

Telehealth ROCKS

School-Based Community Health Worker Toolkit

Step-by-step guidance for building
an SB-CHW program in your school



October 2026

Acknowledgments

Thank you to everyone whose commitment and partnership helped make this publication possible, including those who contributed to the Toolkit Development Workgroup:

- › Hailey Collins, School-Based Community Health Worker, Coffeyville Unified School District 445
- › Deb Cook, RN, AE-C, Certified Asthma Educator and Retired School Nurse
- › Esther Cuevas, School-Based Community Health Worker, Coffeyville Unified School District 445
- › Jenna Cuthbertson, School-Based Community Health Worker, Community Health Center of Southeast Kansas
- › Jaran Dixon, School-Based Community Health Worker, Parsons School District USD 503
- › Morgan Earnheart, School-Based Community Health Worker, Kennett School District 39
- › Melissa Murray, Student Services Coordinator, Coffeyville Unified School District 445
- › Cassandra Oliver, School-Based Community Health Worker, South Callaway R-II School District
- › Meghan Opie, School-Based Community Health Worker, Eldon R-I School District
- › Christi Roberts, Director of Health Services, Kennett School District 39
- › Jennifer Westerman, Community Liaison, Greenbush Southeast Kansas Education Service Center
- › Chase Koob, Workgroup Administrative Lead, Telehealth ROCKS

This publication was supported by the Health Resources and Services Administration (HRSA) through the Evidence-Based Telehealth Network Program (Grant No. G0142541) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$379,273, with 100% of project costs financed with federal funds.

The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government.

Permissions

Content from this document may be used directly or adapted. Users are encouraged to acknowledge this document as a source using the following suggested citation:

Telehealth ROCKS and the Toolkit Development Workgroup. (2026). **School-Based Community Health Worker Toolkit: Step-by-step guidance for building an SB-CHW program in your school.** Available at: www.telehealthrocks.org

Table of Contents

Introduction4

Background5

Social Determinants of Health Framework8

Implementation16

Evaluation and Dissemination 36

Funding and Sustainability..... 43

Frequently Asked Questions 45

Glossary47

Appendix51



Telehealth ROCKS

Introduction

The School-Based Community Health Worker (SB-CHW) model in this toolkit brings together two approaches that rural communities in Missouri and Kansas developed independently to meet needs that neither could address alone.

In Missouri, the Eldon School District partnered with the Federally Qualified Health Center serving the region, Central Ozarks Medical Center, in 2016 to place a community health worker in its schools. In Kansas, Telehealth ROCKS spent years building school-based behavioral health services, using telehealth to bring clinical care and best practices in school mental health to rural districts, where the nearest specialty services were often hours away. The Missouri work demonstrated what changes when someone a family already trusts is inside the school, and able to act on the daily obstacles that keep adding up: lack of transportation, insurance navigation, not knowing where to start, alongside limited referral options for medical and behavioral health. The Kansas work demonstrated what happens when a district has somewhere to refer a child once those obstacles are cleared. Building upon this foundational work, Telehealth ROCKS developed the School-Based Community Health Worker model, utilizing telehealth to expand the CHWs' impact.

Our vision is uniting: **schools and communities where every child and family has the resources and skills they need to have the same opportunity for success in school and life.** Our vision drives everything in this toolkit, and our mission is how we pursue it—partnering to transform communities through comprehensive and integrated approaches that amplify existing resources and develop new solutions to meet the needs of children and their families. With every child served, the approach rests on building trust to address family-prioritized needs.

This work is situated within a rural network that made it possible to move these ideas forward. School districts, health centers, education service centers, state agencies, family advocacy organizations, local community partners, students, and families come together to take on problems they can't solve alone. The focus is collaboration over creation. Rather than building parallel services to those that already exist, the network looks for ways to maximize the available resources in their individual communities and share expertise across the network.

Over time, we've watched the SB-CHW model strengthen bridges among schools, families, community organizations, and the broader health system. We've learned what it takes to build a program such as this from the ground up: how the work is funded, how the role is defined, and the partnerships that hold it all together. This toolkit shares those lessons learned and successes we've had along the way; importantly, it also draws from existing resources for CHWs and SB-CHWs (Clinical Scholars, 2022; Rural Health Information Hub, 2026).

This model continues to evolve as communities learn and adapt. We want to keep learning alongside you. If you make modifications, find something that works differently in your context or discover a better approach, we would like to hear about it and invite you to reach out. We hope this toolkit provides a practical starting point for schools, organizations, and communities interested in implementing a School-Based Community Health Worker program leveraging telehealth. Most importantly, we hope it helps local communities increase access to trusted support, better health outcomes, and greater opportunities for children and families.

Sincerely,
Dr. Eve-Lynn Nelson
On behalf of the Telehealth ROCKS team

Background

This toolkit is intended to provide school district administration, School-Based Community Health Worker supervisors, School-Based Community Health Workers, and anyone interested in learning more about the School-Based Community Health Worker model:

- › Step-by-step guidance for implementing Community Health Workers in school settings
- › Roadmap for cross-sector collaboration among schools, healthcare, and community organizations
- › Framework for evaluating program impact and ensuring sustainability
- › [Glossary of acronyms used throughout this toolkit \(page 47\)](#)

Telehealth ROCKS

Telehealth ROCKS (Regional Outreach for Communities, Kids, and Schools) is a federally funded program that focuses on school-based behavioral health and pediatric care. We do this by partnering with local communities to work on social determinants of health, support school-based services, and provide telementoring trainings.

Our Mission

To transform communities through comprehensive and integrated approaches that amplify existing resources and develop new solutions to meet the needs of children and their families.

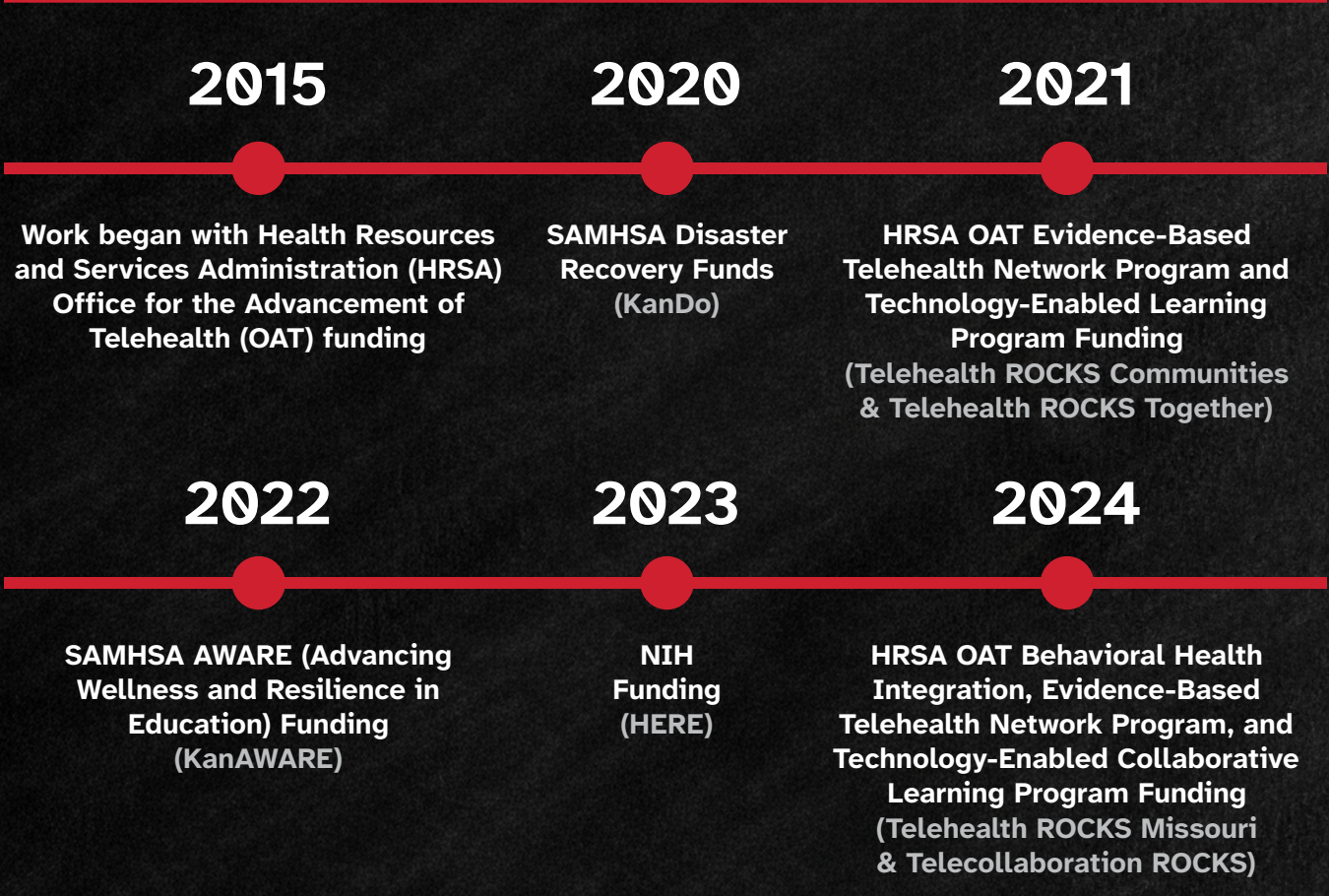
Our Vision

Schools and communities where every child and family has the resources and skills they need to have the exact same opportunity for success in school and in life.

The Telehealth ROCKS Network is an organization of school and community partners, each with their own expertise in best supporting youth and families in their rural communities. Network partners bring an “all teach, all learn” mindset to maximize everyone's passion and talents to meet daunting gaps in behavioral health access and workforce retention.

Our multidisciplinary pediatric specialist core, with broad expertise in child psychology, child psychiatry, developmental and behavioral health concerns, pediatric medical complexity, behavior analysis, and healthy lifestyle interventions, is particularly well suited to support the anticipated needs of local healthcare professionals within our rural network (Nelson et al., 2025). Additionally, the network builds upon a breadth of rich experience in program evaluation, practice facilitation, optimizing technology-enabled collaborative learning engagements, and developing workforce pipeline opportunities (Nelson et al., 2022).

Program Timeline



History of Community Health Workers



Community Health Workers have a long and varied history in the U.S. and worldwide. The American Public Health Association (APHA) Community Health Worker Section defined CHWs as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary among health services, social services, and the community to facilitate access to resources and improve the quality and cultural competence of service delivery.”

Community Health Workers are known by various names: Promotora de Salud, Community Health Advocate, Lay Health Worker, Outreach Worker, Peer Educator, Patient Navigator, Community Care Coordinator, etc. All of these names emphasize the community connection, trust, and adaptation required of the position.

Regional Adaptations and Innovations in the CHW Model

Traditionally, CHWs served as a connection between the healthcare/clinical setting and the community. As the role has evolved, numerous innovations across the Community Health Worker model have been implemented to help meet the needs of specific populations.

Justice-focused Community Health Workers



Community Health Center of Southeast Kansas, a Federally Qualified Health Center serving over 90,000 patients each year across eastern Kansas and northeast Oklahoma, integrated CHWs in their Judicial Services Program in 2025. The program aims to reduce the impact of substance use disorders (SUD) and related justice system involvement across four rural counties. The CHWs support transportation to appointments, rent and utility assistance, clothing and household item assistance, and education and career support. They also assist with the Recovery Court program, aimed to help participants continue their education and build meaningful careers, find safe housing, and improve family stability.

Community Paramedicine and Community Health Workers



The integration of Community Paramedics (CPs) and Community Health Workers into home-based care emerged as a significant innovation to address gaps in healthcare access for rural and medically underserved populations. The Mobile Integrated Healthcare Network (MIHN), also known as SHO-ME MIH Network, pioneered this approach in Missouri, where CHWs coordinate care and assess social determinants of health while CPs provide clinical services including basic preventive care, home safety assessments, medication reconciliation, wound care, and telehealth facilitation during scheduled home visits. By bringing healthcare directly to patients’ homes and addressing both medical and social needs, MIHN programs reduce emergency transports, improve health outcomes, and lower healthcare costs. Community Paramedics and CHWs in MIH programs have been operating in Missouri since the pilot project’s inception and expanded to Kansas in 2024.

School-Based Community Health Workers



The integration of CHWs into school settings emerged as a significant innovation as schools were recognized as a critical setting for addressing social determinants of health and the acknowledgment that educational success is deeply tied to a child’s health. School-Based Community Health Workers help advance schools’ vision for all children to have access to quality education by helping families resolve barriers to reaching their goals and building linkages among the school and community. These barriers are influenced by many factors that include access to healthcare, food, clothing, shelter, and other needs. To help students and families meet these needs and to foster student success and wellbeing, some school districts are making use of Community Health Workers in their schools to help ensure that all students have the same opportunity for success in school and in life. School-Based Community Health Workers (SB-CHWs) have been located in Missouri schools since 2016 and in Kansas schools since 2022.



