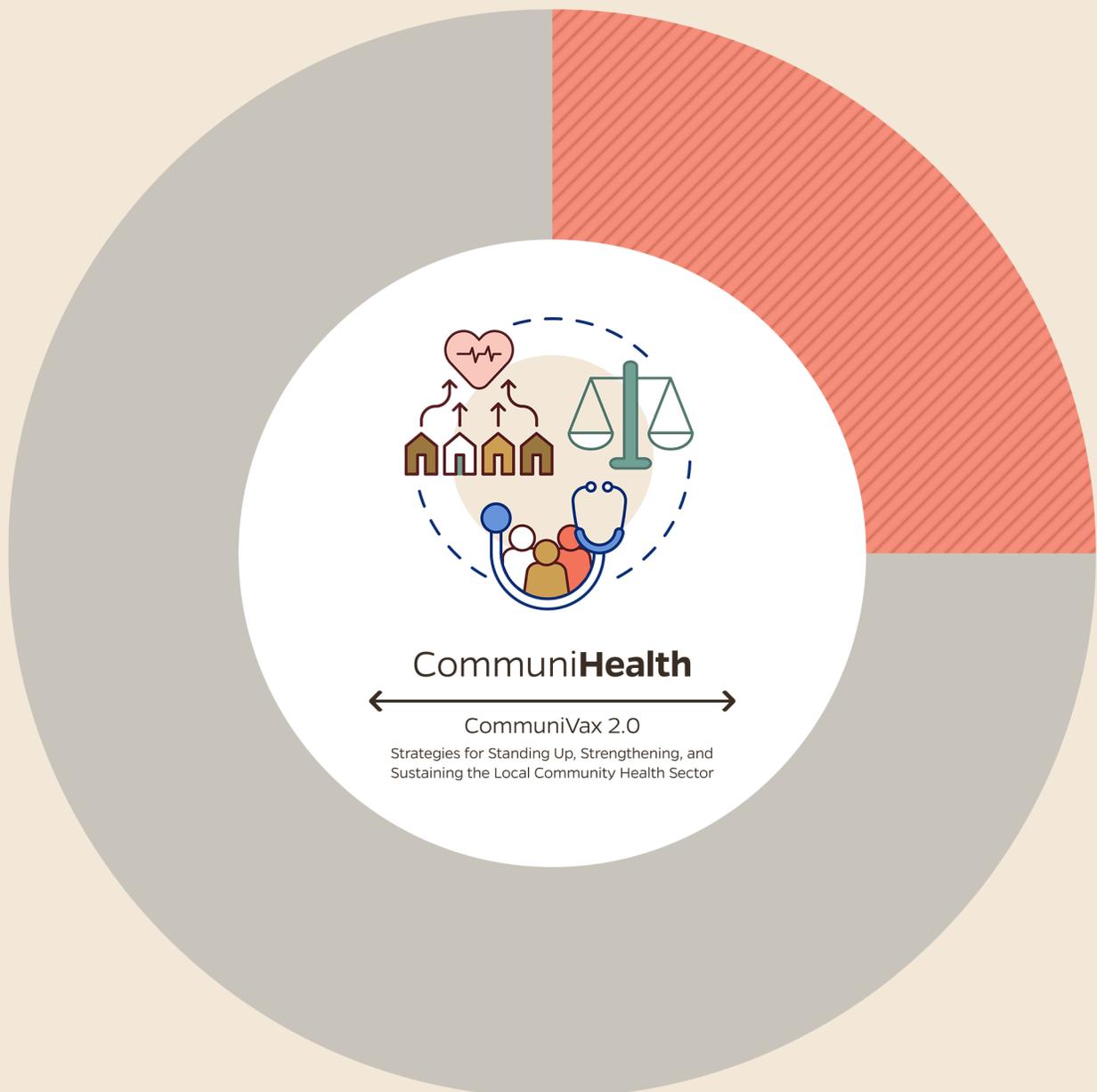




Building a Ground Game: How to Conduct a Community Needs Assessment and Launch a CHW Workforce Development Coalition

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Introduction

Community health workers (CHWs) played a vital role in the emergency response to the COVID-19 pandemic in Alabama.

During this time, community-based organizations (CBOs), faith-based organizations (FBOs), and government centers and agencies mobilized workers with a variety of titles—community health worker, *promotora/promotores*, outreach worker, peer advisor, lay health advisor—but a similar mission: to connect people to the resources they needed to protect and promote their health, including food, transportation, system navigation, testing, personal protective equipment (PPE), and vaccination.

In some Alabama communities, these workers were “natural helpers” in the original sense of the term—trusted family or community members who took it upon themselves to assist those who they saw needed help, as opposed to formally trained CHWs who were deployed for a specific purpose. Dorothy Oliver of Panola, Alabama, is an example of a natural helper. With no formal training, she persuaded more than 98% of the residents of her town to be vaccinated against COVID-19.¹ The involvement of formally trained CHWs often helped to magnify these types of efforts. By leveraging their networks—such as hospital systems and public health departments—CHWs’ efforts can result in scaled-up access to important resources, including health education and clinical services. The common denominator for both natural helpers and CHWs is insider knowledge and support skills. During the COVID-19 pandemic, these combined efforts proved highly effective to connect community members with organizations and institutions providing needed services.

