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Effective yet Undervalued:

Elevating Community Health Workers

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Introduction

Essential Role of Community Health Workers to Community Health

Community health workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the communities they serve.[1] They are also known by other terms, including lay health worker, outreach worker, patient navigator, community health educator, and promotores de salud.[2] These key members of the health-care team emerged in the 1960s, at a time when public health and health-care models were evolving and the understanding of disease processes was expanding.

By 2010, when as many as 50 million Americans were uninsured, CHWs became increasingly visible as an effective intervention to better connect people to health-care systems. There were calls for their greater inclusion in the health-care team, along with full integration across the health-care landscape for better health outcomes in marginalized and diverse populations. These calls had been increasing over time, as demonstrated in the landmark 2002 Institute of Medicine report, *Unequal Treatment*, in which the committee called for greater roles for the CHW to help improve access to care, control costs, and reduce health disparities among under-resourced and overlooked populations.[3]

Delineation of CHW Work and Mission

While the roles of CHWs have and will continue to evolve, the critical work of the CHW has remained the same—to serve as a bridge between the community and health services navigation and as outreach workers helping clients to access health and/or social services.[4] CHWs play a key role in connecting clients to vital services as trusted members of the community, or who know and respect the community. They also help to address the wide range of economic, environmental, social, and political challenges confronting these communities. In addition, due to this trust relationship, they are key observers for changes over time, not only in individuals but also in communities, assessing the level of community engagement or reticence to accept/embrace new health messages or technologies.[5] Their role in COVID-19 vaccination in vulnerable communities exemplifies this key observer/participant role.

CHWs are also uniquely positioned as resources for services and social justice. They are the vital care extenders in communities that are often overlooked, marginalized, and vulnerable. This alone expands the number of roles and settings in which their contributions can be critical to successful intervention outcomes. A central part of this project included capturing the voices of CHWs, providing insights into their daily work, the challenges, and the barriers to enhancing outcomes. Their insights highlight the intersection of the issues that affect outcomes and limit the translation of these lofty goals into practical and realistic actions.

CHW Role Expansion and Increased Outreach

CHWs play an ever-expanding list of roles, along with their associated duties. Their role in providing not only health education but also assistance and support with lifestyle modification and in addressing common chronic health conditions, such as asthma, diabetes, hypertension, and obesity, is well documented (see Figure 1). They provide critical bridges to community and health services, investing significant time and effort to expand access to those services, while supporting efforts to improve health-care quality and cultural competence.[6]

The extent of the resources that may be needed to achieve these goals is highlighted in an example provided by a Philadelphia CHW: "CHWs may be used to transition a patient to insulin for their diabetes management; however, the prescriber may be unaware of the patient's living situation, which could include lack of refrigeration, food, or both, making the safe storage of insulin, not to mention initiation of insulin therapy, difficult, as well as ill-advised".[7] The CHW is expected to identify resources, provide linkages to services, and develop a plan for maintaining engagement to assure patient compliance, adherence, and follow-up.[8]

Figure 1. Examples of CHW Duties

Source: Milken Institute (2025)

The communities served include not only those marginalized and vulnerable due to economic or health education/literacy needs but also those living as sexual and gender minorities. It has been proven that CHWs consistently demonstrate rapport, establish trust, and identify resources, demonstrating both effectiveness and a solid return on investment (ROI).

Despite these findings and the abundant literature on the successful outcomes that CHWs have achieved, they remain an underutilized and underappreciated resource in the health-care ecosystem.

CHW Underutilization and Its Potential Costs

"Underutilized" in this context is based upon health-care economics and is ***not*** about worker perceptions or estimations; it is a specific term with a clear definition. Utilization, in terms of health-care utilization, is primarily determined by the ***need for service*** (i.e., levels of illness and disability), the availability of services, and the resources available for providing and paying for service.[9] Underutilization in health care refers to the ***failure*** to provide necessary medical services or interventions that could significantly benefit patients, leading to preventable harm or suboptimal health outcomes.[10]

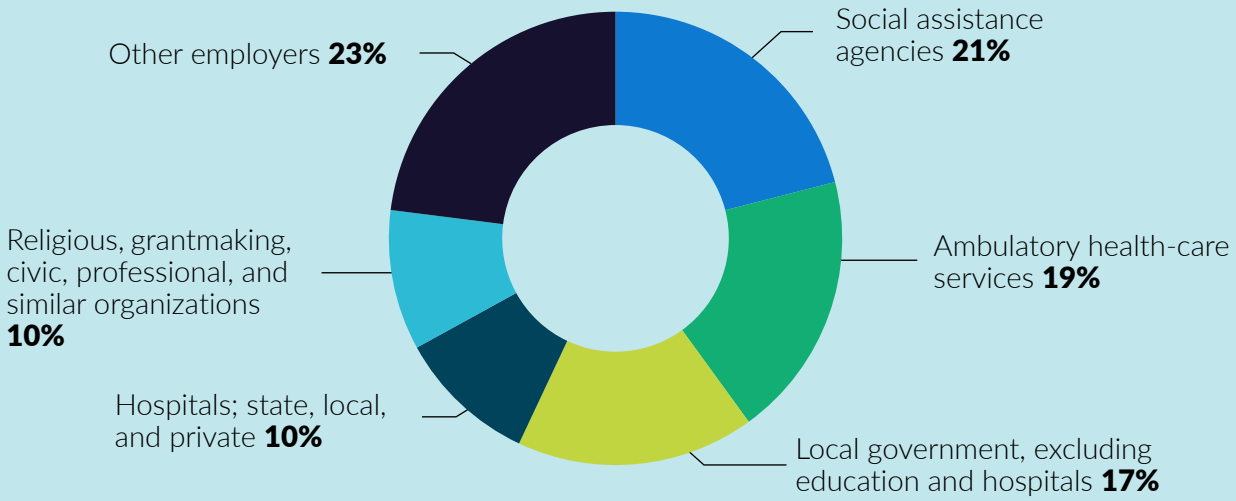
Using this health economics framework, CHWs are significantly underutilized by every metric. The ROI, demonstrated unequivocally by a randomized controlled trial, averages a return of $2.70 for every $1 invested.[11] Multiple studies have repeatedly demonstrated that CHWs effectively improve the outcomes in a long list of conditions, including asthma, breastfeeding, diabetes, hypertension, HIV, stroke prevention, and more.[12] Recently, they have proven to be valuable assets in pharmacies, helping to address health-related social needs, as well as effective recruiters for community-based research.[13]

As these data exist, the question remains: Why are CHWs underutilized, and what are the barriers to increasing their utilization? The response requires an examination of how CHWs are used across settings, and who employs them—health-care organizations, community-based organizations (CBOs), state and local health departments, and pharmacies.

Where Are CHWs Utilized?

