

The Community Health Worker Core Consensus (C3) Project

A Report of the C3 Project: Phase 1 and 2

Together Leaning Toward the Sky



**The Community
Health Worker
Core Consensus
Project**
TTUHSC EL PASO

**A National Project to Inform
Community Health Worker Practice and Policy**

Coordinated by Texas Tech University Health Sciences Center El Paso

December, 2018

The Community Health Worker Core Consensus Project's (C3 Project) primary aims are to expand cohesion in the field and to contribute to the visibility and greater understanding of the full potential of Community Health Workers (CHWs) to improve health, community development, and access to systems of care.



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Dear Reader,

This report offers a review of findings from the Community Health Worker Core Consensus (C3) Project for work carried out from 2014-2018 in two phases. To see other C3 Project resources, visit C3project.org.

The C3 Project's reports and graphics are intended to support Community Health Workers (CHWs) and other stakeholders working to foster the growth and development of CHW practice and related policies, ultimately increasing the capacity of CHWs to promote health equity and access to systems of care.

A primary product of the C3 Project is the contemporary set of comprehensive CHW roles, skills, and qualities that were vetted and refined by CHW networks throughout the country before their release in 2016. They are shared again here in full, in a checklist format, to promote their ongoing use. We invite your ongoing review of these lists as we are cataloguing feedback for the next cycle of review. Please send comments and feedback to info@C3project.org.

This report also features work conducted by the C3 Project team since the release of those lists. Specifically, it shares highlights related to the examination of best practices for the assessment of CHW skills. See the C3 Project Assessment Toolkit that grew out of this research. The toolkit includes self-assessment and 360-degree full perspective assessment tools. The toolkit can be found on the website noted above.

This report also includes findings from an analysis of the impact of setting on CHW roles and competencies. As an outcome of this review, we offer several visual frameworks shared in the report. Also see a C3 Project CHW infographic integrating elements of the settings frameworks. The infographic is available for download on the website.

Finally, in this report we also feature highlights on the use of C3 Project findings based on outreach efforts to promote endorsement of the identified roles and competencies. That effort is ongoing. We would love to hear about how you have used these lists. Please send news of their use to our attention at the email noted above.

On a personal note, I want to thank the C3 team member collaborators for their on-going participation in the project, some through many phases of this work. Each of you has brought a unique knowledge and contribution to our efforts and to the CHW field overall. Please see their names in the Acknowledgments at the back of this report. A special thanks to our C3 Project current chairs – las hermanas Floribella Redondo and Gail Hirsch. Please see their report introductory letters following this letter.

As a long-awaited national CHW association emerges at the national level to provide independent leadership and an advocacy voice for CHWs and for those they serve, we offer these C3 Project resources. It is our hope that this report and our other C3 Project tools help to support the full integration of CHWs wherever they serve and support the work of the new association. Our aim is to help CHWs realize their full scope of practice and competencies to move us forward to greater health equity and access to care for all.

**Best,
Lee Rosenthal**

E. Lee Rosenthal, PhD, MS, MPH

The Community Health Worker Project Core Consensus (C3) Project Principal Investigator/Director
Texas Tech University Health Sciences Center El Paso

December 15, 2018

C3 Project Advisory Chairs' Letters to Readers

Introduction to the C3 Project's "Together Leaning Toward the Sky" Report

Dear Readers,

As a Community Health Worker (CHW), I feel confident that the Community Health Worker Core Consensus (C3) Project findings provide an opportunity for our workforce to be more fully understood as a professional workforce. Prior to this endeavor, we have been working in communities without defining our roles. We were trying to tell the story of what we do individually, not cohesively as a profession.

Because of the efforts of the C3 Project, we now are equipped with tools that define and share our CHW roles and core competencies. We have access to a consensus-driven reference sharing our unique roles, skills and qualities that are required for success. I am thankful to the C3 Project team for providing us this platform and formalizing the important work we do each day to advance the health of our communities. We have much more to accomplish, but together, our profession will grow stronger.

Sincerely,

Floribella Redondo

Co-Chair, C3 Project Advisory Group

Dear Readers,

As individual states, including my home state of Massachusetts, explore and pursue initiatives to strengthen and sustain the Community Health Worker (CHW) workforce, the significance of the Community Health Worker Core Consensus (C3) Project's work cannot be underestimated. The C3 Project's findings and recommendations, which define a common set of core roles and competencies for CHWs, were developed from a careful national study informed by CHW networks. This latest report from the C3 Project is rooted in the first significant national study of the CHW workforce – the National Community Health Advisor Study (NCHAS) – 20 years ago. The C3 Project sought to build consensus among CHWs, and diligently engaged CHWs from across the country in both leading the project and providing essential feedback every step of the way. I am grateful for this work and confident that the C3 Project findings and recommendations will serve as a touchstone for the field for years to come.

Thank you,

Gail Hirsch

Co-Chair, C3 Project Advisory Group

Executive Summary

The Community Health Worker Core Consensus Project's (C3 Project) primary **aims are to expand cohesion in the field and to contribute to the visibility and greater understanding of the full potential of Community Health Workers (CHWs)** to improve health, community development, and access to systems of care.

Importantly, the C3 Project **offers a single set of CHW roles and competencies** for reference by those both inside and outside the field as they work to build greater support for and sustainability among CHWs in all settings. Central to the C3 Project's work was the analysis of previously accepted CHW roles and competencies from the National Community Health Advisor Study^{1,2} compared to current benchmark documents. This crosswalk led to the development of a contemporary list of recommended roles and competencies. (The term "competencies" is used here to include skills and qualities.) Notably, the C3 Project team decided not to propose new qualities, instead choosing to endorse existing research on qualities.^{3,4} From that research, clearly the "connection to the community served" emerged as the most critical quality. Given well established qualities, the C3 Project's work focused on identification of contemporary roles and skills. Following the development of the lists of recommended roles and skills, the C3 Project team actively solicited feedback from CHW associations and networks across the country. **After incorporating input from a majority of existing CHW networks**, the C3 Project team disseminated a **recommended list of 10 roles and 11 skills** and as noted above, **endorsed existing knowledge about qualities**. *For the roles and competencies, see Tables 1 and 2. For details on methods, see the 2016 Phase 1 report, [Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field](#).⁵*

After releasing the roles and competency recommendations in 2016, the C3 Project team proceeded to explore best practices related to the assessment of CHW skills and to examine the potential impact of CHWs' service setting on CHW roles and skills. The team also conducted stakeholder outreach to expand understanding and adoption of C3 Project recommended CHW roles and competencies. This led to the **development of an assessment toolkit** designed to share field-driven, evidence-based recommendations, tools, and resources for supporting a comprehensive assessment of CHWs' work.

Additionally, findings on the impact of setting on CHW work revealed a preferred reliance on the **same core roles and competencies, regardless of work setting**, suggesting the importance of endorsing common core roles and competencies for CHW in all settings. Findings also indicated the need for CHWs to identify areas of additional training needed for specific settings. Frameworks developed by CHWs and stakeholders depicted these findings and help communicate the common core roles and competencies of CHWs in all settings.

