Georgia Health Policy Center

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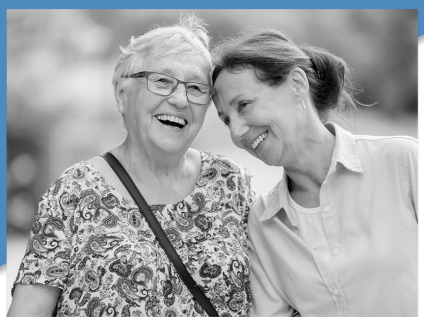



Community Health Worker for COVID Responses and Resilient Communities

Presented to Georgia Department of Public Health, Chronic Diseases and Prevention Section

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report provides evaluation findings on the Train, Deploy, and Engage strategies comprising the Community Health Worker for COVID Responses and Resilient Communities program (CCR-2109) led by the Chronic Diseases Prevention Section within the Georgia Department of Public Health. This program was implemented to increase the workforce and enhance the capacity of Community Health Workers (CHWs) funded under the CCR-2109 grant throughout Georgia to enhance responsiveness and preparedness to address COVID-19 and similar public health emergencies especially among populations living with, or at risk of developing chronic diseases. The evaluation focused on assessing the training provided, the deployment of CHWs within organizations and care teams, and their ability to connect individuals with resources and services.

Key Findings

Successes:

- **Comprehensive Training:** CHWs received comprehensive training to equip them for their roles, including core competencies, chronic disease prevention, behavioral health, and COVID-19 basics.
- **Expanded Reach:** The reach of CHWs' education and messaging efforts significantly increased over the three years of the program, reaching over 300,000 individuals.
- **Increased Referrals:** CHWs made substantial referrals to resources for health and social conditions, with a particular focus on COVID-19 vaccinations, housing, and social services.
- **Enhanced Organizational Integration:** CHWs were successfully integrated into various organizations and care teams, demonstrating strong alignment with their roles and responsibilities.
- **Positive CHW Experiences:** CHWs reported positive experiences with their training, employment, and integration into their organizations. They also expressed a strong sense of value and influence within their respective workplaces.

Challenges:

- **Need for Additional Training:** CHWs expressed a desire for more practical training in areas such as community partnership building and navigating diverse cultural contexts.
- **Referral Process/Resource Accessibility:** CHWs reported some challenges with connecting individuals with the resources to which they were referred. Addressing needs related to housing and transportation proved to be particularly challenging due to limited resources and availability.

The GHPC offers the following recommendations for DPH's consideration in efforts to continue the activities of the program.

- **Continue efforts to increase the CHW workforce, CHW capacity building, and to support the work of CHWs:** Given the positive experiences reported by CHWs and their employers/supervisors, as well as the results of the program, efforts to continue program activities would be valuable to communities throughout Georgia and could lead to the achievement of the program's intended intermediate outcomes that have begun to surface.

- **Provide additional support to facilitate the work of CHWs:** Providing additional CHW training on community partnership building and navigating the diverse contexts, needs, and experiences of the populations served can strengthen the work of CHWs. Also, facilitating CHW awareness of or access to local resources they can use to serve their communities can also support their work; this may be a centralized, online repository of resources.
- **Assess and strengthen the completion of referrals:** To better ensure that the needs of the priority populations are met, assess the extent to which referrals lead to resource or service provision and better health outcomes. Formalizing, standardizing, and requiring the documentation of referrals initiated and completed may support this task.

EVALUATION OVERVIEW

This final annual evaluation report contains the findings of the evaluation of the three-year Community Health Worker for COVID Responses and Resilient Communities program (CCR-2109). In collaboration with the Georgia Department of Public Health (DPH), the Georgia Health Policy Center (GHPC) evaluation team developed an Evaluation and Performance Measurement Plan (EPMP) specific to the implementation of CCR-2109 in Georgia. The EPMP aligns with the implementation-ready (IR) strategies defined by the Centers for Disease Control and Prevention (CDC) as reporting requirements for CCR grantees across the nation. This evaluation focuses on IR strategies 1, 3, 4, 6, and 7 described below.

According to the program design, the IR strategies are contained in three categories Train, Deploy, and Engage. As defined by the CDC, Train strategies focus on increasing the capacity, skills, or roles of community health workers (CHW) to provide priority populations with services and support pertaining to COVID-19 response efforts; Deploy strategies focus on increasing the CHW workforce that deliver services to manage the spread of COVID-19; Engage strategies focus on increasing the utilization of clinical services and community resources among individuals at the highest risk of poor health outcomes, or priority populations.[1,2] The evaluation questions below address the IR strategies and additional factors that are specific to the implementation of CCR-2109 in Georgia. Additional factors the evaluation assesses include: (a) efforts directed toward populations in Georgia communities living with, or at risk of developing, chronic conditions, (b) CHW employment terms, positions, roles, and integration in organizations and any variations across settings (i.e., metro/rural Georgia, clinical/community-based organization, and organizations internal or external to DPH)[3], and (c) disparities in access to resources and services addressed.

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[1] Definitions for Train, Deploy, and Engage categories and strategies are found in DP21-2109 Performance Measure Guidance and Definitions Version 2 – July 2022 developed by CDC's National Center for Chronic Disease Prevention and Health Promotion and recipients.

[2] "**Individuals at highest risk for poor health outcomes**: Individuals at highest risk for poor health outcomes from COVID-19 include older adults, people from racial and ethnic minority groups, people with disabilities, and those with certain underlying medical conditions. Details on medical conditions and other factors that put individuals at higher risk of poor health outcomes from COVID-19 can be found at: People with Certain Medical Conditions | CDC." DP21-2109 Performance Measure Guidance and Definitions Version 2 – July 2022

[3] Internal organizations refer to the 12 public health districts throughout Georgia and five regional cancer coalitions funded by CCR-2109 that employ CHWs. External organizations refer to implementing organizations

Program Components Evaluated

Train

IR1: Identify and collaborate with community wide efforts to ensure comprehensive acquisition of knowledge, roles, and skills by CHWs so they are prepared to successfully engage with existing state and/or local public health-led actions to manage COVID-19 among priority populations within communities.

IR3: Align training opportunities for CHWs with the primary actions of state and/or local public health led efforts to address the underlying conditions and/or environments that increase the risk and severity of COVID-19 infections among priority populations within communities.

Deploy

IR4: Integrate CHWs into organizations and care teams to support the public health response to COVID-19 among priority populations within communities.

Engage

IR6: Coordinate and/or promote opportunities, such as messaging/education within communities and clinical settings to facilitate the engagement of CHWs in addressing the needs of those at highest risk for poor health outcomes, including those resulting from COVID-19.

IR7: Facilitate engagement of CHWs in the care, support, and follow-up across clinical and community settings of priority populations at highest risk for poor health outcomes, including those resulting from COVID-19.

Evaluation Questions

This evaluation aimed to answer the following main evaluation questions.

1. How effectively do CHW trainings equip the CHW workforce with capacities to successfully engage with priority populations within Georgia public health districts? (Associated IR Strategy: IR1)
    a. To what extent are CHWs equipped to address underlying conditions that serve as risk factors for COVID-19 among priority populations? (IR3)
    b. Are CHWs representative of and/or knowledgeable of their communities?
    c. Under what terms are CHWs hired (e.g., employment status, compensation) and to what extent are these adequate?
2. How do CHW positions, roles, and integration vary by setting (clinical, community-based organization, health district) and by rural/urban status of community?
3. How effective are employer trainings in building organizational capacity to hire, retain, integrate and support CHWs? (IR4)
4. To what extent does the DPH-supported infrastructure promote the reduction of the disparity in COVID-19 risk demonstrated by the “two Georgias” (rural Georgia and metro Atlanta)? Mitigate undue COVID-risk? Reduce disparities in access to community resources and services?

(ARCHI and United Way of Greater Atlanta) and their affiliated organizations that employ CHWs (Atlanta Masjid Al-Islam, Grady Health System, the Martin Luther King Sr. Community Resources Collaborative, and Mercy Care).

