

Building and Sustaining the Community-Based Healthcare Workforce: An Integrated Talent Management Model

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ABSTRACT

Community health workers, peer supporters, case managers, and other behavioral health paraprofessionals are increasingly important to community-based healthcare delivery. Although a growing evidence base supports the value of these workers, healthcare organizations continue to face challenges related to recruitment, role clarity, workforce integration, supervision, professional development, career advancement, and retention. Existing literature addresses many of these workforce functions independently, providing limited guidance for integrating them across the employee lifecycle. This article synthesizes evidence from community-based workforce development and healthcare talent management literature to propose the Integrated Talent Management Lifecycle for Community-Based Healthcare, an evidence-informed conceptual model for building, developing, and sustaining this workforce. The model integrates 10 interconnected lifecycle stages, from strategic workforce planning through workforce sustainability, within nine cross-cutting foundational principles. It provides a structured approach for examining workforce practices as an integrated organizational system and for translating those practices into organizational action, measurement, and continuous improvement. Because the model has not yet been empirically validated, a phased research agenda is proposed to examine its content validity, feasibility, measurement, relationships with workforce and organizational outcomes, and applicability across community-based healthcare settings. The model offers a framework for moving workforce strategy beyond recruitment toward the development of organizational systems capable of supporting long-term workforce sustainability.

Keywords: Behavioral Health Workforce, Community Health Workers, Community-Based Healthcare, Talent Management, Workforce Development, Workforce Sustainability

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As healthcare continues to evolve, so do the demands placed on its workforce. Increasing workforce shortages, the growing emphasis on integrated and community-based care, and the need to address the social determinants of health have elevated the importance of community health workers (CHWs), peer supporters, case managers, and other behavioral health paraprofessionals. These individuals have become essential members of interdisciplinary care teams, improving access to services, strengthening community engagement, and advancing health equity [1].

As these roles continue to expand, organizational priorities are shifting beyond recruiting qualified individuals to building, developing, and sustaining a resilient, highly skilled workforce. Although a growing body of evidence supports the value and effectiveness of community-based healthcare workers, healthcare organizations continue to experience challenges recruiting, integrating, developing, supporting, and

retaining this workforce. These challenges contribute to role ambiguity, inconsistent supervision, limited career advancement opportunities, workforce instability, and high turnover, ultimately affecting an organization's ability to meet the growing demand for community-based services.

The challenge is no longer demonstrating why community-based healthcare workers are valuable, but rather understanding how healthcare organizations can systematically build, develop, and sustain this workforce over time. Although the literature provides guidance on individual workforce functions including recruitment, competency development, supportive supervision, role integration, professional development, and workforce retention, these concepts are largely examined independently. Consequently, healthcare organizations have limited guidance for integrating these evidence-based practices into a comprehensive organizational talent management strategy across the workforce lifecycle.

This paper addresses that gap by proposing the Integrated Talent Management Lifecycle for Community-Based Healthcare (ITM-CBH), an evidence-informed conceptual model that synthesizes the current literature into a comprehensive organizational

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framework for building, developing, and sustaining the community-based healthcare workforce. By integrating established talent management principles with the growing body of evidence on CHWs and behavioral health paraprofessionals, the ITM-CBH model provides healthcare organizations with a practical roadmap for strengthening workforce capacity, fostering employee growth and well-being, and supporting long-term workforce sustainability.

Literature Review: Building and Sustaining the Community-Based Healthcare Workforce

The literature reviewed in the development of this conceptual model examines the integration, development, support, and sustainability of paraprofessionals across a variety of healthcare and community-based settings. The conceptual synthesis drew on peer-reviewed and authoritative literature addressing CHWs and community-based paraprofessionals and healthcare talent management, with sources selected for relevance to the workforce functions represented in the model.

Across the literature, organizational infrastructure emerged as an important influence on both workforce and service-related outcomes. Clearly defined roles and competencies, intentional recruitment and preparation, effective team integration, mentoring and supportive supervision, opportunities for continued professional development, and organizational support were consistently identified as important factors in creating environments in which CHWs and other paraprofessionals can succeed [1-5].

Conversely, unclear roles, inconsistent supervision, limited opportunities for advancement, inadequate organizational support, and other workplace challenges were associated with concerns related to job satisfaction, burnout, turnover, and workforce sustainability. These findings suggest that the effectiveness of community-based healthcare workers is influenced not only by the knowledge, skills, and attributes they bring to their roles, but also by the organizational systems and structures that surround and support them. Collectively, the literature provides a foundation for examining workforce development as an interconnected organizational process rather than a series of independent human resource functions [6].

Growth, Value, and Changing Role of the Workforce

The demands placed on the healthcare workforce continue to increase as healthcare needs become more complex and demand for services grows. Persistent shortages across clinical and licensed healthcare occupations further challenge organizations' capacity to meet current and projected needs. These challenges are particularly evident in behavioral health, where national workforce projections indicate continued shortages across multiple licensed occupations, including psychiatrists, psychologists, mental health counselors, marriage and family therapists, and addiction counselors. At the same time, healthcare delivery has increasingly extended beyond traditional clinical settings, with greater attention to prevention, care coordination, behavioral health, social needs, and services delivered within the communities where individuals live and work [7].

Within this changing environment, CHWs, peer supporters, case managers, and other paraprofessionals represent an increasingly

important component of the healthcare workforce. Their value is not based solely on expanding workforce capacity or performing functions that might otherwise be assigned to licensed healthcare providers. Rather, these roles bring distinct knowledge, skills, lived experience, and connections to the communities and populations they serve. CHWs, for example, often serve as a bridge between healthcare organizations and communities by helping individuals navigate services, addressing barriers to care, connecting individuals with community resources, and strengthening communication between clients and healthcare teams. Similarly, peer support workers use lived experience and shared understanding to support recovery, engagement, self-efficacy, and connection to behavioral health services [1,8].

Trust and relationship building are particularly important characteristics of these roles. Community-based healthcare workers frequently interact with individuals outside traditional clinical environments and may have opportunities to understand social, environmental, and practical circumstances that influence an individual's ability to access and engage in care. Recent findings from Ohio illustrate this relationship-centered role: employers described clients as relying on CHWs not only for assistance and care coordination, but also for guidance and as individuals they can trust [9]. National evidence similarly demonstrates that CHWs can improve access to healthcare, preventive service utilization, chronic disease outcomes, patient experience, and health equity when appropriately integrated and supported within healthcare and public health systems [1]. Evidence regarding paid peer support also suggests benefits for selected clinical outcomes, recovery, and self-efficacy, although outcomes vary across populations, settings, and intervention models [8].

As the value of these roles has become increasingly recognized, their responsibilities and the settings in which they work have also expanded. Community-based healthcare workers may participate in care coordination, health education, navigation, outreach, advocacy, behavioral health support, social needs assessment, and interdisciplinary care. This expansion creates opportunities for healthcare organizations to increase their responsiveness to community needs, but it also introduces workforce challenges related to role definition, preparation, integration, supervision, professional development, and long-term sustainability. For example, the 2025 Ohio CHW workforce assessment found considerable variation in the titles used for individuals performing CHW work; one in five employers did not use the CHW title, and those organizations reported more than 30 alternative job titles for individuals performing CHW functions [9].

The growth of this workforce reflects a broader change in how organizations respond to increasingly complex health and social needs and how care is delivered across clinical and community settings. As CHWs, peer supporters, case managers, and other paraprofessionals assume increasingly important roles within healthcare delivery, organizations must consider not only how to expand this workforce, but also how to define, prepare, integrate, support, develop, and retain it. This shift provides the foundation for examining community-based workforce development as a strategic organizational responsibility rather than solely a response to immediate staffing needs. The evidence supports

expanding the workforce, but expansion alone does not ensure workforce effectiveness or sustainability.

Building the Workforce: Roles, Recruitment, and Preparation

Building an effective community-based healthcare workforce begins before an individual is hired. Organizations must first understand the role they are seeking to fill, the competencies required to perform that role, and the organizational structures needed to support the worker once employed. This is particularly important for CHWs, peer supporters, case managers, and other paraprofessionals whose responsibilities may vary across organizations, service settings, and jurisdictions. Role ambiguity can create challenges not only for the individual worker, but also for supervisors, interdisciplinary team members, and organizations attempting to recruit, prepare, integrate, and evaluate employees effectively.

Role and scope ambiguity remain persistent concerns within the paraprofessional workforce. Dormond et al. identified considerable overlap among the activities performed by several behavioral health paraprofessional occupations, including CHWs, peer providers, health navigators, case managers, and addiction counselors. The authors also found variation in how scopes of practice were defined and regulated across occupations and states. Such variation has implications throughout the workforce lifecycle. When organizations do not clearly define the purpose, responsibilities, and boundaries of a role, it becomes more difficult to determine whom to recruit, which competencies should guide selection, what preparation is necessary, how performance should be evaluated, and what support employees need to succeed [10].

