Community Health Worker Roles in Chronic Disease Prevention and Management Guide

A COMPANION GUIDE TO THE MDH CHW LEARNING MODULES

Background

Community Health Workers (CHWs) play a vital role in bridging health and social systems and communities through culturally responsive and community-informed approaches. CHWs work in many different places including the community, home, clinics, local public health, and tribal health.

The Minnesota CHW Scope of Practice includes the following core roles:

- Bridge gap between communities and health/social service systems
- Help patients navigate health and human service systems
- Advocate for individual and community needs
- Provide direct services
- Build individual and community capacity

In Minnesota, the CHW Certificate Program provides foundational academic training, including core concepts in chronic disease prevention and management. Once in the field, many CHWs specialize in specific health topics or populations and may benefit from additional training and resources to support their roles in prevention and management of chronic conditions.

Purpose of this guide

This companion guide provides a quick reference to the MDH online learning modules that cover CHW roles in chronic disease prevention and management. It summarizes the roles of CHWs in chronic disease prevention and management, with a focus on supporting team-based care, patient navigation, prevention and self-management of chronic conditions, and addressing social determinants of health and barriers to care. This guide can be used by CHWs and CHW supervisors to reinforce learning, support practice, and strengthen competencies after the online courses have been completed.

CHW role in screening for and meeting basic needs

CHWs address Social Determinants of Health (SDOH), Health-Related Social Needs (HRSNs), or upstream drivers of health by **helping people meet basic needs first**, recognizing that individuals cannot effectively manage chronic conditions or engage in healthy behaviors until foundational needs such as food, housing, and safety are met.

Key CHW activities in addressing SDOH and barriers to care include:

- **Screen** for health, social, and behavioral health factors
- **Connect** individuals to **community resources** including, using tools such as:
  - **211 / Find Help** – statewide database for basic needs
  - **Fast Tracker MN** – chemical health and mental health treatment
  - **Minnesota Aging Pathways** (formerly Senior LinkAge Line) – or call 800-333-2433, M-F 8 a.m. - 4:30 p.m.
  - **Juniper Community Care Hub** – evidence-based classes and programs
- **Identify co-existing conditions** such as mental health or substance use disorders and **coordinate referrals** to integrated care
- Provide **follow-up** to ensure connections to resources and adherence to care plans

Shared protective factors for chronic disease

There are **everyday actions that people can take** to improve general wellbeing and prevent and improve management of chronic conditions. As CHW's get to know each patient, CHW's often center conversations on habits, routines, culture, and way of life, that can support people in these everyday actions.

Shared protective factors for chronic disease prevention and management include:

- **Drinking water**: Most adults need eight 12-ounce glasses of water a day to be hydrated.
- **Nourishing food**: Eating a colorful variety of healthy foods (fruits, veggies, whole grains, beans, nuts, fish, lean meat, low-fat dairy, herbs).
- **Replenishing sleep**: Adults need 7-9 hours of sleep per night for brain function and concentration.
- **Movement and physical activity**: 150 minutes of physical activity per week, at minimum.
- **Connection and belonging**: Build social connections and support system with family, friends, neighbors, and/or culture, affinity, faith-based or recreational groups.

CHW roles in chronic disease prevention and management – Online learning modules

The grid below outlines the free MDH CHW online learning modules on chronic disease prevention and management topics and the CHW roles and knowledge competencies covered for each topic. To access all courses visit: MDH Community Health Worker Training Courses - MN Dept. of Health

All health conditions

Component	Description
CHW Knowledge	1. Data on incidence and disparities of chronic conditions in the US and MN 2. Basic understanding of risk factors, symptoms, medical terminology, and treatment of chronic conditions 3. How social drivers of health impact prevention and management of chronic conditions 4. Resources in MN for chronic disease prevention, management, and support (e.g. community programs, SDOH supports, etc.)
CHW Role	1. Provide culturally responsive health education and reinforce provider guidance 2. Support self-management and behavior change using evidence-based approaches (e.g., goal setting, 5 A's) 3. Connect clients to clinical care, community resources, and evidence-based programs 4. Identify and address barriers (e.g., transportation, cost, language) 5. Coordinate care and communicate with providers and care teams 6. Conduct outreach, follow-up, and ongoing support
Resources	▪ Chronic Disease Prevalence Dashboard (https://www.health.state.mn.us/diseases/chronic/cdprevdata.html)