5. To what extent does the infrastructure built by DPH achieve short and intermediate-term outcomes (increased workforce delivering services, increased integration of and system-level support for CHWs, increased referrals and use of community resources and clinical services)? What are barriers, facilitators, and recommendations? (IR6, IR7)

The evaluation team utilized the following data collection activities and sources to answer the preceding evaluation questions. This report will provide program year 3 findings in context of findings from years 1 and 2.

CHW Employer/Supervisor Interviews
Between February and April 2024, the evaluation team interviewed nine CHW employers or supervisors. Most individuals had a supervisory role. In summary, interviewees were asked about their thoughts, opinions, and experiences around the role, expectations, onboarding, employment terms of CHWs. The team also asked about successes and challenges with integrating CHWs into their respective organizations, and CHW support provided and needed.

CHW Employer/Supervisor Survey
This survey was utilized in years 2 and 3. Fourteen employers and supervisors of CHWs responded to the survey in year 3 between June and July 2024. Survey questions were contained in the following categories: demographic and background information, CHW employment information (e.g., compensation), training and support received by supervisors to supervise CHWs, organizational definitions and requirements of the CHW role, and sustainability of the CHW role at the organization.

CHW Focus Groups and Interviews
The evaluation team conducted a focus group discussion and individual interviews with a total of 10 CHWs between February and April 2024. Individual interviews were conducted with CHWs (n=3) that were unable to attend the scheduled focus group. In summary, CHWs were asked about their thoughts and opinions on how well they have been prepared and supported to carry out their role by trainings and support from their supervisors in addition to their experiences at their organizations. They were also asked about their familiarity with the needs and lived experiences of the communities they served, their perspective on the resources the community members need to thrive, and their experiences with making referrals.

CHW Survey
This survey was utilized in years 2 and 3. Twenty-seven CHWs responded to the survey in year 3 between May and June 2024. Survey questions were contained in the following categories: demographic and background information, CHW employment information, current roles and activities, perceptions on compensation and value at their employing organization, involvement and embeddedness in organizations, perceptions of training quality, adequacy of resources and support available for the CHW role, frequency of referrals, and plans for future work as a CHW.

DPH Performance Measures Data
On a semiannual basis, DPH reports performance measure data to the CDC. These data correspond to the IR strategies including the ones this evaluation focuses on. The data were shared with the GHPC evaluation team for incorporation in this report.

Meeting Attendance and Notes
Throughout the program, the evaluation team attended meetings including one or more of the following program stakeholders: program staff and internal evaluation team staff at DPH, and external implementing partners (ARCHI, United Way, the Corporation for Supportive Housing, and Morehouse School of Medicine). The meetings centered on updates around program implementation and evaluation. GHPC recorded notes on these monthly meetings and reported them to DPH to highlight key decisions, developments, and potential facilitators and barriers about program implementation.

Monthly Referral Forms
In year 2, the evaluation team collected data on referrals made by CHWs every quarter from the partners at organizations external to DPH (ARCHI and United Way of Greater Atlanta) that supported the employment of CHWs at their partnering organizations (i.e., Grady Health System, Mercy Care, Atlanta Masjid Al-Islam). In year 3, the evaluation team adjusted the frequency of referral data collection to a monthly basis to enhance the accuracy of the data. GHPC collected referral data in alignment with the categories set by the CDC's performance measures; on a high level, the categories were organized into referrals to (1) services to address health conditions and (2) social services. DPH also collected referral data in accordance with these categories from CHWs at the public health districts and regional cancer coalitions (internal organizations).

Limitations
Only supervisors and employers at the public health departments and regional cancer coalitions (internal organizations) responded to the year 3 employer/supervisor survey. Survey data collection did not begin until year 2 and interview data was collected only in year 3, so this limits comparisons that can be made with the first year of the program. Lastly, consistent referral data was challenging to collect from external organizations which has limited the amount of year-to-year analysis the evaluation team could do on these data.

HIGH-LEVEL EVALUATION FINDINGS

The evaluation team assessed the following program components (IR strategies) focusing on processes and the short-term outcomes. With the continuation of the CCR-2109 program or components of the program, the evaluation team expects that the achievement of the short-term outcomes detailed below will lead to the following intermediate outcomes. See the program logic model in Appendix A for further details on precedents to the outcomes.

Intermediate Outcomes:
- Increased reach of CHWs[4] among priority populations
- Continued promotion and integration of CHWs into the workforce
- Enhanced referral management system
- Increase use and utilization of community resources and clinical services to those within priority populations

[4] Unless otherwise noted, "CHWs" refers to CHWs at both internal and external organizations.

Summary of Short-term Outcomes Achieved in the CCR-2109 Program

Short-term Outcome	Progress
Increased skills and ability of CHWs to deliver services in communities	Achieved
Increased workforce of CHWs delivering services among priority populations	Achieved
Increased awareness of CHWs and skills acquisition to support CHWs	Achieved
Increased provision of community resources and clinical services to those within priority populations	Achieved

Train

IR1: Identify and collaborate with community-wide efforts to ensure the comprehensive acquisition of knowledge, roles, and skills by CHWs so they are prepared to successfully engage with existing state and/or local public health-led actions to manage COVID-19 among priority populations within communities.

IR3: Align training opportunities for CHWs with the primary actions of state and/or local public health led efforts to address the underlying conditions and/or environments that increase the risk and severity of COVID-19 infections among priority populations within communities.

Short-term Outcome: Increased skills and ability of CHWs to deliver services in communities.

Not Achieved at All	Partially Achieved	Achieved

Facilitators:

Trainings Created and Available to CHWs

- CHWs did not have difficulty finding trainings that were relevant to their positions
- Supervisors were able to direct CHWs to any trainings that they thought might be beneficial to the CHWs

Trainings Completed

- All CHWs hired under CCR-2109 reported attending multiple trainings before being placed in the field
- CHWs also reported being encouraged and supported in continuing trainings throughout their tenure as CHWs under 2109
- CHWs also reported that the trainings were useful and gave them key skills to perform their duties

Barriers/Potential Challenges:

- CHWs did not feel like the training prepared them for the "soft skills" that they needed, for example, establishing and maintaining relationships with key partners
- The CHWs reported that some of the information in the trainings did not translate to real world experiences
- Most CHWs either did not have or did not know if they had professional development funds available to them

Deploy

IR4: Integrate CHWs into organizations and care teams to support the public health response to COVID-19 among priority populations within communities.

Short-term Outcome: Increased workforce of CHWs delivering services among priority populations

Not Achieved at All	Partially Achieved	Achieved

Facilitators:

- CHWs are employed in 12 public health districts
- CHWs are distributed across the state of Georgia, in both rural and urban areas
- CHWs are in 12 public health districts
- Regional Cancer Coalitions (RCC), Non-profit/non-governmental organizations (NGO), and religious organizations employ CHWs under this grant
- CHWs are hired and compensated for their work

The CHWs all reported being in a paid position

- CHWs work with populations that are vulnerable to chronic disease
- Supervisors and CHWs report working with vulnerable populations, 80% report working with individuals with chronic disease
- CHW report being clear on their duties and the aspects of their jobs

The workforce was increased by the CCR-2109 funding.

- 73% of the CHWs were not in the workforce as CHWs prior to the grant funding
- These CHWs were fully trained and deployed under CCR-2109 funding
- Before 2109 funding, most (86%, n=12) internal supervisors/employers reported having no CHWs.

Barriers/Potential Challenges:

- Building trust with the community took time and intentionality due to historic mistrust between the community and the institutions.

Engage

IR6: Coordinate and/or promote opportunities, such as messaging/education within communities and clinical settings to facilitate the engagement of CHWs in addressing the needs of those at highest risk for poor health outcomes, including those resulting from COVID-19.

IR7: Facilitate engagement of CHWs in the care, support, and follow-up across clinical and community settings of priority populations at highest risk for poor health outcomes, including those resulting from COVID-19.

Short-term Outcome: Increased awareness of CHWs and skills acquisition to support CHWs

Not Achieved at All	Partially Achieved	Achieved

Facilitators:
Increased awareness of CHWs

- CHWs often provided health education through screening events, community health fairs, and other community events
- CHWs built relationships with local organizations and the community residents in the counties they served
- DPH funded 10 awareness videos produced by Georgia Watch to inform the public about the CHW role

Skills acquisition to support CHWs

- In year 3:
    - Supervisors continued attending topical training on CHW supervision. Most supervisors (n=9) participated in training about the CHW model or profession or training specific to supervising CHWs
    - Compared to the other rating options (poor, fair, and good), supervisors most often reported an "excellent" quality of support from their supervisors (n=8), peers (n=6), and from the overall culture of support within their organization (n=7) to provide CHW supervision

Barriers/Potential Challenges: None to report.

