

UNIVERSITY OF MONTANA COMMUNITY HEALTH WORKER TRAINING PROGRAM

CLIENT AND GROUP ENCOUNTERS: OCTOBER 2023 – AUGUST 2025

Data Brief
MAY 2026



BACKGROUND

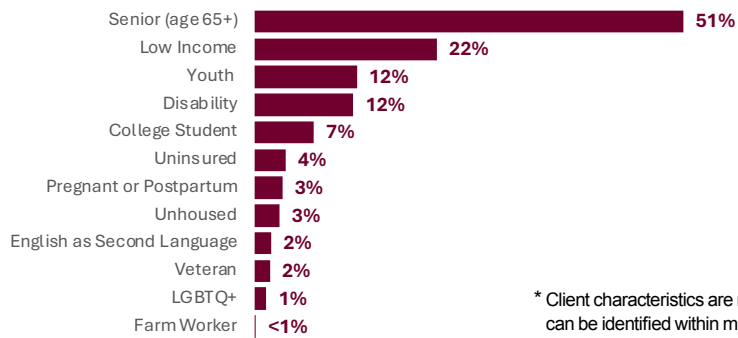
As part of the Community Health Worker (CHW) Training Program, trainees who are working as CHWs or in a related role (referred to as “CHW” throughout) during the three months following completion of the online training were asked to collect information about the clients they served. These are referred to as “client encounters.” This data brief summarizes client encounters collected by 89 trainees representing seven cohorts from October 2023 through August 2025. Each CHW served an average of 29 clients, with a minimum of one and a maximum of 274 over a three-month period¹. In 56% of encounters, the CHW served new clients; the remaining 44% were follow-up meetings with clients they had previously served.

WHO IS BEING SERVED?

A total of **1,477 unique clients** were served. Figure 1 illustrates the known characteristics of clients served by CHWs: 51% were seniors; 22% were low income; 12% were youth; and 12% had a disability (responses were not mutually exclusive).

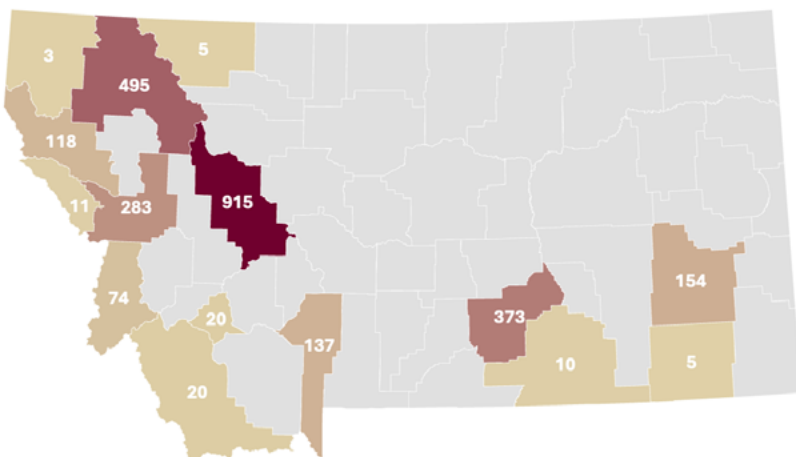
Sixty one percent of client encounters included data on race or ethnicity. Among those with known race and ethnicity, 90% were White, 8% were American Indian/Alaska Native, and 2% identified as Other Races.

Figure 1. Known Characteristics of 1,477 Unique Clients*



* Client characteristics are not exclusive, i.e., a client can be identified within more than one group.

Figure 2. Number of Client Encounters Per County



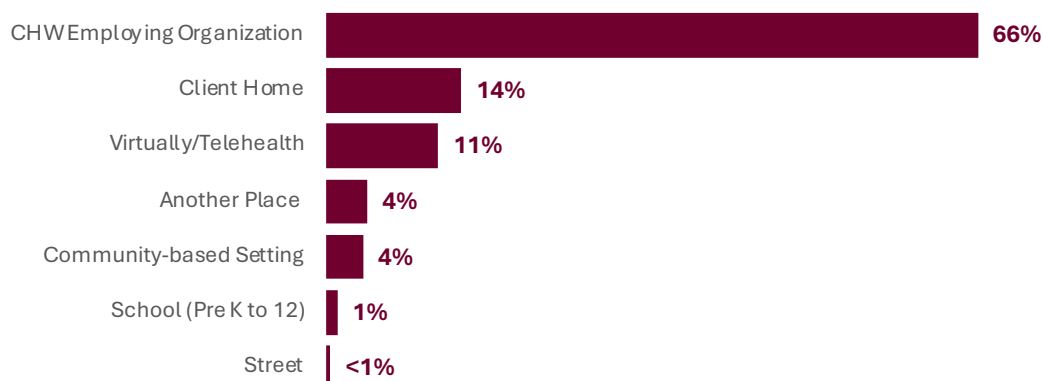
WHERE ARE CLIENTS BEING SERVED?