Social Determinants of Health Framework

According to Healthy People 2030 (Office of Disease Prevention and Health Promotion (ODPHP), n.d.), the Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Understanding these SDOH is essential to improving interventions for health, educational, behavioral and social outcomes.

 Economic Stability	 Education Access & Quality	 Healthcare Access & Quality	 Neighborhood & Built Environment	 Social & Community Context
Connect families facing crisis situations to emergency assistance	Assist students and families in removing barriers to school attendance	Help schedule medical, dental, and behavioral health appointments	Connect families to housing and transportation resources	Organize and participate in school events that increase family engagement
Provide financial literacy education to families to improve budgeting and financial skills	Ensure students' basic needs are met so students can arrive to school ready to learn	Help families navigate insurance, benefits eligibility, and enrollment processes	Manage school-based resources such as clothing closets and food pantries	Help parents understand school policies, expectations and rights
Link parents/caregivers to job training programs, employment services, and workforce development resources	Attend IEP meetings to advocate for the students' and families' needs	Help families understand complex healthcare systems	Advocate for safe routes to school and access to parks, playgrounds, and recreational facilities in the community	Participate in community-based events, coalitions, and committees to advocate for families

SB-CHW Role in Addressing SDOH

School-Based Community Health Workers play a vital role in addressing the social determinants of health that impact student success by working at the intersection of healthcare, education, and community support. Recognizing that factors such as housing instability, food insecurity, lack of transportation, and limited access to healthcare directly affect a student's ability to attend school, focus in the classroom, and achieve academic goals, SB-CHWs implement targeted interventions that remove these barriers and strengthen family capacity. Through trusted relationships and responsive practices, they connect students and families to essential resources while building the skills and knowledge families need to navigate complex systems independently.

The core responsibilities of SB-CHWs related to social determinants of health intervention include:

- › Navigating and assisting families in accessing resources in the school and community

› Helping meet the identified needs of students/families

› Assisting families in developing goals and establishing self-sufficiency skills
- › Building relationships in the school and community

› Providing health and social systems literacy education to families

› Acting as a bridge within the family, school, and community

How can SB-CHWs collaborate with school staff to address social determinants of health?

SB-CHWs collaborate with school staff to address social determinants of health by participating in student support team meetings, parent-teacher conferences, and committee discussions where they share insights about family circumstances and home barriers affecting student success. They work closely with teachers, counselors, administrators, and other school personnel to identify students impacted by food insecurity, unstable housing, lack of transportation, or inadequate sleep, then develop coordinated intervention plans that address both academic

and non-academic barriers. By breaking down the social determinants preventing classroom success and connecting families to community resources that meet fundamental needs, SB-CHWs help school staff understand the root causes of attendance, behavioral, and academic challenges within the school setting. This collaborative approach ensures that when outside stressors are removed and basic needs are met, students can come to school ready to focus, learn, and thrive, while also allowing educators to focus their efforts on their students' educational goals.

As a new SB-CHW, what can I do to help support my school's staff in addressing the social determinants of health of families in our district?

- › Attend parent teacher conferences

› Attend Student Intervention Team meetings

› Attend IEP Meetings

› Attend School Board Meetings
- › Conduct Home Visits

› Join school and community-based committees, task forces, or workgroups

› Share SDOH and outcome data

Impact of SDOH on Student Success

School-Based Community Health Workers create meaningful change in students’ lives by addressing the social determinants of health that serve as barriers to educational success. While SB-CHWs do not provide direct academic instruction or clinical treatment, they help create conditions necessary for students to attend school consistently, engage in learning, access needed health and mental health services, and benefit from family support. This section illustrates how SB-CHW activities translate into measurable improvements across four interconnected outcome areas: school attendance, academic performance, student behavioral health, and family engagement with school systems.

Setting the Stage

School Attendance



Chronic absenteeism is defined by the U.S. Department of Education as missing 10% or more of school days in an academic year and is a key early indicator that the student may face academic risk (2023). National data indicated that chronic absenteeism increased sharply during the COVID-19 pandemic period, peaking in the 2021-2022 academic school year, when approximately 1/3 of U.S. students were chronically absent. Although modest improvements were observed in subsequent years, absenteeism rates remain elevated relative to pre-pandemic baselines.

Academic Performance



Students experiencing higher levels of adverse social determinants of health, including economic instability, food insecurity, neighborhood safety concerns, and limited access to social support, are consistently associated with lower academic performance and graduation rates. These challenges are well documented in state education data and child well-being indicators, which show that poverty and unmet basic needs are linked to increased chronic absenteeism, reduced academic achievement, and lower likelihood of on-time graduation.

Student Behavioral Health



Student behavioral and mental health has emerged as a critical concern in the post-pandemic period. National surveillance data indicate high prevalence of psychological distress among adolescents, including persistent feelings of sadness or hopelessness and elevated rates of anxiety and depression-related symptoms (Centers for Disease Control and Prevention, 2023). State and local health profiles for Kansas and Missouri similarly document elevated youth mental health needs, particularly in communities experiencing higher levels of poverty and social disadvantage (CDC, 2023). Behavioral health challenges are related to school disengagement, absenteeism, and difficulties with concentration, motivation, and peer relationships. When unaddressed, these challenges may compound over time, contributing to academic difficulties and increased risk of dropout.

Family Engagement



Family engagement is a well-established protective factor in student outcomes, yet schools in high-poverty and rural communities often struggle to build and sustain meaningful connections with caregivers. Research shows that when families are engaged in their children’s education, students demonstrate improved attendance, academic performance, and behavioral regulation. Barriers such as transportation, work schedules, and distrust of institutions can leave families disconnected from school-based supports.

4 Ways SB-CHWs Impact School Attendance

Transportation

- › Providing direct rides to students
- › Helping families navigate and apply for district busing or community transportation services
- › Providing transportation to medical appointments that would prevent students from attending school

Collaboration

- › Participating in wraparound meetings to identify students struggling with attendance
- › Conducting home visits to uncover root causes of absences and connect families to targeted resources and support



SDOH

- › Identifying and addressing social determinants of health that prevent students from attending school and linking families to resources in the school and community
- › Through home visits and direct engagement, SB-CHWs uncover barriers and provide tailored solutions that remove obstacles and enable consistent school attendance

Advocacy

- › SB-CHWs serve as a bridge between families and school systems
- › Translating complex processes into accessible language
- › Ensuring barriers such as literacy challenges, lack of awareness about available services, or fear of child welfare involvement don’t prevent families from accessing the support they need and their child from attending school

From the Field: Turning Attendance into a Team Effort

“This year we kicked off the Attendance Olympics. Each grade level competes as a team, earning collective points for attendance.

The response has been incredible—students are excited to come to school and the competitive energy is contagious! We’ve worked hard to find innovative ways to approach attendance in our district.”



4 Ways SB-CHWs Impact Academic Performance

Goal-setting & future planning

- › Helping students set goals and create plans for their future, providing direction and motivation for their current educational efforts
- › SB-CHWs recognize that all students' goals and definition of success are different and their support should differ depending on the goal: applying for colleges, trade schools, or finding a well-paying job in the community post-graduation

Removing barriers & addressing SDOH

- › Remove outside stressors that interfere with a student's ability to focus on education, allowing students to concentrate on learning and achievement rather than being overwhelmed by external challenges
- › By partnering with community organizations and connecting to school resources, they eliminate barriers that directly improve students' alertness, confidence, engagement, and overall academic success



Collaborating with school staff

- › Collaborate with school staff to connect struggling students to appropriate supports such as tutoring services, study programs, technology access, or additional classroom accommodations, while also ensuring all students receive the supports they need to stay engaged in the classroom

Advocating for students' needs

- › Advocate for students by meeting with families to discuss concerns, translating complex educational systems, and connecting them to supports
- › Empower families as long-term advocates by providing resources on IEPs, special education navigation, and planning for services such as guardianship, Social Security, and ongoing medical care



From the Field: When Basic Needs Come First

"I attended a Student Intervention Team meeting for a student who was constantly tired and struggling to stay awake in class. After meeting with the family, we discovered the student did not have a bed and was sleeping on the floor, and the family was struggling with food insecurity.

I partnered with a local organization to provide the family with a new bed and added the student to our weekend food pack list.

Within weeks, the teacher noticed the student was more alert, confident, and engaged in the classroom."

4 Ways SB-CHWs Impact Student Behavioral Health

MTSS pyramid

- › Connect students to tiered supports ranging from universal interventions such as recovery rooms and life skills development, to targeted school counselor visits and mental health liaison connections, to intensive services such as therapy with behavioral health providers, ADHD counseling, and medication management



Collaboration

- › Collaborate with school staff to identify students with emotional or behavioral challenges and address family needs through wraparound meetings
- › Use a two-generation approach where improving family access to mental health care, housing, and supports directly enhances student behavior and classroom focus

SDOH

- › Coordinate referrals to mental health services, helping families apply for insurance coverage, and providing transportation to appointments to ensure consistent treatment
- › They also help remove underlying stressors that contribute to emotional dysregulation and classroom disruptions

Mentorship

- › Build trusting relationships with students and families, helping them develop coping strategies, work through challenges, and be a safe space to feel heard and valued

From the Field: Bridging the Gap to Mental Health Care

"I worked with a new student who had recently moved into the school district and wasn't insured. Because of this, the student hadn't seen a doctor and was unable to fill their medication, which was leading to frequent behavior issues and classroom disruptions.

I helped the family apply for Medicaid, got the student seen quickly at our school-based clinic, and helped refill their prescription. I also referred the student to the school counselor and MHIT liaison for additional support.

Within just a few weeks, their teacher said their behavior had improved dramatically."



4 Ways SB-CHWs Impact Family Engagement with the School System

Building Trust

- › Build trusting relationships with parents and guardians through consistent presence and support
- › Help families feel comfortable and informed during school interactions, to create a foundation of trust that encourages families to become more involved in their student's education and access available school resources

Bridging the Gap

- › Serve as a bridge among families, schools, and community by translating school policies and academic expectations for parents and guardians
- › Connect them to community resources through comprehensive resource guides
- › Help families navigate school programs, online systems, and community services so they can fully participate in their student's education



Connecting to Resources

- › Increase family engagement by helping families understand and access school programs such as tutoring, special education, extracurriculars, counseling, free meals, and health services
- › Provide hands-on assistance with enrollment forms, applications, and online systems, while connecting families to volunteer opportunities and school events

Advocacy

- › Advocate for families by providing translation and interpretation services to overcome language barriers in school meetings and communications
- › Offer training to school staff about family values, communication styles, and factors influencing parent involvement, helping schools create practices that adapt to meet community needs



From the Field: Family Engagement Magic

“Our school team created an annual family engagement event to launch the school year, building strong connections among families, students, and staff. We were able to feed over 500 people, provided free school supplies, backpacks, and jackets, and created a fun, community-friendly atmosphere with bounce houses, and prize giveaways. The event establishes trust and demonstrates the school's commitment to supporting all families.”

Key Takeaways of SB-CHWs Role in Addressing SDOH

- › Recognize that SB-CHWs impact academic success indirectly by removing barriers such as transportation challenges, housing instability, food insecurity, and healthcare access issues. Design SB-CHW workflows and caseloads that prioritize identifying and addressing SDOH needs that prevent consistent school attendance and classroom engagement.
- › Implement strategies that address family behavioral health needs, housing stability, and access to resources alongside student-focused interventions. When families receive mental healthcare, stable housing, and economic support, students demonstrate improved behavior, focus, and ability to engage in learning.
- › Integrate CHWs into school teams where they can share insights about family stressors, coordinate referrals across tiered supports, and work alongside teachers, counselors, nurses, and administrators to identify struggling students early and connect them to appropriate resources.
- › Train and support SB-CHWs to build trusting relationships through consistent presence, home visits, and responsive outreach. Trust is the foundation that enables families to engage with schools and access available supports.



Implementation

Defining the scope of work for SB-CHWs is challenging but essential. Unlike traditional school roles, the SB-CHW position is new to educational settings, and stakeholders often hold varying expectations. Establishing clear guidelines that outline the scope of work protects SB-CHWs from burnout, ensures consistent service delivery, guides appropriate referrals, and helps communicate the SB-CHW’s value. This section covers core SB-CHW competencies and activities, scope boundaries, and guidance for navigating multiple systems.