Natural helpers’/CHWs’ local knowledge also should be systematically captured and used to inform state and district policy. Communication between local communities and state and health district agencies is often top-down, meaning that policies and rules may be made or implemented in ways that hamper, rather than facilitate, desired outcomes in local communities. The CommuniVax Coalition was launched during the COVID-19 pandemic to strengthen national and local vaccination efforts in the United States by putting communities of color at the center of those endeavors. CommuniHealth represents the redoubling of those efforts to accelerate the maturation of local community health systems in CommuniVax sites in Alabama, California, and Maryland. The coalescence of community health assets—including CBOs, FBOs, and CHWs—is key to advancing health equity and strengthening trust in public health as the country moves through and beyond the COVID-19 pandemic. As a participant in one of the CommuniVax focus groups explained:

“This is one-on-one influencing, where we are now...and the infrastructure to support that is what [we need]. You know, I think [mass media] campaigns are fine in terms of messaging and those sorts of things, but this [community-level effort] is ground game 101.”

Based on the experiences of the CommuniHealth Alabama team over the past three years, we see the work needed to address the shortcomings in Alabama’s public health and clinical care service delivery, and particularly the access gaps, as analogous to building a successful football offense: we need a strong passing game *and* a strong ground game. At this point, Alabama relies

primarily on its health promotion/health access passing game in the execution of its mission: local public health departments and local providers are the strategically placed receivers who competently serve those who have the instrumental and informational resources to seek services and the skills to successfully navigate the system. Expanding access to public health assurance activities and healthcare providers to those who lack these resources and skills, however, requires a strong ground game. Building a strong ground game in this example involves:

1. training, deploying, and integrating a workforce of locally known and trusted people who can regularly assess community circumstances and identify ways to improve access to the existing system; and
2. regular, two-way communication between local providers and CHWs and between local systems of care and state and district public health/healthcare agencies regarding local health concerns and service delivery.

The Alabama Context

Alabama's CHW workforce is smaller, more diffuse, and less well-connected than those in many other states. Consequently, CHWs' efforts are limited in their reach, and the benefits of CHWs' efforts are under-recognized. However, as noted above, where they are present and given adequate support, CHWs are effective.² Efforts to promote and protect the health of vulnerable communities utilizing CHWs have been taking place in Alabama for more than 20 years and have grown in number and scope over the past decade. These efforts address sexual/reproductive health, substance use, mental health, hearing assessment and assistive technology, diabetes care, and COVID-19 vaccination.

To date, CHWs' efforts have been largely funded through grants. Though most of these efforts are effective, their foci are funder-driven, and the scope and duration of CHWs' paid efforts are limited by the terms of each grant. Currently, however, there are successful federally funded projects operating with an eye toward sustainability. These projects train, place, and integrate CHWs into local providers' service delivery efforts to address mental health and substance use. Additionally, several recently launched state-supported local initiatives are assisting with CHW training and placement in the wake of COVID-19, some of which have explicit long-term workforce development goals. The existence of these projects and their aspirations beyond the status quo suggests that the time is right for a coordinated health equity effort involving CHWs.

Purpose of this Guide

We launched this project with the goals of determining whether there is a perceived need for expanding CHW programs in West Central Alabama, including better support, broader recognition, greater valuation, and sustainable compensation; assessing interest in building a coalition to work toward meeting that need; and establishing the potential initial priorities of such a coalition.

We offer this toolkit as one example of a community health infrastructure development effort centered on CHWs in a state with various challenges, including an understaffed and underfunded public health system and healthcare safety net, a two-century commitment to decentralized government services, longstanding inequalities with respect to the social determinants of health, and marked health disparities. But the state also offers equally longstanding traditions of pride, mutual aid, and support in its communities of color and an unflagging commitment to the pursuit of equal opportunity and equal justice.

Our Aims

To accomplish our goals, we conducted interviews with key stakeholders, including researchers, policymakers, community health workers, and representatives of CBOs and FBOs, state-level agencies and departments, and policy advocacy organizations. Our goals for these interviews were to have stakeholders:

- Assess local capacity to support/promote health and wellbeing (researchers, CBO and FBO representatives, community health workers, state level agency representatives); OR,
- Assess capacity to respond constructively and proactively to chronic and emerging health and health-related challenges (policymakers, state-level agency representatives, policy advocacy organization representatives).
- Share their approach to working with CHWs in terms of recruitment, training, placement, and support; OR,
- Offer their view of the benefits of health equity efforts involving CHWs.
- Weigh in on the need to for a coordinated CHW workforce development effort.
- Assess their willingness to be involved with such an effort.

Our Process

The initial step involved brainstorming a list of stakeholders in multiple sectors (see [Appendix A](#) for an example of the stakeholder table used). To build this list out further, over the course of the project, we asked primary stakeholders to provide recommendations of other contacts.

