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Enabling Trusted Messengers Within the Community Health Information Ecosystem

Learning What Works to Foster Trusted and Effective Communication Channels

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EXECUTIVE SUMMARY

This report responds to a growing recognition that community health workers (CHWs) are essential to public health communication yet are often expected to navigate fragmented and fast-changing information environments without the infrastructure needed to support them. Based on best practice models for CHW service delivery and key stakeholder interviews and focus groups, this assessment examined how health-related information is created, validated, translated, shared, and acted upon among CHWs in Cook County, IL, and explored what can be done to strengthen the broader systems in which they work.

Across the landscape assessment and stakeholder engagement, a consistent set of findings emerged. CHWs are among the most trusted communicators in the health and social service system because of their relationships, cultural alignment, language access, and lived experience. At the same time, the systems around them have yet to provide coordinated, validated, and sustainable support for the role they already play.

CHWs receive information through a highly distributed mix of employers, supervisors, public health communications, associations, peer networks, listservs, and community contacts. They often must verify information independently, adapt it for community use, and navigate outdated or incomplete resource information while also responding to urgent service needs. The report finds that communication challenges are inseparable from broader workforce and service realities. Trust is undermined when information is inaccurate, referrals fail because services are unavailable, and CHWs are asked to carry the strain of fragmented systems with inadequate support.

The assessment findings note that strengthening the CHW information ecosystem does not require a single new model. Instead, stronger performance is needed across several core functions: trusted message validation, timely dissemination, multilingual and culturally grounded adaptation, resource verification, visible service availability, feedback loops, and workforce support. Cook County has significant assets that can be aligned across these functions, including public health departments, health systems, CHW associations and networks, training institutions, community-based organizations, digital referral platforms, and cross-sector conveners.

This report outlines several plausible structural pathways for doing so, including public health-anchored coordination, neutral backbone support, association-led dissemination, and network governance. It recommends a near-term focus on reducing CHW burden and improving reliability through practical communication routines, validation processes, peer learning, and transparent referral information, alongside longer-term efforts to build durable cross-sector infrastructure, shared governance, sustainable financing, and improved accountability for how community knowledge is disseminated, received, and used.

Strengthening the CHW information ecosystem is not a discrete communications project, but rather a broader trust-building, workforce strengthening, and health equity improvement strategy. CHWs already serve as trusted communicators, translators, navigators, and sources of community intelligence. What is required now is coordinated action by public agencies, healthcare organizations, employers, community-based partners, CHW associations, and funders to ensure that the systems around these client advocates and caregivers are organized to support that role. The following report defines the CHW information ecosystem, describes the current landscape and stakeholder perspectives, and presents recommendations for coordinated action.

Now is the time to move from recognition to action. By aligning existing assets, investing in shared infrastructure, and implementing the recommendations in this report, Cook County can build a more accurate, responsive, equitable, and durable information ecosystem—one that strengthens both community trust and institutional responsiveness, with the overall objective of improving access to care and health outcomes in communities.

BACKGROUND

Community health workers (CHWs) play a central role in how health information reaches communities. They translate complex guidance, connect individuals to services, and help people navigate systems that may otherwise feel inaccessible or untrustworthy. They also convey critical insights about emerging needs, barriers, and community concerns. Across a range of roles—from street-based outreach to clinic-based collaboration—CHWs are essential to public health communication, and their effectiveness depends not only on relationships, but also on the strength of the broader information ecosystem that supports their work.

For CHWs to function effectively within this bidirectional communication role, they need adequate training, compensation, organizational support, and timely access to accurate, usable information. Strengthening the CHW information ecosystem can help bridge the gap between community trust and system responsiveness by making CHWs more visible and better supported across funding, policy, and operational contexts—without distancing them from the communities they serve. Done well, it can reinforce CHWs as community-based professionals equipped with the tools, training, and infrastructure needed to sustain their work while protecting their core role as trusted messengers, advocates, and relationship builders.

The need for a robust CHW information ecosystem has become increasingly urgent. The health information landscape is now more complex, fragmented, and fast-moving. According to the Pew Research Center, trust in national news outlets has eroded and people of all ages in the United States are increasingly turning to local news organizations and social media sites.[1] At the same time, local news sources are declining.[2] For Black and Brown populations often served by CHWs, this erosion of the communications infrastructure is often compounded by barriers to digital information, leading researchers to call for access to the internet and other elements of communications infrastructure to be considered a social determinant of health.[3] Meanwhile, the volume and velocity of information, and misinformation, is growing.

CHWs are often expected to interpret rapidly changing guidance, respond to misinformation, and tailor communications across diverse community contexts, frequently without consistent infrastructure or institutional support. At the same time, many investments in health communication and workforce development remain fragmented across sectors, technologies, and organizations. Information systems are often not designed with CHW workflows, community realities, or multidirectional communication needs in mind.

As a result, CHWs may be left to improvise in environments where information is inconsistent, overwhelming, difficult to validate, or disconnected from community priorities. When they are ineffectively supported to advocate for the communities they represent, they can lose trust and credibility within the communities they serve.

Organizational Framework: Locating Health Information Flow Within the Broader CHW Ecosystem

State and federal policy frameworks describe CHW systems as spanning training, certification, Medicaid reimbursement, partnerships, and cross-agency strategies, reflecting a broader, interconnected infrastructure versus a stand-alone workforce. Consistent with that view, this assessment defines the "CHW information ecosystem" as the interconnected network of people, organizations, systems, and coordination structures that shape how health-related information is produced, validated, translated, communicated, used, and acted upon through CHWs.

Within this ecosystem, CHWs are more than recipients or transmitters of information. They function as multidirectional intermediaries who translate and contextualize information for communities; surface community concerns, misinformation trends, resource gaps, and service barriers; adapt communication based on culture, language, trust, and lived experience; and provide feedback to organizations and systems on how information is received, understood, and acted upon.

The ecosystem includes both formal and informal infrastructure. Formal infrastructure includes public health guidance and messaging systems, workforce training and supervision systems, organizational communication practices, referral and resource networks, digital tools and platforms, funding structures, and governance or coordination mechanisms. Informal infrastructure includes peer networks, community relationships, and the relationship-based channels CHWs use to verify and adapt information in real time.

The effectiveness of the CHW information ecosystem depends on several core functions: information validation, message synthesis, dissemination, translation and cultural adaptation, resource verification, multilingual communication, feedback and learning loops, workforce support, and trust-based relationships. When these functions are coordinated and adequately supported, CHWs are better equipped to share accurate, usable information with communities and elevate community experience back to organizations and systems. When these functions are fragmented or left to CHWs to manage individually, the burden of interpretation, verification, translation, and feedback falls disproportionately on the CHW workforce.

This framework is used throughout the report to examine the state of CHW information flow, identify gaps and barriers, and assess opportunities to strengthen the ecosystem without assuming that a single new platform, hub, or organization is the only solution.

Within the broader CHW information ecosystem, this assessment applies a socioecological framework as the primary organizing structure for examining how information flow and communication challenges operate across multiple, interconnected levels. This approach recognizes that communication is shaped not only by individual knowledge, skills, or behavior, but also through relationships, organizational practices, community networks, and broader policy and system conditions.

The Socioecological Framework

The socioecological framework was used to inform the landscape scan, stakeholder interview and focus group questions, thematic analysis, and recommendations. It helped organize findings across the following five levels:

1. **Individual Level:** CHW skills, experience, training, confidence, information needs, and capacity to interpret, validate, translate, and share health-related information.
2. **Interpersonal Level:** Relationships between CHWs, supervisors, peers, community members, trusted messengers, and informal networks that influence how information is accessed, trusted, verified, and shared.
3. **Organizational Level:** Employer-based communication practices, supervision structures, internal workflows, referral systems, training practices, leadership engagement, and organizational processes for receiving and acting on CHW feedback.
4. **Community and Network Level:** CHW associations, learning collaboratives, community-based organizations, local health departments, faith-based partners, resource networks, and cross-sector partnerships that shape how information moves within communities and organizations.
5. **Systems and Policy Level:** Public health guidance systems, Medicaid-related implementation, certification and workforce policy, funding structures, digital referral platforms, and regional or statewide coordination infrastructure that influence the information that is available, how quickly it changes, and how consistently it reaches CHWs.