Short-term outcome: Increased provision of community resources and clinical services to those within priority populations

Not Achieved at All	Partially Achieved	Achieved

Facilitators:

- CHWs established relationships or partnerships with community partners or other resource providers that strengthened referral processes
- Referrals increased considerably each year from year 1 to year 3
- Referral systems (including Unite Us, Find Help, Epic, Community Resource Hubs) were utilized by CHWs

- External organizations utilized mini grants to address social determinants of health (SDOH) by providing resources including rent and utility assistance to those facing financial hardship, meal delivery to those with compromised health, food drives, and health education events

Barriers/Potential Challenges:

- Requirements to report referrals were not set for external CHWs
- Referral processes outside of clinical settings do not appear to be formalized
- Due to varied challenges including resources becoming unavailable, and delayed access to resources, referred individuals have encountered barriers to resources

EVALUATION SUMMARY

This section describes findings based on the quantitative data and thematic analysis of qualitative data related to the Train, Deploy, and Engage strategies. Beyond the data that corresponds directly to the performance measures associated with the strategies, additional data provide context for the implementation of the program and the facilitators and barriers encountered.

Train

To enhance the effectiveness of CHWs in local public health initiatives, DPH and implementing partners implemented comprehensive training courses. These trainings focused on equipping CHWs with the necessary knowledge, roles, and skills to actively participate in community-based interventions. The training curricula were specifically tailored to support local public health efforts aimed at mitigating the heightened risk and severity of COVID-19 infections and other chronic illnesses among priority populations within the target communities.

Strategy Evaluation and Implementation

The target population for this strategy consists of individuals who are disproportionately susceptible to COVID-19 and other chronic illnesses, including those living with or at risk of developing chronic conditions. In alignment with IR strategies 1 and 3, the evaluation team assessed (a) the trainings received by CHWs (e.g., core competency, chronic disease prevention, behavioral health, and CHW/COVID-19 basics) and (b) the activities related to local entities integrating CHWs into planning and operations of community public health responses.

Process and Outcome Evaluation Questions

Process evaluation questions for this strategy monitor or assess the types of trainings completed by CHWs. Outcome questions aim to determine the effectiveness of the trainings at both the CHW and employer levels in serving the target population and advancing the CHW workforce in Georgia.

Types of CHW Trainings

Consistent with the previous year, CHWs received comprehensive training to equip them for their role in implementing interventions that address chronic illnesses within their communities. The same training modules were offered in both year 2 and year 3, so we were able to report across year 2 and year 3. To streamline analysis, the data from these two years were combined.

Table 1. Trainings offered under CCR-2109 and the percent of CHWs surveyed in years 2 & 3 that took those trainings

Trainings	Total Percent of CHW that attended in Year 2 and 3
CHW Core Competency Training	87%
Behavioral Health Training	56%
Heart Healthy Ambassador Training	60%
CHWI Asthma Education Training	54%
Morehouse School of Medicine CHW Education Training	49%
Diabetes Prevention Training	53%
Catalyst Training for CHWs	47%
The Corporation for Supportive Housing CHW Training	38%

Over the two years, 45 unique CHWs completed the annual CHW survey. Table 1 provides a detailed breakdown of the trainings offered and the percentage of CHWs who completed each training in year 2 and year 3. It is important to note a substantial decrease in attendance for the CHW core competency training in year 3, likely due to many CHWs completing this training at the beginning of their tenure.

CHW Perception of Training Outcomes

Overall, CHWs expressed satisfaction with the training programs attended in both year 2 and year 3. There were no substantial differences in training ratings between the two years, so ratings for both years are combined (see Figure 1). The Behavioral Health Training was particularly well-received, with 100% of CHWs finding it useful or extremely useful. Additionally, CHWs noted that the trainings effectively prepared them to address COVID-19 and collect data on services, referrals, and supports provided to their clients.

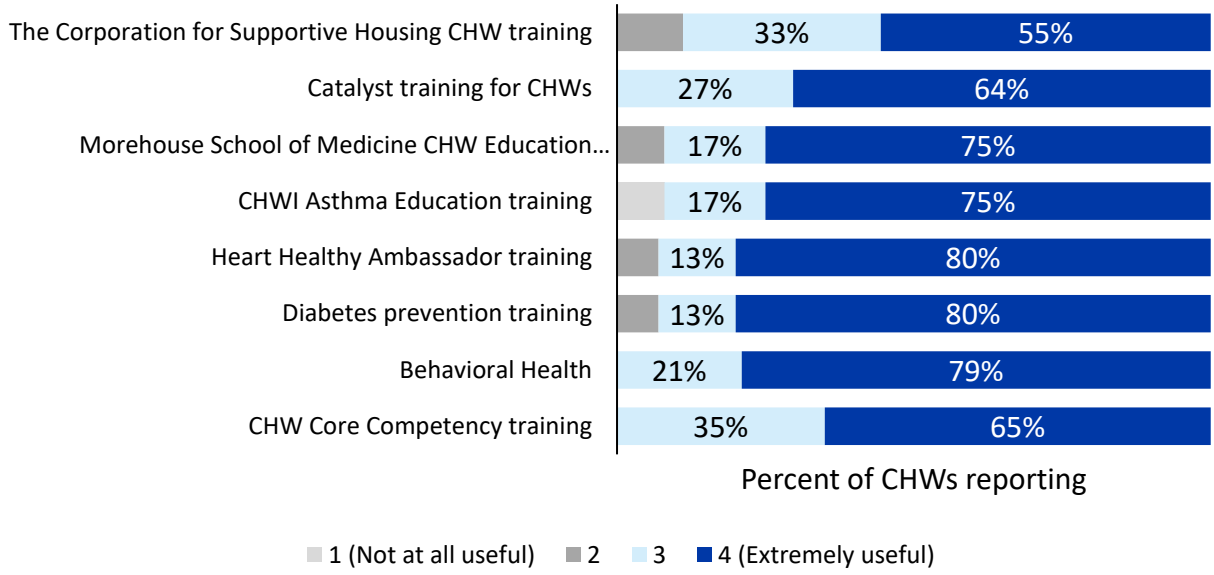


Figure 1. CHWs perception of the usefulness of trainings under CCR-2019 in both year 2 and year 3.

> *"I always think there can always be more training on cultural competency. We live in the South, you can think you're being polite by calling people ma'am and sir, but that can be offensive, making any types of assumptions. Just being reminded that everyone is different and you really have to pick and choose your words very carefully without being standoffish and without feeling like you're tearing on thin ice. I think that would be great."*
> *-CHW Supervisor*

Additionally, CHWs reported feeling encouraged to seek out and participate in trainings that they identified on their own. Many expressed that their supervisors were supportive of these endeavors, often discussing potential training opportunities and providing encouragement to attend. For instance, one CHW noted, "My supervisor definitely encourages me to attend as many trainings as I can. She tells me that I can leave the office if I need to attend a conference or training."

While CHWs found the trainings valuable, they felt that they lacked preparation for certain aspects of their roles, particularly those involving "soft skills." Many CHWs expressed a desire for more practical training on topics such as building relationships with community partners, navigating diverse cultural contexts, and effectively seeking out and utilizing

community resources. As one CHW noted, "The trainings from the DPH didn't really prepare me for community resources, like how to find them, what partners or organizations to reach out to."

Support of CHWs in Pursuing Relevant Training

In both year 2 and year 3, CHWs reported feeling encouraged to attend trainings that aligned with their work and appreciated the availability of additional training opportunities through their organization (Figure 2). However, monetary support for continued training was lacking for CHWs working in metro areas, with only 22% reporting being paid to attend further trainings compared to 50% of their rural counterparts. Despite this, 58% of CHWs indicated having access to professional development funds (Figure 2).