CHWs are used in a broad range of settings to address the health needs of diverse yet vulnerable and underserved populations. These include rural and urban settings, clinical practice, clinical research, and pharmacies (see Figure 2). However, their employment is not always well supported, and ways to improve not only their utilization but also their outcomes remain highly variable, depending on the setting.[14]

Figure 2. Top Employers of CHWs



Source: Milken Institute (2025), adapted from US Bureau of Labor Statistics Occupation Outlook Handbook for Community and Social Services

CHW Work Settings

CHWs work in both rural and urban settings. Access to care in rural portions of the US remains uneven and is often problematic. The consequences of this are reflected in the ongoing decline in health status in rural areas after a brief period of improvement.[15]

Most rural deployments of, and interventions by, CHWs focus on health education, linkage to resources, or both.[16] In addition, most studies of CHWs in rural settings report improvement in measured outcomes, while others that examined cost suggest positive returns on investment. Yet support for their full integration into rural health care continues to lag.[17]

Urban settings are common for CHWs, especially given their use in community-academic partnerships, CBOs, local and state health departments, and more recently, as part of community-based participatory research. As with rural CHWs, these workers are often from the same communities they serve, and are often hampered by the same structural barriers and violence that affect their clients and are also documented to affect patient outcomes and motivation.[18]

Despite this, CHWs can and do address these barriers through several approaches, including effecting policy change through advocacy. This has been successfully achieved in settings where CHWs are trained in advocacy while receiving technical assistance in creating strategic advocacy plans. As members of the communities they serve, CHWs are uniquely positioned to respond to needs, as well as lead efforts to identify policies that negatively affect community health outcomes.[19]

Models of CHW Utilization

There are many ways that CHWs can and have been utilized, and all fall within four distinct types. The type of model also affects not only the compensation of the CHW but also the stability of such compensation (e.g., grants versus salaried positions within a health-care or community-based organization). These models include:

- community–clinical linkage
- employment within health-care systems (increasing in frequency)
- integration with payers (such as with a Medicaid program)
- coordination by a health department[20]

Despite the effectiveness of these models, CHWs continue to be underutilized, and stable compensation for their time and services remains elusive. Other funding that supports CHWs includes grants, nonprofit revenues, and general revenues, all of which are subject to external conditions, including changing priorities and economic climate. Decisions to change policy or funding directions can and do have significant implications for funding the CHW workforce, affecting its growth and the development of additional skills and credentialing.

Other models for CHW reimbursement are urgently needed and must be considered in both the evolving health-care delivery system and the changing models of care reimbursement in the US.[21] Finally, calculating the cost—true cost—of CHW services is important, especially in a value-based care system. The health education and advocacy that they can achieve, as well as the creation of cultural and community ties to engage patients and engender trust, provide positive returns on investment. This is before one considers the real cost savings that better health outcomes bring.

Methodology

Most articles about CHWs are written by community researchers, health economists, physicians, or social scientists—in short, everyone but CHWs. In the prior sections of this report, the unique contributions of these trusted health messengers have been delineated, including the accompanying challenges, such as uncertain compensation, widely varying job descriptions and titles, and limited job security. To better understand the work of CHWs, their daily tasks and caseloads, the challenges they face, the diverse needs of their clients, and their reasons for selecting this career, as well as their perceptions of their role and sources of job satisfaction, the Public Health team at the Milken Institute developed a project to explore these areas through focus groups.

As CHW job descriptions and duties vary by locale, two comparable cities in the same region were selected, with similar population demographics. These demographics included education, population diversity, health-care system size, and rates of poverty. This allowed for examination of the similarities as well as the differences between the experiences and challenges, including subtle nuances in each area, despite comparable locales.

To ensure a plan that allowed for the inclusion of candid CHW feedback, prior to developing any protocol methodology, CHWs from national organizations to state and local health departments were invited to provide feedback about the project. The CHW feedback was central to the shaping of the project, from the creation of the overall framework to the types of probes used to maximize input. The majority of studies on CHWs do not include them or their feedback, making this step essential for establishing trust and reflecting their input accurately. In addition, approaches and settings that would maximize convenience and comfort, while minimizing fears about retribution and job termination were developed.

The resulting project shape and directions were also reviewed by two additional senior CHWs at organizations with extensive experience utilizing and field-placing CHWs, who provided several suggestions, including the optimum duration of each focus group meeting.

It was essential to have CHW input from project inception to execution, not only to ensure that the approach and execution were responsive to CHW concerns but also to operate within the guidance provided early in the project by several CHWs:

"Nothing about us, without us."

Focus Group Cities' Comparability

Baltimore and Philadelphia were selected as comparison cities because they share several characteristics that directly affect the roles, work, and caseloads of CHWs. Both cities have several major medical centers where CHWs are part of the care delivery system. Those centers also have large clusters of under-resourced populations in their catchment areas. Violence, poverty, undereducation (which correlates with lower health literacy), and diverse populations with limited language proficiency are also comparable between the cities.

Despite Philadelphia being almost three times larger, the two are comparable, with nearly identical percentages in several categories. Both cities' populations have identical percentages of females (53 percent) and nearly identical median ages (36.1 and 35 years) and educational attainment (87.2 percent, 88 percent completed high school). The comparable demographics of the two cities can be found in Table 1.

Table 1. Demographic Characteristics of Baltimore and Philadelphia

Variable	Baltimore	Philadelphia
Demographics		
Population	577,193	1,550,542
Sex—%Female	53	53
Median Age	36.1	35.6
Race %		
White	26	33
Black	59	38
Asian	2	8
Hispanic/Latino	8	16
Native American	0	0
Other	1	1
Two or more	3	4
Median Income (USD)	59,623	60,302
Live below the poverty level	21%	20.3%
Education		
High School	87.2	88
Bachelor's Degree	35.4	35.7

Source: US Census American Community Survey 5-Year data (2023), adapted by the Milken Institute (2025)

Focus Group Member Characteristics

To be eligible to participate, a CHW needed at least six months of experience in the field. If they had left the field and moved on to other work, their last date worked as a CHW could not be more than six months before the date of the focus group. This was to ensure that there was time to develop community experience and limited time to become disconnected from the field and its work, hopefully limiting both inexperience and recall biases.

The CHWs in both groups were experienced, with a range of four to twenty-two years in the field. Participating CHWs had a history of activity in projects designed to study, as well as amplify, their work. One had been a CHW as part of the original landmark study demonstrating the significant ROI for every dollar invested in a CHW.[22] Two of the CHWs had participated in a photo voice exhibit that amplified the challenges and issues CHWs faced and was ultimately published in a prestigious health journal. Another had co-authored a paper about managing CHWs.

The different backgrounds demonstrate that this was a cohort with close ties to the field, a breadth of experience, and familiarity with the conduct of community-based research and focus groups. Many of the CHWs had experienced challenges like those their clients were trying to navigate: homelessness, poverty, lack of resources, and single-parent constraints. This meant that while they were experienced in addressing the challenges, they were also deeply committed to a positive outcome.

The participants were employed across a range of care settings, but the majority were linked to hospital or clinic-based primary care. Private community agencies employed others, and a few were based in emergency or trauma services departments.

Both group meetings were held in community spaces that were comfortable and known to the CHWs, and no recording equipment was allowed. All the participants received a focus group packet, which included consent forms, a nondisclosure agreement, and an explanation of Chatham House rules. They were advised to expect to receive a number at the beginning of the meeting, and any references to themselves or to each other were to be by number ***only***. Contingency plans were made in case a name was spoken, but the situation never arose.