This framework was useful to identify where communication breakdowns occur and how system-level conditions affect CHW effectiveness. For example, CHWs may have strong individual communication skills and trusted community relationships but still face barriers when resource information is outdated, eligibility rules change rapidly, service availability is limited, or organizations lack formal pathways for CHWs to elevate community insights.

The framework guided recommendations to prioritize building shared infrastructure over relying on CHWs to address systemic gaps alone. Opportunities include improvements in validation, translation, dissemination, resource verification, feedback loops, workforce support, and coordination across public health, healthcare, community-based organizations (CBOs), workforce entities, and funders.

Strengthening how information reaches CHWs is therefore not only a communications challenge. It is a workforce strategy, a trust-building strategy, and a health equity strategy.

PURPOSE OF THIS ASSESSMENT

Against this backdrop, ensuring accuracy, relevance, and usability of health information cannot rest solely with CHWs. Strengthening the CHW information ecosystem requires shared responsibility across public health, health systems, CBOs, workforce entities, and public and private funders.

This report is intended to inform that shared effort by identifying where focused investment, coordination, and infrastructure could strengthen the creation, validation, and flow of health information in ways that support CHWs and the communities they serve.

To support that goal, the report examines the following:

1. How health information reaches CHWs
2. How CHWs share information with community members and elevate community insights back to organizations
3. Where communication breakdowns and misinformation risks emerge
4. Which infrastructure, investments, and coordination models could strengthen trusted bidirectional information flow

METHODS

This analysis was designed to inform CHW communication and integration planning with a focus on Cook County, IL, as well as related efforts by public health agencies, funders, payers, and other state and local health departments seeking to strengthen the role of CHWs as trusted community liaisons.

Health Management Associates (HMA) first conducted a landscape scan that included a literature review related to CHW communication methods (see Appendix D). This analysis identified best practices and models that have been designed to promote CHW communications, which informed the questions asked during four key informant interviews and six focus groups conducted in January–April 2026 (see Appendix E). Participants included CHWs,

CHW supervisors, organizational leaders, and representatives from entities responsible for CHW-related research, training, and advocacy. CHWs and CHW employers represented service areas within Chicago and Cook County, Lake County, and statewide. While the primary focus of this analysis is within Cook County, stakeholder engagement intentionally included a select group of statewide and regional representatives, including organizations serving broader Illinois geographies and neighboring counties such as Lake County. These participants were included because they play an important role in shaping the systems, policies, workforce training, communication channels, and resource infrastructure that directly influence how health information reaches CHWs in Cook County. Their perspectives helped contextualize local findings within the broader Illinois CHW landscape and identify existing models, infrastructure, and best practices that may be relevant for Cook County implementation considerations. See Appendix C for a complete list of stakeholders.

Findings were analyzed thematically to identify information pathways, trusted sources, validation practices, upstream feedback mechanisms, misinformation risks, and infrastructure opportunities. Recommendations for next steps were developed based on stakeholder input, community assets, and identified best practice models.

This assessment was qualitative and designed to inform planning rather than produce statistically representative findings. Limitations to this process included the compressed timeline and reliance on a sample of informants who were already convening for purposes of information sharing. Further, the focused geography and urban lens may limit generalizability of these findings, which should be interpreted as a snapshot of stakeholder experience, current ecosystem assets, and implementation opportunities. The scope of stakeholder engagement was not intended to represent every CHW, employer, public health agency, or CBO in Cook County or the broader region. In addition, because the CHW information ecosystem is evolving quickly, some conditions described in this report may continue to change, particularly those affected by grant-funded CHW program timelines, pending CHW certification, implementation of the CHW Medicaid benefit in Illinois, and network development to support social health delivery.

KEY FINDINGS

This section synthesizes findings from the landscape assessment, stakeholder interviews and focus groups to highlight what matters most in strengthening CHW communication and information exchange in Cook County. Broadly, it is evident that CHWs are indispensable trusted messengers, but the systems around them do not yet provide the coordinated, validated, and sustainable infrastructure needed for them to serve in that role at full strength. The most important opportunity is not simply to improve how information is transmitted; it is to build the conditions that allow CHWs to access accurate information quickly, adapt it effectively for community use, and channel community intelligence back into health and social systems in ways that lead to action.

1. Because CHWs are the system's most trusted communicators, sufficient support is needed to maximize their impact.

Trust is the cornerstone of CHW effectiveness. Community members believe CHWs because they have shared language, lived experience, cultural alignment, and ongoing relationships with each other. Trust, however, is not self-sustaining. It can be strengthened when CHWs have access to clear, current, validated information, and it can be strained when CHWs are left to navigate conflicting guidance, outdated resources, or unclear service availability on their own. As one employer noted, ***"CHWs are the voice of the community."*** Protecting and strengthening that voice requires more than recognition of CHW value; it requires intentional infrastructure that reinforces their credibility rather than asking them to compensate for systemic fragmentation.

2. The information environment is fragmented, uneven, and labor-intensive to navigate.

CHWs operate in a highly distributed communication environment with no single, trusted, comprehensive pathway for information exchange. Instead, CHWs piece together information through internal organizational channels, peer networks, listservs, public health communications, community-based partners, and direct outreach to service providers. The landscape assessment identified this as a structural gap. Strong assets exist, but they typically operate in parallel rather than as part of a coordinated system.

Stakeholders described the practical consequences in vivid terms. CHWs are often inundated with information yet still lack confidence that what they are reading or hearing is current or complete. They routinely cross-check details, call organizations directly, and compare guidance across sources.

As one CHW explained, ***"Sometimes I'm scanning the internet, and the information is not up to date."*** Another described the instability created by turnover and shifting relationships, saying, ***"We need to shift channels as the people change."*** A third stakeholder further noted that ***"there is no one way"*** to obtain information, adding that ***"information flow is less important than actual service access."*** Together, these findings underscore that CHWs face not only an information problem, but an information and access problem in which inaccurate, incomplete, or fast-changing information can erode trust and waste valuable time.

3. Peer networks are doing critical validation work, but they cannot substitute for coordinated infrastructure.

One of the most promising findings from the stakeholder interviews is that CHW peer networks and learning collaboratives have become some of the most trusted and useful spaces for validating information, troubleshooting barriers, and sharing practical solutions in real time. In some cases, CHW networks supplement information sharing limitations within the organizations where CHWs are employed. According to one CHW, ***"Ideally we'd have regular meetings, but our current configuration doesn't allow it so it's more word of mouth."*** This conclusion aligns with the landscape assessment's emphasis on feedback loops, trusted messengers, and structures that support message validation and adaptation. CHWs rely on these networks because they are proximate to practice and rooted in the realities of community work.

A network leader described this confidence directly: ***"We haven't faced concern about accuracy and appropriateness because we are a public health group—we are the validators."*** Yet the broader findings suggest that reliance on peer validation alone is insufficient. **No single entity currently synthesizes and vets information across public health, healthcare, and community systems in a way that is broadly trusted and consistently accessible across the CHW ecosystem,** leaving CHWs dependent on informal workarounds and uneven access to quality information. The implication is not to replace peer networks, but rather to build a more formal infrastructure that complements them—one that preserves workforce trust while reducing duplication, uncertainty, and burden.