During this later work on assessment and settings, the C3 Project team succeeded in expanding the endorsement, support, and utilization of the C3 Project recommendations with affirmations from more than **15 national public health organizations** (see Table 3) and professional associations, and acknowledgment and use by at least **20 state policy initiatives**. Throughout, the C3 Project has sought to build consensus to better support the full scope of CHW practice and CHW capacity to serve individuals and communities.

American Public Health Association Definition of CHW:

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Introduction

The Mission of the Community Health Worker Core Consensus Project

The Community Health Worker Core Consensus Project (C3 Project) aimed to expand cohesion among Community Health Workers (CHWs) and other stakeholders in the field and contribute to the visibility and understanding of the CHW profession. To accomplish this mission, C3 Project team members sought to engage CHWs at every step so that their voice served as a key source, setting the tone and direction of the C3 Project through CHW leaders' critique and appraisal of C3 Project findings and direction of their use.

The C3 Project focused on four areas/outcomes from 2014-2018:

- 1) Producing a contemporary list of recommended CHW roles and competencies, including skills and qualities, that form the full scope of CHW practice (see *Figure 1*)
- 2) Building consensus among CHWs and allies for use of recommended roles and competencies
- 3) Identifying tools and methods for best assessing and supporting CHW skills
- 4) Exploring the impact of clinical and community settings on CHW roles and competencies

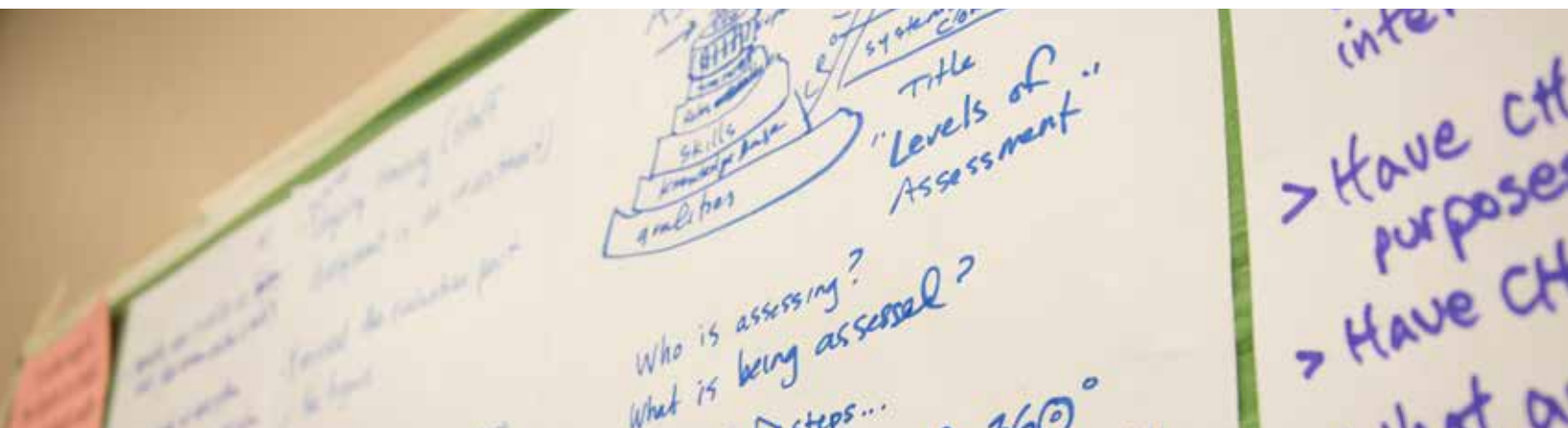
The Origins of the C3 Project: National Community Health Advisor Study

Many members of the C3 Project team led and participated in a previous study, The National Community Health Advisor Study⁶, funded by the Annie E. Casey Foundation. That study had four major components, including one revisited by the C3 Project: the development of proposed CHW core roles and competencies. All four NCHAS components shared common data sources (a non-random sample national workforce survey, a series of focus groups and discussion forums from across the U.S.), and all components were guided by a majority-CHW advisory council.

CHW Leadership: C3 Project Team Initiative and CHW Engagement

Nearly two decades later, the C3 Project team identified a need to revisit findings and recommendations made in the NCHAS. Recognizing that even 20 years later, no single leadership organization represented the CHW field; the C3 Project team worked to ensure CHW engagement and leadership in multiple ways. This aligned with the self-determination resolution put forward by the American Public Health Association in 2014⁷ (<https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/15/13/24/recognition-and-support-community-health-workers-contrib-to-meeting-our-nations-health-care-needs>). As with the NCHAS, the team used a community-based participatory research approach, which involved CHWs and other CHW field stakeholders in the leadership of all aspects of the C3 Project.⁸

The C3 Project consisted of several components carried out over two phases. Throughout the two phases, the team employed various strategies to integrate the CHW guidance we prioritized, including leadership provided by CHW fellows, CHW consultant/staff members, and several majority-CHW advisory groups for



various project components. Senior advising partners, including CHWs and others working to organize the field at the state and national levels, helped refine the presentation of findings in the form of a toolkit and frameworks and contributed to the exploration of options for dissemination. CHWs and other stakeholders assisted in the development of research strategies, aided in data interpretation, and guided the formation of recommendations. This leadership and these activities align with community-based participatory research principles and practices where stakeholders serve as partners in the development, conduct and dissemination of research.

Overview of Phases 1 and 2

The C3 Project, 2014-2018, investigated several topics. A primary goal focused on the development of a comprehensive list of contemporary CHW roles and competencies. Following that work, the C3 Project team examined approaches to assessing skills and explored the impact of work setting on CHW roles and skills.

The C3 Project sought to answer the following questions:

- 1) Roles and competency changes: How have CHW roles, skills, and qualities changed over time in the U.S., particularly since the release of the NCHAS in 1998?
- 2) Today's roles: What contemporary roles (scope of practice) best capture the work of CHWs today in any setting?
- 3) Today's competencies: What skills and qualities (collectively, competencies) do CHWs need to fulfill these roles? Note: A decision to look only at skills was made early in the C3 Project; though endorsement of *CHW qualities was emphasized.
- 4) Outreach and messaging: Who should be part of the review and refinement of these findings and who can help with the continued national and regional consensus-building? What key messages help elicit feedback and endorsement? What groups will already endorse current roles and competencies guidelines put forward by the C3 Project?
- 5) Assessment strategies: What are the best methods to assess proficiency in the newly affirmed 10 skill areas for a 360-degree review of performance by and for CHWs?
- 6) Settings impact: What is revealed when exploring the impact of a CHW's work setting on their roles and needed skills, emphasizing distinctions between CHWs serving in clinical and community settings?
- 7) CHW engagement: How do we authentically engage CHWs in this work now and in the future to ensure that they inform our findings and our recommendations for their use at every step?



