Evaluation of the Asian and Pacific Islander Community Health Worker Program in Santa Clara County

December 2024

JSI

Executive Summary

The Asian and Pacific Islander Community Health Worker (API CHW) program was implemented in 2021 with the mission of serving Asian American and Native Hawaiian/Pacific Islander (AA & NHPI) communities in Santa Clara County, developing a cadre of culturally competent CHWs, and providing opportunities for community-based organizations (CBOs) to convene and build their capacities.

In 2024, County of Santa Clara Public Health Department (SCCPHD) contracted JSI Research and Training Institute, Inc. (JSI) to conduct an evaluation of the program's activities, outcomes, and impact. The goals of the evaluation were to assess progress toward meeting programmatic goals and objectives, identify organizational-and CHW-level strengths and challenges of the program, and to measure the program's progress on advancing systems change. The primary purpose of the evaluation was to generate insights and recommendations to improve the design and implementation of the API CHW strategy for Santa Clara County in years to come. JSI conducted a mixed methods evaluation including data abstraction of key programmatic reports, and interviews and focus groups with subject matter experts, SCCPHD, AACI, CBOs, and CHWs.

Findings highlight the program's reach, along with key activities and notable accomplishments.

Active Organizations Involved	Active CHWs Involved	Total CHW-Led Activities	Total Encounters	Total In-Person Encounters	Total Virtual Encounters	Total Non-County Grants & Contracts
10	55	1,332	1,646,705	25,626	1,621,079	$1,445,000

** Data as of Program Year 4, Quarter 1*

These outcomes were supported through key programmatic strengths for CBOs and CHWs alike, as well as identified challenges. The top organizational strengths included the trainings provided by AACI to CHWs, the building of a CHW-CBO network, and the information and resources provided by AACI to CBOs. Challenges included measuring and reporting outcomes, insufficient organizational and staff capacity, and funding. For CHWs, the primary strengths were their ability to reach the community and the provision of culturally and linguistically responsive services. This was related to key challenges, including the complexity of community needs and the sustainability of their role. Taken together, these findings produced evidence of broader systems change as a result of the establishment of a collaborative network, increased organizational capacity, the delivery of prevention-oriented, community-responsive services, and improved sustainability.

Informed by these findings, and to leverage the significant achievements by the API CHW program, the following recommendations were made:

Recommendation 1	**Continue Investment in the API CHW Program**
Recommendation 2	**Increase CBO and CHW Involvement in Program Implementation, and Awareness and Advocacy Efforts**
Recommendation 3	**Conduct Rigorous, Ongoing Evaluation**
Recommendation 4	**Advance Programmatic and Organizational Sustainability Beyond Funding**

The API CHW Program exemplifies a model for addressing health disparities through culturally informed, community-driven approaches and offers valuable insights for expanding similar initiatives in other sectors and to serve other populations. It is well-positioned to continue building on the achievements of the program to ensure the promotion of health and wellness among AA and NHPI populations.

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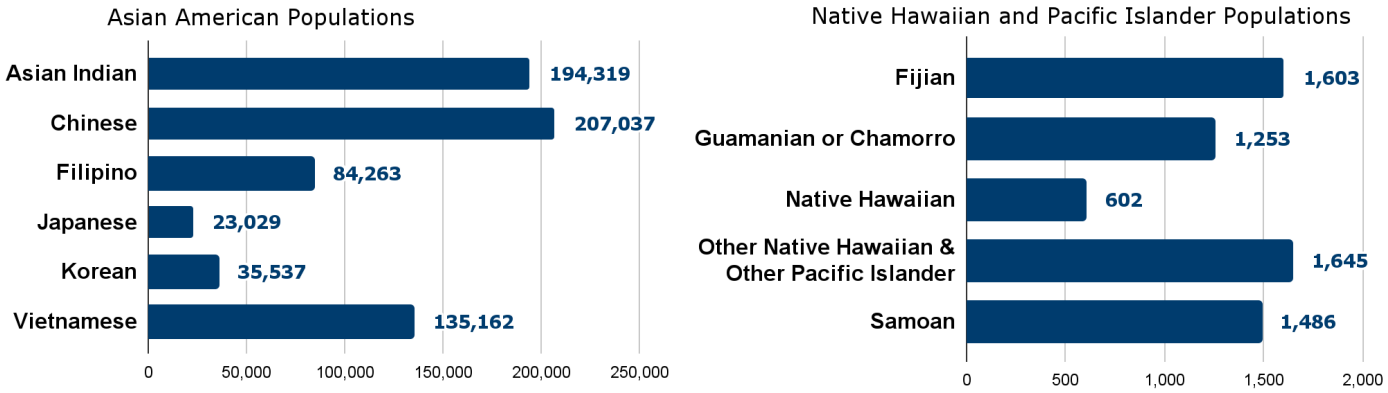
Introduction

Asian American and Native Hawaiian/Pacific Islander (AA and NHPI)[1] populations are among the fastest-growing racial groups in California and nationwide.[2] From 2010-2020, AAPI Data reports that the Asian American population grew by 39% and the Native Hawaiian/Pacific Islander population grew by 29% across the United States (U.S.). In Santa Clara County, Asian Americans comprise 38.9% and Native Hawaiian/Pacific Islanders 0.4% of the population as of 2022.[3] Together, these populations are projected to grow by 50% by 2060, underscoring the need for targeted health interventions.[4]

Figure 1. Estimated AA and NHPI Residents in Santa Clara County



Source: AAPI Data | AANHPI Community Data Explorer
Note: Data from American Community Survey 2022 5-year microdata sample accessed through IPUMS USA, University of Minnesota, www.ipums.org. Estimates for the following groups are derived from a small sample (fewer than 100 people) and should be interpreted with caution: Guamanian or Chamorro, Native Hawaiian, Samoan, Fijan, and Other Native Hawaiian and Other Pacific Islander. Ethnicity groups represent those who identify with that group alone, not 'alone or in combo.' Data does not include 84,211 Asian American individuals or the 14,600 Native Hawaiian and Pacific Islander individuals who identified multiple ethnicity groups.

Despite their growth, AA and NHPI communities face significant health disparities, including higher rates of tuberculosis, liver cancer, and cardiovascular diseases compared to other racial and ethnic groups. For example, in Santa Clara County, Vietnamese, Filipino, and Pacific Islander populations experience

[1] This report utilizes the term "Asian American and Native Hawaiian/Pacific Islander" (AA and NHPI) to include all people of Asian, Asian American, Native Hawaiian, and/or Pacific Islander ancestry who trace their origins to the countries, states, jurisdictions, and/or the diasporic communities of these geographic regions. This term recognizes Asian American as a social and political identity and separates Native Hawaiian from Pacific Islanders as to acknowledge the distinct cultural, historical, and socio-political contexts of these groups. We recognize this term is imperfect and how groups identify is part of a "dynamic, continuing process of self-determination and self-identification" (Asian Pacific Institute on Gender-Based Violence, *Census Data & API Identities*).
[2] https://aapidata.com/wp-content/uploads/2024/02/Health-Mental-Health-and-Social-Service-Needs-of-AANHPIs-main-draft-6-23-2022.pdf
[3] https://data.census.gov/table/ACSDP1Y2023.DP05?q=DP05&g=05XX00US06085
[4] https://files.santaclaracounty.gov/migrated/aha-report_0.pdf

disproportionate burdens of tuberculosis and obesity.[5] These disparities highlight the importance of tailored, culturally specific programs to address diverse needs.

The experiences of AA and NHPI, like other racial groups, are shaped by geopolitical and socioeconomic contexts. AA and NHPI populations began arriving in the U.S. in the mid-1800s, with Chinese laborers comprising the first significant wave, followed by Filipino immigrants in the early 20th century, and more recently, refugees and immigrants from Southeast Asia, South Asia, and the Pacific Islands. These migration waves were influenced by geopolitical factors, such as U.S. immigration policies and wars.[6] For instance, Pacific Islanders from Freely Associated States face unique challenges in accessing services due to non-citizen status. Understanding the health disparities faced by AA and NHPI populations requires considering the broader historical, socioeconomic, and political determinants that have shaped their experiences and health outcomes.

AA and NHPI are distinct racial groups but have been historically grouped together by government classifications or as part of community-based strategies to build coalitions and political identities. While aggregating the AA and NHPI categories can be useful in recognizing shared experiences, it can also oversimplify the experiences of different groups. Over 50 ethnic groups and 100 languages are represented under the AA and NHPI umbrella, yet this diversity of experience, cultures, histories, and health needs cannot be adequately captured without attention to subpopulations and data disaggregation. For instance, AA and NHPI populations are disproportionately affected by tuberculosis. However, not all subpopulations share this health challenge equally. In Santa Clara County, Filipinos, Vietnamese, Asian Indians, and Chinese communities specifically face a larger health burden of tuberculosis case rates compared to other AA and NHPI subpopulations. Furthermore, Medicare data show that diabetes is most prevalent among Asian Indians and Native Hawaiians, while hypertension is higher among Filipinos and Vietnamese.[7] Addressing these disparities requires disaggregated data and targeted approaches, as without subgroup-specific data, interventions risk oversimplifying diverse needs. In 2024, the Office of Management and Budget (OMB) updated federal data collection standards to expand and refine racial and ethnic categories to support more accurate, detailed data.

In 2017, Santa Clara County's Asian and Pacific Islander (API) Health Assessment identified leading concerns, such as liver cancer, mental health, and senior poverty.[8] These findings informed the creation of the Asian and Pacific Islander Community Health Worker Program, designed to deliver culturally tailored services to address these health inequities. This evaluation report documents the resultant activities and outcomes of the 2021-2024 county-funded health improvement effort – the Asian & Pacific Islander Community Health Worker Program.

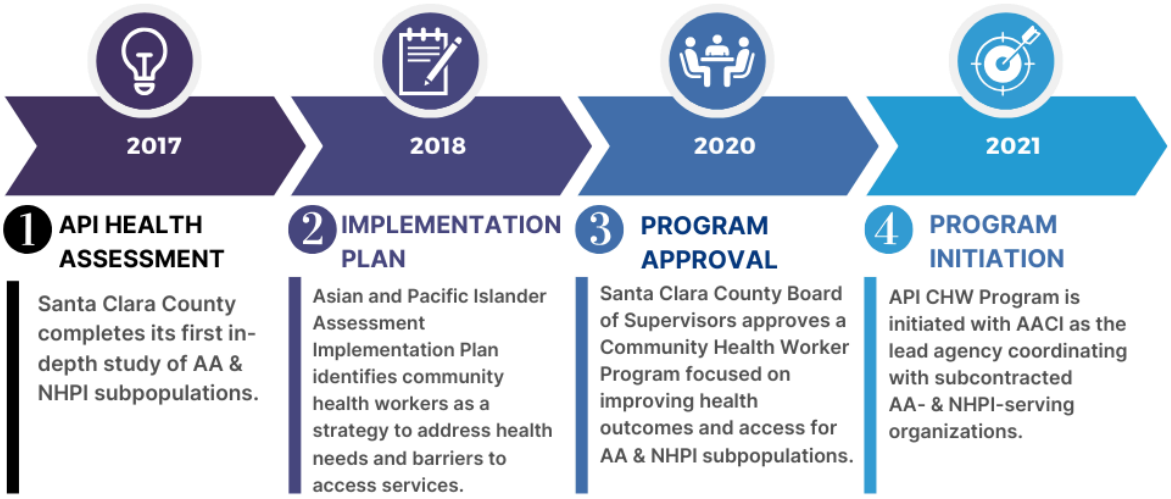
[5] www.ama-assn.org/system/files/2020-05/che-aapi-data-report.pdf
[6] https://aapidata.com/data/2024-national-factsheet-whiaanhpi-and-aapi-data/
[7] https://academic.oup.com/biomedgerontology/article/77/2/299/6365933
[8] https://files.santaclaracounty.gov/migrated/aha-report_0.pdf

Asian & Pacific Islander Community Health Worker Program Overview

In 2018, the County of Santa Clara Public Health Department (SCCPHD) partnered with AACI to develop an implementation plan to address the health disparities identified in the 2017 API Health Assessment. As part of the implementation plan, a community health worker model was identified as a highly promising strategy for addressing the needs identified by the community. Community health workers (CHWs) are a community-based workforce playing a critical role as trusted messengers, advocates, and access points for navigating the healthcare system. Research demonstrates that many CHW interventions can reduce healthcare utilization and can support improved health outcomes.[9] California networks such as the Community Health Workers, Promotoras, and Community Health Representatives (CHW/P/Rs) Coalition have highlighted how CHWs expand access to health care through their connections to the communities they serve.[10] Additionally, California has the largest CHW workforce in the nation, leading the country in CHW employment in 2022.[11]

> *Community Health Workers, Promotoras, and Community Health Representatives (CHW/P/Rs) play a critical role in ensuring that marginalized community members are not overlooked in achieving health and wellness. CHW/P/Rs directly experience how health care systems may be challenging to access, afford, or utilize due to socio-economic, cultural, or linguistic barriers, and they use their experience and knowledge to help community members navigate this complex system. They also use their experience to transform how the system operates to reach better health outcomes, reimagine the patient experience, and achieve cost effective care. CHW/P/Rs bring California one step closer to addressing the growing health disparities marginalized communities face.* - CPEHN

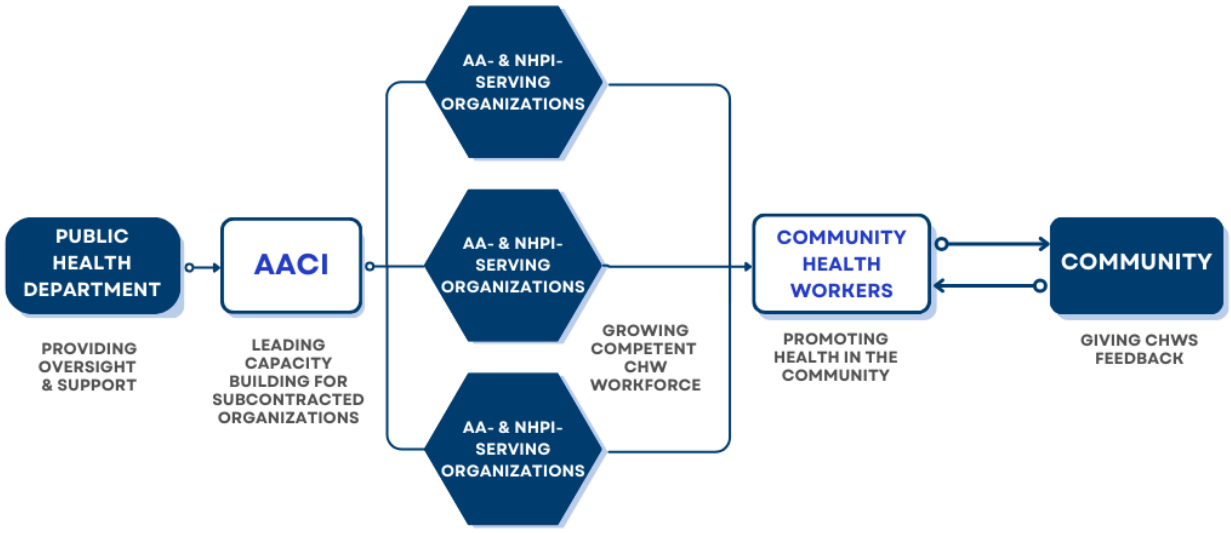
Figure 2. Timeline of the API CHW Program Development and Implementation



[9] https://link.springer.com/article/10.1007/s11606-016-3922-9#Sec16
[10] https://cpehn.org/assets/uploads/2024/03/2024-CHWPR-Policy-Agenda-1.pdf
[11] https://www.bls.gov/oes/2022/may/oes211094.htm#nat

The Asian and Pacific Islander Community Health Worker (API CHW) Program[12] began in 2021 to serve ethno-specific communities in Santa Clara County, recruiting and training culturally competent CHWs, and providing opportunities for grassroots community-based organizations (CBOs) to convene and build their capacities. The API CHW Program prioritized Asian Indian, Chinese, Filipino, Japanese, Korean, Pacific Islanders, and Vietnamese populations. Since no single organization could effectively reach all seven populations, AACI was selected as the lead agency to oversee the program and subcontract with other CBOs. With AACI's support, these CBOs trained CHWs to provide health education and outreach services. The following AA- and NHPI-serving community-based organizations are partnering with AACI in this program: AACI Senior Wellness Program (Chinese-serving), India Community Center (ICC) (Asian Indian-serving), International Children Assistance Network (ICAN) (Vietnamese-serving), Korean American Community Services (KACS) (Korean-serving), Lead Filipino (Filipino-serving), Regional Pacific Islander Task Force (RPITF) (Native Hawaiian, Pacific Islander-serving), SEWA USA (SEWA) (Asian Indian-serving), Vietnamese American Roundtable (VAR) (Vietnamese-serving), VIVO, Inc. (VIVO) (Vietnamese-serving), Yu-Ai Kai (Japanese-serving), and Bayanihan Community Center (Filipino-serving; withdrew in Program Year 1).

Figure 3. SCC API CHW Program Design



In the program's first three years, it aimed to develop its foundation, strengthen the capacity of organizations, expand its scope to communities, and foster a network of AA- and NHPI-serving CBOs and CHWs. In Year 4, the program shifted focus to help CBOs retain their CHW workforce and sustain activities beyond the duration of this program.

Table 1 provides an overview of how the API CHW Program evolved over time. In Year 1, AACI focused on launching the program, responding to the needs of COVID-19, and addressing health topics identified in the 2017 API Health Assessment. The program was designed to reach seven priority AA and NHPI subpopulations, but it started with three populations due to initial resource constraints. The initial service populations were selected based on CBO capacity, COVID-19 data, and community needs.