4. CHWs do much more than deliver messages—they translate, adapt, and make information usable.

Effective communication is more than dissemination; it is about translation, contextualization, and relational delivery. CHWs do more than pass along information from institutions to communities. They interpret it through shared cultures, languages, safety concerns, and lived realities so that it becomes understandable and actionable. Stakeholders emphasized that literal translation is often insufficient, and that CHWs frequently adapt messages themselves to make them relevant and trustworthy.

Their approach to outreach is similarly adaptive—shifting across in-person engagement, printed materials, text, phone, social media, teleconferencing, and community events depending on what is safest and most effective. One CHW shared, ***"I carry materials in my purse,"*** illustrating how deeply this role is embedded in everyday life.

Another described pivoting from in-person meetings during the pandemic: ***"Since day 1 of the quarantine, we created Inform and Connect segments—a program that is broadcast every week to inform the community about resources available to help the Latino community."*** Another explained how outreach had to evolve in response to more recent community conditions: ***"Person-to-person and face-to-face is more personal, but due to the climate and in these times, we're now on Zoom."*** These findings reinforce that any future communication model must support message adaptation and multilingual access as core functions, not as afterthoughts.

5. The system underuses CHWs as a source of community intelligence.

The landscape assessment identified feedback mechanisms as a core function of effective public health communication, and the stakeholder findings highlight why that matters. CHWs gather rich, real-time insight into community conditions, emerging concerns, misinformation, resource gaps, and shifting service needs. Yet in many organizations, the pathways for elevating that information remain informal, inconsistent, or weakly connected to decision-making. Stakeholders repeatedly called for clearer structures for upstream communication so CHW observations can inform organizational and system responses.

As one leader noted, ***"It's always about how empowered CHWs feel to share what they learn… they should have proper channels to do that."*** Another stated that ***"collaborating with a community health worker network helps identify the gaps in the broader Cook County communities."*** One organization has integrated ***"mission moments"*** to highlight CHW impact, with a leader noting that ***"our board of directors meeting starts with 10–15 minutes of these."*** Strengthening CHW communication is not just about sending better information to community members. It is equally about creating durable pathways for reporting community insight back to the systems designed to address local needs.

6. Communication effectiveness is inseparable from workforce conditions, well-being, and service capacity.

Stakeholders were very clear: Communication challenges cannot be solved in isolation from broader workforce and system realities. CHWs are often expected to carry complex, emotionally charged, rapidly changing information while also facing the same hardships as the communities they serve. They may be helping clients navigate food, housing, mental health, or Medicaid challenges that they themselves are also experiencing. Stakeholders cited examples of CHWs supporting Medicaid enrollment when they themselves do not have coverage. CHWs shared the concern that such needs will be met with stigma in the workplace. As one CHW put it, ***"now I'm going to be seen as fragile, just like my community."*** While some organizations make arrangements to ensure that CHWs have access to needed social services, a CHW leader argued, ***"CHWs need fair compensation for the value they bring… They see the compensation disparities within the organizations where their own salary and benefits are not enough to live on."*** Stakeholders also described the emotional intensity of the role CHWs perform. One CHW said, ***"People tell us to take a [mental health] break, but we're going home and caring for others… so that doesn't really assist us."*** Another reflected, ***"We live in survival mode most of the time."***

CHWs also work in an environment in which even accurate referrals may not result in access because services are unavailable, over capacity, unsafe to approach, or difficult to trust. A CHW summarized the service-side limitations CHWs confront directly: ***"If there are not services…what can we do?"*** This situation creates messenger strain and reinforces that workforce support must be part of any communication strategy. These comments highlight that sustainable communication infrastructure must include supportive supervision, reflective spaces, trauma-informed support, continuing education, and adequate funding stability—not just better message pipelines.

7. The strongest path forward is to align and strengthen existing assets around a few core functions.

Taken together, the landscape assessment and stakeholder findings do not point to a single ideal structure so much as to a clear set of functions that any viable model must perform well: trusted message validation, timely dissemination, multilingual and culturally grounded adaptation, visible service availability, and formal feedback loops that move community insight into decision-making. **The landscape assessment suggests several plausible structural pathways—a public health anchored model, a neutral backbone or platform, an association-led hub, or a network governance model—and stakeholder interviews indicate that each has relevant strengths if implemented in a way that protects trust and reduces burden on CHWs.**

The clearest near-term implication is that Cook County already has a foundation on which to build. It can start by aligning existing assets, including public health agencies, CHW associations, employers, training institutions, and community-based networks, around a shared communications function. Stakeholders' interest in trusted local anchors, ambassador models, regular coordination routines, and practical one-stop access points reinforces this direction. One advocate observed that "***leading organizations need to coordinate more closely,"*** and another informant emphasized, ***"these are important times that call for innovation and new ways of working with and in community settings."***

The central strategic conclusion is that CHWs already serve as trusted communicators. The next phase of work is to build the shared infrastructure that enables them to deliver information and services that are more accurate, sustainable, and actionable across the system. As one leader summed it up, ***"CHWs should not be expected to function as bridge builders without adequate resources."***

RECOMMENDATIONS & OPPORTUNITIES

Strengthening the CHW information ecosystem requires coordinated action at the individual, interpersonal, organizational, community, systems, and policy levels. The following recommendations are designed to strengthen the creation, validation, flow, adaptation, and use of information through CHWs in ways that are practical, responsive, and shared across the entire CHW ecosystem. The recommendations focus on what can be done in the near term to reduce the current strains and improve communication reliability, as well as to outline longer-term action necessary to build a more durable, equitable, and trusted infrastructure.

CHWs and Frontline Teams

CHWs and frontline teams are closest to community information needs and are often the first to identify when messages are unclear, resources are outdated, or service access is constrained. Recommendations for this group focus on equipping CHWs with practical tools, training, and escalation pathways while avoiding additional uncompensated care burden.

Near-term priorities, next 12–18 months, include:

- Equip CHWs with practical tools and supports that make information easier to interpret, validate, and share, including message briefs, referral verification checklists, plain-language summaries, and scripts for fast-changing topics
- Expand access to continuing education on health communication, teach-back, motivational interviewing, public education, digital communication, and misinformation response

- Support routine access to reflective peer spaces where CHWs can test messages, troubleshoot barriers, and share what they see in community settings
- Create clearer pathways for CHWs to flag inaccurate resource information, report communication challenges, and escalate urgent community concerns without relying solely on informal workarounds

Longer-term priorities:

- Recognize communication, translation, resource navigation, and community feedback as core CHW competencies within workforce development and continuing education pathways
- Build sustainable access to reflective supervision, trauma-informed supports, and career advancement opportunities
- Ensure workforce strategies include CHW-like roles across settings, including promotoras, outreach workers, peer navigators, care coordinators, and other community-facing staff who perform trusted communication and navigation functions

Employers and Organizational Leaders

Employers are central to how CHWs receive information, share community insights, and experience support in their day-to-day work. Recommendations for employers should focus on making communication routines more predictable, assigning responsibility for information quality, and ensuring CHW insights inform decision-making.

Near-term priorities, next 12–18 months:

- Establish predictable communication routines and formalize how CHW knowledge moves within organizations, including regular team huddles, weekly supervision check-ins, and brief end of day or end of week debriefs
- Organizations should designate responsible individuals for validating external information before it is shared broadly and maintain a current internal resource directory with named owners for updates
- Create straightforward reporting channels that CHWs can use to communicate community concerns, misinformation patterns, service barriers, and system failures to supervisors and leadership
- Strengthen supportive supervision by ensuring that supervisors understand CHW workflows, communication burdens, and the emotional impact of navigating unmet needs
- Have leadership teams routinely review CHW-generated insights and make visible how their feedback is informing decisions, program adjustments, or external advocacy

Longer-term priorities:

- Embed CHW feedback into quality improvement, program design, leadership decision-making, and governance
- Develop durable systems for maintaining current resource and referral information, ensuring that internal communication practices are designed with CHW workflows in mind rather than layered on top of already stretched roles
- Invest in leadership development so supervisors, executives, and boards understand the strategic value of CHWs as trusted communicators and community intelligence partners
- Demonstrate not only how information is disseminated to CHWs, but also how information from CHWs is received, interpreted, and acted upon

CHW Networks, Associations, and Community Partners

CHW networks, associations, community care hubs, and community partners are well positioned to support peer validation, cross-organizational learning, multilingual adaptation, and feedback synthesis. Recommendations for this group should focus on strengthening the connections between CHWs, employers, public health, healthcare, and CBOs.