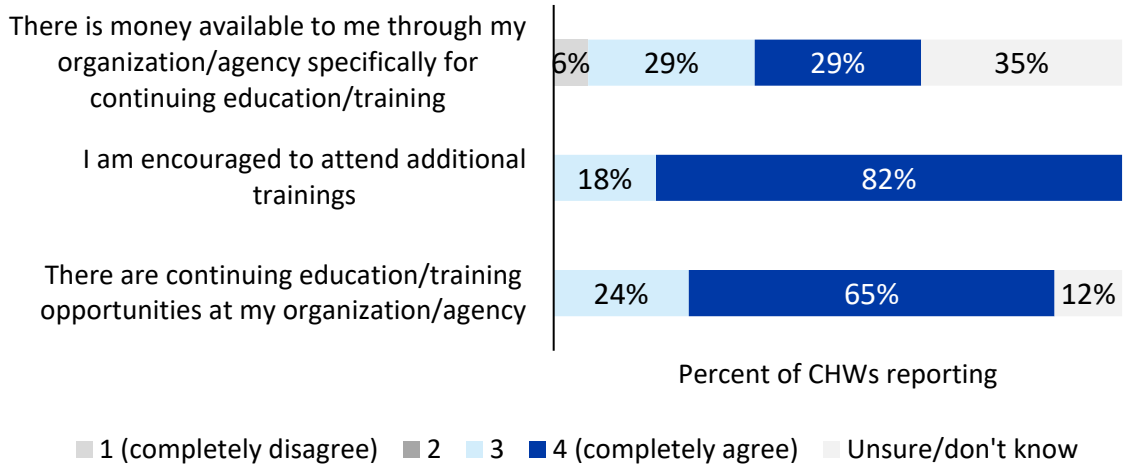


Figure 2. Percent of CHWs in years 2 and 3 reporting on their perception of availability of trainings and if they felt encouraged to take additional trainings

In addition to taking the initiative to seek out trainings, CHWs also reported that supervisors often shared information about upcoming training opportunities, encouraging their CHWs to participate. As one CHW noted, "They [supervisors] encourage me to take these trainings when they pop up. They say, 'oh, you need this one. Go ahead and take this one too.'" This proactive approach from supervisors demonstrated their commitment to fostering professional development among their team members.

CHW Experience and Alignment with the Communities that They Serve

Across year 2 and year 3, CHWs reported that the training they received effectively prepared them to serve their communities. Additionally, their ability to connect with and work effectively with the populations they serve was a key factor. The top three areas of relatability identified were sharing the same racial or ethnic background and sharing the same language (see Table 2).

Table 2. The most frequently endorsed ways that CHWs reported relating to the communities they served in year 2 and year 3.

How do you personally relate with the people/community that you serve?	Percent of CHWs reporting
We live in the same neighborhoods	36%
We share the same race/ethnicity	59%
We belong to the same religion (e.g., church, temple)	21%
We share the same language(s)	54%
We experience the same health conditions	36%

Deploy

To bolster the public health response to COVID-19 among priority populations within communities, CHWs were integrated into various organizations and care teams.

Strategy Evaluation and Implementation

The target population for the Deploy strategy included partner organizations responsible for hiring CHWs, encompassing the 12 funded Public Health Districts, five RCCs, United Way of Georgia (UWGA), and Atlanta Regional Collaborative for Health Improvement (ARCHI). To evaluate this strategy, IR4 was assessed to measure (a) the number and types of organizations or entities integrating CHWs into local COVID-19 response efforts and (b) the number of CHWs employed by each partner organization and care team.

Process and Outcome Evaluation Questions

Beyond IR4, the evaluation team assessed how well CHWs were integrated into organizations and care teams by examining factors such as employment terms, supervision, CHWs' service delivery responsibilities, and their roles within the organization. The outcome question assessed the effectiveness of employer/supervisor trainings in building organizational capacity to hire, retain, integrate, and support CHWs in their work environments.

CHW and Employer/Supervisor Demographics

Over the two years (year 2 and year 3), 50 unique CHWs funded under CCR-2109, who completed at least 50% of a CHW survey, were included in the analysis. The majority were women (92%, n=46) and Black (56%, n=28), with the remainder identifying as White (32%, n=16), Latinx (8%, n=4), or Asian (2%, n=1). Most CHWs resided in the metro area (n=16). Respondents primarily held college undergraduate degrees (52%, n=26) or graduate degrees (32%, n=16). For many, this was their first experience as a CHW (66%, n=33), while those with prior CHW experience had worked in the field for at least seven months to three or more years outside of CCR-2109.

Employers and supervisors of CHWs were also surveyed. Twelve employers and supervisors completed the survey, representing six organizations within DPH and two external organizations (a non-profit/non-governmental organization and a federally qualified health center). Most employers and supervisors were White (43%, n=6) or Black (29%, n=4) women (79%, n=11).

Table 3. List of organization types that CHW served in and the number and percent of CHWs in each organization type according the CHW survey

Organization type	Percent of CHWs in Year 3	Number of CHWs in Year 3
Health Departments	38%	10
Non-profit organization/non-governmental organization (NGO)	23%	10
Non-profit community-based coalition	15%	4
Clinical - Federally qualified health centers	12%	3
Religious entities	4%	1
Other	8%	2

Hiring and Deployment of CHWs

In year 3, most responding CHWs were deployed in rural Georgia (70%, n=19), with the remaining 30% (n=8) based in the Atlanta Metro Area. This represents a shift from year 2, when CHWs working in rural areas accounted for just over half of those deployed (56%). Health Departments remained the primary employer of CHWs (38%, n=10), followed by non-profit/non-governmental organizations (23%, n=6). The remaining CHWs were employed through non-profit community-based organizations, religious organizations, and federally qualified health centers (FQHC, see Table 3).

Populations Served and Services Provided

Table 4 presents a breakdown of the most frequently served populations by CHWs across year 2 and year 3. In general, CHWs reported serving individuals with chronic conditions, ethnic or racial minorities, and seniors, regardless of geographic location. However, rural Georgia CHWs served a broader range of populations, including postpartum individuals and farm or migrant workers.

The most common CHW activities included providing health education and information (n=47) and conducting outreach (n=43), such as presenting at community organizations or events. More than half of CHWs also engaged in providing direct services (e.g., screenings, resources), care coordination and case management, and advocating for resources and policies to benefit individuals and communities.

Table 4. Most frequently reported populations that CHWs reported working with across both year 2 and year 3.

Population	Percent of CHWs Serving Population in years 2 and 3	Number of CHWs Serving Population in years 2 and 3
Individuals with chronic conditions	80%	42
Racial or ethnic minorities	77%	41
Seniors (over the age of 65)	71%	38
Families with infants/children/adolescents	51%	27
Individuals who are unhoused	47%	25
Individuals with a disability	36%	19

Terms of Employment

According to survey responses from employers/supervisors and CHWs, all CHWs are paid employees, with the majority (81%) working full-time. Most of the RCCs and external organizations (1) have well-defined roles for their CHWs, (2) adhere to the American Public Health Association's definition of a CHW, (3) include the 10 core roles of a CHW in their written scope of work, training, or job description, and (4) require CHWs to complete a state or CHW network/association-recognized CHW core competency-based training program before or after hire.

Paid CHWs receive either hourly wages or salaried compensation. Reported hourly rates for full-time CHWs ranged from $16.00 to $27.68 per hour, while salaries ranged from $37,500 to $54,000. There is no apparent correlation between CHWs' work settings and their pay. However, education level may influence pay, as only those with graduate degrees reported salaries of $45,000 or higher.

Most supervisors/employers (85%, n=11) indicated that CHWs are eligible for promotions and pay increases. Internal organizations reported offering a variety of benefits beyond the standard health,

dental, and vision coverage, including sick leave, transportation or mileage reimbursement, and retirement or pension programs.

CHW Roles

According to supervisors and CHWs, CHWs are expected to be highly motivated and proactive individuals who are actively engaged in their communities. As one CHW supervisor noted, "I'm looking for a go-getter and a bringer-backer, someone who can go out and investigate and bring back their findings."