Arthritis

Component	Description
Module	**Supporting Arthritis Management - The Role of CHWs Online Module**
CHW Knowledge	1. Recognize risk factors for and describe the management and treatment of arthritis. 2. Describe the 5 A's (Ask, Advise, Agree, Assist, Arrange) and how to use them with arthritis patients. 3. Identify a referral process to evidence-based lifestyle management programs and physical activity (PA) interventions. 4. Things people could do at home to manage arthritis. 5. Resources and communication tools to promote physical activity.
CHW Roles	1. CHW roles in assisting individuals with arthritis 2. Mediating between health care system and community to ensure people with arthritis get services. 3. Providing culturally appropriate and accessible health education and information. 4. Providing informal counseling and social support, utilizing the 5 A's. 5. Teaching or referring clients to evidence-based programs such as Walk with Ease.
Resources	▪ Supporting Arthritis Management - The Role of CHWs Online Module (https://minnesota.myabsorb.com/?KeyName=k1FAWoolBcsH-gyApOAH) ▪ Supporting Arthritis Management - The Role of CHW - Resources (https://www.health.state.mn.us/communities/commhealthworkers/courses/arthritis.html) ▪ Minnesota Department of Health Arthritis Program (https://www.health.state.mn.us/diseases/arthritis/index.html) ▪ Minnesota Department of Health communication tool kit (https://www.health.state.mn.us/diseases/arthritis/docs/letswalktoolkit.pdf) ▪ Arthritis Foundation-Minnesota (https://www.arthritis.org/local-offices/mn) ▪ Arthritis in Minnesota Fact Sheet (PDF) (https://www.health.state.mn.us/diseases/arthritis/docs/mnarthritis.pdf) ▪ Center for Disease Control and Prevention Arthritis (https://www.cdc.gov/arthritis/index.html) • Programs & Classes | Juniper (https://yourjuniper.org/programs-classes/)

Asthma

Component	Description
Module	Helping Clients with Asthma – A Community Health Worker Approach
CHW Knowledge	1. Data on disparities and outreach to those in underserved populations. 2. Describe the basic physiology and the signs and symptoms of asthma. 3. Describe the two primary types of medication: controller medications and quick relief medications. 4. Recognize and provide a simple explanation of the importance of correctly using inhalers and spacers/holding chambers. 5. Demonstrate proper technique and use of an inhaler and spacer/holding chamber. 6. Recognize environmental and non-environmental triggers of asthma. 7. Describe basic mitigation strategies for environmental asthma triggers in the home (preventing, removing, and reducing). 8. Describe what's in an Asthma Action Plan and how to explain the three zones – green, yellow, and red. 9. Identify when signs and symptoms of a client diagnosed with asthma are worsening and when the client should be referred to a healthcare provider. 10. Recognize what may be signs and symptoms of asthma in a client who has not been diagnosed with asthma to refer them for an assessment. 11. Understand Asthma Home Based Services and make referrals. 12. Recognize the Asthma Resources provided in this training.
CHW Role	1. Asthma Home Based Services – Conduct referrals and home visits. 2. Bridging between primary care Local Public Health, and Tribal Health to provide information and services in the Enhanced Asthma Care Services Act. 3. Referrals to PCP and specialists for Asthma management. 4. Reinforce the Asthma plan of care prescribed by the client's provider and contained in their asthma action plan, 5. Help identify substances and conditions that may trigger asthma and suggest ways to reduce the triggers or their impact. 6. Identify social determinants that affect asthma control and coach and provide resources on how to manage those barriers. 7. Identify care needs and assist with coordination and access to the appropriate care team member.

