

Planning and Conducting Research with Community Health Workers in Community Health Center

Settings: Resources and
Lessons Learned from The
Network for Community-Engaged
Primary Care Research

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Glossary of Terms

This glossary provides definitions of toolkit terms and acronyms to support a common understanding among Community Health Center, Community Health Worker, and research partners.

ACE	Assessing Community Engagement
CEAL	Community Engagement Alliance
CHC	Community Health Center
CHW	Community Health Worker
CHW-SYSTIM	Community Health Workers Systematically Assessing and Addressing Social Determinants of Health to Improve Outcomes in Community-based Health Centers
CCTS	Center for Clinical and Translational Science
CIRT	Community Involvement in Research Training
FTE	Full-Time Equivalent
IRB	Institutional Review Board
NCPCR	Network for Community-Engaged Primary Care Research
NIH	National Institutes of Health
OCHIN	Not an acronym. OCHIN is a health technology nonprofit organization that provides healthcare technology and support services to community-based healthcare organizations, advancing community health and well-being.
PBRN	Practice-Based Research Network
RCT	Randomized Controlled Trial
REDCap	Research Electronic Data Capture
SOP	Standard Operating Procedures

A Toolkit for Community-Engaged Primary Care Research

Welcome to this toolkit for community-engaged primary care research! This toolkit shares practical, adaptable resources developed and used in a study with Community Health Workers (CHWs) and Community Health Centers (CHCs) for other community-engaged research teams doing similar work. It reflects a comprehensive, collaborative, practice-informed approach to planning and conducting research in community-based primary care settings, including CHC onboarding, CHW training, implementation support, data collection, and dissemination activities.

Contents were developed with the [Network for Community-Engaged Primary Care Research](#), or NCPCR, community, clinical, and scientific partners and advisors for use in the Community Health Workers Systematically Assessing and Addressing Social Determinants of Health to Improve Outcomes in Community-based Health Centers (CHW-SYSTIM) study.

This toolkit should be used as a library or menu of resources rather than a playbook. Links to templates, guides, and supporting documents are included throughout to allow users to explore materials in greater depth and adapt them for their own study design, partner organizations, or population needs.

Follow-up questions or requests for additional information, contact Anna Steeves-Reece (steevesreecea@ochin.org).

Toolkit development

The [Network for Community-Engaged Primary Care Research](#) (NCPCR) is a research initiative within the National Institutes of Health (NIH) Community Engagement Alliance (CEAL). NCPCR is a partnership between academic institutions, research organizations, and CHCs to design and test interventions to address differences in health outcomes and improve representative participation in research. It builds on established infrastructure, relationships, and expertise across three established primary care networks: [Health Choice Network](#) (HCN), the [Southeast Regional Clinicians Network](#) (SERCN) within Morehouse School of Medicine, and [OCHIN](#) (not an acronym).

NCPCR provides CHCs with centralized systems and support for research participation to enable large-scale, community-engaged trials like CHW-SYSTIM. This includes engagement with CHWs, CHCs, and network advisors to ensure that research is grounded in community experience and practical application. Resources in this toolkit are a direct product of this engagement. Tools here comprise the common templates and processes developed with engagement partners for use and adaptation across CHCs taking part in CHW-SYSTIM.

Community-Engaged Research Approach

NCPCR Partners

Practice-Based Research Networks

Each Practice-Based Research Networks (PBRNs) partner brought unique expertise, relationships, and infrastructure that was developed and supplemented through development of common NCPCR processes, systems, and tools for CHW-SYSTIM. Individual CHCs took part through their individual PBRN and were continuously supported by their PBRN staff (Support Coaches) through the Implementation Support Team.

Southeast Regional Clinicians Network – SERCN:

- Within Morehouse School of Medicine National Center for Primary Care
- Robust, equity-based community-engaged research infrastructure to improve health equity
- Over 4 million patients in 117 CHCs across 8 states

Health Choice Network – HCN:

- One of the first funded Health Center Controlled Networks
- Longstanding engagement for technical assistance, quality improvement, and practice-based research
- Over 3 million patients across 150+ CHCs in 20 states

OCHIN:

- National non-profit company providing health information technology and services
- Comprehensive research database and infrastructure for dispersed, practice-based research
- Over 5.8 million patients across 262 CHCs in 39 states

Advisory Board

The NCPCR Advisory Board provided ongoing expert oversight and guidance for NCPCR and the CHW-SYSTIM study. Advisors included:

- 5 Community Patients & Caregivers
- 4 Health System or Network Leaders
- 4 Clinician Researchers
- 3 Scientific Researchers

Advisors contributed expertise from their community, organizational, and professional perspectives including lived experience, communication, community engagement, implementation science, CHC engagement, practice-based research, EHR data use, and health information technology.

The CHW-SYSTIM study team consulted and collaborated with Advisory Board partners through routine meetings and offline review of materials to:

- Design the social care intervention
- Develop the training approach, CHC engagement, and materials, and monitor training period challenges, questions, or adaptations
- Design implementation support structures and strategies, and monitor implementation period challenges, questions, or adaptations
- Collaboratively monitor challenges to refine implementation support and mitigation strategies for CHC patient outreach and enrollment
- Synthesize and interpret lessons learned and CHC recommendations for future social care and CHC-partnered research endeavors

CHC Partners

CHW-SYSTIM included 25 CHCs that were recruited and enrolled in the study through their respective PBRNs. CHCs were randomized to the intervention (CHW-led social needs care, N=12) or control (usual care, N=13) at baseline. Intervention sites partnered with the Implementation Support Team, including the NCPCR Engagement Core, throughout the intervention to adapt implementation and associated support strategies. CHC partners synthesized lessons learned with recommendations for future social care and CHC-partnered research at the end of the study.

Each intervention site designated a CHC team (see Role Descriptions section for templates) to conduct and support study activities:

- **CHW:** At least one staff member in a CHW or equivalent role (e.g., care coordination, navigation, health promotion)
 - Complete research compliance certification and CHW-SYSTIM training
 - Conduct patient outreach, consent, social needs screening, referral, follow-up, and documentation
 - Take part in CHW Learning Collaborative
- **Study Champion:** A senior or supervisory CHW or organizational leader
 - Serve as primary point of contact with study team
 - Support the CHW's role and study activities, liaise with the CHC and study team
 - Optional participation in CHW Learning Collaborative

Theories & Frameworks for Community Engagement

NCPCR applied the Assessing Community Engagement (ACE) to plan and evaluate our approach to working with CHC and advisory partners. The ACE model is designed to help understand how community engagement contributes to improving health outcomes and advancing health equity. It emphasizes community engagement as an ongoing, collaborative process grounded in trust, shared decision-making, and co-learning to strengthen partnerships and support the development of more effective and equitable health systems.

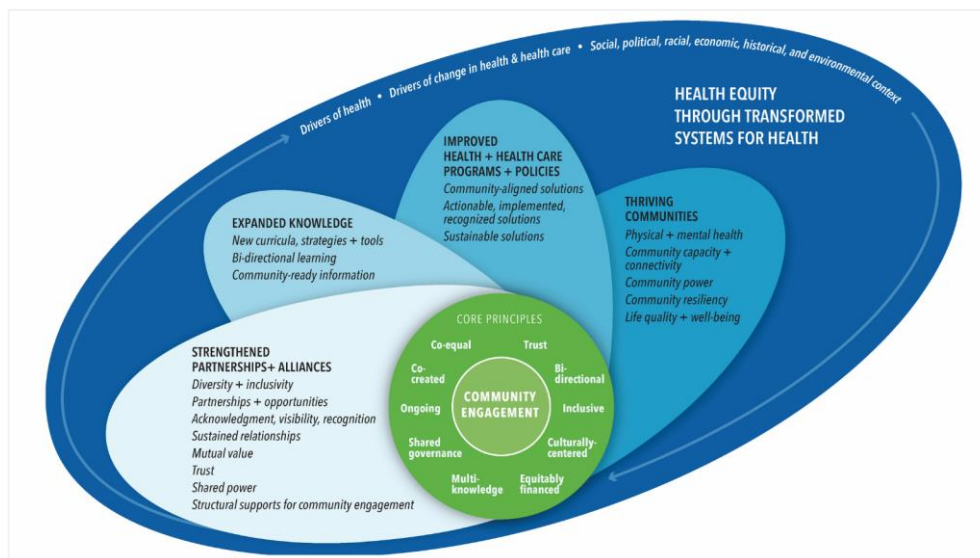


Figure 1. Health Equity Through Transformed Systems for Health Conceptual Model

This conceptual model illustrates how meaningful community engagement contributes to health equity by strengthening partnerships, informing system transformation, and improving health outcomes.

In CHW-SYSTIM, we used the core principles to guide and focus engagement with CHWs, CHCs, and network advisors throughout the study (Table 1). Routine, \structured engagement (Table 2) supported continuous feedback, shared leand refinement of implementation approaches to better meet local contexts and needs of each CHC and the communities they served.

Domains for health system transformation were incorporated to organize ongoing collaboration around lessons learned, compilation of recommendations for future related work, summative evaluation, and dissemination and communication planning. The ACE framework helped strengthened partnerships, build capacity within health centers, and connect generation of practice-based evidence for CHW-led social needs care efforts in CHCs with the broader context of upstream social determinants of health.

Table 1. NCPCR Partner Engagement Throughout CHW-SYSTIM

This table summarizes how Practice-Based Research Network partners, Advisory Board members, and Community Health Center participants contributed to key phases of the CHW-SYSTIM study.

	Study design	Intervention design	Outcomes & comparators	Outreach & recruitment	Implementation support	Lessons learned	Evaluation	Dissemination & communication
PBRN Partners	✓	✓	✓	✓	✓	✓	✓	✓
NCPCR Advisory Board		✓	✓	✓	✓	✓	✓	✓
CHW and CHC Participant Partners		✓	✓	✓	✓	✓	✓	✓

Table 2. Routine Engagement Touchpoints

This table outlines the frequency, duration, and purpose of routine meetings and engagement activities involving study partners, Advisory Board members, and participating health centers.

PBRN Partners	Meeting Length and Cadence
CHW-SYSTIM study team	• 60 minutes every other week
Implementation Support Team	• 60 minutes every week
Internal PBRN teams	• 30-60 minutes every week
Engagement Core	• 60 minutes every other week
Administrative Core	• 60 minutes every week
NCPCR Advisory Board	
Onboarding	• 1:1 orientation meeting and as needed administrative support
Meetings	• 90 minutes every other month
CHW-SYSTIM Close	• 90-minute NCPCR partner convening (preliminary results, lessons learned, future use, dissemination)
Evaluation	• Alternate facilitation and experience surveys every 6 months • Summative evaluation survey at end of study
CHC Partners	
Recruitment	• 30–60-minute opportunity review meeting with PBRN partner

Onboarding	• 20–30-minute baseline survey (current workflows, staffing, tool use, prior research experience)
<i>Intervention Sites</i>	•
Training Period	• 60-minute CHW training sessions every week • 60-minute PBRN Support Coach session every month
Intervention Period	• 60-minute PBRN Support Coach session every month • 90-minute CHW Learning Collaborative session every month • 10-minute check-in survey every month – <i>optional</i> • 60-minute CHW-SYSTIM Office Hours every month – <i>optional</i>
Study Close	• Two 180-minute CHC partner convenings (compile lessons learned, develop recommendations for similar future work) • 90-minute NCPCR partner convening (preliminary results, lessons learned, future use, dissemination)
Evaluation	• Facilitation and experience survey every [month?] • Summative evaluation survey (1 response per CHC)
<i>Control Sites</i>	•
Study Close	• One 180-minute CHC partner convening (contextualize lessons learned, develop recommendations for similar future work)

	• 90-minute NCPCR partner convening (preliminary results, lessons learned, future use, dissemination)
	• Summative evaluation survey (1 response per CHC)

Health Center Recruitment

Health centers were recruited for CHW-SYSTIM using a structured, criteria-driven, and phased approach designed to ensure alignment with CEAL priorities and study feasibility. Eligible health centers were first identified based on geographic location, patient demographic composition reflecting CEAL priority populations, and the availability of a Community Health Worker (CHW) or equivalent staff member to support study activities.

Recruitment followed a tiered prioritization strategy. Initial outreach focused on health centers located within CEAL catchment areas, followed by those within CEAL states, and then expanded to additional centers meeting demographic criteria if recruitment targets or representation goals were not met. This phased approach allowed the study team to rapidly assess progress and adjust recruitment efforts to maintain geographic and population diversity.

Engagement activities included partnerships with Primary Care Associations to facilitate introductions, informational webinars, and distribution of study materials. Interested health centers participated in information sessions, submitted a soft commitment, and completed data assessments to confirm eligibility and capacity. Final selection was based on a comprehensive review of submitted data to determine readiness and alignment with study requirements.

This approach ensured a balanced, representative sample of health centers while maintaining flexibility to meet recruitment milestones and study goals.

Health Center Onboarding

Health Center Onboarding activities oriented participating CHCs to the CHW-SYSTIM project and facilitated their formal onboarding into the study. These efforts helped ensure all sites had a clear understanding of the project's goals, expectations, and their respective roles, while fostering alignment, readiness, and engagement across both intervention and control sites to support successful participation in the study.