> *"They have to be great problem-solvers and have to be super resourceful. And so we can't teach that. So in our interview questions, we try to be as strategic as possible to glean that information in our interview questions that this person can be resourceful and can problem-solve and doesn't frustrate easily. That's baseline. Those are some baseline soft skills that everybody's got to have because this work is very difficult and our patients can be very difficult and their situations are very complex. And so a CHW has got to be, they also have to be resilient."*
> *-CHW Supervisor*

Supervisors report looking for individuals with 'soft skills' that will help them succeed in this position. Particularly, effective communication and relationship-building skills are essential for CHWs. As another supervisor stated, "CHWs must be able to build rapport and relationships, both within the organization and outside." Additionally, CHWs should be organized, reliable, and accountable, demonstrating a commitment to their work and a willingness to learn and grow.

Knowledge of public health principles and the ability to navigate complex situations are also important for CHWs. One supervisor emphasized the need for CHWs to be "knowledgeable about public health principles" and "able to navigate those quick-thinking situations."

Another 'soft skill' CHW supervisors look for is being empathetic and committed to helping others. As one supervisor noted, "CHWs need to be able to connect with others, listen to them, and be empathetic."

CHW Integration into Organization

Sixty-seven percent of CHWs have been employed by their current organizations for over a year, indicating a relatively high degree of tenure. The majority of CHWs surveyed reported strong integration within their organizations, as evidenced by factors such as having an organization-issued email address and being included in site-wide communications (82%), participating in staff meetings (68%), receiving site-specific training (68%), possessing a site-issued badge (67%), and having a dedicated workspace (65%). These indicators suggest a high level of organizational commitment and involvement.

CHWs also reported feeling valued in the organizations where they were employed across both year 2 and year 3 of the grant, with CHWs reporting that they agree or completely agree that their organization values their work as a CHW (96%), they feel valued by their supervisor (95%), and they feel valued by the rest of the team (94%, see Figure 3).

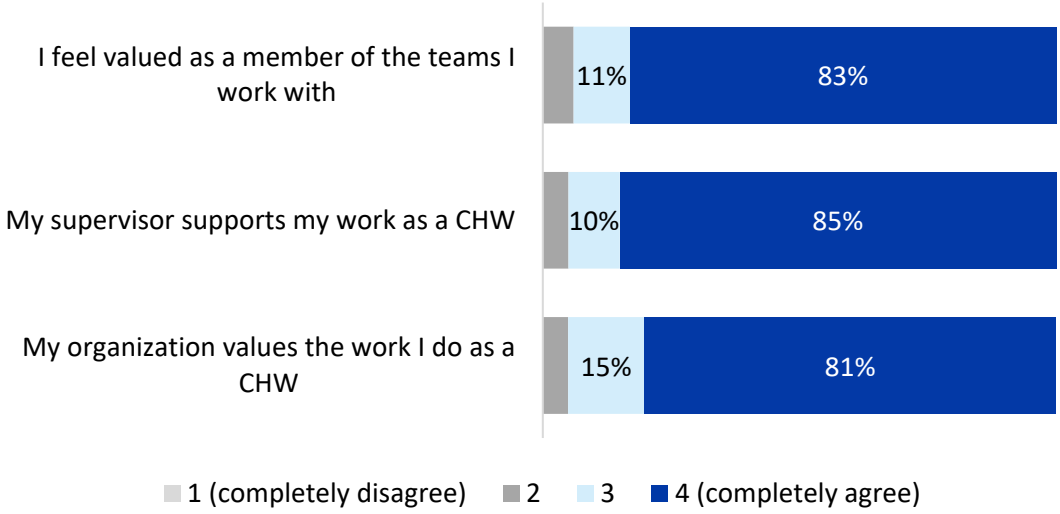


Figure 3. CHW report of their perception of how supported and valued they are at their organization and by their supervisors, both in year 1 and year 2.

Additionally, most CHWs reported that they have influence at their respective organizations. Most reported that people who influence change in their organization seek their opinion and participation (75%, n=36) and that they have influenced the way things are done at their respective organizations including trainings and policy (61%, n=30, see Figure 4). The interviews affirmed these findings and further illuminated that while the input and suggestions of CHWs are sought out and encouraged, in most cases, they do not directly influence policies at their organization or beyond.

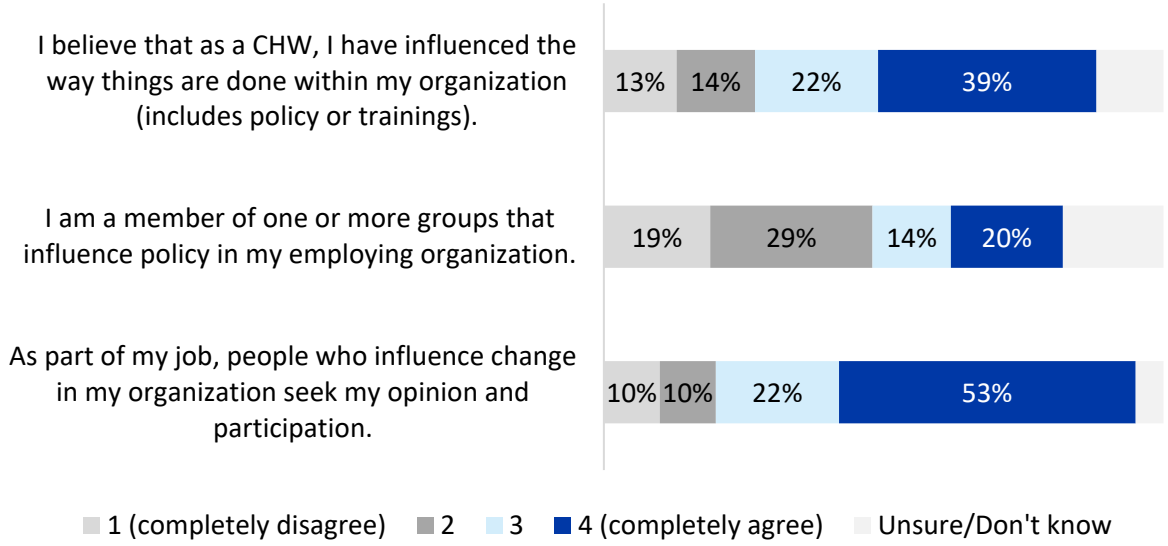


Figure 4. CHW report of their perception of how their ability to influence policy at their organization, in both year 1 and year 2

Establishing Trust with the Community

Building trust is a cornerstone of effective CHW work, facilitating strong relationships and enabling CHWs to provide essential support to community members. Trust building was one area that many CHWs reported having to work to specifically accomplish. As one CHW noted, "Building trust takes time and effort. It's about showing people that you care and that you're there to help." Another CHW emphasized the importance of cultural sensitivity and respect: "It's important to be aware of the unique experiences and perspectives of the community you're serving."

> *"I [had] to introduce myself and get to know them (community members). And, I guess, they were already familiar with the last CHW, so getting to know me is another process. I feel like also the last one was already established in the community and they were more familiar with her. So getting myself established in all the communities has been a little difficult, and getting them to have trust is another big thing."*
> *-CHW*

To establish trust, CHWs stated that they had to demonstrate reliability, consistency, and a genuine commitment to the community's well-being. As one CHW explained, "Trust is earned through actions. By being reliable and consistent, people will start to see you as someone they can count on." Building trust can be particularly challenging in communities with historical trauma or mistrust of healthcare providers. In such cases, CHWs must approach their work with sensitivity and understanding, acknowledging past injustices and demonstrating a commitment to equity.

Leveraging existing community relationships can also facilitate trust-building. By working with trusted community leaders and organizations, CHWs can gain access to individuals who may be hesitant to engage with traditional healthcare providers.

Ultimately, CHWs reported that they were able to build rapport by demonstrating their knowledge, skills, and commitment to the community, as a result, CHWs reported they were able to earn the respect and confidence of individuals and families. As one CHW stated, "When people see that you're genuinely trying to help them, they're more likely to trust you."

Engage

To increase the connection of individuals to community resources and clinical services, CHWs made and followed up on referrals among the communities they serve.