Defining Scope of Practice

Typical SB-CHW activities and responsibilities

Direct Family Support

- › Identify, navigate, and coordinate resources to meet student and family needs
- › Organize resources to increase accessibility for families/school staff
- › Determine eligibility for benefits and insurance and help families through the enrollment process
- › Build trust with students and families and advocate for their needs within the school and community systems
- › Collaborate with school and community partners to address unmet student and family needs
- › Conduct home visits or phone check-ins with families
- › Provide health education to families
- › Provide linkages to social service, medical, and behavioral health systems

School Collaboration

- › Manage or facilitate school-specific resources such as clothing closets, food pantries, hygiene items, etc.
- › Collaborate with school staff to support students and families in meeting educational goals
- › Meet with all levels of school staff so they know how SB-CHWs can help both students and families
- › Create flyers to make school staff aware of SB-CHWs and how they can help

Community Connection

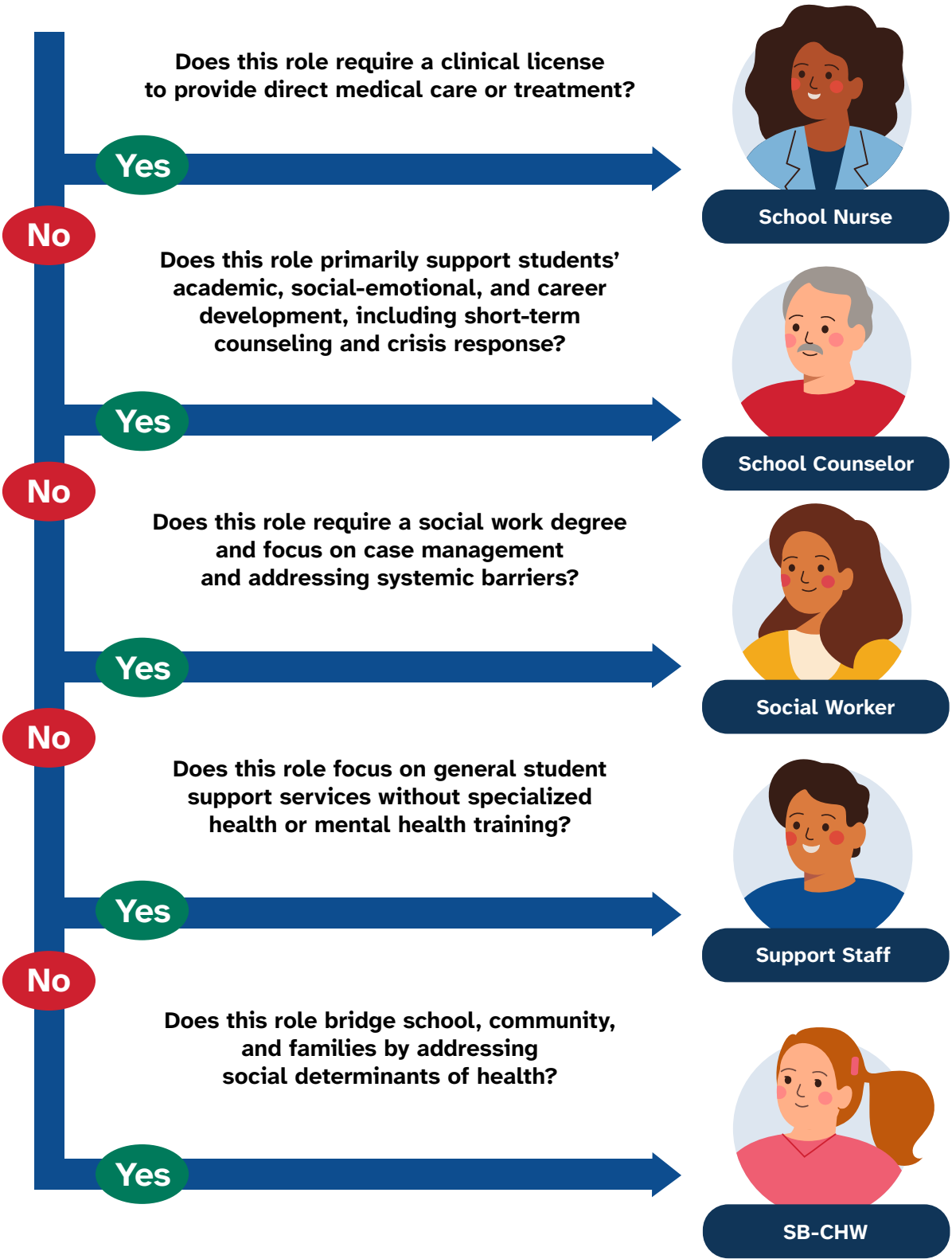
- › Set up meetings with CBOs/helping organizations that meet the highest needs and orient yourself to your community
- › Utilize social media for engaged communication with families and community
- › Participate and facilitate community and school events/collaborations that strengthen family and school connections and engagement
- › Build relationships with everyone!

Program Administration

- › Document outreach efforts, referrals, and outcome metrics in order to track trends in student and family needs to help the district and community identify gaps and plan strategic interventions

Differentiating Roles

Below is a flow chart to better understand the distinction between School-Based Community Health Workers and other school professionals who also impact student and family success.



Key Takeaways of Defining SB-CHW Scope

- › A clearly defined scope of work, determined by key school and community stakeholders, protects SB-CHWs from burnout and ensures the intervention fills the identified gaps.
- › SB-CHWs are not clinicians, counselors, or social workers. They serve as a bridge among families, the school, and community resources, addressing the social determinants of health that affect student success.
- › The SB-CHW role is comprehensive by design, spanning resource navigation, benefits enrollment, home visits, health education, and community partnerships, but it should always be defined clearly and implemented to meet the identified school and/or community need.
- › SB-CHWs should be trained to perform data collection and complete comprehensive documentation, provide community outreach, and address unmet needs across the family, school, and community landscape.



Recruiting and Hiring

Finding the right SB-CHW for your district is one of the most important steps in building a successful program. Telehealth ROCKS recommends prioritizing the following skills and qualities when recruiting to ensure a strong fit for your school and community and to align with nationally recognized CHW standards.

- › Communication Skills
- › Interpersonal & Relationship-Building Skills
- › Service Coordination & Navigation Skills
- › Education and Facilitation Skills
- › Advocacy Skills
- › Building Individual and Community Capacity
- › Individual & Community Assessment
- › Outreach Skills
- › Professional Skills and Conduct
- › Evaluation and Research Skills
- › Knowledge Base



Essential competencies for effective SB-CHWs

Kansas and Missouri certification bodies share the following essential competencies for effective CHWs:

- › Professionalism and Conduct
- › Self-awareness
- › Service Coordination and System Navigation
- › Education to Promote Healthy Behavior Change
- › Advocacy
- › Individual and Community Capacity Building
- › Effective Communications Strategies
- › Responsiveness to community and family needs
- › Documentation and Reporting
- › Use of Public Health/Community Health Concepts and Approaches
- › Individual Assessment
- › Community Assessment

Educational Requirements and Recommended Experience

CHWs typically possess a high school diploma or equivalent, with postsecondary education or certification usually preferred. The Telehealth ROCKS SB-CHW Model encourages school districts to hire SB-CHWs that will match the professional qualifications of the surrounding school district staff while prioritizing the above personal characteristics to fill the gap in care.

Employment Models

One of the earlier and most consequential decisions when establishing a School-Based Community Health Worker program is determining the employment model: Will CHWs be employed directly by the school district, by a community-based organization (CBO) or healthcare partner, or through a shared/hybrid arrangement? This decision has significant implications for supervision structures, funding streams, role clarity, resource access, and program sustainability. There is no right or wrong approach—each model offers distinct advantages that must be weighed against your community’s unique context, existing partnerships, funding landscape, and organizational capacity.

School District-Employed Model

In this model, CHWs are hired, supervised, and paid directly by the school district. They function as district employees with the same benefits, policies, and schedule as teachers, counselors, and other school staff.



Advantages

- › SB-CHWs have direct access and are usually more deeply integrated with school staff, leadership, student information systems, and internal communication channels
- › Fewer barriers to accessing attendance records, academic performance, and IEP/504 information
- › SB-CHWs are readily available on campus, increasing opportunities for informal connections with students, families, and staff
- › SB-CHW work directly supports district wellness policies, family initiatives, and attendance improvement efforts



Challenges

- › SB-CHWs may have to work harder to identify and connect with community resources outside the school system
- › Without clear boundaries, SB-CHWs may be asked to take on tasks outside their scope due to district staffing pressures
- › School districts may struggle to sustain SB-CHW positions if reliant solely on general education funds

Key Considerations for Choosing an Employment Model

- › Funding sustainability: Which model has the most reliable, long-term funding streams for SB-CHW positions? Can Medicaid billing be leveraged?
- › Existing infrastructure: Does the school district or CBO have established supervision, training, and support systems for SB-CHW staff?
- › Community relationships: Which organization has stronger, more trusted relationships with the families and communities you aim to serve?
- › Resource access: Where do gaps in resources exist, and which employment model positions SB-CHWs to most effectively fill those gaps?
- › Data and technology systems: Which model allows more seamless data integration for tracking referrals, outcomes, and program impact?

Community-based Organization-Employed Model

In this model, CHWs are employed by a community-based organization (such as a healthcare entity, public health department, or social service agency) and placed in schools through partnerships or contracts with the school district.



Advantages

- › When employed by organizations that provide services (FQHC, food bank, housing agency), CHWs can facilitate immediate enrollment or service access without external referral processes
- › CBOs often have broader community connections & multiple contact points with families beyond schools
- › CBOs may have access to healthcare billing, Medicaid reimbursement, foundation grants, and diversified revenue streams unavailable to school districts



Challenges

- › It may be more difficult to fully integrate SB-CHWs into the school environment, requiring intentional relationship-building and role clarification
- › Accessing student-level school data requires MOUs, data sharing agreements, and careful FERPA/HIPAA navigation
- › If SB-CHWs split time across multiple sites or spend significant time in the community, they may have fewer informal touchpoints with students and staff

Key Takeaways
of Recruiting and Hiring SB-CHWs

- › The right hire matters more than the perfect resume. Make sure to prioritize candidates who demonstrate strong relationship-building, responsiveness to individual and family needs, and community ties alongside any formal qualifications.
- › SB-CHWs typically hold a high school diploma or equivalent, but the Telehealth ROCKS model encourages districts to align qualifications with local staff standards while keeping lived experience and personal characteristics in mind.
- › Key things to consider when choosing an SB-CHW employment model: funding sustainability, existing support structure and community relationships, resource access, data and technology system access.
- › Both school-district employed and CBO-employed models have distinct advantages that must be weighed against your community’s unique context, existing partnerships, funding landscape, and organizational capacity.



Training and Certification

Both Kansas and Missouri offer standardized, competency-based curriculum for CHWs to earn a certificate through post-secondary education institutions. While a certification is not currently required for CHW employment, it is increasingly recognized by employers as evidence of foundational training for the role and is required for billing CHW services covered under Medicare and Medicaid. Kansas recognizes Missouri certification, but Missouri does not currently recognize Kansas certification.

Classroom instruction covers topics that include the role of Community Health Workers, public health, chronic disease management, mental health, health outreach, community organizing and advocacy, client-centered counseling, conducting client interviews, care management and home visits.

Recertification

CHWs must apply for recertification every two years.
To qualify for recertification, CHWs must complete 20 hours of Continuing Education Credits aligned with the CHW Core Competencies. Of the 20 Continuing Education Credits required, 6 hours must be focused on Ethics and HIPAA training.

KS

Kansas

CHWs in Kansas are certified through the Kansas Community Health Worker Coalition. CHWs can complete certification through one of the approved curriculum providers on the Kansas CHW Coalition website. (Kansas Community Health Worker Coalition, n.d.)

MO

Missouri

CHWs in Missouri are certified through the Missouri Credentialing Board. CHWs can complete certification through one of the certified curriculum providers on the Missouri Department of Health and Senior Services CHW webpage. (Missouri Credentialing Board, n.d.)

CHWs in both states can become certified through one of the following pathways:



***Be sure to confirm up-to-date process information on applicable state website**

Telehealth ROCKS recommends supplemental training for School-Based Community Health Workers to support their integration in the school setting.

Suggested training topics include:

- › FERPA compliance
- › IEP/504 Plan familiarity
- › Student & family rights
- › Mandatory reporting laws



SB-CHW Onboarding

Effective onboarding is essential to any SB-CHW program’s success. It equips new CHWs with the knowledge, skills, and confidence to navigate the intersection of education, healthcare, and community systems from day one. Comprehensive onboarding clarifies role boundaries, establishes consistent practices, builds school partnerships, and protects students, families, and CHWs through grounding in confidentiality, mandatory reporting, and safety protocols.

School Integration Strategies and Relationship Building

Successfully integrating a Community Health Worker into a school setting requires intentional planning, clear communication, and ongoing support. The strategies below are designed to help administrators, program leaders, and SB-CHWs build a strong foundation from day one.

1. Establish responsibilities of SB-CHW within the school setting

Before an SB-CHW is onboarded, it is essential that their role is clearly defined and communicated across the school system. Uncertainty about what an SB-CHW does — and does not do — can create confusion among staff, families, and community partners and limit the SB-CHW’s effectiveness.

School leadership should establish the SB-CHW’s core responsibilities, what their documentation obligations are, and how their work connects to existing school support structures such as MTSS, attendance committees, and student intervention teams prior to their onboarding. Having a clear role description that is implemented from the top down sets the SB-CHW up to be used effectively and prevents overlap or gaps with other staff roles.