Competency frameworks can provide greater structure while preserving the flexibility and community connection that are central to many paraprofessional roles. The Community Health Worker Core Consensus (C3) Project established nationally recognized CHW roles and competencies through a consensus-building process that incorporated CHW perspectives and practice experience. The C3 framework identifies core roles and skills that reflect the breadth of CHW practice, including cultural mediation, care coordination and system navigation, advocacy, outreach, individual and community assessment, communication, relationship building, and professional skills and conduct. Competency frameworks can therefore serve as more than standards for training. They can provide a foundation for role design, job descriptions, recruitment and selection criteria, onboarding, performance expectations, and continued professional development [11].

Clear roles and competency expectations should subsequently inform how organizations recruit and select members of the workforce. Recruitment of CHWs has traditionally emphasized connection to and understanding of the communities served rather than relying exclusively on formal educational credentials. Schleiff et al. Emphasize the importance of selecting CHWs in ways that reflect the roles they will perform and the communities in which they will work. Community membership, acceptance, communication skills, interpersonal abilities, and other personal attributes may be particularly important because relationship building and trust are fundamental to CHW practice. As

these roles become increasingly integrated into healthcare organizations, recruitment and selection processes should consider both role-specific competencies and the interpersonal and community-based attributes necessary for effective practice [5].

Selection, however, represents only the beginning of workforce preparation. Initial training must translate defined roles and competencies into the knowledge and skills employees need to function effectively within their organizations and communities. Schleiff et al. emphasize that training should be aligned with the tasks CHWs are expected to perform and should incorporate practical, competency-based learning. They further recognize that successful CHW programs require preparation beyond the CHW alone. Supervisors, other healthcare workers, and communities also need an understanding of CHW roles and how CHWs fit within the broader health system. From this perspective, onboarding should not be viewed solely as an employee orientation process. It also requires organizational preparation to ensure that the workplace is ready to integrate and support the individual entering the role [5].

McCaughy and Somers provide an example of how structured workforce preparation can extend beyond initial classroom education. Their Community Health Worker Academy combines certification education, continuing professional development, internships, and registered apprenticeships to support CHW workforce development. Experiential learning provides opportunities for participants to apply competencies in healthcare and public health settings while receiving guidance from individuals within those environments. This approach demonstrates how competency development, experiential learning, and workplace support can be connected rather than treated as isolated workforce activities [4].

The literature therefore suggests that workforce preparation extends beyond hiring individuals who meet minimum qualifications and providing them with initial training. Organizations themselves must be prepared to receive and support the workforce they recruit. This preparation includes defining roles and competencies, aligning recruitment and selection practices with those expectations, preparing interdisciplinary teams to understand paraprofessional roles, establishing structured and competency-based onboarding processes, and ensuring that appropriate mentoring and supportive supervision are available as employees transition into practice. Organizational readiness and workforce readiness are therefore interdependent [1,4,5].

Taken together, the evidence suggests that building the community-based healthcare workforce is not simply a recruitment challenge. Role definition, competency development, recruitment, selection, onboarding, and organizational preparation are interconnected processes. An intentional workforce strategy begins with role clarity and carries that clarity through recruitment, preparation, integration, and early workforce support.

Integrating and Supporting the Workforce

Hiring and preparing community-based healthcare workers are necessary steps in workforce development, but they do not ensure successful integration into healthcare organizations. Once

individuals enter practice, their ability to contribute effectively depends in part on how well their roles are understood, accepted, and incorporated into existing teams and workflows. The literature suggests that successful integration requires more than placing CHWs and other paraprofessionals alongside clinical staff. Organizations must intentionally create the relationships, structures, and support systems that allow these workers to contribute their distinct knowledge and skills while functioning as valued members of the broader care team [1,3].

Role clarity remains important after recruitment and onboarding. Payne et al. In their examination of CHW integration across 13 healthcare organizations, identified organizational capacity, support for CHWs, clarity of healthcare roles, and clinical workflow as important factors influencing integration. Clearly defining the CHW role is therefore not only a workforce-design issue; it is also an organizational integration issue. Other members of the care team must understand what CHWs are expected to do, where their responsibilities intersect with those of other team members, and where appropriate boundaries exist. Without shared understanding, organizations may underutilize CHWs, assign responsibilities that do not align with their intended role or scope of practice, or create confusion and duplication within the care team [3].

Interprofessional relationships are similarly important and may develop over time rather than immediately following employment. Washburn et al. Identified three stages in the development of relationships between CHWs and other healthcare professionals: limited understanding of the CHW role, conflict and competition, and eventual engagement and integration into patient care teams. These findings suggest that team integration should not be assumed to occur simply because a CHW has been hired or assigned to an interdisciplinary team. Instead, organizations may need to intentionally support communication, role understanding, relationship building, and interprofessional learning as new workforce roles are introduced into established systems of care [12].

Organizational acceptance is closely connected to these relationships. CHWs occupy a distinctive position between healthcare systems and the communities they serve, and their effectiveness is partly rooted in their community knowledge, relationships, and ability to work across traditional organizational boundaries [1]. Successful integration therefore requires organizations to value this expertise rather than expecting CHWs to conform completely to traditional clinical models. Brown et al [2]. Similarly emphasize that supervisors must recognize the value of CHW expertise and understand the communities in which CHWs work. Organizational acceptance involves recognizing the CHW as a contributing member of the team while preserving the characteristics of the role that make it valuable to clients and communities.

Workflow integration translates role acceptance into daily practice. Payne et al [3]. Found that clinical workflow was a central factor in CHW integration. Organizations must determine how CHWs communicate with other team members, participate in referrals and care coordination, document their work, access needed information, and contribute to care planning. When these processes are unclear or poorly aligned, even well-prepared

workers may experience difficulty functioning effectively within the organization. Conversely, intentional workflow design can help ensure that CHW contributions are understood, accessible to other team members, and incorporated into the delivery of care.

Integration must also be accompanied by ongoing developmental support. Mentoring can provide an important bridge between formal preparation and independent practice by helping workers translate training into practice, navigate the organization, build confidence, and support professional growth. Although mentoring is sometimes incorporated within broader descriptions of supportive supervision in the CHW literature, distinguishing its developmental purpose may be useful when structuring workforce support [2].

Supportive supervision provides a related but broader organizational function. Brown et al. describe supportive supervision as a collaborative approach characterized by two-way communication, joint problem solving, mentoring, and attention to the circumstances in which CHWs perform their work. Effective supervision requires supervisors who understand the CHW role, recognize the value of community expertise, remain accessible, and can provide appropriate guidance and support [2].

Mentoring, supportive supervision, and coaching can therefore be viewed as related but distinct components of workforce support. Mentoring is primarily proactive and developmental, helping employees build confidence, professional identity, and capacity over time. Supportive supervision provides ongoing guidance, reflection, feedback, organizational support, and accountability. Coaching can be used more selectively when an employee needs focused assistance in strengthening a particular competency, developing a skill, or addressing a performance concern. Brown et al. (2) include both mentoring and coaching within supportive supervision; however, distinguishing these functions conceptually may help organizations align the type of support provided with the developmental or performance needs of the employee.

This distinction also shifts workforce support from a primarily reactive process to a more developmental approach. Rather than waiting until an employee experiences difficulty and then responding with corrective coaching, organizations can establish mentoring and supportive supervision as routine components of employment. Whether proactive mentoring reduces the subsequent need for corrective coaching or other performance interventions has not been established by the current literature and represents an important area for future research. Nevertheless, intentionally differentiating these forms of support provides a basis for examining how organizations can invest resources earlier in the employee lifecycle to promote competency, confidence, engagement, and professional growth.

Taken together, the literature indicates that successful workforce integration is both structural and relational. Role clarity and workflow establish how community-based healthcare workers function within an organization, while interprofessional relationships and organizational acceptance influence whether their contributions are understood and valued. Mentoring and

supportive supervision provide continued developmental and organizational support, with coaching available when focused assistance is needed.

Developing, Engaging, and Retaining the Workforce

Once community-based healthcare workers have been recruited, prepared, and integrated into the organization, workforce development becomes an ongoing process. Initial training and onboarding provide a foundation for practice, but employees continue to encounter changing client needs, organizational expectations, service environments, and opportunities for professional growth. Sustaining an effective workforce therefore requires continued attention to competency development as well as the broader employee experience, including job satisfaction, workload, compensation, recognition, psychological safety, and well-being. Together these factors shape whether employees are able and willing to remain engaged in their work.

Continuing education is particularly important as community-based healthcare roles expand and evolve. Schleiff et al [5], emphasize that CHW education should extend beyond initial training to maintain and expand competencies and respond to changing community and health system needs. McCaughtry and Somers similarly demonstrate how certification, continuing education, experiential learning, internships, apprenticeships, and professional development can be connected within a broader workforce development structure. Together, these approaches position continued learning as both a means of maintaining competency and a foundation for professional growth and advancement [4].

