Community Health Toolkit

Bridge to Health Equity Foundation

For Community Health Workers and Advocates

This comprehensive toolkit provides evidence-based strategies, practical resources, and real-world examples for promoting health equity in your community. It is designed to support frontline health workers, community advocates, care coordinators, and anyone working to improve population health.

The Critical Role of Community Health Workers

Community Health Workers (CHWs) are frontline public health workers who are trusted members of the communities they serve. They bridge the gap between health systems and communities, improving access and quality of care while reducing costs.

The Evidence for CHWs

• Cost-effectiveness: CHW interventions save $2.47 for every dollar invested, primarily through reduced emergency department visits and hospitalizations.
• Clinical outcomes: CHW programs improve control of chronic diseases (diabetes A1C reductions of 0.5-2.0%, blood pressure reductions of 5-10 mmHg).
• Healthcare utilization: CHW support reduces hospital readmissions by 20-40% and inappropriate ED use by 25-30%.
• Patient satisfaction: 89% of patients who work with CHWs report high satisfaction with their care.
• Health equity: CHWs are particularly effective in underserved populations, reducing disparities in outcomes.

Core CHW Competencies

• Communication skills: Active listening, motivational interviewing, health education
• Cultural mediation: Understanding community culture, values, and communication styles
• Resource coordination: Knowledge of community resources and how to navigate systems
• Advocacy: Empowering clients to advocate for themselves and advocating on their behalf
• Service coordination: Linking clients to healthcare, social services, and community resources
• Capacity building: Helping individuals, families, and communities build skills and resilience
• Outreach: Engaging hard-to-reach populations and building trust
• Documentation: Maintaining accurate records while protecting confidentiality

Assessment Tools: Identifying Needs and Assets

1. Community Health Needs Assessment (CHNA)

A systematic process to identify priority health issues and assets in your community.

Key Steps:

• Define your community: Geographic boundaries, demographic profile, existing data
• Engage stakeholders: Form a committee with diverse community representation
• Collect quantitative data: Health outcomes, demographics, social determinants (from health departments, census, hospitals)
• Gather qualitative data: Surveys, focus groups, interviews with community members and key informants

• Identify assets: Community organizations, faith institutions, schools, informal networks
• Analyze and prioritize: Use criteria like magnitude (how many affected), severity (impact on health), changeability (can we address it)
• Develop action plan: Set goals, strategies, responsibilities, and timelines
• Implement and evaluate: Track progress with measurable indicators

Sample CHNA Survey Questions:

• What are the top 3 health issues affecting your neighborhood?
• What makes it difficult to stay healthy in your community?
• What resources or services are missing or hard to access?
• What strengths does your community have that support health?
• Who do you trust to provide health information?

2. Individual Social Determinants of Health Screening

Standardized tools help identify social needs that affect health. The two most widely used are:

PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)

• 17 core questions covering demographics, family/home, money/resources, education, employment, social integration, optional stress
• Validated for use in health centers and community settings
• Available in multiple languages
• Free toolkit at prapare.org

AHC (Accountable Health Communities) Screening Tool

• 10 core questions covering housing, food, transportation, utilities, safety
• Developed by CMS for use in healthcare settings
• Brief and easy to administer (2-3 minutes)
• Available for free download from cms.gov

Sample SDOH Screening Questions:

Housing: "What is your housing situation today?" (Options: I have housing / I do not have housing / I am worried about losing my housing)

Food: "Within the past 12 months, you worried that your food would run out before you got money to buy more." (Options: Often true / Sometimes true / Never true)

Transportation: "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" (Yes/No)

Utilities: "In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?" (Yes/No)

Safety: "Do you feel physically and emotionally safe where you currently live?" (Yes/No)

Best Practices for SDOH Screening:

• Explain why you're asking: "We ask everyone these questions because they affect health, and we want to connect you to resources."
• Build trust first: Don't screen on first contact; establish rapport
• Offer multiple formats: Paper, tablet, verbal administration, or take-home