Health Center Baseline Assessment

The Health Center Baseline Assessment was developed to better understand control and intervention sites' existing social needs screening workflow and referral-making activities, experiences working with CHWs, and prior experiences in research before implementation of the CHW-SYSTIM trial. The assessment was completed by CHC administrators and staff members with the most knowledge about these activities and required approximately 20 minutes to complete. Aggregate findings for control and intervention sites were summarized and shared with participating CHCs during trial onboarding meetings.

⇒ For more, visit: [Baseline Assessment](#)

CHW “Get to Know You” Questions

To facilitate relationship-building and ensure a smooth introduction to the project, the intervention development team sent out an introductory email, which included a “Get-to-Know-You” questionnaire designed to gather insights on CHWs' backgrounds, experiences, and support needs. Aggregate, de-identified results were shared with CHWs during the first training session.

⇒ For more, visit: [Get to Know You Questions](#)

Virtual Onboarding Sessions

The virtual onboarding sessions oriented both intervention and control sites to the CHW-SYSTIM project by providing a high-level overview of its goals, research questions, and study design. These sessions aimed to ensure a shared understanding of the project's purpose, including the importance of addressing social needs in CHCs, while clearly outlining the distinct roles, expectations, and contributions of intervention and control sites within the study.

Intervention Sites

The intervention site onboarding session focused on orienting and preparing sites to implement the CHW-SYSTIM intervention, emphasizing the importance of active participation, capacity-building, and how the project will generate evidence on effective CHW-led social needs strategies in CHCs.

This session highlighted intervention-specific expectations, such as engaging CHWs and champions in training, conducting patient screening and referrals, documenting activities, and participating in ongoing coaching and learning collaboratives. It also outlined key roles, timelines, and resources required to support implementation and ensure consistency across sites.

Control Sites

The control site onboarding session focused on orienting control sites to their passive but essential role in validating study outcomes rather than implementing new care practices. The content emphasized the study design, including the role of control sites in contributing outcome data that will be directly compared to intervention sites to determine the impact of the intervention. This session highlighted control-specific expectations, such as completing baseline assessments, designating a project champion, providing usual care during the study period, and participating in final dissemination activities.

Role Descriptions

Role descriptions and coaching frameworks, provided clear guidance on team functions and implementation supports, reinforcing alignment and capacity across sites.

Community Health Workers (CHWs)

Staff member implementing the CHW-SYSTIM intervention. Responsibilities include participating in all project training, intervention, and follow-up activities.

⇒ Full role description for CHWs: [CHW_Role_Description](#)

Champions

Supports and oversees project activities at their CHC, including maintaining capacity and motivation on the project. Their main role is to help ensure that the CHW can work effectively towards project goals and objectives.

⇒ Full role description for Champions: [Champion_Role_Description](#)

Support Coaches

To further support CHWs in their roles, each CHW was paired with a designated Support Coach. These coaches provided ongoing guidance, troubleshooting assistance, and reinforcement of key training concepts, to ensure that CHWs felt confident in implementing the intervention, patient enrollment, and social risk screening.

⇒ Full role description: [Support_Coach_Role_Description](#)

Pre-Intervention Training Period

Training Overview

The 3-month training program included synchronous virtual training sessions, weekly meetings with Support Coaches, and asynchronous workbook activities. Through these activities, CHWs strengthened their skills in social needs activities, and developed new skills regarding the ethical conduct of research and documentation processes for the CHW-SYSTIM research study.

All CHCs in the CHW-SYSTIM research study identified a champion and at least one CHW to oversee and implement all project activities, respectively. During the training period, the CHWs completed multiple activities to orientate themselves to the project and be able to successfully carry out the intervention. Through synchronous and asynchronous training activities, intervention CHCs demonstrated their learning and commitment in the areas of patient-centered social needs screening and referral, and the ethical conduct of research.

Timeline

Pre-Intervention Period: 4 months

- Onboarding & Pre-Training Phase: 1 month
- Training & Workflow Development Phase: 3 months

Goals

CHW-SYSTIM study goals:

- Prepare CHWs to deliver the full CHW-SYSTIM intervention effectively
- Build foundational knowledge in:
 - Human subjects research and consent processes
 - CHW core skills and intervention delivery
 - Develop and refine site-specific workflows for recruitment, screening, referral, and follow-up
 - Ensure readiness to meet study targets (e.g., enrolling and supporting patients during the intervention phase)

- Establish consistent practices for patient outreach, screening, and care coordination

CHW-SYSTIM Project Training Goals

- 1. Get to know each other, build trust, and create a sense of community, shared learning, and support.**
- 2. Learn how to implement the CHW-SYSTIM intervention, including:**
 - Responsible conduct of research.
 - CHW-SYSTIM tools and resources.
 - Patient-centered social needs screening and navigation.
 - Project documentation processes.
- 3. The training team is also eager to learn from YOU and to improve this project based on your feedback!**

Figure 2: Example of CHW-facing training goals from CHW-SYSTIM Training

This figure summarizes the key training goals designed to prepare CHWs for research participation and intervention implementation.

Training Structure

CHW Role (8 hrs/week):

- Participate in weekly training and planning sessions
- Complete human subjects and foundational CHW training
- Engage in support coach meetings and surveys
- Collaborate on developing site workflows for implementing the intervention

Champion Role (1 hr/week):

- Provide support to CHWs as needed during training and preparation
- Assist with integrating workflows into clinic processes

Staffing / Effort Allocation:

- **0.20 FTE CHW** during onboarding and training periods

- **4 hours/month of champion time** to support implementation planning
- Flexibility for CHW responsibilities to be carried out by individuals in similar roles (e.g., navigators, social workers)

CHW Training Topics

The CHW-SYSTIM training approach was designed to prepare CHWs to effectively carry out their roles in a community-engaged intervention research study while maintaining fidelity to research protocols. Training topics focused on building foundational knowledge in the responsible conduct of research, including human subjects' protections, ethical recruitment, and informed consent, alongside practical skills for participant engagement and study implementation.

Recognizing that most CHWs had limited prior research experience, training emphasized applied learning and integration of research activities into existing CHW workflows. Standardized tools—such as SOPs and structured guides—were developed to reinforce consistency across sites and support day-to-day implementation. Core training areas also included participant recruitment and consent processes, as well as data collection and documentation using REDCap, ensuring accurate recording of study activities.

Training was reinforced through comprehensive resources, including the CHW-SYSTIM Training Workbook, targeted refreshers, and Q&A materials, which provided ongoing support throughout the study period. Evaluation mechanisms were embedded to capture CHW feedback and inform iterative improvements to training content and delivery. Together, these training topics and resources ensured CHWs were equipped to confidently and consistently implement research activities within a primary care setting.

Responsible Conduct of Research

Training on the responsible conduct of research was designed to equip Community Health Workers (CHWs) with the foundational knowledge and tools needed to participate in research activities within the CHW-SYSTIM study. Given that many CHWs were new to research, training focused on practical application of key concepts, including human subjects protections, ethical recruitment practices, and informed consent, to support appropriate and compliant participant engagement.

To promote consistency across sites, these concepts were reinforced through standardized workflows, standard operating procedures (SOPs), and job aids that CHWs could apply directly in their day-to-day activities. Training emphasized how research requirements integrate into CHW workflows, rather than treating them as separate tasks.

In parallel, training on data collection and documentation processes (e.g., REDCap) provided CHWs with clear guidance on how to accurately capture study data, addressing common gaps in familiarity with research systems. Supplemental materials, including refreshers and Q&A resources, were developed to reinforce learning over time and support sustained fidelity throughout the study period.

CIRTification Online

CIRTification Online is a free, web-based training in human research protections from the University of Illinois Chicago Center for Clinical and Translational Science (CCTS) tailored specifically to the needs and roles of community research partners.

The online version of CIRTification introduces learners to the basics of the research – the terminology, people, and methods. It also reviews the history of research abuses that has informed current ethical principles, rules, and regulations.

Learners complete a knowledge quiz at the end of the program and receive a date-stamped certificate of completion. **The program takes about 4 hours and can be completed in multiple sessions.**

CIRTification Online | Center for Clinical and Translational Science | University of Illinois Chicago. (2025). Uic.Edu. <https://ccts.uic.edu/resources/cirtification/online/>

⇒ For a guided tour of the program, visit [CIRTification Online](https://ccts.uic.edu/resources/cirtification/online/)

We acknowledge use of CIRTification training in human research protections from the University of Illinois Chicago Center for Clinical and Translational Science (CCTS), which is supported by the National Center for Advancing Translational Sciences (NCATS), National Institutes of Health, through Grant Award Number UL1TR002003.

Participant Recruitment & Informed Consent

The Participant Recruitment and Informed Consent materials were developed to support Community Health Workers (CHWs) effectively conduct patient outreach, enrollment, and consent processes for the CHW-SYSTIM study.

- *Patient Outreach Tracking Sheet*

The Patient Outreach Tracking Sheet provided a structured approach for monitoring outreach efforts with eligible patients, ensuring organization and follow-through.

⇒ For more, visit: [Patient_Outreach_Tracking_Sheet](#)

- *Patient Enrollment & Screening Guide*

The Patient Enrollment & Screening Guide served as a standard operating procedure to guide CHWs through outreach, informed consent, and eligibility screening workflows.

⇒ For more, visit: [Patient_Enrollment_Screening_Guide](#)

Patient Consent Questions & Answers

The Patient Consent Questions & Answers document provided additional support by addressing common questions from CHWs regarding the consent process.

Collecting Data

The REDCap training materials were developed to equip Community Health Workers (CHWs) with the knowledge and skills needed to participate effectively in the CHW-SYSTIM research study. The REDCap User Guides provided foundational and study-specific instruction on data entry and documentation processes, addressing CHWs' limited familiarity with research workflows and the REDCap system. The Form 2 Refresher served as a supplemental resource to reinforce learning, clarify documentation expectations, and address common questions, ensuring accurate and consistent recording of study outcomes over time.

- *REDCap User Guide*

The REDCap User Guide walked users through the steps required for REDCap data entry for the CHW-SYSTIM research study. The secure REDCap database was used for documenting two major forms; Form 1: Consent and Screening and Form 2: Referral and Follow-up. Most CHWs were unfamiliar with REDCap as a database and needed training on how to use REDCap and the processes for data collection for the CHW-SYSTIM research study.

⇒ For more, visit: [CHW-SYSTIM REDCap User Guide](#)

- *REDCap Form 2 Refresher*

The REDCap Form 2 Refresher was used to refresh CHWs on and provide more specific detail on the process for documenting study outcomes since due to the extended period of time between the initial training and the point of follow-up with consented study participants. The study team also wanted to provide detailed examples based on questions received from CHWs regarding proper documentation and expressed need from the research team.

⇒ For more, visit: [CHW-SYSTIM REDCap Form 2 Refresher](#)

Key Training Resources

CHW-SYSTIM Training Workbook

The workbook functioned as a comprehensive training and implementation guide that ensured CHWs could consistently carry out the CHW-SYSTIM intervention and support patients' social needs within a research setting. The workbook served as a structured, step-by-step training tool, combining:

- Learning modules and objectives
- Practice activities
- Checklists and schedules
- Documentation and workflow guidance

The workbook also prepared CHWs to implement the study intervention, including:

- Patient outreach and consent
- Social needs screening
- Referrals to resources
- Follow-up and documentation

To reference or adapt the CHW-SYSTIM Training Workbook, please use the following citation:

Steeves-Reece A, González L, Gunn R, Nelms P, Kassaye H, Espinoza K, Ebinger K, Lanman K, Ochoa A, Templeton A. CHW-SYSTIM training workbook. Network for Community-Engaged Primary Care Research; 2025.

Health Center Facing CHW-SYSTIM Study FAQs

The Study FAQs provides a high-level overview of the CHW-SYSTIM research study, including its purpose, goals, and key CHC personnel. They were designed to inform CHC staff about how the study worked, why it was important, and where to direct questions.

⇒ FAQs in English: [Health Center Facing Study FAQs English](#)

⇒ FAQs in Spanish: [Health Center Facing Study FAQs Spanish](#)

Evaluation

The CHW Training Evaluation Survey was administered after each training module to systematically collect and review CHW feedback, to monitor training effectiveness, identify gaps or support needs, and inform iterative refinements to training content and delivery throughout the training period.

⇒ For more, visit: [CHW Training Evaluation Survey Template](#)

Intervention Period

Intervention Period Overview

The intervention period focused on the identification and recruitment of patients with social needs, connecting them to resources, and supporting their access to care. Through structured CHW and CHC engagement, this period focused on building consistent workflows for recruitment, enrollment, referral, and follow-up, which ensured accurate documentation and continuous learning. Ongoing collaboration with study team support coaches further reinforced effective implementation and helped sustain the delivery of the intervention.

Timeline

Intervention Period: 10 months

- Intervention Phase: 7 months
- Follow-up Phase: 3 months

Goals

Intervention Phase Goals:

- Recruit, consent, and enroll 120 patients with identified social needs
- Connect patients to resources through referrals
- Conduct ongoing follow-ups to support resource access
- Ensure accurate documentation of all intervention activities

- Engage CHWs in learning and support activities (collaboratives, coaching, surveys)

Follow-up Phase Goals:

- Assess whether patients successfully received referred resources
- Continue intervention activities as needed to support outcomes
- Capture CHW insights and lessons learned at the end of the study

Structure

Estimated weekly effort for CHWs and Champions was estimated in advance by the study team to guide planning and support consistent implementation across sites; actual time spent varied based on site-specific workflows and needs.