Continued development, however, represents only one dimension of the employee experience. Employees also experience the organization through their workload, compensation, relationships, opportunities for recognition and advancement, and the degree to which they feel supported and valued. These conditions are particularly relevant for community-based workers, who may manage complex client needs while navigating healthcare organizations and community environments. The 2025 Ohio Statewide Assessment of the Community Health Worker Workforce identified persistent workforce challenges even as the CHW workforce and its roles continued to grow, underscoring the importance of organizational attention to the conditions under which CHWs perform their work [9].

Recent research also brings greater attention to CHW job satisfaction, mental health, and workplace well-being. Rokicki et al [6]. Examined these dimensions directly, reflecting an important expansion in the workforce literature from what CHWs contribute to healthcare systems toward how CHWs themselves experience their work. This distinction is significant. An organization may employ workers who possess the appropriate competencies and are effectively integrated into care teams yet still experience workforce instability if employees encounter unsustainable workloads, inadequate compensation, insufficient opportunities for advancement, limited recognition, or workplace conditions that undermine their well-being. Workforce effectiveness and employee well-being should therefore not be treated as competing organizational priorities.

These workforce concerns occur within a healthcare environment in which organizations must simultaneously respond to workforce shortages, increasing service demands, and financial pressures. Shortages can increase workload among the existing workforce and contribute to burnout, while productivity expectations and administrative requirements may further intensify demands on employees. In many healthcare settings, productivity is also closely connected to reimbursement and organizational financial sustainability, creating pressure to prioritize billable or service-producing activities over activities that do not generate immediate revenue. Although continuing education, mentoring, reflective supervision, and professional development may strengthen workforce capacity over time, participation in these activities requires protected time that can compete with productivity expectations. Evidence from the broader healthcare workforce demonstrates that excessive workload, time pressure, administrative burden, and productivity demands can contribute to burnout and reduced professional well-being. The challenge for organizations is therefore not simply whether developmental supports are available, but whether employees and supervisors have sufficient time and organizational permission to participate in them. When productivity consistently takes precedence over learning, mentoring, supervision, and recovery, organizations may unintentionally limit the very workforce development activities intended to strengthen competency, engagement, well-being, and retention [13,14].

Psychological safety is also relevant to the employee experience. Community-based healthcare workers need environments in which they can ask questions, seek assistance, discuss difficult situations, acknowledge uncertainty, and contribute their perspectives without fear that doing so will diminish their standing within the team. For workers whose value may derive partly from lived experience, community knowledge, or perspectives that differ from those of traditionally credentialed professionals, an organizational climate that values their contributions is especially important. Psychological safety can therefore be understood as part of the broader organizational environment in which learning, collaboration, mentoring, supervision, and employee well-being occur.

Retention is not simply a matter of whether an employee remains on the payroll. Employees may remain while experiencing disengagement, burnout, limited professional growth, or declining well-being. Workforce success should therefore be assessed more broadly through competency, engagement, job satisfaction, well-being, professional development, and retention.

Developing, engaging, and retaining the workforce consequently requires attention to both competency development and the broader employee experience. Importantly, retention should not represent the endpoint of workforce development. As employees gain experience and expertise, organizations have an opportunity to develop existing talent into mentors, supervisors, leaders, and other sources of future organizational capacity.

Career Mobility, Leadership, and Workforce Sustainability

Retention alone does not ensure that experienced employees have opportunities to grow, assume new responsibilities, or contribute to the development of others. A sustainable workforce

requires career pathways, leadership development, mentoring, and succession planning that allow employees to build careers rather than remain indefinitely within static roles.

Career pathways are particularly important as community-based healthcare roles become more established and professionalized. McCaughtry and Somers identify career advancement as an important component of CHW workforce development and demonstrate how continuing education and experiential development can contribute to longer-term pathways. Career mobility may include formal promotion, expanded responsibilities, specialization, movement across programs, mentoring roles, and other forms of internal mobility. Visible opportunities for development can position community-based roles as meaningful careers with opportunities for increasing responsibility and leadership [4].

Leadership development should likewise extend beyond preparing employees for formal management positions. Community-based healthcare workers exercise leadership through relationship building, community engagement, advocacy, problem solving, and the translation of community needs into organizational action. Gines et al. found differences in leadership-related interests and experiences among CHWs across age and experience groups. Younger CHWs in their study placed greater emphasis on mentorship and role modeling, while older CHWs showed greater interest in policy-oriented advocacy. These findings suggest that leadership development may take different forms across career stages and that organizations may benefit from providing multiple pathways through which employees can develop and exercise leadership [15].

Advocacy represents one such form of leadership. CHWs frequently serve as intermediaries between communities and healthcare systems and may identify barriers, inequities, or unmet needs that are less visible from within traditional organizational structures. Developing employees' capacity to communicate these observations, participate in organizational decision-making, and advocate for improvements can expand the concept of leadership beyond positional authority. In this sense, leadership development can include preparing employees not only to supervise others, but also to influence systems, represent community perspectives, and contribute to organizational learning.

Mentoring can also extend across career stages. Early mentoring may support confidence and organizational navigation, while later mentoring can support career exploration and leadership development. Experienced employees may subsequently become mentors themselves, transferring knowledge and supporting new workers.

This developmental progression has implications for succession planning. Talent management in healthcare extends beyond recruiting and retaining employees to include whole-workforce development, leadership development, succession planning, and the deliberate cultivation of future organizational capacity. Applied to the community-based healthcare workforce, this perspective suggests that organizations should identify and develop talent internally rather than relying exclusively

on external recruitment whenever leadership, supervisory, mentoring, or specialized positions become available. Internal mobility can preserve organizational and community knowledge while providing visible evidence that employees can build careers within the organization [16].

Workforce sustainability therefore extends beyond maintaining adequate staffing. It requires organizational capacity to recruit talent, develop competencies, retain knowledge and experience, support employee well-being, create opportunities for advancement, and prepare individuals for future roles. Organizations must also learn from workforce data and employee experiences and adapt workforce strategies as community needs, funding environments, and service delivery models change.

From this perspective, retention is an important outcome but not the endpoint of talent management. Employees who remain accumulate knowledge, relationships, competencies, and experience that can contribute to mentoring, leadership, succession, and organizational adaptability. Career mobility and leadership development therefore connect individual growth with longer-term workforce sustainability.

From Fragmented Workforce Practices to Integrated Talent Management

The literature reviewed in the preceding sections demonstrates substantial attention to individual components of community-based healthcare workforce development. Role clarity, competency development, recruitment, training, onboarding, team integration, mentoring, supportive supervision, continuing education, employee well-being, career development, and retention have each been identified as important considerations for building and sustaining the workforce. Collectively, this evidence provides considerable guidance regarding what organizations can do to support CHWs and other paraprofessionals. Less developed, however, is an organizational framework for connecting these practices across the employee lifecycle. Talent management provides a useful perspective for considering these workforce activities not as independent human resource functions, but as interconnected components of a broader organizational strategy.

Talent Management in Healthcare

Talent management extends beyond the administrative functions traditionally associated with human resource management. Although definitions vary across the literature, talent management generally involves the intentional alignment of workforce practices with organizational strategy and includes activities related to attracting, selecting, developing, engaging, deploying, and retaining employees while building the workforce and leadership capacity needed for the future. Within healthcare, this perspective is particularly relevant because organizations must simultaneously respond to the workforce shortages, changing service demands, evolving models of care, employee expectations, and the need to maintain organizational capacity over time.

Turner conceptualizes talent management in healthcare as an integrated organizational strategy rather than a collection of isolated workforce activities. His framework encompasses talent

strategy and organizational alignment, attraction and recruitment, whole-workforce development, employee engagement, retention, leadership development, and succession planning. Importantly, this approach places workforce development within the broader strategic direction of the organization. Decisions about whom to recruit, how employees are developed, how talent is retained, and how future leaders are prepared are therefore connected to organizational priorities rather than treated as separate human resource processes [16].

This broader perspective is supported by subsequent healthcare talent-management literature. In a systematic review of 24 studies, Mitosis et al. Identified nine major categories of talent management factors within healthcare organizations: programming, attraction, development, preservation, performance assessment, work climate, organizational culture, succession planning, and leadership. Their findings reinforce the multidimensional nature of talent management and demonstrate that workforce sustainability depends on organizational practices extending from workforce planning and recruitment through development, engagement, retention, and leadership succession [17].

More recent research continues to support a lifecycle perspective. Zulfiqar et al. In a systematic review examining talent management among international nurses, identified recruitment and selection, retention and turnover, career progression, professional development, discrimination and racism, culture, and communication as major themes in the literature. Although this work focuses on a specific segment of the nursing workforce, it illustrates the value of examining workforce experiences across multiple stages of employment rather than addressing recruitment, development, or retention independently [18].