The ground rules for group participation were also reviewed, including accepting diverse viewpoints and disagreeing respectfully. All participants were also instructed to stow their phones. Finally, written submission of additional comments was allowed up to two weeks after the focus group was completed, to be submitted via the CHW project email box. The responses were printed and the names redacted before being added to the project data files. In short, multiple steps were taken to ensure participants' comfort with the process and to protect their confidentiality.

Probes and Themes

The probes and themes were developed in response to the CHW feedback and suggestions received during the project conception and development. The probes revolved around five discussion topics:

1. Reasons for becoming a CHW
2. Populations targeted and served
3. Being a part of the health-care team
4. Working within a health-care system
5. Challenges and opportunities

The questions posed within this framework often opened other areas for discussion. The facilitator allowed these discussions to proceed in an organic manner but returned to the original probe, even if to summarize the topic. As more issues arose than time would accommodate, all participants were offered the opportunity to submit written comments to a monitored email box. The probes that received little or no attention were emailed to the participants, and they were given a two-week time frame to respond if desired. Approximately 40 percent of the Philadelphia participants and 50 percent of the Baltimore group opted to provide additional comments in writing.

Emerging Themes

Six major themes clearly emerged: (1) what CHWs say to each other about the job, (2) limited resources and ballooning caseloads, (3) job stresses and how to cope with them, (4) experiences being part of the health-care team, (5) the opportunities to effect change, and (6) the dark side of the work no one discusses. Each of these major themes has subthemes, which are presented below, along with quotes from the participants. These quotes are also contrasted with what has been written in scientific literature. The findings are also summarized in a table at the end of the section (see Table 2).

Theme 1. What CHWs Say to Each Other About the Job

CHWs had a lot to say about the job. The discussions provided an opportunity for sharing among the group members, many of whom included powerful vignettes that reflected the challenges of being between the client and the clinic or provider. This major theme covers four subthemes that emerged: (1) their preparatory experiences for the job, (2) the critical role of altruism, (3) their many skills with many uses, and (4) a caution to always remember the client perspective.

Preparatory Experiences

- "Before I became a CHW, I was the original information superhighway in my neighborhood. You needed to find out something, people came to me."
- "For me, I was a young, single mom, trying to find resources. Some people knew [where to go] but I didn't, so I would find them and then I would share them to help people out."
- "I was raised in ---- and watched my family give out food, shoes, whatever people said they needed. My parents would try to help, but behind closed doors, we struggled. We say to people that there are resources out there, but who is going to do something, because, in fact, there is a lack of resources, and these are dying communities."

The Critical Role of Altruism

- "I wanted to see change in the world. I wanted to see poor people being able to get help or make a change without feeling that something was expected in return."
- "I have had some hard times, but I've also had good health and feel blessed, so I want to do what I can to help others."
- "It is exciting when I can show up and actually help someone, using the gifts God gave me to help someone else."

Many Skills, Many Uses

- "I began in a clinic that was predominantly Latino. I came in pedaling fast with lots of ideas… As a true Libra, I'm about assisting patients and ensuring that they are self-sufficient. I don't do handholding. I was homeless, but I always made sure I followed up and spoke up. They have to learn to advocate for themselves, and we can teach them."
- "Being a CHW is kind of sexy right now, but it isn't for everyone. This isn't fast food or retail. It's a people job; you have to be ok talking to people you don't know or even might just otherwise walk past."
- "We used to do Christmas activities, delivering gifts. There was a shootout where we were, but the kids were glad to get those big wheels. We just ran back to the car."

Remember the Client Perspective

- "You have to meet people where they are at, not where you want them to be."

- "Patients may be illiterate, and there may also be cultural differences, and you have to respect that. Sometimes that means telling the providers you can't use doctor talk; you have to break the information down in a way they can understand."
- "One client wasn't feeling good in the clinic. She kept asking for me. She didn't want the head person, but she wanted me. Once she saw me, she calmed down. The doctor didn't like that she preferred to talk to me. He felt some kind of way. He asked if I had a degree. We put a plan [together] for her. As a community peer specialist, if you ask for me, I am here. She didn't see him; she wanted me. She said, 'I only came back here because of her.'"

It has been well recognized that the unique bond that CHWs form with their clients and within communities occurs because they are trusted. A mixed methods study of CHWs in Iowa underscores this essential point, as trust—and the bond it creates—is essential for CHWs to achieve many important successful outcomes.[23]

However, the role of CHWs goes far beyond the creation of trust and achieving health outcomes; it includes health education, advocacy, and social justice. As noted in the *American Journal of Public Health*, "Community health workers are powerful and credible because they emerge from contexts in which there is a need for connection to the mainstream precisely because of conditions of health, social, economic, environmental, or political exclusion. The role has flourished, historically and presently, because there is a community need for an ombudsman, an advocate. Community health workers understand the complexity of the needs and are able to translate the issues to others in decision-making positions."[24]

Theme 2: Limited-Resource Clients and Ballooning Caseloads

As group participants became more comfortable with each other and shared experiences, the realities of providing care linkage and support to individuals with severely limited resources became apparent. Three major areas of concern emerged as subthemes: (1) the under-resourced client, (2) high caseloads, and (3) burnout and trauma.

Under-Resourced Clients

- "There are so many people without housing, from 20 to 90 years old, living in conditions that vary from hotels to being unhoused or living in unsafe, dilapidated homes. It is hard to execute a treatment plan when the person doesn't even have heat or windows."
- "So many of our clients have needs that directly affect what we can do for them—I would say at least 60 percent of them have no heat or water, utilities, refrigerator, the basics. The ER provider wants to start them on insulin, but that person may not have food or even a refrigerator, which makes therapy initiation difficult as well as unsafe. It falls to us to find a refrigerator or get the power turned on."

- "It is a lot of legwork. They only see the medical piece. But there is an in-between part… I had a client moving into a new house, needing money for pillows, sheets, etc. I got the money for this [got their items] and they came and picked it up."

High Caseloads

- "I've been doing this for four years, and I have never had a caseload under 80 clients. And there are all these issues—hard issues—not for one but all of them, and then you are expected to just go back to the office and do it all over again."
- "We also have on top of that, all of this quantitative data we have to meet. Those behind the computers don't realize what we see and the homes we go in—but they tell me 'We need you to do 100 more.' That's just not possible."
- "Like, not everything is cut and dried. It may be that you succeeded—but then the water is cut off, or they need X. You just can't cut people off either, it can take longer than your supervisor thinks [it should], but it takes time."

