What is a community health worker?

Community health workers help people access healthcare and social services. They are typically members of the communities where they work and share factors such as life experiences, language, ethnicity and/or socioeconomic status with the populations they serve. CHWs help patients increase their health knowledge and self-sufficiency through outreach, community education, social support and advocacy. They can help bridge gaps between under-resourced/underserved populations and the healthcare system by building trusting relationships with each of their patients ([CHW Fact Sheet](https://nyhealthfoundation.org/resource/fact-sheet-community-health-workers-in-new-york-state/), NY Health Foundation).

CHWs help patients, and sometimes their families, navigate complex systems. They meet patients where they are, addressing each patient individually. A vital link between health and social service programs, CHWs facilitate access to housing, food or transportation and provide chronic disease education ([National Urban League Alliance: Community Health Worker Initiative](https://www.aha.org/national-urban-league-community-health-worker), American Hospital Association).

CHWs are part of a patient’s care team and can increase the team’s awareness of any healthcare access barriers the patient may face while building knowledge and respect for the patient’s cultural and societal norms.

The many roles of community health workers

Social services navigation and referrals

Care coordination

Patient advocacy

Cultural medication

Coaching

Chronic disease health education

Supplementing healthcare services

Outreach and education

*Ultimately, CHWs bridge the gap between the care team and the patient, providing support for unmet needs*

The impact of community health workers

The goal of a CHW is to reduce health disparities for those who experience barriers to healthcare access due to race, ethnicity, language, literacy, income, transportation, or cultural values. CHWs engage with patients to decrease emergency department visits and readmissions by increasing patient engagement with their healthcare team ([CHW Model Improves Quality Care, Reduces ED Utilization and Length of Stay](https://www.vizientinc.com/insights/articles/2024/community-health-worker-model-improves-quality-care-reduces-ed-utilization-and-length-of-stay), Vizient Health).

CHW interventions have the potential to produce meaningful and measurable results that can influence health systems’ costs. CHW interventions, such as connecting a patient with a primary care provider, can help to lower medical costs as there is a decrease in emergency department visits for non-emergency needs ([Toolkit: Building a Community Health Worker Program](https://www.aha.org/system/files/2018-10/chw-program-manual-2018-toolkit-final.pdf), American Hospital Association).

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| Sample workday of a CHW | |
| 8:00am – 9:00am | Review patient list, check for ED visits/admissions, respond to referrals, update progress notes, prep for visits for the day. |
| 9:00am – 9:15am | Morning team meeting. |
| 9:15am – 9:45am | Patient 1 – connect patient with dental provider; call and schedule appointment for patient, call patient to inform them of date/time, schedule transportation if needed |
|  | Patient 2 – patient was discharged home following a 4-day hospital admission; call patient to check on the following:   * Did they pick up any new meds from the pharmacy? * Is there food in the house? * Has the transition of care appointment been scheduled, and does transportation need to be arranged? |
| 9:45am – 10:00am | Travel to community stakeholder meeting. |
| 10:00am – 11:00am | Local community stakeholder meeting. |
| 11:00am – 12:30pm | Patient 3 home visit – assist patient with completing SNAP application, drop off application at social services on return to the hospital. |
| 1:00pm – 1:30pm | Meet with social work about new referrals. |
| 1:30pm – 2:30pm | Meet patient 5 at her new patient ENT appointment. |
| 2:30pm – 3:15pm | Patient 5 – meet with patient (new referral), to complete questionnaires. |
| 3:15pm – 3:45pm | Patient 6 – Care team meeting with patient 5 and spouse, PCP and nutritionist to discuss diabetes management. |
| 3:45pm – 5:00pm | Complete progress notes, upload documents from new referral, prep for tomorrow’s visits. |