Community Health Worker Programs: A Case Study Compendium

Six models to guide program development

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Care management models built to address only clinical risk fall short of fully addressing the nonclinical needs of many patients, particularly those with several social risk factors. Typical models center around a team of nurse care managers who coordinate care for patients with chronic illnesses. But as providers recognize that social needs often compound clinical acuity, it becomes clearer that traditional members of the care team aren’t equipped to address them. Evidence suggests that community health workers (CHWs), which are non-clinical, non-licensed workers sourced from the community, can successfully partner with patients to fill many social gaps in care. When executed strategically, CHW programs can result in a substantial financial ROI.

Community health workers specialize in developing strong relationships with at-risk patients to address social needs and drive self-management. While all programs aim to address social needs, the focus on chronic disease self-management support ranges from minimal to central to the role. Outside of these two common goals, programs differ widely in who they target, how staff is deployed, and how the program is integrated into the health care infrastructure. This research report compares six best-in-class community health worker care team models across key components of programming, including scope of role, target population, and hiring model.

This compendium is part of a series. Request additional resources to optimize program development:

- **The Case for Implementing a Community Health Worker Program:** Download a customizable ready-to-use slide deck to make the case for investing in a CHW program
- **Implement a Community Health Worker Program Toolkit:** Use this toolkit for step-by-step guidance on how to develop the right program for your organization
- **Community Health Worker ROI Estimator:** Use this tool to quantify the return on investment of based on cost savings tied to total cost of care reductions

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Advisors to our work

The Population Health Advisor team is grateful to organizations that shared their insights, analysis, and time with us. We would like to recognize the following organizations for being particularly generous with their time and expertise.

With sincere appreciation

**City Health Works**  
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*Community Health Worker*

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*Chief Strategy Officer of the Center for Community Health Workers*  
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*Senior Community Health Worker*
Community health workers: An introduction
What is a community health worker?

Program design varies based on primary goal of patient management

**Primary goals of community health worker programs often two-fold**

As defined by the CEO of City Health Works, Manmeet Kaur, a “community health worker’ is an umbrella term that means one thing: a non-clinical person hired from the community that they serve.” For populations with unmet social needs, CHWs are a lower cost alternative to RN care managers to support at-risk patients. CHWs specialize in developing strong relationships with patients. All programs use CHWs to address patient’s social determinants of health, and few broaden the scope the CHW role to drive chronic disease self-management. Most programs then base key performance indicators on the scope of the CHW role.

No two programs are alike, as organizations base programming on system strategy and resource availability. Program design varies across patient inclusion criteria, care team deployment, and the timeframe for patient management. However, CHW programs also share similarities beyond the common goals, including:

• **Care team integration:** Some organizations may integrate CHWs into the care team to increase care management capabilities by offloading social support. However, many organizations decide to keep CHWs independent to protect the integrity of the role and ensure they’re working top-of-license.

• **Target population:** Organizations often start with a narrow target population likely to benefit most from support (e.g., high-risk Medicaid patients) to perfect operations and exhibit a positive ROI to leadership. With buy-in, program scope often grows to at-risk subpopulations (e.g., undocumented immigrants).

• **Funding strategy:** Most programs launch with grant or pilot funding. Once they demonstrate ROI, program leaders make the case for internal investment to ensure long-term sustainability.

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**Address social determinants of health**

- Address and surface latent non-clinical needs that preclude clinical stabilization
- Navigate patients to relevant social services for long-term support

**Drive chronic disease self-management**

- Support patients in achieving personal goals leading to improved outcomes
- Drive health system engagement; navigate clinical appointments

**Increasing focus on health coaching**

Increasing focus on health coaching

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An overview of community health worker programs

