

Community Health Worker/ *Promotores*/Representative Training Program Best Practices

**Final Project Report
March 2026**

Lalitha Vaidyanathan, Independent Consultant

This paper was made possible by a grant from the California Health Care Foundation.

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Executive Summary

In 2022, California's Department of Health Care Access and Information (HCAI) was tasked with developing a statewide certificate program for community health workers/*promotores*/representatives (CHW/P/Rs). However, due to substantial reduction in the CHW/P/R workforce budget in the Budget Act of 2024, as well as feedback gathered during statewide listening sessions (held 2022–24), a decision was made **not to establish a statewide certificate for individuals** or a program accreditation function. Due to this change in direction, HCAI, in partnership with the California Department of Health Care Services (DHCS), is releasing these best practices for CHW/P/R training programs. These best practices are a set of **voluntary recommendations** that seek to offer:

- **Clarity.** Clear expectations for what CHW/P/R training programs should provide
- **Consistency.** A common CHW/P/R training framework to help programs across the state align in approach and quality

Since these best practices are voluntary, they are not enforced and do not change DHCS's qualification requirements for CHW/P/Rs.¹

These best practices were developed through secondary research, statewide stakeholder interviews, guidance from a project workgroup (which included DHCS), and feedback from HCAI's CHW/P/R Initiative Advisory Workgroup (CHW/P/R Advisory Workgroup). This project was funded by the California Health Care Foundation (CHCF).

This research revealed that CHW/P/R training programs in California take different approaches to training based on type of participants, purpose of training, organizational needs, constraints, and other factors. The different approaches serve specific purposes and are valuable to participants and the field. Despite the differences, common best practices emerged across these programs that guided the creation of this Best Practices Framework.

The following is a summary of the Best Practices Framework, which is organized into 12 categories:

1. **Training philosophy and methodology.** Tailor training to meet participants where they are in terms of language, literacy, ways of learning, and technical skills. Ensure training is accessible to a diversity of CHW/P/Rs, honor and uplift the experience and wisdom of participants, ground training in cultural humility, and prioritize interactive, peer-based learning over traditional lectures.
2. **Core competencies.** Align training curriculum to the 11 Core Skills in the National C3 Council's competencies, ensure training covers key sub-skills, and teach and apply the core competencies in cultural, regional, and context-specific ways. The depth to which the C3 skills and sub-skills are covered in the foundational training should be based on the needs of communities being served and the specific roles CHW/P/Rs play in those communities.
3. **Training structure.** Provide a minimum of 80 hours of training to CHW/P/Rs to acquire a certificate of completion. This may include foundational or core training, supervised

field work, and specialty training. CHW/P/R employer organizations should provide or refer out to training programs to provide at least six hours of ongoing professional development annually.

4. **Training program transparency.** Clearly communicate the roles, settings, and type of employment the training prepares graduates for so that prospective participants can make informed choices. Clearly communicate training hours, content covered, field work expectations, and approach to learning and assessment. Offer a participant orientation before the start of training to set appropriate expectations. Clearly communicate career advancement services and resources available upon graduation to gain meaningful employment.
5. **Training instructor qualifications.** Ensure training is led or co-led by experienced CHW/P/Rs with lived experience.² Instructors should have some experience in, and be able to model, training methods like adult learning and popular education and should ideally be proficient in the language in which the training is provided. Evaluate instructors at least annually. Engage CHW/P/Rs in the development and ongoing updates to training curricula.
6. **Training format.** Deliver some part of the training in person to be able to assess participant performance, especially for field work and practicums. Deliver some part of the training virtually to keep the training accessible and to build CHW/P/Rs' capability to deliver services virtually. Favor synchronous training to engage participants, create community, and learn from peers. Limit asynchronous training to self-study, reviewing material, taking a quiz, and engaging on the content with peers on discussion boards. Provide technical assistance for participants less familiar with technology.
7. **Training participant assessment.** Use performance-based assessments that allow participants to demonstrate their skills and knowledge. Include mechanisms for participants to assess instructors as well as each other. Engage participants in the design of assessments for shared value and meaning.
8. **Training enrollment requirements.** Keep requirements to enroll in the training program to a minimum to ensure the program is accessible to all CHW/P/Rs, specifically by not requiring the following: educational requirements such as a high school diploma or GED, language proficiency in English, and digital literacy.
9. **Training fees and costs.** Keep training costs to participants free or close to free, including by offering financial aid and scholarships. Pay regular wages for participants currently employed as a CHW/P/R and consider paying a stipend for field work or internships for those not yet employed.
10. **Training program evaluation.** Conduct ongoing evaluations, establish a process for regular reviewing of evaluation results, and implement improvements highlighted in evaluations.
11. **Training organization credibility and qualifications.** Given the community-rooted nature of the CHW/P/R profession, training organizations in California should be rooted in the communities being served.
12. **Other good practices.** Create a network to keep CHW/P/R graduates connected after completion of training. Where CHW/P/R are unable to participate in training due to lack

of childcare, transportation, and other such needs, consider providing necessary supports.

Project Background and Context

Project Background

In 2022, the California Department of Health Care Access and Information (HCAI) was tasked with developing a statewide certificate program for community health workers/ *promotores*/ representatives (CHW/P/Rs). However, the Budget Act of 2024 significantly reduced the original CHW/P/R workforce budget allocation. Additionally, feedback gathered during [statewide listening sessions](#) (2022 to 2024), hosted by the California Health and Human Services Agency (CalHHS), the California Department of Health Care Services (DHCS), and HCAI reaffirmed the need for community-informed and flexible approaches. As a result, **HCAI will not be establishing a statewide certificate for individuals or a program accreditation function at this time.**³ However, CalHHS, DHCS, and HCAI remain committed to exploring future options to strengthen and sustain the CHW/P/R workforce. Continued progress in this space will depend on both securing appropriate authority and identifying additional resources and funding.

In the meantime, HCAI — in partnership with DHCS — is releasing this Best Practices Framework for CHW/P/R training programs. This Best Practices Framework is not a certification or accreditation framework but rather, it is intended to be a set of helpful, **voluntary recommendations** that seek to preserve the core values of the field, provide guidance without over-professionalizing the field, make training accessible for everyone, and build a shared framework grounded in community knowledge and experience and in research. HCAI and DHCS hope these best practices offer benefits including:

- **Clarity.** Clear expectations for what CHW/P/R training programs should provide.
- **Consistency.** A common CHW/P/R training framework so programs across the state can align in approach and quality.

Because these best practices are voluntary, they are not enforced and do not change DHCS's qualification requirements for CHW/P/Rs.⁴

Project Structure and Methodology

This project's structure and methodology are based on a combination of secondary research, extensive stakeholder interviews, guidance from a project workgroup, and feedback from the CHW/P/R Advisory Workgroup.

- **Secondary research.** Reviewed research reports on CHW/P/R training in California (please see [Appendix I](#) for the list of references), along with training approach and curricula of organizations interviewed for this project.
- **Stakeholder interviews.** Conducted close to 40 interviews with a diverse range of stakeholders including members of the project workgroup, CHW/P/R training programs including community-based organizations (CBOs), managed care plans (MCPs), county

health departments, colleges and universities, workforce development, and labor organizations. Please see [Appendix B](#) for a full list of interviewees.

- **Project workgroup input.** Integrated ongoing feedback from a dedicated nine-member project workgroup consisting of representatives from HCAI, DHCS, CHCF, and community consultants. The members of the project workgroup are listed in [Appendix A](#).
- **CHW/P/R Advisory Workgroup consultation.** Engaged HCAI's formal CHW/P/R Advisory Workgroup — a majority of whom are active CHW/P/Rs — and integrated their feedback into the Best Practices Framework. A list of members is included in [Appendix C](#), and additional information about the workgroup can be found on [HCAI's website](#) (PDF).⁵
- **Stakeholder feedback.** A draft of the Best Practices Framework was shared with all training stakeholders interviewed for this project (please see [Appendix B](#) for the full list of interviewees) and their feedback integrated into the framework. A draft was also shared with organizations working with Community Health Representatives - California Rural Indian Health Board (CRIBH) and California Consortium for Urban Indian Health (CCUIH) – and their feedback integrated into the framework.

These research findings, while broadly representative of the field in California, are limited by the sources informing the process and are not comprehensive.

Funding for this project was provided by CHCF.

Research Findings

CHW/P/R Training Approaches

CHW/P/R training organizations interviewed for this project design and deliver training in diverse ways. Although approaches vary and there are no prescribed models, research shows some trends in training approaches by organization type; these approaches are summarized in the table below. They are not mutually exclusive, and many organizations take blended approaches. The ones described here reflect feedback from the organizations interviewed for this project and are not comprehensive.

Organization Type	Community-Based Organization	Employer-Focused Organizations (e.g., MCPs, Workforce Development Orgs, County Health)	Academic Organizations (e.g., Colleges and Universities)
Organization goals	Train CHW/P/Rs and typically also provide services in community	Train CHW/P/Rs to meet specific needs of employer partners, do not typically provide services in community	Primarily training and education, do not typically provide services in community
Key features	• Rooted in popular education⁶ • Centers the whole person, transformative experience, provoke change in community, egalitarian relationships • Highly responsive to community needs	• Training competencies tailored to the needs of employer partners such as MCPs, county health depts., Federally Qualified Health Centers (FQHCs) • Emphasis on workplace skills • Employer typically supplements with workplace-specific training	• Institutional structures and standards of the academic setting drive the curricular approach • Most provide credits transferable toward advanced study including degree acquisition

	<i>“Who we are is more important than what we know, as who we are is what determines who we are in community.”</i> <i>“The approach is spectacularly powerful, and CHWs trained are impressive.”</i>	<i>“We have a core curriculum but often customize it for employers.”</i> <i>“We teach communication, teamwork, etc., skills that employers want.”</i>	<i>“The California Community College CHW Model Curriculum includes skills assessment that is innate to college programs . . . our students can transfer to a CSU.”</i>
Structure	• Modular, ongoing, shorter duration, requires taking less time out from life and work • Basic training, specialty trainings, time in community (field work), continued learning all seen as parts of a seamless process of ongoing training and development • Typically cohort-based	• Basic training plus separate specialty training modules • In some cases, training custom-built for employers • Field work — employer-partner apprenticeship, or based on specific employer need • Typically frequent, cohort-based (e.g., every few weeks or months)	• Longer trainings (didactic and field work) • Credit-bearing for degree pathway • Typically semester-based