Burnout and Trauma

- "Trauma is a huge part of what we do, and it is hard because you have to go out and help someone, but in the process, you may be re-traumatized. They do give us 'do you' days and other organized responses to try and help. But the truth is, you may have to deal with something you have already dealt with, and it triggers you all over again."
- "Self-care is a battle, but you have to take care of yourself. Self-care for CHWs is different… Self-care is not working. Like, you get the kids off and then you go back to bed and not get out until 3 p.m. Sometimes you just have to sleep to turn your brain off—so you don't brush your teeth, you don't wash your butt, you don't go outside, you don't even answer the phone because [you] just don't have it [in you]."
- "I resigned from my first CHW job because the provider was so nasty, not just to patients but to the employees. She was nasty, rude, and racist. I confronted her, and then she chose to target me. She said I did not know how to do my job because my supervisor did not always have eyes on me. She emailed her personal feelings about me to get me fired."

The populations that CHWs tend to engage with and assist are among the most marginalized, vulnerable, and overlooked. These clients are not only disadvantaged but also struggle with multiple chronic diseases. Concern about the long-term effects of chronic exposure to these stressful conditions is not new; however, most of the research up to 2008 focused upon nurses and social workers.

The effects of these conditions upon the CHWs working in maternal health were studied, and it was demonstrated that there were clear predictors of burnout and compassion fatigue (CF), including high work hours and caseloads.[26] CF, as well as burnout, have significant effects on the delivery, as well as outcomes, of health interventions delivered by health-care, emergency, and community services personnel.

Given what CHWs are exposed to daily, it is not surprising that they develop sequelae, such as burnout, loss of job satisfaction, and CF, among other conditions. Unfortunately, Cocker and Joss, in a 2016 article in the *International Journal of Environmental Research and Public Health*, noted that data are lacking to support the best way to protect and prevent CF through modification of individual and organizational factors.[27]

They noted, "Professionals regularly exposed to the traumatic experiences of the people they service, such as healthcare, emergency and community service workers, are particularly susceptible to developing CF. This can impact standards of patient care, relationships with colleagues, or lead to more serious mental health conditions such as posttraumatic stress disorder (PTSD), anxiety or depression."[28]

Theme 3: Job Stresses and Coping Approaches

All the participating CHWs discussed working long hours, managing challenging clients, and trying to perform well while protecting themselves and their families from the ever-present and persistent job-associated stresses. When discussing these issues, CHWs extended support to each other while they shared their specific challenges and issues. Four subthemes quickly emerged: (1) personal safety, (2) wearing many hats, (3) balancing work and boundaries, and (4) salary and funding instability.

Personal Safety

- "Doing this job, there are times you are going to see and hear some things, and they can be upsetting or frightening. It's okay to feel frightened, but you cannot show fear. They can smell fear. You don't let them see you sweat—you keep that inside."
- "Safety is the one challenge I can say I face every day going into the community. It's always there—we work in tough places, and I don't think less crime will ever happen."
- "Their stories can be dark, real dark, and part is dark and gray."

Wearing Many Hats

- "Sometimes you have to do multiple things and wear many hats. Like we have many roles, but the most important one, in my opinion, is health coach. You can have an influence on patients, like pointing out the importance of taking medication as directed and giving simple examples to help patients understand what the medicine does to prevent future problems."
- "Our hats are many because we contribute to healthier communities in ways that are deeply personal, culturally relevant, and practical. We are health educators, advocates, bridge builders, care coordinators and navigators, data collectors, and first responders."
- "We have to act in all kinds of situations. Remember when the plane [carrying the child back to Mexico] crashed in Northeast Philadelphia and destroyed people's homes and killed others? We were called in to help: to provide legal help, medical help, just do it all. But it is

maddening when the social worker or nurse calls and asks you 'How did you get this done?' with such a condescending tone—like you don't have a degree and yet you were able to get this done? How?"

Balancing Work and Boundaries

- "Providers come in with a mission, I come there with a purpose. So, when I am home, they tell me I am to turn off my work phone off hours, and I do. What they are trying to control is my personal phone; they said, 'you need to block their number.' I understand setting boundaries, but boundaries need to be set with them, too. Some of these people have my personal number because their crises cannot wait."
- "Upper management challenges your decisions, and yet you are the one who has to address the issues: falls, injury, no utilities, or they come back to cut their services, and you have to be the one to tell the client and still see them. Feels unfair."
- "Stay humble and remember I am doing the best I can. If I can't do it, I accept that. I have my own happiness to balance. I know that I am doing my best, and I am putting in a good fight. I am not expecting a yes every time; I'm being humble. I want to think about my health and mental health."

Salary and Funding Instability

- "Most positions are grant-funded; we need a reimbursement code."
- "To be honest, we are the lowest of the totem pole—and we are grant-funded. Why can't we have our own billing code? Why can't the hospital create a position for us that they fund? Instead, it sounds like they want our services but only if someone else pays for it."
- "We are so underutilized, and we are needed because we can do so much more. I mean, at the church, the school, clinics, lots of places we are needed, and we can do so much to help, but they want us to do everything for nothing. I mean, this whole 'now you need a bachelor's degree' thing—I looked into that and asked how much would it pay. I'm not getting a bachelor's degree for $15 [an hour]."

Stable funding for CHWs has been an ongoing issue that workers addressed in conversations in almost every area we explored. Despite changes in federal funding, for the majority, funding for CHW services is primarily grant funding, unstable, and can end at any time, with minimal notice. The CHWs we spoke with shared their stories of being laid off over Zoom.

Baltimore seemed to have been particularly affected, given the impact of funding reversals at major medical centers. Many were terminated and barely able (or even unable) to meet the financial needs of their families.

As one CHW told us, "I was fired over Zoom, and in the beginning, I was sad. And then after a few days, I was mad—I felt disrespected, I had done so much for that community. But the providers chipped in and got a pot of money together for my position, and they worked with another department and were able to get me a job under case management. They liked my work and how I worked with them."

Not everyone is that fortunate, nor is that always possible. Many CHWs were laid off after the COVID pandemic receded because the funding for those positions was either grant-based or in the form of emergency dollars that lapsed once the emergency had concluded, a 2023 article in the *Journal of Community Health* noted.[29]

"Funding instability imperils the advances made by CHWs, and efforts are needed to institutionalize the CHW workforce with sustainable funding models. While Medicaid reimbursement models exist in some states, these models are often limited to healthcare services, overlooking a critical function of the CHW model: building community resilience and mobilizing the community for social change."[30]

This view appears to be frequently repeated in more recent publications. "...it is apparent that states need to implement clear and stable mechanisms for funding, payment, or reimbursement for CHW services," a 2021 article in *Public Health Reports* noted. Laws authorizing CHWs to bill for services through Medicaid or other existing public assistance laws provide a promising option for long-term CHW sustainability. We anticipate that states that have both enacted legal CHW funding mechanisms and provided funding for CHW workforce development will be in an improved position to take advantage of the anticipated growth in CHWs in the coming decade."[31]

Theme 4: Being Part of the Health-Care Team

This theme is the first of the remaining three that did not arise during conversation but from specific questions or probes. However, for each of these themes, once the question was posed, the responses came in a torrent: quickly, with emotion, and with anecdotes to amplify the points. Given the amount written about the importance of integrating CHWs into health-care teams, hearing about CHW experiences on the health-care team was essential.