<table>
<thead>
<tr>
<th>Source</th>
<th>Program Details</th>
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<tbody>
<tr>
<td>Kalispell Regional Medical Center</td>
<td>1 FTE&lt;br&gt;GOAL: ADDRESS SOCIAL NEEDS ✔&lt;br&gt;GOAL: AID SELF-MANAGEMENT ✗&lt;br&gt;TARGET POPULATION: Patients with 3+ inpatient visits over 6 months&lt;br&gt;PANEL SIZE PER CHW: 65 patients per year&lt;br&gt;PROGRAM OUTCOMES: Reduced inpatient visits by 57%, observation visits by 30%, and ED visits by 31%</td>
</tr>
<tr>
<td>Mercy Health System</td>
<td>3 FTEs&lt;br&gt;GOAL: ADDRESS SOCIAL NEEDS ✔&lt;br&gt;GOAL: AID SELF-MANAGEMENT ✗&lt;br&gt;TARGET POPULATION: High-risk patients with high rates of acute utilization&lt;br&gt;PANEL SIZE PER CHW: 25-30 patients per week&lt;br&gt;PROGRAM OUTCOMES: Social support from CHW and SW¹ reduced ED visits by 31%, hospitalizations by 32%, and avoided $170K in costs</td>
</tr>
<tr>
<td>NewYork-Presbyterian Hospital</td>
<td>49 FTEs&lt;br&gt;GOAL: ADDRESS SOCIAL NEEDS ✔&lt;br&gt;GOAL: AID SELF-MANAGEMENT ✔&lt;br&gt;TARGET POPULATION: Patients with 2+ chronic conditions, 2+ ED visits, and multiple social needs&lt;br&gt;PANEL SIZE PER CHW: 35 active patients at once&lt;br&gt;PROGRAM OUTCOMES: Adult program: 62% of patients improved A1C, 82% didn’t readmit&lt;br&gt;Pediatric program: reduced inpatient visits 76%, ED visits by 68%</td>
</tr>
<tr>
<td>University of Pennsylvania Health System</td>
<td>50 FTEs&lt;br&gt;GOAL: ADDRESS SOCIAL NEEDS ✔&lt;br&gt;GOAL: AID SELF-MANAGEMENT ✔&lt;br&gt;TARGET POPULATION: Under- or uninsured patients living in high-risk service area zip codes&lt;br&gt;PANEL SIZE PER CHW: 15-30 active patients at once&lt;br&gt;PROGRAM OUTCOMES: Measured 2:1 ROI through reduced utilization; improved access, and quality</td>
</tr>
<tr>
<td>University of New Mexico Health System</td>
<td>51 FTEs&lt;br&gt;GOAL: ADDRESS SOCIAL NEEDS ✔&lt;br&gt;GOAL: AID SELF-MANAGEMENT ✔&lt;br&gt;TARGET POPULATION: Patients of all acuities, Medicaid beneficiaries, returning citizens, undocumented immigrants, children at risk for abuse&lt;br&gt;PANEL SIZE PER CHW: 25-30 active patients at once&lt;br&gt;PROGRAM OUTCOMES: Measured 4:1 ROI, 83% fewer admissions</td>
</tr>
<tr>
<td>Mount Sinai Health System</td>
<td>6 FTEs shared across provider organizations in Harlem&lt;br&gt;GOAL: ADDRESS SOCIAL NEEDS ✗&lt;br&gt;GOAL: AID SELF-MANAGEMENT ✔&lt;br&gt;TARGET POPULATION: PC² program: Patients with uncontrolled conditions&lt;br&gt;CHF program: Inpatients with uncontrolled CHF&lt;br&gt;PANEL SIZE PER CHW: 30 active patients at once&lt;br&gt;PROGRAM OUTCOMES: City Health Works diabetes-specific programs led to a $600 average PMPM drop by 10 weeks and 1.6 average A1C reduction at 1 year</td>
</tr>
</tbody>
</table>

¹) Social worker<br>²) Primary care<br>³) Conditions include CHF, diabetes, asthma, hypertension, and depression

Source: Population Health Advisor interviews and analysis

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### An overview of community health worker programs (cont.)