Target participants	Accessible to a diversity of participants including those with low or no digital or language literacy	Employees of county health depts. local health jurisdictions, MCPs, FQHCs, health systems, etc. Some employers require a GED or high school diploma	Requires digital and language literacy; GED or high school diploma sometimes required for those interested in the pathway to degree acquisition
Examples	• Visión y Compromiso's Promotoras Transforming Families and Communities training • El Sol's Basic CHW Certificate	• Inland Empire Health Plan's CHW Certificate Program • Futuro Health's CHW Training • Worker Education & Resource Center's CHW Training • Touro University California's Community Health Worker Micro-Credential	• Chaffey College's CHW certificate training • Community College of San Francisco's CHW Certificate Program

Training Philosophy and Methods

While CHW/P/R training organizations in California employ different training models (described above), all share some foundational principles that serve as best practices:

- **Meet participants where they are**, particularly regarding language and literacy, ensuring training is accessible to CHW/P/R participants from diverse backgrounds.
- **Recognize, honor, and lift up the experiences, skills, knowledge, and wisdom** that participants bring to the training. View training as an opportunity to build upon these strengths.
- Ground the training approach **in principles of cultural humility**.
- **Prioritize interactive and engaging methodologies over traditional lectures**, incorporating discussions, reflections, role-plays, simulations, case studies, and peer-based learning to enhance participant involvement.

"The [training] delivery method needs to meet [participants] where they are, recognize the wisdom and knowledge that they come in with, and help to lift them up. It needs to be participatory and problem based."

Core Competencies

Stakeholders agree that CHW/P/R training should align with all the CHW core skills outlined in the [C3 competencies](#).⁷

Stakeholders suggest that, as a best practice, training programs should teach and apply the core competencies in cultural, regional, and context-specific ways. Within the 11 core skills, training programs should pay specific attention to covering the key C3 sub-skills listed in the table below. In addition, stakeholders suggested several additional core competencies as being important for California that are not currently listed as C3 sub-skills — these are also included in the table below.

The emphasis and depth to which each of the C3 competencies is covered in the training can be based on a variety of factors including the needs of specific employers, the needs of the specific community served, the role the CHW/P/Rs will play in the community, the experience CHW/P/Rs bring into the training, or certain institutional requirements of academic standards.

“We cover all [the C3 skills] but make decisions on what to emphasize . . . some things we do more lightly; for example, participating in evaluation and research.”

Feedback from the CHW/P/R Advisory Workgroup highlighted recognition that different levels of emphasis of specific core competencies prepared graduates for different roles or settings (e.g., community outreach, health care setting, case management, Enhanced Care Management). The CHW/P/R Advisory Workgroup stressed the need for training programs to clearly define what role or setting it prepares graduates for so that participants can make informed decisions and have the right expectations of roles, settings, and salaries upon graduation. Clear and transparent communication by training programs is also important for employers to make informed recruiting decisions.

C3 CHW Core Skills	Key C3 Sub-Skills to Emphasize	Additional Sub-Skills Not Included in C3
Communications	• Active listening • Documentation	• Trauma-informed communication • Documentation of accurate and relevant patient information
Interpersonal and relationship building	• Motivational interviewing • Conflict management and resolution • Cultural humility • Coaching and support	
Service coordination and navigation	• Barriers to care coordination • Coordinating care including accessing resources, overcoming barriers, making referrals • Case management including follow-up, tracking care, and referral outcomes	• Working collaboratively in interdisciplinary teams across public health, social services, and health care sectors

Capacity building	• Conducting community organizing	
Advocacy	• Speaking up for individuals and communities	• Understanding fundamentals of policy advocacy
Education and facilitation	• Empowering and learner-centered teaching strategies	
Individual and community assessment		
Outreach skills	• Case finding, recruitment, and follow-up • Building and maintaining current resource directory, or if one already exists, interacting with and updating it	
Professional skills and conduct	• Ethics, HIPAA, and confidentiality • Boundary setting and self-care • Personal safety • Lifelong learning and professional growth • Workplace conduct (including handling disagreement, conflict) • Technology	• CHW/P/Rs' scope of practice • Technology (basic computer skills, digital literacy)
Evaluation and research		• Basic introduction to evaluation and research methods
Knowledge base	• CHW/P/R field, history, and role • Introduction to public health • Basics of US health (especially Medi-Cal and Medicare) and social services (e.g., benefits) • Social determinants of health and health disparities • Pertinent health issues • Health behavior change	• Pertinent health issues, including basics of trauma-informed care, emotional and mental health, chronic disease, and infectious disease (e.g., COVID-19)

Example 1. Touro University California's CHW Micro-Credential — Core Learning Objectives and C3 Skills Covered in the Training

Touro University California's Community Health Worker Micro-Credential provides foundational training for community health workers aligned with the C3 skills and roles. The following course description serves as a good example of how an 80-hour course can provide participants with the basic skills to be a community health worker.

- Analyze the role of community health workers to reduce health inequities and improve patient outcomes, which includes developing strategies for service coordination and care navigation and building client capacity.
 - C3 skills: Service coordination and navigation, communication skills
- Develop a strong foundation of health knowledge to provide support, education, and advocacy for clients including public health, social determinants of health, chronic disease management, behavioral health, health lifestyle, self-care, and the health and social service systems in the US.
 - C3 skills: Knowledge base, interpersonal and relationship-building skills
- Demonstrate professional skills and conduct, which includes goal setting, balancing priorities, critical thinking, appropriate use of technology, continuing education, personal safety in the workplace, application of ethical and legal standards, and boundary setting.
 - C3 skills: Professional skills and conduct, communication skills
- Apply effective communication and interpersonal relationship-building skills with a foundation in cultural humility and trauma-informed care, including motivational interviewing, conflict resolution, and managing difficult conversations.
 - C3 skills: Communication skills, interpersonal and relationship-building skills
- Develop skills to competently provide client and community education, group facilitation, and advocacy at the individual and systems level.
 - C3 skills: Advocacy, education, and facilitation
- Apply strategies to participate in individual and community assessments, which include the use of standardized screening tools, conducting community needs assessments, and community asset mapping.
 - C3 skills: Individual and community assessment
- Apply outreach skills, which include how to engage community effectively, how to perform outreach in different ways, and building and maintaining an up-to-date resource inventory.
 - C3 skills: Outreach skills
- Develop evaluation and research skills to identify root causes, apply evidence-based best practices of community-based participatory action research, identify priority needs and issues, design research, collect data, share results, and engage stakeholders in decision making.
 - C3 skills: Evaluation and research, capacity building

Example 2. Inland Empire Health Plan's CHW Certificate Program — Quote About Training Emphasis

The CHW Certificate Program of the Inland Empire Health Plan (IEHP) is another good example of an 80-hour training that prepares participants to function as frontline CHW/P/Rs on integrated care teams serving Medi-Cal members, with a focus on reducing barriers to care and improving health outcomes in underserved communities. The following quote describes the specific skills the training program focuses on:

“Community health workers (CHWs) play a critical role in connecting IEHP members to essential health care services, and our training program is designed to amplify their impact. We equip CHWs with the skills to navigate the health care system, advocate for members, and clearly explain available and covered services. Beyond practical knowledge, the training emphasizes the broader context — how their work advances health equity, identifies priority populations, and drives measurable community outcomes. We encourage participants to set bold, actionable goals, culminating in a capstone project where they conduct field-based community assessments, identify pressing health issues, and apply social ecological models to bridge theory and practice.”

Training Structure

Training structure includes key elements such as duration, field work, specialty training, and continuing education.

Stakeholders feel that foundational training, supervised field work, specialty training, and ongoing professional development and learning are beneficial for CHW/P/R participants to meet and respond to community needs. Stakeholders suggest giving training organizations options to achieve this by either:

- Combining a shorter foundational training with supplemental specialty training modules that meet the specific needs of the community being served, mentored or otherwise supervised field work, and frequent and ongoing professional development.
- Having a longer foundational training coupled with a longer, more formal internship or apprenticeship.

Beyond the basic/foundational training, stakeholders feel that CHW/P/R participants can benefit from ongoing professional development and learning, which can take the form of:

- Learning about a specific topic to respond to a community need that has arisen
- Additional education, training, and degrees to advance in the CHW/P/R career
- Additional specialty training to meet a need in the community (e.g., chronic disease, behavioral health, substance abuse)
- Peer-based learning with other CHW/P/Rs about best practices
- Additional training recommended by a supervisor
- Updating knowledge about changes in government rules, laws, guidance, and practices

Research shows that CHW/P/R training typically takes around 80 hours and can be a combination of foundational training, supervised field work, and specialty training.⁸

Stakeholders agree that field work should be an important part of the CHW/P/R foundational training, and suggest a length that makes it worth the employer's time but not so long that it becomes a barrier to participation. Many stakeholders see paid internships as an important way to overcome the barrier to participation among CHW/P/Rs.

"It is a challenge to get employers to take interns . . . if you ask an employer to take a CHW intern, you need time to onboard and then actually practice. You need a minimum of 20 hours."

"I have mixed feelings about [required] field work as it could be a barrier [to CHW/P/Rs]."

"Getting paid internships . . . would bring in a lot more [CHW/P/Rs]."

Example of Foundational Training Structure: Inland Empire Health Plan's CHW Certificate Program

The CHW Certificate Program of the Inland Empire Health Plan (IEHP) prepares participants to function as frontline CHW/P/Rs on integrated care teams serving Medi-Cal members, with a focus on reducing barriers to care and improving health outcomes in underserved communities. The following describes IEHP's CHW Certificate Program structure:

Duration. 80 hours over two weeks, plus 8 hours of field work completed after the training at the employer site, attested by the employer

Timing. Monday to Friday, 9 AM–3 PM, then 3 PM–5 PM for independent work to complete capstone project

Training format. Conducted on-site (virtual not offered at this time); capstone project work is asynchronous, rest is synchronous

Example of Specialty Training: La Alianza Member Organizations

La Alianza is a coalition of 18 community-based organizations (CBOs) in California who employ and support *promotoras* and CHWs. La Alianza's member organizations provide a wide variety of specialty training modules to CHW/P/Rs in their network. A sample of these is listed below:

- **Comité Civico del Valle.** Air quality monitoring, pesticides, environmental exposure, heat-related exposures, water sampling, biomonitoring sample collection
- **Esperanza Community Housing.** Mental health, mercury poisoning and colorism, colon cancer, breast cancer, asthma 101, skin cancer, sexual assault, HIV, OSHA regulations
- **The Latina Center.** Systems of abuse of the elderly, parenting, child trafficking

"Training and professional development is ongoing. . . . As she gets questions from the community, she learns. . . . It is important to practice as she learns."