Subthemes that emerged from probing this area included (1) integration into the health-care team, (2) team hierarchy and challenges, and (3) linking the patient to the system. Given the greater diversity of opinions for these last three themes, a larger sample of the individual responses is provided.

Integration into the Health-Care Team

- "When I have some providers acting nasty, our conversation will be through email, so it is recorded. I am not going back and forth with you. I tell them we are not having this conversation. I know that my response will be used against me."

- "It has gotten better, but in the past, it was really difficult… I would have to explain my role each and every time I would attend a patient's appointment. It was stressful and created insecurities about me as a person and as a CHW."
- "Overall, I have been treated with respect and included, but there are often instances where the care team is misinformed or unaware of our role."
- "It can feel like we are a dumping ground, with what they give to us. They send us the frequent flyers, the hard cases: HIV+, unhoused, mental health issues, substance use disorders, sickle cell disease—you name it. They automatically dump them on the CHW, and the referrals are not clear, or they are out of date. Then you have to push them to get the information because once they made the referral, they didn't do any other follow-up."

Team Hierarchy and Challenges

- "The term CHW is stereotyped, because it has that community at the front of it, and they know you don't need a degree, so that puts us in a class or category where they don't figure we know very much. The term creates a picture in their mind of who you are, where you came from, and no degrees—so the term 'community' turns people off. Like, 'oh, they can't do anything.'"
- "I don't feel valued at times. We don't have an education, but we have the experience."
- "Social workers and community resource centers can be vague. Once they do what they need to do, they get indignant, short, and rude when you call them [for more information]. But I tell them, you need to tell the client I'm coming, so you figure it out."
- "They need to understand that we are to be a bridge between the clinic and the community. That means we can do face encounters with patients and have the unique opportunity to accompany them to court, the doctor appointments, the social security office, etc., and we actually wait with the patient until that appointment is completed."

Linking the Patient to the System

- "CHWs are the ones seeing the patient, but few opportunities are given to discuss interventions or improvements needed to best deliver their services."
- "CHWs are both the face of the community and the face of the hospital system or clinic. We can enhance the health-care system and care linkage. We just need more open-minded people willing to learn and not always think they are the experts."
- "Yeah, I get requests, but there is no information. Well, I make them do their job. I call them up and say 'Hey, you made the referral, and I need a number or a contact to activate the referral, so you need to get that. Oh yeah, you need to do your job.'"

- "I always enjoy that moment when people get it, that light bulb goes off. I can accept that I may not be there when they do get it, but they call me, and they got it. It could be six months to a year ago, and I'll hear about it through the system. Sometimes the client has an issue with, say, a boyfriend, but they call to me [sic] to say, 'Hey, I got it, and thank you.' It's just a great feeling."

Calls for greater integration of the CHW into the health-care team have occurred since 1995 and were reiterated in the National Academies publication *Unequal Treatment* in 2002.[32] These publications and many others hail CHWs as an integral part of the health-care workforce and note that greater integration would help improve health outcomes. However, despite how integral and critical they are for addressing health disparities and improving health outcomes, there appears to be an ongoing disconnect between what is written and what happens in daily practice.

Since the initial calls for the integration of CHWs into the health-care workforce, changes have occurred. CHWs are employed in a greater range of settings, including clinical practices, health-care systems, research, and even as pharmacy assistants, and have been shown to be effective in all of them.

Yet significant barriers and challenges remain, even with implementing CHW integration. This observation was echoed in a published study of the challenges anticipated when implementing an evidence-based model for CHW integration into the health-care team. Shreiger et al., in a 2024 *JAMA* paper, noted:

"Clinical integration, or the extent to which CHWs were able to embed themselves within clinical settings and collaborate with other health care professionals, was cited as a barrier. Although the evidence-based model emphasized facilitating clinical integration, CHWs and other program staff reported disrespect and skepticism of the CHW role from other health care professionals (e.g., social workers and case managers)."[33]

If CHWs are to be fully integrated into primary health care teams in the 21st century and beyond, there must be a continued shift from the current practice to a model where all team members are respected and valued. This evolution can and will benefit the team as well as their patients.

"Effective community health workers are strongly embedded in the communities that they serve; they have clear supervision within the health care system; they have clearly defined roles in the health care system; and they are well trained and have a defined system of advancing their education and roles within the health care system," a 2011 article in the *Journal of Ambulatory Care Management* noted.[34]

Theme 5: Opportunities to Effect Change

As with theme 4, this theme emerged in response to probes, specifically about the bright spots in the work—what gives them hope and what opportunities for change they would like to see. Each of the participants, despite the challenges and examples of condescension and disrespect, felt that their work was meaningful and had no intention of leaving the field. They did have suggestions for effecting change and improving a challenging system. The areas emerging included (1) being a voice for the voiceless, (2) increasing provider awareness of CHW role and abilities, and (3) watching growth happen.

Being a Voice for the Voiceless

- "I saw this [patient's] chart, saw his blood pressure, and I said [to the provider], 'You let him walk out of here? I am going to call him to see if he is still alive.' I called him, I told him to 'go to the hospital, I will get you transportation.' I mean, I had to, I have never seen a blood pressure that high written in a chart—he could have had a stroke or a heart attack or just died."
- "I find the relationships exciting… I can't begin to tell you the number of people I have encountered in this line of work. My goal has always been to leave that person in a better space when I leave them, whether it be through providing services and resources, empowering them, or offering a kind and encouraging word. I am motivated to see others reach their potential, improve their health, and to live a healthier quality of life physically, emotionally, and spiritually."
- "My biggest source of satisfaction is when I'm able to build relationships with patients and other coworkers, cheering on the patient and [being] happy to see the progress they have made."

Increasing Provider Awareness of CHW Role and Abilities

- "I would inform health-care leaders of the importance of the collaboration we bring to the table, that there is an expectation of speaking truth to the patient's situation, which can provide better decision-making in the patient's care."
- "Our organization has had many discussions with the leaders of the health-care team and expressed our concerns with them. I feel confident that our CEO has been clear on our roles as CHWs … The relationship between teams has improved tremendously. Occasionally, there are issues, but I think this comes from the high turnover of nurses and social workers who work in different departments. By the time workers get the understanding of what we do, they move on, and the newer workers have no idea of what we do."
- "We spend time conducting assessments and advocating for services, but then the decision is made that they are not medically necessary, and the patient ends up going back to the

hospital. We are the ones seeing the patient but are not allowed the opportunity to discuss the needs or implementation, which in turn hurts them."

Watching Growth Happen

- "Sometimes I get to the point where I think I just can't take it. But then the patients energize me, the respect and trust they have. Words cannot describe it. I'm not sure I would open up like they do. To open up to a complete stranger, it takes courage to do it."
- "There was a person [in the office] who was mad at a mom for giving her kids Cheetos. They are often so far removed from [the] situation. She had to ride the bus as transportation, get something for the kids at the corner store because that is all that was available. Something is better than nothing. I helped her get a Dollar Tree basket and helped educate [her] on preparing the night before. I have to tell the providers in the clinic to stop making people wait so long—with an hour wait and an hour bus trip, it is like a four-hour field trip in total. It's too much."
- "I just didn't want to go into the field that day, and my supervisor said, 'Well, you could stay here.' When the client called me and asked me if I was in the office … she said she had to come down to see me, and I told her no, you can just call me later, or we can do this over the phone. But she was like insistent, 'No, I'm coming down to you.' I mean, it was raining, hard, storming, and she came down to check on me just to make sure I was alright. She had a coffee for me, and she said, 'No, you show up for me, so why can't I show up for you?' She came out in a pouring thunderstorm."