Figure 1:
The CHW's Roles and Competencies Support Pyramid

**CHW Qualities: The C3 Project did not review CHW qualities. Knowing this could impact interpretations on the importance of qualities, the team agreed that whenever promoting new roles and skills, the C3 Project should also always include discussion of the central importance of qualities. Qualities, such as connection to the community served, help to facilitate the trust and relationships CHWs need to be effective in their work with the individuals, families, and communities they serve. This aspect of CHWs has long been valued and stands the test of time.*

Use the following checklists to assess how CHW role and skills linked to CHW trainings, practice, and/or policies align with the Community Health Worker Core Consensus Project.

ROLES

Table 1: COMMUNITY HEALTH WORKER ROLES/SCOPE OF PRACTICE	
<input type="checkbox"/> Checklist for personal, programmatic, and policy review	Community Health Worker Core Consensus Project Roles/Scope of Practice
<p>Role: Functions that CHWs serve in communities and the health care system. For example, CHWs provide health education.</p> <p>Scope of Practice: An all-inclusive list of roles and tasks which an occupation includes in its scope of work. The exact mix of these roles and tasks for any one individual will vary based on the needs of those served and host organizations.</p>	
ROLE	SUB-ROLES
<input type="checkbox"/> 1. Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems	<ul style="list-style-type: none"> a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate) b. Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication
<input type="checkbox"/> 2. Providing Culturally Appropriate Health Education and Information	<ul style="list-style-type: none"> a. Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)
<input type="checkbox"/> 3. Care Coordination, Case Management, and System Navigation	<ul style="list-style-type: none"> a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping address barriers to services d. Documenting and tracking individual and population level data e. Informing people and systems about community assets and challenges
<input type="checkbox"/> 4. Providing Coaching and Social Support	<ul style="list-style-type: none"> a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (including chronic disease) d. Planning and/or leading support groups
<input type="checkbox"/> 5. Advocating for Individuals and Communities	<ul style="list-style-type: none"> a. Advocating for the needs and perspectives of communities b. Connecting to resources and advocating for basic needs (e.g. food and housing) c. Conducting policy advocacy
<input type="checkbox"/> 6. Building Individual and Community Capacity	<ul style="list-style-type: none"> a. Building individual capacity b. Building community capacity c. Training and building individual capacity with peers and among CHW groups

<input type="checkbox"/> 7. Providing Direct Service	<ul style="list-style-type: none"> a. Providing basic screening tests (e.g. height, weight, blood pressure) b. Providing basic services (e.g. first aid, diabetic foot checks) c. Meeting basic needs (e.g., direct provision of food and other resources)
<input type="checkbox"/> 8. Implementing Individual and Community Assessments*	<ul style="list-style-type: none"> a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environmental assessment) b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)
<input type="checkbox"/> 9. Conducting Outreach*	<ul style="list-style-type: none"> a. Case-finding/recruitment of individuals, families, and community groups to services and systems b. Follow-up on health and social service encounters with individuals, families, and community groups c. Home visiting to provide education, assessment, and social support d. Presenting at local agencies and community events
<input type="checkbox"/> 10. Participating in Evaluation and Research*	<ul style="list-style-type: none"> a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community consent processes c. Participating in evaluation and research: <ul style="list-style-type: none"> i) Identification of priority issues and evaluation/research questions ii) Development of evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings

***Asterisks denote new roles from 1998-2016; several sub-roles have been expanded**

C3 Project, 2018 | www.C3Project.org

Table 2: COMMUNITY HEALTH WORKER COMPETENCIES: SKILLS

<input type="checkbox"/> Checklist for personal, programmatic, and policy review	Community Health Worker Core Consensus Project Skills
<p>Skill: The ability, coming from one’s knowledge, practice, and aptitude, to do something well. A core role or a task that must be performed may be supported by multiple skills.</p>	
SKILLS	SUB-SKILL/DESCRIPTION
<input type="checkbox"/> 1. Communication Skills	a. Ability to use language confidently b. Ability to use language in ways that engage and motivate c. Ability to communicate using plain and clear language d. Ability to communicate with empathy e. Ability to listen actively f. Ability to prepare written communication including electronic communication (e.g., email, telecommunication device for the deaf) g. Ability to document work h. Ability to communicate with the community served (may not be fluent in language of all communities served)
<input type="checkbox"/> 2. Interpersonal and Relationship-Building Skills	a. Ability to provide coaching and social support b. Ability to conduct self-management coaching c. Ability to use interviewing techniques (e.g. motivational interviewing) d. Ability to work as a team member e. Ability to manage conflict f. Ability to practice cultural humility
<input type="checkbox"/> 3. Service Coordination and Navigation Skills	a. Ability to coordinate care (including identifying and accessing resources and overcoming barriers) b. Ability to make appropriate referrals c. Ability to facilitate development of an individual and/or group action plan and goal attainment d. Ability to coordinate CHW activities with clinical and other community services e. Ability to follow-up and track care and referral outcomes
<input type="checkbox"/> 4. Capacity Building Skills	a. Ability to help others identify goals and develop to their fullest potential b. Ability to work in ways that increase individual and community empowerment c. Ability to network, build community connections, and build coalitions d. Ability to teach self-advocacy skills e. Ability to conduct community organizing
<input type="checkbox"/> 5. Advocacy Skills	a. Ability to contribute to policy development b. Ability to advocate for policy change c. Ability to speak up for individuals and communities

<input type="checkbox"/> 6. Education and Facilitation Skills	<ul style="list-style-type: none"> a. Ability to use empowering and learner-centered teaching strategies b. Ability to use a range of appropriate and effective educational techniques c. Ability to facilitate group discussions and decision-making d. Ability to plan and conduct classes and presentations for a variety of groups e. Ability to seek out appropriate information and respond to questions about pertinent topics f. Ability to find and share requested information g. Ability to collaborate with other educators h. Ability to collect and use information from and with community members
<input type="checkbox"/> 7. Individual and Community Assessment Skills*	<ul style="list-style-type: none"> a. Ability to participate in individual assessment through observation and active inquiry b. Ability to participate in community assessment through observation and active inquiry
<input type="checkbox"/> 8. Outreach Skills*	<ul style="list-style-type: none"> a. Ability to conduct case-finding, recruitment and follow-up b. Ability to prepare and disseminate materials c. Ability to build and maintain a current resource inventory
<input type="checkbox"/> 9. Professional Skills and Conduct	<ul style="list-style-type: none"> a. Ability to set goals and to develop and follow a work plan b. Ability to balance priorities and to manage time c. Ability to apply critical thinking techniques and problem solving d. Ability to use pertinent technology e. Ability to pursue continuing education and life-long learning opportunities f. Ability to maximize personal safety while working in community and/or clinical settings g. Ability to observe ethical and legal standards (e.g. CHW Code of Ethics, Americans with Disabilities Act [ADA], Health Insurance Portability and Accountability Act [HIPAA]) h. Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements i. Ability to participate in professional development of peer CHWs and in networking among CHW groups j. Ability to set boundaries and practice self-care
<input type="checkbox"/> 10. Evaluation and Research Skills*	<ul style="list-style-type: none"> a. Ability to identify important concerns and conduct evaluation and research to better understand root causes b. Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) c. Ability to participate in evaluation and research processes including: <ul style="list-style-type: none"> i) Identifying priority issues and evaluation/research questions ii) Developing evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings

11. Knowledge Base

- a. Knowledge about social determinants of health and related disparities
- b. Knowledge about pertinent health issues
- c. Knowledge about healthy lifestyles and self-care
- d. Knowledge about mental/behavioral health issues and their connection to physical health
- e. Knowledge about health behavior theories
- f. Knowledge of basic public health principles
- g. Knowledge about the community served
- h. Knowledge about United States health and social service systems

**Asterisks denote new skills from 1998 -2016; several sub-skills have been expanded*

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Establishing Consensus

Data Source Selection and Crosswalk Analysis

The C3 Project team determined the best way to identify changes over time in CHW core roles and competencies was to choose a range of frequently consulted source documents and examine them through a crosswalk. The NCHAS served as a baseline for this review because of the widespread use of the study's recommended roles and skills. The crosswalk process compared the study's roles and skills with newer, frequently cited benchmark documents at the leading edge of the field to focus on what was new and distinct from the earlier findings of the NCHAS. In total, the team selected seven sources, including: five states with emerging standards; one widely recognized curriculum; and the national Indian Health Service's Community Health Representative (CHR) Program scope of practice guidance.

To carry out the crosswalk analysis, the C3 Project team developed a matrix table to compare all collected source documents to the NCHAS list of core roles and skills. The team focused on identifying innovations, specifically new roles and skills, seeing these adaptations as important refinements that reflected new contemporary contexts. The C3 Project team integrated all newly identified roles and skills into a proposed list brought forward for review and consideration. The full C3 Project team of staff, consultants, CHW fellows, and advisory members reviewed the findings, and from this review, they assembled an updated list of roles and skills and affirmed current data on CHW qualities for national review.

Consensus Building

The formal proposed Phase 1 of the C3 Project ended with production of the list of core roles and competencies from the crosswalk analysis. However, the C3 Project team and advisors agreed that before these were distributed more widely, CHW leadership in the field needed a chance to review and refine the findings. Thus, the team and numerous stakeholders and allies volunteered to undertake a larger consensus building effort: the CHW Network/Association Review. To formally guide this process, the C3 Project created a second majority-CHW advisory group to lead the Network/Association Review.

The now larger team invited all known CHW networks/associations at the local, state, regional, and national levels to participate, and 23 of 45 known groups at the time undertook this review. The review method put forward by the C3 Project Fellows called for a minimum of five network members to review the roles and skills – with four of those five members being CHWs.

Outreach to Build Consensus

The C3 Project team conducted varied outreach strategies to carry out the Network/Association Review. At the start, a series of kick-off conference calls in English with Spanish translation provided an opportunity to learn about the C3 Project and the requested review. Support materials were provided, including a PowerPoint in English and Spanish. Other support strategies included continued follow-up with CHW networks, assigned "buddy" networks, presentations at conferences, "sign-on" announcements in national newsletters, and meetings with national organizations. Any input given by groups not in CHW networks and associations was noted and catalogued for future cyclical reviews.

Following the national review and integration of feedback

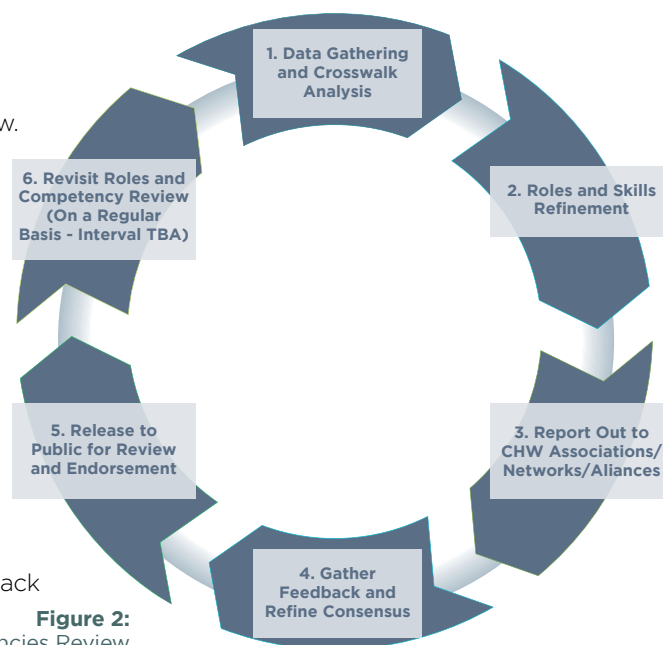


Figure 2:
CHW Roles and Competencies Review Cycle

from the networks and associations, the C3 Project began the release of its findings in a summary and full report. The first venue for release was the CHW field's national Unity Conference; release at the American Public Health Association Annual Meeting and various other venues followed. In the future; this sort of national review cycle is proposed on a regular basis to keep roles and competencies in sync with contemporary practice (See Figure 2). The appropriate interval for such a review is yet to be determined in collaboration with stakeholders in the field, namely CHW leadership.



Figure 3:
Combined CHW Qualities Wordcloud Based on
Prior Research as Endorsed by the C3 Project



Findings - Roles and Competencies

(Skills and Qualities) Defined

The C3 Project recommendations include a total of 10 roles and 11 skills. Though similar in number, roles and skills are not intended to match each other; rather multiple skills may support several distinct roles. As noted earlier in this report, CHW qualities were not reevaluated; instead, the C3 Project team asked for affirmation and endorsement of existing knowledge about CHW qualities, with “connection to the community served” being the most critical. A display of the qualities previously put forth by the NCHAS and the CHW Network of New York City⁹ and supported by the C3 Project can be found in *Figure 3*.

The C3 Project recommended updates to the roles and skills included: 1) three new roles and updates in the language of a fourth role; 2) three new skills were also added and two skills were updated. Several new sub-roles and skills were also added including five new sub-skills to the skill known as Knowledge Base. New roles and skills are indicated by asterisks in Tables 1 and 2. For detailed information on the changes and updates, please refer to the C3 Project’s Phase 1 Report, *Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field*.¹⁰



C3 Project Endorsement and Applications

Following the release of the C3 Project core roles and competency recommendations, the team began work on other areas briefly outlined at the start of this report including continued outreach to stakeholders for endorsement, a look at CHW skill assessment strategies, and the impact of setting on CHW roles and skills. This work incorporated a majority-CHW advisory group for each of the three components underway. A highlight of this period was a meeting in El Paso that brought the full C3 Project team together, including staff, advisors, and partners, to review findings and make recommendations. (Team photos shared in this report are from that Convening in May, 2017.)