Example of Ongoing Professional Development: Transitions Clinic Network

The Transitions Clinic Network (TCN) is a California-based national organization committed to reversing the harm of mass incarceration on communities. TCN trains CHWs who have histories of incarceration and supports their employment and integration into the public health and primary care system. The CHWs engage and support patients returning from incarceration and serve as liaisons to navigate health and social services.

As part of its CHW Training Program, TCN offers ongoing professional development to CHWs in its network through monthly sessions and one-on-one mentoring with a lead CHW. Sessions are webinar-based and open to any CHW in the network. Topics are determined based on requests from CHWs in the network and based on real-world challenges; for example, working with patients living with HIV, social determinants of health, goal setting, effective motivational interviewing, etc. Sessions are often cofacilitated with CHWs in the network.

“The monthly trainings we call fireside chats are based on what I am hearing and requests from CHWs. We leverage real CHW challenges into trainings to boost their effectiveness. We also do one-on-one mentoring where I [lead CHW] check in with CHWs to talk things out [about challenges they are facing].”

Training Program Transparency

Stakeholders strongly encourage training programs to clearly communicate that the training emphasizes specific topics to prepare graduates for specific employer roles and settings. For example, work in community outreach, health care settings, or Enhanced Care Management roles may require CHW/P/Rs to have specific knowledge and skills beyond foundational skills. It is important for training programs to communicate clearly and transparently what settings and roles a training prepares CHW/P/Rs for so that participants can make informed decisions about which training program to enroll in. This communication is also important for CHW/P/Rs to have the right expectations of job roles and settings they are qualified for and their associated compensation. Finally, training program transparency is also important for employers to make informed recruiting decisions.

“The CHW title is the same, but they have different job descriptions and different pay levels. . . . This creates confusion in recruitment.”

“Shorter trainings lead to \$20/hour outreach roles, while longer programs qualify CHWs for hospital/clinic positions with higher pay. Without transparency, community members may take [shorter] training expecting hospital roles. . . . This leads to disappointment.”

Stakeholders emphasize the need for training organizations to go over requirements and assignments with participants before the start of training to ensure that participants know what they are taking on, and to set expectations about the level of effort required to complete the training.

“Programs should have a clear statement of what content is covered, what is not going to be covered, training hours, supervised field work, approach to learning and assessment. So participants can understand before they sign up and hold the training entity accountable.”

Finally, stakeholders recommend that training programs be clear about the career advancement services and resources they offer (e.g., employment placement services, career counseling or advising, and connections to or networking opportunities with employers). This clarity will ensure that participants know what to expect in terms of accessing meaningful employment upon graduation.

Training Instructor Qualifications

Stakeholders feel that CHW/P/Rs should be engaged in the development of training curriculum and their feedback, experience, and on-the-ground learning should form the basis of ongoing updating of training curricula.

In addition, stakeholders believe training should be led or co-led by experienced CHW/P/Rs. Depending on the setting of the training the CHW/P/R instructor could be paired with faculty co-leads (academic settings), clinicians (clinical settings), or others as appropriate. Stakeholders feel that it is helpful for all instructors to have some experience in training methods such as adult learning, popular education,⁹ participatory learning, experiential learning, etc., and for instructors to model those approaches in their instructional approach.

“We prefer to hire CHWs with passion for the work and then train them up to be educators. Because this is such “heart” work you have to have someone who is passionate and can convey that in the training.”

“To teach people how to do outreach, how to do motivational interviewing, you need to have done it yourself. You can’t have theoretical knowledge. For example, if we are teaching how to assess clients for suicide, an experienced CHW trainer can say “let me tell you my experience.” They can speak with authority based on what they have done in their communities.”

Training Format

Most stakeholders feel that a hybrid approach that combines in-person training with virtual learning is the best way to train CHW/P/Rs because their work or personal commitments may not allow them to attend an entire training period in person. Several stakeholders shared that they have found virtual training on weekday evenings and in-person training on weekends to be a good, accessible option.

Also, given the increasing need for CHW/P/Rs to provide services virtually (e.g., telephonic care coordination, remote screening, virtual outreach), virtual training helps prepare CHW/P/Rs to meet this need. Some virtual training is also helpful in training CHW/P/Rs in the use of digital tools and resources. Stakeholders caution, however, that virtual training should be implemented with careful consideration of the community context. For example, in communities, especially in rural areas, with no or only limited access to high-quality, high-speed broadband internet

service, virtual training and service delivery may not be feasible. In these situations, in-person training close to where CHW/P/Rs live is preferable.

Stakeholders also share that it is best practice to use synchronous training (where the instructor interacts in real time with participants, whether in person or virtually) for the following areas:

- Teaching and practicing motivational interviewing, communications skills, and relationship building
- Drawing out and building on participants' skills, knowledge, and experience, cultural identity, feelings, and priorities
- Being in community, practicing, and making mistakes
- Learning from peers

It is recommended that field work and practicums be in person.

According to stakeholders, asynchronous training (where the instructor and participant do not interact in real time), on the other hand, can be best practice for self-study, reviewing material, taking a quiz, or engaging with content with peers on discussion boards.

“Good training techniques draw out the participant’s knowledge and experience, cultural identity, feelings, priorities, and build on that. That takes time, a lot of encouragement, and cannot be done asynchronously. It has to be done synchronously, as it requires being together in community, practicing and making mistakes, talking together about what good looks like. Peers are important teachers. There is a role for asynchronous training where participants do some reading on their own time, watch videos, take a quiz, engage in asynchronous discussions with peers.”

“We use a hybrid training delivery format. We do Sundays in person and weekday evenings online. Some in-person time is very important. When we did our substance abuse module, [participants] were crying — they needed more space and needed to be with other people.”

Training Participant Assessment

Stakeholders share that training organizations use a variety of approaches to assess participants' learning, including observations, teach backs, pre- and post-testing, self-reported assessments, individual and group projects, self-study and reports, case study assignments, quizzes, and role-plays.

Performance-based assessments are seen as a best practice that allows participants to demonstrate their skills and knowledge in realistic scenarios (e.g., role-plays, motivational interviewing, conducting client assessment, developing client support plans).

“[Community College of San Francisco] has the most amazing assessment — the final assessment is a role-play. They set up scenarios and then assess participants’ skills in communications, ethics, [etc.]”

Other best practices suggested by stakeholders include 360 assessments, where participants can assess instructors; peer assessments; and assessment design informed by participant input.

“We came up with a 23-item rubric for assessing CHWs that we developed with learners. When you invite learners to be part of determining the assessment, you get a different level of commitment. Assessments should not be imposed — it should be cocreated to have shared value and meaning. It should not be a dirty word where I [the trainer] am going to find fault. I want people to reclaim that word. We ask participants to team up and cofacilitate a model group with other trainees. Then the trainees give feedback [to their peers] based on the rubric.”

Training Enrollment Requirements

Stakeholders feel that requirements to enroll should be kept to a minimum so they are not a barrier to aspiring CHW/P/Rs from diverse backgrounds. Stakeholders suggest training programs be accessible to CHW/P/Rs, regardless of factors such as educational background (high school diploma or GED), English language proficiency, digital literacy, and so on.

It is also best practice to offer an orientation to the technology tools to be used in training (e.g., Zoom, Canvas, etc.) before starting the training to ensure participant comfort and ability to use the technology needed.

Example: Touro University California’s CHW Micro-Credential

Touro University California’s Community Health Worker Micro-Credential provides 80 hours of foundational training for community health workers aligned with the National C3 Council’s CHW skills and roles. Touro University orients participants to the training requirements and assignments before starting the course. They also orient participants to the technology tools needed to participate in the training (Zoom and Canvas).

“Before we start training, we go over requirements and assignments and make sure people are ready for it. We also teach them about the technology tools we use.”

In addition, the course policies and procedures list the specific requirements as follows:

- **Class setting.** This course includes 80 hours of student contact in synchronous remote sessions, self-study materials, and in-person sessions.
- **Course policies and procedures:**
 - This course requires 80 hours of applied learning activities, divided into two sections of 40 hours each. Continuation into the second section is contingent on completion of the first. A maximum of one missed virtual session (up to 3 hours) is allowed.
 - This course series is to be administered via Canvas. Internet access is required to access all materials.
 - Students are required to complete all assigned hours to receive a passing grade.
 - This training must be completed in one continuous series. If the student drops out and wishes to return, they would need to complete the entire training when they return.

Training Fees and Costs

Stakeholders feel that the cost to participate in CHW/P/R trainings should not be a barrier to aspiring participants. Best practice should be free or close to free. A symbolic payment by CHW/P/R trainees to the training program is a useful mechanism to reinforce trainee commitment and help to incentivize training attendance and continuation.

Stakeholders recommend that financial aid and scholarships to cover 100% of fees be made available and that textbooks be lent to those who cannot afford them. Stakeholders also recommend that CHW/P/Rs already working with an organization when they attend the training be paid their regular wages during training. Many stakeholders highlighted the financial challenges CHW/P/Rs may face in taking time to attend training and field work and suggest that where possible, CHW/P/Rs be paid a stipend to at least complete field work.

Training Program Evaluation

Stakeholders agree that best practice is for training programs to have some form of ongoing evaluation so they can ensure the training meets the evolving needs of CHW/P/Rs, and where possible, of employers.

They suggest that best practice includes evaluation of different aspects of training, such as CHW/P/Rs' understanding of the material, competencies, pacing, training format, and satisfaction with instructors. In addition, at a minimum, evaluations should include anonymous post-training surveys of participants and a process for regularly reviewing the evaluations and taking action to improve training as needed.