2. Familiarize the SB-CHW with the school environment and population

An SB-CHW’s effectiveness is deeply tied to how well they understand the environment they are working in and the community they are serving. Dedicate intentional time at the start of the CHW’s onboarding to helping them learn the school’s culture, layout, daily routines, and student population.

This includes learning about the demographics and backgrounds of the school community, and reviewing available data on student needs — including SDOH indicators, chronic absenteeism rates, and any existing health or behavioral health trend data.

Regarding placement, an SB-CHW is typically located within a designated school building in order to build the trust and consistent presence that makes this role effective. Being physically present in the school allows SB-CHWs to develop organic relationships with students, staff, and families over time. However, school districts have found success with SB-CHWs located outside of the school building as well — particularly in models where the district is partnering with a community-based organization to employ the SB-CHW. In these cases, establishing a regular, predictable schedule for when and where the SB-CHW is present at each school is critical to maintaining visibility and trust.

3. Introduce the SB-CHW to the school community

Ensuring the SB-CHW is integrated into the broader school community is one of the most important early investments a district can make. Everyone in the school community — staff, families, and community partners — should understand how to connect a student or family to the SB-CHW. Referral processes should be simple, clearly communicated, and easy to access. Consider posting referral information in staff common areas, including it in school handbooks, and reviewing it at the start of each school year.

Introductions should happen at multiple levels and through multiple channels:



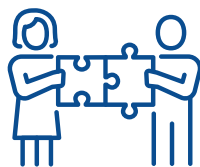
School Staff

Introduce the SB-CHW at staff meetings, professional development days, and department gatherings. Provide all staff — including teachers, front office staff, school nurses and counselors, and administration — with a clear, simple explanation of the SB-CHW’s role and how to make a referral. Staff who interact with students and families every day are often the first to notice when someone needs support, and they need to know who to call.



Families

Use school newsletters, back-to-school nights, parent-teacher conferences, and community events to introduce the SB-CHW to families. Consider creating a simple one-page flyer in all languages spoken in the school community that explains who the SB-CHW is, what they help with, and how to reach them.



School and Community Partners

Ensure that community organizations, healthcare providers, and other partners who work with the school are aware of the SB-CHW and understand how they fit into the broader support network. These relationships are essential for making referrals and coordinating wraparound care.

4. Establish a strong support system for the SB-CHW

SB-CHWs work at the intersection of health, education, and social services — navigating complex family situations, systems, and needs on a daily basis. Without adequate support, even the most skilled and dedicated CHW can experience burnout, isolation, or role drift. Building a robust support structure from the beginning is essential to the long-term sustainability of the program and the wellbeing of the SB-CHW.

Direct supervision

Every SB-CHW should have a clearly identified direct supervisor who provides regular check-ins, case consultation, and performance feedback. Supervisors should understand the CHW model, have realistic expectations for caseload and outcomes, and be accessible when the CHW encounters a difficult or complex situation. Supervision should be a space for both accountability and support.

School-based support team

In addition to a direct supervisor, SB-CHWs benefit greatly from being integrated into the school’s existing support team. This typically includes school counselors, mental health staff, school nurses or health staff, social workers, and special education coordinators. Regular communication and collaboration with these team members allows the SB-CHW to coordinate care, avoid duplication of services, and ensure students and families are receiving comprehensive support across all of their needs.

Peer connection

Where possible, connect SB-CHWs with other CHWs for peer support, shared learning, and professional community. The CHW role can be isolating, and having colleagues who understand the unique demands of the work is invaluable. Telehealth ROCKS hosts a monthly community of practice for School-Based Community Health Workers, their supervisors, and community-based partners.

Self-care and sustainability

Build in structures that support the SB-CHW’s wellbeing — whether that is regular reflective supervision, access to employee assistance programs, or simply a workplace culture that normalizes talking about the weight of the work. A supported CHW is a more effective CHW.



Referral System Development

A well-designed referral system is the backbone of an effective School-Based Community Health Worker program. Clear processes for identifying students in need, connecting them to support, and tracking follow through, allows schools to collect relevant data and demonstrate program impact. The components below will help your program build a referral system that is efficient and effective.

Workflow Design for Student and Family Identification and Referral

Before your SB-CHW sees their first student, your team should have a clear answer to a basic but critical question: **how does a student or family get connected to the SB-CHW in the first place?** Referral workflows define who can make a referral, how they make it, what information needs to be included, and what happens after a referral is submitted.

Referrals to an SB-CHW typically come from multiple sources — teachers who notice a student is struggling, school counselors managing complex caseloads, nurses who identify unmet health needs, administrators flagging attendance concerns, or families who reach out directly. Your workflow should account for all of these entry points and make the process as low-barrier as possible. Work with your school team to map out the full referral pathway from identification to first contact, and make sure every staff member who interacts with students understands their role in it.

Develop a referral questionnaire that collects the necessary contact information for the student and family, the preferred time to contact, and the reason for referral. [See Appendix for an example CHW Referral Questionnaire](#)

Screening Tools for SDOH Needs

Once a student or family is connected to the SB-CHW, a structured screening tool helps ensure that the full picture of their needs is captured — not just the presenting issue that triggered the referral. Two widely used tools in school-based and community health settings are:

PRAPARE

PRAPARE (Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences) is an evidence-based SDOH screening tool that assesses needs across domains including housing, food security, employment, transportation, social support, and safety. It is highly used by FQHCs, clinics and hospitals, and other community-based organizations. (PRAPARE, 2023)

Arizona Self-Sufficiency Matrix

Arizona Self-Sufficiency Matrix (ASSM) is an evidence-informed tool that measures a family’s level of self-sufficiency across 18 domains over time. This measure was adapted for school use and is not clinically diagnostic. It is particularly useful for initially identifying where a family is on a continuum from crisis to thriving and tracking progress over time (Arizona Coalition to End Homelessness, n.d.).

Your program should select the screening tool that best fits your community’s needs, your documentation system, and your reporting requirements — and ensure that SB-CHWs are trained to administer it in a trauma-informed way. [See Appendix for Example SDOH Assessment Matrix](#)

Referral Tracking Systems

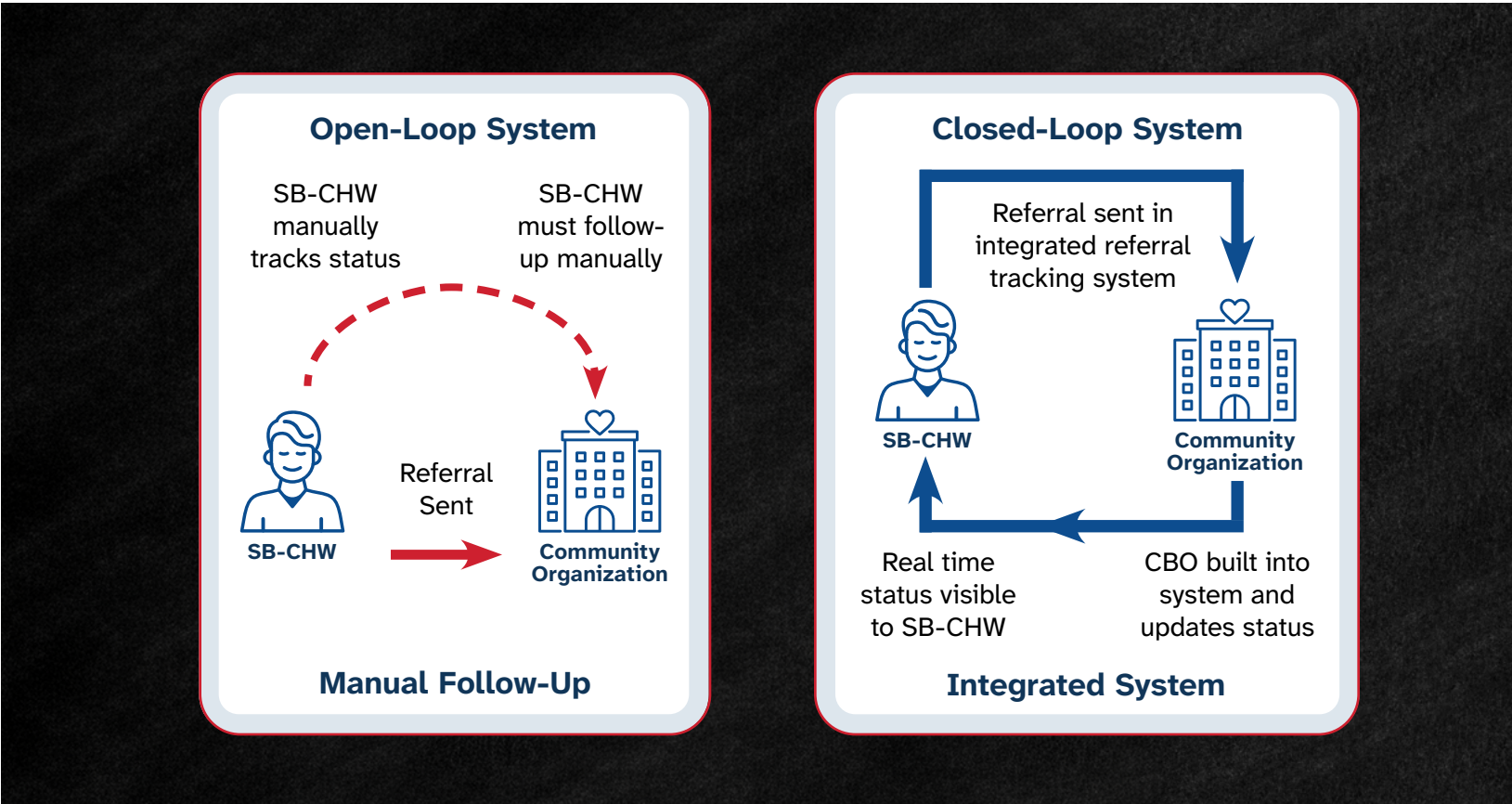
Making a referral is only the first step. A referral tracking system allows your program to monitor the status of every referral, ensure timely follow-up, identify bottlenecks in the process, and demonstrate the scope and outcomes of the SB-CHW’s work over time.

At minimum, your tracking system should capture:

- › Basic demographics, including insurance status
- › Case management and follow-up notes
- › Referral source
- › Outgoing referrals
- › Reason for referral

Referral tracking systems can be as simple as a shared spreadsheet or a more coordinated shared electronic health record or social referral platform. The most important considerations are its ease of use and the ability to meet documentation and reporting requirements.

After the SB-CHW accepts the referral and identifies the family’s immediate needs, they will refer the family to resources that can help meet those needs. This can be done through two different processes:



Community CareLink is an example of a platform designed to support closed-loop referral communication among schools, community organizations, and health providers. It allows referrals to be sent, tracked, and confirmed across organizations, creating a shared record of what was offered and what was accepted.

Daily Operations

Documentation Requirements

Consistent, accurate documentation is one of the most important aspects of an SB-CHW’s daily work. Documentation captures the story of the SB-CHW’s impact and generates the data needed to sustain and grow the program over time.

Your program should establish clear documentation expectations from the start, including what needs to be recorded after every student or family interaction, how quickly documentation should be completed, where it is stored, and who has access to it. Telehealth ROCKS recommends developing a Documentation Expectations Guide tailored to your program’s tools and requirements as a practical resource to share with the SB-CHW during onboarding. Clear expectations from day one prevent inconsistent habits that are difficult to correct later. [See appendix for a template THR Documentation Expectations Guide.](#)

Case Management Approaches

SB-CHWs use a relationship-centered approach to case management that looks different from traditional social work or clinical case management. Rather than directing a family’s plan, the CHW walks alongside families — helping them identify their own goals, navigate systems, access resources, and build the confidence and skills to advocate for themselves over time.

Effective case management in this model is built on trust, consistency, and follow-through. It means checking in even when things seem stable, meeting families where they are — sometimes through home visits — and understanding that progress is rarely linear. SB-CHWs should have access to a clear framework for how to open, manage, and close cases, as well as guidance on when to escalate concerns to a supervisor or connect a family to a higher level of care.

Managing Caseload Size and Prioritization

One of the most common challenges in SB-CHW programs is caseload management. Without clear guidelines, CHWs can quickly become overwhelmed — taking on more cases than they can meaningfully serve and stretching their capacity to the point where quality of care suffers.

Recommended caseload sizes vary depending on the complexity of needs in the community, the SB-CHW’s experience level, the availability of community resources, and the documentation requirements of the role. As a general framework, new SB-CHWs typically begin with 5–10 active cases and build toward 15–25 as they gain experience and confidence. Your program should establish caseload guidelines and build in regular check-ins to ensure your SB-CHW is not carrying more than they can effectively manage.

Telehealth ROCKS has developed a 30-, 60-, and 90-day guide to support new SB-CHWs as they onboard into their role.

FIRST 30 DAYS: Foundation & Orientation

The first 30 days are about getting oriented, building your foundation, and introducing yourself to the people and places that will define your work. Focus on listening, observing, and learning before jumping into action.