Component	Description
Resources	▪ Helping Clients with Asthma – A Community Health Worker Approach (Helping Clients with Asthma – A Community Health Worker Approach) ▪ Asthma Data Quick Facts - MN Dept. of Health (https://www.health.state.mn.us/diseases/asthma/data/index.html) ▪ Asthma Medications (https://www.health.state.mn.us/diseases/asthma/medications/index.html) ▪ Top-10-Inhaler-Mistakes-for-Adults.pdf (nationaljewish.org) ▪ Reducing Environmental Triggers of Asthma in the Home Resources - MN Dept. of Health (https://www.health.state.mn.us/diseases/asthma/reta/resources.html) ▪ Strategies for Addressing Asthma in Homes (https://www.cdc.gov/asthma/media/pdfs/2024/06/home_assess_checklist_P.pdf) ▪ Reducing Environmental Triggers of Asthma in the Home - MN Dept. of Health (https://www.health.state.mn.us/diseases/asthma/reta/tableofcontents.html) ▪ Asthma Home-Based Services - MN Dept. of Health (https://www.health.state.mn.us/diseases/asthma/professionals/home-basedservices.html)

Dementia and healthy aging

Component	Description
Module	Dementia Training for Community Health Workers
CHW Knowledge	1. Understand and view dementia as a public health issue. 2. Understand ways to reduce the risk of dementia and be able to share 10 healthy habits for your brain. 3. Know the signs and symptoms of dementia and the importance of detecting and diagnosing dementia early. 4. Understand the important role of dementia caregivers and which community-based organizations provide caregiver support services and supports. 5. There are different cultural understandings and ways of communicating about dementia. Understand levels of awareness about dementia and how the disease or symptoms are understood, stigmatized, discussed, treated etc. within the communities you work and serve. 6. How to ask about or bring up memory loss and/or cognitive concerns with clients and their families. 7. Understand resources for caregiver support.
CHW Roles	1. Share ways to reduce the risk of dementia and how to support brain health as we age. 2. Identify signs and symptoms of dementia, address concerns with clients/families, and assist clients and families to connect with a medical provider for further conversation and testing. 3. Share the importance of detecting and diagnosing dementia early. 4. Assist in finding resources to complete health care directives, including culturally responsive advanced care planning tools. 5. Connect clients with culturally appropriate resources to help them understand their dementia symptoms or diagnosis and plan for next steps. 6. Provide suggestions and help make referrals for caregiver support and dementia friendly activities. 8. Support clients/families with disease management and avoidable hospitalizations (i.e. medication management, fall prevention, safety and wandering). 9. Support management of any co-occurring conditions.
Resources	▪ Dementia Training for Community Health Workers (https://minnesota.myabsorb.com/#/online-courses/4ab401c6-8cf7-4f73-91ab-29b42ee4fec9)

Component	Description
	▪ Alzheimer's Disease and Related Dementias - MN Dept. of Health (https://www.health.state.mn.us/diseases/alzheimers/index.html) ▪ Community Care Hub - YourJuniper (https://yourjuniper.org/community-care-hub/) ▪ Services for Older Minnesotans | Aging Pathways (https://mn.gov/aging-pathways/) ▪ Minnesota-North Dakota Chapter | Alzheimer's Association (https://www.alz.org/mnnd) ▪ Caregiver Support | Lutheran Social Service of MN (https://www.lssmn.org/services/older-adults/caregiver-support-respite)