Use of Roles and Competencies

At the time of this writing, at least 20 state policy initiatives have adopted the C3 Project recommendations as a starting point for deliberations on definitions and policies regarding CHWs. Additionally, a variety of national organizations have endorsed or otherwise supported the roles and competencies (see *Table 3*). Evaluation of the team's outreach efforts found the great majority of surveyed stakeholders were familiar with the C3 Project and had used or planned to use its findings in their organizations. Uses varied (see *Table 4*), including:

- as a reference to define CHWs
- for assistance in securing resources and funding
- in planning training or education opportunities for CHWs, and
- in strengthening existing community health worker infrastructure.



Table 3: Selected Organizations Supporting and Endorsing C3 Project Recommended Roles and Competencies (as of 10/2018)

Organization	Action Taken
American Diabetes Association	Included C3 Project recommendations in Standards of Care
National Association of Community Health Centers	Issued a support letter for C3 Project
Health Resources and Service Administration	Uses C3 Project recommendations as a standard when providing technical assistance to HIV/AIDS grant recipients working with CHWs
Centers for Disease Control and Prevention Guide to Community Preventive Services (The Community Guide)	Cites the C3 Project and lists the roles and skills; includes CHWs as evidence-based best practice in the prevention and management of targeted health issues (CDC, 2017).
American Nurses Association	Issued a support letter for the C3 Project
National Rural Health Association	National Endorsement
MHP Salud	National Endorsement and adapted its core skills curriculum for national use by following C3 Project Recommendations
National Commission for Health Education Credentialing (issuers of CHES certification)	National Endorsement
Care Coordination Systems	Adapting its core skills curriculum for national use by following C3 Project Recommendations
Health Resources in Action	National Endorsement
National Network of Public Health Institutes	National Endorsement
Northwest Regional Primary Care Association	National Endorsement
National Center for Healthy Housing	National Endorsement
North Carolina Community Health Center Association	Endorsement
Southern New Hampshire AHEC	Endorsement

Table 4: Uses for Consideration for C3 Project Roles and Competencies Lists

C3 Project CHW Roles and Competency lists can be used:
<ol style="list-style-type: none"> 1. As a reference to define CHWs 2. For comprehensive education about CHWs 3. For assistance in securing resources and funding 4. For planning training or education for CHWs and managers 5. To aid in job description development 6. To strengthen existing community health worker infrastructure 7. As a reference point for policies pertaining to CHWs

Assessment of CHW Skills by, for, and with CHWs

In looking at CHW skills assessment, the C3 Project team aimed to understand how CHW proficiencies could be assessed in a way that supports the growth and development of individual CHWs and strengthens the field overall. The team worked with CHWs, CHW educators and trainers, and CHW supervisors to better understand best practices in order to provide field-driven, evidence-based recommendations, tools, and resources for supporting a comprehensive assessment of CHWs' work. The team produced a framework around which to organize CHW assessment approaches and resources (see *Table 5*) and an assessment toolkit.

The Community Health Worker Assessment Toolkit: A Framework for the Assessment of Skill Proficiency to Promote Ongoing Professional Development, released in late 2018, was designed for use by program managers, supervisors, trainers, CHWs and others in CHW supervisory roles to assess their team and provide meaningful feedback. (see *Figure 5*).

The Community Health Worker Assessment Toolkit includes:

- Recommended program elements to support the assessment of CHW skill proficiency;
- Case studies of exemplary programs;
- Specific assessment tools for assessing the C3 Project recommended skills;
- A self-assessment tool for supervisors;
- A self-assessment tool for CHWs;
- A job description template for recruiting CHWs; and
- An interview guide to be used by hiring managers when recruiting CHWs.

The C3 Project team asserts that there are numerous benefits in effectively and regularly assessing CHW skill proficiencies. Notably, this process can:

- Reduce CHW turnover;
- Improve CHW confidence;
- Improve CHW capacity to deliver interventions with greater fidelity; and
- Enhance effectiveness in working with community members and team members.

The C3 Project notes that as skill assessment contributes to more proficient CHWs, it subsequently improves patient health outcomes. Assessment can also lead to better integration of CHWs into teams by expanding CHW supervisors' understanding of their roles and competencies and passing this information on to clinical managers, leadership, employers, and other stakeholders. This can also lead to more appreciation of CHWs and their value to the communities and organizations they serve. In addition to these benefits, assessment of CHW proficiency can also improve organizational capacity by building recognition of how CHWs overcome barriers, forge clinical linkages, and help people reach their health goals.