Documentation Requirements

- › Complete all school onboarding requirements, including HIPAA, FERPA, and home visitation safety training.
- › Familiarize yourself with the school buildings, daily schedules, and school calendar.
- › Learn the school’s rules, regulations, policies, and procedures — understanding how the school operates is essential before you can effectively advocate within it.
- › Attend staff meetings and introduce yourself to teachers, counselors, nurses, administrators, and other support staff. Make both scheduled and unscheduled contact — the goal is to become a familiar and trusted presence.
- › Shadow experienced School-Based Community Health Workers if possible. Observing how other SB-CHWs navigate their role and build relationships is one of the most influential ways to learn.

Get to Know Your Community

- › Get out into your community and introduce yourself to local businesses, faith communities, and organizations that offer resources to families.
- › Begin reviewing Social Determinants of Health and other school data and trends relevant to your school community to understand the types of needs you’ll be addressing.
- › Find out the current needs and concerns at your school — ask questions and listen carefully across school staff, administration, community members and families.

Prepare for Student and Family Outreach

- › Determine how you want to get the word out to families about who you are and what you do. Consider school newsletters, flyers, social media, announcements, or presence at school events.
- › Make yourself present and available in school common areas, hallways, the cafeteria, and recess to begin building familiarity and trust.
- › Review existing SDOH workflows, documentation systems, and referral pathways used by your school or program.



30-Day Checkpoint

By the end of your first month, you should feel oriented to your school district, have introduced yourself to key school staff and community partners, and begin to develop a clear picture of the needs you will be addressing.

DAYS 31–60: Building Relationships & Building Your Caseload

The second month shifts from orientation to action. You’ll begin building deeper relationships with students, families, and community partners, start accepting referrals, and take your first steps toward a manageable caseload.

Connect with Students and Families

- › Make yourself visible and accessible to students — eat lunch with them, visit recess, and spend time in common areas where students pass through. These informal moments are where trust is built.
- › Work with your supervisor and school administration to determine a manageable caseload level and support systems for if your caseload becomes too heavy.
- › Develop referral pathways that work for you and your school district. Begin accepting referrals and building your caseload.
- › Practice motivational interviewing and de-escalation strategies in your early family interactions.
- › Strengthen your documentation habits, case management processes, and follow-up practices from the start.

Integrate into School Systems

- › Join MTSS, IEP/504, Student Assistance/Intervention Team (SAT/SIT), attendance committees, and any other relevant school meetings. Getting a seat at these tables early helps you collaborate on student needs and establish your role as part of the team.
- › Make yourself aware of the student and family resources that exist across the school district and where any gaps may be that you could help fill.
- › Develop referral workflows with school counselors, nurses, and administrators so the process for connecting students to you is clear and consistent.
- › Develop documentation processes for case notes, referrals, follow-up attempts, SDOH assessments and other metrics being tracked.

Grow Your Community Network

- › Continue building partnerships with community agencies, resource networks, and local businesses who already assist families with needs. These partnerships will be helpful when you need to connect families to services.
- › Join community coalitions, action teams, and community boards to stay up-to-date with community needs and happenings and to create a long-term avenue for advocacy.



60-Day Checkpoint

By the end of month two, you should have an active caseload, be participating in school team meetings, and have begun establishing meaningful relationships with students, families, and community partners.

DAYS 61–90: Independent Practice & Community Impact

The third month is about establishing your independence, deepening your impact, and demonstrating your value as a fully integrated member of the school team. You’ll manage a consistent caseload, lead community engagement efforts, and reflect on your growth.

Manage Your Caseload with Confidence

- › Continue case management across school and community referrals, maintaining consistent check-ins and follow-through on all open cases.
- › Continue documenting student/family progress and outcomes carefully — this data will tell the story of your impact.

Lead Community & Family Engagement

- › Begin planning family and community engagement events throughout the school year. Bringing families together and introducing yourself to the broader community builds trust, reduces barriers to asking for help, and reinforces your role as a connector.
- › Identify at least one gap in school-based resources and execute a plan to fill it. This could be a weekend buddy pack program, hygiene kits, a clothing closet, a school food pantry, etc.

Reflect, Evaluate & Grow

- › Review your caseload data for patterns — are there recurring needs, gaps in services, or opportunities to improve referral processes? Use this information to recommend process improvements to your team or supervisor.
- › Set professional development goals for the months ahead, including any additional training, certifications, or skills you want to build.

Mentorship and support program recommendations

- › [Telehealth ROCKS Program](#)
- › [Community Health Worker Association of Missouri](#)
- › [Kansas CHW Coalition](#)
- › [National Association of CHWs](#)
- › [Agencies Working Together](#)
- › [Kansas Department of Health and Environment](#)

For more information on any of these supports, please reach out directly to Telehealth ROCKS.



90-Day Checkpoint

By the end of your first 90 days, you should be operating independently, managing a full caseload, actively contributing to school teams and community engagement, and have a sense of your professional development goals for the first year.

30-60-90 Day Reflection Guides

This reflection guide is designed to support Community Health Workers during their first three months in a school-based role. It can be used by SB-CHWs themselves as a personal growth tool, or by supervisors and program administrators to structure check-ins, inform coaching conversations, and document early implementation experiences.

The prompts are not an evaluation tool. They are meant to surface honest reflection and open dialogue between SB-CHWs and their support team. However this guide is used, the goal is the same: to help SB-CHWs grow in their role, identify where additional support is needed, and build the self-awareness that sustains this kind of work over the long term.

First 30 Days

- › Who have you connected with so far that you feel most comfortable with on staff? Who do you still need to spend more time getting to know?
- › What has surprised you most about your school or community so far?
- › Where do you feel confident in your role? Where do you still feel uncertain or unsure?
- › What are the most common needs or challenges you are already seeing among students and families?
- › What is one thing you want to do differently or more intentionally in the next 30 days?

First 60 Days

- › What has been your biggest success with a student or family so far? What made it work?
- › What has been your most challenging case or situation? What did you learn from it?
- › How are your relationships with school staff developing? Are there any relationships that need more attention or repair?
- › Are there any gaps in community resources that you are noticing repeatedly? What ideas do you have for addressing them?
- › How are you taking care of yourself? Is there anything about the emotional weight of this work that you need support with?
- › What is one goal you want to accomplish before your 90-day mark?

First 90 Days

- › Looking back at your first day, what do you know now that you wish you had known then?
- › What impact have you had on a student, family, or the school community that you are most proud of?
- › How has your understanding of your role evolved since you started? Has anything shifted in how you see the work?
- › What skills or knowledge do you most want to develop in your first year?
- › What boundaries or self-care practices have helped you sustain yourself in this role? What do you want to be more intentional about going forward?
- › What is one thing you want to accomplish or change in your first year?

Key Takeaways of SB-CHW Onboarding

- › Effective onboarding starts before the SB-CHW's first day. The school leadership should have the role clearly defined and communicated to staff, families, and community partners beforehand.
- › The first 30 days are the most pivotal for setting an SB-CHW up for success. They should be spent listening, learning, and taking time to understand the school culture, community needs, and existing systems.
- › An SB-CHW without a strong support structure is at high risk for burnout. A successful SB-CHW program should establish clear supervision, peer connection, and self-care practices from the start.
- › A well-designed referral system is the backbone of the program. School staff need to know how to make a referral, families need to know who the SB-CHW is, and the SB-CHW needs tools to follow-up on student and family interactions.
- › Consistent documentation from day one allows the SB-CHW program to demonstrate impact and generate the data needed to sustain and grow the program over time.



Evaluation and Dissemination

What Does Evaluation Look Like in School-Based CHW Programs?

Evaluation is the systematic collection, analysis, and interpretation of data to assess program implementation, effectiveness, and impact. For School-Based Community Health Worker programs, evaluation serves multiple critical functions: demonstrating accountability to funders and stakeholders, guiding continuous quality improvement, informing program adaptation, and building the evidence base for CHW interventions in educational settings. Effective evaluation captures both process measures and outcome measures.

Process measures document program activities, reach, and implementation fidelity

- › Number of students and families served
- › Types and frequency of SB-CHW contacts (home visits, phone calls, school-based meetings)
- › Referrals made and completed to community resources
- › Services provided (care coordination, navigation, advocacy, education)
- › SB-CHW caseload size and composition
- › Time from identification to first SB-CHW contact
- › Geographic distribution of services within the district

Outcome measures assess changes in student, family, and school-level indicators that result from SB-CHW services

- › Attendance rates and chronic absenteeism reduction
- › Access to healthcare (establishment of medical/dental appointments, insurance enrollment)
- › Connection to mental health and substance use services
- › Family engagement in school activities and IEP/504 meetings
- › School discipline incidents and suspensions
- › Academic performance indicators (grades, test scores, promotion rates)
- › Graduation and dropout rates
- › Student and family satisfaction with services
- › Social determinants of health outcomes (housing stability, food security, income)

What Kind of Data Should We Collect?

SB-CHW programs must think through how to be comprehensive with data collection while also considering capacity and feasibility. Data collection and reporting requirements can vary based on who employs the SB-CHW and what the included funding sources are.

Programs typically navigate three overlapping data collection ecosystems:

School District-Specific Data

- › Attendance rates and chronic absenteeism reduction
- › Access to healthcare (establishment of medical/dental referral pathways, insurance enrollment)
- › Connection to mental health and substance use services
- › Family engagement in school activities and IEP/504 meetings
- › School discipline incidents and suspensions
- › Academic performance indicators (grades, test scores)
- › Graduation and dropout rates
- › Student and family satisfaction with services
- › Social determinants of health outcomes (housing stability, food security, transportation access)

Grant-Specific Data

- › Baseline and follow-up surveys or assessments
- › Standardized outcome measurement tools (depression and anxiety screeners, food security screeners, social needs assessments)
- › Quarterly or annual performance reports with defined metrics
- › Evaluation protocols that include comparison or control groups
- › Compliance documentation (participant consent forms, eligibility verification)
- › Budget reporting and cost-per-participant calculations

CBO-Specific Data

- › Referral tracking and warm handoff documentation
- › Service completion and outcome data from partner agencies
- › Client satisfaction surveys administered by community partners
- › Population-level health or social service utilization data
- › Community needs assessment data that informs program targeting

[See Appendix for a sample reporting template](#)

Routine Data Sharing with Leadership

Successful SB-CHW programs establish routine meetings with school and community partner leadership to review data and goals. These might be:

- › Monthly check-ins with principals or district administration
- › Quarterly presentations to school boards or superintendents
- › Bi-annual reviews with funding partners or CBO boards
- › Annual strategic planning sessions informed by evaluation data

Regular data review creates accountability, builds buy-in, surfaces implementation challenges early, and ensures program goals remain aligned with organizational priorities.

What is Dissemination?

Dissemination is the strategic communication of evaluation findings, program impact, and lessons learned to specific audiences in formats tailored to their information needs and decision-making contexts. It is not simply reporting numbers; it is the translation of data into compelling stories, visual presentations, and actionable insights that inform policy, practice, and resource allocation.

Effective dissemination requires understanding:

- › Who needs the information (funders, policymakers, school staff, families, community partners, researchers)
- › What they need to know (overall impact, specific outcomes, cost-effectiveness, implementation lessons)
- › Why they need it (accountability, decision-making, quality improvement, advocacy, replication)

Building a Foundation for Dissemination

Before effective dissemination can occur, key stakeholders need to understand what an SB-CHW is and does. This is an ongoing educational process through:

- › Enrollment materials: Flyers in student enrollment packets introducing the SB-CHW program
- › Regular email updates: Brief monthly or quarterly updates to school staff and families highlighting CHW activities and success stories
- › In-person meetings: Presentations at staff meetings, parent-teacher conferences, back-to-school nights, and community forums
- › Champions within the district: Identifying and empowering administrators, teachers, nurses, and counselors who have seen SB-CHW impact firsthand to advocate for the program
- › Modeling after other programs: Site visits or information-sharing with established SB-CHW programs to demonstrate what's possible

Once staff utilize SB-CHW services and see the benefit firsthand, they become the program's best ambassadors. Therefore, early dissemination should focus on building awareness and trust, not just reporting outcomes.

How to Target Dissemination for Different Audiences

Different audiences respond to different types of storytelling, and effective dissemination often requires showcasing data to tell the story of impact.

Programs should ask:

1. What does this audience care about most? (Student outcomes, cost savings, community impact, implementation lessons, etc.)
2. What decisions will they make with this information? (Funding allocation, policy changes, program continuation, replication, staffing, etc.)
3. How much detail do they need? (Executive summary vs. comprehensive report)
4. What format is most accessible to them? (Written report, presentation, infographic, story, publication, etc.)
5. What is their level of familiarity with SB-CHW programs and school-based health services? (Do we need to educate first?)