“Once a cohort is completed, a post-course evaluation is required [for participants]. Then, every quarter, the [training program] manager reviews the evaluation results with instructors. Then the feedback comes to me [chief learning officer], and [we decide] what adjustments to make.”

Training Organization Credibility and Qualifications

Stakeholders strongly recommend that, given the community-rooted nature of the CHW/P/R profession, the best way to train and support that workforce is to be rooted in community. As such, stakeholders recommend that CHW/P/R training organizations fulfill a few criteria to qualify to operate in the state:

- **Have stated, and be driven by, values** such as commitment and love for community, passion for health, passion for protecting families, and passion for meeting the needs of marginalized communities.
- **Be located in or near and rooted in the community** being served, and have experience with and relationships in the community.
- **Understand, are familiar with, and have experience in the CHW/P/R field** or have a proven track record of providing workforce training.
- **Have knowledge of California laws, health programs, and barriers to care.**

- **Conduct trainings codesigned and, where possible, co-led** by experienced CHW/P/Rs from the community.

Additional Stakeholder Feedback

The research findings in the previous section were primarily informed by secondary research, stakeholder interviews, and guidance from the project workgroup. To develop the Best Practices Framework, these findings were supplemented with additional stakeholder feedback as follows:

- Feedback on the research findings from the CHW/P/R Advisory Workgroup gathered through workshops and email
- Feedback on the draft Best Practices Framework from training entities interviewed for this project
- Feedback on the draft Best Practices Framework from organizations working with Community Health Representatives (CRIBH and CCUIH)

The project consultants are deeply grateful to these stakeholders for taking the time to provide feedback, which significantly improved the quality of the Best Practices Framework. The project consultants, Tim Berthold, Joe Lee, Yali Ruiz, and Lalitha Vaidyanathan, guided by the project workgroup, incorporated the majority of feedback received. In deciding how best to integrate the feedback, the project consultants were guided by the following principles of equity:

- Inclusion of a broad spectrum of perspectives representing California's CHW/P/R community
- Value and respect for all high-quality training approaches and programs

Where, in a minority of cases, feedback was not incorporated, it was to ensure that no training approach or program would be perceived as being more valuable than others. This framework recognizes all approaches that result in high-quality training for CHW/P/Rs as valuable.

Details on specific feedback received from the CHW/P/R Advisory Workgroup, training entities, and CHR organizations, along with how the feedback was addressed, are included in [Appendix F](#), [Appendix G](#), and [Appendix H](#) respectively.

Best Practices Framework

The CHW/P/R Training Best Practices Framework is a summary of research conducted with diverse stakeholders statewide. The research findings and the framework were reviewed by the CHW/P/R Advisory Workgroup (the majority its members are active CHW/P/Rs) as well as training entities interviewed for this project — and their feedback was incorporated into this framework.

This research found that CHW/P/R training programs in California take different approaches to training based on type of participants, purpose of training, and organizational needs and constraints. The different approaches serve specific purposes and all hold value to participants and the field. Despite the differences, this research found best practices in common across the training programs — these are summarized in this Best Practices Framework and organized into the following twelve categories:

1. Training philosophy and methodology
2. Core competencies
3. Training structure
4. Training program transparency
5. Training instructor qualifications
6. Training format
7. Training participant assessment
8. Training enrollment requirements
9. Training fees and costs
10. Training program evaluation
11. Training organization credibility and qualifications
12. Other good practices

1. Training Philosophy and Methodology

- **Understand, acknowledge, honor, and lift up, and see training as a way to build on, the lived experience, skills, knowledge, and wisdom** that CHW/P/Rs bring to the training.
- **Ground the CHW/P/R training in principles of cultural humility and respect.** Recognize and give credit when drawing on different cultural practices.
- **Meet participants where they are**, especially in terms of preferred language, literacy levels, technical skills, and ways of learning, and ensure the training is accessible for CHW/P/Rs coming from a diversity of backgrounds.
 - Where it is not feasible to train CHW/P/Rs in the language spoken in their community, provide support for CHW/P/Rs to translate the lessons and resources into their local language or dialect.
- **Prioritize interactive and engaging methodologies** over traditional lectures and textbook learning, incorporating methods such as discussions, reflections, role-plays, simulations, case studies, project work, shadowing, and peer-based learning.

2. Core Competencies

- **Align foundational training curriculum to the 11 CHW Core Skills** in the [National C3 Council's competencies](#).¹⁰
- **Cover the key C3 sub-skills as well as additional core competencies** not currently included as a sub-skill within the C3 competencies but suggested by stakeholders. These are listed in the table below.
- **The depth to which the C3 skills and sub-skills are covered in the foundational training should be based on the needs of communities being served** and the specific roles CHW/P/Rs play in those communities. Where greater depth in particular core skills or sub-skills is required, the training organization may choose to include them in a longer foundational training or to teach them in a specialty training.

- Teach and apply the core competencies in cultural, regional, and context-specific ways.

C3 CHW Core Skills	Key C3 Sub-Skills Recommended to Be Covered	Additional Sub-Skills Not in C3 Recommended to Be Covered
1. Communications	• Active listening • Documentation	• Trauma-informed communication • Documentation of accurate and relevant patient information
2. Interpersonal and relationship building	• Motivational interviewing • Conflict management and resolution • Cultural humility • Coaching and support	
3. Service coordination and navigation	• Barriers to care coordination • Coordinating care including accessing resources, overcoming barriers, making referrals • Case management including follow-up, tracking care, and referral outcomes	• Working collaboratively in interdisciplinary teams across public health, social services, and health care sectors • Navigating specific health systems and barriers (Federal, State, and Tribal)
4. Capacity building	• Conducting community organizing	
5. Advocacy	• Speaking up for individuals and communities	• Understanding fundamentals of policy advocacy
6. Education and facilitation	• Empowering and learner-centered teaching strategies	• Culturally competent and whole person-centered care
7. Individual and community assessment		• Gathering and documenting community concerns regarding their health outcomes • ACE's screening to understand barriers and service referrals needed

8. Outreach skills	• Case finding, recruitment, and follow-up • Building and maintaining current resource directory, or if one already exists, interacting with and updating it	• Conducting local outreach e.g., at health fairs, community events, Tribal cultural community events
9. Professional skills and conduct	• Ethics, HIPAA, and confidentiality • Boundary setting and self-care including stress management, healthy coping skills, and reducing secondary trauma • Personal safety • Lifelong learning and professional growth • Workplace conduct (including handling disagreement, conflict) • Ability to use pertinent technology	• CHW/P/Rs' scope of practice • Specific technology skills: basic computer skills, digital literacy
10. Evaluation and research		• Basic introduction to evaluation and research methods
11. Knowledge base	• CHW/P/R field, history, and role • Introduction to public health • Basics of US health (especially Medi-Cal and Medicare) and social services (e.g., benefits) • Social determinants of health and health disparities • Pertinent health issues • Health behavior change	• Pertinent health issues, including basics of trauma-informed care, emotional and mental health, chronic disease, and infectious disease (e.g., COVID-19) • Social determinants of health examples could include: systemic inequities, neighborhood and built environment, access to healthy food options, social support, housing

3. Training Structure

Training structure includes key elements such as duration, field work, specialty training, and continuing education.

CHW/P/R training can happen in many diverse settings, including in the community, within academia, and at an employer's site or another site contracted by an employer. Trainings in different settings often have unique characteristics (e.g., core competencies emphasized, training methods used, how curriculum and training are structured and delivered) and may serve different purposes (e.g., specific needs of an employer or employment setting, specific needs of a community being served, CHW/P/Rs' role in the community, pathway for degree acquisition). However, they are all valuable and necessary to serve the needs of a diverse state like California. Notwithstanding these differences, the following are considered best practices in how to approach training across these settings:

- **Provide at least 80 hours¹¹ of training for CHW/P/Rs to acquire a certificate of completion.**¹² This training should include foundational or core training that covers the core competencies outlined in Section 2, "Core Competencies," of this Best Practices Framework; supervised field work; and any specialty training required to meet the specific needs of the community served. Training programs can structure the curriculum in ways that best serve the needs of the community.
- **Field work should be an important part of the CHW/P/R training,** be of a length that makes it worth the employer's time, and, ideally, be paid to overcome any barriers to CHW/P/R participation. Field work can include time CHW/P/Rs spend continuing their community work after training, provided it is done under regular supervision or structured mentorship (e.g., scheduled check-ins, co-visits, group case conference) of an instructor from the training organization. Best practice field work includes experiences that are practice-based and reflect the reality of CHW/P/Rs' work. Such practices could include, for example, simulation labs; shadowing clinical partners, CBOs, or health plans; or virtual and in-person service delivery. Training organizations are encouraged to provide field work sites and supervisors with clear guidelines for field work goals, tasks, responsibilities, documentation of hours, and evaluation of CHW/P/R performance.
- Organizations employing CHW/P/Rs should provide, or refer out to training programs to provide, at **least six hours of ongoing professional development annually**, following foundational training. This additional education may be provided in person or virtually depending on topic. Sample best practice topics in ongoing professional development include the following:
 - Education on a specific topic needed to respond to a new community need
 - Additional education, training, or degrees to advance in the CHW/P/R career
 - Additional specialty training to meet a specific need in the community (e.g., chronic disease, behavioral health, substance abuse)
 - Peer-based learning with other CHW/P/Rs about best practices
 - Additional training recommended by a supervisor
 - Knowledge about changes in government rules, laws, guidance, or practices
- CHW/P/R employer organizations and training programs providing ongoing professional development should make ongoing professional development available to individual

CHW/P/Rs regardless of employment status (e.g., employee, independent contractor, co-op, not currently employed) so that all CHW/P/Rs can continually learn, grow, serve their communities, and advance in their careers.

4. Training Program Transparency

- **Provide a clear statement** of what content is covered in the training, training hours, supervised field work expectations, approach to learning and assessment, and which employer roles and settings the training prepares its graduates for. This can help to ensure CHW/P/Rs make informed choices on how the training aligns with their personal and professional goals.
- **Offer a participant orientation** before the start of training to be clear and transparent about program requirements, expectations around use of digital tools, and assignments to ensure that participants know what they are taking on, and to set expectations about the level of effort required to complete the training.
- **Be clear about career advancement services and resources offered** such as employment placement services, career counseling or advising, education options to continue career advancement (e.g., primary care, behavioral health, nursing, public health, social work), and connections to or networking opportunities with employers, so that participants are clear about opportunities to obtain meaningful employment after completing training. Share sample CHW/P/R job descriptions, typical wage ranges, and advancement pathways where possible.