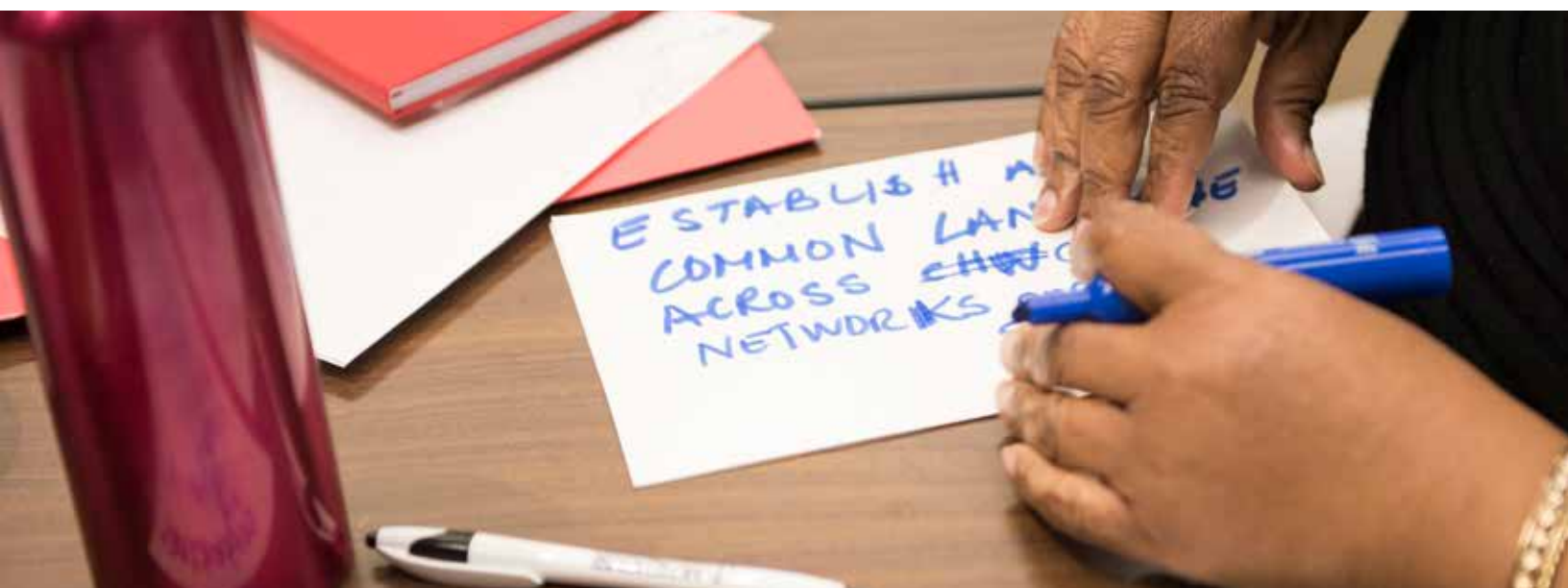


Table 5: Guiding Principles for CHW Skill Assessment	
Use innovative, mixed methods and technologies for hiring, training, and skill assessment whenever possible:	
<ul style="list-style-type: none"> • Include didactic and non-didactic approaches. • Provide on-the-job opportunities for shadowing, one-on-one training, and coaching by experienced CHWs, supervisors, clinical staff, and others. • Prioritize CHW knowledge and life experience -- CHWs are partners in skill assessment. 	
Conduct CHW assessment with cultural competency and humility:	
<ul style="list-style-type: none"> • Develop the assessment process together with CHWs. • Establish fair assessment tools and methods that reflect and honor the work of CHWs. 	
Assess throughout the lifecycle of the program:	
<ul style="list-style-type: none"> • Understand that skill proficiency assessment takes time, trust, and patience. • Employ an assessment process during the hiring process to help managers and leadership make the best choices and inform them of the training needs of the people they hire. 	
CHWs should play an active role in assessing themselves, their peers, and their work environment:	
<ul style="list-style-type: none"> • Make sure CHWs understand that the purpose of assessment is to allow for professional development so that they can work most effectively and address any deficiencies (continuous quality control). Otherwise, assessment may be perceived by CHWs as code for discipline. • Create opportunities for CHWs to add insight and support to jointly solving problems in staff meetings, case management, huddles, and other team activities. 	
Involve those served by CHWs in assessment:	
<ul style="list-style-type: none"> • Offer opportunities for community members and patients to give feedback on CHW services. 	
Supervisors should be regularly assessed in order to ensure they are providing effective support to CHWs:	
<ul style="list-style-type: none"> • Provide training and practice opportunities for staff new to supervising CHWs. • Allow CHWs the chance to assess quality of supervision, institutional support for their work, adequacy and quality of training (initial and ongoing), respect, and opportunity for community engagement. • Encourage supervisor presence and consistent mentoring to minimize CHW turnover and set the foundation for meaningful assessment. • Determine the factors that affect CHW work, so supervisors can offer appropriate support to ensure CHW success. 	
Consider contextual factors (e.g., support from management) that may impact CHW assessment	

Evaluating the Influence of Settings on CHWs

The goal of the C3 Project team in looking at the setting of CHW work and service was to identify if “place specific” roles and skills needed to be delineated to strengthen CHWs’ capacity to serve in varied settings, including clinic and community settings. The team focused on the contexts of education and training, service and practice, and within policy and regulatory frameworks. To begin this work, the C3 Project team solicited input from CHWs and other stakeholders through an online national survey. Two bilingual open “Town Hall” webinars and three virtual focus workshops followed the survey. The C3 Project team designed these venues to gather input on the use and importance of the recommended roles and skills in both clinical and community-based settings.

Based on the several methodologies described above, combined with C3 Project advisor input, the C3 Project recommends core roles and competencies stay uniform in their application across all settings. Feedback confirmed that physical location of any given CHW does not define a CHW’s focus. Findings revealed CHWs work across a spectrum of locations, and at any one time, they may be more focused on the community’s needs or an agency-driven (often clinical) agenda, independent of where CHWs are physically based. This is portrayed in CHW Settings Continuum Framework below (See Figure 4).

The C3 Project team's recommendations addressed:

- 1) **Training and Education:** Broad initial trainings for CHWs are recommended, including preparation for all roles and skill areas, whereas continuing education and training could more appropriately be setting-specific.
- 2) **Practice and Service:** Roles and skills may be tailored to selected settings, but when designing CHW programs and services, integration of a widest possible scope of practice is encouraged.
- 3) **Policy and Regulations:** Policies should ensure support for the full range of CHW roles and competencies - both skills and qualities, including training to support CHW roles and skills in policy advocacy - for their own CHW profession and for policies in support of the individuals, families, and communities they serve.

Ultimately, the C3 Project team developed three schematic frameworks developed and presented at various meetings in 2017 and then refined based on feedback from CHWs and other stakeholders. Each framework initially targets varied audiences including CHWs; allies, employers, and trainers; and researchers and policymakers. Upon review, stakeholder feedback suggested each framework should be used with all audiences. A more complete discussion of the three featured frameworks follows. Additionally, please refer to the C3 Project's Infographic **"CHWs are Pivotal to Health and Well-being,"** that seeks to integrate key aspects of each framework.



Exploring CHWs in Contexts: Visual Frameworks to Foster Dialogue

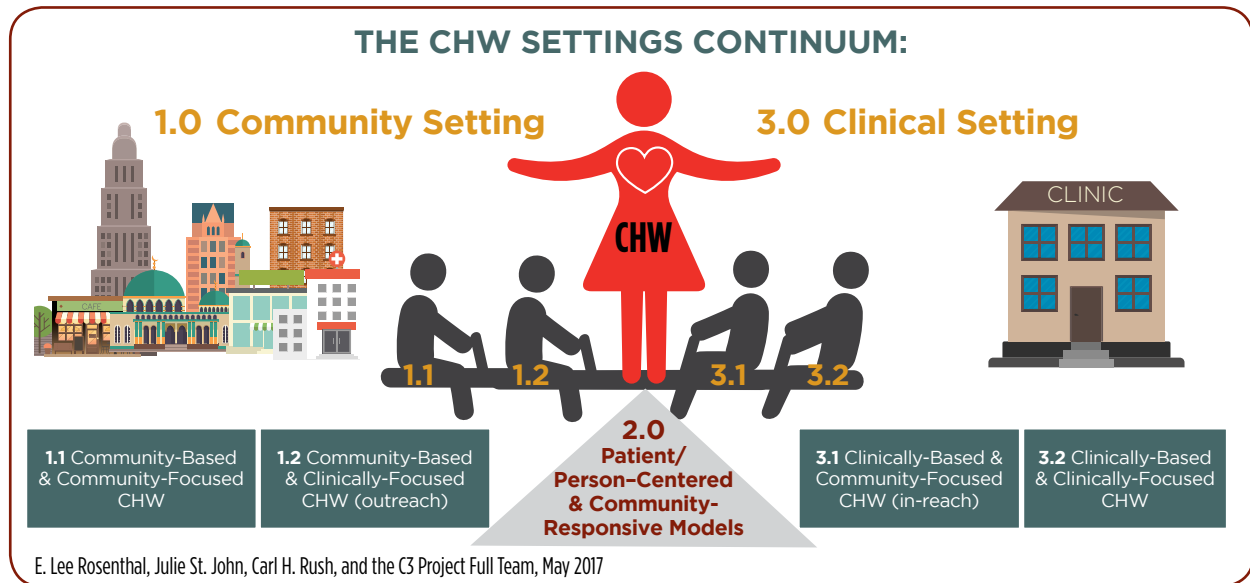


Figure 4: CHW Settings Continuum Framework

CHW's primary service setting and their focus within that setting may be aligned or the setting and the focus may be distinct from one another. At different times, individual CHWs themselves may be serving along any point on the spectrum.