Diabetes

Component	Description
Module	Community Health Worker (CHW) Role in Primary Diabetes Care
CHW Knowledge	1. Explain what diabetes is, the types of diabetes and who is at risk. 2. "Know Your Numbers" for blood sugar and A1c. 3. Describe the short and long-term complications of diabetes. 4. Identify how CHWs can support the Diabetes Care Team and the person with diabetes and their support people. 5. Explain the health habits to manage diabetes. 6. Explain the health habits to prevent diabetes for those with prediabetes. 7. Identify ways to effectively support patient and families impacted by diabetes or prediabetes. 8. Resources for the Diabetes Prevention Program.
CHW Role	1. Identify people at risk for diabetes and encourage them to talk to their doctor or seek medical care. 2. Remind patients of visits and tests that are due. 3. Reinforce diabetes health education provided by the care team. 4. Follow-up and support patients with lifestyle goals between visits to follow provider recommendations such as taking medications as prescribed, exercise/movement, healthy diet, etc. 5. Provide resources to address barriers to care. 6. Promote participation in and/or facilitate Diabetes Self-Management Education and Support (DSMES) and Diabetes Prevention Programs (DPP).
Resources	▪ CHW Role in Primary Diabetes Care (https://minnesota.myabsorb.com/#/online-courses/69fc052b-ec93-4be7-ac9f-ad3693410b05) ▪ Competencies - Hypertension, Pre-diabetes and Diabetes (PDF) (https://chwsolutions.com/wp-content/uploads/2018/05/Appendix-A-Hypertension-Pre-Diabetes-Diabetes-FINAL-1.pdf) ▪ CHW Best Practices for Diabetes | CHW Solutions (https://chwsolutions.com/wp-content/uploads/2018/06/EXAMPLE_CHW-Best-Practices-for-Diabetes-1.pdf) ▪ Diabetes Self-Care Tips (ADCES7) https://www.adces.org/diabetes-education-dsmes/adces7-self-care-behaviors) ▪ Diabetes Prevention - MN Dept. of Health (https://www.health.state.mn.us/diseases/diabetes/prevent/diabetesprevention.html)

Heart health

Component	Description
Module	Heart Health Conditions: Education for Community Health Workers
CHW Knowledge	1. Incidence and disparities of heart conditions in the US and MN. 2. Basic understanding of heart conditions and medical terminology such as heart disease, atherosclerosis, cholesterol, blood pressure. 3. Describe risk factors that lead to heart health conditions that cannot be changed (e.g. age, race/ethnicity, family history, etc.). 4. Describe ways patients can change heart condition risk factors that can be changed. 5. Understand critical health markers and recommended ranges or numbers for these. 6. "Know your numbers" and how individuals can take action and manage numbers such as blood pressure, cholesterol, etc. 7. Identify 2 ways to help your client after having a heart attack. 8. Resources for SMBP and BP Hubs, etc.
CHW Role	1. Provide education on risk factors and provide self-management support for risk factors that can be changed. 2. Support patients in "knowing" their health numbers and how to take action and manage their numbers. 3. Connect patient with their provider a. Make sure they are attending each appointment b. Connect with provider for questions with patients 4. Help patients explore the possibility for cardiac rehabilitation. 5. Speak with their pharmacist regarding medications. Identify potential for local support groups.
Resources	▪ MDH Online Learning Module: Heart Health for CHWs (https://minnesota.myabsorb.com/#/online-courses/b0dfd71a-be6d-4e02-8de0-befb8b34cd13) ▪ MDH Heart Health Handouts and Videos (https://www.health.state.mn.us/diseases/cardiovascular/tools/materials.html) ▪ Know Your Numbers | American Heart Association (https://www.heart.org/en/health-topics/diabetes/prevention--treatment-of-diabetes/know-your-health-numbers)