[12] This program recognizes the diverse experiences and needs of Asian, Asian American, Native Hawaiian, and Pacific Islander experiences. After discussions with community-based organizations and stakeholders, the racial identification of "Asian and Pacific Islander" was used to support a shorter programming name that can be more easily and widely communicated.

Vietnamese and Filipino communities were prioritized due to COVID-19 testing rates and outcomes, while Asian Indians were included to support intimate partner violence prevention, aligning with the API CHW Program's integration with the Public Health Department's Violence Prevention Program. In Year 1, AACI secured three subcontracts with CBOs serving these three populations– however, Bayanihan Community Center later withdrew from the program due to limited organizational capacity.

Given AACI's role as a health clinic, it played a leading role in addressing COVID-19 during Year 1. By Years 2 and 3, the program expanded by subcontracting with additional CBOs to reach all seven subpopulations. The scope for CHW activities expanded, introducing evidence-based programs in Year 3 and increased collaboration with partners beyond AACI. Topics evolved from the 2017 API Health Assessment to incorporate input from CBOs.

In Year 3, AACI helped CBOs work toward the sustainability of their CHW programs by leading and supporting grants. In Year 4, AACI is leading the program and is developing training, systems, and workflows to support CBOs and CHWs with CHW Medi-Cal reimbursement benefit, including the development of a Vietnamese CHW certification training program.

Table 1. API CHW Program Overview

	Program Year 1 April 2021- Jun 2022	Program Year 2 July 2022-June 2023	Program Year 3 July 2023- June 2024	Program Year 4* July 2024 - June 2024
Summary of Achievements	**Program launch**– establish subcontracts, and training curriculum for CHWs **CHWs**– train, focus on COVID-19, chronic conditions such as hypertension, intimate partner violence	**Program expansion**– increase subcontracts, improve processes including evaluation and reporting, provide greater capacity building and technical assistance to CBOs **CHWs**– train, broaden to other health and wellness topics	**Program expansion**– increase subcontracts, consider sustainability for CBOs' CHWs, submit and support grants, foster greater collaboration amongst CBOs, hire Master Trainer for CHWs **CHWs**– train, expand to evidence-based programs	**Program expansion**– increase subcontracts, develop trainings and workflows to support CHW integration into health systems and sustainability for CBOs' CHWs, support CBOs with data collection **CHWs**– train, grow capacity to support intimate partner violence
Priority Populations Engaged	**6,270 Encounters** Asian Indian Filipino Vietnamese	**816,301 Encounters** Asian Indian Chinese Filipino Japanese Korean Vietnamese	**694,054 Encounters** Asian Indian Chinese Filipino Japanese Korean Pacific Islander Vietnamese	**130,080 Encounters** Asian Indian Chinese Filipino Japanese Korean Pacific Islander Vietnamese
Contracted Organizations	**3 Organizations 24 CHWs** • *Bayanihan Community Center (withdrew)* • SEWA USA • VIVO, Inc.	**7 Organizations 51 CHWs** • AACI Senior Wellness Program • Korean American Community Services • Lead Filipino • SEWA USA • Vietnamese American Roundtable • VIVO, Inc. • Yu-Ai Kai	**8 Organizations 61 CHWs** • AACI Senior Wellness Program • Korean American Community Services • Lead Filipino • Regional Pacific Islander Task Force • SEWA USA • Vietnamese American Roundtable • VIVO, Inc. • Yu-Ai Kai	**10 Organizations 55 CHWs** • AACI Senior Wellness Program • India Community Center • International Children Assistance Network • Korean American Community Services • Lead Filipino • Regional Pacific Islander Task Force • SEWA USA • Vietnamese American Roundtable • VIVO, Inc. • Yu-Ai Kai
Additional Grants & Contracts	--	**$1,000,000** HRSA Community Funding Project supported the program's expansion for more subcontracts with AA- and NHPI- serving CBOs, more training and capacity building initiatives, and more insights from evaluation efforts.	**$270,000** Sobrato Foundation supported CHW workforce development and capacity building including expanding training to Latino/Hispanic Promotoras and drafting a workflow for CHW Medi-Cal billing.	**$175,000** California Health Care Foundation supporting developing frameworks for the CHW Regional Accelerator Program. City of San Jose contracted for outreach and communication to Chinese, Filipino, Korean, and Vietnamese communities.

** Data for program Year 4 is incomplete as it is still ongoing (July 2023 - June 2024).*

*** Bayanihan Community Center withdrew from the program due to limited organizational capacity*

Note: Data also includes seven health initiatives led by AACI during Program Year 1. Total encounters may include a duplicated count of individuals who were engaged in multiple or ongoing program activities. The number of active CHWs at any given time fluctuates given factors such as turnover and employment status (e.g. interns).

Evaluation Overview

Evaluation Objectives & Questions

In 2024, after three years of program implementation, SCCPHD contracted JSI Research and Training Institute to conduct a comprehensive evaluation of the program's activities, outcomes, and impact. This evaluation was tailored to meet the needs of three key audiences:

- **SCCPHD** – to measure the output, outcome, and impact of the API CHW program; to generate lessons learned, and identify areas for improvement and scale up/spread.
- **AA- & NHPI-serving CBO**s – to share learning, models, strategies, and tools that can help advance the CHW approach in the AA- and NHPI- serving community.
- **Funders and public health leaders** – to showcase this program's impact and potential, to garner continued and/or new funding, and to develop champions for this work.

The evaluation objectives were to:

1. **Assess** progress toward meeting programmatic goals and objectives.
2. **Evaluate** outcomes for distinct audiences (e.g., AA and NHPI communities, CHWs, and CBOs).
3. **Improve** the design and implementation of the AA and NHPI CHW strategy for future use in Santa Clara County.

To ensure relevance, key audiences and evaluation questions were aligned with programmatic goals and stakeholder priorities. This evaluation was designed to answer the questions articulated in Table 2, which focuses on program activities and outcomes, program design, and systems change. The evaluation questions informed the development of interview and focus group guides (See Appendix C).

Table 2. Evaluation Questions to Assess the API CHW Program

Evaluation Area	Evaluation Question	Key Concepts
Program Activities & Outcomes	Q1: What did the API CHW program accomplish in terms of types of activities completed, health and other topics covered, CHWs and individuals reached, etc.?	Examples of activities include workshops and outreach events. Examples of topics covered include COVID-19 and intimate partner violence.
Program Design & Experience	Q2: To what extent did the design of the program – including AACI's function/role with SCCPHD and with subcontractors – result in a high-quality collaboration able to meet the programmatic goals and objectives?	Indicators of high-quality collaboration include: communication, resource-sharing, partnering on community engagement or

		service delivery activities, or jointly securing funding.
Systems Change	Q3: How did programmatic efforts advance system change and work towards improving population health outcomes?	Indicators of systems change include: reducing barriers for healthcare access, integrating CHWs in the clinic to community referral system, addressing challenges with the inequitable funding model for CHW work.

Findings aim to shape the SCC API CHW program, advance CHW approaches in other AA and NHPI communities, and showcase the potential of CHWs to reduce health inequities.

Methods Overview

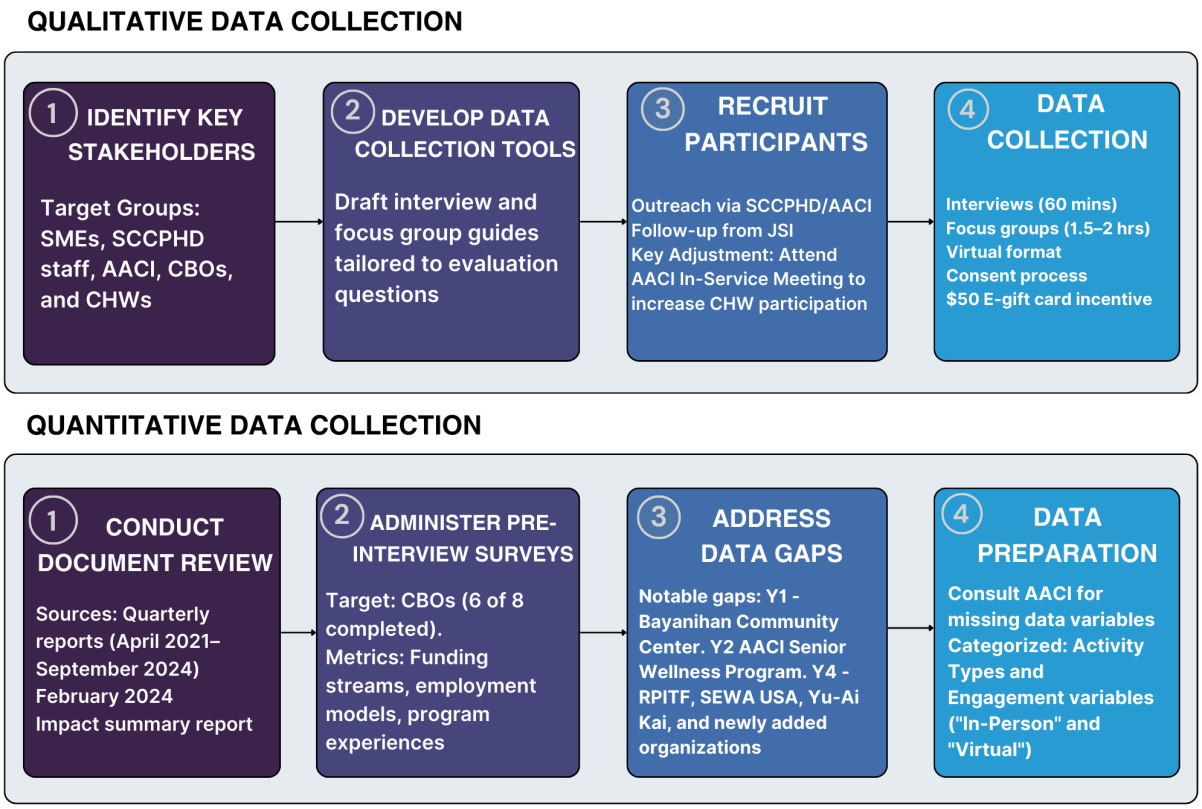
Evaluation Design

To understand the impact of the API CHW program, the evaluation team conducted a rigorous multi-level, mixed-methods evaluation. This approach combined quantitative and qualitative methods to triangulate findings and provide a holistic understanding of program activities, implementation, and outcomes. The JSI team, with support from SCCPHD and AACI, developed an evaluation plan including a logic model, specific objectives, and data collection methods and analyses. Data collection steps and activities are outlined in Figure 4. For more information about methods, please see Appendix B.

Quantitative Data Extraction & Analysis

Quantitative analyses assessed overall programmatic activities and selected outcomes aligned with the evaluation's goals. Quantitative data were extracted from program documents, primarily from quarterly reports aggregated by AACI and supplemented by an impact summary report from February 2024. Quarterly reports included programmatic activities and outputs reported by AACI and CBOs from April 2021-September 2024. A pre-interview survey was also used to capture key organizational metrics, such as funding streams and employment models. Six of the eight CBOs that participated in interviews completed the survey. The analysis sometimes required the recategorization of data to produce descriptive statistics, including frequencies and percentages, to summarize programmatic outputs.

Figure 4. Data Collection Flow Chart



Qualitative Data Collection & Analysis

Qualitative data were collected through interviews and focus groups with subject matter experts, program staff from SCCPHD, AACI, and CBOs and CHWs participating in the API CHW Program. Qualitative data were analyzed to identify key themes and address specific evaluation questions. To complement thematic analysis, qualitative data were quantified using two approaches. First, frequency and proportion analysis measured the prevalence of themes by calculating the proportion of excerpts coded for each theme across all participant types. Second, respondent-level analysis quantified the number of participants from specific groups (e.g., CBOs, CHWs) who spoke to each theme. This dual approach ensured that both thematic relevance and diversity of stakeholder perspectives were captured. For systems change (Q3), an inductive approach was taken to identify factors demonstrating systems change outcomes across both qualitative and quantitative data. Key themes and recommendations were presented to SCCPHD and AACI for review and triangulation.

Table 3 summarizes the strength of each theme across participant groups, quantifying both the frequency of coded excerpts and the number of participants contributing to each theme. For instance, themes referenced as “most participants” reflect input from at least 75% of a given participant group, while “some participants” represent input from 25–50%.

Table 3. Theme Strength Criteria and Narrative Language

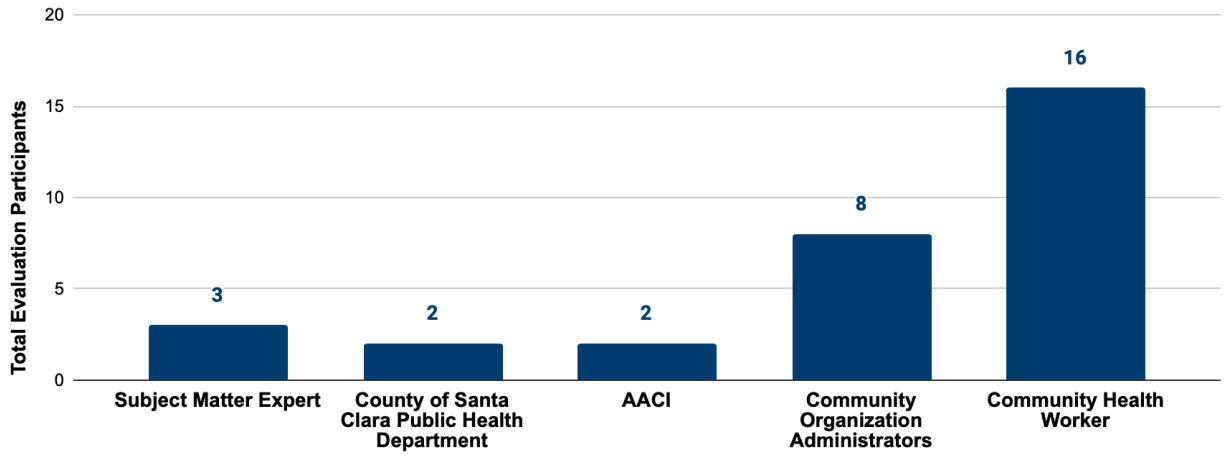
CBO COUNT (N=8)	CHW COUNT (N=16)	THEME STRENGTH	NARRATIVE LANGUAGE
1	1	NEGLIGIBLE	ONE
2-3	2-5	WEAK	SOME
4-5	6-11	MODERATE	SEVERAL
6-7	12-16	STRONG	MOST; MAJORITY
8	16	VERY STRONG	ALL; EVERY

Note: This table illustrates thresholds for theme strength. For example, themes categorized as strong reflect input from at least 75% or a given participant group, and may be referred in text as most participants, or the majority of participants.

Participants

The evaluation engaged a diverse group of stakeholders, as summarized in Figure 5. CBO participants represented eight organizations involved in the API CHW program. Most CBO participants (75%) also served as CHWs, reflecting dual roles within their organizations. For reporting purposes, participants were categorized by their primary roles during the evaluation. Dual-role participants were included in both CBO and CHW categories only when participating in separate activities (e.g., interviews and focus groups).

Figure 5. Evaluation Participants by Type



Note: Graph collates all qualitative data collection activities including key informant interviewees and focus group interviewees. For reporting purposes, participants were categorized by their primary roles during the evaluation. Dual-role participants were included in both CBO and CHW categories only when participating in separate activities (e.g., CBO key informant interviews and CHW focus groups).

Results

Findings are presented below for each of the three evaluation questions. The first section highlights CHW activities and their reported outcomes, along with insights from CBOs and AACI. The second section examines the program's design and its influence on implementation, outcomes, and impact for CBOs and CHWs. The third section explores the API CHW program's contributions to systems change, particularly in reducing inequities within AA and NHPI communities in Santa Clara County.

Program Accomplishments & Contributions Towards Improved Health

The following section provides data in response to the evaluation question:

> ***What did the API CHW Program accomplish in terms of types of activities completed, health and other topics covered, CHWs and individuals reached, etc.?***

Overall Program Activities & Outcomes

The API CHW Program has experienced significant growth since its launch in April 2021 (Table 1). In the first year, the program partnered with 4 CBOs, which conducted 38 activities and 6,270 encounters. Encounters included vaccination or screening recipients, event attendees, individuals engaged at public events, and digital metrics such as emails sent and social media interactions.[13] By the second year, the program expanded considerably, with 8 CBOs conducting 385 activities and 816,301 encounters. While the third year saw continued growth in the number of CBOs involved, CHWs hired, and activities completed, quarterly reports indicated a decrease in the total number of encounters compared to the previous year. This decline may reflect a broader shift as individuals transitioned from virtual activities to in-person activities following the peak of the COVID-19 pandemic. As the program enters its fourth year, growth is expected to continue with the inclusion of two additional CBOs.

Over the years, the program and participating organizations successfully secured additional funding amounting to $1,445,000 in grants and contracts. The HRSA Community Funding Project accounted for the majority of this funding, enabling the program to expand its reach among AA and NHPI subpopulations. These funds have been used to subcontract with additional CBOs, enhance training and capacity-building initiatives, strengthen the development of a collaborative network, and gather valuable insights through evaluations. AACI also secured two grants:

1. **The Sobrato Foundation**: Focused on CHW workforce development and capacity building.
2. T**he California Health Care Foundation**: Supporting the CHW Regional Accelerator Program.