<table>
<thead>
<tr>
<th><strong>REFERRAL STRATEGY</strong></th>
<th><strong>PROGRAM LENGTH</strong></th>
<th><strong>CARE SETTING</strong></th>
<th><strong>HIRING MODEL</strong></th>
<th><strong>PROGRAM FUNDING</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kalispell Regional Medical Center</td>
<td>Inpatient care teams refers patient to dyad prior to discharge</td>
<td>30-90 days post-discharge</td>
<td>Meets patients during admission, offers home visits, attend PCP appointments</td>
<td>Internally hired and trained; deployed in a dyad with a RN</td>
</tr>
<tr>
<td>Mercy Health System</td>
<td>Centralized RN offering telephonic transition support refer highest-risk patients to triad</td>
<td>Six weeks post-discharge</td>
<td>Makes home visits, performs assessments, and connects with community resources</td>
<td>Internally hired and trained; deployed in a triad with a RN and a LSW</td>
</tr>
<tr>
<td>New York-Presbyterian Hospital</td>
<td>Inpatient and outpatient care teams refer patients via EMR; CBO staff outreach proactively</td>
<td>Six months</td>
<td>Meets patients during admission, patient visits occur in homes and community-based organizations</td>
<td>Sub-contracted from community partners, internally trained; CHWs a separate, standalone program</td>
</tr>
<tr>
<td>University of Pennsylvania Health System</td>
<td>Web-based platform uses algorithm to identify target patients</td>
<td>Two weeks post-discharge, four weeks post-discharge, or six months</td>
<td>Meets patients during admission or in the primary care clinic; patient visits occur in the home or community</td>
<td>Internally hired and trained; CHWs a separate, standalone program</td>
</tr>
<tr>
<td>University of New Mexico Health System</td>
<td>Predictive modelling identifies target patients (e.g., high utilizers)</td>
<td>One to six months</td>
<td>Offers support in the community, primary care, and the ED</td>
<td>Internally hired and trained; CHWs a separate, standalone program</td>
</tr>
<tr>
<td>Mount Sinai Health System</td>
<td>Care team reviews EMR risk reports (e.g., zip code, diagnoses) to determine outreach</td>
<td>Three months of active health coaching, nine months of maintenance</td>
<td>Meets patients in the primary care setting after care team referral or in the inpatient setting to plan for discharge</td>
<td>Externally hired and trained through a community partnership; CHWs a separate, standalone program</td>
</tr>
</tbody>
</table>

Source: Population Health Advisor interviews and analysis.
Case study compendium
Extend care management capacity with dyad model
Kalispell pairs CHWs with RNs to assist with social support and home visits

Kalispell Regional Medical Center employs a CHW in a dyad with an RN navigator. The team, called the Complex Care Team, provides 30 to 90-day post-discharge support for rural, at-risk patients with clinical and psychosocial needs. The CHW increases the RN’s capacity by using weekly check-ins and home visits to assess and meet patients’ clinical needs. During home visits, the CHW uses an iPad for a tele-visit with the RN to limit RN travel time to remote locations. The Complex Care Team has reduced inpatient visits by 57%, observation visits by 30%, and ED visits by 31%¹.

Complex Care dyad relies on CHW to extend RN reach across rural service area

<table>
<thead>
<tr>
<th>Location</th>
<th>Hospital</th>
<th>Patient’s home</th>
<th>PCP office</th>
<th>Telephone</th>
<th>Patient’s home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role</strong></td>
<td>RN and CHW meet patient during admission to enroll and build rapport</td>
<td>Both attend the initial home visit to perform clinical and social needs assessments</td>
<td>RN attends first PCP visit one-to-two weeks post-discharge</td>
<td>CHW touches base with patient weekly to check on progress and cement patient education</td>
<td>CHW performs additional home visits as needed to address patient’s non-clinical needs</td>
</tr>
<tr>
<td></td>
<td>Team debriefs and creates care plans with defined next steps</td>
<td>CHW may attend additional appointments for social and emotional support</td>
<td>CHW facilitates tele-visit with RN over an iPad to assess clinical status</td>
<td></td>
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</tr>
</tbody>
</table>

58% Reduced inpatient admissions¹
30% Reduced observation hospital visits¹
31% Reduced emergency department visits¹

¹) Data measured six months after intervention start date.