Strategy Evaluation and Implementation

The populations that CHWs served as determined by their employing organizations encompassed the priority populations whose needs would be addressed through the Engage strategy. The evaluation team assessed IR strategies 6 and 7 to measure (a) the number of individuals reached through education and messaging and (b) the number of individuals that were referred to resources for specific health and social conditions that increase the risk for COVID-19.

Process and Outcome Evaluation Questions

Beyond IR strategies 6 and 7, the evaluation team assessed facilitators and barriers around communicating health information, making referrals and connecting individuals to the resources they need.

CHW opportunities (e.g., messaging and education) within communities and clinical settings to address needs of the priority populations:

From year 1 to year 3, the reach of education and messaging from the CCR-2109 program increased starting from approximately 5,777 individuals reached in year 1 to 244,319 individuals in year 2, and 318,398 individuals in year 3 (Table 5). Topically, this education and outreach addressed chronic conditions, COVID-19, preventative measures, and living a healthy lifestyle. Methods used for this outreach and education included messaging through social media, webinars, and websites; internal CHWs disseminating messaging; speaking at events and door-to-door outreach. Relatedly, through the public health districts and RCCs, DPH accomplished additional outreach through mass media campaigns that communicated information about COVID-19 in year 1 (n=259,852) and year 2 (n=1,837,078). Year 2 and year 3 (as of May 2024: n= 2,281,221) campaigns included information on the core roles and other functions of CHWs.

Table 5. Individuals in Communities or Clinical Settings Reached by Internal CHWs through Messaging and Education Year 1 to Year 3

Year 1	Year 2	Year 3
5,777	244, 319	318,398

CHWs reported that the populations they serve include, or exclusively consist of, individuals with chronic diseases (i.e., hypertension and diabetes) and others that are likely to be at the highest risk of poor health outcomes including outcomes from COVID-19.[5] In the interviews, CHWs and their supervisors shared various ways in which CHWs carry out health education and considerations they

[5] "**Individuals at highest risk for poor health outcomes**: Individuals at highest risk for poor health outcomes from COVID-19 include older adults, people from racial and ethnic minority groups, people with disabilities, and those with certain underlying medical conditions. Details on medical conditions and other factors that put individuals at higher risk of poor health outcomes from COVID-19 can be found at: People with Certain Medical Conditions | CDC." DP21-2109 Performance Measure Guidance and Definitions Version 2 – July 2022

make as they educate this population. Tabling was the most common method CHWs reported using to disseminate health information. Other examples of health education methods are shared below.

- CHWs…
  - raised community awareness and understanding of public health district offerings or services
  - attended appointments with patients and reinforcing the information communicated by the healthcare provider
  - utilized screening events to refer individuals to services they would need for health education
  - partnered with community members to discuss their health rather than telling them what they should do, or relatedly, learned through training to understand clients more and judge them less
- Supervisors introduced CHWs to community partners and provided materials to support CHW provision of health information
- Tools used by CHWs for health education:
  - DASH (Dietary Approach to Stopping Hypertension) for those with high blood pressure or high glucose
  - Healthy Heart Ambassador Program
  - Resource guides, sheets, and booklets
  - Blueprint for Wellness events

Referrals for health and social conditions:

Referrals made by CHWs increased considerably year to year. In year 1, CHWs reported making approximately 1,676 referrals[6] and most of these referrals were to vaccination sites (n=622) and housing services (n=410). In year 2, CHWs made approximately 46,724 referrals, and most referrals were also to COVID-19 vaccination sites (n=14,694) and housing services (n=11,555). In year 3 (up to May 2024), CHWs made approximately 65,098 referrals; up to February 2024, most referrals were for social services which included referrals specifically for connecting uninsured individuals to services and unspecified referrals.

Table 6. Year 1 to Year 3 Referrals Made by CHWs

Program Year 1	Program Year 2	Program Year 3
1,676	46,724	65,098

In the interviews, CHWs reported that their most common referrals pertained to diabetes, power of attorney (for older adults), hypertension, clothing, food, housing, employment, utilities, and

[6] One referral does not always equate to one individual referred as one individual could receive multiple referrals.

transportation. The following examples show the specific resources that CHWs connected community members, clients, or patients with.

Examples of Resources Referred by CHWs

- Rent or mortgage assistance
    - For example, Neighbors Helping Neighbors (financial program: one-time service--assistance with utilities, rent, mortgage for those in cancer treatment)
- House or apartment access
- Exercises specific to older adults
- Chronic disease prevention programs (e.g., Healthy Heart Ambassador, DASH, diabetes prevention program, Fruit Street Clinic diabetes prevention program)
- Dental care for undocumented adults (e.g. Joy Clinic)
- Life insurance
- Medicaid, Medicaid
- Organizations to help individuals with low-income or that are uninsured gain access to prescriptions at lower costs (e.g., medication, glasses, medical equipment like BP monitors and glucometers)
- Smoking hotline
- SNAP

CHWs approached making referrals in a variety of ways depending on the resource or organization and their own processes, and the CHWs' employing organization's processes. External CHWs reported that they mostly made year 3 referrals by giving individuals information about a service provider using flyers, pamphlets, or a contact number (n=2185). Setting up an appointment for the individual (n=39) and other unspecified methods (n=10) were other ways referrals were made. In general, CHWs typically initiated referrals through screening events, and they followed up on most referrals to facilitate connections to resources. Referral processes inside of clinical settings (e.g., Grady or Mercy Care) were the most formal. For example, a CHW in a clinical setting gathers or reviews information from a screening, such as an SDOH screening, checks to see what resources a client qualifies for, then uses Epic (an electronic health records system) to add referrals, and may complete a resource provider's online process or send an email (on behalf of clients) as some resource providers prefer. The CHW may follow up on referrals during client check-ins, or the resource providers will inform the CHW that they have spoken with the client that was referred to them.

Outside of clinical settings, referral processes entailed one or more of the following.

- CHWs, and possibly other staff, use an intake form to collect an individual's blood pressure reading, whether it is hypertensive, and their contact information if they have interest in programs that will help address their health condition(s)
- CHWs and clients call organizations together to connect to resources
- CHWs contact clients or patients to follow up on referrals
- Self-report: clients inform CHWs of their progress with referrals either via phone or in person

- If a CHW is in close partnership with a resource provider, they will call the office to check whether a patient made an appointment
- CHWs use some form of tracking sheet to keep track of their follow-up efforts

One CHW supervisor provided insight into how having a referral process has been valuable in enhancing the support of community members' health:

"Well, the fact that we actually have a referral system, so that's a big one. And that we are referring to our programs. So we didn't have the Healthy Heart Ambassador Program. We just sent them off to their primary care physician, and we're not able to have a continued conversation with that person who is at risk, about how important it is to go to your physician. I think having more time to converse with people can be really valuable in their path towards better health. So I think that that has changed, so we've been able to offer people more services."

When asked what tools they found useful for making referrals, CHWs offered a variety of platforms and resources that they tend to use. Among these are Unite Us (especially for obtaining Meals on Wheels), a community resource guide of local resources, the Georgia Tobacco Quit Line (it gives a form where individuals can put their preferred time and method of contact), Wholesome Wave (helps with SNAP and health insurance), and the Atlanta Center for Self Sufficiency (offers a "plethora of services").

> *"I think just having that relationship with the agencies and knowing what they have and what they bring, knowing that if I [make a referral], I know that it's guaranteed to get a response, compared to just giving someone a resource and just assuming that it is going to work out and not even knowing because I'm not familiar with the organization."*
> -CHW

Being aware of local organizations and nonprofits, and building relationships with organizations, other resource contacts, and the community members served made it easier for CHWs to make referrals. A couple of CHWs reported that being engaging and personable helped them to have more open conversations that helped them connect individuals to resources. Most CHWs reported that having a direct contact at a resource provider made it easier and more comfortable to call and find out about the suitability of a resource for individuals they would like to refer. Also, establishing relationships helps with responsiveness of resource providers. Having relationships with resource providers help CHWs to better circumvent challenges with referrals leading to dead ends because the resource provider is not responsive or because the provider is no longer in business or unavailable because it ran out of funding. Other referral challenges CHWs reported encountering were that resources were not available in a timely fashion because of long wait periods, resources being unavailable, and the volume of referrals can exceed the caseload capacity of a CHW.