Near-term priorities, next 12–18 months:

- Develop a network development action plan that reinforces connectivity across existing CHW networks, community care hubs, and associations
- Identify trusted "anchor and ambassador" arrangements that pair local public health or intermediary capacity with community-rooted outreach organizations
- Pilot shared message review processes for high-priority topics
- Expand learning collaboratives that allow CHWs and employers to surface questions and verify information together

Longer-term priorities:

- Formalize the role of CHW networks, associations, and community care hubs in ecosystem coordination, peer learning, multilingual adaptation, resource verification, and feedback synthesis
- Determine which coordination structure, or combination of structures, can most effectively sustain the core ecosystem functions identified in this report
- Develop a coordinated ecosystem in which trusted message review, multilingual adaptation, referral transparency, peer learning, and feedback synthesis are routine rather than episodic using CHW associations and networks

Policymakers, Public Agencies, and Funders

Policymakers, public agencies, and funders can help stabilize the ecosystem functions that no single organization can maintain alone. Recommendations for this group focus on flexible funding, coordination capacity, workforce supports, and alignment with broader CHW infrastructure efforts.

Near-term priorities, next 12–18 months:

- Provide flexible funding for communication coordination, CHW continuing education, supervision, language access, peer learning spaces, and employer capacity to formalize communication and feedback routines.
- Support staff or intermediary roles that can coordinate updates, maintain resource information, and reduce the verification burden on CHWs
- Embed expectations for validated communication, community feedback loops, and CHW-informed adaptation into grants, contracts, and demonstration projects
- Clarify communication related to CHW certification, Medicaid-related implementation, and workforce expectations to reduce confusion among CHWs and employers
- Support pilot testing of coordination functions before investing in larger-scale infrastructure

Longer-term priorities:

- Establish sustainable financing for the ecosystem functions identified in this report, including validation, translation, resource verification, feedback synthesis, workforce support, and coordination
- Align reimbursement, workforce, public health, and community-based strategies so communication functions are supported as part of the broader CHW infrastructure
- Create accountability expectations for organizations that rely on CHWs, including maintaining validated information, supporting feedback loops, and protecting workforce well-being
- Support shared governance structures that include CHW representation and preserve community trust
- Invest in evaluation measures that assess trust, usability, reach, access, workforce experience, and whether CHW feedback informs system action

CONCLUSION

Strengthening the CHW information ecosystem is an urgent strategic imperative for Cook County. It is not a discrete communications initiative, but a broader effort to align trust, infrastructure, accountability, and service coordination with the realities facing communities and the CHWs who serve them. CHWs already function as trusted communicators, translators, navigators, and sources of community intelligence; what is now required is a commensurate commitment from public agencies, healthcare organizations, community-based partners, employers, associations, and funders to organize the systems around them accordingly. This is a critical moment to move from recognition to action.

The findings and recommendations in this report provide a practical foundation for that work. Acting now—through coordinated investment, shared governance, and sustained implementation—can help Cook County build an information ecosystem that is more accurate, responsive, equitable, and durable, and better able to ensure that community knowledge informs the systems designed to serve the public.

APPENDIX A. INTERVIEW & FOCUS GROUP QUESTIONS

Background and Context

CHWs are vital informants for the community. They are trusted health informants and educators for topics like immunizations, services to address social determinants of health, available benefits, etc. For healthcare organizations and systems, CHWs represent the voice of the community. They play a critical role in gathering and sharing community needs and gaps with provider organizations and policymakers, in order to inform systemic changes. Examples might include sharing information with healthcare providers about why populations are not accessing care, identifying barriers to community well-being or health that can be addressed by new programs, identifying locally held values and beliefs that require attention for culturally responsive service delivery, etc.

HMA has support from the Michael Reese Health Trust and the Community Memorial Foundation to talk with CHWs and their employers from throughout the Chicagoland area in order to learn what is working, and what is not working, to support bidirectional information sharing among CHWs. We want to understand what is needed to ensure an effective feedback loop for CHWs as a conduit for information to the community, from the community back to the organization, from the organization to the CHW, and so forth.

We're exploring what is and isn't working to ensure that CHWs have timely and health-related information and that they are effectively able to share timely information they are learning from the people they are assisting with their employers and other partners in the community.

Within a socioecological model, we are also interested in gathering information at the individual level—not just about channels, but what would equip CHWs to do what they do best (e.g., mental health support given the current environment, legal support at the organizational level because of Immigration and Customs Enforcement (ICE), digital training to improve information sharing using social media, etc.).

1) Current-state information ecosystem

Aiming to answer: How information moves today (tools, channels, pathways) and challenges

- How do CHWs most commonly receive the latest public health information from their employers? (tools, platforms, processes)?
- What are the common channels (such as social media, newsletters, alerts) CHWs are using to get information about public health and safety (formal and informal)?
- How do CHWs share information with community members?

- How do CHWs most commonly share what they are learning, from their work in the community, in order to inform their organizations about necessary programming or organizational responses.
- In addition to the mechanisms and processes or "channels" for information flow, what kinds of training, supervision, emotional or legal supports are needed to equip CHWs for their role as health educators and community advocates/representatives?
- When CHWs are not able to get information they need or when they aren't able to "report up" what they're learning, what are the common barriers?

2) What works + what to learn from

Aiming to answer: Which solutions/strategies are effective and why; what evidence to adopt

- What's working to support accurate, timely information flow to and from CHWs today?
- Why do these methods and approaches work?
- What specific tools, best practices, or evaluations should we review as we strengthen CHW communication capacity?

3) Future state + feedback loops

Aiming to answer: What "good" looks like, including bidirectional flow with the community

- What would improve accurate and timely bidirectional information sharing for CHWs?
- If an immediate improvement could be financed and implemented right away, what would that be?
- What else should we be asking or considering that we haven't covered?

APPENDIX B. COMMUNICATION PRACTICES AND EVIDENCE-INFORMED MODELS

Practice/Model	What It Enables	Evidence Base (examples)	Success Factors/Enabling Conditions	Feasability/ Adoption
Rapid validation + single "source of truth" workflow (coordination hub)	Consistent, vetted guidance; faster updates; reduced message drift across organizations	Centers for Disease Control and Prevention (CDC) Crisis & Emergency Risk Communication (CERC) principles; WHO infodemic management guidance; public health coordination models[4]	Clear governance; designated reviewers; update cadence; escalation pathway for ambiguous guidance; version control	High
Multichannel dissemination playbook (push + pull channels)	Ensures CHWs receive information across different access points (SMS, supervisors, toolkits, events, peers)	Public health comms frameworks and trusted messenger initiatives; field implementation examples[5]	Channel-specific templates; timing rules; low-bandwidth options; supervisor reinforcement	High
Pre-bunking /misinformation response toolkit for CHWs	Prepares CHWs to address common myths and emerging misinformation while maintaining credibility	Infodemic management literature; vaccine confidence efforts; trusted messenger research[6]	Short scripts; scenario drills; escalation pathways; "what to do when you don't know" guidance	High