"CHWs' lived experiences and trust-building qualities make them uniquely equipped to improve access to care and increase uptake of preventive services, particularly among communities who have been harmed by the health care system or who have systematic barriers to care, such as limited insurance access or language barriers."[35]

Theme 6: The Dark Side of This Work

The focus group contributions would be incomplete if they did not include the darker challenges that confront CHWs and the populations they serve. As trusted ambassadors, CHWs reflect their communities, which are composed of marginalized, vulnerable, poor, and sometimes stigmatized populations. This means they bear witness to, as well as experience, the same issues that confront their clients.

While they have a wealth of personal experience that they rely on to assist clients and secure resources, their lack of traditionally recognized accomplishments, such as degrees, contributes to hierarchical treatment within the health-care team and system. It also means they witness, and often attempt to intervene, when racism, classicism, elitism, and other biases appear that may affect the outcome for their clients. This is an area that is rarely mentioned in the CHW literature,

further elevating the importance of covering it here. There are three distinct subthemes: (1) bearing witness—bullying, condescension, and racism; (2) the issue of the degrees; and (3) issues ignored mean case services denied.

Bearing Witness—Bullying, Condescension, and Racism

- "One time, a lady missed an infant follow-up for post-delivery. She was in so much pain, she didn't realize the appointment [had passed]; she didn't come in, they said, 'Call Child Protective Services [CPS] on her for not going to her appointment.' I asked the patient, 'What do you need to get here?' She said she can't lift herself or barely her baby, and she doesn't have support. The doctor was so bad that interns were scared of her, but I refused to call [CPS] because the woman had a need. She [the doctor] tried to get me fired."
- "It is better now, but I used to be questioned and challenged all the time. They [the social workers] acted like, because I didn't have a degree, I wouldn't be able to do anything, and then would act surprised when I actually could obtain resources they couldn't for the client. It really caused me a lot of stress and made me feel less confident. I had to learn to not be ashamed of where you came from or the experiences you had. Because your past has made you who you are; you are someone's answer."
- "Now that I am in the ER as a CHW, we see the same people coming back. They [providers] get annoyed and ask me, 'What is the issue?' Well, they are often homeless, undocumented, some running from ICE. We are supposed to be working as a team. They [the providers] didn't like it. I had a lot of pushback from providers."

The Issue of Degrees

- "They want us to do something for nothing. I was at a CHW conference before COVID; they were using CHWs in schools. I came back to Baltimore after the conference, then I got a call [from a CHW employer]. They said they loved me but could only pay $15 an hour. They don't love me enough, then, and I had to have a degree."
- "It is really hard to see this as a long-term career path. The pay is low, and there are limited opportunities for growth. They talk about personal development and education, but it isn't affordable with these wages."

Issues Ignored Can Mean Case Services Denied

- "When we are pulled, we are to do it all—be the doctor, the social worker, and the advocate—but there are no notes! Some need help with an application, some need housing—but there is no house, so there are no meds. I had one where the baby had died, but the person kept saying they needed diapers and baby formula for a baby. I said in the office, 'There is a mental health issue out there that needs attention,' but they just pushed it aside."
- "I had a patient we did all these assessments on, and I told my supervisor, 'We need to maintain or even increase the services.' But the supervisor takes it and sends it to an internal

doctor who doesn't know the patient but agrees with them, and the services get cut. Then they send you back to tell the patient, which is not only unfair, it is dangerous. It is upsetting when you find out they had to go back to the hospital, when having a few more services would have been helpful. But I'm not a doctor or a nurse—it feels like my recommendations are dismissed."

The unifying theme here is the biases that the CHWs have witnessed in the provision of care for the populations they serve and their experiences trying to intervene. Intervening can be costly, and CHWs shared the consequences, from being bullied to demeaned, and their lack of postsecondary education used to justify this approach. These experiences not only create barriers for CHWs to feel included as integral members of the health-care team, but also negatively affect client outcomes.

For almost two decades, investigators studying CHWs who are part of a health-care team have recognized this problem, but the conversations among CHWs during the focus groups for this report indicate that health ecosystems have not yet acknowledged or addressed it, as indicated in the two examples below.

"Clinicians and health system leaders may also discount CHWs' expertise and unique patient-centered role, focusing instead on their ability to convince patients to accept medical advice, reduce costly hospitalizations, or complete administrative tasks at a lower cost than when performed by other clinical team members," a 2011 article in the *American Journal of Public Health* noted.[36]

Similarly, Allen and Escoffery amplified this in their 2019 paper in the journal *Preventing Chronic Disease*, "Qualitative interviews with CHWs and with healthcare organizations employing CHWs emphasized the importance of educating clinical care team members on the unique contributions and value of CHWs in improving health outcomes for patients, clearly outlining a defined scope of work, and ensuring that CHWs can continue to stay connected to the community."[37]

Table 2. Summary of CHW Themes and Subthemes, with Illustrative CHW Quotes

Themes	Subthemes	Illustrative Quotes
What CHWs say to each other about the job	Preparatory experiences	"It is so exciting when I can show up and actually help someone, using the gifts God gave me to help someone else."
	The critical role of altruism	
	Many skills, many uses	
	Remember the client perspective	
Limited-resource clients and ballooning caseloads	Under-resourced clients	"I would say at least 60 percent of them have no heat, or water, utilities, refrigerator, the basics."
	High caseloads	
	Burnout and trauma	
Job stresses and coping approaches	Personal safety	"Safety is the one challenge I can say I face every day going into the community. It's always there—we work in tough places, and I don't think less crime will ever happen."
	Wearing many hats	
	Balancing work and boundaries	
	Salary and funding instability	
Being part of the health-care team	Integration into the health-care team	"I don't feel valued at times. We don't have an education, but we have the experience."
	Team hierarchy and challenges	
	Linking the patient to the system	
Opportunities to effect change	Being a voice for the voiceless	"My biggest source of satisfaction is when I'm able to build relationships with patients and other coworkers, cheering on the patient and [being] happy to see the progress they have made."
	Increasing provider awareness of CHW role and abilities	
	Watching growth happen	
The dark side of this work	Bearing witness—bullying, condescension, and racism	"When we are pulled, we are to do it all—be the doctor, the social worker, and the advocate—but there are no notes! Some need help with an application, some need housing—but there is no house, so there are no meds. I had one where the baby had died, but the person kept saying they needed diapers and baby formula for a baby. I said in the office, 'There is a mental health issue out there that needs attention,' but they just pushed it aside."
	The issue of degrees	
	Issues ignored can mean case services denied	

Source: Milken Institute (2025)

Recommendations

As CHWs identified the challenges and opportunities of their profession, their insights, in addition to the published findings from decades of research, provided a framework from which the recommendations in this section evolved. In this section, we present four recommended areas for action/intervention to respond to the needs of CHWs. These recommendations address issues CHWS faced on the health-care team, in their compensation structures, with their caseloads, and in responding to the demands of their work, including the associated health challenges.