Initial contact with the identified stakeholders was made through email (see [Appendix B](#)). Team members reached out to stakeholders with whom they had existing relationships. Most interviews were conducted virtually via Zoom (n=16). Two were conducted in-person.

Each interview contained three parts:

- Eliciting stakeholders' assessments of community health in Alabama using adapted COPEWELL self-assessments of community health and wellbeing and countermeasures (see [Appendix C](#) for the assessment tools)^{3,4}
- Querying stakeholders' experiences with health promotion/healthcare access initiatives involving CHWs
- Asking stakeholders' opinions about the need for a coordinated, collaborative CHW workforce development effort and their interest in being involved with such an effort (see [Appendix D](#) for the full interview guides).

For the Zoom interviews, we attached the adapted self-assessment tools to a reminder email sent the day before the interview. This gave the interviewee the opportunity to preview the self-assessments. Following the interviews, we sent all interviewees thank you emails (see [Appendix B](#)).

The interview analysis focused on CHW models, approach to training, relationships with providers, relationships with state and federal organizations, funding sources, and short- and long-term goals. Moving forward, we plan to share the findings of our project with the stakeholders we interviewed by emailing them a copy of this guide as well as our completed report or web link.

What We Learned

Based on our experiences and the analysis of interview data, we suggest the following actions for other groups building a CHW workforce:



Identify and utilize “outside” resources

- Search for and adapt existing tools. Because we wanted our interviewees’ responses to reflect their experience with enacting community health in Alabama *and* with health promotion/healthcare access initiatives involving CHWs, we looked for an existing assessment tool to guide our inquiry. Though originally intended to assess community functioning and predict resilience in the context of natural disasters, we found the COPEWELL self-assessment tools appropriate and user-friendly.^{3,4} Our first interviewee suggested changes to the original COPEWELL capacity rating activity, and we edited the text to make the assessment shorter and more consistent with our inquiry.
- Pursue potentially beneficial affiliations. We recommend that interested parties join their regional or national CHW organization. Joining the National Association of Community Health Workers (NACHW) gave us access to their database, which gave us a place to start in terms of exploring “community health worker” as an occupational identity in Alabama. National or regional associations may be particularly useful if you are relatively new to the area or to CHW initiatives.
- Seek the advice of people with relevant experience, whether geographically near or distant. The CommuniVax Coalition working group, many of whom assumed CommuniHealth roles, included people whose experience with organizational leadership and launching initiatives is broad and deep. One member of the working group with public health administration experience in city and state governments and involvement in nonprofit leadership expressed a keen interest in understanding what might be done to strengthen the public health infrastructure in Alabama, where a decentralized approach to service delivery was the norm and where the local capacity to work with CHW-oriented initiatives was highly uneven. We invited him to be a part of our team, and he agreed, bringing great value in the form of helping to make connections, providing excellent strategic advice, and demonstrating the importance of researching potential partners before inviting their participation.



Build on existing connections AND seize opportunities to expand your reach

- Build on existing connections. Our work with CommuniVax gave us the opportunity to interact with stakeholders at multiple levels of the public health/healthcare ecology, which was important to understanding and documenting the successes and challenges of the COVID-19 vaccine rollout. Consequently, we planned a multilevel inquiry into experiences with/perceived need for an expanded CHW workforce. CommuniHealth team members who were recruited for their knowledge of community health initiatives throughout the state helped make valuable connections to state-level organizations, institutions, and actors with established or developing programs utilizing CHWs (e.g., Partners in Health, Area Health Education Centers [AHEC], Veterans Administration [VA]) with whom we had not previously connected. We were affirmed in this approach by our interviewees’

experiences in implementing programs involving CHWs. These interviewees emphasized the importance of provider and state-level partnerships, particularly regarding CHW placement and occupation sustainability (i.e., consistent work, reasonable workloads, and fair wages).

- Seize opportunities to expand reach. Our senior adviser encouraged and facilitated a connection with a CHW training and support network in a neighboring state, Louisiana, where the legislature recently approved Medicaid reimbursement for CHWs. The similarities in population profile and political environment between the two states, and our Louisiana colleagues' generosity in sharing their insights and experiences, makes this group a promising model for our efforts. They have agreed to provide additional informational and appraisal support, and we are eager to learn from them. Taking the time to research what has been done and to make connections with those whose circumstances are similar but who are further along the path is a good investment.



Include developing AND established CHW initiatives

- Seek advice from people with diverse experiences. Working in a decentralized service delivery environment risks siloed efforts and missed opportunities to learn about and from each other. Among our team member connections, our multilevel approach, and our consistent posing of the question, “Who else should we talk to?”, our interviewees ran the gamut in terms of experience with initiatives involving CHWs. We spoke with the leaders of newly funded initiatives that are approaching their launch, newly developed CHW training programs, and efforts run by researchers, as well as representatives of CBOs and FBOs with decades of experience with CHWs. This positional diversity is a strength of our coalition because it supports a holistic view of the community health infrastructure and contributes to the development of a mission, goals, and working groups by learning from and offering benefits to a range of members.