Source: Kalispell Regional Medical Center, Kalispell, MT; Population Health Advisor interviews and analysis.
Enhance wrap-around transition support with CHWs

Mercy patients receive customizable social support from integrated CHW

CASE EXAMPLE
Mercy Health System
Three-hospital health system, a member of Trinity Health • Southeastern PA

Mercy Health System employs CHWs as part of a triad care transition team. The other two care team members include a population health nurse and a social worker. The most clinically complex patients receive support from the entire triad. Nurses provide clinical support for recently discharged high-risk patients, while the social worker and CHW provide personalized psychosocial support. The majority of CHW care occurs in the home. CHWs take on 25-30 patients at once for between one-to-six weeks depending on acuity. The resulting care delivered by the triad resulted in more streamlined care transitions, warm handoffs, improved quality of live, a 31% reduction in ED use, a 32% reduction in inpatient use, and $170K in estimated cost avoidance¹.

Mercy Health System’s CHWs offer in-depth social support for most complex patients in transition

Clinic support

Social support

Population health nurses

Primary care

• Manage patients with multiple chronic conditions post-discharge; provide ongoing support to more fragile patients

• Receive referrals from nurses providing telephonic support in centralized corporate office

Social worker

Primary care, hospital

• Provide strengths-based counseling, community referrals and legal services to patient and family

• Receive referrals from population health nurses, triage complex cases to CHW for additional support

Community health worker

Patient home

• Perform home visits, safety assessments, food insecurity assessments, home cleaning arrangements

• Identify unmet social needs, connect with community resources, and communicate findings to the care team

Patient acuity

31%
Reduced emergency department visits¹

32%
Reduced inpatient utilization¹

$170K
Estimated cost avoidance¹

¹) Data measured over eight months in a longitudinal analysis.

Source: Mercy Health System, Southeastern PA; Population Health Advisor interviews and analysis.
Create community feedback loops using CBO-sourced staff

NewYork-Presbyterian cements community partnerships, streamlines CHW role

NewYork-Presbyterian (NYP) subcontracts staff from community-based organizations¹ (CBOs) to offer CHW services to rising-risk adult and pediatric patients². CHWs are co-trained and co-managed by the hospital and CBOs, but are primarily based in the CBOs. Subcontracted CHWs have experience working with target patients, knowledge of the social determinants of health, and the ability to easily communicate and coordinate across settings. The adult program improved A1C levels for 62% of patients and 82% did not readmit in 30 days³. The pediatric program decreased hospitalizations by 76% and ED visits by 68%⁴.

Provider-CBO partnership deploys CHWs to support patients across settings

**NewYork-Presbyterian’s role**

*Funding*

The hospital pays for CHW salaries, benefits, office space, and stipends for day-to-day activities⁵

*Infrastructure*

- Program leaders set CHWs up with badges under their contractor status to enable face-to-face meetings with patients at different locations across the health system
- A dedicated program director manages CHWs and supports providers in meeting patients clinical needs

**Community-based organization’s (CBOs) role**

*Staffing*

14 CBOs that each meet different social needs⁶ (food insecurity, domestic violence, legal services, education support) recommend and recruit community-sourced staff to work as NewYork-Presbyterian CHWs

*Community relations feedback loop*

CHWs provide feedback into community priorities to help NewYork-Presbyterian’s CHW committee plan and modify service offerings

**Community health workers’ role**

*In the health system*

- Meet patients in the inpatient setting when admitted
- Reinforce disease management tips in outpatient clinics
- Participate in weekly team huddles across settings

*In the CBOs*

- Identify patients proactively in community
- Connect patients to social services via warm handoff
- Support navigation to other clinical services