Improve Health-Care Team Integration

Despite repeated calls for the full integration of CHWs into the health-care team, more work remains to be done. As recently as 2024, reports of challenges to implementing evidence-based CHW team models included condescension and a lack of respect for CHWs.[38] CHWs in our focus groups also reported condescension, bullying, and racism from members of health-care teams, including social workers, nurses, and even physicians. There is no easy approach to remediate these issues; it will require probing the multiple issues that drive these behaviors, such as protection of turf, lack of understanding of job roles, and racism. Lack of a degree and provider mistrust of

CHWs due to the close bonds they form with patients are contributors.

The CHWs provided suggestions for approaching the issues during the focus groups. To combat the misunderstanding and concerns about their qualifications and roles, they suggest widespread education across health-care teams. This will ensure that team members are familiar with CHW roles and that CHWs will neither replace nor derail the work of existing health-care team members.

"I am comfortable that our CEO has been clear on our roles as CHWs and expectations of the health-care teams," one CHW said. "I think some of the confusion comes from high turnover among the nurses and social workers. By the time they understand our roles and what we do, they move on and then the new workers have no idea what we do, and we have to start all over again."

It is essential for health-care teams to learn not only about the role of the CHW, but also the many skills they possess, and the experiences they bring to the portfolio of work with which they are presented. Their utility extends far beyond addressing problems or challenges that other professionals cannot or won't "fix," such as building trust, as well as providing an important bridge to the health-care team. "CHWs are viewed as the people who will pick up the pieces and fix everything. I sometimes think they believe we have magic wands," said one CHW.

Finally, there must be a team culture of mutual respect. Every member of the health-care team plays a critical role in the healing and recovery of the patient. CHWs are a part of the team that can bring unique perspectives as well as insights into patient needs. "Health-care team members need to remember the importance of the collaboration that we bring to the table, speaking truth to a patient's situation, which can provide better decision-making in the patient's care," said one CHW.

In summary, better health-care team integration is still needed. Approaches can include:

- Education of all health-care team members about the role of CHWs.
- In teams with repeated turnover where information may not be consistently transferred to new members, it will be important to team function and cohesion to repeat the information, perhaps through staff updates.
- Upper management must not only be aware of the roles of CHWs but also reinforce the importance of their roles and model respect for their unique contributions. Supporting health-care team integration by supporting CHW roles also sends a clear message about the importance of CHWs to those on the team, as well as managed by it.
- CHWs should be a part of the health-care team education, including providing examples of how they can work supportively with social workers and nurses. Including them also helps minimize confusion, demystify their contributions, and nurture open dialogue.

Enactors: Health-care team leaders, CEOs, department heads, CHWs

Improve Compensation and Service Reimbursement

The financial insecurity of CHWs surfaced repeatedly throughout the focus groups, regardless of the probes. It was an especially sensitive issue in the Baltimore discussions, where grant cuts had significantly affected that CHW community. One of the participants was let go over Zoom; another was released and unable to find new employment. Feelings ran high about their unique position because of the sources of their salary support. Consider the following comments:

- "Most positions are grant-funded; we need a reimbursement code."
- "I was fired over Zoom. We were federally funded."
- "Why can't we have our own billing code? Why can't the hospital create a position for us that they fund? Instead, it sounds like they want our services but only if someone else pays for it."

The well-established net economic value to society of CHWs is larger than the already impressive financial ROI due to cost savings. CHWs also improve patient health outcomes, as has been demonstrated through a randomized controlled trial.[39] The total social benefits of CHWs have easily outweighed their costs in the use cases that have been experimentally studied.

However, CHWs run into a problem in their funding mechanism that is common among preventive services. The benefits of CHWs do not always accrue to the parties that are responsible for bearing their cost. Alternatively, even when the benefiting party is responsible for the cost, the associated benefits may not be immediately apparent. This creates a situation where CHWs generate large social benefits (which include a cost savings windfall), but those benefits are not felt by the party responsible for paying for CHWs, leading to a lack of incentive to pay for them.

Consider this simple case, where CHWs are used by a party that both pays for them and gets the benefit of cost savings, but the savings are not salient to the payer. This would be a situation where CHWs are paid for by an insurer, such as a state Medicaid program or a private plan. In this case, the plan pays for CHWs who provide services to plan beneficiaries who, in turn, have fewer and less expensive inpatient stays.

Unfortunately, in this case, the cost savings are unlikely to be attributed to the CHWs. Though the linkage between CHWs and cost savings has been established in trials, it does not appear on a payer's balance sheet. The payer can see the expense of paying for the CHWs, but, unless they are running internal analytics where CHW-assisted patients are compared to an appropriate control group, there will be no direct evidence linking their spending on CHWs to reduced expenditures.

This misalignment is exacerbated in situations where the party paying for CHWs is not the party that realizes the cost-saving benefit. For example, where the CHWs are paid for by a hospital as part of hospital-level wraparound services, they show up on the hospital balance sheet as an expenditure, and the cost savings accrue to the insurers that are paying for patient care.

What Are the Possible Solutions?

- One solution is based on better data analytics. Appropriately tracking which patients receive CHW services and comparing them to similar patients who did not receive services will provide a reasonable estimate of the financial savings due to CHWs. This can be done via propensity score matching or "digital twin" methods using internal insurer or hospital data.
- When the employer of the CHWs is the same party that pays for patient care, this information generation is sufficient. The analytics will either reveal that CHWs are sufficiently responsible for cost savings to offset their costs (as experimental evidence suggests they will) and the payer will self-fund them as they are a net money-maker, or they will reveal that CHWs are net unprofitable and will need to find a secondary funding source to make up the difference. In this latter case, grant funding—the current common funding model for CHWs—could be applied and would only need to make up the difference in profitability as opposed to paying for the entire program.
- When the employer of the CHWs is a different party from the one that pays for patient care, the information generation would need to be paired with negotiation. The CHW employer could approach the payer with clear evidence of the value generated by the CHW service and request direct payment for CHW services. As long as there is a cost savings generated (which is suggested by experimental evidence), then the negotiations should be reduced to deciding how to appropriately split the cost savings between the two parties.

Enactors: Third-party payers, hospital systems, private insurers

Adjust the Caseload

Caseloads and client needs were frequently cited as concerns during the focus groups. Most of the referrals to CHWs have extensive medical and resource needs, the majority of which cannot be resolved quickly or easily. As a result, the caseload feels overwhelming, especially as demand for services continues to grow without additional staffing. This can lead to several issues, including compassion fatigue, burnout, and ultimately triggering health issues, including insomnia, anxiety, and depression. CHWs in the discussion groups noted the following:

- "Our caseload is heavily dealing with chronic diseases, like diabetes, hypertension, and obesity. Some of it is to help people stay at home independently."
- "About 60 percent of the time, we encounter no water, electricity, or basic services."
- "Those behind the computers don't realize what we see and the [kind of] homes we go in—but they tell me, we need you to do 100 more. That's just not possible."
- "I've been doing this for four years and I have never had a case load below 80."

