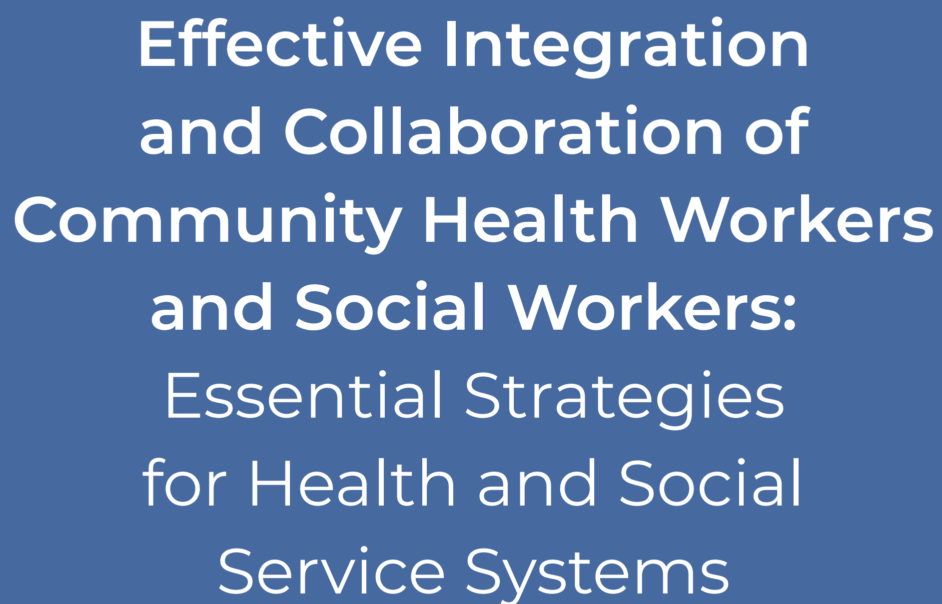

Effective Integration and Collaboration of Community Health Workers and Social Workers: Essential Strategies for Health and Social Service Systems

The Coalition for CHW-SW Collaboration

The Coalition
for CHW-SW Collaboration
is a national workgroup comprised
of over two dozen community
health workers (CHWs),
social workers (SWs),
and public health experts

This project is supported by CCHA
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Executive Summary

Social workers (SWs) and community health workers (CHWs) bring unique yet complementary skills to address complex health and social needs, particularly among marginalized populations. CHWs excel in building trust and addressing social determinants of health (SDOH), while SWs focus on clinical, policy, and systems-level interventions. Despite their shared goals of advancing health equity and improving outcomes, unclear roles, fragmented systems, and limited integration guidance often hinder collaboration.

This report synthesizes findings from a literature review, three years of discussions among members of the Coalition for CHW-SW Collaboration, and a qualitative research study to provide actionable recommendations for enhancing CHW-SW integration and collaboration.

Integration challenges, such as misaligned expectations, unclear workflows, and systemic barriers, can negatively impact care delivery, job satisfaction, and patient/client outcomes. Addressing these issues requires organizational readiness, including leadership buy-in, resource allocation, and fostering power-sharing among team members. Effective collaboration improves care coordination, reduces costs, and advances health equity by addressing both medical and social needs holistically. Effective collaboration relies on mutual respect, shared goals, and interprofessional training.

This report outlines a conceptual framework, presents case examples, and offers practical strategies for organizations to improve CHW-SW integration and collaboration. Recommendations focus on considerations for organizations and teams in building capacity towards effective CHW and SW collaboration and integration: from adopting nationally established role definitions and creating integrated care models to providing reflective supervision and ensuring demographic alignment between teams and the communities served. The value of developing sustainable financial plans, advocating for policy changes, and investing in professional development for both workforces are also highlighted.