Acknowledge the difficulties AND see the possibilities for state-level collaboration

- Recognize the gaps in and opportunities for collaborative support in local communities. One challenge to community-based health promotion initiatives posed by a state-level commitment to decentralization can be that state-level administrators may be unwilling to advocate for or create policies that support communities that win grants to successfully implement them. This resistance can reflect a kind of “capacity blindness”—the apparent presumption of a level playing field across communities with respect to their implementation skills and resources. In our case, it manifested as a “hands-off after award” approach to the goal of strengthening local community health infrastructure across the state. “Communities know their own needs and how to address them better than anyone,” was the expressed conviction. This conviction is not wrong, *and* it does not preclude appropriate implementation support.
- Leverage states' interest in their grantees' success. States have an interest in seeing grantees succeed, so it may be possible to leverage that interest in service of better state support for local communities' grant implementation efforts. We see this possibility with the newer, state-funded CHW training and deployment initiatives

previously mentioned. If our coalition can demonstrate that implementation support contributes to successful state-funded initiatives, some policymakers and state agency leaders may be persuaded to reconsider their bootstrap approach to local community health and include implementation resources in their offerings to grantees. These resources might include information on successful program models, training on model selection and adaptation, connection to CHW training resources, and connection with organizations and individuals with experience in the types of state-funded initiatives communities are attempting to implement.



Identify commitments

- Identify and coalesce around goals and commitments. Compromise is a necessary aspect of collaboration; therefore it is important to identify your goals and commitments prior to looking for coalition partners. Our needs assessment served us well in this regard. Having the opportunity to learn about the broad range of approaches to CHW initiatives helped us identify goals and commitments we wanted to pursue within the coalition and those we would pursue on our own if the coalition chose other priorities. These coalition goals and commitments include:
 - Equity in participation and representation: In the spirit of “nothing for us without us,” CHWs must be coalition members and leaders.
 - Data collection, evaluation, and dissemination: Documenting and sharing processes, successes, and challenges are critical elements of successfully building infrastructure and securing funds.
 - Rural health prioritization: While underserved communities exist in both rural and urban areas, many people only imagine city neighborhoods to be in need. Rural health, however, is equally important. In addition, underserved rural and urban communities share some challenges and face unique ones. CHW initiatives thus should be tailored for the setting, and population density should not be the primary driver of resource allotment when building up the community-based workforce.
 - Natural helper/CHW model creation: Our data suggest that a majority of Alabama’s current CHWs are adult women who fit the definition of “natural helper,” a community member with no specific training or certification who knows the community and its needs, is known and trusted by community members, and who may have a history of involvement in other volunteer or paid community-level initiatives. Notably, however, many ideas about growing the CHW workforce captured during our interviews included recruitment through traditional educational channels (e.g., high school, community college, internships, paraprofessional and professional training programs), potentially excluding natural helpers. We do not see these two potential pools of CHWs as incompatible, and we believe that natural helpers offer added value in terms of their knowledge of the community, significant soft skills, and potential as trainers of apprentice CHWs. We intend to advocate strongly for an approach to workforce development that centers and honors what natural helpers bring to this work.



Use data to identify diverse perspectives and potential challenges

- Collect qualitative data to identify key stakeholders’ various perspectives and possible opportunities. One of the benefits of conducting this needs assessment was the opportunity to better understand CHW training and learning about the various CHW models being implemented across the state.
 - Training standardization: Currently, each initiative manages CHW training in its own way—writing their own training programs, implementing or drawing on existing training programs, and/or seeking out partner organizations for training. One stakeholder endorsed the idea of establishing state-level CHW certification to help move toward sustainable funding for CHW services, while others did not identify training standardization as a necessary next step. All mentioned training as an important part of CHW effectiveness.
 - Training type: The overwhelming preference for the CHW initiatives we encountered to conduct their own training appeared to be driven by the breadth of endeavors involving CHWs. Though there is arguably an essential CHW skill set, endeavor-specific training may not be practical to centralize, at least initially. In addition to any necessary didactic instruction, practical components to CHW training can be approached in a variety of ways, including short-term traineeship, apprenticeship, or employee onboarding.
 - Training accessibility: However and wherever training takes place, there are issues of accessibility. In rural areas, online training raises issues of broadband access. In-person training can pose transportation challenges. Other access issues include eligibility for training. For example, undocumented persons and formerly incarcerated persons who have the potential to function brilliantly as CHWs may be ineligible for certification by the state depending on how the guidelines for licensure and certification are written.
 - CHW models: We identified the CHW initiatives described by our interviewees in terms of their practices around recruitment, placement, accountability, and duration of work. We created a grid describing these qualities and four “CHW models”: natural helper, initiative-specific, traineeship, and workforce development. This grid is a way to think about the options for CHW initiatives and their critical elements.