Numerical data, statistics, and metrics are most persuasive to:

- › Policymakers and legislators who need evidence of cost-effectiveness, population-level impact, and return on investment
- › Funders and grant reviewers evaluating program performance against stated objectives
- › Healthcare systems and insurers assessing value-based care outcomes and utilization patterns
- › School district leadership tracking accountability measures and resource allocation
- › Researchers and evaluators contributing to evidence-based practice



Narratives, testimonials, and case examples are most persuasive to:

- › Families and community members who want to understand how the program helps real people
- › School staff who need to see practical examples of CHW impact on students they know
- › Community partners building trust and understanding program value
- › Media and public audiences seeking community connection
- › CHWs themselves who benefit from recognition and shared learning

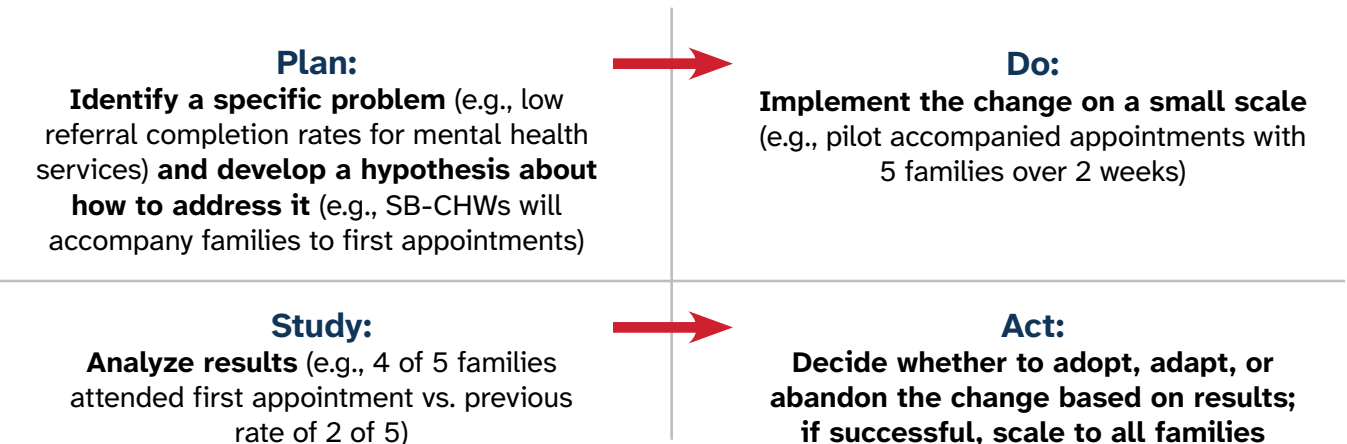
Continuous Quality Improvement Frameworks

Effective CHW programs rely on continuous quality improvement (CQI) to adapt to local needs and ensure implementation fidelity. CQI is an ongoing learning process embedded in program operations. Below are several complementary frameworks that can be used in CHW and school-based interventions:

1 - Plan-Do-Study-Act (PDSA) Cycles

PDSA cycles provide a structured method for rapid testing and refinement of program components, allowing teams to identify barriers, test solutions, and improve service delivery in real time (Institute for Healthcare Improvement, 2020).

How to apply PDSA in SB-CHW programs:



PDSA cycles work best when they are short (1-4 weeks), focused on a single testable change, and involve the people doing the work (SB-CHWs, school staff, families).

2 - Community Health Worker Assessment and Improvement Matrix (CHW AIM)

CHW AIM is a CHW-specific framework designed to assess core program elements such as role clarity, supervision, data use, and community linkages, supporting systematic program strengthening (Ballard et al., 2018).

CHW AIM evaluates programs across key domains including:

- › **CHW role and integration:** Are roles clearly defined and understood by school partners?
- › **Training and professional development:** Do CHWs receive adequate initial and ongoing training?
- › **Supervision and support:** Are supervision structures supportive and sustainable?
- › **Data and quality improvement:** Are data systems in place to track and improve performance?
- › **Financing and sustainability:** Are funding streams diversified and reliable?

CHW AIM helps programs conduct periodic self-assessments and identify priority areas for improvement.

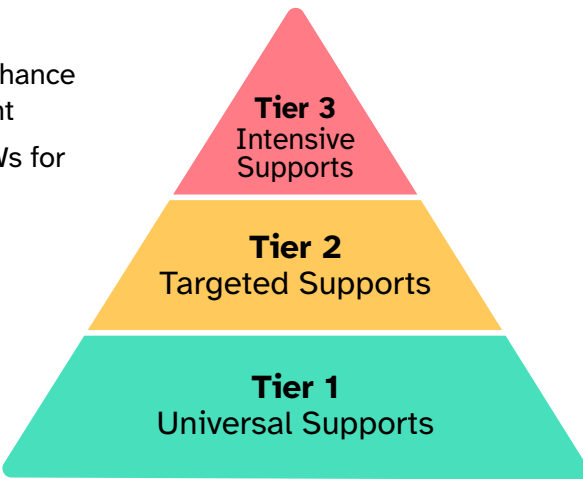
3 - Chronic Absenteeism Reduction Effort (CARE)

The **Chronic Absenteeism Reduction Effort (CARE) framework**, developed in Washington, D.C., is an effective approach based on tiered outreach and support that leverages community health workers to decrease barriers to school attendance ([“Chronic Absenteeism Reduction Effort PLAYBOOK,” 2019](#)).

CARE uses a tiered intervention model:

- › Tier 1: Universal Supports and Prevention by CHW to enhance school-wide practices that promote student engagement
- › Tier 2: Targeted Supports and early intervention by CHWs for students with emerging absenteeism
- › Tier 3: Intensive, Individualized Supports — e.g., case management — facilitated by CHWs for students with chronic absenteeism

This framework provides a practical roadmap for SB-CHW programs focused on attendance improvement and can be adapted to local contexts.



4 - RE-AIM Framework

RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) is widely used to evaluate public health and school-based programs, facilitating assessment of outcomes, scalability, and sustainability (Glasgow et al., 2019).

- › **Reach:** What proportion of eligible students/families are we serving?
Are we reaching those with greatest need?
- › **Effectiveness:** What impact is the program having on intended outcomes?
Are there unintended consequences?
- › **Adoption:** Are different schools or staff adopting CHW services at similar rates?
What are barriers to adoption?
- › **Implementation:** Is the program being delivered as intended?
What adaptations have been made?
- › **Maintenance:** Can the program be sustained over time?
What factors support or threaten maintenance?

RE-AIM is particularly valuable for programs planning to scale or replicate across multiple school sites, as it systematically examines factors that influence spread and sustainability.

Together, these CQI frameworks enable rigorous evaluation while allowing flexibility to adapt CHW services to evolving school and community needs. Programs should select frameworks that align with their goals, capacity, and stakeholder preferences, and can adapt frameworks to address their unique quality improvement needs.

The Role of SB-CHWs in Evaluation and Dissemination

SB-CHWs themselves play a critical role in both evaluation and dissemination:

In Evaluation:

- › SB-CHWs are the primary data collectors through encounter documentation, referral tracking, and family surveys
- › SB-CHWs provide qualitative insights about barriers, successes, and program improvement needs
- › SB-CHWs participate in quality improvement discussions and framework implementation
- › SB-CHWs contribute to responsiveness of evaluation tools and processes

In Dissemination:

- › SB-CHWs educate about their role through everyday interactions with families, school staff, and community partners
- › SB-CHWs share success stories that illustrate program impact
- › SB-CHWs may participate in presentations to school boards, community meetings, or conferences
- › SB-CHWs ground dissemination in authentic community voice and lived experience

Programs should provide training and support for SB-CHWs engaged in dissemination activities, recognizing that public speaking or formal presentations may be new skills for some CHWs.

Key Takeaways of Evaluation and Dissemination

- › Evaluation serves multiple purposes such as demonstrating impact to funders, guiding continuous quality improvement, and building the evidence base for SB-CHW programs.
- › Effective dissemination is audience-centered and outcomes must be packaged differently for different stakeholders
- › Continuous quality improvement frameworks enable programs to adapt to local needs, test solutions in real time, and systematically strengthen implementation while maintaining fidelity to core CHW functions.
- › CHWs are central to evaluation and dissemination.



Funding and Sustainability

Building a sustainable SB-CHW program requires careful planning from day one. While initial enthusiasm and startup funding can launch a program, long-term success depends on establishing reliable revenue streams, demonstrating measurable value, and creating operational structures that can adapt to changing landscapes.

Community Health Worker funding strategies vary significantly across settings, and understanding these differences is critical when establishing a school-based program.

Federally Qualified Health Centers (FQHCs) may have established infrastructure for Medicaid billing and can leverage their reimbursement rates to support CHW services as part of comprehensive care teams.

Mental health centers and behavioral health organizations often access funding through state mental health authorities, substance abuse prevention grants, or managed care contracts that recognize CHWs as qualified providers of certain preventive and care coordination services.

Community-based organizations typically rely on a diverse funding portfolio including foundation grants, state and local contracts, and fee-for-service arrangements with healthcare partners.

Schools, however, operate within a distinct funding ecosystem that may include school wellness funds, special education services (when CHW activities support IEP or 504 plan implementation), school-based health center grants, and potentially, Medicaid’s Free Care program. School districts must navigate the intersection of education and healthcare funding streams while adhering to both FERPA and HIPAA requirements.

When building an SB-CHW program through partnerships, it’s essential that everyone understands how their respective funding mechanisms work and where opportunities for braided funding exist.



The following questions are designed to guide school districts and community partners through critical considerations before launching an SB-CHW program. These questions do not prescribe a single path forward; instead, they prompt the essential conversations that should occur among key stakeholders, including school leadership, health systems, community-based organizations, families, and SB-CHWs themselves.

Your answers will shape a program model tailored to your community’s unique context, resources, and needs. We encourage planning teams to revisit these questions regularly, not just during the startup phase. As your program matures, as funding landscapes shift, and as community needs evolve, these questions can serve as a framework for ongoing reflection and adaptation. Programs that build sustainability thinking into implementation from day one are better positioned to overcome challenges, seize opportunities, and ultimately deliver lasting impact for the students and families they serve.

Funding and Sustainability Questions

Funding & Billing

1. What services align with allowable funding streams and what data is required to sustain them?
2. Do we have a process for billing Medicaid for CHW services?
3. What funding sources do we have access to braid or blend funding?
4. What grant funding or other revenue is available in our community, state, or region?
5. What data do we need to collect? Do we have any reporting requirements?
6. How can we continue services and support staff after time-limited funding?
7. What partnerships can we build to support grant and revenue seeking?
8. How can we innovate or adapt our program according to current funding priorities?

Demonstrating Program Value

1. How will we demonstrate value and outcomes to funders and program leadership?
2. Who is responsible for communicating program success to stakeholders?
3. Who are the stakeholders in our community that we need to have at the table?
4. How do we demonstrate return on investment (who else benefits in our community)?
5. How do we demonstrate impact on academic outcomes?

Quality Improvement

1. What are the desired outcomes from having an SB-CHW program?
2. What is the foundational goal for why we hired an SB-CHW?
3. How will we measure family and student satisfaction with CHW services?
4. Who on our team is responsible for QI efforts?
5. What is the best way to collect feedback from our staff, students and families, and the community?

Employment Models

1. Do we have a sustainability or scale-down plan that protects core SB-CHW services?
2. What employment model works best for our district –school district employed, CBO employed, or a shared employment model?
3. What advancement and professional development opportunities exist for CHWs to support retention?
4. Is our compensation package comparable to similar positions in our region?
5. How do we ensure continuity of care during CHW absences or turnover?

Frequently Asked Questions (FAQs)

This section addresses common questions that arise when planning, launching, or expanding a school-based Community Health Worker program. Questions are drawn from the experiences of districts, administrators, program coordinators, and CHWs who have navigated this work across a range of community contexts.



Whether you are exploring whether a CHW program is right for your school or district, working through implementation details, or troubleshooting challenges in an existing program, this section is designed to help you find answers quickly and move forward with confidence.

1. Why would a school district want to add an SB-CHW?

Students cannot fully engage in the classroom when basic needs go unmet. An SB-CHW helps address social determinants of health barriers and helps the school build stronger relationships with families who have historically been harder to reach. Watch the [From Classroom to Community: The Transformative Role of Community Health Workers](#) short video on the Telehealth ROCKS website.

2. How does an SB-CHW help with day-to-day basic needs that our families face?

SB-CHWs build trusting relationships with families to identify and address needs across the social determinants of health. SB-CHWs walk alongside families—helping them identify their own goals, navigate systems, access resources, and build the confidence and skills to advocate for themselves over time.

3. What if a need presents itself and our SB-CHW cannot find any resources to help?

This will happen, and SB-CHWs should never promise something they cannot deliver. Over time, an SB-CHW who tracks unmet needs is well-positioned to help build new community partnerships and advocate for resources that fill persistent gaps.

4. What kind of budget should we expect to provide our CHW to help meet basic needs in a moment when the need is urgent?

Most districts do not have a budget that provides discretionary funds for their SB-CHW, so SB-CHWs should develop strong relationships with local organizations and businesses that maintain flexible or emergency funds.

