Examining Differences in Community Health Worker (CHW) Training Based on Organizational Experience With CHWs: A Call for CHW Workforce Sustainability

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As the COVID-19 crisis unfolded, community health workers (CHWs) in the United States were quickly identified as an essential workforce of health professionals that could reach community members who were at the highest risk for the negative effects of COVID-19.

The reliance on CHWs during the COVID-19 pandemic has accelerated decades-long advocacy for sustainable funding for CHWs. Advocates argue, in part, that CHW programs must be up and running with trained CHWs and existing relationships with communities to most effectively respond to public health emergencies.

Here we provide insight into this discussion in the context of the Centers for Disease Control and Prevention's Community Health Workers for COVID Response and Resilient Communities (2021 to 2024) national initiative. Specifically, we explore the extent to which CHW training varied according to the recipient organization's previous experience working with CHWs. (*Am J Public Health*. 2026;116(S4):S358–S364. https://doi.org/10.2105/AJPH.2026.308557)

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Community health workers (CHWs), who are trusted members of the community they serve, rely on their lived experience and intimate knowledge of the community to act as a link between the community and health and social services to build local capacity to withstand health threats.[1] Attention often shifts toward CHWs in times of crisis given their ability to support populations at greatest risk for negative consequences in public health emergencies. This phenomenon was evident most recently during the COVID-19 pandemic.

As the COVID-19 public health crisis unfolded, it became clear that historically marginalized populations were experiencing COVID-19 and its adverse effects at disproportionately high rates.[2] Historically marginalized populations are often medically disconnected or underserved members of minoritized communities (e.g., nondominant racial and ethnic groups, people with disabilities, older adults). Given the detrimental health effects these communities were experiencing because of COVID-19, CHWs were quickly identified as an essential workforce of health professionals that could reach disconnected community members[3] to increase health access and knowledge, combat adverse COVID-19 health consequences, and promote COVID-19 preventive practices in the pandemic response.

For decades, CHWs and CHW allies have called for sustainable funding for CHW programs in the United States, and the focus on CHWs in light of the COVID-19 pandemic has heightened the call for sustainable programs.[4,5] As stated by Rodriguez et al.,[4(p698)] "A national CHW workforce could and should

have been in place at the start of the pandemic to address issues ranging from vaccine hesitancy, barriers to accessing testing, and low health literacy and misinformation to the broader social, economic, and behavioral health needs of vulnerable populations." In 2023, the National Association of Community Health Workers published a report providing guidance to state policymakers on CHW sustainable financing.[6] In that report, sustainable financing was defined as occurring when CHW funding is part of an organization's regular budget rather than relying on time-limited funds.

A central argument in advocacy for sustainable funding is that CHW programs must be up and running with trained CHWs and existing relationships with communities to most effectively respond to public health emergencies as well as ongoing public health issues. In contrast, when CHWs are funded by short-term grants, CHWs are often laid off at the completion of the grant and relationships with the community suffer.[6] Here we provide insight into this discussion in the context of the Centers for Disease Control and Prevention's Community Health Workers for COVID Response and Resilient Communities (CCR) initiative by comparing CCR recipients' training experiences on the basis of their readiness for mobilizing CHWs at the start of the initiative.

CCR INITIATIVE

The 3-year CCR program (2021–2024) funded 67 recipients across the United States, including state and local health departments, US territories and freely associated states, and tribal nations or tribal organizations (see De Jesus et al.[7] for more information). The goals of the CCR program were to implement CHW strategies to decrease the effects of COVID-19 on communities at highest risk for detrimental health outcomes and to increase communities' ability to respond to public health emergencies.[8] Of the 67 total recipients, 30 focused on building capacity for CHW efforts and 37 focused on expanding existing CHW programs. As illustrated in the CCR logic model (Wiggins et al., p. xxx), the short-term goal of the CCR "train" strategy was to increase CHW skills, capacities, and roles to support public health response efforts among the populations of focus. In turn, increased CHW capacity would yield increased reach among the populations of focus (intermediate outcome), ultimately decreasing the impact of COVID-19 and increasing resilience to public health emergencies (long-term outcome).