Leadership development and succession planning further demonstrate the long-term orientation of talent management. Succession planning requires organizations to look beyond current vacancies and identify the competencies and leadership capacity that will be needed in the future. A recent systematic review examining talent identification and succession planning among nursing unit managers identified competency assessment, leadership development, coaching, and performance evaluation among the strategies used to identify and prepare future leaders. From a talent management perspective, developing employees therefore serves both immediate workforce needs and longer-term organizational continuity [19].

Taken together, the healthcare talent management literature suggests that workforce planning, recruitment, development, engagement, retention, leadership development, and succession are most useful when they are strategically aligned rather than implemented as independent initiatives. This orientation is particularly relevant in an environment of workforce shortages and competing organizational demands. Recruitment without development may increase staffing without building long-term capacity. Training without opportunities for application, mentoring, or advancement may improve knowledge without creating a sustainable career pathway. Retention without continued development may preserve staffing levels without building future mentors, supervisors, or leaders. Talent management therefore shifts the organizational question from

how to manage individual workforce functions to how those functions can be intentionally connected across the employee lifecycle to build present and future workforce capacity.

The Remaining Gap

The community-based healthcare workforce literature and the broader healthcare talent management literature provide complementary perspectives, but they have largely developed along different lines. Research focused on CHWs and other paraprofessionals provides important evidence regarding role definition, competency development, community-based recruitment, training, team integration, mentoring, supportive supervision, continuing education, employee experience, career development, and workforce retention. This literature offers considerable insight into the characteristics and organizational supports needed for community-based healthcare workers to function effectively.

The healthcare talent management literature, in contrast, provides a broader organizational perspective. It emphasizes strategic alignment, workforce planning, recruitment and attraction, employee development and engagement, leadership development, succession planning, and workforce sustainability [16,17]. Rather than concentrating on a particular occupational group or workforce practice, this literature considers how multiple talent-related functions can contribute collectively to organizational capacity.

These bodies of evidence intersect in important ways. The role and competency literature can inform whom organizations recruit and how performance expectations are established. Evidence regarding recruitment and training can inform talent acquisition and onboarding. Research on team integration, mentoring, and supportive supervision can inform how employees are incorporated into the organization and supported after entry. Literature addressing continuing education, job satisfaction, well-being, and retention can inform the employee experience, while emerging work on career pathways, mentoring, leadership, and advocacy can inform longer-term talent development. Healthcare talent management principles provide an organizational structure through which these practices can be viewed as related components of a workforce lifecycle rather than as separate interventions.

What remains underdeveloped is an integrated framework that brings these bodies of evidence together specifically for the community-based healthcare workforce. Existing CHW and paraprofessional literature provides evidence for many of the individual practices necessary to build and sustain the workforce, while healthcare talent management literature provides broader principles for strategically aligning workforce functions across an organization. Neither body of literature, however, fully explains how healthcare organizations might connect role design, recruitment, onboarding, integration, mentoring and supervision, professional development, employee experience, career mobility, leadership development, and workforce sustainability across the lifecycle of CHWs and other community-based paraprofessionals.

This gap is important because fragmentation can occur even when individual workforce practices are evidence informed. An

organization may establish strong recruitment practices without clearly defined roles, provide effective initial training without structured mentoring, offer supportive supervision without meaningful career pathways, or focus on retention without developing employees for future leadership. Each practice may have value independently, yet the absence of integration can limit the organization's ability to build workforce capacity systematically over time.

Table 1: Synthesizes the Evidence Reviewed in the Preceding Sections and Illustrates How Findings from the Community-Based Healthcare Workforce Literature Align with broader Talent Management Functions. The Synthesis Demonstrates that many Components of an Integrated Workforce Strategy are Already Supported within the Literature. The proposed Contribution is Therefore not the Creation of Entirely New Workforce Practices, but the Organization and Integration of Existing Evidence into a Coherent Lifecycle Framework Designed for Community-Based Healthcare Organizations

Table 1 : Evidence Synthesis Supporting the Integrated Talent Management Lifecycle for Community-Based Healthcare (ITM-CBH)

ITM-CBH lifecycle stage	Evidence-supported workforce considerations	Key supporting literature	Talent management connection	ITM-CBH synthesis
Strategic Workforce Planning	Assess workforce and community needs; anticipate staffing and competency requirements; consider organizational growth, acquisitions, restructuring, and other workforce transitions; assess organizational infrastructure and capacity to support both existing and incoming employees.	(9, 16, 20, 21)	Strategic alignment; workforce planning; talent strategy; organizational capacity and change	Positions workforce planning as the starting point of the lifecycle and connects community and organizational needs with role design, recruitment, development, and workforce transitions. Information generated throughout the lifecycle feeds back into future planning.
Role & Competency Design	Clearly define roles, scope, responsibilities, boundaries, and competencies; address role ambiguity and overlapping functions.	(3, 10, 11)	Job/role design; competency identification; performance expectations	Uses role clarity and competencies as the foundation for recruitment, onboarding, performance development, and career progression.
Talent Acquisition & Selection	Recruit individuals who reflect and understand communities served; consider competencies, interpersonal attributes, community relationships, and role fit in selection.	(2, 5, 16, 17)	Talent attraction; recruitment; selection	Integrates community-centered recruitment with competency- and attribute-based selection within an organizational talent strategy.
Competency-Based Onboarding	Align initial training with expected roles and competencies; incorporate experiential learning; prepare supervisors, teams, and organizations to receive and support new workers.	(2, 4, 5)	Employee entry; development; organizational socialization	Extends onboarding beyond employee orientation to include competency development and organizational readiness for successful integration.
Team Integration	Establish role clarity among team members; build interprofessional relationships and organizational acceptance; integrate communication, referral, documentation, and care processes into workflow.	(1, 3, 12, 21)	Deployment; organizational integration; work climate	Treats integration as an ongoing structural and relational process connecting onboarding with effective participation in the organization.
Mentoring & Supportive Supervision	Provide developmental relationships, guidance, reflection, feedback, problem solving, organizational support, and accountability; use focused coaching when specific developmental or performance needs arise.	(2, 4, 15)	Employee development; performance support; engagement	Distinguishes proactive mentoring and ongoing supportive supervision while positioning coaching as targeted support rather than a separate lifecycle stage.
Continuous Professional Development	Provide continuing education and opportunities to maintain, expand, and apply competencies as roles, community needs, and service environments evolve.	(4, 5, 16)	Talent development; continuous learning; competency development	Positions learning as a continuing workforce investment rather than an activity limited to initial training or remediation.

Employee Experience & Well-being	Attend to job satisfaction, workload, compensation, recognition, psychological safety, organizational support, well-being, burnout, engagement, and retention.	(6, 9, 16, 17)	Engagement; work climate; retention; employee experience	Broadens workforce success beyond retention to include the conditions under which employees can remain engaged, supported, healthy, and able to develop.
Career Mobility & Leadership Development	Establish career pathways, advancement and internal mobility opportunities; develop leadership capacity; support mentoring across career stages; recognize advocacy and community influence as forms of leadership.	(4, 6, 15, 16)	Career development; leadership development; succession	Connects individual professional growth with development of future mentors, supervisors, leaders, and other sources of organizational capacity.
Workforce Sustainability	Monitor workforce needs and outcomes; retain knowledge and experience; develop succession capacity; adapt workforce strategies to changing organizational and community needs.	(1, 9, 16, 17)	Retention; succession planning; organizational sustainability; future workforce planning	Treats sustainability as both an outcome and a feedback mechanism, with workforce experience and outcomes informing the next cycle of strategic workforce planning.

Note: ITM-CBH= Integrated Talent Management Lifecycle for Community-Based Healthcare. The table synthesizes evidence from CHW, paraprofessional, and healthcare talent management literature. Individual sources may address more than one lifecycle stage. The ITM-CBH synthesis represents the author's proposed integration of existing evidence and should not be interpreted as evidence that the complete lifecycle model has been empirically validated.

Building on this synthesis, the following section introduces the Integrated Talent Management Lifecycle for Community-Based Healthcare (ITM-CBH), an evidence-informed conceptual model that connects workforce planning, role and competency design, talent acquisition, onboarding, team integration, mentoring and supportive supervision, professional development, employee experience and well-being, career and leadership development, and workforce sustainability. The model is intended to provide a structure for understanding how these functions interact across the workforce lifecycle and to generate propositions that can be examined through future research and organizational application.

Integrated Talent Management Lifecycle for Community-Based Healthcare

The preceding synthesis demonstrates that many of the workforce practices necessary to build, develop, and sustain the community-based healthcare workforce are supported across existing bodies of literature. The ITM-CBH brings these practices together within a coordinated organizational framework that connects workforce planning, role design, recruitment, onboarding, integration, development, employee experience, career growth, and long-term workforce sustainability. The proposed conceptual model is presented in Figure 1



Figure 1: Integrated Talent Management Lifecycle for Community-Based Healthcare (ITM-CBH)

Note. The 10-stage lifecycle is supported by foundational principles that guide equitable, sustainable, and community-centered workforce development. Coaching is not a separate lifecycle stage, but a targeted support strategy used as needed within the workforce development process.