5. Training Instructor Qualifications

- **Have trainings be led or co-led by experienced CHW/P/Rs with relevant lived experience** to the community being served. Depending on the setting, pair the CHW/P/R instructors with faculty co-leads (in academic settings); clinicians (in clinical settings); health, public health, or social services providers or managers; or others as appropriate.
- **Ensure all instructors have some experience in training methods** such as adult learning, popular education,¹³ participatory learning, experiential learning, trauma-informed approach, etc.
- **Ensure CHW/P/R instructors model the above approaches** in their instructional approach.
- **Ideally, CHW/P/R instructors are proficient in the language in which the training is provided.**
- Instructors should **keep up-to-date with developments** in areas such as public health, community health, and social determinants of health so they are aware of trends in the field and can help equip CHW/P/Rs to address emerging health challenges.
- **Engage CHW/P/Rs in the development of training curriculum.**
- **Integrate CHW/P/Rs' feedback, experience, and on-the-ground learning** into ongoing updates of the training curricula.
- **Evaluate instructors at least annually** for quality and consistency of performance. Evaluations could include self-evaluation, as well as those from training participants, peers, and supervisors. Couple these evaluations with coaching and support for instructors to address areas of growth.

- As needed, **supplement instructors with guest speakers or experts** on relevant topics.

6. Training Format

- **Deliver some part of the training in person** so instructors can assess how well CHW/P/Rs are understanding and integrating the training. It is recommended that fieldwork and practicums be in person.
- **Deliver some part of the training virtually** to keep training accessible and to build CHW/P/Rs' capability to deliver services virtually:
 - Virtual delivery keeps training accessible for participants who have work or personal commitments that would not allow them to attend the entire training period in person — for example, by offering virtual training on weekday evenings and in-person training on weekends.
 - Also, given the increasing need for CHW/P/Rs to provide services virtually (e.g., telephonic care coordination, remote screening, virtual outreach), virtual training helps prepare CHW/P/Rs to meet this need.
- The above guidance on virtual training should be implemented with careful consideration of the community context. For example, in communities, especially in rural areas, with no or only limited access to high-quality, high-speed broadband internet service, virtual training and service delivery may not be feasible. In these situations, favor conducting training in person. In consideration of long distances between locations in rural areas, favor conducting training close to where CHW/P/Rs live.
- **Offer additional technical assistance for CHW/P/Rs** less familiar with technology around accessing broadband internet service and the use of digital tools and platforms to access virtual components of training.
- **Use synchronous training** (whether in person or virtual) for (1) teaching and practicing motivational interviewing, communications skills, and relationship building; (2) drawing out and building on participants' skills, knowledge, and experience, cultural identity, feelings, and priorities; (3) being in community, practicing, and making mistakes; and (4) learning from peers.
- **Limit the use of asynchronous training** to self-study, reviewing material, taking quizzes, and engaging on the content with peers on discussion boards.

7. Training Participant Assessment

- **Assess CHW/P/Rs' learning** through a variety of approaches such as observations, teach backs, pre- and post-testing, self-reported assessments, individual and group projects, self-study and reports, case study assignments, quizzes, and role-plays.
- **Use performance-based assessments** to allow the CHW/P/Rs to demonstrate skills and knowledge in realistic scenarios. These can include, for example, role-plays, motivational interviewing, conducting client assessment, and developing client support plans. Ensure assessments are culturally relevant, trauma-informed, and strengths-based, avoiding punitive approaches and providing opportunities for redemonstration and feedback.
- **Assessments** should ideally include mechanisms for CHW/P/Rs to assess instructors as well as each other.

- **Engage CHW/P/R participants in assessment design** so assessments can have shared value and meaning to both instructors and CHW/P/Rs.
- **Ensure that the instructor is adequately trained and knowledgeable** in conducting participant assessments as suggested above.

8. Training Enrollment Requirements

- **Keep requirements for training program enrollment to a minimum** to ensure the program is accessible to all aspiring CHW/P/Rs. Specifically, not requiring the following can keep trainings more accessible: educational background (high school diploma or GED), English language proficiency, and digital literacy.
- When the number of applicants exceeds training spaces available, training organizations can **select the best cohort** by using criteria to help select applicants who are highly motivated, have lived experience in communities being served, and are prepared to complete training requirements. Taking into consideration literacy levels, applicant motivation may be assessed by requesting a letter of interest where they describe why they are interested in taking the training.

9. Training Fees and Costs

- **Keep costs to participate in training free or close to free** so that it is not a barrier to aspiring CHW/P/Rs.
- **A symbolic payment by CHW/P/R participants** to the training program is a useful mechanism to reinforce CHW/P/Rs' commitment and can help to incentivize training attendance and continuation.
- Where training cannot be offered for free or at a reduced cost, **make financial aid and scholarships available** to cover 100% of fees, and lend textbooks to aspiring CHW/P/Rs who have limited financial means.
- If CHW/P/R participants are already working with an organization when they attend the training, employer organizations should **pay their regular wages during training**.
- If CHW/P/R participants are not employed at the time of training, and taking time out to attend training and field work could pose a barrier to participation, consider **paying a stipend for field work or internships**.
- **Pursue available public funding, subsidies, or partnerships** to secure resources and funds that support CHW/P/R training fees and costs.

10. Training Program Evaluation

- **Conduct ongoing evaluation** to ensure the training meets the evolving needs of CHW/P/Rs and, where possible, of employers.
- **Evaluate different aspects of training**, including CHW/P/Rs' understanding of the material, competencies, pacing, training format, satisfaction with instructors, the quality of instruction, curriculum, language access, training facilities and infrastructure, and cultural competence. It is also suggested to conduct six- to 12-month follow-up surveys to assess CHW/P/Rs' employment outcomes and skill application.

- **Include anonymous post-training surveys of CHW/P/R participants**, at a minimum, for all evaluations. The survey instrument should allow CHW/P/Rs to provide qualitative comments and suggestions for improvements.
- **Put a process in place for regularly reviewing the evaluations** (e.g., at least once a quarter) and taking action to improve training as needed. Include CHW/P/Rs in the review and action recommendation process.
- To continually improve training quality, training programs and instructors are encouraged to **network and learn from peer training programs**. In addition, emerging training programs are also encouraged to learn from more established training programs.

11. Training Organization Credibility and Qualifications

Given the community-rooted nature of the CHW/P/R profession, training organizations should be rooted in the communities served.

The following criteria describe the ways in which this value of being rooted in community can be operationalized, at a minimum:

- **Have stated, and be driven by, values** such as commitment and love for community, passion for health, passion for protecting families, and passion for meeting the needs of marginalized communities.
- **Be located in or near the community** being served and be rooted in and have experience with and relationships in the community.
- Where possible, **include CHW/P/Rs in the governance of the organization** — for example, on the board of trustees or directors, on a separate CHW/P/R advisory board, or other governance mechanisms.
- **Understand, be familiar with, and have experience in the CHW/P/R field** and have a proven track record of providing CHW/P/R training.
- **Have knowledge of California laws, health programs, and barriers to care.**
- **Conduct trainings codesigned and, where possible, co-led** by experienced CHW/P/Rs from the community.

12. Other Good Practices

- Create a “network” to keep CHW/Rs graduates connected after successfully completing the program
- Where CHW/P/R are unable to participate in training due to lack of childcare, transportation, and other such needs, consider providing necessary supports.

Conclusion

HCAI and DHCS are deeply grateful to the CHW/P/R community for their engagement, input, and feedback throughout this project. HCAI and DHCS hope these voluntary best practices preserve the core values of the field, provide guidance without over-professionalizing the field, make training accessible for everyone, and build a shared framework grounded in community

knowledge, experience, and research. HCAI and DHCS also hope that these best practices ultimately are successful in fulfilling the two main purposes for which they were developed:

- **Clarity** — to provide clear expectations for what CHW/P/R training programs should provide
- **Consistency** — to provide a common CHW/P/R training framework so programs across the state can align in approach and quality

Appendices

Appendix A. Project Workgroup Members

- Libby Abbott, Deputy Director, Office of Health Workforce Development, HCAI
- Tim Berthold, Public Health Consultant and Author (Community Consultant)
- Angela Brand, Section Chief, Behavioral Health & Policy, HCAI (replaced Jalaunda Granville, Health Workforce Policy Section Chief, HCAI)
- Carlina Hansen, Senior Program Officer, CHCF
- Erica Holmes, Assistant Deputy Director, Health Care Benefits & Eligibility, DHCS (replaced Michael Freeman, Assistant Deputy Director, Health Care Benefits & Eligibility, DHCS)
- Hovik Khosrovian, Policy Section Chief, Healthcare Workforce Development, HCAI
- Joe Lee, Founder and Principal Consultant, Community Health Synergy (Community Consultant)
- Melanie Perkins, Project Manager, PMP, Healthcare Workforce Development, HCAI
- Chris Perry, Policy Manager, HCAI
- Yali Ruiz, PhD, CEO and Consultant, Bair Ruiz Enterprises (Community Consultant)
- Chinyelu Ugwuanyi, State Policy Specialist, HCAI

Appendix B. Stakeholders Interviewed

Project Workgroup

Round 1 (May 2025)

- Libby Abbott, Deputy Director, Office of Health Workforce Development, HCAI
- Tim Berthold, Public Health Consultant and Author
- Jalaunda Granville, Health Workforce Policy Section Chief, HCAI
- Michael Freeman, Assistant Deputy Director, Health Care Benefits & Eligibility, DHCS
- Carlina Hansen, Senior Program Officer, CHCF
- Hovik Khosrovian, Policy Section Chief, Healthcare Workforce Development, HCAI
- Joe Lee, Founder and Principal Consultant, Community Health Synergy
- Yali Ruiz, PhD, CEO and Consultant, Bair Ruiz Enterprises
- Chinyelu Ugwuanyi, State Policy Specialist, HCAI

Round 2 (June/July 2025)