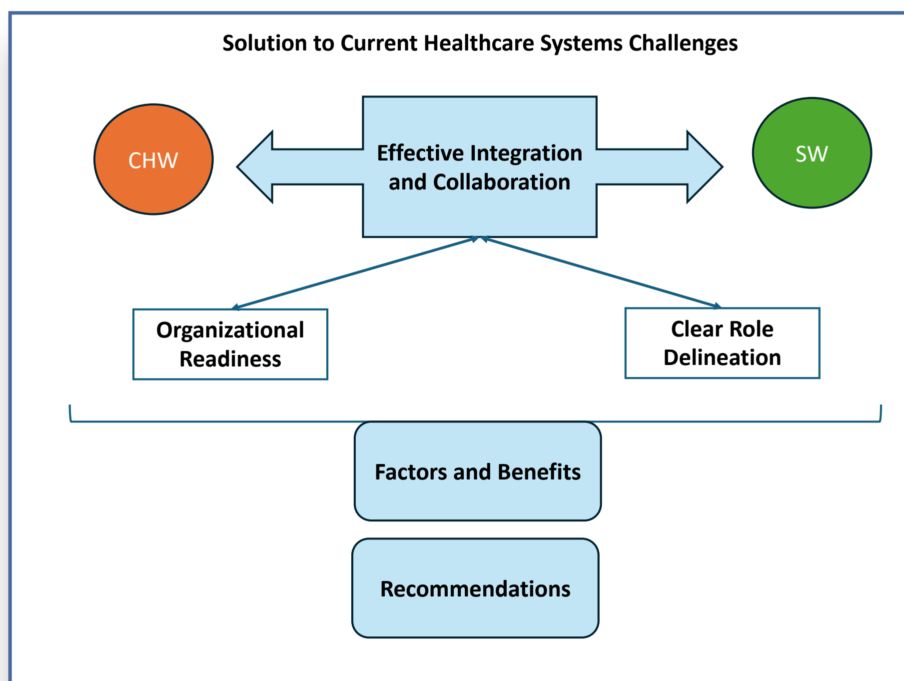
By leveraging the complementary strengths of CHWs and SWs, fostering mutual respect, and addressing systemic barriers, organizations can create effective, person-centered care models that enhance care coordination, reduce health disparities, and contribute to more equitable health and social service systems.

Introduction

Social workers (SWs) and community health workers (CHWs) have different roles and scopes of practice, yet both workforces are often engaged in addressing complex health and social needs in healthcare, public health, social service, and in community settings. By leveraging their complementary skills and expertise, CHWs and SWs can work together more effectively to address the holistic needs of individuals and communities. However, there is limited research and guidance on how to promote their effective collaboration and integration across the continuum of care - ensuring person-centered care over time, with the goal of filling gaps in care from community-based prevention programs to clinical interventions in inpatient, outpatient, and community settings.

In this report, a collection of data from literature review, meetings of a national CHW-SW coalition over a period of three years, and a qualitative research study are presented to summarize why CHW-SW collaboration and integration are important for advancing health equity and other health and social sector priorities. This report also presents guidance on the similarities and differences of CHW and SW roles and scopes of practice, and two case examples of effective integration and collaboration. The report concludes with recommendations that teams and organizations can utilize for their own work in this area (see figure 1).

Figure 1: A Solution to Current Healthcare Challenges



Current Health System Challenges and Opportunities

The ongoing paradox of escalating healthcare costs alongside poor health outcomes has been a national concern for several decades. Furthermore, recent crises including the COVID-19 pandemic and natural disasters have exacerbated health inequities and amplified long-standing challenges related to population health, especially the equitable distribution of quality healthcare, supplies, and other health and social resources. Key policy initiatives like the Affordable Care Act, the Triple Aim, Healthy People objectives and others recognize that Social Determinants of Health (SDOH) are critical areas of focus to address the US health crisis (Koh et al, 2011; Koko, 2022). These national strategic priorities emphasize health equity, and promote a "forward-looking framework" and interdisciplinary collaborations that can enhance the ability of the US health workforce to respond to current and emerging health needs (Zorek et al, 2022).

Two Workforces That Are Part of the Solution

CHWs are frontline, public health professionals that are trusted members of the community due to shared lived experiences, linguistic and/or cultural identities (American Public Health Association [APHA], 2024; Rosenthal et al., 2018). This strong relationship and dedication to the community facilitates trust, especially within marginalized communities. While there is considerable variability across state contexts, many states have implemented voluntary CHW certification and/or core competency training guidelines, which include a specific set of competencies and skills, in addition to a number of hours worked in the community (Berthold & Somsanith, 2024). The CHW core roles and competencies most widely adopted and based on national consensus are from the CHW Core Consensus Project (C3 Project), now the National Council on Community Health Workers Core Consensus Standards (The National C3 Council). C3 recommends 10 roles and 11 skills with a special attention to the qualities that make CHWs a unique workforce. In addition to training in core skills and roles, CHWs often complete additional, specialized training which may focus on prevalent health issues (e.g., diabetes, cancer), populations (e.g., immigrants) or roles (e.g., patient navigation). Finally, CHWs in many states must complete continuing education to recertify, similar to SWs and other licensed healthcare professionals (National Academy for State Health Policy, 2024).