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**Impact of adult CHW program³**

- 62% Patients improved A1C levels
- 82% Patients did not readmit in 30 days

**Impact of pediatric CHW program⁴**

- 76% Decreased hospitalizations
- 68% Decreased ED visits

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1) NewYork Presbyterian’s CHW committee performs an in-depth quantitative and qualitative data analysis to select partner CBOs that address the community’s primary social needs.
2) ≥2 chronic conditions and social needs.
3) Data reflect cumulative impact from January 2012 to June 2016.
4) Data reflect cumulative impact from September 2006 to June 2018.
5) For example, smart phone, tablet, and transportation.
6) Food insecurity, domestic violence, legal services, and education support.

Source: NewYork-Presbyterian Hospital, New York, NY; Population Health Advisor interviews and analysis.
Base patient management timeframe on patient acuity

University of Pennsylvania uses three evidence-based models to tailor support

The University of Pennsylvania Health System (UPHS) employs CHWs across the inpatient and ambulatory care setting under an independent management structure. The evidence-based program, IMPaCT, uses an internal algorithm that includes insurance status and zip code to identify target patients. IMPaCT has three separate workflows that map to patient acuity: short-term transition support, long-term transition support, and chronic disease management support. Overall, the IMPaCT program resulted in a 2:1 ROI, with a 28% decrease in hospitalizations¹, 30% decrease in multiple readmissions², a 12% increase in primary care access², and a 13% increase in HCAHPS³ communication scores².

Acuity level dictates patient enrollment in one of three standalone CHW programs

<table>
<thead>
<tr>
<th>Short-term transition</th>
<th>Long-term transition</th>
<th>Chronic disease management</th>
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<tbody>
<tr>
<td>Supports patients with 1-2 ED visits in the last 6 months; 2 weeks duration</td>
<td>Supports patients with 3+ ED visits in the last 6 months; 3 months duration</td>
<td>Supports patients with 2+ chronic conditions in ambulatory setting; 6 months duration</td>
</tr>
</tbody>
</table>

Risk algorithm informs CHW outreach

- HOMEBASE, an automated workflow management tool integrated into UPHS’s EMR, identifies eligible patients in real time, across inpatient and outpatient settings
- Risk algorithm includes insurance coverage, patient ZIP code, past health care utilization, and chronic conditions

Intake assessment centers around patient goals

- CHW leads 60- to 90-minute conversation with patient during hospital stay or primary care visit
- CHW uses patient engagement tactics (e.g., motivational interviewing) to build patient rapport and uncover sensitive psychosocial needs
- CHW and patient collaboratively set care plan goals
- CHW tracks concrete steps to achieve goals in HOMEBASE

CHW engages patient in ongoing support

- CHW taps into collective knowledge of IMPaCT team to connect patient to relevant social and community services
- CHW has relationship with patient’s care team and communicates clinical concerns
- CHW connects with patient in person and telephonically throughout the duration of the program to ensure their needs are met on an ongoing basis

Impact of effective community health worker care

<table>
<thead>
<tr>
<th>CHW program</th>
<th>Decrease in multiple readmissions²</th>
<th>Increase in primary care access²</th>
<th>Increase in HCAHPS communication scores²</th>
<th>Decrease in hospitalizations¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROI of Penn’s CHW</td>
<td>30%</td>
<td>12%</td>
<td>13%</td>
<td>28%</td>
</tr>
</tbody>
</table>

1) P-value of .11. Data measured after six months of CHW support.
2) Intervention lasted a minimum of two weeks or until the patient was connected with a PCP post-discharge.
3) Hospital Consumer Assessment of Healthcare Providers and Systems.