Though referral processes vary, generally, it appears that CHWs initiating and following up on referrals, or participating in referral processes with the staff they work alongside and resource providers, facilitates the strategic connection of individuals to the resources they need.

Meeting Needs

Internal and external CHWs reported that food access tended to be the easiest need to address while housing and transportation needs tended to be the most difficult to address. Part of the ease or difficulty of addressing needs was connected to the availability of resources. Because there are so many pantries and specialists that can connect clients to benefits (like SNAP), CHWs can more easily address food access needs. CHWs also reported having adequate resources and support to address psychosocial distress, transportation, and employment needs or provide Medicare and Medicaid education, hypertension education, kidney disease education, and breast cancer education. Resources and support were not abundant or available for several needs in addition to the most common ones, housing and transportation; below are some of the insights CHWs shared about the difficulties encountered.

Housing: During the pandemic, rent and utilities resources were abundant; now, funds are not as abundant, but still available. One CHW shared that training to help them support a person facing eviction would have been helpful.

Transportation: One CHW reported having trouble finding transportation to get clients to their appointments. Another CHW reported that the individuals they serve reside in a city where most people do not have cars and there is no transit facility available, and the healthcare resources are outside of their city.

Mental health and other behavioral health services: There are much less options and less accessibility in rural areas. In "larger communities" such as Chatham County, there are many mental health resources, but cost is sometimes a barrier. Transportation was another barrier mentioned. One CHW received training in the community resiliency model which helped them somewhat as the CHW was able to conduct workshops with community members.

Healthcare: Long waiting periods (e.g., two to three months) to get an appointment or long wait times appeared to be common concerns around access to primary care. One CHW reported that as a result, some people (especially in the Hispanic population) will go to the ER instead. Children may have access to dental services via Medicaid but not their parents.

CHWs were asked to detail what additional resources and support they would need to be better able to meet the health or social service needs of the populations they serve. They are as follows.

- Options to meet needs of those with dietary restrictions (due to diabetes or other chronic conditions) through food banks including fresh fruits and supplements like Ensure
- Childcare for those searching for housing or jobs
- Resource repositories:
    - A page of outreach services that are mobile (outreach mobile units) and ways to get them into areas of need.
    - "I wish there were resources available for CHWs to become aware of and share that with the community leaders"—this can be a resource page on GDPH website listing orgs.

To gather insight on the extent to which the needs of priority populations were met, the evaluation team asked CHWs about the extent to which they believed their respective organizations addressed disparities in the communities they served. For all measures pertaining to this question, in year 3, CHWs largely agreed that their organizations are reaching people that are at the highest risk of poor health outcomes (n=18, completely agree), helping to reduce disparities in access to community resource and services for COVID-19 (n=16, completely agree), and helping to reduce disparities in access to community resources and services for chronic illnesses (n=19, completely agree). These findings were nearly the same as those in year 2 (see Figure 5). CHWs being based in organizations that carry out efforts directed at addressing the health and social disparities that communities face may suggest that related efforts specific to the CHW role were shaped and well-supported by their organizations.

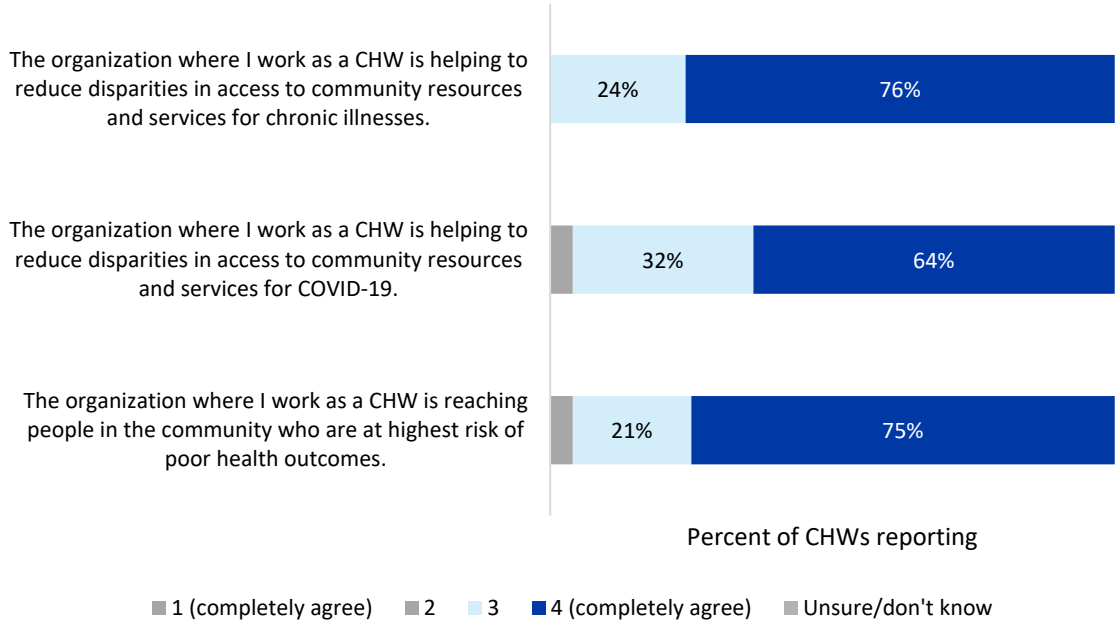


Figure 5. CCR-2109 Organizations Addressing Disparities within Communities

CONCLUSION

The achievement of the short-term outcomes over the past three years suggests that the CCR-2109 program developed a supportive structure, or infrastructure, that promotes the growth and contributions of the CHW workforce in Georgia. The program achieved short-term outcomes through the trainings made available to CHWs and their supervisors through CCR-2109, the employment of approximately 30 CHWs in organizations in rural and metro areas of Georgia, increased awareness of CHWs and their role, support for CHWs in their employing organizations, and increased connection of priority populations to necessary clinical services and community resources. This evaluation did not detect any substantial differences in CHW positions, roles, and integration among the varied settings they occupied. However, referral processes appeared to be more formal in clinical settings, and populations served varied between rural and metro areas. Resource availability varied among geographic areas but not consistently by whether an area was metro or rural.

Though the program initially focused on COVID-19, it ultimately shifted more to addressing the broader needs of the priority populations such as food access, and care and education around chronic diseases. Challenges CHWs encountered in their work were primarily related to not receiving trainings on areas such as partnership building and soft skills to support their interactions with community members, and the limited accessibility or availability of resources to meet the health and social needs of the populations served due to community or policy-level factors.

Both CHWs and their supervisors had largely positive experiences in the program and shared that, in general, the program was valuable for the communities they served, regardless of setting. CCR-2109 provided funding and training that increased the capacity of CHWs to carry out the responsibilities of their role. It also increased the visibility of CHWs and their employing organizations in their communities, and relationships with community partners and members which helped the process of rebuilding the community's trust in the organizations and bolstered the connection of community members to the resources they needed.