We need a forward-looking framework that promotes interdisciplinary collaboration between CHWs and SWs and interventions that address SDOH and advance equity.

SWs use their knowledge of human development and behavior, social, economic, and cultural institutions, and how these factors interact to help people address their needs. While some SWs are clinically-focused with expertise in mental health assessment, diagnosis, treatment and safety planning (National Association of Social Workers [NASW], 2021), others work at the macro-level and have training in community engagement, evaluation, and policy analysis. SWs often hold at least a bachelor's, if not a master's degree in social work. Social work education is accredited by the Council on Social Work Education and requires the inclusion of core competencies in all coursework, as well as field work and internships. Core competencies include demonstrating ethical behavior, engaging diversity, advancing social justice and human rights, community engagement, clinical assessment, clinical intervention and evaluation (Council on Social Work Education, 2022).

There are multiple levels of social work licensure that are issued at the state level. While there is variation across states in terms of clinical licensure requirements, generally it entails: 1) a social work degree from an accredited program, 2) 2,000 to 4,000 hours of clinical work, 3) supervision with a fully licensed SW, and 4) passing the Association of Social Work Board's licensure exam (Association of Social Work Boards, 2024). There are additional requirements for SWs who provide oversight and supervision to SWs in training, and the maintenance of social work licensure includes accruing 20 to 40 hours of continuing education credits, including ethics credits .

Both CHW and SW professions originated from a need to address critical gaps in our health and social systems. The fields evolved from grassroots and volunteer efforts into valued professions recognized across sectors, including healthcare and public health, safety net agencies, schools and community agencies. Both CHWs and SWs are trained professionals that are well positioned to address social needs through standardized assessment, community resource referral and care coordination (Rine, 2016; Taylor et al., 2016). While the practices of both workforces can vary by focus depending on their employers, their services can range from micro-level direct practice to macro-level work. Literature documents their effectiveness in improving health outcomes for patients with chronic diseases, increasing rates of health screenings, reducing emergency rooms visits and readmission, and bridging gaps in behavioral health services, among other benefits.

The potential for effective SW and CHW collaboration is compelling based on their shared values such as social justice and self-determination, as well as shared

training in needs assessment, referral provision and system navigation (Rosenthal et al., 2018; Rowe et al., 2017). CHWs and SWs have been described as the "glue" to multidisciplinary teams, due to their roles in building trust with individuals and communities and bridging gaps between teams and systems (Brownstein & Hirsch, 2017; Craig & Muskat, 2013; Kitchen & Brook, 2005).

Challenges Related to Effective Integration and Collaboration Between CHWs and SWs

Both CHWs and SWs make critical contributions to the healthcare, public health, social service, and community sectors. However, their unique roles and scopes of practice are often misunderstood across professions, amongst other team members like physicians and nurses, or by organizational leadership and administrators. This is further complicated by the fractured nature of health and social service financing across the U.S.

Inadequate integration and attention to the roles and scopes of CHWs and SWs can negatively affect the quality of care and services offered, job satisfaction and patient or participant experience. Instead of employing SWs and CHWs at the top of their respective scopes of practice, organizations may unintentionally duplicate activities, add burdensome steps to workflows that delay care or service, or fail to implement needed interventions due to suboptimal care coordination. These challenges can result in individuals not getting services they need or "falling through cracks." This can also increase the risk for ER utilization, which raises health care costs.

Organizational Readiness is Essential

Organizational readiness is a key precondition for the effective integration of CHWs and SWs into healthcare and public health systems and settings (Lee et al., 2021). Organizations that have the capacity to engage in moving towards optimal CHW-SW collaboration and integration demonstrate a commitment to equity, leadership buy-in, resource investment, and power sharing at both the organizational and team levels. Staff should recognize the importance of addressing the social determinants of health, and understand the need to offer services that support clients holistically. Leadership should demonstrate explicit support to both CHWs and SWs, ensuring their roles are valued and integrated into the organization's mission and strategy.