Recipients

Acknowledging that organizations had varying levels of readiness for mobilizing CHWs, the CCR initiative funded recipients for 1 of 2 purposes: (1) organizations that had limited experience with CHWs were funded to focus on building capacity for CHW efforts (subsequently referred to as capacity building) and (2) organizations that were already working with CHWs were funded to focus on improving and expanding existing CHW efforts (subsequently referred to as implementation ready). Therefore, whereas some CCR recipients had an established CHW workforce with close ties to and experience with addressing the health and social needs of the communities they served, other CCR recipients were in the early stages of developing CHW programs. Comparing these 2 categories of CCR recipients provides some insight into how public health entities are able to mobilize CHW programs based on their previous experience with CHWs.

In the sections to follow, we present national evaluation results that highlight training activities for CCR implementation-ready and capacity-building recipients.

National Evaluation Methods

We analyzed CHW training data collected as part of the CCR national evaluation. We used CCR performance measure data in which recipients reported the numbers and types of health and social service training topics provided to the initiative's CHWs. CCR recipients were required to report semiannually on 14 performance measures focused on process (program activities), outputs (direct program products and services), and outcomes (product and service results) throughout the 3-year funding period for a total of 6 reporting periods. Two performance measures focused on training and thus were included in our analysis.

First, recipients reported the number of CHWs that successfully completed state/local/tribal public health–led COVID-19 response training efforts as determined by relevant public health entities, including skills related to COVID-19 outreach, contact tracing, appropriate use of personal protective equipment, outreach and referrals for vaccination (subsequently referred to as CHWs trained in COVID-19). Second, recipients reported the numbers and type of health conditions or social service needs for which CHWs are provided training to deliver services among populations of focus within communities (subsequently referred to as CHW health condition and social service training). Descriptive statistics were used to examine CCR recipient performance measures. Furthermore, line graphs were used to visualize the types of health condition and social

service training topics in which CHWs were trained across each of the 6 reporting periods.

CHWs Trained in COVID-19

The numbers of CHWs trained in COVID-19 for capacity-building recipients and implementation-ready recipients for each project period are displayed in Table 1. The number of CHWs trained in COVID-19 per reporting period ranged from 97 to 415 for capacity-building recipients; the average across the 30 capacity-building recipients ranged from 3.2 to 13.8 CHWs trained per recipient and reporting period. For implementation-ready recipients, the number of CHWs trained in COVID-19 ranged from 1182 to 3273; the average across the 37 implementation-ready recipients ranged from 31.9 to 88.5 CHWs trained per recipient and reporting period.

Evaluation data on CHWs trained in COVID-19 suggest that implementation-ready recipients were able to more quickly train CHWs to respond to COVID-19. In the first 6 months of the CCR program, implementation-ready recipients, on average, trained more than 10 times as many CHWs than their capacity-building recipient counterparts. This evaluation finding supports the argument that established CHW programs can more swiftly respond to public health crises. Our data further reveal that although the magnitude of the difference in the number of CHWs trained narrowed in subsequent reporting periods, implementation-ready recipients consistently reported substantially more CHWs trained in COVID-19 (the gap between implementation-ready and capacity-building recipients was smallest at the 30-month mark, when implementation-ready recipients reported training on average 3.3 times as many CHWs as reported by capacity-building recipients).

CHW Health Condition and Social Service Training Topics

Figure 1 illustrates trends over the 3-year CCR project period by recipient group (capacity building vs implementation ready) and training topic (social service vs health condition). First, both capacity-building and implementation-ready recipients reported more health condition training topics than social service training topics. Second, trends differed most distinctly by recipient group (solid lines vs dashed lines): whereas capacity-building recipients reported an increase in training topics between the first and second reporting periods followed by relative stability, implementation-ready recipients reported an increase in each reporting period (with the exception of the last reporting period for health condition topics). Also apparent is that the total numbers of training topics were consistently higher for implementation-ready recipients than for capacity-building recipients.