Initiative Models and Characteristics

	Natural Helper	Initiative-Specific	Traineeship	Workforce Development
Recruitment	Community; Word-of-mouth	Community, College/university	College/university	Community college/ University, Word-of-mouth, Social media
Placement	Follow the work	Community partner (CBO, FBO, provider state organization)	Program	Organization/provider partnership
Accountability	Community	Principal investigator	Program	Provider, Community
Duration	Variable	End of project	1 year or less	Variable to stable



Verify findings with stakeholders

- Verify and revise reports based on feedback. By presenting a preliminary report to our interviewees and receiving feedback, we plan to revise the report accordingly. This step is important for the coalition’s credibility as well as being inclusive and accessible.



Embrace serendipity AND keep your options open

- Remain open to and welcome unexpected findings. One very encouraging finding of this needs assessment was learning about a similar budding collaboration targeting CHW workforce development between a University of Alabama-housed CBO and Alabama AHEC. This group has relationships with others around the state—primarily university researchers—whose community health efforts involve CHWs and whose organizing efforts will be valuable to the coalition (e.g., CHW database, soliciting CHW interest in a statewide association). We have agreed to work together.
- Seek out opportunities. We will continue to look for opportunities to advance our priorities—such as focusing on rural community health infrastructure development and including natural helpers, with their distinctive traits and approaches—both as part of the developing coalition and outside of that framework.



Articulate your vision and be open to adaptation

- Use needs assessments to inform vision. In conducting this needs assessment, we gained a better understanding of what a CHW-focused health infrastructure development coalition might look like and the possible elements of a nascent coalition. The model below is a graphic rendering of our vision of what we are calling the Alabama Local Health Infrastructure Coalition (ALHIC):

Proposed Alabama Local Health Infrastructure Coalition (ALHIC) Model



We plan to offer this model, along with the “Initiative Models and Characteristics” table, as jumping-off points to guide discussion of the coalition’s future coalescence and impact.

Final Thoughts

Systematic data collection brings value to development efforts. To accomplish any goal, you must first know your starting point. We embarked on this needs assessment knowing it was an important first step in a project aiming to improve Alabama's local community health infrastructure. In addition to beginning to learn about the current state of Alabama's CHW workforce, we have gained insights that we believe will be beneficial to our developing coalition. These insights include lessons about the similarities and differences among the CHW initiatives we encountered (e.g., longevity, CHW model employed, training); the greater-than-expected level of support for CHW initiatives among existing outreach/policy advocacy organizations; and the promising work already underway to build successful models for CHWs' consistent and sustainably funded presence in local communities. These insights very much informed our proposed coalition model and will provide a solid foundation for initial discussions.

Coalition development involves consistent and effective monitoring and communication. We recognize that although the needs assessment was very helpful in articulating a possible path forward, it was not exhaustive. The group we are joining with has members to whom we have not spoken, either because we did not know of them or because we did not manage to speak with them over the course of our data collection. Additionally, one local safety net provider expressed interest in the coalition, but we were not able to conduct an interview. These gaps remind us that getting the lay of the land is not a one-time event, especially in an environment of high rurality and highly decentralized service delivery. In an environment that lends itself to circumscribed health promotion efforts of varying longevity, regular surveillance and effective communication are key to the success of an inclusive development effort.

Including the perspectives of those less likely to endorse a particular point of view can inform findings and next steps. All the stakeholders we spoke with agreed that CHWs are an important part of the local community health infrastructure. At the same time, among the state-level stakeholders we spoke with, there was limited knowledge of what CHW workforce development might entail and conditional endorsement of the idea that state institutions have a significant leadership role to play in developing the CHW workforce. Some might argue that these findings present barriers to coalition-building and feel that bypassing them are key to less frustration and more success. We argue, however, that by acknowledging potentially challenging circumstances, we can address them in our plans. This approach invites the pursuit of change in the existing environment and underscores the importance of both the "Communication, Documentation & Evaluation" and "Sustainability & Advocacy" elements of the ALHIC model. Documenting and disseminating data about any positive effect of CHWs on the reach and effectiveness of public health/healthcare service efforts and ways that state support of local health infrastructure development translates to better health outcomes may lead to support for policy change.

Conclusion

Our involvement in CommuniHealth marks the *beginning* of our statewide local community health infrastructure development efforts rather than a waypoint within or the culmination of that work. The path we have identified here may change somewhat as we learn more, do more, and evaluate the effects of we have done. Therefore, what we offer is not *the* way to begin but *one* way. On the other hand, having a map for the path forward provides options: to follow, to follow in part, or to choose one's own way entirely. In the realm of community health, judicious choice is paramount, and we hope our lessons are useful to others in finding their paths toward health equity.