High blood pressure

Component	Description
Module	CHW Role in High Blood Pressure Management
CHW Knowledge	1. Describe high blood pressure and why it is important for people to know their blood pressure numbers. 2. Symptoms of high blood pressure. 3. List risk factors for development of high blood pressure. 4. "Know your numbers" or blood pressure categories for blood pressure readings. 5. Understand core concepts of lifestyle factors such as nutrition, physical activity, commercial tobacco, alcohol use, and stress and their impact on blood pressure. 6. Understand how to read food labels, including sodium and potassium. 7. Describe resources for hypertension including evidence-based health education programs.
CHW Role	1. Reinforce education to clients on what high blood pressure is, that it is a risk factor for chronic disease, and importance of keeping it at a healthy level. 2. Encouraging the client to seek medical advice to discuss symptoms, blood pressure readings. 3. Educating, reinforcing ideas, and providing resources on lifestyle factors such as nutrition, physical activity, commercial tobacco, alcohol use, and stress. 4. Provide support to clients in understanding and taking medications as prescribed and removing barriers in obtaining medications. 5. Practice screen, council, refer, and follow-up for high blood pressure management with clients. 6. Supporting clients with accessing care, basic needs, and self-management support and encouragement. Provide education or referral to evidence-based programs such as the Living Well with Chronic Conditions Program.
Resources	▪ CHW Role in High Blood Pressure Management (https://minnesota.myabsorb.com/%23/online-courses/4bca7727-e072-4499-a9a2-4ec8eb473c91) ▪ What is High Blood Pressure? | American Heart Association (https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure) ▪ High Blood Pressure in Minnesota - MN Dept. of Health https://www.health.state.mn.us/diseases/cardiovascular/data/hypertension.html) ▪ Heart Health Materials - MN Dept. of Health (https://www.health.state.mn.us/diseases/cardiovascular/tools/materials.html) ▪ Diabetes Prevention - MN Dept. of Health (https://www.health.state.mn.us/diseases/diabetes/prevent/diabetesprevention.html) ▪ Living with a Chronic Condition | Chronic Disease | CDC (https://www.cdc.gov/chronic-disease/living-with/index.html)

Self-monitoring blood pressure (SMBP)

Component	Description
Module	CHW Role in Self-Monitoring Blood Pressure
CHW Knowledge	1. Understand what SMBP with clinical support entails. 2. Identify validated monitors and appropriately sized blood pressure cuffs using the validatebp.org website. 3. Describe the proper technique for taking blood pressure measurements. 4. Know AMA's 7 steps for SMPB.
CHW Role	1. Identify patients for SMBP with clinical support. 2. Assist in making sure clients are using a validated monitor and appropriate cuff size. 3. Assist clients with finding a validated meter covered by insurance. 4. Provide education and support to understand the importance of managing blood pressure to avoid complications. 5. Helping patients understand how to take blood pressure at home and understand what to do with the readings Reinforce provider recommendations for any changes in treatment plans based on SMBP readings.
Resources	▪ CHW Role in Self-Monitoring Blood Pressure (https://minnesota.myabsorb.com/%23/online-courses/13781c5d-f946-4255-b57c-ad2bd5e4c935) ▪ Self-Measured Blood Pressure (PDF) (https://www.health.state.mn.us/diseases/cardiovascular/documents/smbp.pdf) ▪ 7-step SMBP Quick Guide (PDF) | AMA (https://map.ama-assn.org/sites/default/files/2024-05/7%20Steps%20SMBP%20Quick%20Guide.pdf) ▪ 7 Simple Tips To Get an Accurate Blood Pressure Reading (https://millionhearts.hhs.gov/files/MH_7_Simple_Tips_BP-508.pdf)

Oral health

Component	Description
Module	New Horizons in Dental Public Health: CHWs
CHW Knowledge	1. Describe basic oral health issues (e.g. cavities, gum disease. plaque). 2. Understand oral health in the context of general health (e.g. diabetes, heart disease, pregnancy outcomes). 3. Barriers to accessing oral health care. 4. Resources for oral health promotion and low-cost care options.
CHW Role	1. Help clients understand the importance of routine cleanings. 2. Identify and assist in connecting to a primary dental provider/dental home covered by patient's insurance and/or financial means. 3. Complete the AAP oral health risk assessment tool. 4. Apply fluoride varnish under the supervision of a physician or dentist if trained and authorized to do so. 5. Provide education on the components of a healthy mouth and body including fluoride, brushing, dental visits, eating healthy, and avoiding tobacco. 6. Assist patients and caregivers in setting and working towards oral health self-management goals.
Resources	▪ New Horizons in Dental Public Health: CHWs (https://minnesota.myabsorb.com/%23/online-courses/e51321aa-2f43-4b45-b284-aa85d09f86dd) ▪ Locating Dental Care / Minnesota Board of Dentistry (https://mn.gov/boards/dentistry/resources/locating-dental-care.jsp) ▪ Oral Health Resources for Families - MN Dept. of Health (https://www.health.state.mn.us/people/oralhealth/family/index.html) ▪ Oral Health and Fluoride Varnish (https://www.health.mn.gov/docs/people/childrenyouth/ctc/oralhealth.pdf) ▪ Improve Your Oral Health – Minnesota Oral Health Coalition (https://minnesotaoralhealthcoalition.org/) ▪ Brushing for Two - MN Dept. of Health (https://www.health.state.mn.us/people/oralhealth/family/brushingfortwo.html) ▪ Smiles for Life Oral health Courses (https://www.smilesforlifeoralhealth.org/) ▪ Fluoride Varnish and other trainings for clinics (https://www.youtube.com/watch?v=XOSzqfdWbVI)