- Tim Berthold, Public Health Consultant and Author
- Carlina Hansen, Senior Program Officer, CHCF
- Erica Holmes, Assistant Deputy Director, Health Care Benefits & Eligibility, DHCS
- Hovik Khosrovian, Policy Section Chief, Healthcare Workforce Development, HCAI
- Joe Lee, Founder and Principal Consultant, Community Health Synergy
- Chris Perry, Policy Manager, HCAI
- Yali Ruiz, PhD, CEO and Consultant, Bair Ruiz Enterprises
- Chinyelu Ugwuanyi, State Policy Specialist, HCAI

CHW/P/R Training Organizations on HCAI's CHW/P/R Advisory Workgroup

- Dorel Clayton, Community Health Worker Trainer, Transitions Clinic Network
- Lucia Cloud, CHW Integration Coordinator, Loma Linda University
- Sarah Davila, Program Director and Associate Professor, Chaffey College
- Laura Lopez, Program Coordinator, Touro University
- Andrea Mackey, Associate Organizing Director, California Pan-Ethnic Health Network
- Rosa Perez Quintanilla, Institute for Community Partnership / El Sol
- Cary Sanders, Senior Policy Director, California Pan-Ethnic Health Network
- Three representatives from Visión y Compromiso

Additional Stakeholders

- Mia Arias, Director, CalAIM, CalOptima
- Cheyenne Bond, Enhanced Care Management Lead Supervisor, Bakersfield American Indian Health Project
- Leona Smith Di Faustino, Executive Director, Worker Education & Resource Center
- Belinda Hernandez, CHW Manager, Community Behavioral Health, Inland Empire Health Plan
- Michelle King, Program Director, County of Riverside
- Ashley Kissinger, California Department of Public Health
- Lucero Montoya, Director of Operations, Riverside University Health System-Public Health
- Amrita Rai, Clinical Director, Community Behavioral Health, Inland Empire Health Plan
- Colby Takeda, Cofounder and CEO, Pear Suite
- Daniel Torres, Chief Equity Officer, CalHHS
- Futuro Health
- Public Health Program, County of Tulare
- Tulare County Health & Human Services Agency
- VIVO (Vietnamese Voluntary Foundation)

Appendix C. HCAI's CHW/P/R Initiative Advisory Workgroup Members

- Patricia Alcocer, County of Monterey Health Department, Central Coast
- Moyosore A.S. Buari, Independent Contributor, San Diego
- Dorel Clayton, Transitions Clinic Network, Greater Bay Area
- Maria E. Cruz, Sowing Seeds, Sacramento
- Sarah Davila, Chaffey College, Inland Empire
- Ayarim De Anda, YMCA of San Diego County, San Diego region
- Felipe Flores, San Francisco Community Clinic Consortium and California Association of Community Health Workers Board Member, Greater Bay Area
- Rebecca Harris, Mercy Hospital Folsom, Sacramento
- Alyssa Johnson, Children's Hospital of Los Angeles
- Yoseline Lopez-Mejia, Vayu Health / Touro University / Stanislaus State, Greater Bay Area
- Andrea Mackey, California Pan-Ethnic Health Network, Los Angeles County and statewide
- Maribel Montes de Oca, Visión y Compromiso, statewide
- Candelaria Pahlua Oros, California Health Collaborative, Northern and Sierra
- Rosa Perez Quintanilla, Institute for Community Partnership / El Sol, Inland Empire
- Olivia Rodriguez, Mujeres en Acción, Central Coast, serves the Mixteco-speaking community
- Carrie Schaller, ACE Overcomers, San Joaquin Valley
- Ana Lidia Tutila, Latino Coalition for a Healthy California, Orange County
- Christine Vang, Fresno County Department of Public Health's CHW Network, San Joaquin Valley

Appendix D. Definitions of CHW/P/R Roles

Community health worker

Frontline public health worker who is a trusted member of or has an unusually close understanding of the community served, who connects communities with health and social services, improving access and cultural competence.

Promotores

Natural leader and neighborhood “go to” person known for *servicio de corazón* (“service from the heart”) who primarily serves Latino/x and Spanish-speaking communities, sharing lived experiences and cultural ties.

Community health representative

Trusted frontline public health worker rooted in community, language, and traditions essential to the spectrum of Tribal community-oriented primary health care services.

Other roles include health navigators and community health advisers serving diverse populations across California.

Source: “[CHW/P/R Community Dialogue Summary Webinar](#)” (PDF), webinar, California Department of Health Care Access and Information, June 18, 2025.

Appendix E. CHW/P/R Competencies: Skills and Sub-Skills

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

☐ 6. Education and Facilitation Skills	a. Ability to use empowering and learner-centered teaching strategies b. Ability to use a range of appropriate and effective educational techniques c. Ability to facilitate group discussions and decision-making d. Ability to plan and conduct classes and presentations for a variety of groups e. Ability to seek out appropriate information and respond to questions about pertinent topics f. Ability to find and share requested information g. Ability to collaborate with other educators h. Ability to collect and use information from and with community members
☐ 7. Individual and Community Assessment Skills*	a. Ability to participate in individual assessment through observation and active inquiry b. Ability to participate in community assessment through observation and active inquiry
☐ 8. Outreach Skills*	a. Ability to conduct case-finding, recruitment and follow-up b. Ability to prepare and disseminate materials c. Ability to build and maintain a current resource inventory
☐ 9. Professional Skills and Conduct	a. Ability to set goals and to develop and follow a work plan b. Ability to balance priorities and to manage time c. Ability to apply critical thinking techniques and problem solving d. Ability to use pertinent technology e. Ability to pursue continuing education and life-long learning opportunities f. Ability to maximize personal safety while working in community and/or clinical settings g. Ability to observe ethical and legal standards (e.g. CHW Code of Ethics, Americans with Disabilities Act [ADA], Health Insurance Portability and Accountability Act [HIPAA]) h. Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements i. Ability to participate in professional development of peer CHWs and in networking among CHW groups j. Ability to set boundaries and practice self-care
☐ 10. Evaluation and Research Skills*	a. Ability to identify important concerns and conduct evaluation and research to better understand root causes b. Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) c. Ability to participate in evaluation and research processes including: i) Identifying priority issues and evaluation/research questions ii) Developing evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings

☐ 11. Knowledge Base	a. Knowledge about social determinants of health and related disparities b. Knowledge about pertinent health issues c. Knowledge about healthy lifestyles and self-care d. Knowledge about mental/behavioral health issues and their connection to physical health e. Knowledge about health behavior theories f. Knowledge of basic public health principles g. Knowledge about the community served h. Knowledge about United States health and social service systems
<i>*Asterisks denote new skills from 1998 -2016; several sub-skills have been expanded</i>	
C3 Project, 2018 www.C3Project.org	

Source: "[CHW C3 Roles and Competencies Checklist](#)," National C3 Council.

Appendix F. Key Themes from CHW/P/R Advisory Workgroup Feedback

The CHW/P/R Advisory Workgroup affirmed that the research findings were aligned with their experience in the field. Specific areas highlighted included:

- The importance of CHW/P/R foundational training to cover the core skills necessary to be an effective CHW/P/R regardless of training model.
- The importance of training to build on the valuable skills that CHW/P/Rs bring, such as lived experience, navigating stigma, and cultural credibility.
- The importance of continuing education to support CHW/P/R career advancement.
- The need for training that equips CHW/P/Rs with practical technological skills (e.g., Zoom, email) relevant to particular employer settings.

The CHW/P/R Advisory Workgroup identified additional important needs they recommended be included in the best practices:

- Address rural accessibility challenges, including weak internet connectivity, that may limit accessibility to virtual and hybrid training options, and long travel distances to the closest towns and cities.
- Ensure training is offered in preferred languages and accounts for diverse literacy levels and technical skills.
- Ensure training programs clearly communicate the roles, settings, and type of employment graduates are being prepared for. Doing so will enable participants to make informed decisions and have the right expectations of roles, settings, and salaries upon graduation. It also helps employers to make informed recruiting decisions.
- Provide technical assistance for CHW/P/Rs to access the internet and use digital tools for hybrid or asynchronous training.
- Offer continuing education opportunities for CHW/P/Rs who, by virtue of not being currently employed, may not have access to these opportunities.
- Keeping enrollment requirements to a minimum to maintain training accessibility.

A subset of the CHW/P/R Advisory Workgroup members provided additional feedback via email, highlighting these suggestions:

- The continued need for clear and consistent messaging that the state is not moving forward with statewide certification
- Concern that framing of the three training models may lead to one model being more highly valued than another
- Request for clarity around the term “initial training (~80 hours)”
- Suggestion to rename “instructor credentials” as “instructor qualifications” to honor lived and community experience
- Request for clarity around the use of terms like “360 assessments” and “peer assessments”

The Best Practices Framework was modified to incorporate all the above feedback. For a variety of reasons, some feedback was not included. The following table provides a summary of that feedback along with the rationale.

Feedback	Rationale for Not Including
Centering popular education principles as the foundation of CHW/P/R training	While popular education is a valuable method used by many CHW/P/R training programs, there are other adult learning methods also being used. Centering one places value on one approach over others and goes against the guiding principle of valuing all high-quality approaches.
Integrating the community-based model across all training approaches	Key elements of the community-based model — such as cultural grounding, centering participants' lived experience, and having training be led by CHW/P/Rs — are embedded across many of the best practices.
Partnering with CBOs with a long-standing history of training CHW/P/Rs as a best practice model	While CBOs have played an essential role in training and supporting CHW/P/Rs, elevating one organizational type over others contradicts the commitment to equally respect diverse training providers.

In their feedback, the CHW/P/R Advisory Workgroup also requested a variety of resources and tools, as summarized below, to help in the implementation of these best practices. These have been shared with CHCF, which is supporting the development of CHW/P/R resources:

- Program evaluation templates and tools
- Further guidance on conducting participant assessment including on frequency, feedback loops, and how participant input will inform training improvements

Finally, the CHW/P/R Advisory Workgroup also shared feedback that fell outside the scope of the Best Practices Framework. These have been shared with HCAI and DHCS for appropriate action.

Appendix G. Key Themes from Training Entities Feedback

Feedback on the Best Practices Framework was solicited over email from the 15 training entities interviewed for this project. Ten training entities responded with feedback — their feedback, as well as how the consulting team addressed them, is summarized below.

