, " Health Affairs Blog, May 9, 2020.DOI: 10.1377/hblog20200507.525599
[4] Kangovi, Shreya. "Want to Help Battle COVID-19? Bring in More Community Health Workers." AAMC. June 9, 2020. https://www.aamc.org/news-insights/want-help-battle-covid-19-bring-more-community-health-workers.
[5] "To Strengthen The Public Health Response To COVID-19, We Need Community Health Workers, " Health Affairs Blog, May 6, 2020.
DOI: 10.1377/hblog20200504.336184
[6] Perakslis, Eric D. "Community Health Workers Can Help Fight Covid-19 in the U.S." StatNews, March 31, 2020. https://www.statnews.com/2020/03/31/community-health-workers-fight-covid-19-united-states/.
[7] "CDC - Community Health Worker Resources - STLT Gateway." CDC. August 18, 2016. https://www.cdc.gov/publichealthgateway/chw/index.html.
[8] "Community Health Workers." APHA. Accessed July 22, 2020. https://www.apha.org/apha-communities/member-sections/community-health-workers.
[9] "C3 Project Findings: Roles & Competencies." Home | CHW Core Consensus Project. The Community Health Worker Core Consensus Project, 2018. https://www.c3project.org/roles-competencies.
[10] Campos-Dominquez, T., and Rumala, B.B. (2020). Case Study - Role of Community Health Workers in addressing inequities and systems transformation during COVID-19 and beyond: An opportunity for health department and organizational practices. Community Health Workers and COVID-19 Writing Group.
[11] "Policy Evidence Assessment Report: Community Health Worker Policy Components." CDC Division for Heart Disease and Stroke Prevention, 2014.
[12] Vasan, A., Morgan, J. W., Mitra, N., Xu, C., Long, J. A., Asch, D. A., & Kangovi, S. Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: A pooled analysis of three clinical trials. *Health Services Research*.
[13] Kreps, Sarah, Baobao Zhang, and Nina McMurry. "Contact-Tracing Apps Face Serious Adoption Obstacles." Brookings. Brookings, May 20, 2020. https://www.brookings.edu/techstream/contact-tracing-apps-face-serious-adoption-obstacles/.
[14] Toh, Amos. "How Digital Contact Tracing for COVID-19 Could Worsen Inequality." Human Rights Watch, June 4, 2020. https://www.hrw.org/news/2020/06/04/how-digital-contact-tracing-covid-19-could-worsen-inequality.
[15] Brown, Shoshanah, and Rose Gasner. "Community Testing and Contact Tracing in a Time of Distrust." United Hospital Fund, June 5, 2020. https://uhfnyc.org/news/article/community-testing-and-contact-tracing-time-distrust/.
[16] "Integrating Community Health Workers Into Health Care Teams Without Coopting Them, " Health Affairs Blog, May 10, 2019.
DOI: 10.1377/hblog20190507.746358
[17] Shapiro, A., & Pao, M. (2020, August 10). California And Texas Health Officials: Mistrust A Major Hurdle For Contact Tracers. *National Public Radio*. Retrieved from https://www.npr.org/sections/coronavirus-live-updates/2020/08/10/901064505/california-and-texas-health-officials-on-challenges-they-face-in-contact-tracing
[18]Zarefsky, Marc. "Why African American Communities Are Being Hit Hard by COVID-19." American Medical Association, May 13, 2020. https://www.ama-assn.org/delivering-care/population-care/why-african-american-communities-are-being-hit-hard-covid-19.
[19] Abbasi J. Taking a Closer Look at COVID-19, Health Inequities, and Racism. JAMA. Published online June 29, 2020. doi:10.1001/jama.2020.11672
[20] Kangovi, Shreya. "Why States May Fall Short on Contact Tracing." Institute for Healthcare Improvement, May 20, 2020. http://www.ihi.org/communities/blogs/why-states-may-fall-short-on-contact-tracing.
[21] Goodnough, A., & Steinhauer, J. (2020, July 31). Contact Tracing Is Failing in Many States. Here's Why. *New York Times*. Retrieved from https://www.nytimes.com/2020/07/31/health/covid-contact-tracing-tests.html

[22] Datta, A. (2020, August 17). Digital contact tracing: Why Americans have a problem with it. *Geospatial World*. Retrieved from https://www.geospatialworld.net/blogs/digital-contact-tracing-why-americans-have-a-problem-with-it/

[23] On August 12th the National CBW Alliance hosted a webinar on "Bright spotting/ Contact Tracing & Community Health Response." Details about the webinar, including the recording and media resources, can be found at the following google drive: https://drive.google.com/drive/folders/1JlqZWzf3V3PkoQvFU0a5rwKsj80VbRp6

[24] Ruff, Emmett, and Kelly Murphy. "Community Health Workers are Essential to States' COVID-19 Contact Tracing Efforts." FamiliesUSA, June 17, 2020.