Stroke

Component	Description
Module	Stroke Care for Community Health Workers
CHW Knowledge	1. Describe risk factors for stroke. 2. Describe ways clients can change stroke risk factors that can be changed. 3. Understand and describe Warning signs of stroke: BEFAST (Balance, Eyesight changes, face drooping, arm weakness, speech difficulty, terrible headache). 4. Resources to support clients who have experienced stroke.
CHW Role	1. Educate clients on stroke risk factors and prevention strategies. 2. Reinforce the importance of managing chronic conditions (especially hypertension). 3. Teach recognition of stroke warning signs and appropriate emergency response. 4. Support clients post-stroke with care coordination and follow-up. 5. Connect clients to rehabilitation services and community-based supports. 6. Provide caregiver support and resource navigation. 7. Support patients after a stroke to attend appointments, take prescribed medications, and access resources for healthy food and physical activity.
Resources	▪ Stroke Program - MN Dept. of Health (https://www.health.state.mn.us/diseases/cardiovascular/stroke/index.html) ▪ Heart Health Materials - MN Dept. of Health (https://www.health.state.mn.us/diseases/cardiovascular/tools/materials.html) ▪ American Stroke Association (https://www.stroke.org/)

CHW roles for engagement for provider visits

This grid outlines the roles CHWs play in assisting patients in navigating, preparing for, and attending visits with providers. The services CHWs provide in their own visits with patients include other functions.

Category	Examples
Before an appointment	• Direct outreach • Building trust and relationship • Assist in scheduling appointments • Appointment reminders • Preparing for a visit (e.g., make a list of questions, bring medications and supplements, review what to expect) • Assist and teach to schedule transportation and interpretation for appointments
At a provider appointment	• Personal connection and building trust • Social needs screening, referral and follow-up • Staying present with the patient • Assisting the care team • Taking notes with the patient • Reiterate health information in plain language
After an appointment	• Debriefing the visit • Scheduling (e.g., referrals, specialists, follow-up visits) • ER and hospital follow-up calls • Provide reminders for Rx refills
Between appointments	• Check-in calls • Wellbeing check • Relaying messages from or to the care team • Following up on referrals for clinical and social needs • Assisting patients with medication refills • Assist in understanding and completing paperwork
Screening, brief intervention and referral to treatment	• Screen for clinical and social needs • Refer to community and clinical resources • Provide follow-up for closed loop or bi-directional referrals • Continue serving the person until the need is met or person is out of the risk category
Access to and engagement in primary care and specialty care	• Connect to primary care and specialists • Work towards continuity in health insurance coverage • Establish transportation and interpretation • Take medication as directed

List of resources/references

- **Minnesota CHW Scope of Practice** (https://mnchwalliance.org/about-the-alliance/about-chws/chw-scope-of-practice/)
- **MDH online learning modules** (https://www.health.mn.gov/communities/commhealthworkers/courses/index.html)

Community Resource Directories

- **211 / Find Help** (https://211unitedway.org/)
- **Fast Tracker MN** (https://fasttrackermn.org/)
- **Minnesota Aging Pathways** (https://mn.gov/aging-pathways/)
- **Juniper Community Care Hub** (https://yourjuniper.org/community-care-hub/)

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