• Ensure confidentiality: Explain how information will be stored and used
• Have resources ready: Only screen if you can offer help; screening without resources erodes trust
• Follow up promptly: Contact individuals within 48 hours to discuss results and connect to services
• Track outcomes: Monitor referrals, connections made, and barriers encountered

3. Home Safety Assessment

For home visits, assess environmental risks that affect health:

• Fall hazards: Loose rugs, clutter, poor lighting, unstable furniture, lack of grab bars
• Mold and moisture: Water stains, musty smells, visible mold growth
• Pest infestation: Evidence of rodents, cockroaches, bedbugs
• Temperature control: Adequate heating/cooling, drafts, functioning windows
• Lead hazards: Peeling paint in homes built before 1978
• Air quality: Secondhand smoke, gas stoves without ventilation, air fresheners
• Medication safety: Proper storage, expiration dates, ability to read labels
• Food safety: Working refrigerator, ability to prepare meals, expired food

Community Engagement Strategies: Building Trust and Participation

1. Building Trust in Communities with Historical Trauma

Many communities—particularly communities of color, immigrant communities, and Indigenous communities—have experienced medical exploitation, discrimination, and broken promises. Building trust requires:

• Acknowledge history: Name past harms directly. Example: "We know there are good reasons not to trust healthcare. We want to do better."
• Show up consistently: Be present in the community regularly, not just when you need something
• Keep promises: If you say you'll follow up, do it. Small commitments kept build credibility.
• Share power: Let community members make decisions about programs and services
• Hire from the community: Employ people who look like, sound like, and understand the community
• Be accountable: When you make mistakes, acknowledge them and make amends
• Focus on relationship, not just transactions: Invest time in getting to know people as whole human beings

2. Culturally and Linguistically Appropriate Services (CLAS)

The National CLAS Standards provide a framework for equitable, respectful care:

• Language access: Provide professional interpretation and translation; avoid using family members, especially children
• Cultural adaptation: Modify programs to align with cultural values, beliefs, and practices
• Health literacy: Use plain language, teach-back method, visual aids, and culturally relevant examples
• Respect for traditions: Ask about and incorporate traditional healing practices when appropriate
• Dietary considerations: Understand cultural food preferences and restrictions when discussing nutrition
• Communication styles: Recognize that direct eye contact, personal space, and discussion of sensitive topics vary by culture

• Decision-making: Some cultures prioritize family/community decisions over individual autonomy
• Mistrust of authority: Understand that immigration status, past discrimination, and historical trauma affect interactions

3. Meeting People Where They Are: Effective Outreach Locations

Go to places where community members already gather:

• Faith institutions: Churches, mosques, temples, synagogues
• Schools: Parent meetings, health fairs, after-school programs
• Community centers: Recreation centers, senior centers, libraries
• Businesses: Laundromats, grocery stores, hair salons, barbershops
• Events: Farmers markets, cultural festivals, community meetings
• Public spaces: Parks, playgrounds, transit stops
• Trusted organizations: Food banks, housing agencies, legal aid offices

4. Effective Communication Techniques

• Active listening: Reflect back what you heard, ask clarifying questions, validate feelings
• Motivational interviewing: Ask open-ended questions, affirm strengths, reflect, summarize (OARS)
• Teach-back: "I want to make sure I explained this clearly. Can you tell me in your own words what you'll do?"
• Plain language: Use 5th-grade reading level; avoid medical jargon
• Asset-based framing: Focus on strengths and solutions, not just problems and deficits
• Trauma-informed approach: Recognize impact of trauma; prioritize safety, trustworthiness, peer support, collaboration, empowerment

5. Strategies for Hard-to-Reach Populations

Some populations face additional barriers to engagement:

People Experiencing Homelessness:

• Offer services at shelters, meal programs, and drop-in centers
• Provide immediate assistance (food, clothing) alongside health services
• Use mobile health units and street outreach teams
• Minimize paperwork and identification requirements

Immigrant Communities:

• Clarify that immigration status doesn't affect eligibility for services
• Partner with trusted community organizations and ethnic media
• Ensure interpretation in preferred languages and dialects
• Address fears about public charge and data sharing

Rural Communities:

• Offer telehealth options to reduce travel burden
• Schedule services around agricultural seasons and work schedules
• Partner with local providers like pharmacists and emergency services
• Address transportation barriers with mobile services or ride programs

LGBTQ+ Individuals:
• Use inclusive language on forms (allow self-identification of gender and pronouns)
• Train staff on LGBTQ+ health needs and respectful care
• Display visible symbols of inclusion (rainbow flags, non-discrimination policies)
• Partner with LGBTQ+ community organizations and events

Resource Navigation: Connecting People to Services

Effective resource navigation requires knowing what's available, how to access it, and how to help people overcome barriers. Here's a comprehensive guide to major resource categories:

Healthcare and Insurance

Federally Qualified Health Centers (FQHCs):

• Services: Primary care, dental, behavioral health, pharmacy
• Payment: Sliding fee scale based on income; accept all patients regardless of ability to pay
• How to find: findahealthcenter.hrsa.gov or call 211

Free and Charitable Clinics:

• Services: Basic primary care, sometimes specialty care
• Eligibility: Usually for uninsured or underinsured
• How to find: nafcclinics.org/find-clinic

Insurance Enrollment Assistance:

• Marketplace plans: healthcare.gov or state marketplace during open enrollment (Nov-Jan) or with qualifying life event
• Medicaid: eligibility varies by state; apply year-round at state Medicaid office
• Medicare: medicare.gov; eligible at age 65 or with disability
• CHIP: Children's Health Insurance Program for families with income too high for Medicaid
• Navigators: Free, trained assisters who help with enrollment; find at localhelp.healthcare.gov

Food Assistance

SNAP (Supplemental Nutrition Assistance Program / Food Stamps):

• Benefit: Average $230/month per person for groceries
• Eligibility: Gross income below 130% of federal poverty level (varies by household size)
• How to apply: State social services office or online portal
• Timeline: Can receive benefits within 30 days; 7 days for emergency SNAP

WIC (Women, Infants, and Children):

• Benefit: Specific nutritious foods, nutrition education, breastfeeding support
• Eligibility: Pregnant/postpartum women and children under 5 with income below 185% FPL
• How to apply: Local health department; find at wic.fns.usda.gov

Food Banks and Pantries:
• Services: Free groceries, usually no eligibility requirements
• How to find: feedingamerica.org/find-your-local-foodbank or call 211

Meals Programs:

• School meals: Free or reduced-price breakfast/lunch for eligible children
• Senior meals: Congregate meal sites and home-delivered meals through Older Americans Act (Area Agency on Aging)
• Soup kitchens and community meals: Free, no eligibility requirements

Housing Assistance

Emergency Shelter:

• Services: Temporary shelter, meals, case management
• How to find: 211, local homeless coalitions, faith-based organizations

Rental Assistance:

• Section 8 Housing Choice Vouchers: Tenant pays 30% of income toward rent; voucher covers difference
• Public housing: Income-restricted apartments managed by public housing authorities
• Emergency rental assistance: One-time help for rent/utilities to prevent eviction (availability varies)
• How to apply: Local public housing authority (find at hud.gov/findshelter)

Utility Assistance:

• LIHEAP (Low Income Home Energy Assistance): Help with heating/cooling bills once per year
• Utility company programs: Budget billing, payment plans, shutoff protection
• How to find: State LIHEAP office or 211

Transportation

• Medicaid non-emergency medical transportation: Free rides to medical appointments for Medicaid members
• Medicare transportation benefit: Limited coverage for ambulance and some wheelchair van services
• Transit assistance programs: Reduced fares for seniors, people with disabilities, and low-income riders
• Volunteer driver programs: Free rides through faith communities and volunteer organizations
• Rideshare partnerships: Discounted Uber/Lyft rides for healthcare appointments (check with health plan)
• How to coordinate: Contact patient's insurance plan or local Area Agency on Aging

Employment and Education

• American Job Centers: Free job search assistance, resume help, skills training
• WIOA (Workforce Innovation and Opportunity Act): Funding for job training and education
• Adult education: Free GED preparation, English as a Second Language (ESL), basic literacy
• Community colleges: Affordable vocational training and associate degrees; financial aid available
• Apprenticeships: Earn while you learn in skilled trades
• How to find: careeronestop.org or local workforce development board