[25] Higgins, Elinor. "States Engage Community Health Workers to Combat COVID-19 and Health Inequities." The National Academy for State Health Policy, June 22, 2020. https://www.nashp.org/states-engage-community-health-workers-to-combat-covid-19-and-health-inequities/.

[26] "Community Health Workers in US Contact Tracing Efforts: Current Usage and Dimensions of Involvement. " The Community Health Acceleration Partnership. June 22, 2020.

[27] "To Strengthen The Public Health Response To COVID-19, We Need Community Health Workers, " Health Affairs Blog, May 6, 2020.
DOI: 10.1377/hblog20200504.336184

[28] COMMUNITY HEALTH WORKERS STRENGTHEN COVID-19 RESPONSE (n.d.). In *nachw.org*. Retrieved from https://nachw.org/wp-content/uploads/2020/07/CHWS-STRENGTHEN-COVID-19-RESPONSE-1-PAGER.pdf

[29] Kangovi, S., & Blackstock, U. (2020, July 3). Community health workers are essential in this crisis. We need more of them. *The Washington Post*. Retrieved from https://www.washingtonpost.com/opinions/2020/07/03/community-health-workers-are-essential-this-crisis-we-need-more-them/

[30] Community-Based Workforce Principles for Pandemic Response and Resilience (2020). In *healthbegins.org*. Retrieved from https://healthbegins.org/community-based-workforce-principles/

[31] Roadmap to Recovery: A Public Health Guide for Governors (2020, April 21). In *www.nga.org*. Retrieved from https://www.nga.org/wp-content/uploads/2020/04/NGA-Report.pdf

[32] Building COVID-19 Contact Tracing Capacity in Health Departments to Support Reopening American Society Safely (2020, April 16). In *www.naccho.org*. Retrieved from https://www.naccho.org/uploads/full-width-images/Contact-Tracing-Statement-4-16-2020.pdf

[33] A National Plan to Enable Comprehensive COVID-19 Case Finding and Contact Tracing in the US (n.d.). In *www.centerforhealthsecurity.org*. Retrieved from https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/200410-national-plan-to-contact-tracing.pdf

[34] https://www.congress.gov/bill/116th-congress/senate-bill/3606/text

[35] https://joebiden.com/build-back-better/#

[36] https://chw.upenn.edu/2020/04/17/callstoaction/

[37] Ballard, M., M. Bonds, and J. Burey. "Community Health Worker Assessment and Improvement Matrix (CHW AIM): Updated Program Functionality Matrix for Optimizing Community Health Programs." Community Health Impact Coalition (2018). Available from : https://static1.squarespace.com/static/5a0507ca6f4ca346d3a11552/t/5c10f3f24d7a9cec045e0284/1544614899673/CHW+AIM+Updated+Program+Functionality+Matrix_Dec-2018.pdf

[38] Ballard, M., & Furth, R. (n.d.). Assessing CHW Program Functionality with the Community Health Worker Assessment and Improvement Matrix (CHW AIM). In *chwcentral.org*. Retrieved from https://chwcentral.org/assessing-chw-program-functionality-with-the-community-health-worker-assessment-and-improvement-matrix-chw-aim/

[39] Schechter, J. (2020, January 28). Evaluate to Innovate: Use of the Community Health Worker AIM Tool in Northern Togo and the Bronx, USA. *Medium*. Retrieved from https://medium.com/@IntegrateHealth/evaluate-to-innovate-use-of-the-community-health-worker-aim-tool-in-northern-togo-and-the-bronx-54bd90544274

[40] Opinion: Weak health systems kill — here's how we can stop that from happening (2020). Available from: https://www.devex.com/news/opinion-weak-health-systems-kill-here-s-how-we-can-stop-that-from-happening-97410