CHW Role:

- Intervention (est. 32 hrs/week):
 - Patient recruitment, consent, enrollment
 - Social needs referrals and follow-ups
 - Documentation in REDCap
 - Participation in learning collaboratives, coaching sessions, and surveys
- Follow-up (est. 16 hrs/week):
 - Patient outcome follow-up
 - Continued support and intervention as needed
 - Participation in end-of-study convenings

Champion Role (1 hr/week throughout):

- Provide ongoing support to CHWs during both intervention and follow-up phases
- Assist with implementation and troubleshooting

Staffing / Effort Allocation – Intervention Period

- CHW Effort:
 - **0.80 FTE (32 hours/week)** dedicated to delivering the intervention

- Responsible for patient recruitment, consent, enrollment, referrals, follow-up, and documentation
- Champion Effort:
 - 1 hour/week (approximately 4 hours/month)
 - Provides ongoing support, guidance, and assistance with implementation at the site
- Overall Allocation Purpose:
 - Structured to ensure sufficient CHW capacity to deliver the full intervention to the target patient population

Provides consistent, low-intensity champion support to reinforce workflow integration and problem-solving

CHW Learning Collaborative

The CHW Learning Collaborative was designed to provide a structured, ongoing shared learning environment that supported successful Community Health Worker (CHW) implementation of the intervention. The CHW Learning Collaborative sessions combined implementation support with collaborative learning and continuous improvement across sites through:

- Ensuring CHWs and CHCs have the guidance, resources, and troubleshooting support needed.
- Facilitating peer-to-peer learning through shared experiences, case discussions, and collaborative problem-solving.
- Identifying and addressing challenges early by creating regular touchpoints for feedback, risk identification, and solution development.
- Building community and engagement among CHWs by fostering connection, validating their work, and amplifying successes.
- Generating and sharing best practices to improve and sustain CHW-led social needs interventions and inform future approaches.

Skillset Resume

The CHW-SYSTIM Resume Builder was developed through collaborative discussion during the final Learning Collaborative, where CHWs were guided to identify and articulate the professional skills they developed and strengthened while recruiting patients for the study. This session surfaced key competencies and emphasized the value of CHW contributions, while reinforcing a shared commitment to supporting their long-term professional growth.

Insights from this session were synthesized into a formal skills summary and compiled into the CHW-SYSTIM Resume Builder, which was finalized and shared with participating CHWs. This tool was designed to recognize CHW contributions, support ongoing professional development, and equip CHWs with a structured resource to communicate their expertise and advance their careers.

⇒ For more, see: [CHW_Skillset_Resume](#)

Plans for Attrition or Adding New CHWs/Champions

Given the length of the study intervention period, it was likely that there would be cases of either Champion or CHW attrition. The study team determined the essential training materials and steps that needed to be completed to onboard new individuals in these respective roles. These activities were to be carried out within two weeks of CHC staff turnover to facilitate a prompt continuation of the intervention while maintaining its integrity.

⇒ For more, visit: [CHW-SYSTIM Plans for Adding New CHWs or Champions](#)

Support Coaching

The Support Coaching Plan, which outlines the roles and responsibilities of the Support Coaches, established a structured and consistent approach to implementation support, and detailed the data collection processes to be followed throughout the intervention period. This plan ensured alignment across all CHCs and streamlined the coaching process.

Support Coaching Plan

The CHW-SYSTIM Coaching Support Plan provided a structured framework for defining and standardizing the role of Support Coaches within the NCPCR CHW-SYSTIM project. It established a consistent, shared understanding of coaching responsibilities, expectations, and activities to ensure effective and aligned support across participating CHCs. Support coaching was both structured and responsive—enabling coaches to adapt to the unique context of each CHC while maintaining accountability and consistency across the project — through individualized support, ongoing communication, continuous learning and adaptation, documentation and reporting, and data use and feedback. Tailored guidance, coaching, and resource connection, coaches helped CHWs and Champions operationalize intervention strategies, strengthen workflows, and implement sustainable practice improvements.

⇒ For more, visit: [Support Coaching Plan](#)

- *Support Coach Activities Template*

The Support Coaching Activities Template was a structured workbook used by support coaches to track engagement, document interactions, and monitor progress with intervention CHCs over time. The template provides guidance for topics to address during meetings with respective intervention CHWs and Champions and formatted so that intervention study staff were able to easily review detailed notes on key topics in order to develop and provide additional support as needed.

⇒ For more, visit: [Support Coach Activities Template](#)

Dissemination Activities

Dissemination activities were designed to share key lessons, foster cross-site collaboration, and highlight the impact of the CHW-SYSTIM project across participating CHCs and stakeholders. Through a series of structured convenings, these activities enabled CHWs, CHC staff, and partners to exchange practical recommendations for implementing CHW-led social interventions, reflect on research partnerships, and review preliminary findings and future directions. The sessions emphasized collective learning, stakeholder engagement, and the translation of insights into sustainable practices. Complementing these efforts, the CHW-SYSTIM Resume Builder and skillset development work recognized and documented the professional competencies CHWs gained during the study, in support of ongoing CHW career advancement and advocacy. Together, these activities ensured that knowledge generated from the study was shared, actionable, and beneficial for both intervention and control CHCs as well as for future initiatives.

End of Study Convenings

The End of Study Convenings were composed of three virtual meetings aligned with project closeout to share key lessons learned.

Session 1

The first session brought together CHWs and CHC staff from 12 intervention CHCs to review recommendations gathered from intervention sites for control sites, focusing on:

- Key considerations for implementing CHW-led social interventions, including essential operational supports.
- Practical insights and recommendations for conducting research in partnership with CHWs and CHCs.

Session 2

The second session brought together 38 CHWs and CHC staff from 18 participating CHCs, representing both intervention and control sites. The session fostered cross-site collaboration and shared learning, with key insights captured through graphic notetaking. The NCPCR study team shared top recommendations from intervention sites identified during the first convening, followed by perspectives from CHWs representing intervention CHCs.

Session 3

The third and final session brought together study stakeholders including CHCs, CHWs, Advisory Board members, as well as NIH representatives. The NCPCR study team presented preliminary findings, lessons learned, and future directions, including sustainability and potential applications.

Community Partner Recommendations for Future Projects

The recommendations for CHCs and researchers were developed through a structured, community-engaged process that brought together CHWs, CHC staff, researchers, and partners to reflect on implementation and research experiences. Through a series of facilitated convenings, participants synthesized key lessons from implementing CHW-led social needs care and conducting community-engaged research across diverse settings.

In the End-of-Study Convening sessions, participants engaged in breakout discussions, cross-site sharing, and prioritization activities to identify common facilitators, barriers, and best practices. This iterative process resulted in consensus-driven, experience-based recommendations that were refined through dialogue and grounded in real-world implementation. The recommendations reflect recurring themes across settings, including the importance of strong relationships, community partnerships, structured workflows, and patient-centered engagement.

The final recommendations for CHCs focus on strengthening implementation capacity—such as investing in CHW workforce development, integrating social needs screening into routine care, and building community partnerships—while the recommendations for researchers emphasize reducing participation burden and improving collaboration through clear expectations, streamlined processes, and ongoing support. Together, they provide practical, stakeholder-informed guidance to support future implementation, sustainability, and scaling of CHW-led models and community-engaged research.

Recommendations for Health Centers Implementing CHW-led Social Needs Care Interventions

- Foster community partnerships
- Have CHWs from the community and for the community
- Ensure all staff understand the role and importance of CHWs
- Make social needs screening a standard practice
- Provide ample training and preparation for CHWs

Prioritize capacity, support, and funding for CHWs

Recommendations for Research Teams and Funders Working with Health Centers

- Streamline documentation
- Ensure clear roles, activities, expectations
- Use simple consent language and processes
- Provide training and role-playing opportunities
- Provide ongoing, timely support
- Prepare for patient interpretation needs early on
- Stay in tune with community partner needs and priorities

Resource Appendix

Health Center Baseline Assessment

This assessment collects information about existing social needs workflows, Community Health Worker capacity, and prior research experience to inform implementation planning and site support.

Page 1

Community Health Workers Systematically Assessing and Addressing Social Determinants of Health to Improve Outcomes in Community-based Health Centers (CHW-SYSTIM): Baseline Assessment

The Network for Community-Engaged Primary Care Research (NCPCR) created this Baseline Assessment to learn about control and intervention sites' social needs screening and referral-making activities and experience working with Community Health Workers (CHWs) before the CHW-SYSTIM trial starts. The Baseline Assessment should be completed by health center administrators and staff members with the most knowledge about these activities. The term "social needs" is used in this survey to refer to various factors impacting a patient's well-being. We recognize that other terms, such as social determinants of health (SDOH), adverse SDOH, or social risks might also be used. Please keep this in mind as you respond to questions regarding social needs. Thank you for your time and thoughtfulness while completing this survey! It should take your team about 20 minutes to complete.

Organization name: _____

Please list the names of all individuals completing this form. _____

For each individual listed above, please specify their role(s) in the organization in the same order. _____

Email of primary contact completing form: _____

SOCIAL NEEDS SCREENING PRACTICES

Does your organization currently have any formal efforts to screen patients for social needs (e.g., food, housing, transportation) in primary care? ☐ Yes ☐ No

Please briefly summarize any formal efforts to screen for and address patients' social needs (e.g., food, housing, transportation) at your organization. _____

Which of the following social domains does your organization screen for? (select all that apply)

- ☐ Food
- ☐ Housing
- ☐ Transportation
- ☐ Financial Resource Strain
- ☐ Medical Costs
- ☐ Utilities
- ☐ Other: _____

Please describe: _____

Which screening tools does your organization use (in full or in part) to document patient social needs? (select all that apply)

- ☐ Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- ☐ Accountable Health Communities Health Related Social Needs (AHC-HRSN)
- ☐ Other: _____

CHW “Get to Know You” Questions

This questionnaire gathers information about Community Health Workers’ backgrounds, experiences, and training needs to support relationship building and tailor project support.

Welcome to the CHW-SYSTIM project! We’re looking forward to getting to know you and working together. **Please complete the questions below and return this document by <<date>>.** Feel free to tell us as much or as little as you like. We will use this information to improve the training and to start building community across the Community Health Workers (CHWs) taking part in this project.

A note that we will refer to your role on this project as a Community Health Worker (CHW), but we realize that you may not have “CHW” in your health center title or job description. Regardless of your title, we will work to build and strengthen foundational CHW skills as a group.

Questions:

- Your Name:
- Your Current Job Title:
- How long have you worked at your health center and what are your roles and responsibilities there?
- Please tell us a little about yourself – your background, languages you speak, anything you’d like to share to help us (the project team and fellow Community Health Workers/CHW equivalents) get to know you better.
- What was your path to this work - how did you get started, and what do you enjoy most about your work?
- Please share your work or lived experience related to social determinants of health / social needs activities (for example, screening or supporting patients when they have needs related to transportation, food, or housing).
- Have you ever been involved with a research project before? At your current place of work or somewhere else? If so, please briefly tell us about any research-related experience you have.

Role Descriptions

Community Health Worker (CHW)

This resource outlines the responsibilities, qualifications, and expectations for Community Health Workers participating in the CHW-SYSTIM project.

The Community Health Worker (CHW) is an integral part of the care team who performs duties at the paraprofessional level to support patients with social risks like food insecurity and housing instability in accessing needed services. CHWs in the CHW-SYSTIM project do not need to be certified as CHWs, but they do need to have pertinent CHW-related skills and training as outlined below. Appropriate staff may be serving in roles like health promoters, health navigators, or peers. Any non-certified CHWs joining the project will receive CHW foundational training prior to the intervention. CHWs will serve as liaisons between health centers and community organizations to facilitate timely access to supportive services for patients experiencing diabetes and hypertension by increasing self-sufficiency through outreach, referrals, navigation, education, information counseling, and advocacy.