CCR evaluation data on training topics over time reveal substantial differences between implementation-ready and capacity-building recipients. Implementation-ready recipients that had existing CHW programs showed an overall pattern of increasing numbers of health condition and social service training topics throughout the CCR program (except for a dip in health condition trainings for the final reporting period). Conversely, capacity-building recipients that had recently developed CHW programs reported lower numbers of health condition and social service training topics that were consistent across time. When considered in light of the debate about whether existing CHW programs are better able to respond to public health crises, the evaluation data on CHW training topics suggests that existing CHW programs have greater capacity and infrastructure to continually develop and implement training on a variety of topics. Given that training is essential to CHW response, especially in times of public health crises, the development and implementation of

TABLE 1— Numbers of Community Health Workers Trained in COVID-19 for Capacity-Building and Implementation-Ready Recipients Across the Program Period: United States, 2021–2024

Program Period (Months)	Capacity-Building Recipients, No. (Mean per Recipient)	Implementation-Ready Recipients, No. (Mean per Recipient)
6	97 (3.2)	1182 (31.9)
12	237 (7.9)	1688 (45.6)
18	237 (7.9)	1781 (48.1)
24	318 (10.6)	1702 (46.0)
30	415 (13.8)	1679 (45.4)
36	397 (13.2)	3273 (88.5)

Note. CHW = community health worker. The Community Health Workers for COVID Response and Resilient Communities initiative funded recipients for 1 of 2 purposes: (1) organizations that had limited experience with CHWs were funded to focus on building capacity for CHW efforts and (2) organizations that were already working with CHWs were funded to focus on improving and expanding existing CHW efforts.

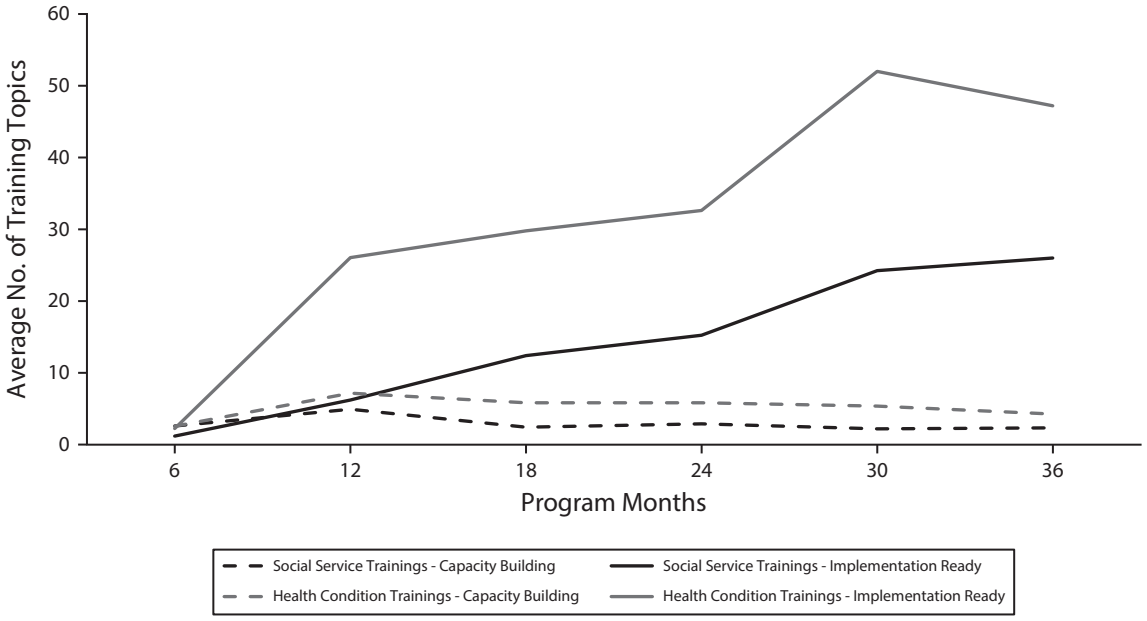


FIGURE 1— Average Numbers of Health Condition and Social Service Training Topics for Capacity-Building and Implementation-Ready Recipients Across the Program Period: United States, 2021–2024

relevant training is critical to maximize CHW effectiveness.