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Appendix A: CommuniHealth Alabama Stakeholder Table

CBOs/FBOs	Provider Organizations	Government Departments and Agencies	Civic/Political Leadership	Researchers & Research Institutions	NGOs, foundations, advocacy organizations
Sowing Seeds of Hope	Cahaba Medical Care	AHEC	Alabama Conference of Black Mayors (see roster)	UA Faculty, Department of Anthropology	Partners in Health
Project Horseshoe Farms	Whatley Services, Inc	Alabama Department of Public Health (ADPH)	Congressional Representative	UA Faculty, Department of Community Health	Alabama Arise
Rural Alabama Prevention Center	Rural Health Medical Program, Inc.	Alabama Cooperative Extension Systems	State Senator	UA Faculty, Department of Speech and Communicative Disorders	
Pickens County Community Action Committee		Veteran's Administration	State Senator	UA Faculty, School of Nursing	
Alabama HOPE			State Representative		
Connection Health					

Appendix B: CommuniHealth Sample Emails

Interview Request Email

Hello,

[Assessment team member name] here. I am a faculty member in anthropology at the University of Alabama. I got your name from [name of team member known to recipient], who is working with me on a multi-site project based at Johns Hopkins University Center for Health Security called CommuniVax. In its first iteration (November 2020 – December 2021), its aim was to support distribution of the COVID-19 vaccine in communities of color in six US locations – Alabama being one. One of the findings of our work probably won't surprise you: Alabama's public health 'ground game' – the density, consistency, and sustainability of local health education, promotion and support efforts and two-way, effective communication and coordination regarding those efforts with public health at the regional and state levels – is poor.

CommuniVax is now in its second iteration, and the Alabama team has elected to examine current efforts to improve the local community health infrastructure in Alabama counties that experience health disparities using community health workers (CHWs). To this end, we are conducting interviews with stakeholders we have identified as currently utilizing or supporting the utilization of CHWs in health promotion, communication, education and support efforts. We hope that you and/or other AHEC staff members or leadership will be willing to take part in an interview within the next several weeks to discuss:

- The state of community health and wellbeing in the communities you work with
- Health promotion/health service delivery efforts you know of or are involved in that include CHWs
- Your opinion regarding whether your community would benefit from expanding the reach and effectiveness of its CHW workforce (including training, a formal resource and support network, recognition of the importance of the role and demand for CHWs, and sustainability (policies, funding)).
- Your opinion on the next steps for expanding the reach, effectiveness and sustainability of Alabama's CHW workforce.

The interview takes about an hour, but we can tailor it to whatever time you have available. We are happy to speak with a small group (no more than 7 people) or an individual. The mode is also flexible – we are happy to conduct the exchange in person or via Zoom.

I hope this conversation is something that interests you and that your schedule can accommodate. I look forward to hearing from you.

Sincerely,

[Assessment team member]

Reminder Email

Hello [interview participant],

I am looking forward to our interview tomorrow at 1pm. I have attached a document to this message that we will be discussing in the interview. It is a self-assessment of community capacity to engage in something called “countermeasures’ – engagement in health policies, practices, and programs that enable the community to counteract the effects of existing and emerging health threats.”

We will spend the first portion of the interview discussing this document and your assessment of the capacity for effective countermeasures in your service area. If you have time and wish to review the document before your interview, I welcome you to do that. If you do not have time, don’t worry. We’ve allotted time for that in the interview.

I look forward to meeting you tomorrow at 1pm.

[Assessment team member}

Thank You Email

Dear [interviewee],

This is just a quick note to thank you for taking the time to speak with us yesterday. I learned a lot about how [organization name] enacts the concept of ‘community-based care.’ The information you shared will be very helpful to us in our effort to build the local public health infrastructure in Alabama. I hope we can continue to call on you as a partner in this important effort.

Sincerely,

[Assessment team member]

Appendix C: COPEWELL Assessment Tools

Health and Wellbeing

HEALTH & WELLBEING

Health and wellbeing involve a community's capacity to promote, nurture, and protect the physical, mental, emotional, and spiritual health of all people where they live, learn, work, worship, and play.

WHAT HEALTH AND WELLBEING MIGHT LOOK LIKE IN COMMUNITIES WITH...

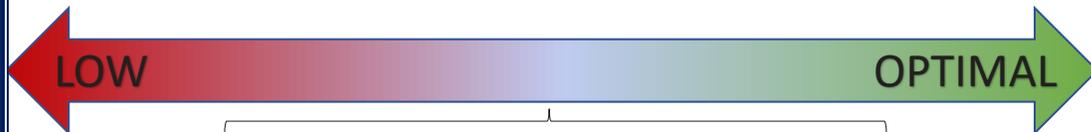
LOW CAPACITY:

Residents feel little sense of purpose and are emotionally and socially cut off from others. People see themselves as unable to influence their future. Places where people play, work, learn, live, and worship are not conducive to physical, mental, emotional, or spiritual health. Music and the arts are not part of most people's lives; there is little pride in or celebration of the community. Rates of disease, injury, and illness are high. Ill health is seen as unavoidable. People with functional and access needs are pushed out of a full and active community life. Quality child care and eldercare are scarce and/or unaffordable. People hesitate to seek out mental health support and can't find options when they do.