Practice/Model	What It Enables	Evidence Base (examples)	Success Factors/Enabling Conditions	Feasability/ Adoption
Ambassador/ evidence dissemination model (e.g., PCORI-style approaches)	Structures how evidence-based content is translated and shared through trained, trusted messengers	PCORI dissemination and implementation model; ambassador initiatives; public health dissemination programs[7]	Role clarity; training; ready-to-use materials; ongoing support; simple research tracking	Med–High
CHW communication skills + health literacy training	Improves clarity, confidence, and consistency in delivering complex information	Health literacy intervention research; CHW training evaluations; public health implementation studies[8]	Short modules; role-play; refreshers; supervisor coaching; topic aligned scripts	Med–High
Curated toolkit repository for local adaptation	Reduces reinvention; supports shared scripts, visuals, FAQs, translation banks	Public health toolkits; dissemination models; program evaluations[9]	Curation standards; tagging; maintenance ownership; easy access/download	High

Practice/Model	What It Enables	Evidence Base (examples)	Success Factors/Enabling Conditions	Feasability/ Adoption
Translation + cultural adaptation pipeline	Supports multi-language and literacy-level communication grounded in community context	Health literacy and cultural competence literature; language access standards; implementation examples[10]	Community review; multiple literacy levels; audio/visual options; defined turnaround expectations	Med
Frontline feedback loops (CHW → hub)	Real-time refinement of messaging; surfaces confusion or misinformation early	Risk communication practice; quality improvement approaches; community engagement models[11],[12]	Low-friction reporting; visible response cycles; psychological safety; synthesis cadence	Med
Workforce support tools (e.g., lightweight digital/AI digital supports)	Accelerates translation, summarization, and CHW-ready briefing without replacing human judgment	Emerging digital health literacy literature; implementation pilots; workforce development examples[13]	Human review; guardrails; audit trail; training; privacy/ security alignment	Med

APPENDIX C. LIST OF STAKEHOLDERS

Stakeholder Group/Entity	Description of Engagement
Sinai Urban Health Institute	Key informant or stakeholder input related to CHW training, infrastructure, and ecosystem coordination
Chicago-Cook Steering Committee	Three meetings informing CHW communication and ecosystem planning
Illinois Public Health Institute and HAP Foundation	Stakeholder input related to public health, workforce, and system coordination
CHW Learning Collaborative	Focus group or stakeholder discussion with CHWs/CHW network participants
CHW Supervisor Learning Collaborative	Focus group or stakeholder discussion with CHW supervisors
Lake County CHW Focus Group	Regional focus group providing additional CHW perspective outside Cook County
Illinois Community Health Workers Association	Stakeholder input related to CHW workforce, communication, advocacy, and association infrastructure

APPENDIX D. LANDSCAPE ASSESSMENT

Public Health Communication Practices Used in CHW Engagement

CHWs are trusted messengers given their proximity to the communities they serve. Trust is built through lived experience, cultural alignment, shared language, and sustained relationships that extend beyond single clinical or programmatic encounters.

However, trust can be either reinforced or weakened by the accuracy and consistency of the information CHWs carry. When messages are clear, relevant, and credible, CHWs strengthen community confidence in health systems and services. When messages are inconsistent, outdated, or difficult to explain, CHWs must navigate uncertainty in real time, often without the infrastructure needed to validate or contextualize information.

Current public health communication best practices emphasize message validation, rapid feedback loops, and multichannel dissemination tailored to trusted messengers. National frameworks such as CDC's Crisis and Emergency Risk Communication (CERC) model and WHO infodemic management guidance similarly emphasize validated messaging, trusted messengers, and rapid feedback loops. **CHWs are central to these models yet often operate without the coordinated infrastructure these practices assume.**

Ensuring CHWs can easily access accurate, translated, and actionable information helps protect the credibility that underpins their role and supports more effective engagement across sectors.

Public health communication offers established approaches for validating, translating, and disseminating health information through trusted messengers, including CHWs. These practices are routinely used in immunization campaigns, emergency response, Medicaid outreach, and community prevention initiatives (see chart in Appendix B). These practices function as building blocks for communication. Their effectiveness depends on the presence of coordination structures, such as a public health-anchored, association-led, neutral backbone, or on network governance approaches described later in this report.

Structural Pathways to Strengthen Information Coordination

Today's environment suggests several viable pathways to improve coordination and the flow of trusted information. These pathways are not mutually exclusive and may co-evolve. Existing Cook County assets could anchor early coordination efforts.

Public Health-Anchored Model

In this approach, a public health authority serves as a primary convener and validator of health information before it reaches CHWs. This model emphasizes consistency, data alignment, and integration with broader health system priorities.

Operational elements could include:

- Centralized message validation tied to public health guidance
- Coordinated distribution through health systems, training institutions, and CHW networks
- Alignment with Medicaid implementation and population health initiatives

Local actors that could contribute:

- Chicago Department of Public Health
- Cook County Department of Public Health
- Health system population health teams
- Sinai Urban Health Institute and other training partners
- Existing CHW networks and emerging hubs

Potential strengths include legitimacy, access to real-time policy and clinical updates, and alignment with public health priorities. Considerations include the risk of perceived top-down messaging and the variability of trust depending on the messenger, community relationships, and communication channels.

This pathway illustrates how existing public health infrastructure could anchor coordination functions if aligned with CHW networks and community-based partners.

Neutral Backbone or Platform Model

This pathway centers on a shared intermediary that aggregates, vets, and distributes information across organizations. The backbone may be a digital platform, a convening entity, or a hybrid model that serves as a neutral infrastructure layer.

Operational elements could include:

- Centralized information repository and distribution channel
- Cross-sector governance structure
- Integration with social service referral networks and community resource platforms

Local actors that could contribute:

- Unite Us or similar resource aggregators and referral platforms
- Regional intermediaries
- Philanthropic organizations

Potential strengths include cross-sector reach, perceived neutrality, and the ability to support coordination across multiple organizations. Considerations include adoption challenges, governance complexity, and long-term sustainability.

This pathway illustrates how existing intermediaries or platforms could support coordinated information flow if aligned with public health, healthcare, and CHW networks.

Association-Led Hub

In this model, CHW associations or workforce development entities assume a primary role in curating and disseminating information to CHWs.

Operational elements could include:

- Peer-informed message vetting
- CHW-facing communications and training integration
- Ongoing workforce feedback mechanisms

Local actors that could contribute:

- Illinois Community Health Workers Association
- Workforce training institutions and collaboratives
- CHW-led networks and coalitions

Potential strengths include workforce credibility, cultural alignment, and relevance to day-to-day CHW practice. Considerations include uneven reach across organizations and potential territorial dynamics among stakeholders.

This pathway illustrates how workforce-centered infrastructure could anchor communication functions while maintaining proximity to CHW needs and realities.

Network Governance Model

This pathway distributes responsibility among multiple actors, who coordinate messaging through shared agreements and communication protocols.

Operational elements could include:

- Shared message review processes
- Distributed communication channels with common standards
- Regular coordination among public health, healthcare, and community partners

Local actors that could contribute:

- Illinois Public Health Association (IPHA)
- Sinai Urban Health Institute (SUHI)
- CHW associations, training partners
- Public health agencies
- Healthcare systems and community-based collaboratives

Potential strengths include distributed trust, shared ownership, and resilience across institutions. Considerations include coordination burden, slower decision-making, and the need for sustained facilitation.

This pathway illustrates how coordination could emerge through structured collaboration rather than a single anchoring entity.

Existing Infrastructure That Can Be Leveraged

Cook County has significant assets that support CHW communication and engagement across public health, healthcare and community settings, including:

- Workforce training institutions
- Professional associations and CHW networks
- Community-based organizations serving as intermediaries
- Public health communications infrastructure
- Digital platforms connecting health and social services
- Philanthropic and cross-sector conveners
- Learning collaboratives and peer networks

These entities shape how information is developed, shared, and interpreted across the CHW system. They provide multiple entry points for distributing guidance, gathering feedback, and supporting community engagement.