Regarding training volume, implementation-ready recipients provided much more health condition and social service training over the project period than capacity-building recipients. This finding may be attributable to the amount of time needed to launch a CHW program. Capacity-building recipients were likely spending a significant amount of time on core skill training and building of community trust as they developed or identified additional CHW training needs. Implementation-ready recipients, which already had an established CHW workforce, were able to expand the training topics offered to CHWs. This finding aligns with previous research showing that countries with trained CHW workforces were able to quickly mobilize CHWs for COVID response[9] and suggests the importance of a well-trained and sustained CHW workforce that can respond to a community's changing public health needs.

Health Condition Training Topics

The numbers and types of health condition training topics for capacity-building and implementation-ready recipients are presented in Figure 2. As displayed in Figure 2a, after the initial reporting period, the most common health condition training topic for capacity-building recipients was mental health (except for the fifth reporting period, in which primary care training and specialty care trainings were slightly higher). For implementation-ready recipients, the most common health condition training topics were primary and specialty care for the first half of the project period and lifestyle interventions for the second half (Figure 2b). Of note, the identical vertical scale for both capacity-building and implementation-ready recipients shows how implementation-ready recipients' health condition training topics were ramped up by the 12-month mark, with only a single implementation-ready health condition below 100. In contrast, the number of health condition training topics for capacity-building recipients remained below 100 for the duration of the study period.

The fact that mental health was the most common health condition training topic for capacity-building recipients likely points to the prevalence of mental health issues (perhaps exacerbated by COVID-19) in the communities served. The initial emphasis on primary and specialty care and later on lifestyle intervention training for implementation-ready recipients may indicate an early focus on mitigating COVID-19 that gave way to a focus on addressing chronic conditions later in the program.

Numbers and Types of Social Service Training Topics

The numbers and types of social service training topics for capacity-building and implementation-ready recipients