Legal Assistance

• Legal Aid: Free civil legal assistance for low-income individuals (housing, family law, public benefits, consumer issues)
• Medical-Legal Partnerships: Lawyers embedded in healthcare settings to address legal issues affecting health
• Immigration legal services: Assistance with citizenship, visas, asylum, deportation defense
• Tenant rights organizations: Help with evictions, housing conditions, landlord disputes
• Healthcare advocacy: Appealing insurance denials, understanding medical bills, filing discrimination complaints
• How to find: lawhelp.org or 211

Behavioral Health and Substance Use Services

• Community mental health centers: Outpatient therapy, psychiatric care, case management on sliding scale
• Crisis services: 988 Suicide & Crisis Lifeline, mobile crisis teams, crisis stabilization units
• Substance use treatment: Outpatient counseling, medication-assisted treatment (MAT), residential programs
• Peer support: Support groups led by people with lived experience (AA, NA, NAMI, DBSA)
• Telehealth: Online therapy and psychiatry (many accept Medicaid)
• How to find: samhsa.gov/find-help or 988

Benefits Screening Tools

Use these free online tools to identify all benefits someone may qualify for:

• BenefitsCheckUp.org - For adults age 55+
• Benefits.gov - Federal and state benefit programs
• State 211 websites - Comprehensive community resource databases
• Aunt Bertha / findhelp.org - Searchable database of social services

Real-World Case Studies: CHWs Making a Difference

Case Study 1: Preventing Hospital Readmission

Background: Maria, a 68-year-old woman with heart failure, was hospitalized 4 times in 6 months. Her care team referred her to a CHW.

CHW Actions:

• Home visit to assess living situation: Found Maria living in 3rd-floor walkup with no working elevator
• SDOH screening revealed: difficulty affording medications, confusion about low-sodium diet, isolation after husband's death
• Coordinated care: Worked with social worker to find ground-floor housing; connected to senior meal program; arranged medication assistance; facilitated home health services
• Health education: Taught symptom monitoring (daily weights, when to call doctor); reviewed medications with teach-back method
• Follow-up: Weekly phone calls for 3 months, then monthly

Outcome: Maria has not been hospitalized in 9 months. She reports feeling "less alone" and understands her health better.

Case Study 2: Supporting a Family Through Crisis

Background: The Johnson family missed multiple pediatric appointments for their 3 children. Referred to CHW for engagement.

CHW Actions:

• Built relationship: Met family at their apartment complex community room (non-threatening location)
• Identified barriers: Mother had lost job and was facing eviction; no car; stress affecting her ability to manage appointments
• Connected to resources: Emergency rental assistance prevented eviction; enrolled children in Medicaid and SNAP; arranged transportation to appointments
• Addressed underlying issues: Connected mother to job training program; referred to free mental health counseling; provided parenting support
• Long-term support: Accompanied family to first few appointments; helped mother create a system for tracking appointments; celebrated successes

Outcome: All 3 children are up to date on well-child visits and immunizations. Mother completed job training and found employment. Family is stably housed.

Case Study 3: Diabetes Management in a Skeptical Patient

Background: James, a 55-year-old Black man with type 2 diabetes, had an A1C of 11.2%. He was skeptical of doctors due to past experiences of discrimination.

CHW Actions:

• Built trust: CHW (also a Black man from the same neighborhood) met James at barbershop to start conversation
• Listened to concerns: James shared experiences of dismissive doctors and fear of medication side effects
• Acknowledged history: Validated concerns; discussed medical racism and Tuskegee Study
• Focused on his priorities: Asked what mattered most to him (being around for grandkids, maintaining independence)
• Made it actionable: Started with one small change (cutting sugary drinks); celebrated success; gradually added more changes
• Facilitated better care: Accompanied James to appointments; helped him prepare questions; advocated for culturally responsive provider

Outcome: After 8 months, James' A1C dropped to 7.8%. He takes medications as prescribed and has regular appointments with a provider he trusts.