The ITM-CBH consists of 10 interconnected stages: (1) Strategic Workforce Planning, (2) Role and Competency Design, (3) Talent Acquisition and Selection, (4) Competency-Based Onboarding, (5) Team Integration, (6) Mentoring and Supportive Supervision, (7) Continuous Professional Development, (8) Employee Experience and Well-being, (9) Career Mobility and Leadership Development, and (10) Workforce Sustainability. Foundational principles, including health equity, community partnership, cultural humility, psychological safety, trauma-informed leadership, mentorship culture, organizational learning, data-informed decision-making, and continuous quality improvement, are intended to influence practices across the lifecycle rather than function as separate stages.

Although presented as a sequence, the ITM-CBH is cyclical rather than strictly linear. Organizations may enter the model at different points depending on existing workforce structures, priorities, and needs, and activities within multiple stages may occur simultaneously. Similarly, an individual employee's experience may not progress through each stage in a uniform sequence. Information generated later in the lifecycle, including employee experiences, competency needs, turnover, advancement patterns, leadership capacity, and changing community needs, should inform subsequent workforce planning and organizational decisions. Workforce sustainability therefore connects back to strategic workforce planning, creating a continuous process of assessment, development, evaluation, and adaptation.

Strategic Workforce Planning

Strategic workforce planning begins with understanding the workforce an organization currently has and the workforce it will need to fulfill its mission in the future. Healthcare workforce planning requires consideration of workforce supply, competencies, service requirements, and changing organizational and population needs rather than focusing solely on current vacancies. Within community-based healthcare, this assessment should also incorporate the needs and characteristics of the communities served [16,20].

Organizations can examine current staffing levels, vacancies, turnover, projected service demand, emerging programs, workforce demographics, existing competencies, anticipated skill gaps, supervisory capacity, and positions that may be difficult to fill or replace. Community health needs, service-access barriers, and changes in the populations served should similarly inform decisions about workforce composition. This stage shifts workforce planning from a primarily reactive response to vacancies toward a strategic consideration of the roles, competencies, structures, and capabilities the organization will need over time.

Strategic workforce planning must also account for organizational change. Acquisitions, mergers, service expansion, restructuring, and integration of external providers can alter workforce requirements, staffing, competencies, reporting relationships,

workflows, and organizational capacity. Evidence from hospital mergers and integrated healthcare systems identifies staffing, workforce management, organizational culture, collaboration, and leadership as relevant considerations during organizational integration [21,22].

Organizations should therefore assess whether infrastructure and supervisory, training, administrative, and communication capacity are sufficient to support both incoming and existing employees. Significant transitions also require timely communication about changing roles, expectations, structures, and processes. From the ITM-CBH perspective, organizational growth is therefore a workforce transition rather than simply a staffing event.

Strategic workforce planning also establishes the feedback function of the ITM-CBH. Data generated throughout the lifecycle, including recruitment outcomes, competency gaps, employee experience, turnover, internal mobility, succession readiness, organizational change, and community needs, can inform subsequent workforce decisions. Planning is therefore both the beginning of the lifecycle and the point to which information from later stages returns.

Role and Competency Design

Once workforce needs are identified, organizations must define the purpose, scope, responsibilities, boundaries, competencies, and performance expectations associated with needed roles. This is particularly important for CHWs and other paraprofessionals because titles, responsibilities, and scopes can vary across organizations and settings. Clearly defined roles and competencies provide a foundation for recruitment, selection, onboarding, supervision, performance expectations, and professional development.

Role and competency design also becomes important during organizational growth or restructuring. When organizations combine workforces or services, apparently similar positions may have different titles, responsibilities, expectations, or scopes across the previously separate organizations. Clarifying these differences before combining positions can help organizations identify overlap while preserving valuable expertise and avoiding assumptions that similarly titled positions are functionally identical.

Within the ITM-CBH, role and competency design is therefore not treated as a one-time job description exercise. Roles and competency expectations may require reassessment as service models, community needs, regulations, technologies, organizational structures, and priorities change. Information from employees performing the work should also contribute to this process because frontline experience can identify emerging responsibilities or competencies that may not be apparent during initial role design.

Talent Acquisition and Selection

Talent acquisition translates workforce needs and role expectations into intentional recruitment and selection strategies. For community-based healthcare workers, recruitment should consider not only formal qualifications but also the competencies, interpersonal attributes, community knowledge

or lived experience, and relationship-building abilities relevant to the role. CHW workforce literature emphasizes aligning recruitment and preparation with the roles workers will perform and the communities they will serve [5].

Selection practices should therefore be aligned with the competencies and expectations established during role design. Structured interviews, behavioral questions, scenarios, and other competency-informed approaches may help organizations assess how applicants communicate, solve problems, build relationships, navigate challenging situations, and demonstrate attributes important to community-based work.

The ITM-CBH consequently views talent acquisition as both community responsive and strategically aligned. The objective is not simply to fill an open position, but to identify individuals whose competencies and attributes align with the role, organization, and communities served.

Competency-Based Onboarding

Hiring represents the beginning rather than the completion of workforce preparation. Competency-based onboarding provides a structured transition from selection into practice by connecting organizational orientation with role-specific preparation and early developmental support.

Onboarding should reinforce the role, scope, competencies, responsibilities, organizational expectations, documentation requirements, communication processes, safety procedures, and workflows relevant to the employee's work. Learning should be connected to the competencies employees are expected to demonstrate rather than relying primarily on completion of orientation activities. CHW workforce literature emphasizes aligning training with expected tasks and competencies and providing continued opportunities for learning and development [5]. Structured workforce development models also demonstrate how education can be connected with experiential learning, internships, apprenticeships, continuing education, and supervision [4].

Importantly, onboarding involves organizational preparation as well as employee preparation. Supervisors and interdisciplinary team members should understand the new employee's role, how that role contributes to care, where responsibilities intersect, and how communication and workflow will occur. Within the ITM-CBH, successful onboarding therefore asks two related questions: Is the employee prepared to enter the organization, and is the organization prepared to receive and support the employee.

The same principle applies to employees entering through acquisition or organizational integration. Experienced workers may require orientation to new policies, technologies, reporting relationships, documentation requirements, and organizational expectations while bringing valuable knowledge, relationships, and practices from their previous environment.

Team Integration

Onboarding introduces an employee to the organization; integration establishes the employee as a functioning and

valued member of the team. Team integration involves role understanding, workflow alignment, communication, trust, interprofessional relationships, and belonging within the organization.

Evidence from CHW integration research demonstrates that integration is influenced by organizational capacity, support for CHWs, clarity of healthcare roles, and clinical workflow [3]. Interprofessional relationships may also evolve over time. Washburn et al [12]. Identified a progression from limited understanding of CHW roles, through conflict and competition, toward engagement and integration into patient care teams.

The ITM-CBH therefore conceptualizes integration as an active organizational process rather than an automatic consequence of employment. Organizations can support integration by clarifying roles across the team, establishing communication and referral pathways, incorporating workers appropriately into documentation and care processes, creating opportunities for interdisciplinary learning, and ensuring that community-based expertise is recognized and valued.

Integration is particularly important when previously separate workforces are combined through acquisition, merger, or restructuring. Differences in organizational culture, workflows, terminology, policies, and expectations may require intentional alignment [21]. The objective should not be to erase prior identities or practices, but to preserve valuable expertise while establishing shared roles, relationships, expectations, and ways of working.

Mentoring and Supportive Supervision

Mentoring and supportive supervision represent a central developmental component of the ITM-CBH. Although these functions may overlap in practice, the model distinguishes them conceptually because they serve different primary purposes. Coaching is similarly recognized as an important developmental strategy but is not represented as a separate lifecycle stage.

Mentoring is conceptualized as proactive development and relationship building. Mentors can help employees translate training into practice, navigate organizational systems, develop confidence and professional identity, explore career opportunities, and prepare for increasing levels of responsibility. Mentoring may begin during onboarding or early integration and continue across later career stages.

Supportive supervision provides ongoing guidance, reflection, feedback, problem solving, organizational support, and accountability. Brown et al [2]. Describe supportive supervision as collaborative and emphasize two-way communication, joint problem solving, mentoring, coaching, and supervisor understanding of the CHW role. Within the ITM-CBH, supportive supervision remains an ongoing organizational responsibility throughout employment rather than an intervention used only when problems occur.

Coaching is conceptualized as more targeted support provided when an employee needs focused development of a particular competency, skill, or aspect of performance. Coaching may

occur at any stage of the lifecycle and may be developmental or corrective depending on the employee's needs. For this reason, coaching is represented in the model as a support strategy rather than an independent stage.

The ITM-CBH further proposes that early and sustained investment in mentoring may have implications for later performance support. Specifically, strong early mentoring may help employees develop confidence, organizational knowledge, role clarity, and competencies before difficulties become established, potentially reducing later reliance on corrective coaching and the organizational resources associated with remediation. This relationship has not been established empirically and should therefore be considered a proposition generated by the model rather than an expected outcome. Future research should examine whether the timing, quality, and intensity of mentoring are associated with subsequent coaching needs, performance outcomes, employee engagement, and retention.