Findings from a recent qualitative research study conducted by the Coalition for CHW-SW Collaboration showed that supportive leaders created a culture of inclusivity by valuing CHW and SW expertise, empowering them to work autonomously (self-determination), engaging them in care management, and championing their knowledge to inform programs and policies. Supportive leaders also invested resources in staff development, specifically training and continuing education, and provided funding for pilot projects. Finally, power sharing was evident in how teams collaborated and in their supervisory structure. While SWs often supervised CHWs, many acknowledged their privilege and power, and intentionally advocated on behalf of and alongside CHWs. Teams rooted in mutual respect and understanding, and willing to learn from each other's unique experiences and expertise, often exhibited greater satisfaction and contentment with their work environments.

Restricting CHWs and SWs from practicing at the top of their scope of practice and exercising their full set of competencies, compromises system effectiveness and advancements towards health equity.

Similarities and Distinctions between CHW & SW Roles

It is important for teams and organizations to determine where CHW and SW roles differ and where they overlap. To assist with understanding role similarities and distinctions, the Coalition for CHW-SW Collaboration, which has been facilitated by CHWs and SWs and has been engaging in this work for three years, conducted an environmental scan and analyzed training competencies and scopes of practice as defined by The National Council on Community Health Workers Core Consensus Standards and The National Association of Social Workers. The research team held focus groups with participants from four health-focused organizations across the United States that employed both CHWs and SWs. Findings from the focus groups were closely analyzed by the research team, and reviewed by Coalition members. Based on findings, the Coalition created a Venn diagram of CHW and SW role characteristics (see Figure 2).

As portrayed in the diagram, CHWs have a strong and intentional focus on engagement and trust-building with community members, due to their unique positioning as members of the communities in which they work and engage. CHWs reported engaging in cultural mediation, implementing care plans, informal or non-clinical counseling and coaching, and health education and outreach. There was an emphasis on the importance of lived experience for CHWs, which was a facilitating factor in building relationships with their participants or clients.

While SWs reported that rapport building was a vital part of their job, SWs were found to engage in more intensive clinical work; their engagement focused on informing clinical aspects of the process such as biopsychosocial assessments, diagnoses, treatment planning, and clinical counseling/therapy. Many SWs also reported being brought in on cases involving interpersonal violence to engage in safety planning and make referrals, if needed. Additionally, macro practice was highlighted by SWs, in the form of organization administration, research, and advocacy. It is important to note that the roles presented in this diagram will vary between settings and organizations.

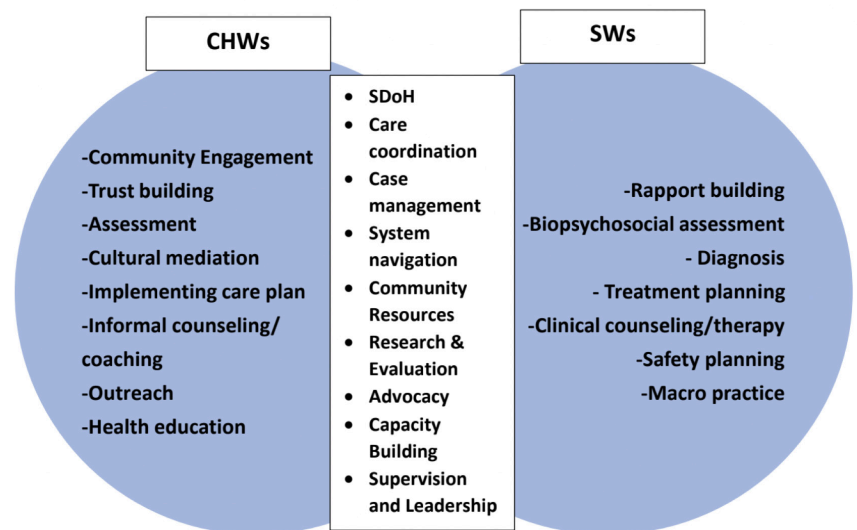


Figure 2: Shared and distinct Community Health Worker (CHW) and Social Worker (SW) roles.