CHWs play a key role in promoting better health in a variety of different communities. They help people learn about health issues and show them ways to live healthier lives. Successful CHWs have special qualities. They know their communities well. They are dedicated to improving the health of their communities. They enjoy teaching others, feel comfortable in front of a group, and know how to work with a group. Successful CHWs are also:

- Good listeners
- Nonjudgmental
- Caring • Patient
- Approachable
- Fair • Open minded
- Helpful
- Motivated
- Reliable

- Confident
- Trustworthy
- Willing to try ways to improve their own health

Primary responsibilities:

- Consent eligible patients per 38 U.S. Code § 17.32 during office visits, via phone, and/or via text (per patient preference).
- Contact patients with Diabetes and Hypertension during office visits, via phone, and/or via text (per patient preference).
- Conduct screening assessments to ascertain patient social risks.
- Consult with clinical team as appropriate.
- Partner and collaborate with internal care team, community partners and providers.
- Support patients in accessing both health centers and community services for identified social risks. Provide coaching, navigation and other support to help patients receive needed services.
- Document all activity in a tracking database (Electronic health record system, survey system).
- Attend and participate in scheduled training and meetings. Topics include:
 - Project Orientation, Importance of Social Risk Interventions
 - Identifying and Outreaching to Eligible Patients
 - Conducting Social Risk Screening
 - Supporting Patients with Social Risks
 - Following Up with Patients About Social Risks
 - Training Closeout, Transitioning to CHW-SYSTIM Intervention Phase
 - (Emphasis on REDCap Intervention Documentation Review)
 - Assigned work outside of meetings will be from the Partners' Community Health Worker Training Classes | Partners In Care Foundation (picf.org)

Education and Skills:

- A minimum of six months of experience in the Community Health Center. This requirement may be negotiable with the project team if the CHW is very experienced and has worked with the health center for a long enough period that they are familiar with its staff and workflows.
- Associate degree from an accredited college or university, or a minimum of two years of related experience and/or training in a health-related setting.
- Provide culturally and linguistically appropriate services to persons of various cultures and backgrounds.
- Oral and written fluency in English and the language of the community being served.
- General knowledge of public health, community resources, and health beliefs.
- Effective oral communication.
- Establish and maintain effective working relationships with clients, staff, colleagues, key stakeholders, community groups, other professionals, and the public.
- Ability to navigate a windows environment and utilize Microsoft Office in a professional setting, including Microsoft Word (ability to create, edit, send, and save documents), Microsoft Excel (ability to create, edit, send, and save spreadsheets), and Microsoft Outlook (ability to create, edit, send, and save correspondence).
- Exercise initiative, tact, discretion, and judgment in carrying out position responsibilities.
- Manage work time appropriately and can work in unstructured and unconventional work settings.
- Effectively prioritize tasks within established project goals and guidelines.

Champion

This role description defines the Champion's responsibilities for supporting implementation, facilitating communication, and promoting project success within the Health Center.

Each Health Center will identify a Champion who will work with the project team and the CHW to establish social risk-related clinic workflows and processes to support NCPCR RCT activities. The Project Champion should be a Health Center staff that understands patient care delivery, outreach, navigation, and referral processes. The Project Champion will have a small, but integral, role in the RCT project and will help support context-setting and vision for project implementation and sustainability. The Champion will participate in qualitative data collection as an interviewee to help identify key learnings from the intervention. Project champions will help facilitate communication between other team members and health center staff. They will also ensure that health center deliverables are completed according to mutually approved timelines.

Support Coach

This resource describes the Support Coach role and expectations for providing implementation guidance, coaching, and ongoing support to participating Health Centers.

Support Coaches will work closely with the NCPCR RCT team to co-develop, finalize, and implement centralized training and support coach support strategies for a CHW-led social risk intervention across 3 PBRNs (OCHIN, the Southeast Regional Clinicians Network, and Health Choice Network). During the trial phase, the Support Coach will provide practice facilitation support to intervention sites (i.e., 13 CHWs) for increased adoption and sustainment of the intervention. Specific tasks will include:

- Co-develop and facilitate CHW training and learning collaborative content, training tasks, and agendas in collaboration with an ORPRN training facilitator/support coach.
- Meet with the intervention health center Champions and CHWs to provide an overview of the project and discuss roles, responsibilities, and project timelines.

- Co-facilitate synchronous CHW training and learning collaborative sessions in collaboration with an ORPRN training facilitator/support coach.
- Coordinate with the health center Champions and CHWs to ensure that their health center staff are aware of the project.
- Analyze CHW training and learning collaborative evaluation results to identify the need for additional CHW support and opportunities for training delivery improvement.
- During the intervention, meet with intervention site CHWs to support them with intervention implementation, including any challenges that may arise in their health centers.

Patient Outreach Tracking Sheet

Instructions for Patient Outreach Tracking Sheet Sample

This guide explains how to use the Patient Outreach Tracking Sheet to organize outreach efforts, monitor patient contact attempts, and support intervention workflow management.

Instructions for Patient Outreach Tracking Sheet		
Eligible Patient Information		
Entered into the worksheet on behalf of the CHW, new patients added monthly.		
Column	Name	Description / Instructions
A	Date Patient Added to Sheet	Date that the patient was first added to the sheet.
B	Patient MRN	Patient's Medical Record Number.
C	First Name	Patient's first name.
D	Last Name	Patient's last name.
E	Date of Birth	Patient's date of birth.
F	Race	Patient's race, according to the EHR. This may be different from what the patient tells you when you connect with
G	Ethnicity	Patient's ethnicity, according to the EHR. This may be different from what the patient tells you when you connect with
H	Sex	Patient's sex at birth, according to the EHR. Recommend that CHWs double check the EHR to view patient's gender and pronouns before contacting.
I	Preferred Language	Patient's preferred language, according to the EHR. This may be different from what the patient tells you when you
J	Hypertension Diagnosis	Response options are "Yes" or "-" (i.e., indicating No) based on whether the patient has a hypertension diagnosis that
K	Diabetes Diagnosis	the eligibility criteria.
L	Phone Number	Patient's phone number, according to the EHR.
Recruitment, Consent, REDCap Form 1, REDCap Form 2		
Entered into the worksheet by the CHW as activities are completed.		
Column	Name	Description / Instructions
M	Date of Most Recent Attempt	Date of your most recent outreach attempt (MM/DD/YY). The date entered here should be updated with each attempt
N	Time of Most Recent Attempt	Time of day of your most recent outreach attempt (e.g., 8:00am, 4:30pm). The time entered here should be updated with each attempt to contact the patient.
O, P, Q, R	Outreach Attempts 1, 2, 3, and 4 NOTE: It will only be necessary to make a 4th outreach attempt if follow-up is still needed based on the 3rd outreach attempt.	No answer = Patient was unavailable (e.g., did not answer the phone) when you tried to contact them. No answer & left message = Patient was unavailable when you tried to contact them, but you were able to leave a voicemail. Contacted & follow-up needed = You spoke with the patient and they expressed interest in the project, but you weren't able to get through both the consent and social needs screening information. Follow up will be needed. Contacted & opted out of the project = You communicated with the patient and they said they did not want to take part in this project. Do not attempt to contact the patient again.
S	Consented	Not applicable = Select "Not applicable" if you were never able to contact the patient. Did not consent = Select "Did not consent" if you were able to contact the patient, but they decided to opt out of the project or opt out of research, in general.
T	REDCap Form 1: Consent and Screening	Not applicable = You do not need to complete the 1st REDCap form because the patient never consented to participate. Incomplete = You have not completed the 1st REDCap form, and still need to do so.
U	REDCap Form 2: Referral and Follow-Up	Not applicable = You do not need to complete the 2nd REDCap form because the patient either did not consent to participate, did not have social needs, or did not want help with their social needs. Incomplete = You have not completed the 2nd REDCap form, and still need to do so. Complete = You have completed the 2nd REDCap form.
Notes		
Entered into the worksheet by the CHW as activities are completed.		
Column	Description / Instructions	
V	Notes that will help you to remember key information about the patient before reaching back out to improve their experience. For example, the best days/times to call	

Patient Outreach Tracking Sheet Sample

This sample tracking sheet demonstrates how patient outreach activities, communication attempts, and enrollment progress can be documented and monitored.

CHW-SYSTIM Patient Outreach Tracking Sheet											
REDCap Link To Be Added Here (OCHIN, SERCN, and HCN health centers will have different links)											
EHR DATA FIELDS											
Eligible Patient Information											
Date Patient Added to Sheet	Patient MRN	First Name	Last Name	Date of Birth	Race	Ethnicity	Sex	Preferred Language	Hypertension Diagnosis	Diabetes Diagnosis	Phone Number
4/21/2025	2345678	PETER B	RABBIT	5/5/1957	Black/African American / White / Filipino / Korean / Chose not to disclose	e.g. Mexican, Mexican American, or Chicano/a, Puerto Rican, Another Hispanic, Latino/a, or Spanish Origin, Non-Hispanic or Latino/a	M	Spanish; Castilian	Y	-	Cell: xxx-xxx-xxx1; xxx-xxx-xxx2 / Home: xxx-xxx-xxx3 / Work: xxx-xxx-xxx4

CHW DOCUMENTATION FIELDS									
Recruitment, Consent, REDCap Form 1, and REDCap Form 2									
Date of Most Recent Attempt	Time of Most Recent Attempt	Outreach Attempt 1	Outreach Attempt 2	Outreach Attempt 3	Outreach Attempt 4 (Only use if follow-up needed from 3rd outreach attempt)	Consented	REDCap Form 1: Consent and Screening	REDCap Form 2: Referral and Follow-up	Notes

Referral & Follow Up Tool Sample

This sample tool illustrates a process for documenting referrals, tracking follow-up activities, and monitoring patient connections to community resources.

Referral & Follow-Up Notes (Optional Tool)

Instructions:

This tab is for patients who (a) consented to participate in this project, (b) screened positive for social needs, AND (c) wanted your help to connect with resources. This might be a helpful place to keep track of your ongoing work to support these patients and connect them with resources. For example, you might want to note their resource preferences, times that are better or worse to contact them, or whether there is something you need to share with their care team

				Action Dates / Timeline			
Patient MRN	Patient Name (First & Last)	Description of Referrals/Navigation to Follow Up On	Follow Up Method (e.g., phone, in-person)	Last Contact Date	Days Since Last Contact	Date to Follow Up	Days Until or Past Due

How Is the Patient Currently Doing With Their Social Needs?	REDCap Forms Complete?	Next Steps	Status Notes (Risks / Issues / Barriers)

Patient Enrollment & Screening Guide

Sample

This guide provides step-by-step instructions for patient outreach, informed consent, eligibility screening, and study enrollment activities.

Pre-outreach steps – starting your day:

- Open and review your **Patient Outreach Tracking Sheet** in SharePoint.
- Ensure you have a place to document each patient's responses about consent, social needs, and other important information as you're speaking with them. Keep in mind that you'll need to transfer this information into **REDCap** for consented patients. You can work with your Champion and Support Coach to think through your workflow for this.
- Make sure you have a quiet, private space to do your project work.
- Check in with yourself. How are you feeling today? Is there anything you need to do ahead of time to be to be present and undistracted when contacting patients?

Pre-outreach steps – before contacting each patient:

- Review the patient's information on the **Patient Outreach Tracking Sheet** to see whether there is anything you should know before reaching out (e.g., the patient's preferred language).
- Self-check-in: Take a couple deep breaths before reaching out to the patient. Keep a beverage/snack nearby.
- Throughout your conversation with the patient, keep in mind strategies you can use to positively impact their experience while interacting with them. Remember to be honest about the purpose of the project and respect the patient's decision about whether or not they want to participate. Do your best to express kindness and a genuine intention to connect the patient with needed resources.

CHW-SYSTIM REDCap User Guide

This guide provides instructions for entering, managing, and reviewing study data in REDCap to support accurate and consistent documentation.

CHW-SYSTIM: REDCap User Guide

Contents

Introduction	1
Logging in steps	2
Form 1: Consent and screening steps	4
Form 2: Referral and follow-up steps	8

Introduction

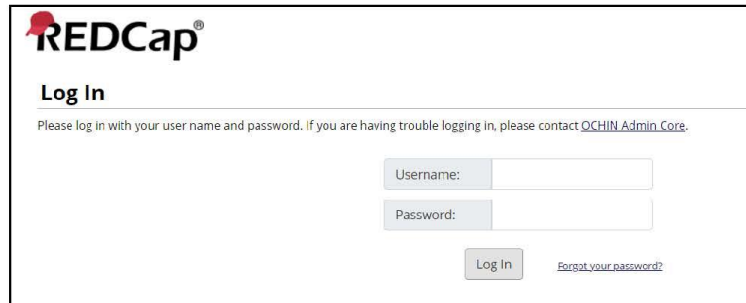
This guide is intended to walk users through the steps required for REDCap data entry for the CHW-SYSTIM research study. The secure REDCap database is used for documenting two major forms; **Form 1: Consent and Screening** and **Form 2: Referral and Follow-up**. A few points we'd like to highlight:

- Please make sure you indicate when these REDCap forms are complete in your Patient Outreach Tracking Sheet Excel file.
- REDCap does not automatically save data and logs users out after a short period of inactivity, so please remember to save your work often.
- The REDCap database and Patient Outreach Tracking Sheet do not replace the documentation you normally do in your EHR. We recognize that the documentation may be duplicative for you. We appreciate your support in collecting this important data during the research project period!

If you have questions about REDCap, please contact your Support Coach.

Logging in steps

1. If you're affiliated with OCHIN, navigate to <https://redcap.ochin.org>. If you're affiliated with MSM or HCN, navigate to <https://redcap.msm.edu>. Consider bookmarking the link for easy access. The link can also be found in the top left-hand corner of your CHW-SYSTIM Patient Outreach Tracking Sheet.



The screenshot shows the REDCap login interface. At the top left is the REDCap logo. Below it is the heading "Log In". A message states: "Please log in with your user name and password. If you are having trouble logging in, please contact [OCHIN Admin Core](#)." There are two input fields: "Username:" and "Password:". Below these fields is a "Log In" button and a link that says "Forgot your password?".

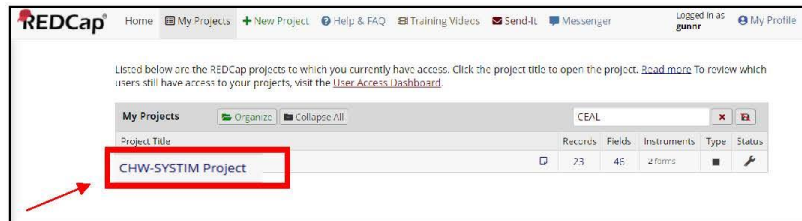
2. Enter your username and password. A two-step verification screen will pop up, prompting you to choose an authentication method. Choose your preferred method to authenticate your login.