Health-care professionals with high rates of exposure to trauma/challenging environments have been shown to have higher rates of CF and burnout. This is also associated with job dissatisfaction.[40] More recently, surveys administered to community health center frontline

personnel, including CHWs, demonstrated that as many as ***one in five*** clinical staff had at least one symptom of burnout. Workload was among the top three predictors of burnout.[41] Exceptionally high caseloads have several effects, including preventing work in other aspects of the job that may be fulfilling, as well as increasing use of personal time to meet the work demand, both of which have been associated with accelerating burnout and care disengagement.[42]

Adjusting caseloads will be challenging due to increased demands upon the health-care system, ongoing loss of health benefits (including Medicaid) for the more vulnerable, and the ever-present effects of health disparities. However, adjusting caseloads, especially in the context of organizational approaches to CHWs, may be the most effective when the work re-evaluation is done within the context of the team, as opposed to CHWs in isolation.

Some data suggest that focusing on three areas may yield better results: (1) development of a work culture that prioritizes person-centered care over productivity and other performance metrics, (2) provision of management skills and practices to overcome bureaucracy, and (3) offering opportunities for employee professional development and self-care.[43]

While the CHWs within the focus groups reiterated the need to be available for clients because of their extensive needs, it should be noted that individuals who create boundaries between their work and nonwork domains tend to experience less work–family and family–work conflicts, a cause of burnout.[44] Job crafting strategies, such as re-crafting the job to alter the characteristics such that it becomes less hindering and more motivating, have also been shown to be helpful; however, this requires organizational support and buy-in.[45] These are deeply entrenched issues that will not be fixed rapidly.

In summary, while this will be a more challenging intervention to enact, possible solutions include:

- Adjusting caseloads through rotating schedules of "off time" that can be incorporated into the larger scheduling protocol without disrupting work planning.
- Providing time management, skill building, and even smartphone caseload and time management strategies to better achieve work–life balance.
- Offering more opportunities for professional development and increased workshop/skill-building opportunities for CHWs to learn and enact self-care protocols.

Enactors: Health-care system administrators, hospital administrators, CBOs, and CHWs

Provide Mental Health and Work Support

There must be, in general, greater alignment between CHWs and their supervisors to understand the settings where they provide services. Workload adjustment is not the only answer to the trauma these workers face daily. In addition to recognition, there must be some allowance for significant mental health support, which can take many forms, from "do you" days to time off on a

regular rotation so it does not hamper scheduling.

Hospital and health-care systems must consider inserting "on demand" and readily available mental health and counseling services that extend beyond traditional employee assistance programs (EAPs). As one CHW told us: "There's secondary trauma too that has to be dealt with. You find out that people die. I mean, you see a patient on Friday, and you log in on Monday, and the record is gone, and you find out they died. It can and does deeply affect you. They do have EAP—like eight sessions—but you get people sometimes for a long time, and then they die. It is very wearing."

This may be an area where there is also room for robotic support, very similar to what has been implemented for seniors and proven successful in Denver, Colorado. A tabletop robot named Ryan teaches a yoga class, reminds seniors about medications, provides jokes, and is a 'listening ear.'"[46] Another socially assistive robot created at the University of Southern California served as a companion, getting seniors to move or even dance with it. This was so successful that many seniors expressed sadness when the robot was removed.[47]

CHWs are reluctant to bring the trauma of the field home to their families, and such a robot could provide a Health Insurance Portability and Accountability Act (HIPAA)-compliant option to release some of the trauma and stress. As these are programmable, they can also be "taught" to suggest mental health support when the CHW expresses specific phrases or feelings. Given the upward pressure on mental health services, this is an additional way to decompress CHWs, with built-in flags that could alert the CHW and their teams that more intensive support is needed. The reflections we heard from CHWs confirm that additional intervention is needed, and it must be culturally and contextually responsive. Among their observations:

- "I watch YouTube videos. Helps me to take my mind off of 'what did you do' and you know that you did the best you can. I came in with a purpose, and that I care."
- "Trauma is a huge part of what we do, and it is hard because you have to go out and help someone, but in the process, you may be re-traumatized."
- "You go to see a patient, and then as they start talking, you realize, 'Oh, there's a problem here,' and you have to tell them, 'I'm going to find someone who can help you,' but you realize you can't be the one to do it. It's triggering you all over again." Addressing mental health and work support needs will be challenging and require creative and innovative approaches.

Recommendations to respond to these needs include:

- Providing a specific number of days off after an accumulation of time in the field. For example, for every 180 days in the field, there are team-mandated three sequential days away from work to allow for decompression.
- Add "on demand" mental health services to allow rapid, "drop in" access for CHWs who have been exposed to significantly traumatic events, such as CHWs in ERs with high rates of gun violence.
- Exploration of extending robotic services such as those provided to seniors to allow CHWs to decompress without risk of HIPAA violations. Such interventions would require programming to identify red flags to alert the team of a critical need for immediate intervention.

Enactors: Health-care systems, health-care team leaders, CHW employers, and CHW managers

Conclusion

This report has presented robust data, establishing that CHWs, who have been on the US health-care scene for over 70 years, possess a unique set of skills that make them critical members of the health-care team. Whether building community bridges to expand health-care access or increasing trust in communities harmed by decades of health-care system neglect, discrimination, unequal access, or institutional racism, there is a clear need for these unique community messengers. They provide a significant ROI, yet their caseloads are escalating while their compensation remains tenuous.

The current need for CHW services is overwhelming and will only increase as budget cuts to federal assistance programs such as Medicaid take effect. Those covered, as well as those who have lost coverage, will continue to present for care with extensive resource needs requiring CHW intervention.

The system, in its current configuration, is an ever-present and all-consuming machine that slowly and excruciatingly wears down CHWs, their clients, and even the administrative staff who oversee the process. Given the well-documented ROI that CHWs provide, there must be a significant change in the reimbursement structure such that these returns can be used to reimburse services as well as to improve compensation. The caseloads also must be adjusted, and models for shifting

caseloads or sharing caseloads in low- and middle-income countries should be examined for generalizability to the US.[48] Finally, as none of these interventions will provide immediate changes or relief, there must be additional mental health and work support services for CHWs.

Trauma and its sequelae were frequently repeated concerns, and these must be addressed. Heavy caseloads, trauma, burnout, and compassion fatigue are among the most often cited challenges they face in the field, as well as barriers to job satisfaction.

There are abundant data on the effectiveness of CHWs and the improved outcomes they bring. Yet the following was a frequent comment in the groups: "Some days I feel like I just can't take it anymore. It is the clients who give you the energy; they give you your flowers, if you will. But every day is a new day to face time pressures, resources, and housing limitations, and the never-ending pressure to do more with less. I don't know how much longer I can do this." We simply must do better.

Endnotes

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