The program's growing reputation and network of AA- and NHPI-serving organizations led the City of San Jose to reach out for a contract aimed at supporting outreach and communication of city-related services to Chinese, Filipino, Korean, and Vietnamese communities. This collaboration also resulted in the City's

[13] Total numbers potentially reflect duplicate counts of individuals engaged in multiple or ongoing activities.

Department of Transportation listing the network of AA- and NHPI-serving organizations as a partner for a federal grant application submitted in 2024. These partnerships and funding opportunities reflect the program's increasing recognition and its value to the community.

Community-Based Organizations' Activities & Outcomes

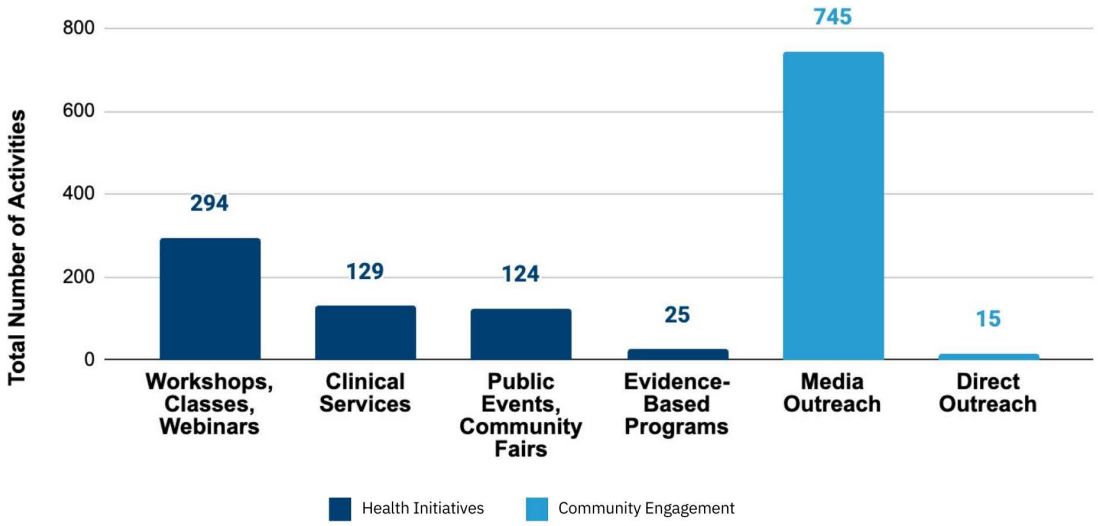
As the lead agency, AACI supported CBOs to strengthen their CHW workforce and organizational capacity, enabling them to provide health education and health promotion activities, reach more community members, increase their visibility, and foster collaboration.

With the program's funding and training, CBOs successfully established and/or developed their CHW workforce. As of the most recent quarterly report (Year 4, Quarter 1), 55 CHWs were actively involved in the program and receiving training from AACI. On average, CHWs at each organization completed a total of 166 health initiatives and community engagement activities. Organizations most actively engaged in the program include KACS (391 activities), VAR (274), Lead Filipino (165 activities), VIVO (162 activities), AACI Senior Wellness Program (140 activities), and Yu-Ai Kai (110 activities). Overall, Vietnamese communities received the highest number of activities (439). This higher engagement may reflect the involvement of two CBOs dedicated to serving Vietnamese communities (VAR and VIVO), compared to one CBO serving each of the other priority populations. Figure 6 demonstrates how program funding enhanced CBOs' capacity to deliver diverse health initiatives and community engagement strategies. These activities varied by each organization, but encompassed:

- Clinical services such as supporting individuals with health screenings and vaccinations.
- Health education efforts include hosting workshops, classes, webinars, and public events.
- Engagement activities involving direct outreach (e.g. visiting senior housing sites, encampment sites, door-to-door efforts) and media outreach (e.g. radio, social media, websites, newsletters, emails, mail).

Media outreach accounted for 56% of all program activities, representing a large proportion of all CHW-led activities. AACI supported CBOs with social media by providing content for posts, with some organizations later creating and sharing their own content. AACI Senior Wellness Program primarily served Chinese senior populations and was the only organization that did not report media outreach activities. Among the four health initiatives, workshops, classes, and webinars were the most frequently conducted by CHWs. On average, each CBO has offered a total of 42 workshops, classes, and webinars. Evidence-based programs were the least common activity and were only offered by three of the eight organizations.

Figure 6. Total CHW-Led Activities by Activity Type

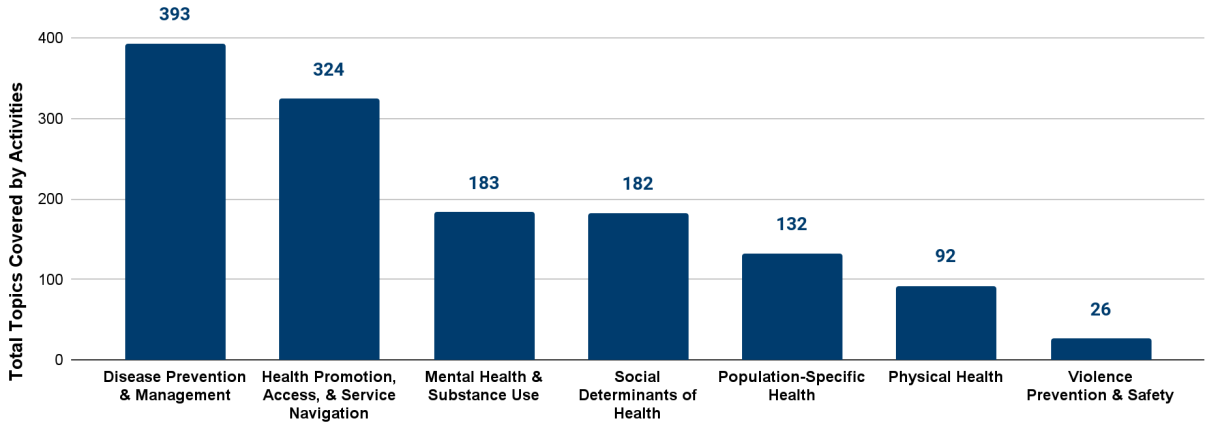


Note: Data include seven health initiatives led by AACI during Program Year 1. Total activities may be undercounted given missing data and reporting under single categories despite some activities spanning multiple areas. Clinical services refers to health screenings and vaccinations supported by CHWs. Evidence-based programs are structured health promotion initiatives developed by established institutions, and supported by research evidence of their effectiveness. Media outreach covers engagement through digital and traditional media (e.g. social media, newsletters, radio, mail). Direct outreach includes door-to-door efforts (e.g. visits to senior housing sites).

CHWs led activities across a wide range of topic areas, with each category encompassing numerous subtopics (Figure 7). Disease prevention and management was a leading topic area, covering health conditions such as cancer, COVID-19, arthritis, hypertension, and diabetes. In health promotion, access, and service navigation, CHWs focused on areas like insurance, prescriptions, and telehealth. Mental health and substance use activities addressed issues such as isolation, stress, and alcohol use. Within that topic area, there was a greater focus on mental health (69%) compared to substance use (31%). CHWs also led initiatives on social determinants of health, including healthy lifestyles and exercise, food access and nutrition, adverse childhood experiences, and civic engagement. Population-specific health activities focused on seniors, LGBTQ+ individuals, women, and children. In physical health, CHWs led initiatives on heart health, eye health, oral health, and migraines. Finally, violence prevention and safety activities centered on intimate partner violence and anti-Asian violence.

Although the topics varied by CBO, all organizations led activities related to disease prevention & management, health promotion, access & service navigation, physical health, and social determinants of health. For CBOs not primarily focused on health, the program enabled CHWs to incorporate health initiatives into existing priorities, such as civic engagement and youth programs.

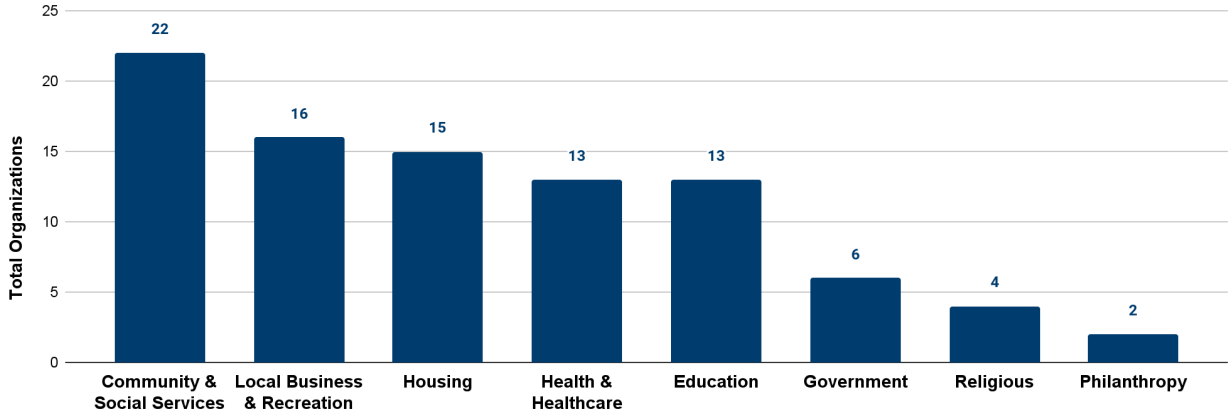
Figure 7. Total CHW Activities by Topic Area



Note: Data include seven health initiatives led by AACI during Program Year 1. Total activities may be undercounted given missing data and reporting under single categories despite some activities spanning multiple areas. Topic areas encompass a range of subtopics, including disease prevention (e.g., cancer, COVID-19, arthritis, hypertension, diabetes), health access and service navigation (e.g., insurance, prescriptions, telehealth), mental health and substance use (e.g., isolation, stress, alcohol use), social determinants of health (e.g., exercise, food access, adverse childhood experiences), population-specific health (e.g., seniors, LGBTQ+, youth), physical health (e.g., heart, eye, oral health), and violence prevention (e.g., intimate partner, anti-Asian violence).

At least 91 organizations supported the program's activities over the last three years. Approximately one in five of all CHW-led activities involved a supporting organization, including partners within and outside of the API CHW program. Key external partners included community and social service organizations, local businesses and recreational groups, housing providers, and entities from the health and education sectors (Figure 8).

Figure 8. Overview of External Supporting Partner Organizations

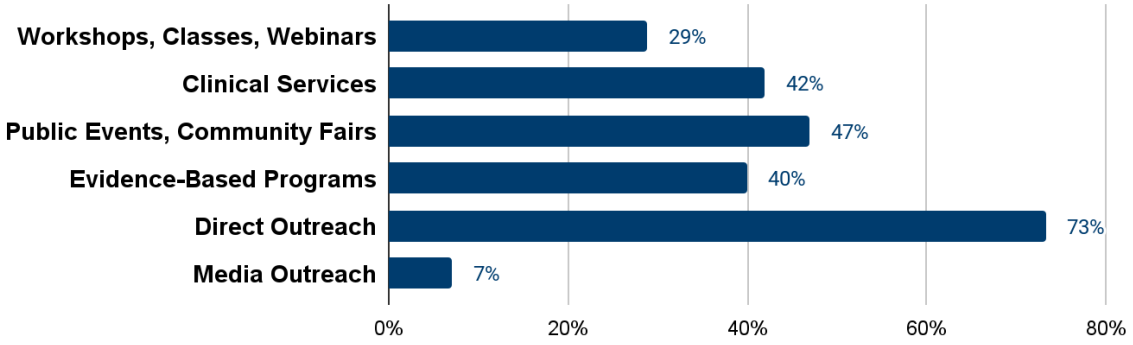


Note: This data does not include partnerships with AACI or other CBOs internal to the program.

Figure 9 illustrates the distribution of CHW-led activities conducted in partnership with external organizations, excluding AACI's direct support. CBOs were most likely to collaborate on direct outreach (73%), public events and community fairs (47%), clinical services (42%), and evidence-based programs (40%). Direct outreach, in particular, was most likely to involve a partner organization, as coordinating visits to places such as housing sites typically requires collaboration. Organizations such as KACS, Lead

Filipino, VIVO, and VAR reported the highest levels of collaborations on activities. While not all organizations conducted activities with partner organizations, all CHWs engaged in collaboration during in-service meetings organized by AACI. These routine meetings convened CHWs from all participating CBOs to foster collaboration.

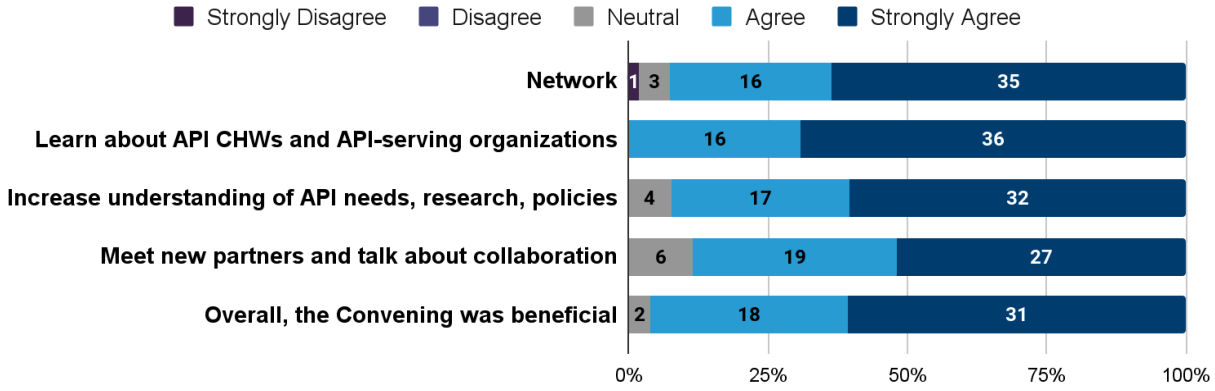
Figure 9. Percentage of CHW Activities Completed with a Supporting Partner Organization



Note: Partners include both internal and external organizations to the program. Clinical services refer to health screenings and vaccinations supported by CHWs. Evidence-based programs are structured health promotion initiatives developed by established institutions, supported by research evidence of their effectiveness. Direct outreach includes door-to-door efforts (e.g. visits to senior housing sites). Media outreach covers engagement through digital and traditional media (e.g. social media, newsletters, radio, mail).

Overall, the API CHW Program cultivated connections across organizations, enabling future collaborative work. One notable example was the API CHW Convening held in May 2024, which brought together stakeholders to showcase the program's achievements, facilitate networking, and share insights on AA and NHPI health data, trends, and policies. At least 95 individuals from local governments, academic institutions, philanthropic organizations, community organizations, and the broader community attended. Approximately 90% of attendees reported positive feedback, indicating the event successfully facilitated new partnerships and collaborations. Figure 10 summarizes the attendee survey responses.

Figure 10. Self-Reported Benefits of May 2024 API CHW Attendees

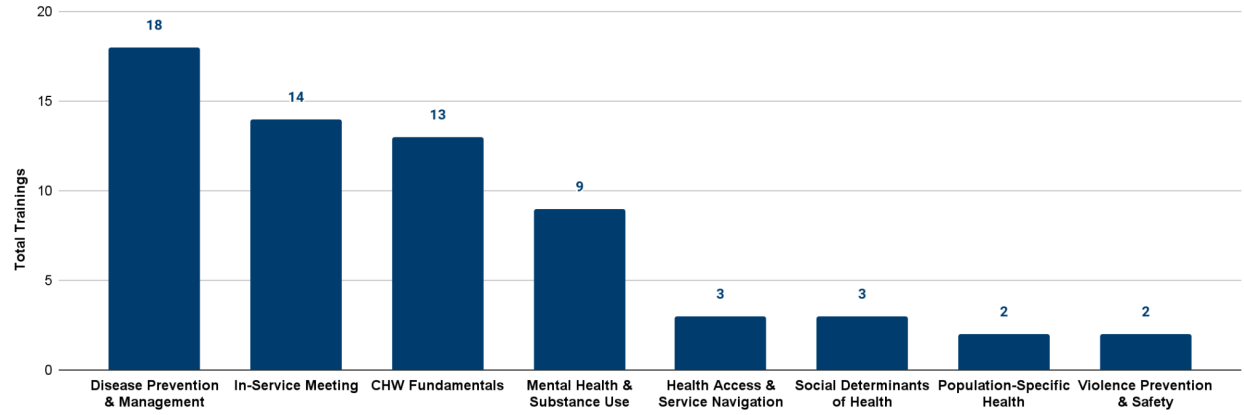


Note: Survey respondents self-reported their experiences at the convening, responding to statements starting with "I was able to…" The statements are shortened for clarity in the graph above.

Community Health Workers' Activities & Outcomes

The number of CHWs in the program varied over time, with the latest quarterly report indicating a total of 55 CHWs. Since 2021, AACI has provided a total of 64 training sessions to CHWs. In the program's first year, AACI partnered with Community Health Partnership to develop a curriculum to train CHWs on fundamental areas such as: motivational interviewing, cultural competency, equity and non-discrimination, client rights and privacy, data collection and evaluation, and teamwork and communication. The leading training topic was disease prevention and management for health conditions such as cardiovascular disease, cancer, diabetes, and tuberculosis. Mental health and substance use were other key topic areas, with AACI organizing separate trainings to support youth, adult, and senior mental health. Other topics covered include health access and service navigation, food access, senior health, and intimate partner violence. In addition to these trainings, AACI coordinated bi-monthly in-service meetings to support CHWs and foster collaboration. These meetings provided a platform for CHWs to share successes, discuss challenges, and exchange resources. While all CHWs were invited, attendance varied based on CBO bandwidth. Figure 11 highlights the range of training topics completed, including in-service meetings. For insights and information on the value of these trainings to CBOs and CHWs, see the findings on CBO-level and CHW-level strengths.