Continuous Professional Development

Competency development continues beyond onboarding as community-based healthcare roles respond to changing clinical, behavioral health, public health, social service, technological, and regulatory environments. Within the ITM-CBH, continuous professional development includes continuing education, reinforcement and expansion of competencies, experiential learning, specialty development, and preparation for future responsibilities [4,5].

Professional development should be responsive both to organizational needs and to employee goals. Workforce data may identify emerging competency gaps, while supervision, mentoring, performance discussions, and employee interests may reveal individual developmental needs. Providing opportunities for growth can therefore strengthen current capabilities while also preparing employees for later career mobility and leadership.

Importantly, access to professional development requires more than making educational opportunities available. Organizations must consider whether workload, scheduling, productivity expectations, staffing levels, and supervisory support allow employees to participate meaningfully in learning activities. Without sufficient organizational support and protected developmental time, continuing education may exist as an opportunity in principle without becoming a realistic component of the employee experience.

Employee Experience and Well-being

The ITM-CBH positions employee experience and well-being as organizational considerations shaped by compensation, workload, recognition, relationships, belonging, psychological safety, organizational culture, opportunities for growth, and perceived support. This perspective is particularly important when workforce shortages and service demands create competing pressures between productivity and workforce development. Developmental and well-being resources have limited value when employees lack sufficient time or organizational support to use them.

Organizational change can intensify these considerations as acquisitions, mergers, restructuring, and service expansion alter teams, workflows, reporting relationships, workloads, and

organizational culture. Workforce management, collaboration, leadership, and communication should therefore remain important throughout organizational integration [21].

Within the ITM-CBH, retention is therefore considered one outcome of a broader employee experience rather than the sole indicator of workforce success. Remaining employed does not necessarily indicate that an employee is engaged, developing, supported, or experiencing positive well-being. Organizations should consequently consider employee experience, job satisfaction, workload, compensation, recognition, psychological safety, well-being, burnout, engagement, and retention together when assessing workforce health.

Career Mobility and Leadership Development

As employees develop competencies and accumulate experience, organizations have an opportunity to convert individual growth into broader workforce and organizational capacity. Career mobility and leadership development provide pathways through which employees can assume expanded responsibilities, develop specialized expertise, mentor others, move across organizational roles, and prepare for formal or informal leadership.

Career pathways may include formal promotion, specialization, expanded responsibilities, movement across programs, mentoring assignments, project leadership, supervisory preparation, and other forms of internal mobility [4]. Leadership can likewise extend beyond positional authority to advocacy, community engagement, problem solving, mentoring, and communicating community perspectives within organizational decision-making.

Mentoring becomes particularly important again at this stage. Employees who benefited from mentoring earlier in their careers may subsequently become mentors to newer workers, creating a developmental progression in which experience is transferred rather than lost. The pathway can therefore extend from employee development to mentorship, leadership, and eventually succession. In this way, professional development produces value beyond the growth of an individual employee by expanding the organization's internal capacity to develop others.

Workforce Sustainability

Workforce sustainability represents the final stage of the ITM-CBH lifecycle, but not its endpoint. Sustainability includes retention, workforce stability, preservation and transfer of institutional knowledge, succession capacity, workforce evaluation, and the organization's ability to adapt to changing workforce, organizational, and community needs. From a talent management perspective, these activities are connected to the organization's capacity to develop and sustain talent over time rather than functioning as isolated workforce initiatives [16].

A sustainable workforce requires sufficient competencies, leadership capacity, knowledge transfer, and adaptability in addition to retention. Organizations can monitor vacancies, turnover, retention, employee experience, competency development, internal mobility, professional development, advancement, mentoring and supervisory capacity, succession readiness, and the workforce effects of organizational change.

Workforce sustainability then reconnects directly to strategic workforce planning. Information about why employees leave, which competencies are difficult to recruit or develop, where advancement opportunities are limited, which roles are changing, and where future leadership gaps are emerging should inform the next cycle of workforce planning. The same process applies when an organization expands, acquires another provider, restructures services, or otherwise changes its workforce configuration. Community needs and organizational priorities may likewise change, requiring reassessment of workforce composition, roles, competencies, structures, and development strategies.

The ITM-CBH therefore conceptualizes workforce sustainability as an adaptive organizational capacity rather than a static outcome. The return from sustainability to strategic workforce planning completes the lifecycle while beginning the next cycle of workforce development.

Foundational Principles Across the Lifecycle

The 10 stages of the ITM-CBH describe organizational processes for building, developing, and sustaining the community-based healthcare workforce. How organizations carry out those processes, however, is equally important. The ITM-CBH therefore includes nine foundational principles that influence decision-making and organizational practices across the entire workforce lifecycle rather than functioning as separate stages: health equity, community partnership, cultural humility, psychological safety, trauma-informed leadership, mentorship culture, organizational learning, data-informed decision-making, and continuous quality improvement.

As illustrated by the outer ring of Figure 1, these principles surround rather than extend the 10-stage lifecycle. Their placement reflects their cross-cutting nature. Health equity, for example, can influence workforce planning, recruitment, role design, employee development, and evaluation. Psychological safety has implications for onboarding, team integration, supervision, mentoring, learning, and organizational change. Organizational learning, data-informed decision-making, and continuous quality improvement help organizations use information generated throughout the lifecycle to adapt workforce practices over time. The foundational principles therefore establish an organizational context within which the 10 stages operate.

Health Equity

Health equity is closely connected to the purpose and value of the community-based healthcare workforce. CHWs frequently work with populations experiencing barriers to healthcare and can connect healthcare and public health systems with communities that have historically experienced limited access or social disadvantage. CHWs' lived experience, community knowledge, and relationships can position them to understand and address factors contributing to health inequities (1). A systematic review of CHW programs similarly found evidence that these programs can promote more equitable access to and use of services, while emphasizing that program design and implementation can influence whether equitable outcomes are achieved [23].

Within the ITM-CBH, health equity should therefore influence decisions throughout the workforce lifecycle. Strategic workforce

planning should consider which communities experience unmet needs and barriers to services. Role design should reflect the needs of the populations served and recruitment and selection should consider community knowledge and relationships when relevant to the role. Training, supervision, career development, and organizational policies should also consider whether members of the workforce have equitable access to support and opportunities for growth. Health equity in the ITM-CBH consequently applies both to the communities served and to organizational practices affecting the workforce delivering those services.

Community Partnership

Community partnership reflects the principle that community-based healthcare work should be informed by, connected to, and responsive to the communities it is intended to serve. CHWs occupy a particularly important position between communities and health systems because their effectiveness can draw on community knowledge, relationships, shared experience, and understanding of barriers that may not be readily visible within traditional healthcare environments [1].

Evidence from community-engaged health research supports the importance of meaningful partnerships and collaborative processes in efforts designed to address health inequities. In a meta-review of 100 reviews of community-engaged scholarship, Ortiz et al. identified relationships among partnership processes, community engagement, and health-equity-oriented outcomes. Within the ITM-CBH, community partnership therefore extends beyond employing individuals who understand the community. Organizations can create opportunities for community perspectives to inform workforce planning, role design, recruitment strategies, service priorities, training, and evaluation. Community partnership helps maintain the connection between organizational workforce strategy and the needs, strengths, knowledge, and priorities of the communities served [24].

Cultural Humility

Cultural humility emphasizes lifelong learning and self-reflection rather than the assumption that an individual can achieve complete competence regarding another person's culture. Tervalon and Murray-García introduced cultural humility within healthcare education as an approach involving ongoing self-evaluation and self-critique, attention to power imbalances, and the development of mutually beneficial relationships with communities [25].

Within the ITM-CBH, cultural humility is applied beyond individual interactions with clients to the organizational practices that shape the workforce. It can influence how organizations recruit employees, design training, develop leaders, engage communities, supervise staff, and make workforce decisions. It also has implications for interdisciplinary relationships because employees may bring different professional backgrounds, lived experiences, community knowledge, and forms of expertise to the organization.

The inclusion of cultural humility as a foundational ITM-CBH principle represents an application of an established healthcare concept to workforce strategy. Rather than assuming that organizations or employees reach a final state of cultural

competence, the model emphasizes continued learning, reflection, respect for differing perspectives, and awareness of power within relationships among organizations, employees, and communities.

Psychological Safety

Psychological safety refers to a team environment in which individuals perceive that they can take interpersonal risks, including asking questions, raising concerns, acknowledging uncertainty, and speaking up about problems. A systematic review of psychological safety in healthcare teams identified leadership behavior, organizational and peer support, familiarity among team members, inclusivity, and an orientation toward learning and improvement among factors associated with psychological safety [26].