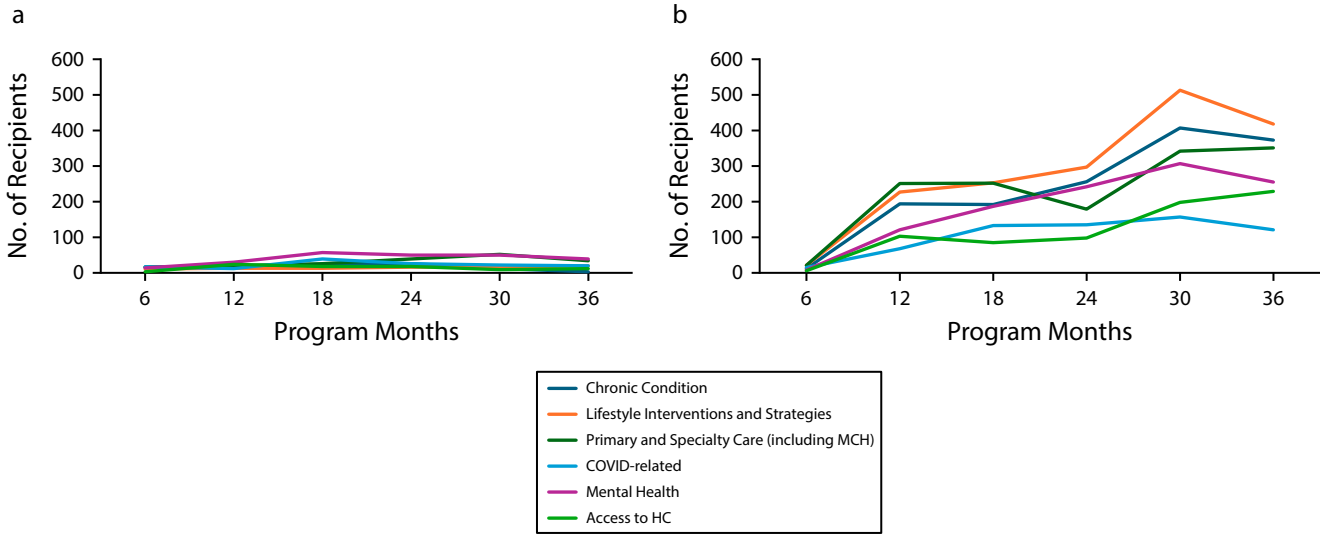


FIGURE 2— Numbers and Types of Health Condition Training Topics Across the Program Period for (a) Capacity-Building Recipients and (b) Implementation-Ready Recipients: United States, 2021–2024

Note. HC = health care; MCH = maternal and child health.

are presented in Figure 3. As displayed in Figure 3a, after the initial reporting period, advancing equity was the most common social service training topic for capacity-building recipients over the remainder of the study period. Figure 3b shows that advancing equity was the most common social service training topic for implementation-ready recipients during all reporting periods other than the second reporting period (when connection of individuals to available social services was slightly higher). Whereas the social service training topics reported by capacity-building recipients remained fairly constant throughout the study period, implementation-ready recipients showed a positive linear trend.

The prevalence of training on advancing equity (i.e., movement toward the attainment of the highest level of health for all people) that cut across both groups of recipients suggests both the urgency of addressing inequitable outcomes in the communities that CHWs serve and CHWs' unique ability to do that work. CHWs advance equity by addressing barriers, building individual and community capacity, and connecting historically marginalized groups to opportunities.

DISCUSSION

Taken together, the CCR national evaluation findings comparing CHW training activities between implementation-ready and capacity-building recipients provide evidence to support the perspective that established CHW programs can quickly train and mobilize CHWs to respond to public health crises. Specifically, implementation-ready recipients were able to more quickly train CHWs to respond to COVID-19 and consistently developed and implemented new training on a variety of health condition and social service topics.

Our findings align with the argument that sustainable financing models for the CHW workforce are necessary if CHWs are to be prepared for public health crises. If CHW programs are sustainably funded and established, trained CHWs can quickly engage in providing services to communities with which they have built trusting relationships. Given the substantial body of existing research documenting CHW effectiveness, discussions around the CHW workforce have shifted from questions about CHW effectiveness to identification of strategies for scaling CHW programs, sustainability, and integration into care teams. Indeed, in a systematic review published in 2023, Knowles et al. concluded that "strong evidence" suggests that CHWs promote health and well-being, enhance patients' perceived care, contain costs, and improve health equity.[10] Evidence of CHW effectiveness and a history of the CHW workforce being consistently called upon to respond to public health emergencies are the foundation for ongoing and recent calls for sustainable funding of the CHW workforce. The CCR national evaluation results highlighted here provide support for this movement.