RECOMMENDATIONS

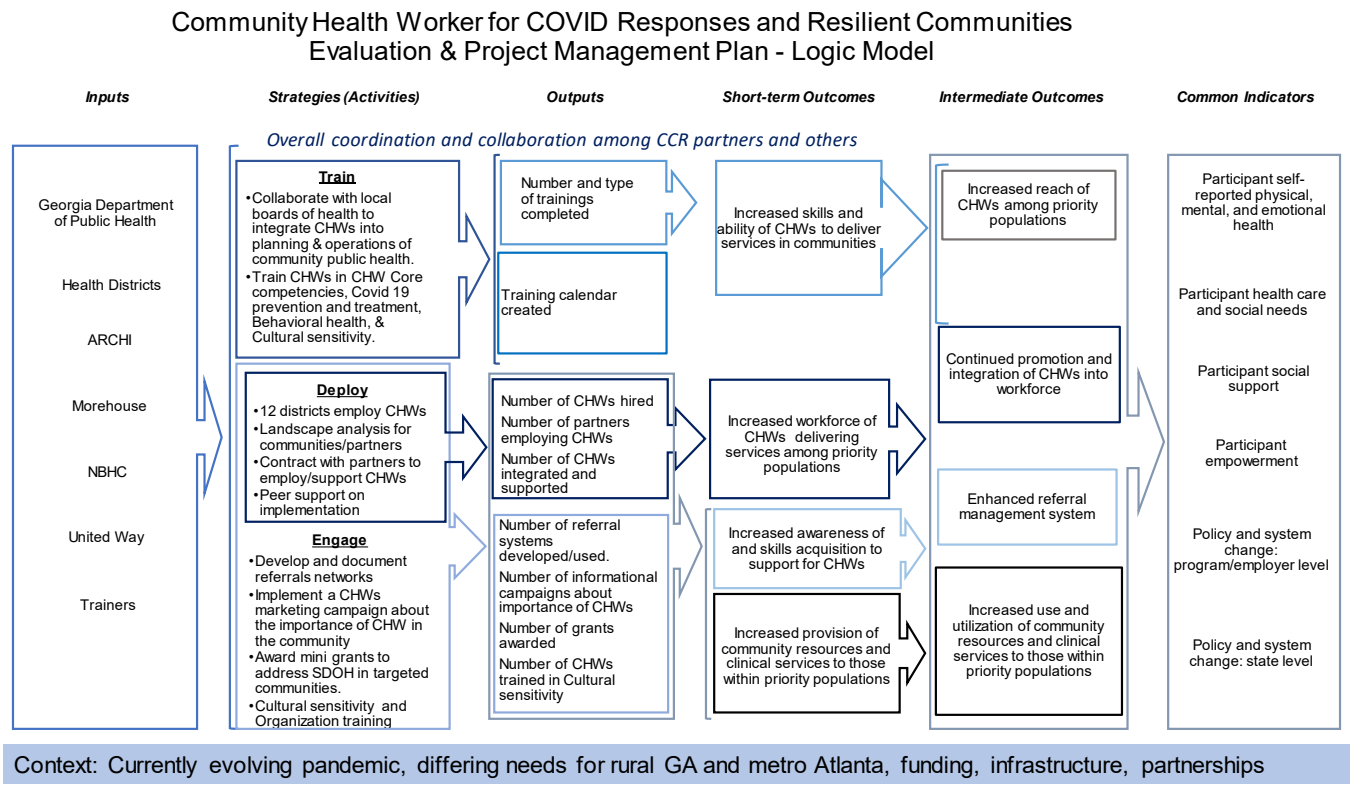
The GHPC offers the following recommendations for DPH's consideration in efforts to continue the activities of the program.

- **Continue efforts to increase the CHW workforce, CHW capacity building, and to support the work of CHWs:** Given the positive experiences reported by CHWs and their employers/supervisors, as well as the results of the program, efforts to continue program activities would be valuable to communities throughout Georgia and could lead to the achievement of the program's intended intermediate outcomes that have begun to surface.
- **Provide additional support to facilitate the work of CHWs:** Providing additional CHW training on community partnership building and navigating the diverse contexts, needs, and experiences of the populations served can strengthen the work of CHWs. Also, facilitating CHW awareness of or access to local resources they can use to serve their communities can also support their work; this may be a centralized, online repository of resources.
- **Assess and strengthen the completion of referrals:** To better ensure that the needs of the priority populations are met, assess the extent to which referrals lead to resource or service

provision and better health outcomes. Formalizing, standardizing, and requiring the documentation of referrals initiated and completed may support this task.

APPENDICES

Appendix A: Program Logic Model



Appendix B: CCR-2109 Success Stories and Reflections

CHWs have played key roles in linking community residents to care and rebuilding community trust in, and awareness of, DPH and internal organizations:

"There has been many one-on-one successes of just needs being met to that degree. People getting linked to immediate care that they need, whether that's, "I need a vaccine. I need to know where to go for X, Y, and Z." I think it has helped us gain trust in the community after the pandemic hurt that for a little bit."
-CHW Supervisor

"…I would say, if we had to rank the success, I would say definitely being able to get people's chronic conditions in a better light, in a better situation, getting housing, getting employment after that, working for years, and now you are up and at them. So that is... We see that as a success as well."
- CHW Supervisor

"Once she was here and got her feet wet and knew what she was doing and got comfortable in her job, that engagement in that community has increased by multiples because [migrant farm workers] trust her. That population in particular is very wary of anyone that they even think is associated with any part of the government. She's been able to quell that suspicion and to actually get people to open up to her and tell her what they need. That just continues to get further and further and further along because this person will hear that, "Yeah, she knows what she's doing, and she's not going to do anything bad to you.""
-CHW Supervisor

"During this time, our community health worker was out there passing out her cards. Got a call maybe a week or so later from someone who wasn't at the event, but I guess the card just got into the right hand. This person found out that they were seven months pregnant, just found out that they were seven months pregnant. Did not have health insurance, couldn't read, just had many different barriers and needed to know not only where to go, but just needed assistance in the process. They felt comfortable enough to call the community health worker who also speaks Spanish. We were able to get them here to talk to our staff to let them know, "Hey, when they come, don't just give them forms they can't read. Let's try this approach. Do they have transportation? Let's see how we can get them here." Even though it's outside of the scope for COVID, we were able to get someone linked to our care who felt comfortable enough to give us a call in a very vulnerable situation."
-CHW Supervisor

"So [CHW #2] actually followed the pattern and the training that [CHW #1] was provided. So everything, all the training that she went through, through Georgia State, we were able to provide to [CHW #2]. And she was trained on our Healthy Heart Ambassadors program, which has been great.
We've been really, really happy to be able to implement that, because in the past, we had done screening in the community, and then we would hand people off to other organizations and pray that they would make it to our FQHCs, or to their primary care physician. But this was a great way for us to say, "Hey, we're the Health Department, we're going to screen you, and then we have this program if you are in the hypertensive range." So it was a great way for people to rediscover what the Health Department does, and for us to really get out there.

So the year that we had [CHW #1], our community outreach was increased by like 200, 300 fold. I mean, it's just been a really wonderful way to get out there. It was just me [over a large geographical area]. So then we were able to double what we normally do. And now with [CHW #2], it's just a big game changer. So we don't have to say no so much. In the past, we weren't able to honor community requests because of conflicts, but now we're able to. People are coming to us, and really counting on us to be at their health events, and to introduce people to our programming, so it's been a game changer for us."
-CHW Supervisor

"Now that our CHWs have been with the communities they serve for a while and gained their trust, we are the go-to organization for resources and help."
-CHW Supervisor

Other related points of success reported by CHW supervisors:

"Enhanced ties with the community"

"Agency visibility"

"More visible in community. More touch points with residents. Educated more individuals in our area. Able to partner with more organizations. Met lots of needs. Got individuals connected to PCP at FQHC."

CCR-2109 Sustainability Reflections

"And I've asked [CHWs], "Find partners that you can have lasting relationships with," and this is why the sustainability of this program is so important to us. We do have to have that consistent presence in the community. And if the state isn't investing anymore in this program, and I hope it does, I'm hoping that they see the value in us getting out there. If we say, "Here we are, please give us people that you think might need our program," and then we disappear, it's not going to be good for public health. It will be to the detriment of the relationships that we have forged, and we've worked really hard for."
-CHW Supervisor

"I think community health workers are important and they are very needed in the community because they are the one person who can connect the community members with the resources and they have the time to talk with them and engage with them. And I feel like a lot of people in the government don't have time to have personal conversations with community members and really get to know them. So I think that they're really important for being personal with the community members and them knowing that there's somebody who works for the government who actually cares and will listen to them. We should definitely keep them."
-CHW

"The program has been very successful. We have been able to utilize the CHWs at all our intervention levels including counseling and education, clinical interventions, long-lasting protective interventions and PSE interventions. Our CHWs were vital to helping pass legislation that requires Georgia health insurance companies to remind and notify clients when and what types of prostate cancer screenings they are

eligible for. They were also involved in worksite health education, hosting our first National Hispanic Cancer Awareness Day event, participating in Black Family Cancer Awareness Week, and other community outreach and education. Our CHWs are consistently and repeatedly thanked for going out to community events and providing education and outreach. Residents tell them that no other organizations provide these types of interventions and that many organizations do not feel it's worth their time to spend time in their communities. This tells us that they value our presence and it is a needed program."

-CHW Supervisor

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