Psychological safety has implications throughout the ITM-CBH lifecycle. New employees need to be able to ask questions during onboarding. Integrated teams need environments in which differing professional and community perspectives can be expressed. Mentoring and supportive supervision require employees to discuss challenges and developmental needs openly. Professional development depends on an environment in which learning and asking for assistance are accepted rather than interpreted as evidence of deficiency. Psychological safety may also be particularly relevant during organizational change, when employees may have questions or concerns regarding changing roles, expectations, structures, and relationships.

Psychological safety also intersects with organizational learning and improvement. Healthcare research identifies speaking up, learning, and engagement in improvement as important reasons for cultivating psychologically safe teams (26). Within the ITM-CBH, psychological safety therefore contributes to an organizational environment in which employees can participate meaningfully in learning, problem solving, and workforce improvement.

Trauma-Informed Leadership

Community-based healthcare employees may work with individuals and communities experiencing trauma, adversity, crisis, poverty, violence, behavioral health challenges, and other complex circumstances. Employees may also encounter significant occupational and organizational stress. Trauma-informed organizational and leadership approaches extend trauma-informed principles beyond interactions with clients to the environments in which healthcare employees work.

A recent rapid evidence synthesis examining trauma-informed organizational and leadership practices identified leadership, organizational culture, workforce education, policy, and practices that promote psychological health and safety as important components of trauma-informed organizational approaches. This emerging evidence supports considering trauma-informed leadership as an organizational workforce principle while also indicating that further research is needed to strengthen the evidence base [27].

Within the ITM-CBH, trauma-informed leadership can influence communication, supervision, organizational change, employee support, and responses to workforce stress. Principles such as

safety, trust, transparency, collaboration, and empowerment are particularly relevant when employees are navigating uncertainty, difficult work environments, or organizational transitions. Trauma-informed leadership should not, however, shift responsibility for workforce well-being to individual employees. It complements rather than replaces organizational responsibilities related to staffing, workload, supervision, compensation, working conditions, and employee support.

Mentorship Culture

Mentoring has an established role in healthcare workforce development. A recent systematic review of mentoring in hospital settings found that mentoring can support professional and personal development, including skill development, professional confidence, self-efficacy, autonomy, resilience, and emotional support, while also identifying variability in mentoring approaches and the need for greater standardization and equitable access [28]. Within the CHW workforce, developmental relationships and quality supervision similarly contribute to workforce preparation and continued professional growth [2,4].

The ITM-CBH extends this evidence by proposing mentorship culture as a foundational principle rather than limiting mentoring to a discrete program or relationship. A mentorship culture reflects an organizational expectation that developing others, sharing knowledge, supporting professional growth, and preparing employees for increasing responsibility are valued activities throughout the workforce lifecycle.

Early career employees may receive mentoring as they translate training into practice and learn to navigate the organization. More experienced employees may use mentoring to explore career opportunities or prepare for leadership. Experienced workers may subsequently become mentors themselves, transferring knowledge and supporting newer members of the workforce. Mentoring can therefore connect onboarding, integration, professional development, career mobility, leadership development, succession, and workforce sustainability.

The evidence supports mentoring as a developmental strategy; however, the elevation of mentorship culture to a cross-cutting organizational principle is a conceptual contribution of the ITM-CBH and requires empirical evaluation. Future research should examine whether organizations characterized by stronger mentorship cultures demonstrate differences in employee development, engagement, advancement, knowledge transfer, performance, or retention.

Organizational Learning

A sustainable workforce strategy requires organizations to learn from experience. Organizational learning involves using information generated through workforce activities, employee experiences, successes, challenges, and changing organizational and community needs to improve subsequent decisions and practices. A systematic review of continuous organizational improvement and learning in healthcare organizations identified several recurring conditions supporting this capacity, including engaged leadership, structured processes for improvement and learning, training and guidance, and teams with appropriate autonomy, accountability, and safety [29].

The cyclical structure of the ITM-CBH depends on this principle. Recruitment outcomes may identify problems with role design. Onboarding experiences may reveal gaps in organizational preparation. Supervision may identify recurring competency needs. Employee experience data may reveal workload or support concerns. Turnover may identify problems requiring attention earlier in the lifecycle. Organizational change may expose weaknesses in communication, workflow, or supervisory capacity.

Within the ITM-CBH, organizational learning occurs when these experiences are not treated as isolated events but are examined for what they reveal about workforce systems. The relevant question is therefore not only whether a workforce practice was implemented, but also what the organization learned from its implementation and how that learning will influence subsequent workforce decisions.

Data-Informed Decision-Making

Data-informed decision-making provides an important foundation for workforce planning, evaluation, and organizational learning. The World Health Organization emphasizes the collection, quality, analysis, dissemination, and the use of health workforce data and evidence to inform workforce governance, management, policy, and planning. High-quality workforce information can help organizations understand current workforce conditions, identify emerging needs, and evaluate whether workforce strategies are producing intended results [30].

Within the ITM-CBH, relevant information may include staffing levels, vacancies, recruitment outcomes, turnover, retention, workforce demographics, competency needs, participation in professional development, employee experience, mentoring and supervisory capacity, internal mobility, advancement, and succession readiness. The specific measures used should reflect organizational priorities and the questions the organization is attempting to answer rather than encouraging data collection for its own sake.

The term data-informed is intentional. Quantitative workforce measures represent one source of evidence, but numbers alone may not adequately explain workforce experiences or organizational conditions. For example, a turnover rate can indicate that employees are leaving but cannot, by itself, explain why. Employee perspectives, supervisor observations, community input, and organizational context may provide information necessary to interpret workforce measures and determine appropriate action. Within the ITM-CBH, data therefore inform rather than replace professional judgment, employee and community perspectives, and organizational learning.

Continuous Quality Improvement

Continuous quality improvement (CQI) reflects an ongoing approach to examining and refining organizational processes rather than assuming that a workforce practice remains effective once implemented. CQI approaches have been used across healthcare settings to improve professional practice and healthcare processes, although evidence regarding the effectiveness of specific CQI approaches and their effects on outcomes is variable. Research on organizational improvement and learning similarly emphasizes the importance of structures

and processes that enable healthcare organizations to learn and improve over time [29,31]

Within the ITM-CBH, CQI can be applied across the workforce lifecycle. Organizations can examine whether recruitment strategies are reaching appropriate candidates, whether onboarding adequately prepares employees, whether mentoring and supervision are accessible and useful, whether professional development opportunities address identified needs, whether career pathways function as intended, and whether workforce outcomes change following organizational interventions.

CQI also connects the other foundational principles. Data-informed decision-making helps identify areas requiring attention. Organizational learning supports interpretation of experience and results. Psychological safety can create conditions in which employees are able to identify problems, discuss concerns, and participate in improvement efforts. Community partnership and health equity can help organizations consider whose experiences and outcomes are represented when determining whether improvement has occurred.

CQI therefore provides a mechanism through which organizations can translate information and learning into action. Changes can be implemented, evaluated, refined, and reconsidered as workforce, organizational, and community conditions evolve. The resulting information returns to strategic workforce planning, reinforcing the cyclical nature of the ITM-CBH.

Integrating the Foundational Principles

The foundational principles should not be interpreted as an additional checklist layered onto the 10-stage lifecycle. Rather, they describe organizational perspectives and conditions that shape how the lifecycle is implemented. Their relative importance and application may differ according to workforce, organization, community, and context, but each has relevance across multiple stages of the model.

The principles are also interconnected. Psychological safety supports organizational learning by creating conditions in which employees can raise concerns and discuss uncertainty. Data-informed decision-making provides evidence that can support organizational learning and CQI. Community partnership and cultural humility strengthen the organization's ability to understand and respond to community perspectives, while health equity provides a lens for considering whether workforce strategies respond to populations experiencing barriers to care. Trauma-informed leadership influences how organizations approach relationships, communication, support, and change. Mentorship culture reinforces employee development and the transfer of knowledge and experience across career stages.

Together, these principles position talent management as more than a collection of human resource practices. Within the ITM-CBH, workforce strategy operates within an organizational environment that values equity, community connection, respect, psychological safety, employee development, learning, evidence, and continuous improvement. The foundational principles therefore provide the context through which the 10 stages of the lifecycle can be implemented in ways that are responsive to both the workforce and the communities it serves.

Operationalizing the ITM-CBH Model

The ITM-CBH is intended to provide organizations with a structured approach for examining workforce practices across the employee lifecycle. Operationalization does not require implementing 10 new programs. Rather, organizations can use the model to assess existing practices, identify gaps or fragmentation, and strengthen alignment across workforce planning, recruitment, development, support, advancement, and sustainability. This integrated approach is consistent with broader healthcare talent management literature emphasizing the importance of connecting workforce functions rather than managing them as isolated activities [16].

Implementation should be adapted to organizational size, resources, workforce composition, community needs, and existing infrastructure. Organizations may assess all 10 stages or initially focus on areas of identified need, such as turnover, onboarding, supervision, or career development. Because the model is cyclical, information generated through implementation and evaluation can inform improvement within individual stages and subsequent workforce planning. Healthcare workforce guidance similarly emphasizes the collection, analysis, and use of workforce data to support evidence-informed planning and decision-making, while organizational learning provides a mechanism for using experience and information to improve workforce practices [29,30].