OPTIMAL CAPACITY:

Most individuals and families perceive their lives are going well: they feel that they have healthy relationships, positive emotions, the chance for creative self-expression, and an ability to reach their potential. Rates of disease, illness and injury are low. People, including those with functional and access needs, can be productive at work and contribute to their community. Public and institutional policies, environments, and attitudes reflect a high value on community, family, and individual health. Residents have wide access to the arts, culture, and the outdoors. Quality health care services are accessible to all. There is ready access to quality and affordable childcare, adult care, and systems to support aging in place.

INSTRUCTIONS: Think about **health and wellbeing** in your community, and mark on the horizontal line where you think your community falls between the description of '**low capacity**' and '**optimal capacity**'. Once you have made your mark, please list the opportunities and strengths of your community in the area of **health and wellbeing**.



OPPORTUNITIES

STRENGTHS

Countermeasures

COUNTERMEASURES

Countermeasures involve health-related policies, programs, and practices that enable the community to counteract the effects of existing and emerging health threats. Countermeasures are a means for communities to engage in health promotion/disease prevention activities in response to structural and environmental challenges.

WHAT COUNTERMEASURES MIGHT LOOK LIKE IN COMMUNITIES WITH...

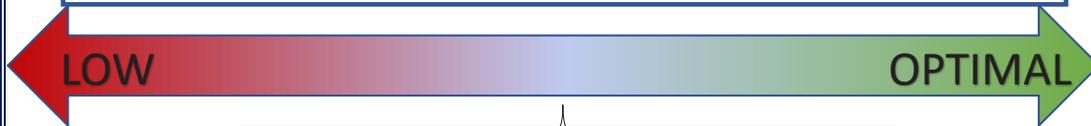
LOW CAPACITY:

CBOs, FBOs, community leaders, health care providers and public health professionals and staff do not interact regularly. Lines of communication between the community and the formal health/public health sector officials are weak and complicated by providers' unexamined assumptions and mistrust among underserved, at-risk groups. Providers and hospitals may work together, but little aside from acute care services receive significant attention. Regional and state public health has limited knowledge of community strengths and challenges, and thus limited ability to recommend, support and monitor countermeasures. Poor agency coordination, lack of outreach to trusted CBO/FBOs, and lack of focus on risk communication hampers the ability to provide consistent, timely, and accurate information about countermeasures. Local organizations' efforts at countermeasures are limited in their reach and impact because of lack of resources.

OPTIMAL CAPACITY:

The network for health promotion is vibrant and diverse, from traditional entities (hospitals, safety net providers, local public health) to community-specific efforts (CBOs, FBOs, university researchers, community foundations, and NGOs). Relationships between public health agencies and communities are strong, and support effective countermeasure recommendations, monitoring, and analysis. Health promotion efforts are effective means of social learning. An ethical framework for allocating scarce resources exists and is known and accepted among all relevant groups. Decision-making processes are designed to be driven by science, ethics, and consultation with stakeholders on multiple levels. Health literacy and public trust in health systems are high.

INSTRUCTIONS: Think about **countermeasures** in your community, and mark on the horizontal line where you think your community falls between the description of '**low capacity**' and '**optimal capacity**'. Once you have made your mark, please list the strengths and challenges that your community faces in the area of **countermeasures**.



OPPORTUNITIES

STRENGTHS

Appendix D: CommuniHealth Interview Guides

Health & Wellbeing

Stakeholder Interview Schedule – Health & Wellbeing

Int ID: _____

Organization _____

Date: _____

Person interviewed: _____

Contact Info _____

Thank you for agreeing to speak with us today; we appreciate your time. For the past year and a half we have been involved in a coalition focused on supporting equitable access to COVID-19 vaccination in communities of color. CommuniHealth, our current project, is focused on building the local public health infrastructure in Alabama communities. Trained community health workers played a large role in COVID-19 vaccination in many communities, including communities in Alabama. However, the effectiveness of these efforts could have been improved by 1) a deeper bench of trained community health workers across the state; and 2) established, two-way channels of coordination and communication with local, regional, and state public health and with health care providers. We are interested in convening a group of like-minded persons who want to work toward establishing 'community health worker' as a recognized, valued and sustainable occupation in Alabama.

We are conducting these interviews with stakeholders we have identified as either already utilizing or supporting the utilization of community health workers in health promotion and/or service delivery. Our aim is to get an idea of where things are currently. Today we will be asking you three things:

- Your assessment of the health and wellbeing in your community/service area
- Health promotion/health service delivery efforts you are currently involved in that include community health workers
- Your opinion regarding whether there is a need for establishing community health worker as a recognized, valued, sustainable (funded) job role in Alabama's public health/health care delivery system, and (if yes) your opinion regarding the next steps are in accomplishing that goal.

INTERVIEWER: Present health and well-being self-assessment module from COPEWELL. Give a few minutes to read.

Part I – Community health and wellbeing

1. How would you describe the capacity of your community in the area of health and wellbeing? Is it closer to low capacity or high capacity?
2. Please tell us a bit about your mission/project goal in regard to community health. What initiatives are you implementing currently? Which of the health and wellbeing bullet points would you say your work addresses?

Part II – Community Health Worker involvement

3. Are community health workers a part of your activities? In what way(s)?
4. Have community health workers been a part of your efforts in the past?