Many training entities responded with appreciation for the Best Practice Framework:

“I appreciate how thoughtfully the recommendations were crafted and how intentionally they reflect community input, flexibility, and lived experience. . . . This is incredibly important work for California, and I truly appreciate the thoughtful, community-first approach you and the workgroup are taking.”

“The draft framework reflects a strong commitment to community-rooted training, honoring lived experience, and cultural humility; flexibility across diverse training settings (CBOs, employer-based, academic); avoiding over-professionalization is a priority voiced consistently by CHWs/Ps/Rs; equity-focused access through reduced enrollment barriers and low/no-cost training; alignment with C3 core competencies, while incorporating additional California-relevant skills. These strengths position California to continue leading nationally in CHW workforce development.”

“I sincerely appreciate the commitment that HCAI and DHCS continue to demonstrate in strengthening and sustaining our workforce, especially given the current budget challenges. This framework represents an important step in protecting the essence of our profession and ensuring trainings remain accessible, respectful, and aligned with the real needs of our communities.”

Training entities provided many helpful suggestions to strengthen the Best Practices Framework. Some of the more substantive feedback that materially changed the Best Practices Framework is summarized below, along with a description of how the feedback was addressed.

Feedback	How It Was Addressed
Section 2. Core Competencies	
Feasibility of covering all C3 skills and recommended sub-skills: <i>“How to cover all skills in an 80-hour course? Should there be an extension or shorter elective course to cover the additional sub-skills?”</i>	Added new point: The depth to which the C3 skills and sub-skills are covered in the foundational CHW/P/R training should be based on the needs of communities being served and the specific roles CHW/P/Rs play in those communities. Where greater depth in particular core or sub-skills is required, the training organization may choose to include them in a longer foundational training or to teach them in a specialty training.
Recognizing the importance of interdisciplinary collaboration:	Added recommended sub-skill under Skill 3, Service coordination and navigation:

<i>“CHWs increasingly collaborate across sectors, so it might be good to add competencies or training content that teaches how to work within multidisciplinary care teams, especially in shared data or shared accountability environments.”</i>	Working collaboratively in interdisciplinary teams across public health, social services, and health care sectors
Suggestion to add sub-skills around policy advocacy, and community organizing and mobilization	Added new key C3 sub-skill under Skill 4, Capacity building: <i>Conducting community organizing</i> Added additional sub-skill under Skill 5, Advocacy: <i>Understanding fundamentals of policy advocacy</i>
Section 3. Training Structure	
Reinforcing the value of practice-based field work: <i>“Reinforce the value of practice-based, realistic fieldwork. . . . Since many CHWs are hired into roles tied to HRSN [health-related social needs] screening, care coordination, or quality metrics, embedding these into field work would be helpful: virtual practice; shadowing with CBOs, health plans, clinical partners; simulation labs.”</i>	Added following language to point on field work: <i>Best practice field work includes experiences that are practice-based and reflect the reality of CHW/P/Rs’ work. Such practices could include, for example, simulation labs; shadowing clinical partners, CBOs, or health plans; or virtual and in-person service delivery.</i>
Suggestions to add guidance for supervision of field work: <i>“Add guidance for CHW-specific field supervision and reflective practice.”</i> <i>“Provide greater clarity on the supervision model for fieldwork, including roles, frequency, and expectations.”</i>	Added following language to point on field work: <i>Training organizations are encouraged to provide field work sites and supervisors with clear guidelines for field work goals, tasks, responsibilities, documentation of hours, and evaluation of CHW/P/R performance.</i>

Referring to the point that says “provide at least six hours of ongoing professional development annually”: <i>“This bullet point is more a recommendation to the program integrating promotores/CHWs than the training program. . . . A more general bullet point recommending providing ongoing professional development spaces.”</i>	Following caveat added to the point: Organizations employing CHW/P/Rs should provide or refer out to training programs to provide at least six hours of ongoing professional development annually, following foundational training.
Section 4. Training Program Transparency	
Suggestion to add the following to the point about “career advancement services and resources”: <i>“. . . stepping stone to a career beyond CHW, such as nurse”</i>	Following language added to the point: Be clear about career advancement services and resources offered such as employment placement services, career counseling or advising, education options to continue career advancement (e.g., primary care, behavioral health, nursing, public health, social work). . . .
Section 5. Training Instructor Qualifications	
Suggestion that instructors should regularly update their knowledge to stay current: <i>“. . . to follow or include current news related to public health concerns (such as a new epidemic . . .)”</i>	Added new point: Instructors should keep up-to-date with developments in areas such as public health, community health, and social determinants of health so that they are aware of trends in the field and can help equip CHW/P/Rs to address emerging health challenges.
Suggestion to regularly evaluate the performance of instructors: <i>“Add clear expectations for ongoing trainer coaching, support, and performance review . . . to maintain consistency and quality across trainings.”</i>	Added new point: Evaluate instructors at least annually for quality and consistency of performance. Evaluations could include self-evaluation, as well as those from training participants, peers, and supervisors. Couple these evaluations with coaching and support for instructors to address areas of growth.
Suggestion to supplement instructors with special guest speakers: <i>“. . . inviting guest experts or speakers for specific training (CPR, FDA, CDC, etc.) or discussion of an interesting topic of choice”</i>	Added new point: As needed, supplement instructors with guest speakers or experts on relevant topics.

Section 6. Training Format

Suggestion to reconsider guidance on virtual training:

“Given how much CHW work now occurs virtually (telephonic care coordination, remote screening, virtual outreach), I recommend calling out that virtual training isn’t just an accessibility accommodation but is also a core modality that builds workforce readiness.”

Best practice guidance revised as follows:

Deliver some part of the training in person so instructors can assess how well CHW/P/Rs are understanding and integrating the training. It is recommended that field work and practicums be in person.

Deliver some part of the training virtually to keep training accessible and to build CHW/P/Rs’ capability to deliver services virtually:

- Virtual delivery keeps training accessible for participants who have work or personal commitments that would not allow them to attend the entire training period in person — for example, by offering virtual training on weekday evenings and in-person training on weekends.
- Also, given the increasing need for CHW/P/Rs to provide services virtually (e.g., telephonic care coordination, remote screening, virtual outreach), virtual training helps prepare CHW/P/Rs to meet this need.

The above guidance on virtual training should be implemented with careful consideration of the community context. For example, in communities, especially in rural areas, with no or only limited access to high-quality, high-speed broadband internet service, virtual training and service delivery may not be feasible. In these situations, favor conducting training in person. In consideration of long distances between locations in rural areas, favor conducting training close to where CHW/P/Rs live.

Section 8. Enrollment Requirements	
Request for guidance on recruitment and selection of participants in a training course: <i>“With limited spaces, how to make selections from the pool of qualified participants (e.g., first come, first served; screening exam; assessment)?”</i> Suggestion to provide wraparound support for participants: <i>“Add support for participants who may face challenges with digital literacy, language access, or housing instability to ensure equitable participation and successful completion.”</i>	Added new point: When the number of applicants exceeds training spaces available, training organizations can select the best cohort by using criteria to help select applicants who are highly motivated, have lived experience in communities being served, and are prepared to complete training requirements. Best practice guidance calls for training programs to meet participants where they are, especially in terms of language and literacy. Added new point to Section 12 of Best Practices Framework - Other Good Practices: Where CHW/P/R are unable to participate in training due to lack of childcare, transportation, and other such needs, consider providing necessary supports.
Section 9. Training Fees and Costs	
Suggestion to provide wraparound support for participants: <i>“Totally agree and suggest building relationships with reentry organizations, MCPs, and provide wraparound supports such as transportation, meals, childcare, or technology assistance to further reduce barriers and increase successful completion.”</i>	Added new point to Section 12 of Best Practices Framework - Other Good Practices: Where CHW/P/R are unable to participate in training due to lack of childcare, transportation, and other such needs, consider providing necessary supports.

Section 10. Training Program Evaluation	
Suggestion to encourage learning across organizations: <i>“ . . . coordination between different training organization for learning from each other”</i> <i>“I also will recommend . . . for emerging training programs, mentor time with experienced training organizations.”</i>	Added new point: To continually improve training quality, training programs and instructors are encouraged to network and learn from peer training programs. In addition, emerging training programs are also encouraged to learn from more established training programs.
Suggestion to conduct six- to 12-month follow-up surveys to assess CHW/P/Rs’ employment outcomes and skill application	Added language: Evaluate different aspects of training, including CHR/P/Rs’ understanding of the material, competencies, pacing, training format, satisfaction with instructors, the quality of instruction, curriculum, language access, training facilities and infrastructure, and cultural competence. It is also suggested to conduct six- to 12-month follow-up surveys to assess CHW/P/Rs’ employment outcomes and skill application.
Section 11. Training Organization Credibility and Qualifications	
Suggestion to add criteria around community governance (CHW/P/R advisory boards, community-led decision-making)	Added new point: Where possible, include CHW/P/Rs in the governance of the organization — for example, on the board of trustees or directors, on a separate CHW/P/R advisory board, or other governance mechanisms.

For a variety of reasons, some feedback was not included. The following table provides a summary of that feedback along with the rationale:

Feedback	Rationale for Not Including
Section 2. Core Competencies	
Suggestion to add to core competencies: <i>“Basic real-life skills, such as using blood pressure monitor machine, checking blood insulin level, checking blood oxygen.”</i>	Depending on the role CHW/P/Rs are playing, this is typically covered by training at the employer site.
Suggestion to add to core competencies: <i>“Data, quality, and compliance — the draft mentions documentation and billing, which is great. I recommend adding (these are often major pain points for both CHWs and employers): credentialing and enrollment processes (especially Medi-Cal requirements); data quality and data integrity; understanding care team roles in clinical vs. community settings; working with payers (documentation for claims, authorizations, HRSN screenings).”</i>	CHW/P/Rs tasked with Medi-Cal enrollment, and those working with payers, should receive additional training at the employer site or additional employer-specific training and as such, this feedback was not incorporated. Data quality and care team roles are addressed in core competencies.
Suggestion to add to core competencies: <i>A. Evaluation and research: basic evaluation and data ethics; community-based participatory research; observational reporting and trend identification</i> <i>Informed consent and confidentiality protections; quality improvement concepts (e.g., PDSA cycles); understanding how data support advocacy and program improvement</i> <i>B. Research-related competencies: ensures alignment with CHW roles in community-driven research, data justice, and safe data practices</i>	Many stakeholders felt Skill 11, Evaluation and research, should be kept light for foundational CHW/P/R training. As such, it is recommended to leave the current language: “Basic introduction to evaluation and research methods” as-is.