The intended use of the CHW Settings Continuum Framework is to enhance understanding of the range of ways CHWs serve in multiple settings. The Continuum shows that regardless of the physical setting of CHWs, they may represent a community and/or clinical perspective. On the far left of the Continuum, the CHW represents and focuses on representing the community's voice on community matters. In the second position, the CHW is in the community but brings in the clinical perspective to the community through outreach. The CHW in the center position represents a CHW at the balance point—reflecting innovative models seeking to deliver patient-centered and community-responsive programs and services. On the right of the Continuum, the CHWs are in a clinical setting with the CHW on the left carrying out community in-reach—bringing the community voice into the clinical setting. The CHW on the far right of the Continuum represents a CHW serving inside the clinical setting who is predominately addressing the facilitation of the medical care system and health education access.

This CHW Settings Continuum Framework was informed by the Consensus Focus Workshops led as a part of the work exploring the impact of setting on CHW roles and skills. In these workshop sessions, discussion indicated that no matter the setting, CHW roles stayed constant. CHW and stakeholder participants revealed that regardless of their setting, CHWs may represent either the clinic's or the community's voice. They suggested that even their uniforms (or lack thereof) reflected who they represented. Participants shared that CHWs worked to balance all of their roles in a middle point of community-focused care.

Lee Rosenthal, Carl Rush and colleagues developed this framework following those workshops to capture this continuum view. C3 Project advisors, partners, and other stakeholders reviewed this framework as a kickoff to a C3 Project May 2017 convening. Feedback suggested that this model was not sufficient to portray the field but that it offered a valuable tool for dialogue. Following the meeting, further review suggested that the middle point of the framework was best portrayed as the many practice models seeking to offer patient-centered and community-responsive care. As can be seen in the framework, on either side of this middle point there are two CHWs. A CHW in each setting focuses on the setting (i.e., the community), and one focuses on the opposite setting (i.e., the clinic). With the input that this framework was not capturing all key CHW elements, other frameworks were developed and refined during the C3 Project's face-to-face El Paso Convening (May, 2017); the most popular frameworks are included here.

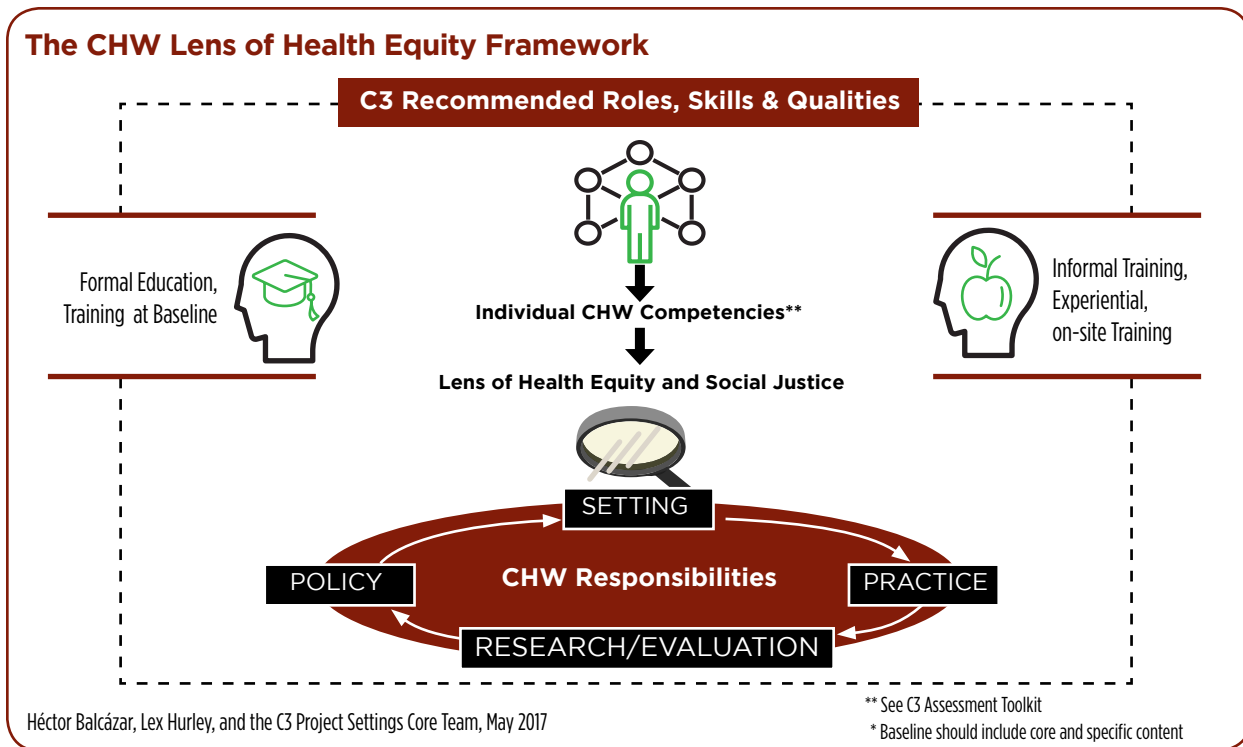


Figure 5: The CHW Lens of Health Equity Framework

The CHW Lens of Health Equity Framework emphasizes the capacity of CHWs to bring the analysis and integration of social justice issues to their work—focusing on bringing that work to fruition in promoting greater health equity. The framework portrays the importance of the broad range of CHW roles and skills that allow them to work in multiple settings both inside and outside of the healthcare sector.