However, these assets largely operate in parallel rather than as part of a coordinated communication system. Information may move effectively within individual organizations or networks, but less consistently across them. As a result, CHWs often rely on relationships and informal coordination to bridge gaps between public health guidance, healthcare communications, and community messaging.

The existing infrastructure provides a sturdy foundation for strengthening validation, coordination, and feedback mechanisms without creating entirely new systems. The pathways described in the following section illustrate how these assets could be aligned and leveraged to support the flow of more consistent and trusted information.

Strategic Implications

Cook County's established CHW ecosystem and institutional partnerships position it to test and refine how these pathways function in practice. The landscape points not to a single dominant model, but instead to an opportunity to strengthen core functions such as validation, coordination, and feedback mechanisms that can operate across multiple structures.

Early efforts may focus on aligning existing assets and piloting coordination mechanisms that improve information flow without requiring immediate structural change.

Over time, these efforts could inform the evolution of a more formalized communication infrastructure, grounded in local trust, workforce realities, and system alignment.

Priorities for stakeholder engagement included validating how CHWs currently access and trust information, identifying influential intermediaries, understanding the risks of misinformation, assessing readiness for different coordination approaches, and strengthening support for translation and message adaptation.

APPENDIX E. STAKEHOLDER INTERVIEWS AND FOCUS GROUPS

How CHWs Currently Receive Public Health Information

CHWs access information through a highly distributed ecosystem of formal and informal channels, with no single consistent pathway. Stakeholders emphasized that there is "no one way" information is shared or accessed, and no single platform serves as a comprehensive or consistently used source of information. As a result, CHWs navigate multiple channels depending on the topic, urgency, and context.

Internal Organizational Communication. Information is commonly received through organizational communications, including team meetings, supervisor check-ins, internal emails, and employer-led trainings. Examples included lunch and learn sessions presented on Zoom, internal newsletters highlighting programs and updates, and structured staff meetings where health information is shared. Trainings and conferences were also cited as important sources of information, particularly related to policy updates, certification requirements, and the evolving CHW Medicaid benefit.

CHWs also rely heavily on external networks and listservs. Frequently cited sources include listservs and communications distributed by the Illinois Community Health Workers Association (ILCHWA), the National Association of Community Health Workers (NACHW), the IPHA, the Illinois Department of Public Health (IDPH), and the Health & Medicine Policy Research Group (HMPRG). These channels provide ongoing updates related to public health guidance, workforce development, and available community resources. Some listserv communications also include invitations to meeting and in-person learning opportunities, reinforcing both information sharing and relationship-building.

Peer Networks and Learning Collaboratives. Emerging as one of the most important and trusted sources of information, CHWs described these spaces as critical for sharing resources, validating information, and troubleshooting challenges in real time. Learning collaboratives allow CHWs to raise questions related to eligibility criteria, confirm service availability, and exchange knowledge about what is working in different communities. Participation in these spaces varies based on topic relevance, and many are CHW-driven, contributing to their credibility and usefulness.

Community Resources. Access to information is also shaped by relationships with community-based organizations and partners, including local health departments, 211 and similar resources, food access networks, housing collaboratives, and legal service providers. Stakeholders emphasized that access is often dependent on who a CHW is connected to, rather than a standardized system. As a result, CHWs with stronger networks may have greater access to timely and relevant information.

As a CHW network representative said, "We haven't faced concern about accuracy and appropriateness because we are a public health group—we are the validators."

Resource Navigation and Curation. CHWs described being inundated with information, making it difficult to assess what is current, accurate, and most relevant to their work. This challenge is especially pronounced when information changes quickly, is presented differently across sources, or relates to sensitive or politicized topics. CHWs are expected to navigate information across a broad range of domains, including Medicaid eligibility, housing, immigration, behavioral health, food access, legal services, and public health guidance. Stakeholders noted that keeping up with changes across these areas is challenging, particularly in domains where resources are limited or conditions are rapidly evolving.

CHWs also described the need to actively verify information. Stakeholders noted that contact lists, eligibility criteria, and service availability frequently change, requiring CHWs to invest additional time to ensure accuracy. CHWs often cross-check information, call organizations directly, and confirm details before sharing information with community members, particularly when resources may be outdated or inconsistent.

How CHWs Share Information with Community Members

Multichannel Community Outreach. CHWs use a range of communication approaches to share health information and connect community members to resources, adapting their methods based on setting, audience, and individual needs.

Common approaches include canvassing, group-based outreach, such as presentations at community-based organizations, engagement with faith-based institutions, participation in health fairs, and tabling at community events. CHWs frequently distribute printed materials, often supplemented with QR codes, to ensure information is accessible in multiple formats.

Language Access and Cultural Adaptation. Language and translation skills are critical, and often literal translations are insufficient to establish context and understanding. CHWs provide culturally grounded interpretation and frequently adapt messages themselves so that information is understandable, relevant, and usable for the people they serve.

One-on-One Engagement. One-on-one engagement remains central to CHW practice. CHWs described providing individualized support through follow-up phone calls, emails, and text messages, as well as in-person interactions in clinic waiting rooms, homes, and community settings. Many emphasized the importance of being prepared to share information at any time. One CHW noted, ***"I carry materials in my purse,"*** reflecting the expectation that CHW information sharing is embedded in everyday interactions.

Digital and Social Media Channels. CHWs use digital and social media channels to share information. Stakeholders noted that Facebook, Instagram, and LinkedIn are commonly used, with some CHWs posting regular updates based on information they compile from trusted sources.

Adaptive Outreach. CHWs also described adapting outreach strategies in response to community safety concerns. One CHW shared, ***"Since day 1 of the quarantine, we created Inform and Connect segments—a program that is broadcast every week to inform the community about resources available to help the Latino community."*** Stakeholders noted that some communities have felt unsafe congregating because of ICE activities, leading some regularly held community gatherings to move online. As one CHW explained, ***"Person-to-person and face-to-face is more personal, but due to the climate and in these times, we're now on Zoom."***

How CHWs Share Community Insights with Their Supervisors and Organizational Leaders

Formal and Informal Feedback Channels. Stakeholders described uneven processes for CHWs to share what they are learning from community members back to their organizations. Some organizations have formal mechanisms in place, while others rely on informal communication, supervisor relationships, or word of mouth. Across stakeholder groups, there was wide agreement that CHWs need clear, formalized channels for reporting what they hear, observe, and learn in the community.

According to one leader, ***"It's always about how empowered CHWs feel to share what they learn, they should have proper channels to do that. It's important that they have a framework because it's not organic in most organizations."*** Another employer emphasized that ***"CHWs are the voice of the community"*** and require a direct method for reporting what they hear and learn. A government leader amplified this sentiment and noted that ***"collaborating with a community health worker network helps identify the gaps in the broader Cook County communities."***

Supervision and Leadership. Weekly supervision meetings and monthly or weekly convenings were the most commonly cited methods for CHWs to share information with their employers. In some settings such meetings are remote given the distribution of the CHW teams across the County, and some take place inconsistently. As one stakeholder said, ***"Ideally we'd have regular meetings, but our current configuration doesn't allow it, so it's more word of mouth."***

Stakeholders noted that these meetings also involve checking in with CHWs who represent the communities they serve and, as such, often experience the same stressors as those they are serving. Not only are CHWs in need of some of the same resources as their clients, but their role as an employee is the same role they play in every other part of their life (e.g., their neighborhood, faith-based community, family, and personal network) outside of work. As one CHW noted, ***"People tell us to take a mental health break, but we're going home and caring for others…so that doesn't really assist us."***

This reality is especially notable when public health crises emerge, such as COVID and mass deportation actions like the recent ICE raids. As one CHW supervisor noted in describing the CHW information exchange, ***"I meet with them weekly to check in about how they're feeling, once a month we meet to discuss how they're feeling about the community, and then I meet with the CEO. They're working evenings, weekends… How are they feeling and are they seeing changes in the community? Last year in September and October they were afraid about the events and their families—it wasn't only about their safety at the event… it was concern about their own families, their children. It changed scheduling and the way of communicating…everything."*** One key informant described speaking to a CHW who was experiencing symptoms of trauma after witnessing a person taken by ICE while she was working in the community. In response to significant stress, one organization provided a one-day retreat. Another organization funded a movie outing during which the organization paid the CHWs for their time.