A total of **2,623 client encounters** (including initial and follow-up encounters) were recorded and included in the analysis. Figure 2 illustrates the distribution of encounter locations by county. As of August 2025, seventy-five percent of encounters were conducted in a HRSA designated rural county.

¹ Note: Due to the grant’s reporting deadline, cohort 7 collected encounter data for only one month.

Figure 3. Location of Encounter

Figure 3 illustrates where CHWs met with their clients to provide services. The majority of clients were served within the agency or organization in which the CHW worked.



HOW ARE THEY BEING SERVED?

CHWs provide support based on client needs. Figure 4 illustrates the most reported CHW roles, with navigation, care coordination, and/or case management occurring in over half of the encounters. Across all roles, CHWs spent under 10 minutes in 43% of encounters; 10-29 minutes in 25%; 30-59 minutes in 15%; and 60-120 minutes in 18%. A range of roles are necessary to address clients' social determinants of health, which were identified in 54% of client encounters.

CHWs reported making referrals in 757 client encounters (29%). While not all clients required referrals, CHWs provide them as needed. Figure 5 illustrates the types of referrals made. Among those clients who received referrals, the most common were for healthcare, food assistance, and health care coverage.

Figure 4. Top 5 Roles Provided During Client Encounters (n=2,623)

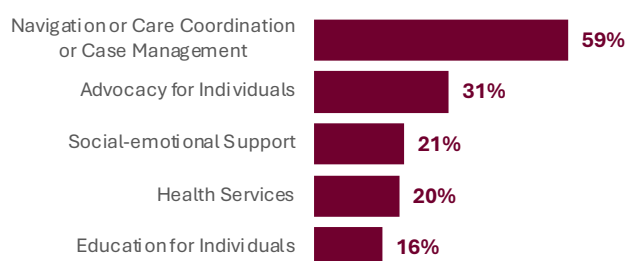
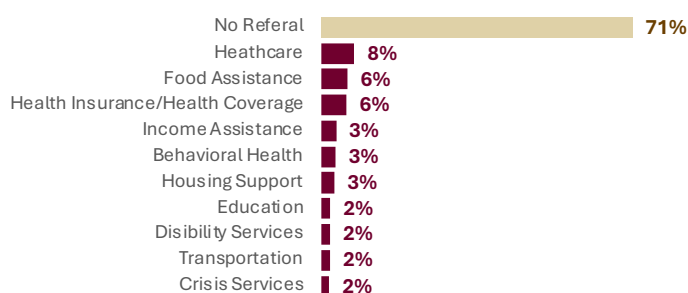
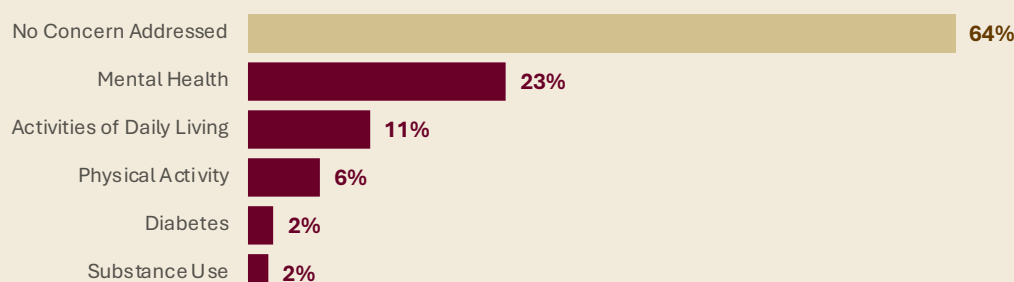


Figure 5. Types of Referrals Made During Client Encounters with a Referral (n=2,623)



In 948 encounters (36%), CHWs supported clients in addressing a health concern. Figure 6 illustrates the top five health concerns reported in these encounters, with mental health being the most frequently cited (23%).