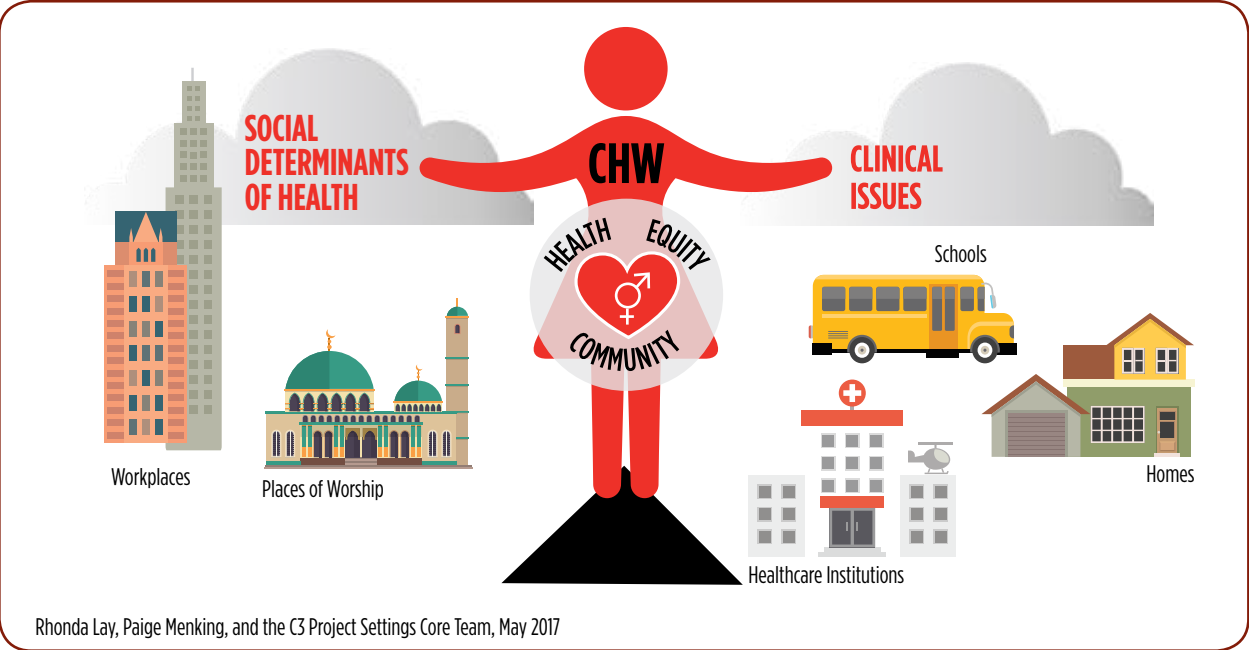


The CHW Lens of Health Equity Framework portrays CHWs bringing a lens of health equity to all of the work they do. This framework highlights that CHWs serve in many sites and play roles both inside and outside the health care system. It portrays that CHWs move forward our understanding and capacity to act on social justice issues and move individuals and communities toward greater health equity. Héctor Balcázar and colleagues proposed this model in response to the review of the Settings Continuum Framework discussed above; many participants worked together to refine it.



**The Dancing CHW Framework:
Balancing Determinants of Health and Clinical Care
on Nimble Feet**

The Dancing CHW Framework was the innovation of a CHW C3 Project advisor who, after two days of discussion of settings frameworks and the C3 Project overall, came forward with the vision. Rhonda Lay described a CHW as someone on nimble feet – balancing the social determinants of health on the one hand and the health and human service systems on the other hand – with the heart of a CHW at the center. The framework grew to include the various potential CHW service provision settings in the background. This figure has been used as a point of departure for discussion and was performed and well received by all as the “CHW Dance” at both national and regional CHW conferences starting in 2017.



Rhonda Lay, Paige Menking, and the C3 Project Settings Core Team, May 2017

Figure 6: The Dancing CHW Framework

The Dancing CHW Framework depicts a CHW working to address the determinants of health on the one hand, while on the other hand, navigating and facilitating access to health and social services. The framework portrays the CHW as nimble footed, with their heart at the center—guiding all their work.



• Evidence has because it ex based and less
 • Avoid subjective loaded language
 Formal/informal certified/non certified
 • Need to read over understand is
 • Where is 'community'?

Implications and Next Steps

Many next steps are possible to further the work of the C3 Project, the most obvious of which is regularly updating the proposed roles and competencies at appropriate intervals to be determined by those in the field and available resources. We hope this is linked to emerging CHW field leadership over time. Meanwhile, the C3 Project team will continue to collect feedback to inform future reviews. **You may direct any feedback to info@c3project.org.**

Other opportunities are varied and include further investigating the CHW skill identified as “Knowledge Base,” which expanded from three to eight dimensions in the initial review. An effort could also be undertaken to map the roles to needed skills. The roles and competencies could also be adapted to career pathways. Additionally, it is likely that the continued use of these roles and competencies in the development of standards at the state, regional, and national level will be ongoing. Related efforts are underway in the Common Indicators Project examining core evaluation measures.

On a practical level, we are interested in exploring and showcasing how roles and competencies are put into action. Opportunities are under development to foster exchanges on how people are using the C3 Project roles and competencies.

Ongoing Dissemination and Revision

The C3 Project team will continue to work on ongoing dissemination of its findings, making related resources available and accessible for future review and development, as needed by the field. As a part of this plan, an independent website was developed (www.C3Project.org) to house C3 Project recommendations and related resources.

CHW Leadership

A national association provides an invaluable base for the growth and development of a profession. In the case of CHWs, the long evolution of such an association has meant that until now the CHW field has not had the benefit of a dedicated CHW-centered national organization to support its development.

With the new presence of the National Association of Community Health Workers (NACHW), the further development of the field will surely follow. Based on a brief review of other health professions, it is likely that at some point there will be an examination of guidelines of the scope of practice and competencies of CHWs by CHWs. It is our hope that the C3 Project findings and the CHW-informed and driven consensus that we have pursued will serve as a resource to NACHW leadership in the future.

Until that time, the C3 Project will continue efforts to sustain this work and provide support in the new association’s efforts to promote self-determination of the CHW workforce throughout the United States. Ultimately, we know that through the increased visibility and integration of CHWs that a national association will foster, CHWs will be better able to contribute to the health and well-being of the many individuals, families, and communities they so capably serve. The C3 Project aims to support just that.



Acknowledgements

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- Note: We honor Don, who passed away in Oct. 2018, for his contributions to the CHW field in Arizona and nationally, especially in the areas of Key Considerations for CHW education and for the promotion of truly accessible community college access for CHWs nationwide.*

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The C3 Project is based in the Department of Medical Education at the Paul L. Foster School of Medicine at Texas Tech University Health Sciences Center El Paso, home to C3 Project Principal Investigator/Director, E. Lee Rosenthal, PhD, MS, MPH. The C3 Project was carried out in collaboration with the Project on CHW Policy and Practice at the UT Health Science Center at Houston's School of Public Health in the Institute for Health Policy, home to Project Co-Director Carl H. Rush, MRP. The C3 Project was additionally carried out in collaboration with Texas Tech University Health Sciences Center, home to Project Co-Principal Investigator, Julie St. John, DrPH.

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Texas Tech University Health Sciences Center El Paso, 2018

A product of the Community Health Worker Core Consensus (C3) Project

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- ⁵ Rosenthal, Lee, Carl Rush, and Caitlin Allen. “Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field.” CHW Core Consensus Project, 2016. <https://sph.uth.edu/dotAsset/28044e61-fb10-41a2-bf3b-07efa4fe56ae.pdf>.
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- ¹⁰ Rosenthal, Lee, Carl Rush, and Caitlin Allen. “Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field.” CHW Core Consensus Project, 2016. <https://sph.uth.edu/dotAsset/28044e61-fb10-41a2-bf3b-07efa4fe56ae.pdf>.
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**Holding Up the Lens
of Health Equity**



**Balancing Community and
Health Systems' Needs and Goals**