Figure 11. Total CHW Training by Topic Area

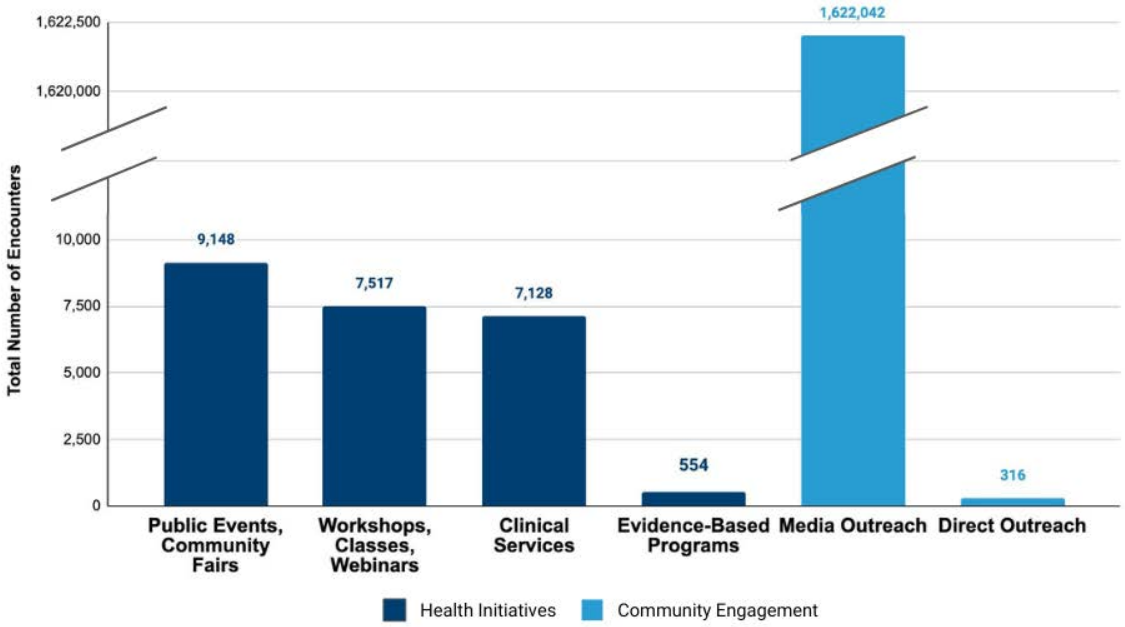


Note: Total trainings may be undercounted given reporting under single categories despite some trainings spanning multiple areas. Training topic areas encompass a range of subtopics (e.g. CHW fundamentals include motivational interviewing and cultural competency, social determinants of health include food access and lead poisoning).

Santa Clara County Community Activities & Outcomes

CHWs increased access to health education and culturally-inclusive services by conducting 1,332 health initiatives and community engagement activities targeted to AA and NHPI individuals in Santa Clara County. CHWs tailored their efforts to meet community needs and preferences, offering a variety of activity types, outreach styles, and topics related to health and overall wellness (as further described in findings related to Q2). Overall, 1,646,705 encounters were made by CHWs as a result of this program. Figure 12 presents the total number of encounters by activity type and may include a duplicated count of individuals who were engaged in multiple or ongoing CHW-led activities. According to quarterly reports from April 2021 to September 2024, the different health initiatives ranged from an average of 22 to 74 encounters per activity. In terms of community engagement efforts, media outreach and direct outreach averaged 2,177 and 21 encounters per activity, respectively.

Figure 12. Total Encounters by Activity Type



Note: Data include seven health initiatives led by AACI during Program Year 1. Total encounters may include a duplicated count of individuals who were engaged in multiple or ongoing program activities. Total activities may be undercounted given missing data and reporting under single categories despite some activities spanning multiple areas. Clinical services refer to health screenings and vaccinations supported by CHWs. Evidence-based programs are structured health promotion initiatives developed by established institutions, supported by research evidence of their effectiveness. Media outreach covers engagement through digital and traditional media (e.g. social media, newsletters, radio, mail). Direct outreach includes door-to-door efforts (e.g. visits to senior housing sites).

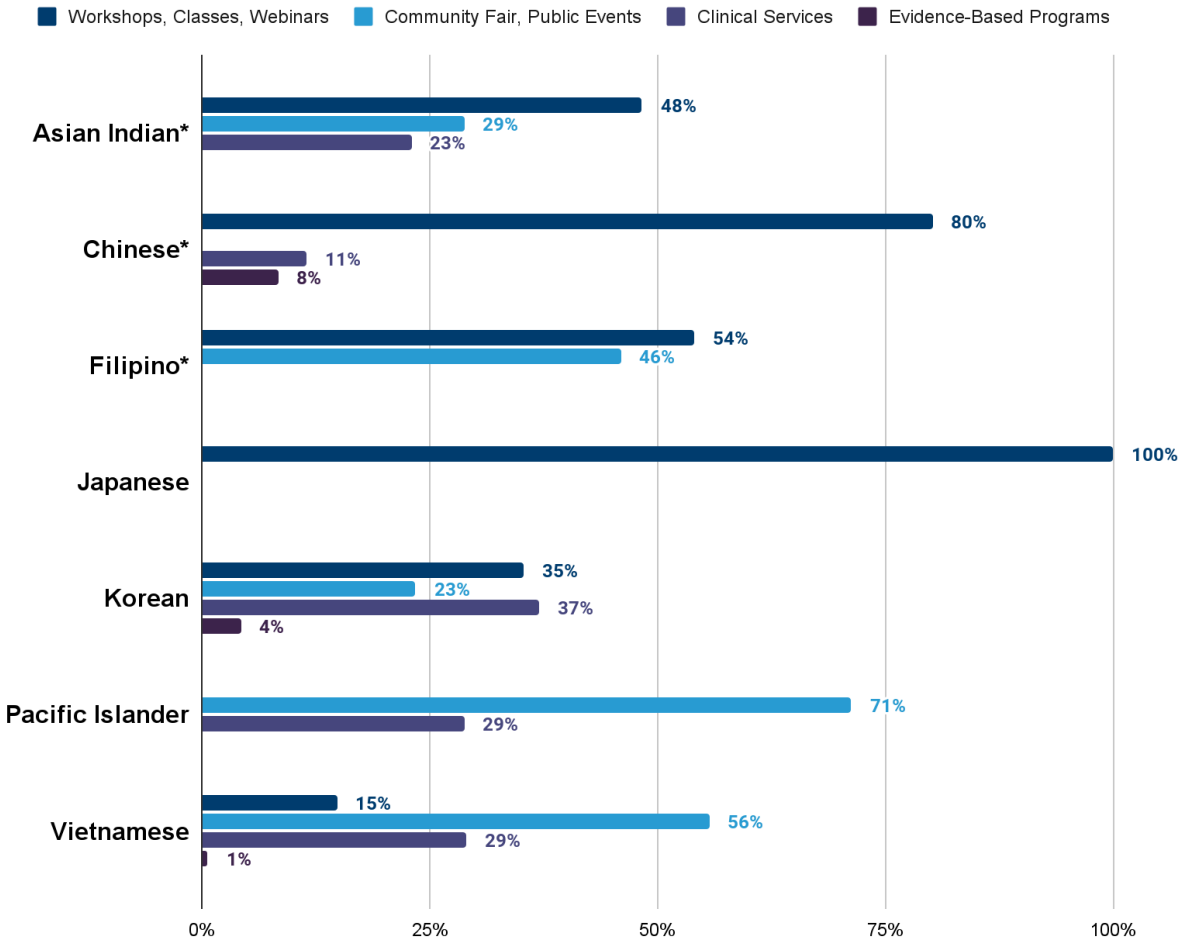
Primarily working within community settings, CHWs reported a total of 25,626 in-person encounters. Direct outreach (e.g. door-to-door efforts) included the fewest number of encounters overall, making up less than 1% of all encounters. These direct outreach encounters were mostly with Filipino and Korean communities. Only a small number of workshops, classes, and webinars were hosted virtually (31 activities with 150 virtual encounters). The majority of the 1,622,042 virtual encounters resulted from media outreach activities (e.g. social media, newsletters, radio, mail). Media outreach was a leading activity reported by CHWs and accounted for 98.5% of all encounters. Over 75% of all encounters with Filipino, Japanese, Korean, Pacific Islander, and Vietnamese communities involved media outreach engagement. According to quarterly reports, there were no recorded media outreach encounters for Asian Indian and Chinese populations. However, AACI notes that this reflects an underrepresentation of CBO activities in the current dataset. Virtual engagement was most prominent amongst Vietnamese and Korean populations. KACS relied on Korean American websites to connect with Koreans, while VAR and VIVO used a combination of social media, email, and newsletters. Their media outreach efforts significantly boosted overall program participation, with Korean and Vietnamese communities representing 64.6% and 30.8% of all encounters, respectively. High-impact media outreach activities included:

- KACS's monthly newsletters which resulted in up to 175,000 encounters.
- VAR's health event promotions on KMRB 1430 AM radio which resulted in up to 30,000 encounters.

CHWs engaged AA and NHPI subpopulations differently across community health initiatives, as detailed in Figure 13. Asian Indian, Chinese, Filipino, Japanese, and Korean communities primarily participated in classes, workshops, and webinars, while Pacific Islanders and Vietnamese communities were most often engaged at public events and community fairs. According to the quarterly reports, only Chinese, Korean, and Vietnamese populations participated in evidence-based programs. These variations in activity participation by AA and NHPI population may reflect:

- Differences in CBO capacity and CHW outreach preferences.
- A need for tailored strategies to address each subpopulation's unique needs.

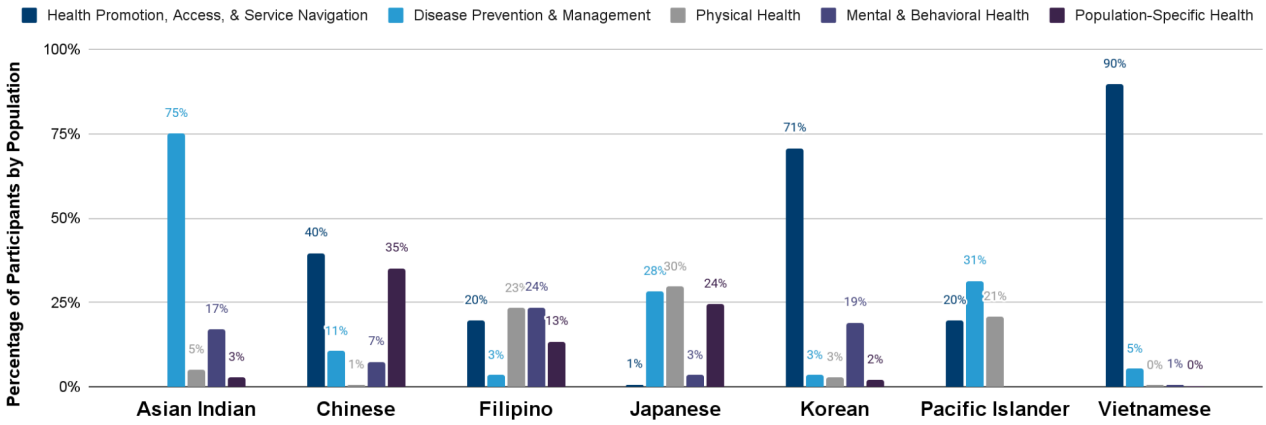
Figure 13. Percentage of Population Served by Activity Type



Notes: AACI clarified some activities were completed but are missing or not reflected in quarterly reports. Specifically, this graph does not include clinical services provided to Filipino populations, evidence-based programs for Asian Indian populations, or public events and community fairs for Chinese populations.
Total activities may be undercounted given missing data and reporting under single categories despite some activities spanning multiple areas. Clinical services refer to health screenings and vaccinations supported by CHWs. Evidence-based programs are structured health promotion initiatives developed by established institutions, supported by research evidence of their effectiveness.

Each AA and NHPI subpopulation engaged with CHWs across diverse health topics, with some groups receiving broader content coverage than others. Figure 14 outlines the leading activity topic areas by subpopulation. All AA and NHPI subpopulations were engaged in disease prevention and management, as well as physical health. CHWs led at least one activity in all seven topic areas (e.g. disease management, health access, mental health and substance use, physical health, population-specific health, social determinants of health, violence prevention) for Chinese, Filipino, Korean, and Vietnamese communities. Korean and Vietnamese communities primarily engaged with CHWs on health promotion, access, and service navigation. Asian Indian communities primarily received services focused on disease prevention and management. For Chinese, Filipino, Japanese, and Pacific Islander communities, there was a greater distribution of activities across topics.

Figure 14. Leading Activity Topic Areas by Population.



Note: The graph includes the overall top five health and wellness topics covered by CHW activities organized by AA and NHPI population. Values between 0% and 1% are noted as 0%. Topic areas encompass a range of subtopics, including health access and service navigation (e.g., insurance, prescriptions, telehealth), disease prevention (e.g., cancer, COVID-19, arthritis, hypertension, diabetes), physical health (e.g., heart, eye, oral health), mental health and substance use (e.g., isolation, stress, alcohol use), and population-specific health (e.g., seniors, LGBTQ+, youth).

While there is no available data on health outcomes of the individuals engaged in the program, CHWs reported qualitative evidence of positive changes, including:

- Increased access to healthcare services.
- Improved health behaviors, such as greater openness to stigmatized health topics.
- Distribution of resources like blood pressure monitors.

(See additional results in Program Design and Experience).

Program Design and Experience

This section seeks to answer the evaluation question:

> ***To what extent did the design of the program – including AACI's function/role with SCCPHD and with subcontractors – result in a high-quality collaboration able to meet the programmatic goals and objectives?***

Given the multi-level nature of the program, findings are divided into two sections:

1. Organization-level design and experience, focusing on impacts relevant to CBOs.
2. CHW-Level design and experiences, reflecting CHW-specific insights.

Findings are presented in rank order based on the number of coded excerpts across all participant types. Findings are also centered on the voices of relevant participant types. For instance, Organization-Level Strengths prioritize CBO perspectives, while CHW-Level Strengths highlight CHW insights.

> *"This program really amazed me. They really combined all different cultures, languages and even each organization or community group, they have different goals to achieve. And they combine everyone together. Also we can gather all these resources, no matter if it is from a medical center or the health care group or anything you can imagine - we can make it. It's like a snowball growing bigger and bigger. So that's really powerful."* -CHW

Organization-Level Design and Experience

This section includes strengths and challenges of both the program design, and AACI as lead agency, which had organization-level impacts.

Organization-Level Strengths

CBOs largely indicated that the program met or exceeded their expectations, with 83.3% strongly agreeing, and 16.6% agreeing with this statement. All CBO interviewees identified strengths related to the program's design or AACI's implementation. Table 4 summarizes the top strengths, their prevalence in coded excerpts, and their importance to CBOs.

Table 4. Organization-Level Strengths of the API CHW Program

ORGANIZATIONAL STRENGTHS	Excerpt Analysis		Participant Analysis	
	EXCERPT COUNTS (N=147)	PERCENT OF EXCERPTS	CBOs	PERCENT OF CBOS
TRAININGS	32	21.8%	6	75.0%
BUILDING OF A COHORT/NETWORK	26	17.7%	7	87.5%
OTHER INFORMATION AND RESOURCES PROVIDED	24	16.3%	6	75.0%
AACI CHARACTERISTICS (COMMUNICATION, SUPPORT, EXPERTISE	17	11.6%	5	62.5%
INCREASED CBO CAPACITY	14	9.5%	3	37.5%
FUNDING	12	8.2%	7	87.5%
FLEXIBILITY	9	6.1%	5	62.5%
COLLABORATIVE CO-DESIGN	7	4.8%	4	50.0%

Note: Each theme is listed with its prevalence as a percentage of all excerpts coded as organizational strengths, and the proportion of CBOs that highlighted it. 'Coded excerpts' refer to specific statements categorized by theme during analysis.

Trainings. 21.8% of excerpts on programmatic strengths focused on trainings, with 75% of CBOs identifying them as beneficial. Respondents valued the alignment of training topics (e.g., motivational interviewing and mental health) with community needs, and praised the train-the-trainer model introduced in Year 3. Trainings benefitted not only CHWs but also broader CBO staff. For example, one interviewee shared how mental health first aid training extended beyond CHWs, improving organizational capacity.

Building of a Cohort/Network. Building a cohort or network was reported as a programmatic strength in 17.7% of excerpts, with 87.5% of CBOs identifying this as a strength. Participants appreciated the opportunity to connect, build relationships, and address shared challenges in program implementation.

CBOs reported that the cohort model increased trust between organizations and facilitated collaborations on activities, events, and client referrals. The value of collaboration was also highlighted in the pre-interview survey; 5 of the 6 CBOs (83.3%) selected this one of the most beneficial programmatic elements. [Note: This finding is further discussed in Q3 on Systems Change.]

Information and Resources Provided. 16.3% of the programmatic strength excerpts focused on the value of the information and resources provided to CBOs, beyond the trainings. Information included public health data, translated materials, and messaging for social media and other channels. These resources addressed language barriers, which were particularly challenging for Chinese, Filipino, Korean, Vietnamese, and South Asian communities. Interviewees provided examples of how previously, language barriers have caused community members to not receive timely information during the COVID-19 pandemic or contributed to experiences of isolation. One CBO noted that AACI's responsiveness in addressing community needs, such as providing medical supplies like masks and blood pressure monitors, was a key strength.