5. How is an SB-CHW different from a school social worker or counselor?

SB-CHWs focus on social determinants of health needs and community connections and do not provide direct clinical services. The roles are designed to complement each other so that everyone works at the top of their training and no need falls through the cracks. [See the role distinction flow chart on page 17.](#)

6. Why are they called “Community Health Workers”?

The title comes from the public health field, where Community Health Workers have long served as bridges between communities and health and social service systems, reflecting a whole-person approach to wellbeing. Community Health Workers are known by various names: Promotora de Salud,

FAQs, continued

Community Health Advocate, Lay Health Worker, Outreach Worker, Peer Educator, Patient Navigator, Community Care Coordinator, etc. School districts have flexibility in how they name the role and should use a title that best reflects the work being done locally.

7. Does an SB-CHW have to have ongoing training?

Yes, ongoing training is important for professional growth and maintaining the skills needed to serve families well. [Certification requirements are addressed in the certification section of this toolkit, page 23.](#)



Glossary

- Advocacy:** Promoting the support, opportunities, and conditions students and families need to reach their full potential.
- AIM (Assessment and Improvement Matrix):** e.g. Community Health Worker Assessment and Improvement Matrix (CHW AIM)
- APHA (American Public Health Association):** A national organization that advances public health through education, advocacy, research, and professional development.
- ASSM (Arizona Self-Sufficiency Matrix):** A strengths-based assessment tool used to measure an individual's or family's level of self-sufficiency across multiple life domains.
- CARE (Chronic Absenteeism Reduction Effort):** An effective framework for tiered outreach and support that leverages community health workers to decrease barriers to school attendance
- CBO:** Community-based organization, such as a healthcare entity, public health department, or social service agency
- Chronic absenteeism:** Missing at least 10 percent of school days, or approximately 18 days in a year, for any reason, excused or unexcused
- CHW (Community Health Worker):** A trusted member of the community who facilitates access for the people they serve to needed resources
- CNA (Certified Nursing Assistant):** A healthcare professional who provides basic patient care and supports nursing staff under supervision.
- CP (Community Paramedic):** A specially trained paramedic who provides preventive, follow-up, and nonemergency healthcare services in community settings.
- CPS (Child Protective Services):** Government agencies responsible for investigating reports of child abuse or neglect and ensuring child safety and well-being.
- CQI (Continuous Quality Improvement):** An ongoing, systematic process of collecting, analyzing, and using data to progressively enhance organizational services, processes, and outcomes
- Dissemination:** The strategic communication of evaluation findings, program impact, and lessons learned to specific audiences in formats tailored to their information needs and decision-making contexts.
- DV (Domestic Violence):** A pattern of abusive behaviors used to gain or maintain power and control over a family member, intimate partner, or household member.
- EHR (Electronic Health Record):** A digital version of a patient's health information that can be securely accessed and updated by authorized healthcare providers.

Evaluation: The systematic collection, analysis, and interpretation of data to assess program implementation, effectiveness, and impact.

FAPE: Free appropriate public education

FERPA (Family Educational Rights and Privacy Act): A U.S. federal law that protects the privacy of student education records and applies to all educational institutions that receive U.S. Department of Education funding. It grants parents (and students 18 or older) the right to access records, request corrections, and control the disclosure of their information

FQHC: Federally Qualified Health Center

HIPAA (Health Insurance Portability and Accountability Act): A federal law designed to protect sensitive patient health information from being disclosed without the patient’s consent or knowledge

HRSA: Health Resources and Services Administration

IDEA (Individuals with Disabilities Education Act): A federal law that ensures children with disabilities receive a free appropriate public education (FAPE) and related services in the least restrictive environment.

IEP/504 Plans

IEP (Individualized Education Program): A legally binding written plan that outlines special education services and individualized supports for a child with a disability. Protected by federal law under the IDEA (Individuals with Disabilities Education Act), it ensures students ages 3 to 21 receive a free appropriate public education (FAPE)

504 Plan: Outlines how schools will provide accommodations and remove barriers for students with disabilities, allowing them to access the general education curriculum on an equal basis with their peers

LPN (Licensed Practical Nurse): A licensed healthcare professional who provides basic nursing care under the supervision of a registered nurse or physician.

MHIT (Mental Health Intervention Team): A program-specific team model used within Telehealth ROCKS and Kansas-based behavioral health initiatives to coordinate access to mental health services and supports.

MIH (Mobile Integrated Healthcare): A patient-centered healthcare delivery model that expands care beyond traditional clinical settings by providing coordinated services in homes and communities.

MIHN (Mobile Integrated Healthcare Network): A coordinated system that connects healthcare providers, community paramedics, emergency services, and community resources to improve access to care and reduce unnecessary hospital utilization.

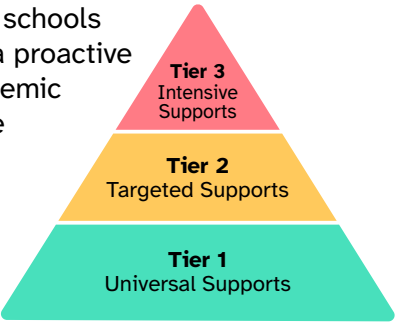
Motivational interviewing: A collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within

an atmosphere of acceptance and compassion (Miller & Rollnick, 2013, p. 29).

MOU (Memorandum of Understanding): A formal agreement between organizations that outlines roles, responsibilities, and expectations for collaboration.

MTSS (Multi-tiered Systems of Support): A framework designed to help schools identify students who need extra help and provide support early. MTSS is a proactive and evidence-based approach that focuses on delivering high-quality academic and behavioral instruction and intervention to ensure every student has the opportunity to succeed.

- **Tier 1:** Universal Supports
- **Tier 2:** Targeted Supports
- **Tier 3:** Intensive Supports



NIH: National Institutes of Health

OAT: Office for the Advancement of Telehealth

Outcome measures: Indicators used to assess changes in student, family, and school-level outcomes that result from SB-CHW services.

PDSA (Plan-Do-Study-Act) Cycles: A structured method for rapid testing and refinement of program components, allowing teams to identify barriers, test solutions, and improve service delivery.

PRAPARE (Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences): A standardized assessment tool used to identify social determinants of health and connect individuals and families with supportive services.

Process measures: Track the specific steps or actions taken to deliver a service

RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance): Used to evaluate public health and school-based programs, facilitating assessment of outcomes, scalability, and sustainability.

RN (Registered Nurse): A licensed healthcare professional who assesses, plans, coordinates, and delivers patient care.

SAMHSA: Substance Abuse and Mental Health Services Administration

SB-CHW (School-Based Community Health Worker): Trusted members of the school and the community they serve, coordinating across school staff and connecting students and families to resources and services needed for each student’s health and academic success.

SDOH (Social Determinants of Health): The conditions where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Self-care: Maintaining personal well-being, resilience, and effectiveness to support sustainable contributions to the school community.

SIT (Student Intervention Team) Meetings: A collaborative group of educators, counselors, and specialists who identify and assist students struggling with academics, behavior, or attendance.

SUD (Substance Use Disorder): A medical condition characterized by the recurrent use of alcohol or other substances despite significant impairment, health consequences, or distress.

Sustainability: Preserving the resources, relationships, and practices needed to support long-term success and continuous improvement.

THR / Telehealth ROCKS (Regional Outreach for Communities, Kids, and Schools): A federally funded program that focuses on school-based behavioral health and pediatric care. We do this by partnering with local communities to work on social determinants of health, supporting school-based services, and telementoring trainings.



Appendix

Telehealth ROCKS

Job Description Template52

Suggested Interview Questions 55

Intro Flyer Template 56

CHW Referral Questionnaire57

Sample Reporting Template 58

Example SDOH Assessment Matrix59

THR Documentation Expectations Guide 63

References 65



Job Description Template

[Organization Name]
JOB DESCRIPTION

School-Based Community Health Worker (SB-CHW)

Department	[Insert Department]
Reports To	[Insert Supervisor Title]
Work Schedule	[e.g., Full-time, 8 hrs/day, school calendar]
Salary Range	[Insert Range]
Location	[Insert Service Area / School District]

Position Summary

The School-Based Community Health Worker (SB-CHW) focuses on addressing social determinants of health and navigating students and families through complex healthcare needs within the [School District/Organization] catchment area. This position assists with food insecurity, transportation, community referrals, benefits and assistance applications, and other individual barriers to health and wellness.

SB-CHWs are passionate advocates for their school communities. They strive to understand, motivate, and support students and families in achieving their health and wellness goals by eliminating barriers, setting collaborative goals, and working within multidisciplinary school and care teams. SB-CHWs often provide support in nontraditional settings, including family homes, neighborhoods, and community sites.

Essential Performance Functions

Student and Family Engagement

- › Meet students and families in the school, home, clinic, or community setting to conduct needs assessments and screenings, including identification of socio-economic issues affecting overall health.
- › Engage students and families in developing health and social goals; coach effective management of health conditions, self-care, and other socio-economic issues using motivational interviewing and other evidence-based techniques.
- › Build and maintain trusting relationships through regular follow-up via phone calls, home visits, and visits to other relevant settings.
- › Provide support in crisis response situations as needed.

Care Coordination and Navigation

- › Assess unmet health and social needs and connect students and families with appropriate community and organizational resources, with clear guidance on how and why to access them.
- › Coordinate care and assist with understanding care plans and instructions, including making follow-up appointments and accessing prescriptions or other supports.
- › Address barriers to health access through activities such as Medicaid enrollment assistance, prescription assistance applications, and benefits navigation.

- › Assist with appointment scheduling, essential documents and paperwork, health fairs, outreach events, and other assigned activities.
- › Utilize technology and telehealth capabilities to connect students and families to care.

School and Community Collaboration

- › Collaborate with school administrators, nurses, counselors, and other staff to establish an integrated, school-based health team model promoting student health and educational success.
- › Build and maintain positive working relationships with students, families, school staff, providers, community organizations, and other partners.
- › Work collaboratively, respectfully, and effectively within school and care teams.
- › Attend team meetings and contribute to the problem-solving model for students and families.

Data, Documentation, and Quality

- › Maintain accurate and confidential records, including daily logs of visits, documentation of student and family contacts, and required data entry within assigned timelines.
- › Contribute to and utilize data to achieve program goals, improve health outcomes, and advance community health indicators.
- › Work to address health challenges by contributing to innovative workflows, operational changes, and continuous quality improvement efforts.
- › Complete accident/incident reports for students and staff as required.

Professional Development and Compliance

- › Complete required training and professional development courses, including the Community Health Worker Certification Program, within required timeframes.
- › Complete all other required training on schedule (e.g., defensive driving, first aid, applicable program-specific trainings).
- › Maintain all required certifications and licensure in good standing.
- › Perform other duties as assigned.

Qualifications

Education and Experience

- › Preferred: Education or experience in Public Health, Education, Community and Family Services, Health Coaching, Case Management, Social Work, Nursing (CNA, LPN, RN), or a related field.
- › Equivalent combination of education and relevant lived experience will be considered.
- › Familiarity with local community resources, school systems, and the populations served is strongly preferred.

Certifications and Licensure

- › Valid driver’s license required
- › [State Community Health Worker Certification must be obtained within the first year of employment.]
- › [List any additional required certifications]

Other Requirements

- › Must successfully pass a background check.
- › Must have reliable transportation to travel throughout the service area.
- › [List any additional requirements]

Knowledge, Skills, and Abilities

- › Strong interpersonal skills with the ability to establish trust and rapport with individuals, families, school staff, and community partners.
- › Ability to work both independently and as a productive member of a multidisciplinary team.
- › Organized and able to manage multiple tasks and priorities effectively; adapts positively to change.
- › Knowledge of community resources, care systems, social determinants of health, and relevant disease processes.
- › Ability to handle emergency and crisis situations calmly and effectively.
- › Computer proficiency, including Microsoft Office and Electronic Health Record (EHR) or case management software.
- › Commitment to confidentiality in compliance with HIPAA, FERPA, and organizational policy.
- › Demonstrates professional judgment and appropriate ethical boundaries at all times.
- › Communicates effectively through appropriate channels; uses proper chain of command for complaints and escalations.

Working Conditions

Work is performed in a variety of settings, including schools, community locations, family homes, clinics, and administrative offices. Travel throughout the assigned service area is required. The employee is regularly required to sit, stand, walk, use hands and arms, and communicate verbally. The employee must be able to occasionally lift and move up to [X] pounds. Reasonable accommodations will be made to enable individuals with disabilities to perform essential functions.

This job description is not an exhaustive list of duties. Additional responsibilities may be assigned as needed to meet organizational goals.