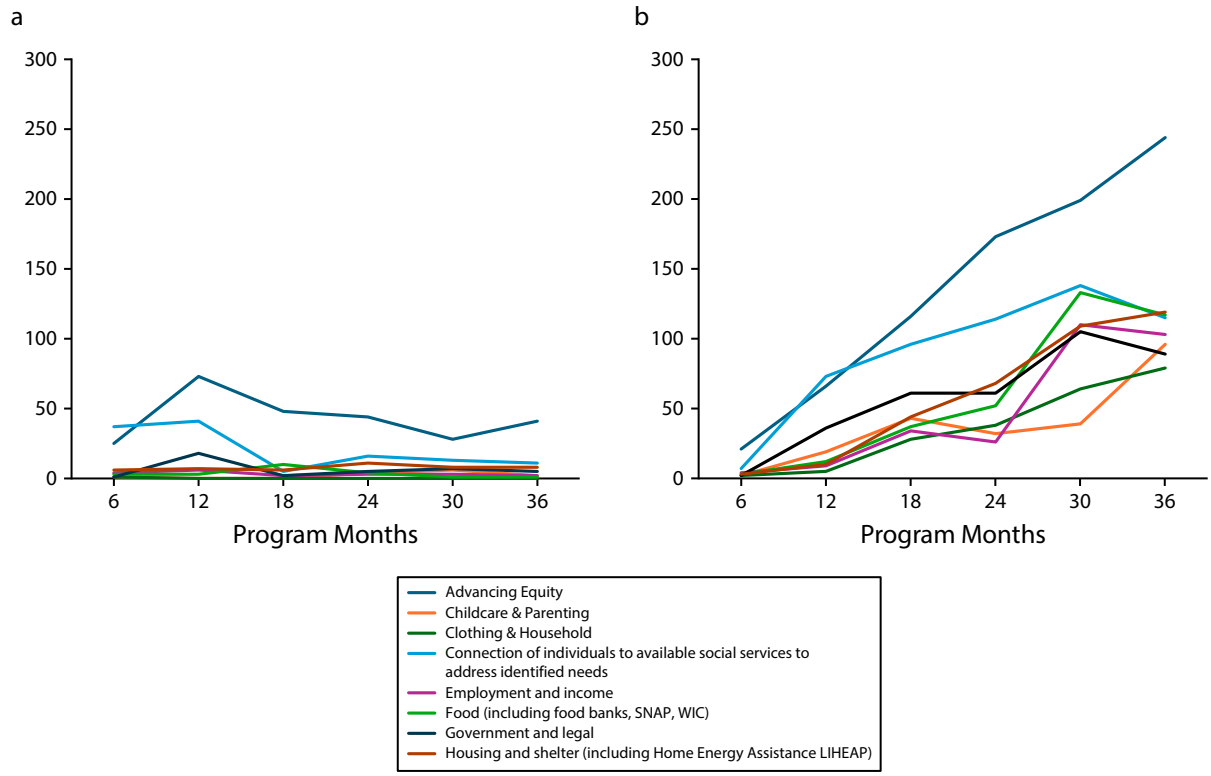


FIGURE 3— Numbers and Types of Social Service Training Topics Across the Program Period for (a) Capacity-Building Recipients, and (b) Implementation-Ready Recipients: United States, 2021–2024

Note. LIHEAP = Low Income Home Energy Assistance Program; SNAP = Supplemental Nutrition Assistance Program; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

Although these evaluation findings provide some evidence of the value of sustained CHW programs, there were a number of limitations. First, there are limitations of the use of implementation-ready versus capacity-building recipient status as a proxy for organizational experience with CHWs. Implementation-ready recipients' programs tended to be larger in scope than those of capacity-building recipients, which could affect the breadth and depth of their training programs. Future research should incorporate additional measures of organizational experience with CHWs.

Second, we were unable to modify the program performance measures established in the notice of funding opportunity. Number of training topics is not an ideal measure of the content, quality, or methodology of the training in which CHWs participated. Therefore, it is recommended that future studies examine the training methodology used in CHW training given the emphasis on the importance of methodology in previous studies.[11–16] Future studies should also seek to explore the associations between CHW programs' readiness to mobilize CHWs and (1) the outcomes associated with populations served by CHWs, (2) the characteristics of communities served (e.g., community need, demographics, local resources, community workforce), and (3) additional organizational characteristics (e.g., organizational leadership, human resources infrastructure). AJPH

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CONFLICTS OF INTEREST

The authors declare no potential conflicts of interest with respect to the research, authorship, or publication of this article. In addition, no copyrighted material, surveys, instruments, or tools were used in the research described.

HUMAN PARTICIPANT PROTECTION

This research received approval by the institutional review board of Arizona State University.

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