AACI Characteristics. 100% of CBOs identified AACI's leadership as a strength, with 66.7% emphasizing AACI's accessibility and communication.

Respondents noted AACI's proactive planning, timely reminders, and support with program implementation and reporting processes. All CBOs affirmed they had received needed support, with 4 of the 6 (66.7%) indicating strong agreement.

Increased CBO Capacity. 13.8% of excerpts highlighted the program's role in increasing CBO capacity, with 83.3% of CBOs attributing their ability to hire and train CHWs directly to program funding. Interviewees noted that this funding provided additional staff and dedicated time to expand programming.

> *"I think that if this program were to sunset it would be hard to find an agency like AACI that already has a cultural understanding, but also an understanding of how we work as an organization and nonprofit….I think, in terms of a program specifically on health equity and community health workers I don't think there's a program like it."* -CBO

> *Without this program the Filipino community wouldn't have a Community Health Worker program. We've always wanted to become more involved in health equity, and we expanded our organization in that way.* -CBO

The program enabled organizations to extend and integrate health initiatives into existing programming. For example, one CBO noted:

> *We already do education in general, for youth, for seniors, or the general Vietnamese community. [The program] makes it so that we can easily tack on health, because health is intersected with so many different things. Having this [program] gave us the resources to implement and integrate health into those things.* -CBO

One organization expanded its CHW-led programming from one senior housing location to over ten off-site locations. Another organization reached 60-70% of their community in their preferred language, addressing long-standing barriers through AACI's focus on language access. Additionally, other CBOs developed new health equity initiatives and secured grant funding, largely due to the training and health education focus developed during the program.

CBOs attributed this capacity growth to the close alignment of the API CHW program with their organizational priorities, as reflected in the pre-interview survey where 100% of CBOs indicated strong alignment.

Funding. Funding was identified as a program strength by 87.5% of CBOs, particularly for its role in hiring or subsidizing CHWs, covering operational costs, and expanding community outreach to underserved segments (e.g., older adults). One organization specifically highlighted the benefit of funding tied to community resource distribution, such as providing masks and health education materials to vulnerable populations.

Flexibility. CBOs highlighted program flexibility as a strength, noting that it allowed them to adopt culturally responsive and sustainable approaches tailored to their distinct AA and NHPI populations. For example, flexibility enabled one organization to expand outreach in the preferred languages of their community, addressing long-standing barriers to engagement.

> *One of the things that I really liked about the CHW program was they give us - each ethnic group, each organization - the freedom or flexibility to come up with the best outreach method, the best implementation plan…" -CBO*

Collaborative Co-Design. Half of the CBOs (n=4) praised the collaborative co-design process with AACI, which ensured the program was responsive to community needs. Respondents highlighted AACI's proactive approach, such as creating feedback mechanisms through surveys and focus groups. This process directly informed programmatic adjustments, such as refining training curriculum topics to address mental health and cultural competency. In the pre-interview survey, all CBOs (100%, n=6) agreed: "Our organization was able to customize this program to fit our needs and other existing priorities."

Programmatic Challenges

Participants identified several challenges with the program design and implementation. Table 5 summarizes these challenges, including the frequency of mentions in focus groups and interviews. All CBOs (100%) reported at least one challenge.

Table 5. Organization-Level Challenges of the API CHW Program

ORGANIZATIONAL CHALLENGES	Excerpt Analysis		Participant Analysis	
	EXCERPT COUNTS (N=105)	PERCENT OF EXCERPTS	CBOS (N=8)	PERCENT OF CBOS
MEASURING AND REPORTING OUTCOMES	22	20.4%	3	37.5%
ORGANIZATIONAL/STAFF CAPACITY	18	16.7%	4	50.0%
FUNDING (SUSTAINABILITY, SUFFICIENCY)	15	13.9%	6	75.0%
TRAININGS	14	13.0%	5	62.5%
STAFFING	12	11.1%	2	25.0%
DIVERSE COMMUNITY NEEDS	11	10.2%	3	37.5%
INITIAL PROGRAM PLANNING*	8	7.4%	0	0.0%
AACI COMMUNICATION	5	4.6%	2	25.0%
LACK OF DISAGGREGATED DATA	4	3.7%	2	25.0%

*This theme was only identified by SCCPHD/AACI

Note: Each theme is listed with its prevalence as a percentage of excerpts coded as organizational challenges from interviews and/or focus groups, and the proportion of CBOs that highlighted it. 'Coded excerpts' refer to specific statements categorized by theme during analysis.

Measuring & Reporting Outcomes. The most frequently reported challenge (20.4% of excerpts) was measuring and reporting outcomes. This issue was raised by SCCPHD, AACI, and CBOs, highlighting difficulties in collecting and reporting outcomes due to limited organizational or staff capacity, and the nature of CHW activities. SCCPHD and AACI noted the need for better systematized data collection and reporting. However, CHW activities, such as health fairs and door-to-door engagement, posed challenges for precise data tracking. Significant barriers also existed for measuring individual-level change or unduplicated engagement.

Most data collected focused on process metrics (e.g., individuals reached). Tracking long-term health outcomes or behavior changes resulting from CHW efforts was not feasible. Many organizations lacked the capacity to follow up with participants after events, complicating assessments of the impact on health behaviors or service access. For more focused activities, organizations used pre- and post-surveys to measure the knowledge gained by participants or the impact of the workshops. Satisfaction surveys were also utilized for classes and workshops.

Organizational/Staff Capacity. Organizational capacity challenges were reported in 16.7% of excerpts, and identified by 50% of CBOs. For several CBOs, CHWs' responsibilities were added to existing staff roles, for example for pharmacists, nurses, or instructors. This approach created significant workload pressures, limiting staff capacity for essential activities like:

- Data collection and reporting – Administrators struggled to balance tracking program outcomes with other responsibilities.
- Fostering collaborations – Staff lacked time to build partnerships with other organizations.

These capacity constraints often resulted in reduced program efficiency and hindered the ability to scale or enhance program activities.

Funding. Funding was identified as a programmatic challenge by 75% of CBOs. CBOs reported reliance on API CHW Program funds for operations, which often fell short of program demands. CBOs expressed frustration that funding constraints impacted their ability to hire and retain CHWs or develop partnerships.

> *"Right now, (without the API CHW program funding) we'd have to really question if we could sustain the program. I think if we were able to sustain this program it'd be on a very limited capacity... but I don't think we'd be able to have such expansive work and reach." -CBO*

To address long-term sustainability, some CBOs identified diversifying funding sources as a priority. In the pre-interview survey, 66.7% (4 of 6 respondents) reported supplementing CHW program costs with other grant funding. Additionally 33.3% (2 of 6 respondents) indicated plans to apply for additional grant funding in the future.

Some CBOs also explored reimbursement for medically-focused CHW services as a sustainable funding option but expressed mixed views. Table 6 outlines these perspectives, highlighting both optimism for sustainability and concerns about feasibility.

Table 6. Distribution of Support and Reservations Regarding CHW Reimbursement, by Participant Type.

REIMBURSEMENT	Support		Reservations	
	n	%	n	%
SMEs, PHD, AACI (n=7)	4	57.1%	4	57.1%
CBOs (n=8)	3	37.5%	3	37.5%

Note: Counts reflect the number of participants in each group expressing support, reservations, or both.

Those in the SME, PHD, and AACI category expressed support due to the potential of reimbursement to promote sustainability for CBOs and the CHW workforce, and to ensure CHWs are connected to healthcare organizations. Reservations from this group included frustrations about the low reimbursement rate, concerns about whether CBOs could navigate the hurdles associated with reimbursement, and recognition that this would only be applicable to those CBOs and CHWs interested

in providing medically-focused services. CBOs also noted as a strength the ways reimbursement could contribute to the financial suitability of organizations, ensuring CHW's time could be covered. They expressed reservations around the extent to which they had the time or capacity to take the necessary steps to pursue reimbursement. This mix of views underscores the complexity of implementing reimbursement models. One participant explained how clinical reimbursement models might not appeal to all CHWs:

> *I think one of the things that scares me about the clinical part... the medical reimbursement part, I think, is wonderful. But what I'm already seeing is even their rollout of that program is only appealing to a certain kind of CHW - it's only appealing to a CHW that may only be interested in that environment. It's not appealing to the CHW that we need more out in the community – CHWs who are comfortable going into neighborhoods or comfortable in situations where not everybody is comfortable.* -AACI

Trainings. Training challenges affected both CHWs and CBOs. Participants noted difficulty balancing training requirements with other responsibilities. Some CHWs expressed a desire for earlier notice and a more consistent training schedule. CHWs who joined the program later identified gaps in onboarding, specifically foundational training tailored to their role. Additionally, participants felt that training requirements sometimes duplicated existing organizational expertise or created fatigue for CHWs pursuing certification. CHWs who spoke English as a Second Language (ESL) noted challenges navigating the materials.

Staffing. CHW staffing challenges were distinct but closely tied to organizational capacity, representing 11.1% of challenge excerpts. Some CBOs struggled with recruitment and retention, relying on part-time or volunteer staff, interns, and contract employees. Table 7 outlines the staffing models implemented by CBOs, highlighting that none hired dedicated full-time staff for this program.

Table 7. CBO Self-Reported Staffing Models from the Pre-Interview Survey

ITEM	COUNT (N=6)	PERCENT
NOT NEWLY HIRED, AN EXISTING EMPLOYEE ADDED THE CHW ROLE TO THEIR EXISTING JOB RESPONSIBILITIES	4	66.7%
HIRED CONTRACT WORKERS	3	50.0%
HIRED PART-TIME EMPLOYEES	1	16.7%
HIRED INTERNS	1	16.7%
NOT NEWLY HIRED, AN EXISTING EMPLOYEE MOVED TO A CHW ROLE	1	16.7%
HIRED AS FULL-TIME EMPLOYEES	0	0.0%

AACI reflected on the impact that reliance on volunteers has on staff retention:

> *We're seeing now three years into the program the agencies that hired or that use their own team have the longest running group of CHWs – they're there, they're still a part of them. And then the people who were utilizing folks from their community, either through a volunteer program or the community themselves – we're seeing some turnover…The ones that use their infrastructure of staffing definitely had more consistency.* -AACI

Diverse Community Needs. The diversity within AA and NHPI communities posed significant challenges, as identified by three CBOs (n=3). These challenges included:

- Tailoring trainings to reflect the linguistics, cultural, and national diversity within the AA and NHPI population.
- Providing culturally responsive services that aligned with the distinct needs of these subgroups.

One CBO emphasized that addressing this diversity required substantial time for planning and implementation, which had implications for staff capacity.

Initial Program Planning. Although initial program planning was not directly identified as a challenge by CBOs, it emerged in SCCPHD and AACI interviews as a contributor to longer-term programmatic challenges. Both partners noted the need for:

- More upfront consultation with the community to identify needs and refine the program structure.
- Time to build relationships with AA and NHPI organizations to foster collaboration and ensure sufficient organizational capacity for implementation.

AACI Communication. Some CBOs (n=2) and CHWs (n=2) expressed a preference for more proactive communication from AACI. Specific concerns included:

- CBOs seeking advanced notice of deadlines for reporting and program updates.
- CHWs requesting earlier notification about training schedules.

Lack of Disaggregated Data. Two CBOs (25.0%) highlighted the importance of disaggregated data to identify the specific needs of AA and NHPI communities. Without subgroup-specific data, CBOs faced challenges in:

- Pinpointing programmatic needs and designing responsive interventions.
- Addressing intra-community differences, as aggregate data often obscures distinct needs within subgroups.

One SME/SCCPHD/AACI participant emphasized that within-group disaggregation is critical for avoiding assumptions and ensuring programs effectively serve diverse AA and NHPI populations.

> *"Most counties during the early pandemic didn't have good data that disaggregated NHPI. So we didn't really know how our population fared unless people did those deep dives and pulled us apart. During vaccine dissemination, we measured at above 100% vaccination in many counties… It's an erroneous data output." - CBO/CHW*

CHW-Level Design and Experiences

This section examines strengths and challenges of the program design and AACI's leadership, focusing on the experiences and perspectives of CHWs.

CHW Strengths

All CHW participants identified one or more strengths of the API CHW Program. Table 8 summarizes CHW-level programmatic strengths, their frequencies, and the extent to which CHWs emphasized these strengths.

Table 8. CHW-Level Strengths of the API CHW Program

CHW STRENGTHS	Excerpt Analysis		Participant Analysis	
	EXCERPT COUNTS (N=108)	PERCENT OF EXCERPTS	CHWs (N=16)	PERCENT OF CHWs
COMMUNITY REACH	35	32.4%	14	87.5%
CULTURAL RESPONSIVENESS	30	27.8%	9	56.3%
AACI TRAINING, INFORMATION & RESOURCES	28	25.9%	9	56.3%
SERVICE CONNECTION	7	6.5%	1	6.3%
CBO SUPPORT	6	5.6%	4	25.0%
COHORT/NETWORK	6	5.6%	1	6.3%

Note: Each theme is listed with its prevalence as a percentage of excerpts coded as CHW strengths from interviews and/or focus groups, and the proportion of CHWs that highlighted it. 'Coded excerpts' refer to specific statements categorized by theme during analysis.

Community Reach. Many excerpts (32.4%) identified community reach as the most significant CHW strength. CHWs emphasized their ability to effectively connect with and engage diverse community members. CHWs played a critical role in reaching isolated populations, such as seniors with limited mobility. They reported success in engaging community members through programs, activities, and the distribution of culturally relevant resources and information, often tailored and translated for their communities.

This theme correlated strongly with Cultural Responsiveness. Half of the CHWs who discussed their capacity to engage their community attributed their success to shared identity characteristics, such as nationality or language.

CHWs described their outreach work as deeply meaningful and fulfilling, both personally and professionally fulfilling.

Cultural Responsiveness. Cultural responsiveness was the second most common strength, representing 27.8% of excerpts. It was identified by 87.5% of CHWs as a key factor in their ability to connect with community members. CHWs highlighted their common language, cultural understanding, shared mental

frameworks, and emotional connection as critical elements for building trust and addressing unique community needs.

> *They're very observant or very conscious when people are asking them to share certain things about themselves, or who's talking to them...There's a history in Philippine culture about distrust of government and distrust of people in power... if we're able to establish trust they're more willing and open to share a lot of the concerns and issues that they're having.. being able to connect with our community members on the same basis of identity helps us build that trust and connect them to the people that they need to but also it helps to guide a lot of that work that we do - CHW*

For example, interviewees identified patterns and provided insights into why people often do not seek healthcare services – Vietnamese communities often utilize urgent care over preventative care and Filipino communities often do not want to burden others with their problems.

CHWs described how their lived experiences and cultural understanding enabled them to tailor and deliver resources in ways that were meaningful and well-received by the community. They felt that their deep understanding of topics and approaches that would resonate stemmed from shared cultural backgrounds, as well as an awareness of different histories and racialized experiences across generations. For one first-generation American CHW, their lived experiences and position within the community proved especially valuable for bridging generational gaps and addressing age-specific needs, such as language barriers faced by older adults.

> *A lot of staff and interns are Vietnamese American… We understand the history of our people in our community and a lot of people that we serve are refugees and immigrants. They have deep rooted trauma from that history. But we also are in a unique space, because we can relate to the youth and understand all the nuances that come with being Vietnamese American and growing up in America… That's how we've been able to flourish and get recognized in the community because we have this unique position where we're really bridging both generations – CBO/CHW*

In contexts where government distrust is high, CHWs acted as bridges, fostering trust between communities and the organizations. AACI leveraged this trust to strengthen the AA and NHPI network, enhancing outreach and program impact.

AACI Trainings, Information, & Resources. More than half of CHWs (56.3%) valued the resources and information provided by AACI for community distribution. This aligns with AACI's organizational strengths but underscores CHWs' appreciation for specific resources, such as personal protective equipment, blood pressure monitors, Narcan, and fentanyl test strips.

CHWs highlighted the impact of AACI's culturally tailored trainings, particularly those focused on blood pressure, mental health first aid, anxiety management, and CPR. CHWs reported that the trainings improved their confidence in handling challenging situations, such as suicide crises, and enhanced their ability to engage meaningfully with community members.

One CHW noted that the focus on AA and NHPI communities not only addressed service gaps but also strengthened their cultural competence and sense of self-identity.

Service Connection. Seven excerpts (6.5%) emphasized CHWs' role as connectors to essential services. CHWs facilitated linkages to programs, networks, and health organizations, addressing social determinants of health and ensuring holistic care for community members.

CBO Support. Four CHWs (25.0%) identified organizational support as a key strength. They appreciated onboarding and professional development opportunities. Some noted that supervisors regularly checked in to ensure the sustainability of their work.

Cohort/Network. In six excerpts (5.6%), CHWs highlighted the value of a larger AA and NHPI CHW cohort in supporting their work. They appreciated the trust built within the cohort, which facilitated service referrals and collaboration across programs. CHWs also valued opportunities to network through trainings and meetings to learn about the needs of other AA and NHPI ethnic groups.