Factors of Effective CHW and SW Collaboration and Integration

While organizational readiness and clarity on CHW and SW scopes of practice and roles are crucial to effective CHW and SW collaboration and integration, there are additional factors to consider. The Coalition for CHW-SW Collaboration created a conceptual framework to outline the structural, systemic, and organizational factors that influence CHWs and SWs as well as identify key practices that facilitate collaboration and integration. To learn more about the conceptual framework, please refer to this research article for more details (Petruzzi et al, 2024).

Collaboration is the process by which different health and social care professional groups work together through clear team goals, role clarification, shared team identity and team commitment, interdependence, and team integration (Reeves et al., 2010; Reeves et al., 2017). Ample evidence suggests that interprofessional collaboration supports effective workflows and patient safety in healthcare settings by reducing communication failure, diagnostic errors, and other examples of preventable patient harm (Ma et al., 2018; Rosen et al., 2018). Additionally, interprofessional collaboration has been shown to improve health outcomes related to chronic health conditions such as diabetes or depression (Castelijns et al., 2018; Levengood et al., 2019).

For the purposes of this report, collaboration will primarily focus on CHWs and SWs, but it is important to recognize that interprofessional collaborations may include other healthcare or social service team members such as nurses and Peer Support Specialists. Table 1 highlights factors and benefits of effective collaboration that were identified by focus groups conducted with health and community-based organizations.

Table 1: Factors and Benefits of Effective CHW-SW Collaboration

	Factors of Effective Collaboration					
	Interdisciplinary Training	Role Definition	Flexibility & Autonomy	Regular Communication	Support & Supervision	CE & Career Advancement
Benefits of Effective Collaboration	• Provides clarity about roles and scopes of practice, services provided, and expectations regarding communication • Establishes foundation of respect, trust and understanding	• Sets feasible expectations for patients, community members, care team members and outside organizations	• Encourages CHWs and SWs to be adaptable and modify care plans as needed • Empowers CHWs and SWs to work autonomously • Enhances employee satisfaction	• Ensures that both CHWs and SWs feel comfortable, valued, and heard	• Provides support and guidance from experienced professionals trained in their respective fields • Leverages field-specific values, competencies, and expectations regarding licensure and certification • Mitigates tension and unproductive power dynamics	• Promotes opportunities for shared learning based on areas of expertise • Positions CHWs/SWs for leadership, research, or policy roles within organizations

Healthcare integration is the organizational framework under which healthcare is delivered (Strandberg-Larsen & Krasnik, 2009). Integration within healthcare has largely focused on the integration of behavioral health services in primary care settings, and is usually evaluated based on three primary domains: shared location, shared documentation (including scheduling), and standardized communication (Blount, 2003; Heath et al., 2013). Since this definition is quite clinical in nature and primarily describes healthcare systems, we will utilize a broader definition of integration, namely the incorporation of CHWs and SW as equals within the organization and system that they operate.

Table 2: Factors and Benefits of Effective CHW-SW Integration

	Factors of Effective Integration					
	Patient-Centered Care	Mutual Respect and Understanding	Defined Scopes of Practice	Clear Flow of Services	Shared System of Documentation	Shared Physical Space
Benefits of Effective Integration	• "Centers" the patient in decision-making and when delivering interdisciplinary care	• Recognizes CHW/SW lived experiences and skills • Encourages continuous learning and growing through shared insights	• Ensures that CHWs/SWs practice in line with the ethical standards of their respective fields • Promotes a deeper understanding of both fields, beyond the current setting or intervention	• Maintains strong rapport with stakeholders across healthcare systems, reducing the duplication of services through coordinated care • Promotes high patient satisfaction and community trust	• Ensures that CHWs/SWs stay current on shared care plans • Encourages case consultation and task delineation	• Fosters close coordination and regular communication

Case Examples

The following are two case examples of organizations that participated in the qualitative research study that highlight ways that CHWs and SWs collaborate and are integrated within their team or organizational setting:

Family Solutions

Family Solutions, a program of the South Carolina Office of Rural Health, aims to reduce disparities in maternal and infant deaths, and improve health outcomes from pregnancy through eighteen months postpartum. The program employs a multi-disciplinary team of SWs, nurses, and CHWs who collaborate to provide perinatal support through health education, case management, medical support, and systems navigation. Additionally, the program encourages male involvement by educating and empowering male parents to take active roles in the lives of their partners and infants. The following insights were collected from two virtual focus groups conducted with seven CHWs and four SWs.