5. How big a role do CHWs play in the type of work you do?
6. How did/do you recruit your community health workers? How are they trained?
7. Have the CHWs on your project served as CHWs on other projects? What proportion are experienced workers, and what proportion are new to the work?
8. If there was an established CHW workforce in Alabama, how might their existence affect how you approach your work?

Part III

9. How did your organization come to be/What is the driver for your current efforts?
10. Do you collaborate with other like-minded agencies or organization?
11. (If yes:) What is the nature and frequency of your collaborations?
12. There are many fabulous community health efforts going on across the Black Belt and Alabama in general. Our goal with CommuniHealth is to try to nurture communication and cooperation around an effort to improve Alabama's local community health infrastructure. We are gauging interest in a coalition whose goal is to develop the CHW workforce as a recognized, valued, effectively placed and sustainably funded part of that infrastructure. Is this something you would like to be a part of? (If YES, continue with questions. If NO, SKIP to Q15)
13. What can you suggest as the next steps we could take in forming this coalition?
14. Is there a goal that you think is a bigger priority for a community health coalition? What might that be?
15. Can you name other groups or individuals whose work is community health that we should contact?
16. Any other advice for us?

NOTES:

Countermeasures

Stakeholder Interview Schedule – Countermeasures _____

Int ID: _____

Organization _____

Date: _____

Person interviewed: _____

Contact Info _____

Thank you for agreeing to speak with us today; we appreciate your time. For the past year and a half we have been involved in a coalition focused on supporting equitable access to COVID-19 vaccination in communities of color. CommuniHealth, our current project, is focused on building the local public health infrastructure in Alabama communities. Trained community health workers played a large role in promoting and supporting access to COVID-19 vaccination in many communities, including communities in Alabama. However, the effectiveness of these efforts could have been improved by 1) a deeper bench of trained community health workers across the state; and 2) established, two-way channels of coordination and communication with local, regional, and state public health and with health care providers.

We are conducting these interviews with stakeholders we have identified as either already utilizing or potentially supporting the utilization of community health workers in health promotion and/or service delivery. Our aim is to get an idea of where things are currently. Today we will be asking you three things:

- **Your assessment of the capacity for effective ‘countermeasures’ in your service area. Countermeasures involve health-related policies, programs, and practices that enable communities to counteract the effects of existing and emerging health threats.**
- **The experience of your organization with community health workers (particularly for the implementation of countermeasures)**
- **Your opinion as to whether:**
 - **there is a need to grow Alabama’s community health worker workforce – and for establishing this workforce as a recognized, valued, supported, sustainable (funded) job role in Alabama’s public health/health care delivery system;**
 - **If yes, your opinion regarding the next steps in accomplishing that goal; or,**
 - **If not, your view of how the local health promotion/disease prevention/disease management needs are being adequately met currently.**

Part I - Present countermeasures self-assessment module from COPEWELL. Give a few minutes to review.

1. How would you describe the capacity of the VA in the area of countermeasures? Is it closer to low capacity or optimal capacity? Is the capacity variable within the VA? (If so, could you provide a description of the range of capacity if the hash mark idea doesn’t capture what you have encountered?)
2. Please tell us a bit about health promotion/disease prevention/health care access efforts at the VA. What are your current priorities? Do any of your efforts fall in the realm of what we are

calling 'countermeasures' (health-related policies, programs, and practices that enable communities to counteract the effects of existing and emerging health threats)?

Part II – Community Health Workers' role in your efforts

3. Community health workers are trusted, respected individuals within a community who work to improve individual and community and health through a variety of informational, instrumental, and emotional support activities. Do any of the VAs efforts involve community health workers (consistent with the definition given)? To what degree? Do you see a role for CHWs in the VA's work going forward? If not, are there barriers to utilizing CHWs, or does the VA fill the role CHWs play in other ways?
4. How are the CHWs you work with/have worked with trained? Are training opportunities for CHWs adequate in number, quality and type?
5. In your experience, how often are people who identify themselves as community health workers and function in that role members of the local community? How often they are people from outside the local area who are employed by an agency, organization or research initiative? Do you feel that the two approaches to recruiting and training community health workers offer particular advantages and disadvantages?
6. How might the existence of an established CHW workforce affect the VA's goals and priorities?

Part III

7. What local or state agencies or organizations do you collaborate with in your efforts to serve veterans in this region?
8. What resources (human, informational, material) would make those collaborations more effective?
9. There are pockets of ongoing work to improve local health/public health across the state. Our goal with CommuniHealth is to gather opinions on whether or not those efforts might be improved with a CHW workforce that is adequate to meet local needs and well-supported with respect to training, multi-level recognition, a strong resource and support network, and sustainable and fair compensation. What is your opinion? Are you willing/able to support a coalition aimed improving Alabama's public health infrastructure in this way?
10. If there is promising interest in developing this coalition among a majority of our stakeholders, what would you say our initial priorities should be? Is there a role that you think would be a fit for the VA in this effort?