> *"I think it's really rewarding and refreshing, seeing like different organizations and people from different Asian American communities, just holistically like, come together to have one goal together and just helping others in the community."* -CHW

CHW Challenges

Table 9. CHW-Level Challenges of the API CHW Program

CHW CHALLENGES	Excerpt Analysis		Participant Analysis	
	EXCERPT COUNTS (N=104)	PERCENT OF EXCERPTS	CHWs (N=16)	Percent of CHWs
COMMUNITY COMPLEXITY	34	32.7%	10	62.5%
ROLE SUSTAINABILITY	21	20.2%	4	25.0%
CERTIFICATION	20	19.2%	1	6.3%
COLLABORATION	12	11.5%	5	31.3%
ROLE MISCONCEPTIONS	8	7.7%	1	6.3%
RESOURCE AVAILABILITY	5	4.8%	3	18.8%
TRAININGS	4	3.8%	2	12.5%

Note: Each theme is listed with its prevalence as a percentage of excerpts coded as CHW challenges from interviews and/or focus groups, and the proportion of CHWs that highlighted it. 'Coded excerpts' refer to specific statements categorized by theme during analysis.

Community Complexity. The diverse and complex needs of the communities was a significant challenge for CHWs, with 62.5% (10 of the 16) identifying this as a theme. CHWs highlighted several challenges in addressing community needs, emphasizing the importance of tailored approaches due to unique dynamics across subpopulations. This included addressing language barriers and adapting services to meet social determinants of health.

CHWs also made concerted efforts to engage specific groups, such as youth and seniors, each with distinct histories and challenges. For older adults, activities focused on reducing isolation and improving health literacy, while efforts for youth centered on mental health and substance use.

CBOs prioritized reaching individuals with limited access to services. For example, one organization targeted unhoused individuals as a priority population. However, two CBOs noted recruitment challenges and expressed a desire to expand their reach.

> *For example - diabetes prevention. They're like, 'Oh yeah, I get. These are the things I need to do to reduce diabetes, but I don't have access… I can't do anything about it because I can't walk more than 15 minutes before my joints hurt, or I don't have a car or I live alone and it's really hard for me to get out of bed and do these things.' What we have to do is more than just education - we have to tailor each experience and need to the specific person. -CBO/CHW*

Role Sustainability. Sustainability of the CHW role emerged as a significant concern in 20.2% of excerpts. Key elements of this challenge included low pay, part-time status for many CHWs, demanding workloads, and the lack of benefits such as sick time or health insurance.

The pre-interview survey revealed limited access to benefits among CHWs: 16.7% of CBOs surveyed offered employee benefits, reflecting the broader challenges of sustaining the role.

Certification. Certification emerged as a potential pathway to role sustainability but highlighted divisions among participants.

Table 10. Support and Reservations Related to CHW Certification

CERTIFICATION	Support		Reservations	
	n	%	n	%
SMEs, PHD, AACI (n=7)	1	14.3%	4	57.1%
CBOs (n=8)	4	50.0%	3	37.5%
CHWs (n=16)	1	6.3%	1	6.3%

Note: Counts reflect the number of participants in each group expressing support, reservations, or both.

Participants in macro-level perspective roles (i.e., SMEs, SCCPHD, AACI) raised more concerns about certification than CBOs and CHWs. Concerns included the risk of excluding uncertified CHWs, particularly those without formal education, and the shift away from community-based roles toward more medicalized work.

Some CBO participants noted a connection between certification and reimbursement. They highlighted the administrative burden associated with certification, including its impact on organizational capacity to pursue reimbursement. However, they also acknowledged that reimbursement could support program sustainability.

One CHW noted that certification could create more sustainable career pathways through higher pay and closer integration with medical systems. Others expressed frustration about the time and complexity of certification processes, which can take 6 months to 2 years and have limited availability.

> *I think one of the things that scares me about the clinical part… the medical reimbursement part, I think, is wonderful. But what I'm already seeing is even their rollout of that program is only appealing to a CHW that may only be interested in that (medical) environment. It's not appealing to the CHW that we need more out in the community – CHWs that are comfortable going into neighborhoods or comfortable in situations where not everybody is comfortable in. -AACI*

Collaboration. Collaboration with AA and NHPI CHWs in other organizations and with external providers or organizations was widely valued but faced barriers. Several CHWs (31.3%) identified barriers, including time constraints and the need for stronger relationships. One CHW expressed interest in connecting with medical providers and county services to support patient case management, while another highlighted the importance of building connections with non-health service providers, such as legal service organizations. Additionally, one CHW noted a desire for more CHWs or organizations serving the same subpopulation to enable greater partnership opportunities.

Role Misconceptions. A theme identified by one CHW, and supported with excerpts that included other interviewee types (7.7%) highlighted the lack of clarity surrounding the CHW role, both within the community and among CHWs themselves. The CHW expressed challenges in explaining their role to community members, which impacted their ability to effectively promote programs and services. Additionally, they expressed uncertainty about the specifics of CHW responsibilities and how these differ from other roles. This lack of collective identity was identified as a barrier by one SME, who noted that it impacted movement-building at the state level.

Resource Availability. Three CHWs identified resource awareness and availability as barriers to delivering services, citing challenges related to space and materials. One CHW highlighted difficulties in securing space for small community gatherings and noted the lack of access to equipment, such as a PA system. Others expressed a need for a centralized database of resources, including those available through other AA- and NHPI-serving CBOs and community organizations.

Trainings. Finally, two CHWs (12.5%) highlighted challenges related to trainings, including difficulties in applying the knowledge gained and the time lapse between training and implementation. Additionally, one participant expressed a desire for more Pacific Islander-focused trainings covering a variety of topics.

Systems Change

The aforementioned data offer a detailed perspective of the specific benefits of the API CHW program. However, given the program's intentional design to drive systems change within the AA and NHPI communities in SCC and the CBOs that serve them, a broader examination of its overarching impact is warranted. This section provides evidence to answer the question:

> ***How did programmatic efforts advance system change and work towards improving population health outcomes?***

In order to explore this, select themes from the preceding sections will be reconstituted to illustrate how, collectively, they provide evidence of the impact of the API CHW Program on systems change. These themes are: building a collaborative network, expanding organizational capacity, delivering upstream, culturally-responsive community health services, and increasing sustainability. All of these themes, working together, demonstrate progress toward systems change as a direct result of the activities and efforts of the collaborators within the API CHW Program.

> *There may not have been a presence of health in many Asian-focused activities in the county to the degree that there has been this time. And reaching people about the importance of health is a good thing, it helps build trust. Building trust is the first step in being able to connect with people around changing health behaviors...and addressing structural barriers that impact health. -PHD*

Collaborative Network

The creation of a collaborative network to provide a breadth of services to AA and NHPI communities demonstrates the system of community care. The was highlighted as a programmatic strength by 87.5% of CBOs (notably, 5 of those 7 CBO interviewees (41.4%) were both a program administrator and CHW), and by one CHW participant. This CBO network allowed organizations to work in a pan-Asian/NHPI collective, which has the potential for long-term, community-wide collective impact, as well as impact on the policy level.

AA and NHPI CBOs built relationships with each other through ongoing networking events, trainings, and in-service meetings. This fostered trust-based relationships among CBOs, leading to cross-organizational collaborations, resource-sharing, and referrals for community members. This represents a notable shift as one SCCPHD/AACI participant reflected that CBOs serving the AA and NHPI community used to feel as though they were competing with one another for the same limited resources on grants, or in service delivery for their particular AA or NHPI communities. As reflected in evaluation Q1 and Q2 findings above, the relationships that were established resulted in collaborations between CBOs, and increased trust between CHWs, leading to knowledge sharing and referrals. This trust-driven network strengthened the collective ability to address systemic health disparities, and fostered a more integrated and resilient infrastructure for AA and NHPI communities.

In addition to the collaborative network built by those CBOs participating in the API CHW Program, CBO and CHW participants reported the value of being part of a broader network in part due to the relationships AACI had established with other organizations, and AACI's willingness to facilitate connection and communication between them. This, in conjunction with the collaborative co-design model of the program (noted as a strength among 50.0% of CBOs), contributed to a sense of solidarity and collective power between and among AA- and NHPI- serving organizations.

> *We leverage our our reputation in the community for getting funding, and we leverage our networks for training. And we leverage our network for different partners and collaborations throughout the Santa Clara County. -AACI*

Three SME/SCCPHD/AACI participants identify the as-of-yet untapped potential of this network, to advance policy change at the state level. They identified the ways that this program, and the resulting network, uniquely created collaboration and solidarity among the AA and NHPI workforce. To date, this workforce has lacked the solidarity that other similar CHWs

(e.g., Promotoras) have had. Participants felt that if fully leveraged, this network could become a model and a resource for AA and NHPI advocacy for similar programs state-wide.

Organizational Capacity

Findings indicating an increase in organizational capacity provide evidence of this program's contributions toward systems change. Funding was the primary mechanism for capacity building, noted as a strength by 87.5% of CBOs (7 out of 8). This funding supported program administration, the hiring and training of an AA and NHPI CHW workforce to provide culturally-responsive services, and the provision of translated content and materials. Organizational capacity was further expanded through the training of existing staff as CHWs, and the hiring of new CHWs for the first time.

Trainings, identified as the top organizational strength across all participant types, played a critical role in equipping CHWs with the knowledge and skills to provide culturally- and linguistically-responsive, evidence-based care to their communities. These trainings enabled CHWs to deliver an average of 148 activities per CBO. While challenges remain – particularly around organizational and staff capacity for those serving multiple organizational roles and staff retention– this initial increase in organizational capacity as a result of the API CHW program ensures CBOs are well-positioned to work individually and collaboratively towards finding sustainable paths forward.

Upstream, Community-Responsive Services

The unique ability of CBOs and CHWs to reach members of the AA and NHPI community (highlighted by 87.5% of CHWs) in a culturally responsive manner (highlighted by 56.3% of CHWs), is a distinct strength of the program. This is not surprising given that this represents the central purpose of the program. However, this work is not easy, nor is it straightforward given the vast diversity within and across AA and NHPI subpopulations, as was reflected by several (62.5%) CHWs as a challenge.

> *There's a really key feature of CHWs that aren't recognized by governments, and it's their versatility and ability to meet varied social determinants of health. And during COVID-19, we saw the pandemic not only affect health, we saw it affect people's incomes, housing, food access, employment, violence in the case of Asians, racism and xenophobia... and it's really important that the State as well as the counties take a very intersectional lens and understand that CHWs are providing critical services, not only in connecting people to health services but all these other determinants. - SME*

AA and NHPI CHWs spoke to the many ways they supported individuals in navigating health and social systems, while also taking into consideration the various barriers to services their communities faced, including language and deep-seated mistrust of government systems. CHWs spoke often of the ways that they provided tailored approaches not just based on overarching variables such as language, but often to individual participants, in recognition of their distinct barriers to health (i.e., social determinants). CBOs described the ways that their services have expanded to physically meet people where they are.

What's more, given the co-design nature of the program, the flow of information was not uni-directional from AACI to CBOs to CHWs. Instead, a system of information flow was established which allowed CHWs to elevate community needs to CBOs and AACI, which in turn resulted in responsive trainings and program materials. Taken together, this bi-directional flow of information resulted in the establishment of formal channels through which AA and NHPI needs can be recognized and addressed.

Increased Sustainability

Increased sustainability represents a pivotal element of systems change for the API CHW program. While this is likely to be a continued challenge, as evidenced by it being the most often discussed challenge by 75% (6 of 8) CBOs, there is evidence that in the first year of the program it has become increasingly sustainable for both AACI and the CBOs. The most direct evidence of this is the following collaborative funding that has been secured by AACI through the City of San Jose ($100,000), the Sobrato Foundation ($270,000), and the California Health Care Foundation ($70,000).

AACI is also providing support around certification which is required for reimbursement through Cal-AIM, which was seen by many CBOs as a pathway to sustainability.

> *It's not even just like the through line of having people certified. It's like, what do you do with that? Because if you can't reimburse, or you don't have the capacity for reimbursement, and you don't know all the ins and outs to work with the managed care plans then it kind of stops there. So the next thing on the horizon, after getting certification training for your staff is – how does the admin side handle reimbursement and make that seamless so it's not confusing? And then we're maximizing reimbursement and it's sustainable too. For a lot of our CHWs it's hard to fund with these public health dollars because they're like one year grants. And so we're constantly in the cycle of implementing the project and then applying for more funding whereas a CHW reimbursement structure will give us a more sustainable, reliable funding revenue stream that will keep positions alive longer rather than being beholden to a grant period. -CBO*

To this end, AACI has provided funding for 2 CHWs to attend the CHW Certificate Program at Foothill College. Support for CBOs to become integrated into health care systems also represents a key programmatic activity for Y4. This will be supported in part through the aforementioned funding from the California Health Care Foundation.

Recommendations

Recommendation 1: Continue Investment in the API CHW Program

Several factors impact the long-term sustainability of work in AA and NHPI communities. The deep community embeddedness of each CBO, their collaborative network, and each CBO's long history of serving community members ensures that organizations are well-positioned to meet community needs. However, the financial sustainability of the API CHW program faces challenges, as highlighted throughout the findings.

The County's initial investment in the API CHW Program has led to the establishment of a collaborative infrastructure capable of identifying and addressing the diverse needs of AA and NHPI groups. This program has successfully leveraged grassroots CBO networks, strengthening CHW capacity and enabled culturally responsive, community-driven health promotion through a collective impact approach.

This program has proven effective with AACI serving as the backbone agency. In this role, AACI coordinates ethno-specific CBOs, providing the training and resources needed for tailored service delivery. It has also fostered connections between CBOs, CHWs, and external organizations. Further, CBOs reported that AACI worked closely to overcome administrative capacity constraints. This support empowered CBOs and CHWs to fulfill the API CHW Program's mission by delivering culturally tailored services that improve population health.

In order to ensure that this program achieves its long-term potential, dedicated funding must support both AACI and CBOs in service delivery. Initial funding built relationships, established infrastructure, and supported CHW training and service delivery. Lessons learned have shaped the program's continued evolution. Now in Year 4, several efforts are already underway to ensure the program's long-term sustainability. However, existing funds fall short of supporting the time and resources needed to sustain growth and maximize gains.

Additionally, efforts must focus on ensuring CHW workforce sustainability. The County of Santa Clara's initial investment in the API CHW Program was timely given the growing state and federal focus on CHWs. In recent years, the state of California has allocated $281.4 million to recruit, train, and certify new CHW/P/Rs by 2028.[14] It has also introduced Medi-Cal coverage for CHW services and begun developing statewide certification standards. Continued county funding can ensure that the infrastructure and workforce developed through this program can leverage emergent certification opportunities.

Actionable recommendations:

- Provide financial support for continued coordination and program administration by a backbone agency including:
    - CHW training and capacity building.
    - Strengthening the collaborative network.
    - Facilitating organizational linkages.
    - Assisting CBOs in securing grant funding.
- Support CBOs in seeking reimbursement through Cal-AIM, ensuring they have the capacity and resources to navigate the process.
- Subsidize CHW certification, ensuring equitable access to training and credentialing for diverse CHWs.
- Offer stipends to CBOs delivering community-based CHW services to sustain operations and workforce development.
- Allocate funding to build an AA and NHPI collective workforce, fostering advocacy for policy changes that address unique community needs.
- Dedicate funds for evaluation, including planning and implementation, to measure program impact and inform improvements.

[14] https://cpehn.org/assets/uploads/2024/03/2024-CHWPR-Policy-Agenda-1.pdf

Recommendation 2: Increase CBO and CHW Involvement in Program Implementation, and Awareness and Advocacy Efforts

In the initial years, AACI prioritized establishing structures and processes for the API CHW Program's implementation. Over time, the program evolved to foster greater collaboration and co-design with CBOs and CHWs.

The strength of this program lies in leveraging the trust and relationships that AA and NHPI CBOs have built within their communities. This collaborative approach would allow AACI to ensure program design remains responsive to CBO needs and maintains bidirectional communication between CHWs, CBOs, health care providers, the Santa Clara County Public Health Department (SCCPHD), and the State.

Given the diversity among CBOs and their communities, CBO involvement in key program decisions is essential. We recommend creating an advisory board for the program, comprised of CBO and CHW representatives. This would establish a formal communication mechanism between program administrators and organizations, ensuring input on distinct community needs. Additionally, the API CHW program could connect CHWs to roles in advisory or governing bodies as subject matter experts. Incorporating CHW expertise into the program design and linking them to advocacy opportunities could influence programs, practices, and policies at broader levels.

Actionable recommendations:

- Establish an advisory body with a clear purpose and defined goals
- Engage with CHWs to assess interest, and develop a list of AA and NHPI CHWs available to serve as subject matter experts for organizations, presentations, and policy advocacy.
- Identify and pursue opportunities for policy advocacy to ensure the long-term sustainability of the CHW role.

Recommendation 3: Conduct Rigorous, Ongoing Evaluation

Interviewees consistently identified challenges in data collection and program evaluation. While the program's strength is its ability to equip CBOs to carry out diverse activities and serve distinct AA and NHPI groups, this also presents barriers to standardized outcome measurement.

To address these challenges and support CBOs in collecting standardized data that demonstrate outreach and impact, a comprehensive evaluation plan is required. This plan should include shared outcome indicators wherever feasible to measure program impact across CBOs.

Actionable recommendations:

- Develop a theory of change for how community-based CHWs are expected to contribute to population health outcomes and other long-term changes through their work
- Identify shared proximal indicators of long-term health improvements measurable across CBOs.

- Ground metrics in both evidence and lived experiences through a literature review and close consultation with an advisory body.
- Support CBO-specific evaluation plans
    - Provide technical assistance to help CBOs create tailored theories of change and evaluation plans.
    - Recognize that smaller CBOs may need resource and capacity-building support to meet evaluation requirements.
- Build a centralized database
    - Establish a shared platform where CBOs can capture and upload program data.
    - Enable AACI and SCCPHD to access consistent process and outcome metrics.
- Conduct annual evaluations
    - Highlight the collective program impact and individual CBO outcomes.
    - Share findings to help CBOs leverage evidence of success for grant applications and future funding opportunities.