Recognizing CHW-Like Roles Across Organizations. Stakeholders also emphasized that important community insight may come from workers who function like CHWs but do not formally hold the CHW title. One organization leader indicated that volunteer Promotoras and CHWs support their programs for ***"diagnosis of the community."*** Other stakeholders noted that the CHW role may be played by staff who are not formally CHWs but who should be integrated into the information exchange. ***"The CHW term is a little tricky, even within our organizations"*** and recommended that ***"these champions be looped into the information sharing network."***

Organizational Learning and Leadership Engagement. One CHW supervisor reported using surveys to gather input specifically from CHWs, while other supervisors described regularly eliciting feedback from all community-facing staff through established internal channels.

A CHW supervisor from a large healthcare system shared that the organization is planning a CHW resource fair where CHWs can discuss what they do and what they have learned from other hospital departments, so staff can "better understand the value" of the role.

Another leader described a formal approach to collecting what the organization calls "***mission moments***," during which ***"our staff share their activities that they engage in across the community about connections to service. Our board of directors meeting starts with 10-15 minutes of these."*** In one example, a CHW elevated an immediate need to help a patient get food and stay warm during one of the coldest winter nights, and the clinic responded rapidly with food and shelter support. Another organization routinely invites a CHW to their board meetings to share their experiences and provide a Q&A opportunity for board members to learn more.

Network-Level Feedback and Employer Engagement. Some employers lack a formal process for hearing from their organization's CHWs. In some cases, they are joining CHW networks to leverage the network's processes. A network lead shared, ***"Employers are sending us topics and participating in our lunch and learns."*** A CHW network representative described a planned communication campaign about the new Illinois CHW Medicaid benefit that will ***"support employer growth in this space."*** These examples suggest that CHW networks serve not only as peer learning spaces, but also as intermediaries between CHWs, employers, public health agencies, and workforce infrastructure partners.

Barriers to Timely, Accurate Information Exchange

Limited Neutral Validation Mechanisms. No single entity consistently synthesizes and vets information across public health, healthcare, and community systems in ways broadly trusted across CHW networks. As a result, CHWs often rely on supervisors, peers, and personal judgment to confirm accuracy before sharing information. CHWs reported needing to verify information through multiple sources, including calling organizations, consulting peers, or checking with supervisors before sharing with community members.

Fragmented Message Development. Multiple organizations produce guidance without consistent coordination. Information may be released at different times, framed in different ways, or tailored to specific programs, which creates variability in how messages are interpreted and shared.

Rapid Information Cycles. Social and peer networks move faster than formal communication channels, increasing the likelihood that incomplete or outdated guidance circulates before official updates reach frontline staff. Information related to Medicaid policies, certification requirements, housing availability, and immigration guidance was frequently cited as changing quickly, making it more difficult for CHWs to stay current.

Translation and Adaptation Pressures. CHWs frequently translate and contextualize information independently to ensure cultural relevance and usability. Although this approach strengthens connection and trust, it can also introduce variation in how messages are delivered.

Outdated and inconsistent resource information. Stakeholders frequently noted that contact lists, online resources, and service availability are often outdated or inaccurate. One CHW said, ***"Sometimes I'm scanning the internet and the information is not up-to-date."*** In some cases, community members are referred to services that no longer accept new clients or have changing eligibility criteria. CHWs described needing to call organizations directly to confirm whether services are still available before making referrals, adding another time burden and undermining trust when information is incorrect.

In high-demand areas such as housing, legal services, and behavioral health, CHWs may have information about resources but are unable to connect community members because of limited availability. As a result, some stakeholders noted that ***"information flow is less important than actual service access."*** CHWs do not only face an information gap; they face an information and access problem. A referral may be accurate and still fail if services are unavailable, eligibility rules have changed, language access is limited, or community members feel uncomfortable sharing personal information.

Transparency of Service Availability. CHWs also described challenges with gatekeeping of information, where organizations may inconsistently share updates on services, eligibility, or capacity. Some stakeholders emphasized the need for greater transparency, particularly when services are unavailable or constrained. Another noted that some organizations may limit what they share because updates evolve too rapidly or eligibility is too complex.

Messenger Strain. During periods of evolving guidance, such as changes in immunization recommendations or Medicaid eligibility requirements, CHWs may receive updates from multiple sources at unpredictable times. They must reconcile information quickly while continuing to engage community members who expect clarity and consistency. CHWs described feeling pressure to have answers in real time, even when information is unclear or unavailable, and may experience frustration when unable to connect individuals to needed services.

External pressures can also shift outreach methods, alter communication channels, and increase reliance on trusted partner networks. As a CHW noted in response to ICE raids in her community***, "A lot of people went underground and are hiding. Even if you're not at risk, there's just fear. Community members don't want to share their information for a follow-up, like their phone number or their last name. We have to find a way to support this person in the best way…but if it's from the government, no thank you."***

Workforce Instability and Turnover. Stakeholders noted that workforce turnover within organizations can disrupt communication, which may result in loss of institutional knowledge and require CHWs to rebuild networks for information and resource connections over time. According to one CHW, ***"We need to shift channels as the people change."***

Limited Structured Pathways for Upstream Feedback. While CHWs regularly gather insights from communities, as noted above, some stakeholders shared that mechanisms for reporting this information back to organizations are often informal or inconsistent, relying on word of mouth, emails, or periodic meetings. In some cases, CHWs also reported that feedback is shared but does not result in visible action, reducing motivation to continue elevating insights.

What CHWs Need to Serve as Trusted Communicators & Educators

Workforce Infrastructure and Sustainable Funding. Stakeholders emphasized that strengthening CHW communication requires an investment in workforce capacity, organizational alignment, and sustained support systems, not just improvements in information delivery. CHWs need adequate compensation, stable funding, and stronger workforce infrastructure, including support for volunteer CHWs and those serving populations without Medicaid coverage. Absent these supports, it is difficult to sustain the CHW workforce and fully realize its impact.

Training, Skill Development, and Continuing Education. Training, skill development, and support from other CHWs within a formal network were identified as core components of this foundational infrastructure. CHWs are expected to provide information across multiple domains, including physical health, mental health, financial resources, legal services, food assistance, and more. Training in communication skills, including active listening, teach-back methods, group presentation skills, public education techniques and motivational interviewing, was highlighted as critical to the role.

Stakeholders also noted that access to ongoing training is essential to ensure CHWs feel prepared, particularly in areas such as mental health. One CHW reported feeling underprepared until they received additional training and connected with CHWs in their network who work more closely within the behavioral health system.

A representative from the statewide CHW association indicated that CHWs have requested continuing education to strengthen both communication and administrative capacity. Examples included developing PowerPoint presentations, presenting to groups, enhancing public education skills, and using Excel and other basic administrative tools.

Peer Support and Reflective Spaces. Creating and maintaining space for CHWs to process their experiences and share challenges was seen as essential to maintaining workforce resilience. System-level constraints significantly impact CHWs, and support from their peers is highly valued. Stakeholders consistently highlighted the gap between community need and available services, particularly in areas such as housing, legal support, utilities, and healthcare. As one CHW noted, ***"If there are not services…what can we do?"*** Another stakeholder emphasized that even when direct referral resources are limited, there is still value in building relationships and trust with CHWs.