Table 2: Illustrates how the Lifecycle Stages can be Translated into Organizational Actions and Monitored using Example Workforce Measures. The Actions and Measures are Illustrative Rather than Prescriptive and should be Adapted to Organizational Context. Likewise, the Intended outcomes Represent Proposed Objectives of Itm-Cbh Implementation Rather than Empirically Established Effects of the Model.

Table 2: Translating the ITM-CBH Into Organizational Practice

Lifecycle Stage	Organizational Actions	Example Measures	Intended Workforce Outcomes
Strategic Workforce Planning	Assess current and future workforce and community needs and organizational capacity	Vacancy and turnover rates; staffing projections; identified workforce gaps	Appropriate workforce capacity
Role & Competency Design	Define roles, responsibilities, boundaries, and required competencies	Role clarity; competency expectations; identified role overlap or gaps	Reduced role ambiguity
Talent Acquisition & Selection	Align recruitment and selection with role competencies and community needs	Time to fill; applicant pool; selection outcomes	Improved workforce fit
Competency-Based Onboarding	Provide structured, competency-based onboarding and early developmental support	Onboarding completion; competency progress; 90-day retention	Workforce readiness
Team Integration	Establish role clarity, workflow processes, communication pathways, and team orientation	Role understanding; team integration; employee feedback	Effective collaboration
Mentoring & Supportive Supervision	Provide developmental mentoring and consistent supportive supervision	Mentoring and supervision participation; employee perceptions of support	Competency development and workforce support
Continuous Professional Development	Provide continuing learning aligned with competency and workforce needs	Participation; competency growth; development goals	Expanded workforce capability
Employee Experience & Well-being	Monitor workload, engagement, support, psychological safety, and well-being	Engagement; job satisfaction; workload; burnout; psychological safety	Employee well-being and engagement
Career Mobility & Leadership Development	Establish career pathways, internal mobility, mentoring, and leadership opportunities	Internal mobility; promotion; mentoring roles; leadership participation	Career advancement and leadership capacity
Workforce Sustainability	Monitor workforce outcomes, strengthen succession capacity, and use findings to inform future planning	Retention; tenure; turnover; internal succession; workforce trends	Workforce stability and adaptability

Note. The actions and measures are illustrative rather than prescriptive and should be adapted to organizational priorities, available data, and context. Measures should be interpreted across the lifecycle rather than in isolation. For example, turnover may reflect factors associated with role design, onboarding, supervision, employee experience, career opportunities, or multiple stages. Intended outcomes represent proposed objectives of ITM-CBH implementation rather than empirically established effects of the model.

Expected Outcomes of the ITM-CBH Model

Because the ITM-CBH has not yet been empirically tested, its outcomes should be understood as proposed and testable rather than established effects. The model proposes that greater alignment of workforce practices across the lifecycle may contribute to outcomes at three interconnected levels: the workforce, the organization, and care and communities. These anticipated outcomes provide a foundation for future evaluation of the model.

Workforce Outcomes

At the workforce level, implementation of the ITM-CBH is expected to support employee competency, engagement, well-being, retention, career advancement, and leadership capacity. These outcomes reflect the model's emphasis on role clarity, competency-based preparation, team integration, mentoring and supportive supervision, continuous development, employee experience, and career mobility. Collectively, these practices are intended to create an environment in which employees are prepared for their roles, supported in their work, and provided opportunities for continued growth [16].

Organizational Outcomes

At the organizational level, anticipated outcomes include reduced turnover, improved team functioning, greater workforce stability, reduced recruitment and replacement burden, and stronger succession capacity. Rather than treating these outcomes as isolated workforce indicators, the ITM-CBH proposes that they may reflect the cumulative functioning of multiple lifecycle stages. Organizational learning and the continued use of workforce information can further support adaptation and improvement as workforce and organizational needs change [29].

Care and Community Outcomes

Workforce and organizational outcomes may ultimately influence the organization's capacity to serve individuals and communities. Proposed downstream outcomes include greater continuity of care, improved access to services, stronger community trust, improved quality, and advancement of health equity. Existing evidence demonstrates that well-integrated CHWs can contribute to access, engagement, and healthcare and public health outcomes, while CHW programs may promote more equitable access and service utilization when appropriately designed and implemented [1,23]. Whether implementation of the ITM-CBH contributes to these outcomes, however, remains an empirical question requiring further evaluation.

Implications for Practice and Policy

The ITM-CBH has implications for organizations that employ, develop, or support the community-based healthcare workforce. For community-based healthcare and behavioral health

organizations, CHW employers, and human resources and talent management leaders, the model encourages a shift from managing workforce functions independently toward viewing recruitment, onboarding, integration, supervision, development, employee experience, advancement, and retention as interconnected organizational responsibilities. This perspective is consistent with evidence emphasizing the importance of workforce preparation and continuing development within supportive health system environments [5].

For supervisors and workforce development organizations, the model highlights the importance of extending workforce development beyond initial training. Competency development requires opportunities to apply learning, receive guidance and feedback, participate in mentoring and supportive supervision, and continue developing throughout the employee lifecycle. Evidence from CHW settings indicates that supervision structures and practices can influence the support and effectiveness of the workforce [2]. Workforce development efforts may therefore be strengthened when training is connected to the organizational conditions in which employees are expected to perform.

The model also has implications for policymakers and funders. Investments designed to expand the community-based healthcare workforce should consider not only the number of positions created or workers trained, but also the organizational infrastructure required to integrate, develop, support, and retain those workers. Workforce planning guidance similarly emphasizes the need to align workforce investments with broader planning, management, and system capacity [30]. Funding positions without sufficient attention to onboarding, supervision, professional development, employee support, career pathways, and organizational capacity may limit the sustainability of workforce investments. From an ITM-CBH perspective, workforce expansion and workforce sustainability should therefore be considered together.

Research Agenda and Model Validation

The ITM-CBH is an evidence-informed conceptual model and has not yet been empirically validated. A deliberate, sequential research agenda is therefore needed to examine its content, feasibility, measurement, proposed relationships, and applicability across community-based healthcare settings.

Phase 1: Expert Review and Content Validation

Experts in community-based healthcare, behavioral health, CHW workforce development, talent management, supervision, and organizational leadership should evaluate the relevance, clarity, and comprehensiveness of the model's stages, foundational principles, and proposed relationships.

Phase 2: Organizational Pilot Testing

Pilot studies should examine the feasibility and usefulness of applying the ITM-CBH in community-based healthcare organizations and identify contextual factors affecting implementation.

Phase 3: Development of ITM-CBH Measures

Measures should be developed or selected to assess lifecycle practices and relevant workforce outcomes. Instrument development should follow established procedures for content validation and psychometric evaluation [32].

Phase 4: Evaluation of Proposed Relationships

Empirical studies should test relationships among lifecycle practices and workforce and organizational outcomes. One specific proposition arising from the model is whether structured early mentoring is associated with greater role clarity, competency, engagement, and retention and with less subsequent need for corrective coaching.

Phase 5: Testing Across Settings

Finally, the model should be evaluated across different community-based healthcare organizations, workforce groups, populations, and organizational contexts to determine its applicability and identify adaptations that may be required.

This progression would move the ITM-CBH from an evidence-informed conceptual model toward an empirically tested framework while allowing its components and proposed relationships to be refined as evidence develops.

Limitations

Several limitations should be considered when interpreting the ITM-CBH. First, the model is conceptual and has not yet been empirically validated; therefore, the relationships and outcomes proposed across the lifecycle require testing. Second, the supporting evidence is stronger for CHWs than for some other community-based healthcare and behavioral health paraprofessional groups. Variation in workforce titles, scopes of practice, credentialing requirements, organizational structures, and state requirements may also affect how the model is applied across settings. In addition, some components of the ITM-CBH draw on broader healthcare and talent management literature where evidence specific to community-based workforces remains limited. These limitations reinforce the need for systematic validation and testing across workforce groups, organizations, and settings as outlined in the proposed research agenda.

Conclusion

The evidence supporting the value of community-based healthcare workers has continued to mature, demonstrating their contributions to access, community engagement, service delivery, and health equity [1,23]. The next challenge is not simply expanding this workforce, but creating organizational systems capable of effectively integrating, developing, supporting, and sustaining it over time.

The ITM-CBH responds to this challenge by bringing workforce practices that are often addressed separately into an evidence-informed lifecycle framework. By connecting strategic workforce planning with role design, recruitment, onboarding, team integration, mentoring and supportive supervision, professional development, employee experience, career mobility, leadership development, and workforce sustainability, the model offers a structured approach for strengthening community-based healthcare workforce strategy. Its value now depends on systematic implementation, evaluation, and empirical testing across diverse workforce and organizational settings.

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