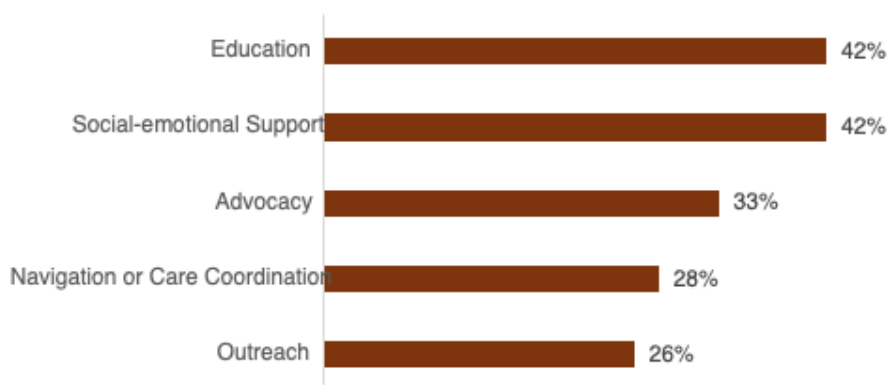
Figure 6. Top Health Concerns Addressed During Client Encounters (n=2,623)



CHWS SERVE GROUPS AND COMMUNITIES

In 109 encounters, CHWs served clients in a group format. Half of these encounters took place within the CHW employing organization, while 13% occurred in community-based settings. Notably, group encounters tended to be significantly longer than those with individual clients—31% lasted one hour and 25% extended beyond an hour. The CHW roles utilized in groups settings also differed from those used in individual encounters. As illustrated in Figure 7, CHWs most frequently provided education (42%), social and emotional support (42%), advocacy (33%), navigation and care coordination (28%) and outreach (26%) in group and community contexts.

Figure 7. Top 5 Roles Utilized in Group and Community Encounters (n=109)



SUMMARY

Encounter data collected by CHWs during the three months following training suggests CHWs are meeting an important need in Montana. As trusted members of their communities, University of Montana-trained CHWs provide case management, advocate for individuals, and support the social and emotional needs of clients. CHWs connect clients to critical referrals for healthcare services, food and income assistance, health insurance, and behavioral health support. CHWs are serving clients with a variety of health concerns, and in the majority of those cases, the concern being addressed is related to mental health. Given this context, the specific training on behavioral health provided by the CHW Training Program is critical.

CHWs are increasingly recognized for their ability to facilitate group-based services and collaborate with community groups to address public health needs. These sessions were notably longer than individual encounters and focused on distinct services such as education, social and emotional support, advocacy, system navigation, and outreach. This aligns with broader research showing that CHWs working with community groups can effectively deliver health education, foster social support, and build community capacityⁱ. Such collaborations not only enhance service delivery but also strengthen the role of CHWs as connectors and advocates within their communities.

In healthcare settings where CHWs are employed, they have proven to be a cost-effective means of delivering care — especially among underserved and lower-income communities.ⁱⁱ Studies have also shown that CHWs can significantly improve mental health outcomes by providing support and connecting clients with and reducing barriers to behavioral health resources.ⁱⁱⁱ In part, these outcomes can be attributed to CHW's ability to build trust and relationships with clients, which leads to better communication and adherence to treatment plans. With a commitment to patient-centered care, CHWs can be especially helpful in increasing an individual's engagement in their own care, ultimately creating better health outcomes overall.^{iv}

Visit our website at umt.edu/ccfwd/training/communityhealth



ⁱ CHW Central. (n.d.). Leveraging the role of community health workers with community groups: Evidence on pro-equity interventions to improve immunization coverage for zero-dose children and missed communities. <https://chwcentral.org/wp-content/uploads/Leveraging-the-Role-of-Community-Health-Workers-with-Community-Groups.pdf>

ⁱⁱ McCarville, E., Martin, M. A., Pratap, P., Pinsker, E., Seweryn, S. M., & Peters, K. E. (2024). Understanding critical factors associated with integration of community health workers into health and hospital systems. *Journal of Interprofessional Care*, 38(3), 507-516. <https://doi.org/10.1080/13561820.2023.2183183>

ⁱⁱⁱ Weaver, A. & Lapidus, A. (2018). Mental Health Interventions with Community Health Workers in the United States: A Systematic Review. *Journal of Health Care for the Poor and Underserved*, 29(1):159-180. doi: 10.1353/hpu.2018.0011.

^{iv} Haywood, M., Garman, A., Johnson, T., Christopher, B-A M., Walker III, R. (2016). Advancing community health workers through higher education: Lessons learned from a basic certificate program implementation. *Pedagogy in Health Promotion*, 3(4), 228-233. <https://doi.org/10.1177/2373379916671957>