Supportive Supervision and Alignment. Stakeholders emphasized the importance of supportive supervision and leadership alignment. Although CHW supervisors often receive training, organizational leaders may have an incomplete understanding of the CHW role or how to support effective integration. This lack of familiarity with CHWs' contributions can result in underutilization of CHW insights, limited recognition of CHW expertise, or missed opportunities to incorporate community feedback into organizational decision-making.

Workforce Well-Being. Many CHWs are working to help people access services that they themselves require. Stakeholders cited examples of CHWs supporting Medicaid enrollment, when they themselves do not have coverage. Another noted that CHWs are concerned that such needs will be met with stigma in the workplace. One CHW leader noted that ***members worry that "now I'm going to be seen as fragile, just like my community."***

To support CHWs, employers shared an array of examples. One said, ***"We try to accommodate the everyday things necessary for life, we try to be adaptable and supportive of our staff."*** Another shared that their organization tells CHWs, ***"If there's a service that we offer here that you need, then that is available to you also. We've had a couple situations where staff have needed rental assistance and we've made connections for staff members to other organizations for conflict free services."*** Another stakeholder observed that CHWs' ability to access resources through their professional networks should not be stigmatized, noting that other professions also benefit from field-specific knowledge and relationships, such as doctors or nurses using professional networks to identify specialists or navigate care.

Trauma-Informed Support. CHWs emphasized the emotional demands of their work and the difficulty of separating professional and personal experiences. One hospital employer shared the story of a CHW who required mental health support after a client's death. The CHW had been working to escalate concerns within the system about the man needing his oxygen replaced more frequently. ***"When he went to the man's house and learned that he had died from waiting for oxygen…it was good that we had social workers available right there. We edited our oxygen protocols as a result of that situation, and mental health support is available to our staff."***

Although self-care is recognized as important, stakeholders noted that CHWs are often last on the list for support. Suggestions included structured opportunities for reflection, such as retreats, dedicated time for decompression, and flexibility to work from home. A CHW shared, ***"We live in survival mode most of the time…. I'm struck by how rarely we get to step back and look at what we did and how we did it. We don't get to look back and consider what could be better."***

Stakeholder-Identified Solutions and Future State Opportunities

Stakeholders described the need to strengthen support structures and build durable capacity. They cautioned that CHWs cannot function as "bridge builders" without adequate resources, emphasizing that dedicated infrastructure and support mechanisms are required. They emphasized the value of combining practices, roles, and relationship-based engagement.

At the organizational level, stakeholders underscored the importance of predictable communication routines and structured feedback loops. They recommended brief end of day team debriefs (e.g., two-minute check-ins) to capture what was challenging, what is working, and observations that might otherwise be missed or forgotten. In addition, stakeholders emphasized consistent weekly check-ins to sustain continuity, monitor progress, and address emerging needs in a timely manner.

At the community level, stakeholders highlighted trusted, locally resonant messaging as a core component of effective outreach. They recommended prioritizing neutral, trusted messages delivered through local ambassadors and supported by funding for locally led efforts. Several interest-holders pointed to the anchor and ambassador approach that a statewide hub is implementing that has been funded to perform this function to expand access to trusted local voices in a long-term, sustainable way. In this model, identified public health lead entities that have established community trust (anchors) coordinate with community-rooted CHW employers (ambassadors) to streamline and support CHW communication. One recommended an ombudsman-type role to "hold space" for CHWs and support difficult conversations, including surfacing and addressing needed changes.

Stakeholders expressed interest in a more integrated CHW network, while recognizing that the current ecosystem has yet to be connected enough to function as an accessible, shared resource. Some CHWs receive timely updates through employers, associations, or collaboratives, while others remain outside those channels. Such uneven access reinforces the need for more intentional communication structures that can reach CHWs consistently and equitably.

Stakeholders envision a more coherent statewide communication and advocacy infrastructure that reduces duplication and supports coordinated action. Suggestions included a membership-based approach and other mechanisms to help CHWs and employers understand statewide challenges and successes, particularly given the volume of activity that can be difficult to track and interpret. Stakeholders described interest in a centralized communication chain and unified database where CHWs can reliably access updates and service information, along with regular collaboration meetings that create space to reflect more often on what is working. Participants noted that effective engagement requires balancing content delivery with relationship-building opportunities, with intentional choices about when informal connection is most useful and when more formal communication is needed.

Stakeholders identified trusted public health messaging and practical information-sharing infrastructure as foundational to effective CHW support. Examples of trusted sources included messaging from Cook County Public Health and the Chicago Department of Public Health (CDPH). Stakeholders described interest in a shared platform that could distribute updates from trusted resources (including app-based delivery), tailor messages for specific audiences, and document what was tailored so that effective approaches can be replicated. Participants also suggested developing a method to share State of Illinois Rapid Electronic Notification (SIREN) announcements with CHWs, particularly for public health changes tied to Illinois policy, noting that pre-vetted information was especially important during the pandemic.

Stakeholders discussed the potential value—and the practical challenges—of creating hubs or "one-stop" access points for CHWs and community members. While CHW co-led hubs, CBO hubs, and CHW centers were described as promising concepts (including bidirectional models where community members can walk in and CHWs can also conduct outreach), stakeholders noted that several organizations are already attempting to serve as hubs and may compete with one another. Given the diversity of organizations, CHW roles, and specialty areas statewide, some participants questioned whether a single "one-stop shop" is feasible; instead, they prioritized connecting existing services into an "inner web" of coordinated resources. Stakeholders also recommended ongoing analysis and reporting from CHWs about how hubs and resource directories are working in practice, paired with regular time to reflect on what is working and what is not. One stakeholder cautioned that aggregated spaces are a risk due to concern about funding sustainability and the potential for both disruption and dependency. Neutrality related to polarized topics was also flagged as a critical consideration to ensure trust from and accessibility in communities where polarization is a risk. A representative from the statewide CHW association shared that they are going into communities to hear from CHWs and are prepared to play a key role. They convene a monthly workforce development committee and host an annual summit. With funding, they noted they could hire a membership coordinator to advance membership capacity for effective communication.

Stakeholders also raised workforce development and accessibility priorities that affect CHW effectiveness and equity. Participants noted that CHW certification requirements remain unclear for many, and that CHWs may assume prior coursework or training satisfies certification expectations; stakeholders reported waiting for additional guidance from relevant boards and indicated that clearer statewide communication is needed. Stakeholders also emphasized language access as an ongoing priority, including expanding live interpretation/translation services and hiring staff fluent in Spanish, Polish, Arabic, and other languages spoken across immigrant communities.

Stakeholders' future state vision centered on making CHW information, services, and coordination easier to navigate while clarifying CHW roles within organizations and communities. Participants described interest in CHW centers and other bidirectional models where community members can walk in for support and CHWs can also conduct outreach in communities. They also emphasized the need for organizations to clearly define the CHW role and provide appropriate training so CHWs can focus on early detection and referrals to the right resources rather than being put in positions that require decision-making about people's safety.

Stakeholders identified several near-term improvements to make information sharing more timely, reliable, and actionable. They recommended establishing "prioritization groups" and "staging efforts" to support rapid, accurate distribution of updates. Once established, public health departments could embed these functions within grants and contracts to ensure they are resourced and consistently implemented.

To enable these improvements, stakeholders emphasized the need for sustainable funding and operational support. Suggested investments included funding for support staff, training to build staff skills, resources that strengthen internal processes and staff support, and CHW support for individuals who are not Medicaid eligible, as well as for volunteer efforts. One stakeholder summarized the urgency of this work by noting that these are "important times" that call for innovation and new ways of working with and in community settings.

ENDNOTES

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