Section 3. Training Structure	
Suggestion to consider allowing prior experience to count toward field work requirements: <i>“Specify when and how CHWs with prior experience may be ‘grandfathered’ in for field work requirements so that existing skills and on-the-job experience are recognized without creating unnecessary barriers.”</i>	DHCS requires that CHW/P/Rs who qualify under the “Experience Pathway” obtain a certification of completion within 18 months. Since training organizations need to be able to observe CHW/P/Rs’ performance, including in field work, to grant a certificate of completion it is not recommended that field work be waived.
Section 11. Training Organization Credibility and Qualifications	
Suggestion to add criteria around funding: <i>“Encourage transparency around funding and potential conflicts of interest.”</i>	The nature of this suggestion regarding conflict of interest is unclear.

Finally, training entities also requested a variety of resources and tools to help implement the best practices. These are summarized below and have been shared with CHCF, which is supporting the development of CHW/P/R resources:

- Training program evaluation template.
- Sample training curriculum, in English and other languages.
- Suggestions for textbooks that can be used in training.
- Examples of statements clarifying what content is covered and which employer roles and settings the training prepares graduates for.
- Additional support around virtual trauma-informed facilitation.

Appendix H. Key Themes from CHR Organizations Feedback

Feedback on the Best Practices Framework was solicited over email from two organizations working with Community Health Representatives (CHR) – California Rural Indian Health Board (CRIBH) and California Consortium for Urban Indian Health (CCUIH). Their feedback, as well as how the consulting team addressed them, is summarized below.

Overall, the Best Practice Framework resonated with CRIBH and CCUIH. These stakeholders provided important feedback and suggestions on several sections of the framework as follows:

- Feedback on Section 1: Training Philosophy and Methodology – suggestion to add standards for cultural protection
 - How the feedback was addressed: second bullet point in that section modified as follows (text in green): “Ground the CHW/P/R training in principles of cultural humility and respect. Recognize and give credit when drawing on different cultural practices.”
- Feedback on Section 2: Core Competencies – suggestions to add Additional Sub-Skills not in the C3 framework
 - How this feedback was addressed: additional core competencies were added as shown in green text below

C3 CHW Core Skills	Key C3 Sub-Skills Recommended to be Covered	Additional Sub-Skills not in C3 Recommended to be Covered
1. Communications	● Active listening ● Documentation	● Trauma informed communication ● Documentation of accurate and relevant patient information ● Using storytelling and personal narratives as a communication mechanism
2. Interpersonal and relationship building	● Motivational interviewing ● Conflict management and resolution ● Cultural humility ● Coaching and support	●
3. Service coordination and navigation	● Barriers to care coordination ● Coordinating care including accessing resources, overcoming barriers, making referrals	● Working collaboratively in interdisciplinary teams, across public health, social services, and healthcare sectors

	Case management including follow-up, tracking care and referral outcomes	Navigating specific health systems and barriers (State, Federal, and Tribal)
4. Capacity Building	Conducting community organizing	
5. Advocacy	Speaking up for individuals and communities	Understanding fundamentals of policy advocacy
6. Education and facilitation	Empowering and learner-centered teaching strategies	Culturally competent and whole person-centered care
7. Individual and community assessment		- Gathering and documenting community concerns regarding their health outcomes - ACE's screening to understand barriers and service referrals needed
8. Outreach skills	- Case-finding, recruitment, and follow-up - Building and maintaining local current resource directory, or if one already exists, how to interact with it and update it	Conducting local outreach e.g., at health fairs, community events, Tribal cultural community events
9. Professional skills and conduct	- Ethics, HIPAA & confidentiality - Boundary setting and self-care, including stress management, healthy coping skills, and reducing secondary trauma - Personal safety - Lifelong learning and professional growth - Workplace conduct (including handling disagreement, conflict) - Ability to use pertinent technology	- CHW/P/Rs' scope of practice - Specific technology skills: basic computer skills, digital literacy
10. Evaluation and research		Basic introduction to evaluation and research methods
11. Knowledge Base	CHW/P/R field, history, and role	Pertinent health issues, including

	• Introduction to public health • Basics of U.S. health (especially Medi-Cal and Medicare) and social service (e.g., benefits) • Social determinants/drivers of health and health disparities • Pertinent health issues • Health behavior change	basics of trauma-informed care, emotional/mental health, chronic disease, and infectious disease (e.g., COVID-19) • Social determinants of health examples could include: systemic inequities, neighborhood and built environment, access to healthy food options, social support, housing
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- Feedback on Section 3: Training Structure. Request for breakdown of what the 80 hours of training would entail
 - How the feedback was addressed: Sentence added to clarify that training programs should structure the 80 hours in any way that best serves their communities: **Training programs can structure the curriculum in ways that best serve the needs of the community.**
- Feedback on Section 7: Participant Assessment. Recommendation that applicants take a preassessment to determine readiness for becoming Community Health Workers, and to gauge their potential success in the program. Pre-training courses could also be offered to help prepare candidates.
 - How the feedback was addressed: This feedback fit better in Section 8 (Enrollment Requirements) and as such, a sentence was added to Section 8: Enrollment Requirements as follows: **Taking into consideration literacy levels, applicant motivation may be assessed by requesting a letter of interest where they describe why they are interested in taking the training.**
- Feedback on Section 9: Training Fees and Costs. Suggestion that CHWs have benefited from supportive services and stipends that assist with gas, housing, childcare, medical equipment, and supplies
 - How the feedback was addressed: This was feedback was received from more than one stakeholder, and also comes up frequently in stakeholder discussions. A new section 12. Other Good Practices was added to the report and this suggestion was added to that section: **Where CHW/P/R are unable to participate in training due to lack of childcare, transportation, and other such needs, consider providing necessary supports.**
- Feedback on Section 10: Training Program Evaluation. Suggestion to create a “network” to keep CHW/Rs connected even after successfully completing the program.
 - How this feedback was addressed: This was added to the new Section 12: Other Good Practices: **Create a “network” to keep CHW/Rs graduates connected after successfully completing the program.**

Appendix I. Research References and Resources

Training Resources

[El Sol Training Center](#) (El Sol Neighborhood Educational Center)

[Training](#) (Visión y Compromiso)

[CHW/P/R Policy Agenda](#) (PDF) (California Pan-Ethnic Health Network)

[Foundations for Community Health Workers](#), 3rd ed. (Wiley, 2024)

[Community Health Worker Micro-Credential](#) (Touro University California)

Research Reports

[Meeting the Demand for Health](#) (California Future Health Workforce Commission Report)

[Advancing California's Community Health Worker & Promotor Workforce in Medi-Cal](#) (CHCF)

[Understanding California's Community Health Worker/Promotor Workforce: CHW/P Training Programs](#) (CHCF)

State of California Resources

[CHW/P/R Initiative](#) (HCAI)

[CHW/P/R Community Dialogue Summary Report](#) (PDF)

[Frequently Asked Questions for Medi-Cal CHW Services — Provider Requirements](#) (DHCS)

[CHW/P/R Community Dialogue Summary Webinar — FAQs](#) (PDF) (HCAI)

Other Resources

[CHW Roles and Competencies](#) (National C3 Council)

[National Association of Community Health Workers](#)

[An Introduction to Popular/People's Education: A Manual for All](#) (Center for Research and Evaluation)

[Cultural Humility Resources](#) (UC Berkeley)

Endnotes

¹ For details on DHCS’s qualification requirements, please see [State Plan Amendment 22-0001](#) (PDF).

² For a definition of “lived experience” please see the “CHW Minimum Qualifications” section in [“Community Health Worker \(CHW\) Preventive Services”](#) (PDF) (last updated October 2025), Section 2 of *Medi-Cal Provider Manual*.

³ For a more detailed sequence of events related to the California Department of Health Care Services (DHCS) and HCAI’s CHW/P/R engagement efforts including the above, please refer to [Community Dialogue Summary Report](#) (PDF), California Department of Health Care Access and Information (HCAI), May 2025.

⁴ For details on DHCS’s qualification requirements, please see [State Plan Amendment 22-0001](#) (PDF).

⁵ [“CHW/P/R Community Dialogue Summary Webinar – Frequently Asked Questions \(FAQs\)”](#) (PDF), HCAI, last updated July 18, 2025.

⁶ Paulo Freire, *Pedagogy of the Oppressed*, trans. Myra Bergman Ramos (Continuum, 1970).

⁷ [“C3 Council Findings: Roles & Competencies,”](#) National Council on CHW Core Consensus Standards.

⁸ Data from CHCF’s [Understanding California’s Community Health Worker/Promotor Workforce: CHW/P Training Programs](#) report from February 2023 show that the duration of training programs varies widely — the average length of training programs in California is 283 didactic hours per program for college- and university-based trainings (public and private) and 87 didactic hours per program for organization-based programs (CBOs and county health departments). Additional data from stakeholders interviewed for this project show workforce/employer-driven models (e.g., Futuro Health, IEHP, Touro, Worker Education Resource Center) averaging about 80–100 hours per program. Several organizations interviewed offer six hours of continued learning per year.

⁹ Freire, *Pedagogy*.

¹⁰ “C3 Council Findings,” National Council on CHW Core Consensus Standards.

¹¹ This best practice recommendation is based on data from CHCF’s *Understanding California’s Community Health Worker/Promotor Workforce* report, which shows that the duration of training programs varies widely — the average length of training programs in California is 283 didactic hours per program for college- and university-based trainings (public and private) and 87 didactic hours per program for organization-based programs (CBOs and county health departments). Additional data from stakeholders interviewed for this project show training in or for employer settings (e.g., Futuro Health, IEHP, Touro, Worker Education Resource Center) averaging about 80–100 hours per program.

¹² For details on “certificate of completion,” please see State Plan Amendment 22-0001.

¹³ Freire, *Pedagogy*.