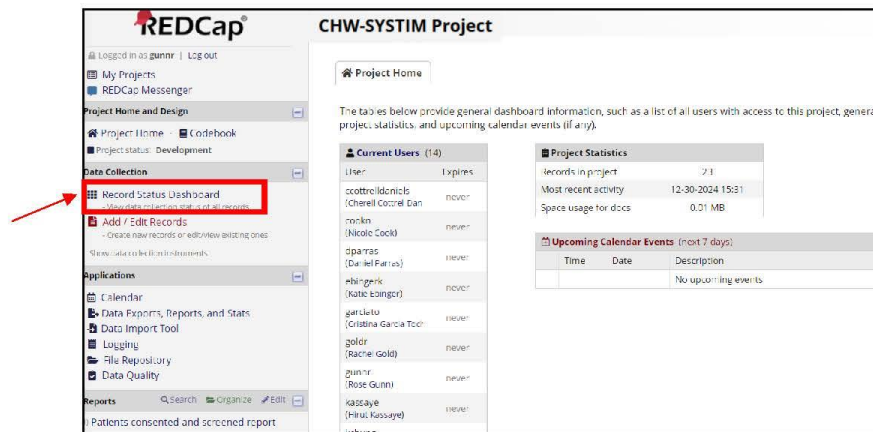
The screenshot shows a dialog box titled "Two-step verification for REDCap login". The text inside says: "Select an option below to complete the second half of REDCap's two-step verification login process. You will not be able to access REDCap until you have completed this verification step." There are two radio button options:

- Google Authenticator:** Open the Google Authenticator app on your mobile device to get the verification code associated with your REDCap user account.
- Email:** Send an email containing your verification code to your email account. Below this, it says "Send to gunnr@ochin.org".

- After logging in, you will see the project name under “My Projects” dashboard. Click on “CHW-SYSTIM Project” to navigate to the database where you will be entering data. If your health center is affiliated with SERCN, the project will be called “CHW-SYSTIM (SERCN)”. If your health center is affiliated with HCN, the project will be called “CHW-SYSTIM (HCN)”.

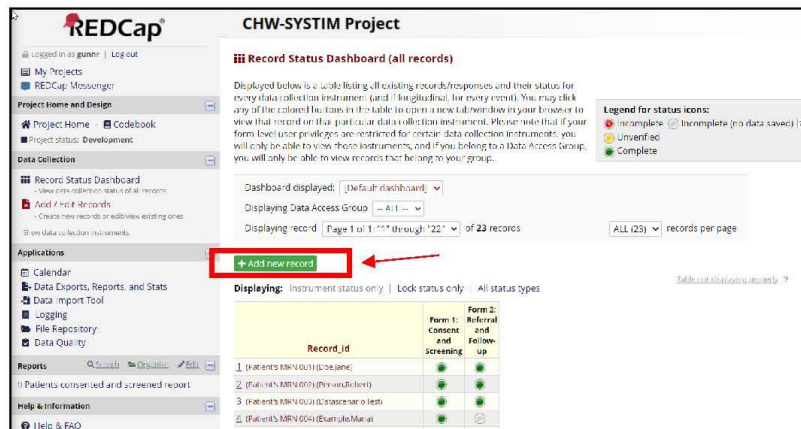


- Clicking on the link will take you to the home page for the project. To begin entering data, navigate to “Record Status Dashboard” and click on the link.

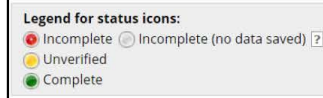


Form 1: Consent and screening steps

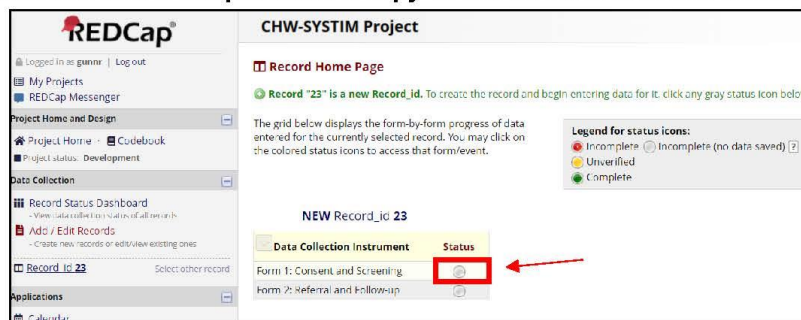
1. From the Record Status Dashboard, select “Add new record.” You will also have a physical, laminated copy of this first form so that you can document the responses in real time and then enter in the results later.



Note: REDCap uses color-coded radio buttons to indicate the status of each form, so it's easy to see which forms are complete and which forms require attention. You can ignore the yellow unverified button since it's not being used for this project.



2. After selecting “Add new record,” you will see a table listing the two data collection instruments that you will use for this project. To begin entering data, click on the radio button next to “Form 1: Consent and Screening”. **This form will only be used for patients who have granted their verbal consent and were provided a copy of the Written Consent Sheet.**



Note: REDCap does **not** automatically save data. You have the option of selecting whether you'd like to save and exit the form or save and stay on the form, go to the next form, exit the record, or go to the next record. REDCap logs users out automatically after 10 minutes of inactivity, so **please remember to save often!**

There may be cases where you can't complete a form in one sitting, in which case you'd select "save and exit record." Mark the record as "Incomplete" in your **Patient Outreach Tracking Sheet** to help you remember to go back to the form to complete.

Patient Outreach Tracking Sheet.xlsx

- Fill out the initial fields in Form 1, which will first ask you to confirm the patient was consented, followed by fields for the patient's medical record number, first name, last name, date of birth, and consent status. You may want to have your **Patient Outreach Tracking Sheet** Excel file open to copy that information. Do your best to double check for typos at this stage.

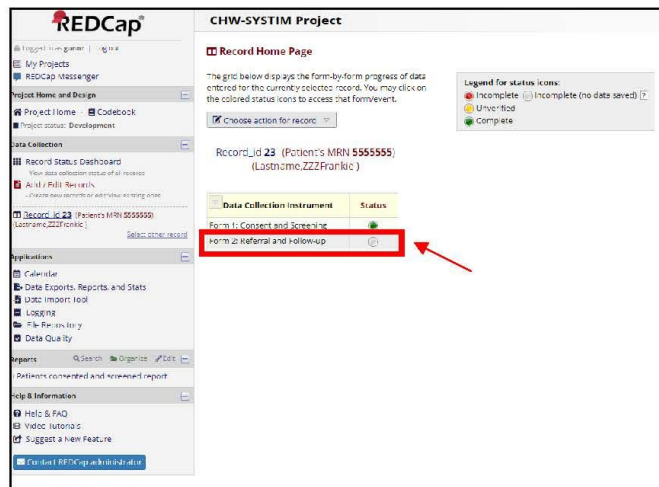
4. Scroll down to complete the “Social Needs Screening Section.” Answer the questions regarding screening outcome, screening date, and pregnancy status. **If the patient screened positive for a social need**, selecting “Yes” will make additional questions appear asking about social need domains and whether the patient indicated they'd like help connecting with resources.
 - Use the “Other” field to document any social needs domains not captured in the available options. The text you enter in the box by “Other” will auto populate fields in the next form, so you may want to consider keeping the text short and simple.
 - Pregnancy status will not prevent a patient from receiving support for their social needs. The study team uses this information to exclude pregnant patients from analysis, per our regulatory requirements.

Note: When exiting incomplete records, you will notice a pop-up message reminding you of fields that haven't been completed.

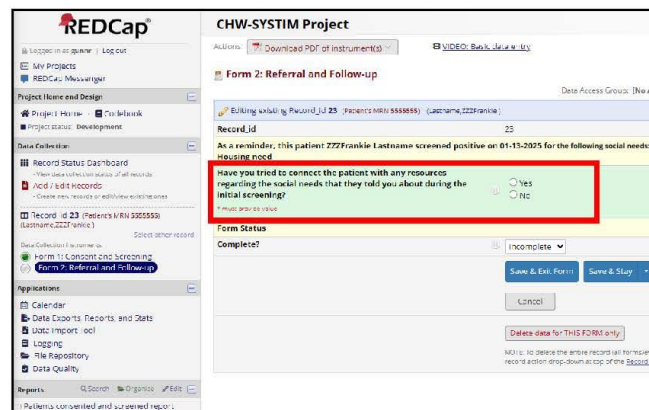
5. To finish, use the drop-down menu under the "Form Status" section to select "Complete." Click "Save and Exit Form."
6. Data entry for the patient is considered complete for Form 1. Mark the form "Complete" in your **Patient Outreach Tracking Sheet** Excel file. The radio button for the form should now appear with a **green** radio button.
7. If the patient had social needs and indicated that they would like your help connecting with resources regarding their social needs, subsequent data entry will be required in Form 2.

Form 2: Referral and follow-up steps

- Form 2 is intended for documenting resource referral and follow-up for patients who have asked for help with their social need(s). Select the radio button by "Form 2: Referral and Follow-up". *Note: This is intended to be completed **after** you have already completed Form 1 for the patient, so the radio button next to Form 1 should appear **green**.*



- After selecting Form 2, you will see one question asking whether you have tried connecting the patient with resources for their social need(s).



3. Selecting “yes” to the question will open up a series of questions about the actions taken to connect the patient with resources. First, indicate the date you most recently tried to connect the patient with resources. Next, please check the boxes that most closely align with how you helped with each social need. A text box is available for writing down any additional details about the referral. You can update this over time.

Data Collection

Record Status Dashboard
View data collection status of all records

Add / Edit Records
Create new records or edit/view existing ones

Record id: 6 (Flowers, Spring) [Select other record](#)

Data Collection Instruments
Form 1: Consent and Screening
Form 2: Referral and Follow-up

Applications
Calendar
Data Exports, Reports, and Stats
Data Import Tool
Logging
File Repository
Data Quality

Reports [Search](#) [Organize](#) [Edit](#)
1) Patients consented and screened report

Help & Information
Help & FAQ
Video Tutorials
Suggest a New Feature
[Contact REDCap administrator](#)

As a reminder, this patient Spring Flowers screened positive on 04-04-2025 for the following social needs: Food need, Housing need, Transportation need, Medical costs need, Other (such as other financial, employment, childcare, or legal need)

Have you tried to connect the patient with any resources regarding the social needs that they told you about during the initial screening? ☒ Yes ☐ No

On what date did you most recently try to connect the patient with resources to address their social needs? * must provide value

Please select all the types of help given to patient in response to their social needs identified on 04-04-2025
Note: only the needs that the patient screened positive for will be listed below.

	Internal referrals to in-house health center resources.	Connected the patient with a referral database (e.g., Social Services Resource Locators such as "211info" or "Unite Us").	Gave the patient written (e.g., paper, text, MyChart) resources information based on a health center-maintained resources list.	Provided more personalized navigation support to connect patients directly with community resources.	The patient either did not want or need help with this issue.	There are no resources available for this need at this time.	Other
Food need * must provide value	☐	☐	☐	☐	☐	☐	☐
Housing need * must provide value	☐	☐	☐	☐	☐	☐	☐
Transportation need * must provide value	☐	☐	☐	☐	☐	☐	☐
Medical costs need * must provide value	☐	☐	☐	☐	☐	☐	☐
Other: Childcare	☐	☐	☐	☐	☐	☐	☐

Please type any additional details about the type of help you provided to the patient.

*Note: Form 2 can only be marked as complete when all of a patients' needs are met, if they either do not want or need further assistance, if you have confirmed that no resources are available for them, or if they do not respond to you after multiple attempts to contact them. As a result, you may find you'll be saving this form and coming back to it again. This form captures your most recent contact with the patient, **so you will need to update the date field and other entries to correspond to your work.***

4. The second section of Form 2 is “Social Needs Follow-up”. This is where you indicate if you’ve followed up with the patient to see if they have received resources for their social need(s).

Social Needs Follow-up

Have you made contact with the patient to see whether or not they have received support with their social needs?

* must provide value

- ☐ No, I was never able to make contact with the patient after multiple attempts.
☒ Yes

reset

- If you were unable to contact the patient to find out whether they accessed resources for their social needs, please select “No, I was never able to make contact with the patient after multiple attempts.”
- If you contacted the patient, please select the “Yes” radio button. Additional fields will appear, prompting you to enter the date of most recent contact and status of support for each of their social needs.

Social Needs Follow-up

Have you made contact with the patient to see whether or not they have received support with their social needs?

* must provide value

- ☐ No, I was never able to make contact with the patient after multiple attempts.
☒ Yes

reset

What date did you last make contact with the patient?