Recommendation 4: Advance Programmatic and Organizational Sustainability Beyond Funding

This recommendation builds upon previous recommendations, emphasizing the critical need for program and workforce sustainability. Sustainability encompasses funding (as discussed above) but also workforce development, capacity building, and organizational resilience. Sustainability efforts are needed to ensure CHWs are supported in developing viable career paths while continuing to serve AA and NHPI communities effectively and culturally responsively.

Actionable recommendations:

- Leverage collective advocacy at the state level
    - SCCPHD and AACI should mobilize the network to advocate for AA and NHPI CHWs at the state level.
    - Focus advocacy on securing higher reimbursement rates and sustainable funding structures for CBOs and CHWs.
- Strengthen grant funding and administrative support
    - Provide ongoing training and mentorship for CBOs in data collection and evaluation to demonstrate impact effectively.
    - Support collaborative grant applications across CBOs and build capacity for independent funding efforts.
    - Assist CBOs pursuing medical reimbursement in building relationships with health plans, organizations, and providers.
- Develop a workforce training and retention strategy
    - Create infrastructure for continuous training to address turnover and reduce reliance on volunteers.
    - Ensure CHWs have access to customized support that reflects their diverse roles, preferences, and needs, including salary, benefits, and workload considerations.
- Facilitate CHW certification
    - Offer tailored guidance for CHWs interested in certification, providing clear pathways to navigate certification processes.

- Ensure sustainability of the CHW role as a viable career path, with fair salary, benefits, working hours, and workload. Given the diversity within this workforce, particularly for those holding multiple roles and/or those working part-time while managing other responsibilities, this requires a customized approach that takes into account CHW preferences.

Efforts towards sustainability must balance flexibility with structure. At the heart of these efforts should be a commitment to honoring the diversity of experiences and needs within the AA and NHPI CHW community. Systems, structures, payment incentives, policies, and workforce pipelines must be developed to support – not replace – the impactful work already being done by CHWs and CBOs.

Across the CHW field, increased professionalization emphasizes outcome-oriented, standardized, and evidence-based programs. While this shift is valuable, overly rigid or prescriptive approaches risk excluding many CHWs whose effectiveness relies on their unique cultural insights and positionality.

This recommendation underscores the need for ongoing CBO and CHW involvement in shaping the program's evolution, ensuring that systems are designed to amplify their voices and meet community needs. Thus this recommendation again supports increased CBO and CHW involvement to shape the program's future.

Summary

Limitations

This evaluation highlights several limitations that should be considered when interpreting the findings. First, the evaluation engaged only 16 CHWs, a small subset of the 55 CHWs actively involved in the program as of Q1 Year 4. This limited sample size may not fully capture the diversity of perspectives and experiences within the broader CHW cohort. Additionally, while distinct interview guides and vocal prompts were implemented to distinguish the roles between CBOs and CHWs, some overlap in perspectives is anticipated. This overlap may present challenges in distinguishing unique insights from each group despite efforts to mitigate this issue.

Another key limitation lies in the difficulty of measuring the API CHW Program's progress toward population health outcomes. While substantial process metrics and some key programmatic outcomes at the organizational level were identified, there are no discernible population health outcomes directly attributable to CHW activities. This reflects the inherent challenges of evaluating community-based CHWs, whose work often focuses on indirect and long-term health impacts rather than the measurable outcomes typically associated with medically-focused CHWs.

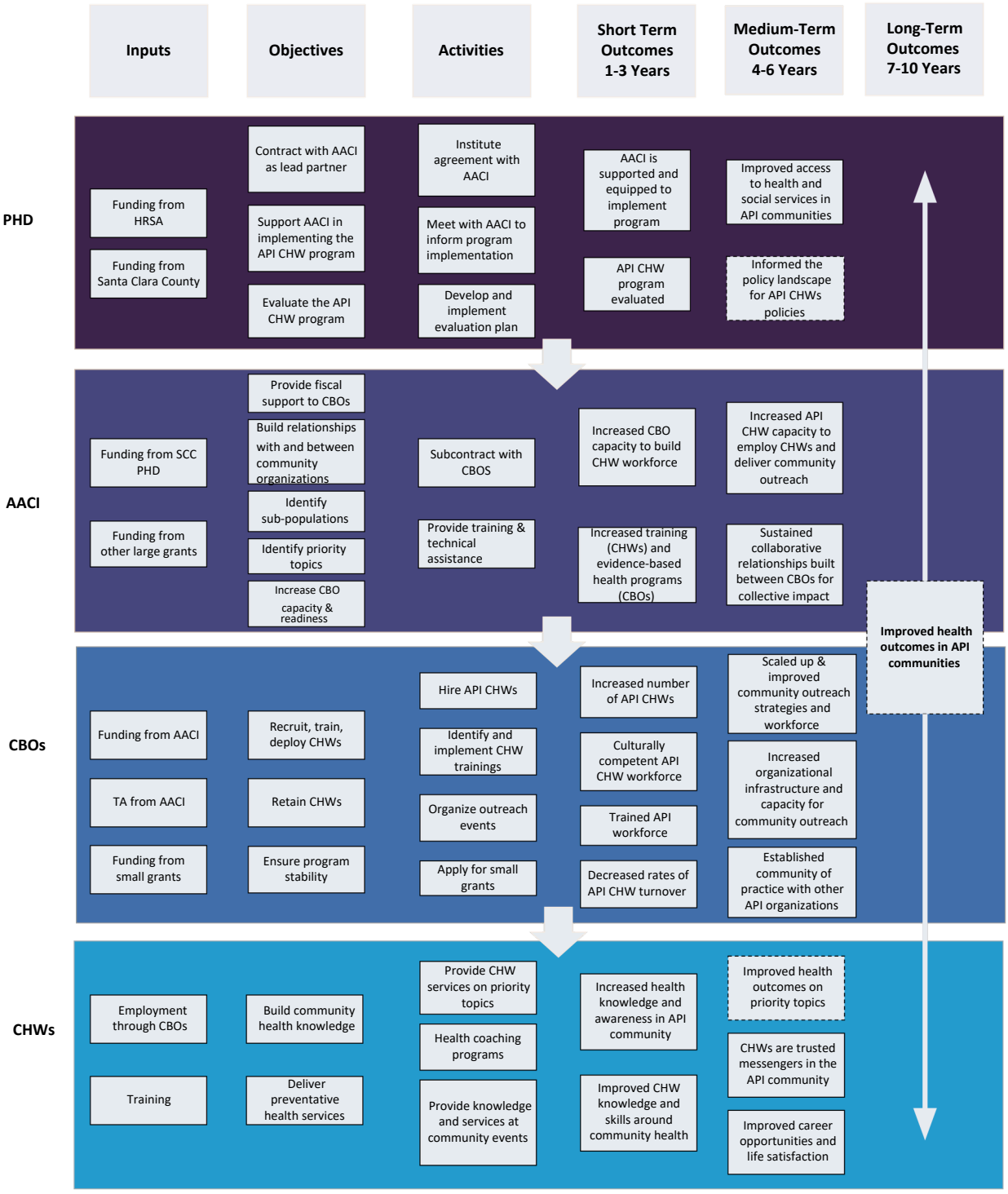
These limitations underscore the complexity of evaluating a multifaceted program like the API CHW Program. While the evaluation provides valuable insights into programmatic strengths and areas for improvement, the findings should be interpreted with these constraints in mind.

Conclusion

The Asian and Pacific Islander Community Health Worker (API CHW) Program in Santa Clara County is a pioneering initiative designed to address health disparities among Asian American and Native Hawaiian Pacific Islander (AA and NHPI) populations. Launched in 2021, the program focuses on recruiting and training AA and NHPI CHWs, building capacity in community-based organizations (CBOs), and building a collaborative network to deliver tailored, culturally responsive health education and services, all in service of advancing systems change. Since its inception, the program has facilitated 1,332 activities, and reached over 1.6 million individuals, demonstrating its breadth of impact. This evaluation assessed the program's design, implementation, and outcomes, identifying significant strides in expanding organizational capacity, fostering a trust-driven network of AA- and NHPI-serving CBOs, and equipping CHWs to address community needs. Challenges such as sustainability, diverse community needs, and the measurement of long-term health outcomes were noted, emphasizing the need for continued investment, enhanced evaluation, and targeted support for CHWs and CBOs. The evaluation offers actionable recommendations to further advance the program's impact, sustainability, and potential to serve as a model for AA and NHPI health equity efforts statewide.

Appendices

Appendix A: Logic Model



Dotted line around outcomes or impacts indicates areas outside the study of the current evaluation.
Bracket indicates shared PHD and AACI Impacts.

Appendix B: Methods

Primary and secondary data collection activities focused on both process and outcome measures. The following outlines a detailed description of qualitative data collection activities and analyses for both qualitative and quantitative findings.

Data Collection

Qualitative Data Collection

All qualitative data were collected virtually. SCCPHD and AACI recruited participants through introductory emails, followed by direct outreach from JSI. Due to insufficient sample sizes for CHWs, the team leveraged AACI's in-service meetings for recruitment and focus groups. Interviews lasted approximately 60 minutes following a consent process, and request for permission to record. Focus groups ranged from 1.5-2 hours. Participants received a $50 electronic gift card as a thank you for participating.

Quantitative Data Extraction

Quantitative data were extracted from program documents. Quarterly reports included programmatic activities and outputs reported by AACI and CBOs from April 2021-September 2024. However, missing data from some organizations (e.g., Year 1 data from Bayanihan Community Center, Year 2 data from AACI Senior Wellness Program) limited the dataset's completeness. To prepare the data for analysis, missing values were addressed where possible and key variables were created or recategorized:

- In-Person Encounters combined data from COVID-19 vaccination participants, health screening participants, workshop attendees, and individuals engaged at fairs or public events.
- Virtual Encounters merged digital metrics (e.g., emails sent, website views, and social media interactions at the time of data reporting).
- Activity types were reorganized into six categories encompassing both health initiatives and community engagement.
- Activity topic areas were reorganized into seven categories relating to health and overall wellness.

Data Analyses

Qualitative Analysis

Qualitative data were analyzed using a two-cycle coding process. In the first cycle, structural coding aligned data with key themes, such as programmatic strengths, challenges, and systems change. A codebook was developed a priori, based on deductive codes derived from interview and focus group questions. Three study staff independently coded an initial transcript and resolved discrepancies through team discussions, leading to minor refinements of the codebook. The revised codebook was then applied to the remaining data by the three coders working independently.

In the second cycle, patterned coding was employed to synthesize data across themes and address specific evaluation questions. For example, programmatic design and experience (Q2) were analyzed through themes like programmatic strengths, challenges, AACI strengths, and AACI challenges. For

systems change (Q3), an inductive approach was necessary due to the multi-level nature of the program. SCCPHD and AACI were responsible for overarching goals and objectives, while CBOs and CHWs focused on service design and delivery. While systems change questions were primarily directed to SCCPHD, AACI, and subject matter experts (SMEs), the foundational contributions of CBOs and CHWs were recognized and incorporated into the analysis. This approach ensured a comprehensive understanding of systems change at all levels of the program.

Qualitative data were also quantified through two approaches:

- Frequency and proportion analysis measured the prevalence of themes across all participant types. The denominator included all coded excerpts from SMEs, SCCPHD, AACI, CBOs, and CHWs. For example, programmatic strengths accounted for a significant proportion of excerpts across participant types, reflecting its importance among stakeholders.
- Respondent-level analysis quantified the number of participants from specific groups (e.g., CBOs, CHWs) who spoke to each theme. For instance, 75% of CBOs highlighted programmatic strengths, while 62% discussed AACI strengths.

For systems change (Q3) an inductive approach was taken. This analytic approach was selected given the multi-level nature of the program and the difference in perspective that each stakeholder entity held. For example, SCCPHD and AACI focused on the broader public health landscape and the alignment between program-wide objectives, while CBOs and CHWs focused on delivery innovations and practices. By analyzing data inductively, the evaluation team identified multi-level systems change evidence across groups, such as enhanced collaboration between CBOs and improved integration of CHWs into health systems.

Quantitative Analyses

Quantitative analyses assessed overall programmatic activities and select outcomes through key variables including total encounters (in-person and virtual), AA and NHPI populations served, activity types, and topic areas. The analysis involved descriptive statistics, including frequencies and percentages, to summarize programmatic outputs. For example:

- **Engagement Metrics**: Media outreach efforts had the highest number of encounters, likely due to the broad reach of platforms such as radio and Instagram. On average, each media outreach activity involved 2,135 encounters which may have included emails sent, media interactions, and/or audience counts. The total number of encounters may include a duplicated count of individuals who were engaged in multiple or ongoing program activities.
- **Activity Topics**: Of the eight categories, disease prevention and management emerged as the most frequently reported focus area of CHW trainings and CHW-led activities.

To ensure consistency in reporting, overlapping activity types and topics were assigned to categories based on their primary focus as initially reported. For example, a combined health screening and education event was classified as a "clinical services" if the CBO reported it under “health screening” and not a “community fair or other public event.”

Appendix C: Data Collection Instruments

A. CBO Pre-Interview Survey

Pre-Interview Survey

JSI Research and Training is working with the Santa Clara County Department of Public Health and AACI to evaluate the Asian and Pacific Islander Community Health Worker Program (API CHW Program). Our goal is to understand how the program went and what could be improved to better support organizations and CHWs in the future.

We understand each organization participating in this API CHW program is different. It would be helpful for our team to understand more about your organization's experience. Your full responses will not be shared with the Public Health Department or AACI, but some information may be reported out at the group/aggregate level (across yours and other organizations participating in the program). Thank you for your time!

Your first and last name:
Organization: [dropdown menu]

1. How do the priorities and programs of the API CHW Program compare to your organization's existing priorities and programs?
    a. Very different, different, neutral, similar, very similar

2. Did your organization have CHWs or a similar role before the program? By similar role, we mean a job that supports people with health education or connections to health and social services.
    a. Yes, we had CHWs or other similar job roles
    b. No, this was our first time having CHWs

3. How did your organization employ CHWs for this program? *Select all that apply*.
    a. Hired as full time employees
    b. Hired as part-time employees
    c. Hired as interns
    d. Hired as contract workers
    e. Not newly hired, an existing employee moved to a CHW role
    f. Not newly hired, an existing employee added the CHW role to their existing job responsibilities
    g. Other, please describe: _____

4. Were CHWs offered employee benefits (health insurance, retirement, paid time off, etc.)?
    a. Yes, offered employee benefits

b. No, not offered employee benefits

5. How does your organization pay your CHW workforce? *Select all that apply.*
    a. Funding directly from our organization
    b. API CHW program funding
    c. Other grant funding
    d. Reimbursement through the Medi-Cal CHW benefit
    e. Planning to apply for other grant funding in the future
    f. Planning to receive reimbursement through the Medi-Cal CHW benefit in the future
    g. Other, please describe: _____

    [skip logic: if grant funding was selected]
    Who provided the grant funding? How long was the grant for?
    _____

6. What parts of the API CHW Program were most helpful for your organization?
    Please pick your top four choices from this list:
    a. Training for our CHWs on health topics (like COVID-19, diabetes prevention, aging, nutrition, etc.)
    b. Training for our CHWs on skills (like motivational interviewing, etc.)
    c. Training for our organization (how to hire CHWs, how to approach state CHW certification and reimbursement, etc.)
    d. Financial support to hire and train CHWs
    e. Time and space for our organization to think about working with CHWs
    f. Collaborations and working with other organizations serving Asians and Pacific Islanders
    g. Collaborations and working with with AACI
    h. Collaborations and working with Santa Clara Public Health Department
    i. Other, please describe: _____

Please tell us how much your organization agrees or disagrees with the ideas below.

7. Our organization received the support we needed to make this program work well.
    a. Strongly disagree, disagree, neutral, agree, strongly agree

8. Our organization was able to customize this program to fit our needs and other existing priorities.
    a. Strongly disagree, disagree, neutral, agree, strongly agree

9. This program met our expectations.
    a. Strongly disagree, disagree, neutral, agree, strongly agree

10. Did your organization collect any information or data related to the topics listed below? *Select all that apply.*
    a. CHW satisfaction with the program
    b. Community satisfaction with the program
    c. Changes to your organization because of the program
    d. Changes to your CHWs because of the program
    e. Changes in health education or health awareness in the community

    [skip logic: if any were selected]
    Can you share a brief summary of what you found about [response category]?

B. SME, PHD, AACI, and CBOs Key Informant Interview Guides

AA & NHPI CHW Interview Guide Background

Introductions

Hello. Thank you for meeting with us today (for CBOs: and for taking time to complete the survey).

We work for JSI Research and Training, a non-profit public health research organization. We are helping the Santa Clara County Public Health Department to evaluate the Asian and Pacific Islander Community Health Worker (API CHW) program.

Our team will introduce ourselves very briefly and will ask you to save your more in-depth introduction for the start of the interview.

Purpose/Process

From April to June, we are interviewing people from the public health department, AACI, community-based organizations, and experts on community health workers across the state. The overall evaluation will focus on understanding the program's achievements, impacts, and learnings. We are also interested in longer-term sustainability for the program and transferable findings for other CHW efforts.

Do you have any questions? Please feel free to ask at any time.

Confidentiality

Your insights as someone directly involved in this program are very important to us. Everything you share will be anonymous- nothing will be linked directly to you. We will synthesize common themes that arise and may feature de-identified quotes, but your name will not be linked to anything you say. If there's anything you share that you want us to keep off record or not quote in any way (even de-identified), please let us know and we will make a note.