Target initial programs to subpopulations under financial risk

UNM Health System achieved long term expanded funding with targeted pilot

University of New Mexico Health System (UNM) deploys CHWs to establish trusting relationships with disengaged, high-risk patients attributed to a local managed care organization (MCO). After a successful pilot, UNM obtained stable, long term funding from internal stakeholders and from additional MCOs to expand programming. While UNM continues to serve the highest-risk, they’ve expanded support to vulnerable subpopulations (e.g., undocumented immigrants, children). UNM Health’s efforts resulted in a 4:1 ROI with 83% fewer inpatient admissions.

CHWs show promising ROI with highest-risk Medicaid patients

**Impetus**  
Local MCOs needed help identifying their high-risk members, provided funding to UNM to hire, train, and deploy CHWs

**Training**  
6 months of didactic training (e.g., health coaching, service coordination) paired with 6 months of field work

**Coordination**  
MCOs contact CHWs if patients miss a clinical service; CHW engages the patient to address potential access barriers and works with providers to reschedule the appointment

**Services**  
**Address social needs:** offer interpretation services, connect with social services, communicate with cultural humility  
**Support disease self-management:** reinforce basic disease education, address health literacy, navigate to clinical care

**Program costs vs. savings**  

<table>
<thead>
<tr>
<th>Costs</th>
<th>Savings</th>
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<tr>
<td>$521K</td>
<td>$2M</td>
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4:1 ROI  
83% Fewer inpatient admissions

Proven program success allows flexibility to focus on narrowed subgroups

**Patients exiting the justice system**  
Impetus: Other institutions (e.g., city government) were concerned about high rates of recidivism

Solution: Collaborated to create a center to welcome returning citizens after their release and connect them to services

**Undocumented immigrants**  
High rates of undocumented immigrants unable or afraid to access care

**Children at-risk for abuse**  
High rates of child abuse in the hospital’s service area

**Lower-risk patients**  
Half of all UNM patients have at least one psychosocial risk factor

Decided to target lower acuity community members to move intervention even further upstream

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1) Managed Care Organization  
2) Control group not managed by CHWs had 53% fewer inpatient admissions  
3) Data measured 12 months after the start of the six month intervention

Source: Johnson, D. et al. “Community Health Workers and Medicaid Managed Care in New Mexico,” Journal of Community Health, June 2012; UNM Health System, Albuquerque, NM; Population Health Advisor interviews and analysis.
Mount Sinai Health System contracts with a health coaching organization, City Health Works, to operate two CHW programs: a primary care-based program targeted to patients with unmanaged chronic conditions¹ and a care transitions program for patients with CHF. Mount Sinai pays City Health Works to manage patients with externally hired, trained, and clinician-supervised CHWs. The CHWs serve primarily as a health coach to support patients with condition self-management and drive regular use of primary care. CHWs supplement existing care management teams who already cover social needs and care navigation (e.g., support behavioral change in the home). City Health Works diabetes-specific programs have lead to a $600 average PMPM drop across 10 weeks, a 1.6 average A1C reduction at one year, and high patient satisfaction, as 90% note they would refer a friend².

Partner-operated CHWs provide health coaching to supplement care management services

Health coaching
- Reinforce care plan, medication plan, and education on chronic conditions across primary care and transitions programs
- Collaborate to determine daily lifestyle modifications that support self management
- Use motivational interviewing to encourage behavioral change

Health system navigation
- Communicate with care management (or dedicated CHF teams) to offer updates on patient progress and alert clinicians in case of urgent medical needs
- Assist in primary care or specialty appointment scheduling
- Attend visits to help advocate for patient needs & teach patients how to prepare for medical appointments

Community resource navigation
- Identify social determinants of health patients are dealing with that interfere with care plan adherence
- Refer patients to ambulatory-based social workers to address social needs and connect to community resources

Ancillary CHW goals

Outcomes from diabetes-specific City Health Works programs²

- $600 Average PMPM drop by 10 weeks
- 1.6 Average A1C reduction at 1 year
- 90% Participants would recommend program to a friend

1) Conditions include CHF, diabetes, asthma, hypertension, and depression.
2) Data measured after three months of intensive coaching and nine months of maintenance.
The best practices are the ones that work for you.℠