* must provide value

MM/DD/YYYY

reset

	No, the patient did not receive help and would still like help with this issue.	No, the patient did not receive help and no longer either needs or wants help with this issue.	No, the patient did not receive help and I have confirmed there is not a resource available for this need at this time.	Yes, the patient has received help for this need but still requires additional support.	Yes, the patient has received help for this need and no longer requires support.	I do not know the status of this need.
Did the patient receive help with: Food insecurity * must provide value	☐	☐	☐	☐	☐	☐
Did the patient receive help with: Housing need * must provide value	☐	☐	☐	☐	☐	☐
Did the patient receive help with: Transportation needs * must provide value	☐	☐	☐	☐	☐	☐
Did the patient receive help with: Medical costs * must provide value	☐	☐	☐	☐	☐	☐
Did the patient receive help with: Other social needs: Childcare	☐	☐	☐	☐	☐	☐

* must provide value

reset

* must provide value

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- c) In the screenshot above, note that there are open text fields where you can add any details about your work with the patient, including barriers you faced in connecting the patient with resources. You will also be able to document if you lost contact with the patient at this follow-up stage.
5. Similar to Form 1, Form 2 can be marked "Complete" under the Form Status using the drop-down menu. As mentioned above, this form will only be complete when the patient's social needs have been met, if they either did not want or need further assistance, if you confirmed that no resources are available for their needs, or if you have not been able to reach them after multiple attempts. Click "Save and Exit Form."
6. Data entry for the patient is considered complete for Form 2. The radio button for Form 2 should now appear with a **green** radio button in REDCap.



Mark the form "Complete" in your **Patient Outreach Tracking Sheet** Excel file.

REDCap Form 1: Consent and Screening	REDCap Form 2: Referral and Follow-up
Complete	Complete
	Not Applicable
	Incomplete
	Complete

Patient Outreach Tracking Sheet.xlsx

These are all the steps needed to complete the REDCap entries for each consented patient. We recognize that there will be overlap in what you document in REDCap and in your EHR. We appreciate your help using REDCap so that we can better understand the impact of your work with your patients. **Please reach out to your Support Coach when questions come up.**

CHW-SYSTIM REDCap Form 2 Refresher

This refresher resource reinforces documentation requirements and provides examples to support accurate completion of referral and follow-up records in REDCap.

CHW-SYSTIM REDCap Form 2 Refresher

REDCap Form 2 Refresher

As a reminder, REDCap *Form 2* is necessary for patients who a) consent to participate, b) screen positive for social needs, and c) want your help connecting with resources. This refresher is intended to provide additional guidance on how to document your work in the referral and follow-up stage of patient engagement within REDCap *Form 2*.

This is critical because **documentation in the REDCap database is the only way researchers can understand the work and effort CHWs put into the project** and reflect that in the study results.

This refresher document covers two key topics about REDCap *Form 2*:

1. Guidance on how to use the free text boxes in *Form 2*
2. How to know when you should mark *Form 2* as complete

Guidance on Free Text Boxes in REDCap Form 2

In this first section, there are two examples of how you might record information using the free text boxes in *Form 2: Referral and Follow-up*. While there is no one right way to record information using these text boxes, **here are some points we would like you to consider:**

- Knowing that you will often have multiple interactions with a patient as you refer them to resources and follow-up on referrals, **do NOT delete your previously recorded details**. Instead, add new details to the text box and include the dates for each new interaction.
- Describe the type of resource, referral, or support provided using the text box, as well as any barriers or challenges.
- You do not need to record the level of detail that you typically would in your EHR. Brief explanations are often suitable in REDCap. *Note: REDCap is a research tool and does not replace the documentation you normally do in your EHR.*

EXAMPLE 1

Example 1, Section 1: Documenting Details on Referrals

In this example, a CHW is documenting their work in the referral section of REDCap *Form 2*. The CHW is using the check boxes to indicate their referrals and the free text box to document their work. The CHW:

- Wrote enough detail about the type of resources provided and how they provided them to the patient to offer context on the social need referral check boxes selected in this section of *Form 2*.
- Did NOT get rid of the existing information they had in the text box. They added additional details about later referrals and support provided to the patient.
- Included the dates in the details they provided. This is helpful since they gave another referral to the patient at a later time and could use specific dates to indicate the different interactions.

On what date did you most recently try to connect the patient with resources to address their social needs?

* must provide value

05-23-2025 M-D-Y

Internal referrals to in-house health center resources.	Connected the patient with a referral database (e.g., Social Services Resource Locators such as "211info" or "Unite Us").	Gave the patient written (e.g., paper, text, MyChart) resources information based on a health center-maintained resources list.	Provided more personalized navigation support to connect patients directly with community resources.	The patient either did not want or need help with this issue.	There are no resources available for this need at this time.	Other
☐	☒	☐	☒	☐	☐	☐

Transportation need

* must provide value

Please type any additional details about the type of help you provided to the patient.

Used FindHelp to find resource for free rideshare vouchers and shared with patient on 5/1. However, patient found out she was not eligible for rideshare vouchers and we called her insurance together in office to connect her with medical transportation assistance on 5/23.

For reference, the CHW in this example used the referral check boxes in the following way:

- First, the CHW provided the patient with a referral for rideshare vouchers they found using FindHelp.org, an online database. The CHW selected the check box "Connected the patient with a referral database" as the best option and provided additional details in the free text box.
- After following up and finding out the patient was ineligible for that resource, they met with the patient in their office to help them connect with their insurance transportation assistance program. In addition to leaving the previously selected check box for the initial referral they provided, the CHW also selected the check box "Provided more personalized navigation support to connect patients directly with community resources."

Example 1, Section 2: Documenting Your Follow-Up Attempts and Interactions

In **Example 1, Section 1: Documenting Details on Referrals**, after providing the initial referral to rideshare vouchers, the CHW was able to follow up with the patient and document that in the follow-up section of *Form 2*. After referring this patient to additional transportation assistance on 05-23-2025, the CHW was unable to successfully follow up with them. Even if they did not contact the patient, the CHW still documented all attempted follow-ups with the patient. *Note: Since the patient could not be contacted after several unsuccessful attempts, the CHW marked REDCap Form 2 "Complete."*

What date did you last make contact with the patient? H 05-23-2025 📅 M-D-Y
* must provide value

No, the patient did not receive help and would still like help with this issue.	No, the patient did not receive help and no longer either needs or wants help with this issue.	No, the patient did not receive help and I have confirmed there is not a resource available for this need at this time.	Yes, the patient has received help for this need but still requires additional support.	Yes, the patient has received help for this need and no longer requires support.	I do not know the status of this need.
☐	☐	☐	☐	☐	☒

Did the patient receive help with: H Transportation needs reset
* must provide value

After actively working with the patient on follow-up activities, did you lose contact with them before finding out what ultimately happened with their resource connections? H ☐ No ☒ Yes reset

What, if any, barriers or challenges did the patient face in obtaining help for their social needs? H Expand

Please describe anything else you would like for us to know about connecting this patient to resources for their social needs. H Expand

Followed up with patient on transportation need in office after PCP visit on 5/23 and provided additional navigation support. Attempted to follow up by phone on 6/1, 6/16, and 7/4 and left voicemail (without a response).

Form Status

Complete? H Complete ▼

Even if you are not able to contact a patient, it is important to document your attempts to make contact. Otherwise, researchers will never know the effort you put into attempting outreach, and it will look like you never tried to follow up after providing a referral.

EXAMPLE 2

Example 2, Section 1: Documenting Details on Referrals

In this example with a different patient, the CHW documented the resources provided and how they were provided across multiple interactions in a different way than the CHW in **Example 1**. The CHW:

- Provided concise, yet helpful information on what and how referrals were provided to the patient in the free text box.
- Added to existing information, instead of deleting previously entered text/checked boxes.
- Included dates when they provided referrals or support to the patient in the free text box.

On what date did you most recently try to connect the patient with resources to address their social needs? M-D-Y

* must provide value

Please select all the types of help given to patient in response to their social needs identified on 04-15-2025
Note: only the needs that the patient screened positive for will be listed below.

	Internal referrals to in-house health center resources.	Connected the patient with a referral database (e.g., Social Services Resource Locators such as "211info" or "Unite Us").	Gave the patient written (e.g., paper, text, MyChart) resources information based on a health center-maintained resources list.	Provided more personalized navigation support to connect patients directly with community resources.	The patient either did not want or need help with this issue.	There are no resources available for this need at this time.	Other
Food need * must provide value		☒	☒	☒	☐	☐	☐
Medical costs need * must provide value		☒	☐	☐	☐	☐	☐

Please type any additional details about the type of help you provided to the patient.

5/1 – shared a referral from [FindHelp](#) for local food pantries. Agreed to follow up with patient in 2 weeks.

5/21 – since pt let me know they're ineligible for food pantry referrals, sent information on enrolling in SNAP benefits via MyChart and sent PCP food prescription referral request. Pt reported needing help paying for medical costs during call. Referred to internal pharmacy assistance program.

In this example, an additional social need (help with medical costs) was identified by the CHW during the referral and follow-up stage. To account for this, the CHW went back to REDCap Form 1 (Screening) and added Medical Costs to the patient's social needs screening, without changing the date of the original screening. **This is an example of how the screening, referral, and follow-up stages can be cyclical rather than linear.**

Example 2, Section 2: Documenting Your Follow-Up Attempts and Interactions

After providing the initial referral in this example, the CHW was not able to reach the patient and documented their follow-up attempt using the text box. At a later date, the CHW followed up with the patient to check if they received help with their social needs. In this example, the CHW:

- Documented both successful and unsuccessful follow-up attempts, as well as follow-ups initiated by the patient. In this case, the patient called the CHW in response to a voicemail.
- Included details of how the follow-up took place and dates of each follow-up and follow-up attempt.
- In this example, the patient still needs help with social needs. The CHW left the record incomplete to continue following up with the patient and providing additional support.

What date did you last make contact with the patient?	
05-21-2025 M-D-Y * must provide value	
	No, the patient did not receive help and would still like help with this issue. No, the patient did not receive help and no longer either needs or wants help with this issue. No, the patient did not receive help and I have confirmed there is not a resource available for this need at this time. Yes, the patient has received help for this need but still requires additional support. Yes, the patient has received help for this need and no longer requires support. I do not know the status of this need.
Did the patient receive help with: Food insecurity * must provide value	☐ ☒ ☐ ☐ ☐ ☐ ☐ reset
Did the patient receive help with: Medical costs * must provide value	☐ ☐ ☐ ☐ ☐ ☐ ☒ reset
After actively working with the patient on follow-up activities, did you lose contact with them before finding out what ultimately happened with their resource connections?	☐ No ☐ Yes reset
What, if any, barriers or challenges did the patient face in obtaining help for their social needs?	Expand
Please describe anything else you would like for us to know about connecting this patient to resources for their social needs.	5/14 – tried contacting pt to follow up on food resources but no answer. Left voicemail. 5/21 – pt called back in response to my voicemail and let me know they are ineligible for referrals and would like support connecting with other resources. They would also like help paying for their medications. 5/28 – called pt to follow up on pharmacy assistance program referral but was not able to leave voicemail.
Form Status	
Complete?	Incomplete

5

Should *Form 2* Be Marked Complete or Incomplete?

REDCap *Form 2* may be marked “Complete” for a patient when one or more of the following is true:

- All of the patient’s needs are met.
- The patient does not want or does not need further assistance from you with their social needs at this time.
- You have confirmed that no resources are available for the patient to address their social needs.
- They do not respond to you after multiple attempts to contact them.

Unless the patient is lost to follow-up, Form 2 should NOT be marked “Complete” if either of the following are selected:

- “No, the patient did not receive help and would still like help with this issue.”
- “Yes, the patient has received help for this need but still requires additional support.”

EXAMPLE 1

Example 1: Incomplete Form 2

In the next example, the CHW kept *Form 2* marked as “Incomplete.” Even though the patient received help for both social needs (food and transportation), they still wanted additional help with transportation. The CHW provided another referral at their most recent interaction and will follow up with the patient to see if that resource met their need before marking *Form 2* as complete.

What date did you last make contact with the patient?							
* must provide value		05-01-2025 M-D-Y					
		No, the patient did not receive help and would still like help with this issue. No, the patient did not receive help and no longer either needs or wants help with this issue. No, the patient did not receive help and I have confirmed there is not a resource available for this need at this time. Yes, the patient has received help for this need but still requires additional support. Yes, the patient has received help for this need and no longer requires support. I do not know the status of this need.					
Did the patient receive help with:							
Food insecurity		☐ ☐ ☐ ☐ ☒ ☐					
* must provide value		reset					
Did the patient receive help with:							
Transportation needs		☐ ☐ ☐ ☒ ☐ ☐					
* must provide value		reset					
After actively working with the patient on follow-up activities, did you lose contact with them before finding out what ultimately happened with their resource connections?		☐ No ☐ Yes					
		reset					
What, if any, barriers or challenges did the patient face in obtaining help for their social needs?							
		Expand					
Please describe anything else you would like for us to know about connecting this patient to resources for their social needs.							
		Expand					
Form Status							
Complete?		Incomplete					

EXAMPLE 2

Example 2: Complete Form 2

In the example above, the CHW later marked *Form 2* “Complete” because, even though not all of the patient’s social needs were met, they lost contact with the patient after several attempts to follow up after their most recent referral.