Documentation, Follow-Up, and Quality Improvement

Documentation Best Practices

• Document in real-time or immediately after encounters to ensure accuracy
• Use objective, non-judgmental language (write "Client stated they don't have reliable transportation" not "Client is non-compliant")
• Include specific details: dates, names of resources, outcomes of referrals
• Protect confidentiality: Store records securely; follow HIPAA regulations; never discuss clients publicly
• Document both successes and barriers: This information helps improve programs
• Use standardized templates and forms when possible for consistency

• Include client strengths and assets, not just problems
• Note cultural or language considerations relevant to care

Follow-Up Timeline and Methods

Immediate (24-48 hours):

• New crisis situations (housing loss, food insecurity, safety concerns)
• High-priority referrals (specialty appointments, urgent needs)
• Post-hospital discharge

Short-term (1 week):

• Check on referrals made at last visit
• Reinforce health education or behavior change goals
• Provide encouragement and troubleshooting

Medium-term (2-4 weeks):

• Review progress toward goals
• Adjust plans as needed
• Assess new needs or barriers

Long-term (monthly or as appropriate):

• Stable clients maintaining progress
• Check-ins to prevent disengagement
• Ongoing support and relationship maintenance

Tracking Outcomes and Impact

Track both process measures (what you did) and outcome measures (what changed):

Process Measures:

• Number of clients served
• Number and types of encounters (home visits, phone calls, clinic accompaniments)
• Referrals made by category (food, housing, healthcare, etc.)
• Successful connections to resources (client actually received service)

Outcome Measures:

• Health outcomes: A1C levels, blood pressure, medication adherence, immunization rates
• Healthcare utilization: Emergency department visits, hospitalizations, preventive visit completion
• Social determinants: Food security status, housing stability, insurance enrollment
• Patient experience: Satisfaction, trust in healthcare, self-reported health status
• Economic impact: Cost savings from avoided hospitalizations, return on investment

Self-Care for Health Workers: Preventing Burnout

Community health work is deeply rewarding but also emotionally demanding. Burnout is a real risk. Prioritizing self-

care is not selfish—it's essential for sustaining your work and serving your community effectively.

Recognizing Burnout and Compassion Fatigue

Warning signs include:

- Physical: Exhaustion, frequent illness, headaches, changes in sleep or appetite
- Emotional: Irritability, anxiety, feeling numb or detached, crying easily
- Cognitive: Difficulty concentrating, forgetfulness, negative thoughts, cynicism
- Behavioral: Withdrawing from others, avoiding work, substance use, reduced productivity
- Compassion fatigue: Decreased empathy for clients, feeling overwhelmed by others' suffering

Self-Care Strategies

Physical Self-Care:

- Prioritize sleep (7-9 hours)
- Move your body regularly (walking, dancing, yoga, sports)
- Eat nourishing food
- Limit alcohol and avoid other substances
- Attend your own healthcare appointments

Emotional Self-Care:

- Maintain social connections outside of work
- Engage in activities that bring joy
- Set boundaries (it's okay to say no)
- Practice self-compassion (treat yourself as kindly as you treat clients)
- Seek therapy or counseling when needed

Spiritual Self-Care (however you define spirituality):

- Engage in practices that connect you to something larger (prayer, meditation, nature, art, music)
- Reflect on your values and purpose
- Find meaning in your work

Professional Self-Care:

- Participate in regular supervision and debrief difficult cases
- Attend peer support groups with other CHWs
- Pursue ongoing training and professional development
- Celebrate successes (yours and your clients')
- Recognize what's in your control and what isn't
- Advocate for systemic change rather than shouldering all responsibility yourself

Organizational Supports for CHW Wellbeing

Employers and organizations should:

- Provide manageable caseloads (typically 40-60 clients per CHW)
- Offer clinical supervision and peer support

- Ensure competitive compensation and benefits
- Create clear job descriptions and career pathways
- Protect time for documentation and self-care
- Provide trauma-informed training and support
- Foster a culture that values wellbeing and discourages overwork

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