If you are okay with it, we'd like to record the interview. This helps us focus on our conversation today rather than trying to capture detailed notes while you speak. We will not share this with anyone outside of our internal JSI team. We will not share it with the public health department or any other organizations. Is it okay with you if we record the conversation for our internal note taking purposes?

- If consent is not given: Thank you for letting us know. We will focus on taking detailed notes during our conversation instead.

Are there any questions before we get started?

AA & NHPI CHW Subject Matter Experts

Introductions

1. Please introduce yourself and describe your work related to CHWs.

Impact

2. Can you tell us more about the potential impact CHWs can have on Asians, Native Hawaiians, and Pacific Islanders communities specifically?
    a. What population health outcomes can CHWs have the greatest impact on?
    b. How are CHWs uniquely positioned to support health interventions or programs?
3. What role has shared backgrounds or identities played between CHWs and the people served? For example, potentially shared cultural understanding, shared language, and/or shared experiences with immigration?

CHW Workforce

4. What strengths do CHWs bring to health and social service organizations?
    a. How should organizations foster and build upon these strengths?
5. What are the prominent challenges CHWs face in California?
    a. What are challenges specific to CHWs working with APIs?
    b. What can organizations do to support CHWs with these challenges?
6. What support or training are important for CHWs to be successful?
    a. How can organizations continuously assess CHW needs?
7. What support or training would be the most helpful for CHWs working with ANHPIs?
    a. How might the work or needs of ANHPI CHWs differ from other racial or ethnic programs like Promotoras?

Systems

8. How do CHWs improve the linkages between health and social service systems?
    a. What is needed to further support these linkages/clinic-to-community models?
9. What are foundational components for a successful CHW role at CBOs?
    a. What should organizations consider before developing or expanding their CHW teams?
    b. How can organizations better recruit and retain CHWs?
10. What is needed at the systems and policy level to better support a sustainable CHW workforce?
11. What are the challenges and opportunities of the recent CHW Medi-Cal benefit?
    a. How can organizations prepare for the new CHW Medi-Cal benefit?
12. What data relating to the development of a CHW workforce is important to measure and track?
    a. What are common challenges to collecting or reporting this data?
    b. How should community-based organizations approach these challenges?

Wrap-Up

13. Is there anything else about CHWs that you wanted to share or emphasize?

Santa Clara County Public Health Department Program Managers

Interviewee / Program Context

1. Please introduce yourself and how you are involved in the CHW program.

Program Development

2. We'd like to get a better idea of what entities influenced how the program was designed. Could you describe how the SCC PHD, AACI, CBOs, and CHWs were involved in designing the program?
    a. Did this change throughout the program?
3. What was it like developing this program in collaboration with AACI?
    a. What worked well?
    b. What could be improved?

Program Design

4. Do you think hiring API CHWs is an effective way for organizations to support Asians and Pacific Islanders?
    a. How similar or different is this program from non-API CHWs or Promotores?
5. How did you design the program to support the needs of APIs and organizations serving APIs?
    a. What information did you use to tailor the program?
    (e.g., health assessments, conversations with individuals or providers, etc.)
6. How did you design the program to support the needs of CHWs?
    a. What key strategies, tools, or training support CHWs and their work with APIs?
7. How did you design this program to support a sustainable CHW workforce at CBOs?
(e.g. career pathways, retention efforts, funding opportunities, capacity development)
    a. Before developing this program, how prepared do you think API-serving CBOs were to employ CHWs?
8. What data did you think was important to measure and track for this program?
    a. What population health outcomes did you envision this program addressing?
    b. How did you learn about CHW or CBO needs throughout the program?
    c. What were any challenges to collecting or reporting data?

Implementation and Impact

9. What successes did you have with the CHW program?
10. What challenges did you have with the CHW program?
    a. How were these challenges addressed?
11. What impact do you think this program has had in Santa Clara County?
(e.g. PHD, CBOs, CHWs, API and non-API community)
    a. Are there other impacts you wish the program was able to have?
12. Has this program helped improve linkages between PHD and community-based organizations? How so?
    a. What does PHD need to better support CBOs?

Recommendations

13. What changes, if any, would you recommend to this program?
    a. How could programs better support CBOs?
    b. How could programs better support CHWs?
14. What training or program design would be the most helpful for those serving APIs?

Wrap-up

15. Is there anything else about the CHW program that you wanted to share or emphasize?

AACI Program Managers

Interviewee / Program Context

1. Please introduce yourself and describe your role with the API CHW program.
    a. What motivated AACI to serve as lead agency on this program?

Program Development

2. We'd like to get a better idea of what entities influenced how the program was designed. Could you describe how the SCC PHD, AACI, CBOs, and CHWs were involved in designing the program?
    a. Did this change throughout the program?
3. What was it like collaborating with PHD?
    a. What worked well?
    b. What could be improved?
4. What was it like collaborating with the CBOs?
    a. What worked well?
    b. What could be improved?

Program Design

5. Do you think hiring API CHWs is an effective way for organizations to support Asians and Pacific Islanders?
    a. How similar or different is this program from non-API CHWs or Promotores?
6. How did you design the program to support the needs of APIs and organizations serving APIs?
    a. What information did you use to tailor the program? (e.g., health assessments, health outcome data, focus groups, conversations with patients or providers, etc.)
7. How did you design the program to support the needs of CHWs?
    a. What key strategies, tools, or trainings support CHWs and their work with APIs?
    b. Before developing this program, how prepared do you think partner organizations were to employ CHWs?
8. What data did you think was important to measure for this program?
    a. What population health outcomes did you envision this program addressing?
    b. What are challenges to collecting or reporting data?
        i. How were these challenges addressed?
    c. How did you learn about CHW or CBO needs throughout the program?

Implementation and Impact

9. What successes did you experience with the program?
    a. For CBOs?
    b. For CHWs?
10. What challenges did you experience with the program?
    a. For CBOs?
    b. For CHWs?
    c. How were these challenges addressed?
11. What role has shared background played between the CHWs and the people they serve? For example, potentially shared cultural understanding, shared language, and/or shared experiences with immigration?
12. How did the program support the CBO's capacity to recruit, train, and support CHWs?
    a. After this program, how prepared do you think organizations are to continue employing CHWs?

b. How has this program helped prepare organizations for the new CHW Medi-Cal benefit?
    i. What are the opportunities and barriers relating to CHW certifications?
c. What do CBOs need to continue building a CHW workforce?

13. How has this program helped improve collaboration?
    a. between partner CBOs?
    b. between the community and different organizations or systems?
14. What impact do you think this program has had on the communities you serve?
    a. Are there other impacts you wish the program was able to have?

Recommendations

15. What changes, if any, would you recommend to this program?
    a. How could programs better support CBOs?
    b. How could programs better support CHWs?
16. What training or program design would be the most helpful for those serving APIs?

Wrap-up

17. Is there anything else about the CHW program that you wanted to share or emphasize?

Community-Based Organization Executive Directors and Program Managers

* *= select the question depending on whether/how the interviewee responded to the survey*

Introduction and Context

1. Please introduce yourself and how you are involved in the CHW program.

Program Design and Development

2. *(Q3 N/A or Neutral) How did the API CHW program fit into your organization's overall goals and existing programs?
   *(Q3 Similar) I noticed in the survey you mentioned that the API CHW Program is similar to your organization's work. How did this program help your organization expand the work you're already doing?
   *(Q3 Different) I noticed in the survey you mentioned that the API CHW Program is different from your organization's work. What interested your organization in starting something different with this program?
3. *(Q10 N/A or Neutral) Were you able to tailor this program to fit your organization's needs?
   *(Q10 Agree) In the survey, you also mentioned your organization was able to customize the program to meet your needs. Can you elaborate? How did you tailor the program to fit your organization's needs?
   a. Did your organization tailor the program more to support *[specific ethnic identity the organization primarily serves]*? How so?
   b. What information did you use to tailor the program?
      (e.g., health assessments, conversations with individuals or providers, etc.)

   *(Q10 Disagree) In the survey, you also mentioned your organization was not able to customize the program to meet your needs. What would you have wanted to change about the program's design?
   c. Would you have tailored the program more to support *[specific ethnic identity the organization primarily serves]*? How so?
4. How was the experience of working with AACI as the lead agency?
   a. Can you walk us through your main interactions and involvement w/ AACI?
   b. What worked well?
   c. What could be improved?

Implementation and Impact

5. Do you feel like you received enough funding to successfully implement this program?
   a. If no, what would additional funding have been most helpful for?
6. How did the program's grant funding work at your organization?
   a. Was it distributed based on activities completed or with required reporting?
   b. How often did you receive the grant funding from the program?
   c. Do you have any input on ways to improve this process for the future?
   d. *(Q7 other grant funding) In the survey you shared you are receiving other grant funding. Who is providing that funding and for how long?
7. What successes did you have with this CHW program?
8. *(Q8 completed) In the survey, we asked you to choose the most helpful parts of the API CHW program. Could you tell us more about why [*Q8 survey responses] were the most helpful for your organization/CHWs?
9. What challenges did you have with this CHW program?
   a. *(Q11 Disagree) Why did this program not meet your expectations?

    b. How has your organization or CHWs addressed those challenges?
10. Based on your survey, we see that your organization [*Q4 had CHWs before/did not have CHWs before] and most CHWs were hired as [*Q5 and Q6 survey responses].
    Did participating in this program help your organization with recruiting, training, and supporting CHWs? How so?
    a. How has this program supported the CHWs professional growth?
    b. Are there training gaps that remain for your organization or CHWs?
    c. How many CHWs did you employ? Full, part time?

11. How has participating in this program impacted your organization? For example, did it change your organization's capacity, teams, community engagement, or lead to any other differences?
    a. *(Q4 No CHWs before) Did your organization change or make adjustments to incorporate the new CHW role?
    b. After this program, how prepared does your organization feel to continue with CHWs?
12. How much did your organization and CHWs collaborate with other organizations because of this program?
    a. What could have improved the collaboration?
13. What impact has this program had on the communities you work with?
    a. Are there other impacts you wish the program was able to have?
14. What role has shared background played between the CHWs and the people they serve? For example, potentially shared cultural understanding, shared language, and/or shared experiences with immigration?
15. How did your organization measure and track data for this program?
    a. Who at your organization was responsible for collecting and reporting data?
    b. What are successes or challenges related to collecting or reporting data?
    c. Whether or not your organization currently tracks this information, what kind of data do you think would have been helpful to collect?
    d. *(follow up as needed re: Q12 data) You noted that your organization collected information on [*Q12 survey responses]. Could you share more about _____?
16. Knowing what you know now, do you think hiring API CHWs is an effective way for organizations to support Asians and Pacific Islanders?
17. In the survey, you mentioned your organization currently uses [*Q7 survey responses] to pay for CHWs. How might your organization approach funding or sustaining CHWs after this program?
    a. [If unsure whether they would pursue Medi-Cal funding] Is your organization considering the Medi-Cal CHW benefit as a funding stream?
    b. *(priority question if Q7 includes Medi-Cal benefit answer) In the survey you noted the recent Medi-Cal CHW benefit. Has this program helped prepare your organization for the new Medi-Cal CHW benefit?

Recommendations

18. What changes, if any, would you recommend to this program?
    a. How could programs better support CBOs?
    b. How could programs better support CHWs?
19. What training or program design would be the most helpful for those working with APIs?

Wrap-up

20. Is there anything else about the CHW program that you would like to share?

C. *Community Health Worker Guides*

CHW Focus Group & Interview Guide

AA & NHPI CHW Interview Guide Background

Introductions
Welcome everyone and thank you for taking time to join this focus group. We work for JSI Research and Training, a non-profit public health research organization. We are contracted with the Santa Clara Public Health Department to evaluate the Asian and Pacific Islander Community Health Worker program that you all have been involved in. Our team will introduce ourselves, share about the focus group today, and then ask to hear from you all.

Evaluation Goals
By talking to people and reviewing other data, overall, we are trying to understand:

- How has this program helped make changes that improve Asian and Pacific Islander health?
- How can Santa Clara County and other organizations support community health workers and improve programs like these?

Evaluation Timeline
From April to June, we will be meeting with community health workers, and people from the public health department, AACI, and other community organizations. Today, we hope to specifically learn more about your perspectives as community health workers and your thoughts about the successes, challenges, and recommendations for the program.

Incentives
To thank you for your time tonight, we will also be emailing everyone a $50 Target gift card. Please note that our team is purchasing the gift cards and it is not an automated process, so it may take up to 2-4 weeks to receive your gift card in your inbox.

Do you have any questions? Please feel free to ask at any time.

Confidentiality/Agreements
Your experiences and opinions are important to us. Everything you share will be anonymous- no one will know who said what. Our team will look for common themes from these conversations and may use quotes in our reports. These quotes will not list your name, organization, or include information that could help others identify you. If there's anything you share that you want us to keep off record or not quote in any way, please let us know and we will make sure to do so.

In order for everyone to have the opportunity to share their insights in this session, we would like to offer some group agreements and invite you all to add your own (can be added in the chat):

- What's said here, stays here (maintain privacy and confidentiality)
- There are no wrong answers
- Listen to understand, not to respond
- Use the chat to express support for ideas or to share opinions with us, the facilitators, privately

Are there any agreements you would like to add? To remove?

Recording Consent
If you are okay with it, we'd like to record our discussion. This helps us focus on our conversation today instead of taking detailed notes while you talk. We will not share this with anyone outside of our internal JSI team. We will not share it with the public health department or any other organizations. To make sure we have everyone's approval, we are going to launch a Zoom poll. Please let us know whether it is okay to record our conversation so that our internal team can review and improve our notes.

Can you give a thumbs up if you are okay with recording our conversation for JSI's internal use only? We won't share this with your organizations, nor with AACI nor with the PHD.

- <u>If there's not 100% consent from participants</u>: Thank you for letting us know. We will focus on taking detailed notes during our conversation instead.

Are there any questions before we get started?

Interview Questions

<u>Introduction</u>
Let's do a brief round of introductions. Could you introduce yourself and share how long you've been a community health worker or worked in a similar role? Let's limit our introductions to about 30 seconds or less.

<u>Context Question: CHW Experience</u>
Tell us about your day-to-day work as a CHW, and in the API CHW Program led by AACI?
- [Probe] What support or processes are there that help with your day-to-day work (providing health education/referrals/working with health and social service organizations)?
- [Probe] What are common challenges you face in your work?

<u>Program Participation</u>
Now, we'd like to focus on the program.

Was it manageable for you to participate in the API CHW program given your other work responsibilities?

What do you like about the program (e.g., trainings, meetings)?
- [Probe] How did the program help you with your day-to-day work?
- [Probe] How did the program help with your professional growth?

What would you change about the program (e.g. trainings, meetings)?
- [Probe] How could the program better support API CHWs specifically?

<u>Program Impact</u>
Thinking of the API CHW program, what impact do you think you've had with the community members you work with?
- [Probe] How have you made a difference in the community?
- [Probe] How have you made a difference at your organization?

Has it been important that you as a CHW and the people you serve have some shared background? For example, potentially shared cultural understanding, shared language, and/or shared experiences with immigration?

- [Probe] How does your identity as an AA, NH or PI support your work with AANHPIs?

Organizational Supports for CHWs

Outside of the API CHW program led by AACI and the public health department, we also want to learn about any other support from your organization.

Do you feel like your organization and the teams you work with support CHWs?

- [Probe] Do they understand the value of CHWs?
- [Probe] What does your organization do to help support you and your work?
- [Probe] What do your coworkers do to help support you and your work?

Do you have any recommendations for how organizations could better support CHWs?

If needed/time allows:

What do you like about being a CHW?

What else would help make your work as a CHW easier?

- [Probe] What do you need to work with the community?
- [Probe] What do you need for your own career?

Closing

Is there anything else about the CHW program or your experience as a CHW that you wanted to share with us?

Appendix D: Additional Data Tables

API CHW Program Broad Overview

Program Year	Total CBOs	Total CHWs	Total CHW Trainings	Total CHW Activities	Total Encounters	Total In-Person Encounters	Total Virtual Encounters	Total Additional Funding
1	3	24	15	38	6,270	2,314	3,956	--
2	7	51	24	385	816,301	11,016	805,285	$1,000,000
3	8	61	18	836	694,054	14,945	679,109	$270,000
4*	10	55	7	73	130,080	1,651	128,429	$175,000
Overall	**10**	**55**	**64**	**1,332**	**1,646,705**	**29,926**	**1,616,779**	**$1,445,000**

** Data for program Year 4 is incomplete as it is still ongoing (July 2023 - June 2024).*

Note: Data includes seven health initiatives led by AACI during Program Year 1. The number of active CHWs at any given time fluctuates given factors such as turnover and employment status (e.g. interns). Total encounters may include a duplicated count of individuals who were engaged in multiple or ongoing program activities. In-person encounters include reported counts of COVID-19 vaccinations, health screenings, class/workshops attendees, or public event attendees that received a handout from CHWs. Virtual encounters include the total number of emails sent and reported number of known views, visits, hits, and shares of digital media at time of data reporting.

Type of Data Collected by CBOs as Reported on the Pre-Interview Survey

ITEM	COUNT (N=5)	PERCENT
COMMUNITY SATISFACTION WITH THE PROGRAM	4	100.0%
CHANGES IN HEALTH EDUCATION OR HEALTH AWARENESS IN THE COMMUNITY	3	80.0%
CHW SATISFACTION WITH THE PROGRAM	1	40.0%
CHW EXPERIENCES WITH THE ORGANIZATION	1	40.0%
CHANGES TO THE ORGANIZATION BECAUSE OF THE PROGRAM	1	20.0%