What date did you last make contact with the patient? M-D-Y
* must provide value

	No, the patient did not receive help and would still like help with this issue.	No, the patient did not receive help and no longer either needs or wants help with this issue.	No, the patient did not receive help and I have confirmed there is not a resource available for this need at this time.	Yes, the patient has received help for this need but still requires additional support.	Yes, the patient has received help for this need and no longer requires support.	I do not know the status of this need.
Did the patient receive help with: Food insecurity * must provide value	☐	☐	☐	☐	☒	☐
Did the patient receive help with: Transportation needs * must provide value	☐	☐	☐	☐	☐	☒
After actively working with the patient on follow-up activities, did you lose contact with them before finding out what ultimately happened with their resource connections?	☐ No ☒ Yes					
What, if any, barriers or challenges did the patient face in obtaining help for their social needs?	 Expand					
Please describe anything else you would like for us to know about connecting this patient to resources for their social needs.	 5/1 – followed up by phone. Patient confirmed they connected with food bank referral and no longer need food assistance. Patient connected with MedRide but would like additional help with transportation to physical therapy. 5/14 – tried to follow up by phone, no answer. Left voicemail. 5/28 – tried to follow up by phone, no answer. Left voicemail. 6/6 – sent follow up letter via MyChart					
Form Status						
Complete?	Complete					

Notice how the date they last made contact with the patient did not change since their first follow up on 05-01-2025. CHWs should only update the date of last contact when they successfully make contact with the patient.

Health Center-Facing CHW-SYSTIM FAQs

This resource provides answers to common questions about the CHW-SYSTIM study, including project goals, participant roles, and Health Center expectations.

English FAQs Sheet

This handout provides an English-language overview of the study and answers to frequently asked questions from Health Center staff.



CHW-SYSTIM Research Study FAQs

Q1 What does CHW-SYSTIM stand for?

Community Health Workers Systematically assessing and addressing social determinants of health To Improve outcomes in community-based health centers.

Q2 What are the goals and activities of the CHW-SYSTIM research study?

The CHW-SYSTIM research study aims to support people living with diabetes and high blood pressure at community health centers. In this study, Community Health Workers (CHWs) screen patients for social needs and strive to get them the necessary help. All patients verbally consent before taking part in the study. Patients who verbally consent to participate receive an information sheet describing the project and who to contact if they have questions.

Q3 Why is the study important?

Learning about whether and how CHW-led social needs efforts improve patients' experiences and health outcomes could a) inform health centers' approaches to social needs management, and b) inform payment policies supporting CHWs.

Q4 What organizations are involved?

This study is funded by the National Institutes of Health. The organizations leading the study are Morehouse School of Medicine and OCHIN. Our health center is one of 12 organizations implementing the CHW-SYSTIM intervention. Intervention health centers come from 9 states (AL, CA, FL, GA, HI, MA, MS, NC, TX) and Puerto Rico.

Q5 Who is involved in the study from our health center?

Each health center implementing the CHW-SYSTIM intervention has a Champion and at least one CHW working on the project. Please reach out to them if you have any questions:

CHW(s):

Champion:

Q6 What if I get a question from a patient about the CHW-SYSTIM study?

Please contact your health center's Champion and CHW(s) to get the patient the answers or information that they need.

Q7 What if I have questions for the CHW-SYSTIM study team?

If you have any questions that neither your health center's Champion nor CHW(s) can answer, please reach out to Anna Steeves-Reece, steevesreecea@ochin.org.



Spanish FAQ Sheet

This handout provides a Spanish-language overview of the study and answers to frequently asked questions from Health Center staff.



Preguntas Frecuentes Sobre el Estudio de CHW-SYSTIM

P1 ¿Qué significa CHW-SYSTIM?

Son las siglas en inglés de Community Health Workers **S**YStematically assessing and addressing social determinants of health **T**o **I**Mprove (CHW-SYSTIM) outcomes in community-based health centers, es decir, Promotores de Salud que Evalúan y Abordan Sistemáticamente los Determinantes Sociales de la Salud para Mejorar los Resultados En los Centros de Salud Comunitarios.

P2 ¿Cuáles son los objetivos y actividades del estudio de CHW-SYSTIM?

CHW-SYSTIM tiene como objetivo apoyar a las personas que viven con diabetes e hipertensión en los centros de salud comunitarios. En este estudio, los Promotores de Salud (CHW) evalúan a los pacientes para conocer sus necesidades sociales y se esfuerzan por brindarles la ayuda necesaria. Todos los pacientes dan su consentimiento verbal antes de participar en el estudio y reciben una hoja informativa que describe el proyecto y a quién contactar si tienen preguntas.

P3 ¿Por qué es importante el estudio?

Conocer si los esfuerzos de necesidades sociales llevados a cabo por los CHW mejoran las experiencias y los resultados de salud de los pacientes y cómo podrían a) informar sobre los enfoques de los centros de salud para la gestión de las necesidades sociales, y b) informar sobre las políticas de pago que respaldan a los CHW.

P4 ¿Qué organizaciones están involucradas?

Este estudio está financiado por los Institutos Nacionales de Salud. Las organizaciones que lideran el estudio son Morehouse School of Medicine y OCHIN. Nuestro centro de salud es una de las 12 organizaciones que implementan la intervención CHW-SYSTIM. Los centros de salud que forman parte de la intervención provienen de 9 estados (AL, CA, FL, GA, HI, MA, MS, NC, TX) y Puerto Rico.

P5 ¿Quién participa en el estudio desde nuestro centro de salud?

Cada centro de salud que implementa la intervención CHW-SYSTIM tiene un Campeón y al menos un CHW trabajando en el proyecto. Comuníquese con estas personas de nuestro centro de salud si tiene alguna pregunta:

Promotores:

Campeón:

P6 ¿Qué pasa si tengo preguntas para el equipo del estudio de CHW-SYSTIM?

Si tiene alguna pregunta que ni el Campeón ni los CHW de su centro de salud puedan responder, comuníquese con Anna Steeves-Reece, steevesreecea@ochin.org



CHW Training Evaluation Survey Template

This survey template collects Community Health Worker feedback on training content, delivery, and support needs to inform continuous improvement efforts.

Survey Description

The purpose of this survey is to receive ongoing feedback from CHWs about their experience participating in the 3-month CHW-SYSTIM training to prepare them for implementing the intervention. The survey will be administered five times during the training period, following each module. The training team will review deidentified survey responses for the purpose of improving the training, when feasible. Only one team member will have access to the full survey responses, and that individual will let the training team know if a CHW requests support with technology.

CHW-SYSTIM Training Evaluation Survey

Thank you for taking the time to complete this survey about your experience with Module [Module Number] of the CHW-SYSTIM training. Your feedback helps us to understand how we can best support your learning during the training period.

The survey should take less than 5 minutes to complete. Your full responses, which include your name, will only be seen by [Staff Member]. Deidentified survey responses, which do not include your name, will be shared with the training team. [Staff Member] will tell the training team to reach out to you if you request support with technology.

Please contact [Staff Member, Email] with any questions.

Please answer the following questions about Module [Module Number, Title] of the CHW-SYSTIM training:

1. First and last name: _____
2. Please share one thing that you learned during this training module that was new to you or one thing you already knew that was reinforced. _____
3. What, if anything, is currently working well in the training? _____
4. What could be improved about the training? _____
5. What additional training resources or support would be helpful?

6. Please rate how strongly you disagree or agree with the following statements. Answer types include strongly disagree, disagree, agree, strongly agree.

(a) I felt comfortable expressing myself if I had something to say or ask.

(b) I feel confident in teaching what I learned to someone else.

7. Do you need any support with technology?

☐ No

☐ Yes. If yes, please explain: _____

8. Is there anything else you would like to share with us? _____

CHW Skillset Resume Builder Sheet

This tool helps Community Health Workers identify, document, and communicate the skills and experience gained through participation in the CHW-SYSTIM project.

Your CHW-SYSTIM Resume Builder

Thank you for serving as a Community Health Worker for the CHW-SYSTIM research study! Through your role and activities on this project, you have demonstrated learning and commitment in the areas of whole-person care and the ethical conduct of research.

Below are some examples you could use to describe your work on this project for things like your resume, performance reviews, or conversations about strengthening CHW roles in your health center.

New & Strengthened Skillsets*

Social & Whole-Person Care

- Quickly building rapport with patients
- Multimodal empathic communication
- Screening patients for social needs, like transportation, housing, and food
- Problem-solving and analytical skills to identify solutions for patients' unique needs
- Flexibility and adaptability to meet patients where they are at
- Networking and building relationships with community-based organizations
- Using the EHR to support and document social care activities
- Empowering patients by supporting their self-efficacy and engagement in their own care

Additional Skillsets

- Strong collaboration with colleagues
- Communicating with different audiences
- Continuous improvement of workflows and practices based on iterative learning
- Sustained creativity and persistence
- Managing time and balancing competing health center priorities
- Resiliency and "rolling with" barriers, challenges, and rejection

Ethical Conduct of Research

- Identifying and confirming whether a person is eligible for a research study
- Outreaching to eligible patients, describing a research study in a layman's terms, and completing informed consent activities
- Regularly documenting research-related data in both Excel and REDCap
- Cross-training health center colleagues on research study activities



* New and strengthened skillsets were identified by CHW-SYSTIM CHWs, Champions, and Practice Coaches at the final CHW Learning Collaborative on 2/3/2026

Onboarding & Training Plans for Adding New CHWs/Champions

This resource outlines onboarding activities, training requirements, and transition procedures for replacing or adding project staff during implementation.

Background:

All health centers in the CHW-SYSTIM research study identified a Champion and at least one CHW to oversee and implement all project activities, respectively. From February through April 2025, these individuals will complete multiple activities to ensure that they are oriented to the project and able to successfully carry out the intervention, which will begin in May 2025. Through synchronous and asynchronous training activities, intervention health centers will demonstrate their learning and commitment in the areas of patient-centered social needs screening and referral, and the ethical conduct of research. *In the likely case of either Champion or CHW attrition, the following activities should be carried out within two weeks of health center staff turnover to facilitate a prompt continuation of the intervention while maintaining its integrity.*

Table 3. Champion Attrition Response Plan

This table outlines the activities and responsible parties involved in onboarding a new Champion and maintaining project continuity following Champion turnover.

Person Responsible	Activity
CHW-SYSTIM Coordinator	• Document date and reason former champion Gray officially left the project • Add new Champion name and email address to contact list • Send welcome/orientation email to new Champion, outlining key upcoming activities to get them oriented to the project • Remove SharePoint access for former Champion • Grant SharePoint access to new Champion

	• Schedule CHW-SYSTIM Onboarding Meeting with new Champion, health center CHW(s), study staff, and Support Coach • Send new Champion standing calendar invite to CHW-SYSTIM Office Hours
Intervention & Training Co-I	• Work closely with CHW-SYSTIM Coordinator and the health center's Support Coach to ensure all attrition plan activities are carried out • Clear and timely communication with MPIs about Champion attrition to ensure all partners are aware of changes/can provide input on next steps • Adapt CHW-SYSTIM Onboarding Meeting slides to fit the timing of the Champion turnover and the health center's context
Support Coach	• Schedule orientation meeting with new Champion • Support Coach/new Champion meeting activities should include: • Ensuring new Champion has access to SharePoint and orienting them to relevant resources and materials (i.e., Patient Outreach Tracking Sheet, Patient Enrollment & Screening Guide, REDCap User Guide, and Written Consent Forms) • Orienting new Champion to where things are currently at with the intervention, how things are going at the health center, and any next steps to keep the intervention (or get the intervention back) on track • Ensure that planned Support Coach/health center meetings now include new Champion on calendar invites

CHW Attrition

Note: The activities below apply to situations where the primary CHW leaves the project. If the health center is adding an additional CHW to the project, the expectation is that the primary CHW and Champion will orient them to SharePoint folders, study materials, and current workflows. See the Appendix for the steps that should be followed if an additional CHW is joining the project.

Activities for new CHWs to complete within 2 weeks of joining the project:

- Meet with Support Coach & Champion to get oriented to the project/be clear on next steps (within 1 week)
- Complete CIRTification training & email certificate to CHW-SYSTIM Coordinator (within 1 week)
- Review all workbook activities that former CHW completed during the training (within 2 weeks)
- Review slide decks from all CHW-SYSTIM training weeks in the folder “1. Resources” (within 2 weeks)
- Watch recordings for the following CHW-SYSTIM training weeks: 3, 4, 6, 8, 10, 11 (within 2 weeks)
- Before implementing the intervention, meet with Support Coach & Champion to walk through the workflow and get any questions answered regarding patient consent, Patient Outreach Tracking Sheet, Documentation in REDCap, or anything else (within 2 weeks)

Table 4. CHW Attrition Response Plan

This table outlines the activities and responsible parties involved in onboarding a new Community Health Worker and supporting a seamless transition into ongoing project activities.

Person Responsible	Activity
CHW-SYSTIM Coordinator	• Gray out former CHW on “Support Coach Sheet” and add note about the date they officially left the project

	• Add new CHW name and email address to “Support Coach Sheet” • Send welcome/orientation email to new CHW, outlining key upcoming activities to get them oriented to the project • Remove SharePoint access for former CHW • Grant SharePoint access to new CHW • Send new CHW standing calendar invite to CHW Learning Collaborative meetings and CHW-SYSTIM Office Hours
Intervention & Training Co-I	• Work closely with CHW-SYSTIM Coordinator and the health center’s Support Coach to ensure all attrition plan activities are carried out • Clear and timely communication with MPIs about CHW attrition to ensure all partners are aware of changes/can provide input on next steps
Support Coach	• Schedule orientation meeting with new CHW and Champion • Support Coach/new CHW meeting activities should include: ○ Ensuring new CHW has access to SharePoint and orienting them to relevant resources and materials (i.e., Patient Outreach Tracking Sheet, Patient Enrollment & Screening Guide, REDCap User Guide, and Written Consent Forms) ○ Orienting new CHW to where things are currently at with the intervention, how things are going at the health center, and any next steps to keep the intervention (or get the intervention back) on track • Ensure that planned Support Coach/health center meetings now include new CHW on calendar invites

	• Schedule and conduct one more meeting with the CHW and Champion before they begin implementing the intervention to ensure that they understand the project and have all their questions answered
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Support Coaching

Support Coaching Plan

This plan defines the role, responsibilities, activities, and expectations of Support Coaches supporting Health Centers throughout the project.