Suggested Interview Questions
School-Based Community Health Worker

1. Why are you interested in the School-Based Community Health Worker role, and what draws you to working with students and families in a school setting?
2. How do you go about building trust with students, families, school staff, and community partners who may not know you yet?
3. How would you build trust with a family who has had negative experiences with schools or agencies in the past?
4. How would you handle a situation where a family is resistant to accepting help or resources? What steps would you take to work through that barrier?
5. A teacher, school counselor, and nurse all have concerns about the same student, but they have different ideas about how to help. How would you approach working with that team to coordinate a response?
6. How would you approach a difficult or sensitive conversation with a student or family — for example, around food insecurity, hygiene concerns, or unsafe living conditions?
7. A student has been falling asleep in class, their grades are declining, and they’ve been visiting the nurse repeatedly asking for snacks. Their teacher mentions the family doesn’t have much money. Walk us through how you would respond.
8. A student shares something sensitive with you and asks you to keep it a secret. How do you handle that?
9. Are you comfortable meeting with students and families in their home or community setting? Can you share an example of a time you worked with someone in a nontraditional environment?
10. What does a successful CHW-family relationship look like to you, and how do you work toward that over time?
11. How do you manage documentation and follow-up when you’re juggling a large caseload with multiple ongoing cases?

Intro Flyer Template

Telehealth ROCKS School-Based
Community Health Workers

[school logo]



[Firstname Lastname] will be serving
[Name(s) of schools served]
students and families.
Work cell: [(555) 123-4567]



[Firstname Lastname] will be serving
[Name(s) of schools served]
students and families.
Work cell: [(555) 123-4567]

Need Help?

Community Health Workers can assist with:

- Basic Needs (Food, Utilities, Clothing, Shelter, etc.)
- Medical Needs (Glasses, Making Appointments, Transportation to Appointments, etc.)
- Assistance with School Attendance
- Anything a Student and Family Needs

Scan to make
a referral:



Or visit:
[your URL here]

In partnership with:

Telehealth
ROCKS

Telehealth ROCKS | School-Based Community Health Worker Toolkit 57

CHW Referral Questionnaire

Please check all that apply.

1. Are you looking for assistance for yourself or someone else?

☐ Myself ☐ My family ☐ Someone else

2. What kind of support is needed? (Please check all that apply):

☐ Housing	☐ Legal Issues
☐ Substance Use	☐ Life Skills
☐ Transportation	☐ Family/Social Issues
☐ Clothing	☐ Community Involvement
☐ Medical	☐ Financial
☐ Employment	☐ Safety
☐ Food	☐ Disability
☐ Education	☐ Medication Assistance
☐ Parenting	☐ Parent Education
☐ Mental Health	☐ Energy Assistance
☐ Income	☐ Other (explain):
☐ Childcare/Child Education	

3. If you are reaching out for assistance for something other than listed, please explain what you require help with:

4. Is there anything else you would like us to know? (Best time to try and contact you?)

5. What medical insurance does the person seeking assistance have?

☐ Uninsured

☐ Medicaid

☐ Medicare

☐ Private insurance

☐ Currently ineligible for insurance

☐ Unknown

See Referral System Development section, page 28

Sample Reporting Template

Student Name	Identified Need	Intervention	Date Contacted	Date SDOH Assessment Completed
Example: Jane Smith	Unable to fill ADHD medication prescription.	Check on insurance status. Assist with getting prescription filled.	1/5/24	1/10/24

See Evaluation and Dissemination section, page 37

Example SDOH Assessment Matrix

Participant Name _____ DOB ____/____/____

Assessment Date ____/____/____ Initial Interim Exit

Program Name _____

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/ or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.		
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.		
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.		
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.		
Child Care	Needs childcare, but none is available/ accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.		

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.		
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English so that language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.		
Health Care Coverage	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g., children) have medical coverage.	All members can get medical care when needed, but may strain budget.	All members are covered by affordable, adequate health insurance.		
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.		
Family/Social Relations	Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Strong support from family or friends. Household members support each other's efforts.	Has healthy/expanding support network; household is stable and communication is consistently open.		

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable; car is adequately insured.		
Community Involvement	Not applicable due to crisis situation; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.	Actively involved in community.		
Parenting Skills	There are safety concerns regarding parenting skills.	Parenting skills are minimal.	Parenting skills are apparent but not adequate.	Parenting skills are adequate.	Parenting skills are well developed.		
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.	No active criminal justice involvement in more than 12 months and/or no felony criminal history.		
Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns.		

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/ alcohol abuse in last 6 months.		
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.	Safety is threatened/ temporary protection is available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe, however, future of such is uncertain; safety planning is important.	Environment is apparently safe and stable.		
Disabilities	In crisis – acute or chronic symptoms affecting housing, employment, social interactions, etc.	Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Building Capacity – asymptomatic – condition controlled by services or medication	Thriving – no identified disability.		
Other (Optional)	In crisis	Vulnerable	Safe	Building capacity	Empowered		

See Referral System Development section, page 28

THR Documentation Expectations Guide

- › All clients should be entered into referral program within **48 hours (or 2 business days)** of becoming aware of the need.
- › As you work with the client on their immediate need, please complete the THR Referral Questionnaire within **1 week** of beginning work with the client.
- › Each issue/need for every client you work with should have the following elements:
 - THR Referral Questionnaire
 - Arizona Self-Sufficiency Matrix
 - Case Management notes and/or Attempted Follow-up Notes
 - Referrals to outside agencies
 - Program start and end date
 - Program Discharge outcome
- › Each issue/need for clients you are referred but unable to work with should have the following elements:
 - If you are unable to work with a family due to being unable to contact them—you should attempt to contact them a minimum of 3 times before discharging as Lost to Follow-up
 - THR Referral Questionnaire
 - Attempted Follow-up Notes for each attempted contact
 - Program start and end date
 - Program Discharge outcome
- › Arizona Self-Sufficiency Matrix expectations:
 - An initial assessment to be filled out within 30 days
 - All clients should have another Arizona Self-Sufficiency Matrix completed **upon discharge** from the program.

General Documentation Rules:

- › Family documentation rules:
 - If providing services to multiple children in a family, all children must have a client profile within referral program with all the above information completed.
 - If providing services to a parent or caretaker, document on the child(ren)’s profile.
 - If providing services to an adult without children, create a client profile for the adult under the general Telehealth ROCKS program.
- › When to discharge a client:
 - If a client was referred for a specific need (e.g., rent assistance) and that need was met and no other needs were identified—the client should be discharged upon completion of need.
 - If there is a gap of 2 weeks with no client interaction or identified needs, the client should be discharged. If a new need is identified afterwards, the client should be enrolled with a new start date.
- › School and community outreach events:
 - If participating in school or community outreach events, document each of these events individually under a Case Management Note under the specific Group Client profile for the school district or community organization that hosted the event.

See Documentation Requirements section, page 30

Data Dictionary:

- › **Client:** student and family referred to SB-CHW for unmet needs
- › **Group Client:** a school district or community organization, used to enter school or community outreach events
- › **Issue/Need:** the incident or needs the student and family was referred to the SB-CHW; each issue will have a start and end date within the program
- › **Encounter:** each time that a student or family interacts with an SB-CHW; encounters are documented by Case Management Notes
- › **Discharge:** a client is considered “discharged” from the program when the issue/need the student/family was referred to the SB-CHW for has been met or one of the other following outcomes applies
- › **Program Discharge Outcomes:**
 - Active: client is currently enrolled in the program
 - Declined: the client was unwilling to work with the SB-CHW
 - Lost to Follow-up: the SB-CHW was unable to reach the client
 - Successfully Completed: needs were fully met through case management with the SB-CHW
 - Partially Completed: the SB-CHW was able to work with the client to meet some or part of their needs
 - Not Completed: the SB-CHW was unable to meet the client’s needs

References

American Public Health Association. (2000). *Community health workers*. APHA Community Health Worker Section. <https://www.apha.org/apha-communities/member-sections/community-health-workers>

Arizona Coalition to End Homelessness. (n.d.). *Arizona self-sufficiency matrix*. <https://www.uwmidsouth.org/wp-content/uploads/Arizona-Self-Sufficiency-Matrix-Printable.pdf>

Ballard, M., et al. (2018). *Community Health Worker Assessment and Improvement Matrix (CHW AIM): Updated program functionality matrix for optimizing community health programs*. Community Health Impact Coalition, UNICEF, USAID, and Initiatives Inc. <https://www.unicef.org/media/58176/file>

Centers for Disease Control and Prevention. (2023). *Youth Risk Behavior Survey data summary and trends report: 2013-2023*. U.S. Department of Health and Human Services. <https://www.cdc.gov/yrbbs/dstr/pdf/YRBS-2023-Data-Summary-Trend-Report.pdf>

Chronic Absenteeism Reduction Effort (CARE) Playbook. (2019). *CARE playbook*. Johns Hopkins Bloomberg School of Public Health. <https://americanhealth.care/sites/default/files/PDFs/CARE-PLAYBOOK.pdf>

Clinical Scholars. (2022). *Toolkit for integrating community health workers in schools*. Robert Wood Johnson Foundation. <https://www.clinicalscholarsnli.org/wp-content/uploads/2022/09/Toolkit-for-Integrating-Community-Health-Workers-in-Schools.pdf>

Glasgow, R. E., Harden, S. M., Gaglio, B., Rabin, B. A., Smith, M. L., Porter, G. C., Ory, M. G., & Estabrooks, P. A. (2019). RE-AIM planning and evaluation framework: Adapting to new science and practice with a 20-year review. *Frontiers in Public Health*, 7, Article 64. <https://doi.org/10.3389/fpubh.2019.00064>

Institute for Healthcare Improvement. (2020). *Plan-Do-Study-Act (PDSA) cycles and the Model for Improvement*. <https://www.ihl.org/library/model-for-improvement>

Kansas Community Health Worker Coalition. (n.d.). *Kansas Community Health Worker Coalition*. <https://kschw.org/>

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.

Missouri Credentialing Board. (n.d.). *Community Health Worker certification*. <https://missouricb.com/chw-c-app/>

National Association of Community Health Centers. (2023). *PRAPARE: Protocol for responding to and assessing patients’ assets, risks, and experiences*. <https://www.nachc.org/resource/prapare/>

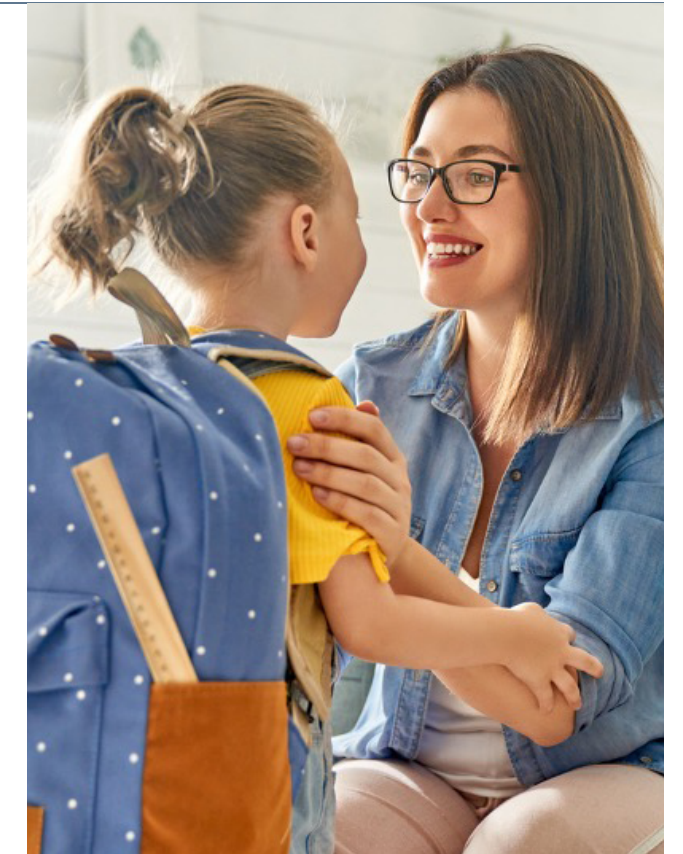
Nelson, E.-L., Punt, S., Stiles, R., & Cain, S. E. (2025). Community health workers: Bridge to pediatric mental health equity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 64(5) , 541-546. <https://doi.org/10.1016/j.jaac.2024.07.917>

Nelson, E.-L., Zhang, E., Punt, S. E., Engel, I. J., Giovanetti, A. K., & Stiles, R. (2022). Leveraging community health workers in extending pediatric telebehavioral health care in rural communities: Evaluation design and methods. *Families, Systems, & Health*, 40(4), 566-571. <https://doi.org/10.1037/fsh0000742>

Office of Disease Prevention and Health Promotion. (n.d.). *Social determinants of health*. Healthy People 2030. U.S. Department of Health and Human Services.
<https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health>

Rural Health Information Hub. (2026). *Community health workers toolkit*.
<https://www.ruralhealthinfo.org/toolkits/community-health-workers>

U.S. Department of Education. (2023). *Chronic absenteeism in the nation's schools*.
<https://www.ed.gov/teaching-and-administration/supporting-students/chronic-absenteeism>



Telehealth ROCKS



telehealthrocks.org

facebook.com/TelehealthROCKS

youtube.com/@telehealthrocks

linkedin.com/company/telehealth-rocks/