In terms of effective collaboration, role definition was identified as a key component. CHWs were described as “foot soldiers” who provide participants with prenatal/postpartum education and emotional/social support, while assessing their needs and connecting them with resources. CHWs build trust and foster rapport with participants by “meeting them where they’re at”, whether by conducting home visits or engaging with them at medical offices. Some CHWs specialize in diabetes or breastfeeding and help patients manage their health symptoms. CHWs also assist participants in navigating entitlement programs such as Medicaid and WIC, pursuing education, and securing employment. Alternatively, SWs focus on providing clinical care to socially or medically complex participants, such as those experiencing mental health issues, substance use, or domestic violence. Their role centers on delivering mental health counseling, coordinating safety and care plans, and managing medical comorbidities. Both CHWs and SWs complete assessments, make referrals, and invite participants to independent life skills and health education classes. Despite these overlaps, neither group reported significant challenges that hindered their ability to serve patients effectively. Clear role delineation — where SWs primarily support high-risk cases and CHWs focus on health education and care plan implementation—helps facilitate efficient task allocation. Active participation by

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both CHWs and SWs in case staffings and multi-disciplinary meetings promotes regular communication and strong care coordination. Furthermore, SWs and CHWs reported that a strong team environment and humility facilitated strong collaboration.

The effective integration of services at Family Solutions (FS) centers on patient-centered care with both CHWs and SWs addressing the social determinants of health and prioritizing participants' outcomes. The team employs a flexible approach to participant management, where CHWs refer high-risk cases to SWs, and SWs can refer participants back to CHWs when appropriate. CHWs and SWs often conduct joint home visits, providing complementary services that enhance the quality of care. Shared physical space facilitates open communication and care coordination. Mutual respect is evident in CHW and SW dynamics; FS has developed a culture of collaboration, where both CHWs and SWs value each other's partnership and the assets they bring to patient care. SWs have a strong understanding of CHW competencies and how they can add value and vice versa. SWs are also mindful of power dynamics, advocating on behalf of CHWs and striving to amplify their roles (power sharing). Finally, CHW integration in community and provider action networks has increased their visibility, strengthened stakeholder rapport, and improved coordination of service delivery.

Camden Coalition

Camden Coalition is a multidisciplinary, community-based nonprofit organization in Camden, New Jersey, that addresses the complex health and social needs of vulnerable individuals. In collaboration with key partners including community members, healthcare providers, and government agencies, Camden Coalition implements person-centered programs and pilots innovative models that address chronic illness and the social determinants of health. Camden Coalition's key initiative is a patient-centered care management program, which empowers individuals to take control of their health. Utilizing a robust and collaborative health data information exchange, patients are identified across the Camden Health System through a triage process conducted by a SW, a CHW or behavioral health navigator. Patients with complex medical needs are flagged for outreach by SWs and CHWs. Patients are typically engaged for 30-60 days and work with nurses, CHWs and/or SWs, based upon their level of acuity. By design, CHWs hold the primary relationship with the client, building authentic healing relationships and offering resources and services, while SWs address more complex or behavioral health issues, including depression, suicidal ideation, and intimate partner violence.

Patients are referred to internal programs and/or external community resources.

Inclusivity is a core value of the organization and is facilitated by leadership buy-in and a commitment to equity. In focus groups with CHWs, the CHWs voiced how they felt supported both personally and professionally, which they said is particularly important given the emotional and physical toll they can experience from working in challenging environments and with complex needs of the individuals they serve. Professionally, CHWs felt that the organization invested in them through training and continuing education. SWs often supervised CHWs and were keenly aware of their privilege. The SWs reported practicing "reflective supervision" and actively sharing power by advocating for CHWs' professional growth, their inclusion on city or county task forces, and by validating their unique skills and expertise. CHWs reported that they felt valued by the organization as their input was often incorporated into existing and future program planning, reinforcing the knowledge and value they bring to the community and clients.