Plan Purpose

The purpose of this document is to have a unified understanding of what it means to be a Support Coach for the NCPCR CHW-SYSTIM project by clearly defining the role and its expectations as well as outlining the core activities NCPCR Support Coaches can anticipate taking part in within the scope of their role.

NCPCR Support Coach Definition

Support Coaches work directly with CHWs and Champions, providing tailored guidance, tools, and coaching to help Health Centers operationalize new knowledge and drive meaningful change (i.e., project intervention).

They are skilled professionals in facilitating change management and strengthening the capacity of individuals and teams to identify and implement relevant solutions and sustain new processes.

Support Coach Expectations

Within the context of the NCPCR CHW-SYSTIM project, there are five key expectations of an NCPCR Support Coach:

- **Individualized Support:** Provide monthly coaching support to CHWs and Health Center Champions for intervention-related objectives during the training and intervention periods of the project

- **Ongoing Communication and Connection:** Engage in ongoing communication and serve as main point of contact for CHWs outside of meetings for NCPCR
- **Ongoing Learning and Adaptation:** Understand intervention tools to provide coaching support to health centers
- **Documentation and Reporting:** Promote shared/continuous learning among training team
- **Data Use and Feedback:** Support CHWs in using data to inform interventions

To ensure alignment in how these expectations are demonstrated across all Support Coaches, this plan has outlined general activities of Support Coaches along with standard outcome measures that demonstrate engagement in each.

- *Expectation 1: Individualized Support.*

Provide monthly coaching support to CHWs and Health Center Champions for intervention-related objectives during the pre-intervention and intervention periods of the project.

Table 5. Individualized Support Activities and Outcome Measures for Support Coaches

This table describes the core activities and expected outcomes associated with providing individualized coaching support to CHWs and Champions throughout the project.

Activity	Outcome Measures
Facilitate kick-off and subsequent 1:1 meetings with CHW and Champion on a monthly basis	• I hold my first meeting with Health Centers in February 2025 and communicate any request for support from the project's Training Coordinator in scheduling this meeting by the time training has begun

	• During the 3-month training period, I schedule and meet with CHWs and Champions together monthly to build rapport, ensure they are working through all training activities, and accessing/understanding intervention tools. • During the intervention period, I meet with CHWs and Champions together monthly to provide coaching support and ensure they are making progress toward project objectives.
Ad hoc support outside of monthly meetings, as needed	• I respond to CHW, Champion, and other project-related communications (e.g., emails) within 2 business days of receiving them. If I am out of office, I ensure there is a plan for the Health Centers I am working with to get their questions or concerns addressed from another member of the study team. • I send a “check-in” email between meetings to those CHWs/Champions who need more support in progressing or are less engaged as a way to adjust my coaching approach to meet the differing needs of Health Centers.
Engage in Intervention check-ins (review survey results, reach out as indicated)	• I review Intervention survey results within 2 business days of receiving them from data team. • I understand each CHW’s engagement in screening and referral activities and whether additional support is needed by reviewing their Intervention survey responses. • Based on my review of REDCap surveys, I reach out to CHWs or Champions outside of scheduled 1:1 meetings, as indicated, or otherwise use survey results to adapt coaching, troubleshoot issues, or request support from Subject Matter Experts.

Review individual CHW/Health Center baseline information, progress updates, and Health Center context that may influence intervention	• Prior to coaching engagements, I review available information on Health Centers and relevant updates to make my interactions more efficient and effective. • My approach to support coaching varies across Health Centers based on my understanding of each Health Center’s context.
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• *Expectation 2: Ongoing Communication and Connection.*

Engage in ongoing communication and serve as main point of contact for CHWs outside of meetings for NCPCR.

Table 6. Ongoing Communication and Connection Activities and Outcome Measures

This table describes how Support Coaches maintain communication, provide follow-up support, and connect Health Center teams with resources and subject matter experts.

Activity	Outcome Measures
Communicate with CHWs and Health Center Champions outside of monthly meetings	• I communicate before and after regularly scheduled meetings to provide CHWs and Champions with reminders, agendas, meeting notes, and follow ups to support clarity, accountability, and communication across coaching engagements.
Connect CHWs and Champions to Subject Matter Experts and resources as indicated	• During or after my interactions and communications, I respond to the needs and requests of CHWs/Health Centers and connect them to the appropriate or relevant stakeholder, Subject Matter Expert, and/or resources.

	• When appropriate, I attend meetings between Health Centers and Subject Matter Experts or other stakeholders to gather and provide helpful insights and serve as a convener as needed.
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• *Expectation 3: Ongoing Learning and Adaptation.*

Understand intervention tools in order to provide coaching support to Health Centers.

Table 7. Ongoing Learning and Adaptation Activities and Outcome Measures

This table outlines activities that help Support Coaches develop project knowledge and apply lessons learned to support Health Centers effectively.

Activity	Outcome Measures
Attend CHW training and learning collaborative sessions	• I engage in the live CHW training sessions to learn necessary project knowledge and context, support breakout groups, and build rapport with Health Centers. I bring the content from those sessions into my coaching support with CHWs and Champions. • If I cannot attend a training session, I inform the Training Coordinator and watch the session recording within 1 week to stay on track with the CHW training schedule. • I attend monthly learning collaborative sessions during the project's intervention and follow up periods to stay current on what CHWs across practice-based research networks are learning and experiencing.
Engage in coaching-focused support meetings with training team	• I attend monthly training team meetings to further my project-related knowledge (e.g., intervention tools), learn project updates, and share promising practices with other coaches. If I am unable to attend a meeting, I reach out to the meeting organizer.

- *Expectation 4: Documentation and Reporting.*

Promote shared and continuous learning among the training team.

Table 8. Documentation and Reporting Activities and Outcome Measures

This table summarizes expectations for documenting coaching engagements and sharing insights to support continuous learning across the project team.

Activity	Outcome Measures
Document engagements and insights from Health Center meetings	• I regularly track my notes from interactions with CHWs and Champions in a standard template in SharePoint that are concise yet detailed enough such that I, other coaches, and members of the training team can understand what has taken place in my work with a Health Center and learn from any insights gained. • I document meeting summaries during my coaching engagements and share them with the CHW and Champion after each coaching session to clarify action items, track progress, and improve accountability.

- *Expectation 5: Data Use and Feedback.*

Support CHWs and Champions in using data to inform interventions

Table 9. Data Use and Feedback Activities and Outcome Measures

This table outlines how Support Coaches use data review and audit-and-feedback strategies to support Health Center implementation and performance improvement.

Activity	Outcome Measures
Engage in audit and feedback to help Health Center teams to achieve outreach and enrollment objectives	• During the intervention period, I review outreach and enrollment data with CHWs and Champions to provide targeted information that allows them to understand the data being shared, track progress towards goals, and adjust their performance accordingly.

	• I communicate with the project's data team to gather and review outreach and/or enrollment data in an appropriate format prior to 1:1 meetings with CHWs and Champions in order to provide feedback that is clear and actionable. • I do not use data to judge or shame Health Centers– rather, I use it to help them identify potential gaps, areas of strength to build on, and motivation and knowledge for Health Centers to implement their intervention most effectively.
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- *Support Coaching Engagement Outline*

Below is an Engagement Outline in support of the Coaching Support Plan described above. This Engagement Outline provides more detailed content in support of the activities Coaches are expected to engage in throughout the NCPCHW-SYSTIM project.

Table 10. Pre-Intervention Support Coaching Engagement Outline

This table provides an overview of key coaching activities and content delivered during the onboarding and training phases of the project.

Meeting / Activity	Content
Attend pre-intervention CHW training sessions	CHW Training Schedule:
Review individual CHW/ Health Center baseline information, progress, updates, Health Center context that may influence intervention	Examples of Initial Data Available to Review:
Facilitate kick-off meeting with CHW and Champion	Example Agenda (60 minutes):

Facilitate subsequent 1:1 meetings with CHW and Champion on a monthly basis	Example Agenda (60 minutes):
Facilitate transition to intervention meeting	Training to Intervention Transition Week:
Document engagements and insights from CHW/Champion meetings	Purpose: For Support Coaches to track updates as they engage with Health Centers in a format that allows for shared learning and transparency.
Engage in coaching-focused support meetings with training team	Purpose: Provide a dedicated opportunity for Support Coaches to ensure they have the appropriate project-related knowledge and updates, are on track with their practice support, and can share and learn promising practices with one another.

Table 11. Intervention-Period Support Coaching Engagement Outline

This table summarizes coaching activities, discussion topics, and implementation support provided during the intervention period.

Meeting / Activity	Content
Facilitate intervention kick-off meetings with CHW and Champion	Example Agenda (60 minutes):
Facilitate Subsequent Monthly Meetings with CHWs and Champions	Description: Greetings; Review enrollment numbers; Discuss any questions and/or barriers; Identify opportunities for improvement and best practices; Recap discussion and outline next steps.

Engage in audit and feedback to help health center teams to achieve outreach and enrollment objectives	Audit and Feedback Definition: A strategy used by coaches to motivate change and improvement. It is a summary of the performance of a Health Center over a specified period aimed at providing targeted information (e.g. on patient outreach, project enrollment) – in this case to a CHW and Champion - to allow them to assess and adjust their performance.
Engage in Intervention check-ins (review survey results, reach out as indicated)	Description: Automated check-in surveys, emailed to CHWs
Engage in coaching-focused support meetings with training team	Purpose:
Document engagements and insights from Health Center meetings	Purpose: For CHWs to track updates as they engage with health centers in a format that allows for shared learning and transparency.
Attend learning collaborative	Purpose: Opportunity for CHWs to share what is going well, and how to find solutions as challenges arise; Place for sharing any needed refreshers with CHWs (e.g., REDCap data collection)

Support Coach/CHW 1:1 Meeting Sample Agenda

This template provides a structured format for coaching meetings focused on project progress, implementation support, and action planning.

Table 12. Support Coach and CHW Meeting Agenda Template

This table provides a structured agenda and documentation tool for recurring coaching meetings between Support Coaches, CHWs, and Champions.

Meeting Date:		
Meeting Attendees:		
Topics	Agenda Items	Notes
<u>CHW Updates</u> <i>What activities have taken place since the last meeting?</i>		
<u>Project Progress</u> <i>Are tools being used as expected? Are they on track?</i>		
<u>Audit and Feedback</u> <i>What data was reviewed?</i>		
<u>Coaching Check-In</u> <i>What accomplishments, successes, challenges, or risks have emerged?</i>		
<u>Next Steps</u> <i>What do they plan to do between now and the next meeting?</i>		
<u>Resources, Supports</u> <i>Any resources, SMEs, etc. needed for support?</i>		

Table 13. Support Coach and CHW Action Item Tracker

This table is used to document action items, ownership, and follow-up activities identified during coaching meetings.

Action Item (what, when, how)	Owner (who)

Support Coach Activities Templates

This workbook-style tool serves as a centralized location for documenting coaching activities, tracking Health Center progress, recording meeting notes, and accessing key project resources.

Figure 3. Support Coach Activities Template Workbook

Screenshot examples of the Support Coach Activities Template used to document coaching engagements, monitor Health Center progress, and provide access to project resources and reference materials.

Support Coach / Health Center Activities Workbook												
Support Coach Name:												
Support Coach PBRN:												
Health Center Name	Introductory Mtg Feb	Mid-Training Mtg Mar	Training Closeout Apr	Check-In May	Check-In Jun	Check-In Jul	Check-In Aug	Check-In Sep	Check-In Oct	Check-In Nov	Check-In Dec	Total
	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0
0 = Not Completed 1 = Completed												
SUPPORT COACHING RESOURCES:												
1. Support Coaching Workspace (contains items below) - LINK												
2. Support Coaching Plan (role, activities) - LINK												
3. Agenda Template for Health Center Meetings - LINK												
4. See "Support Coach" tab of this sheet for up-to-date info about the health centers you're working with and activities they've completed - LINK												
5. CHW Training Session Attendance Excel Sheet - LINK												
6. CHW Training Evaluation Survey Folder - LINK												
7. Intervention Check-In Survey Folder - LINK												
8. Learning Collaborative Survey Folder - LINK												
9. "1. Resources" (training recordings & slides) - LINK												
10. Add links to your health center folders, here:*												
* Health center folders contain the CHWs' Training Workbooks. Review to see whether CHWs are completing their weekly activities.												

CHW Name(s):	
Champion Name(s):	

Meeting Type	Meeting Date	Attendee Names	General Meeting Notes	Training Updates <i>Is the CHW attending trainings & completing activities? If not, what is the plan to do so?</i>

[illegible][illegible]