In terms of effective collaboration, one key component was standardized training. Both CHWs and SWs were trained in an internally-developed patient engagement framework they call COACH (C: create a care plan, O: observe the normal routine, A: assume a coaching style, C: connect tasks with vision and priorities, H: highlight effort with data) that provides patient-centered care. In terms of effective integration, shared physical space was identified as a facilitator. CHWs and SWs share office space and their calendars. CHWs and SWs often conducted home visits together; however, this integration was dependent upon where the SW was located - either in the office or the community.

Finally, Camden Coalition has led county-wide efforts to coordinate care across health and social service organizations through a health information exchange (HIE) system, which allows health care professionals to appropriately access and securely share a patient's medical information electronically (Assistant Secretary for Technology Policy, 2023). Camden Coalition actively identifies participants who have been hospitalized, follows up with participants after hospital discharge, and collaborates with community partners to improve their transition back into the community. It also encourages interorganizational collaboration and routine communication about client needs and updates to prevent unnecessary hospital readmissions and improve health outcomes.

Recommendations

Based on analysis of the literature review, rich dialogues amongst members of the national Coalition for CHW-SW Collaboration and data from the qualitative research, we present the following recommendations and considerations for organizations and teams that are building capacity towards effective CHW and SW collaboration and integration.

Considerations for Planning

- Adopt nationally established CHW and SW workforce definitions and scopes of practice.
- Include both CHWs and SWs in the design of programs, care models and team roles, including processes for referrals, follow-up protocols, shared case reviews and other elements of care coordination. Discuss when and how communication about participants/clients will occur.
- Choose supervisors for both CHWs and SWs that have experience in the respective roles and the communities being served and are familiar with reflective supervision. Recognize the capacity of leaders within each workforce to supervise their peers. New supervisors of CHWs should take a CHW Supervisors training course.
- Ensure that teams include members whose demographic characteristics and lived experiences reflect the communities they serve. This is an essential component for CHWs, and is particularly important for marginalized racial and ethnic populations.

Considerations for Cross-Training and Information Sharing

- Utilize the National C3 Council (the C3 Project) and NASW practice standards and guidelines to increase understanding of CHW roles and core competencies among all organizational team members (not just the SWs and CHWs).
- Facilitate shared learning discussions among team members and in supervision meetings about historical contexts of both professions and of the communities being served, and the intersectional dynamics of race, ethnicity, class, and power.
- Ensure shared access to documentation, including individual-level records when possible, to facilitate communication and reduce duplication of work. Provide shared spaces for teams to meet and collaborate for improved integration into organizations and systems.

Considerations for Organizational and/or Team Leadership

- Communicate the commitment of team and organizational leadership towards both workforces and to optimal CHW-SW collaboration and integration.
- Create template job descriptions and standardized career ladders with appropriate pay scales for CHWs and SWs.
- Be aware of potential conflict that can arise between CHWs and SWs driven by provider system efforts to cut costs and maximize revenues.
- Support CHW and SW professional development and membership in professional associations.
- Develop a long-term financial plan towards sustainability of both CHW and SW services.
- Support and contribute to local, state and national advocacy efforts to improve CHW/SW integration and collaboration as a promising strategy to advance health equity.

Next Steps and Future Opportunities

Next steps for the national Coalition for CHW-SW Collaboration include the development of organizational and team training focused on promoting effective collaboration among CHWs, SWs, and other professionals on their teams or in their organizations. These trainings will aim to enhance communication, teamwork, and mutual understanding. Coalition members will continue to contribute to the scholarly discourse by submitting articles for peer review and developing presentations for various audiences on our dialogues, research findings and best practices. These articles will share valuable insights and lessons learned to contribute to the evidence base supporting effective collaboration between CHWs and SWs. Additionally we will develop a call to action, or a concise policy brief, summarizing key research findings and recommendations for local, state and federal policymakers.

There are several opportunities for CHWs, SWs, allied professionals, public health practitioners, and researchers to engage in this work including sharing best practices and successful models with the national Coalition for CHW-SW Collaboration and with others in the field. Further research could focus more in-depth on the roles, capacities, and potential impacts of CHWs and SWs, as well as on distinctions between roles and how they are implemented, particularly in care coordination, SDOH assessments, community engagement, and program leadership. More research is also needed on best practices for integration and collaboration, and the roles that health information systems and supervision models may plan in facilitating effective collaboration. Relatedly, additional research and dialogue is needed on existing Interprofessional Education (IPE) initiatives and model programs involving CHWs and SWs.

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