

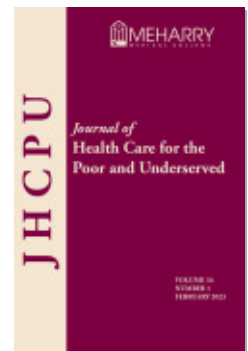


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Integrating Community Health Workers into Hospital Systems  
Through a Social Work Partnership: A Report from the Field

Talar W Markossian, Kelly McCabe, Jacob Ginn, Yesenia Galvan, Melinda Banks, Stacy Ignoffo



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# Integrating Community Health Workers into Hospital Systems Through a Social Work Partnership: A Report from the Field

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*Summary:* While studies support the effectiveness of community health worker (CHW) services, best approaches for CHW integration in health systems are not well understood. We describe early outcomes from a partnership between a safety-net hospital systems' social work department and CHWs to address adverse social determinants of health of high-risk patients.

*Key words:* Community health worker, social determinants of health, social worker, health systems integration.

## Overview

Community health workers (CHWs) are frontline public health professionals who are well positioned to address some of the U.S.'s extensive and growing health inequities<sup>1</sup> through a focus on social determinants of health (SDoH) and marginalized populations.<sup>2</sup> Community health workers come from or have a close understanding of the communities they serve.<sup>3</sup> Their shared experiences with patients and firsthand knowledge of patients' neighborhoods and cultures often differentiate them from other providers who care for patients with complex needs, including many social workers (SWs) and nurse case managers.<sup>4</sup> Community health workers are increasingly recognized as valuable members of the health care workforce and agents to help reduce inequities.<sup>5,6</sup>

The objective of this report from the field is to describe the development and evolution of a methodically structured partnership between SWs and CHWs to address adverse SDoH affecting patients who visit the emergency department (ED) or are admitted to

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hospital in-patient units in an urban safety-net hospital system. Our approach toward deploying CHWs as partners with SWs—to serve as connectors between health, social, and community systems—provides an innovative framework for integrating CHWs in health systems, an approach that could be replicated in other health systems to address unmet social needs among patients and improve outcomes.

**Community health worker outcomes.** Community health worker approaches have been studied and recommended in many areas including pediatric<sup>7-11</sup> and adult asthma management,<sup>7,12</sup> breast cancer screening<sup>13,14</sup> and navigation,<sup>13,15</sup> colorectal<sup>16</sup> and cervical<sup>17</sup> cancer screenings, cardiovascular disease prevention,<sup>18</sup> and diabetes prevention<sup>19</sup> and management.<sup>20-24</sup> Community health worker interventions have also been associated with improvement in perceived quality of primary care and reduction in 30-day readmissions.<sup>25,26</sup> Studies demonstrate that using CHWs can provide cost-savings and return on investment;<sup>27-31</sup> for example, Sinai Urban Health Institute's CHW-led, home-based asthma management programs have demonstrated substantial cost savings, ranging from \$2.33 to \$7.79 per dollar spent.<sup>7-9,32</sup> While these studies support the effectiveness of CHW services, the key components of a successful CHW program are not well understood.

**Community health workers in the new health care landscape.** Recent changes in the payment and delivery landscape driven by the Affordable Care Act<sup>33</sup> and payers including Medicaid,<sup>34</sup> which incentivize providers to focus on SDoH,<sup>35</sup> have expanded opportunities for CHW integration within health systems. However, the mechanisms by which CHWs are integrated into health systems and the health care workforce have not yet been adequately addressed in the literature.<sup>2,36</sup> This lack of understanding of CHW integration at the health system level impedes CHWs' effectiveness in improving the health of individuals and communities.

**Community health worker roles in a health system.** According to the National Community Health Advisor Study,<sup>37</sup> the seven core roles of CHWs are: “1) Providing cultural mediation between communities and health and human services; 2) Providing informal counseling and social support; 3) Providing culturally appropriate health education; 4) Advocating for individual and community needs; 5) Assuring people obtain necessary health and social services; 6) Building individual and community capacity; and 7) Providing direct services.”<sup>[p. 6]</sup> Research is limited about the roles of CHWs integrated within health systems and the relationship between CHWs and other providers. There is also lack of consensus about CHW competencies within health systems.<sup>38</sup>

Five key barriers have been identified that impede the likelihood of success of CHW programs.<sup>39</sup> These are insufficient health systems integration, disease-centric interventions, lack of clear work protocols, high-turnover and variable performance of CHWs, and methodological limitations of studies evaluating CHW programs that may be changing over the most recent year.<sup>39</sup> According to key informant interviews, an important CHW competency includes the ability to function as a member of a health care team while maintaining a distinct care philosophy. This care philosophy includes serving as the link between hospitals and communities, advocating for patients, demonstrating empathy to providers, representing the community when interacting with providers, and representing providers when interacting with the community.<sup>38</sup>

Four types of CHW health system integration have been identified,<sup>38</sup> which are

**Box 1.**

**TYPES OF COMMUNITY HEALTH WORKER (CHW) HEALTH SYSTEM INTEGRATION<sup>a</sup>**

Type	Characteristics
Direct hires	CHWs are integrated into the health care team. Health systems hire and train their own CHWs.
Community partners	An external entity that has a formal partnership with the health system employs CHWs. In this model, CHWs do not necessarily function as a member of the health care team.
Informational resource	CHWs serve as an external information-sharing resource to educate providers (without formal partnership or communication channels between the CHWs and providers).
Independent	CHWs accept referrals and have no other roles.

*Note*

<sup>a</sup>Adapted from Malcarney MB, Pittman P, Quigley L et al. 2017<sup>38</sup>

described in Box 1. Regardless of the approach, key factors contributing to the successful integration of CHWs included frequent and unrestrained communication between CHWs and providers about patient care, sharing expertise between CHWs and providers, and CHW autonomy.<sup>38</sup>

**Relationship between social workers and community health workers.** Although SW and CHWs share a focus on striving for social justice and often work in similar settings,<sup>40</sup> CHWs are noticeably absent from the social work literature.<sup>40</sup> In Box 2, we compare the role of SW and CHWs in health care systems, based on information extracted from the literature. While the effectiveness of CHWs in changing patients' behaviors and contributing to improved health outcomes is not well understood,<sup>41,42</sup> studies suggest that CHWs are superior to providers at serving as "someone who cares,"<sup>43,44</sup> and this may play a pivotal role. There is emerging evidence that a partnership between SW and CHWs may be beneficial for meeting the needs of under-resourced communities.<sup>40</sup> This partnership can create a process through which individuals and communities can achieve self-determination.<sup>45</sup>

**Sinai Urban Health Institute's (SUHI) community health worker and social work partnership program.**

For over 20 years, SUHI has developed and tested health interventions using the CHW model.<sup>46</sup> Here we describe a partnership between SUHI CHWs and SWs within two Sinai Chicago (Sinai) hospitals — Mount Sinai and Holy Cross. Sinai serves approximately 1.5 million community members living in Chicago's West and Southwest Sides and is

## Box 2. CHARACTERISTICS OF SOCIAL WORKERS AND COMMUNITY HEALTH WORKERS IN HEALTH CARE<sup>a</sup>

Characteristics	Social Worker	Community Health Worker (CHW)
Credentials and training	Baccalaureate or master's degree in social work from an accredited school or program. Typically licensed or certified in the practitioner's jurisdiction. <sup>48</sup>	Ranges from on-the-job training to established training programs through community-based providers and formal community college-based programs.
Funding	Mostly employed by the organization.	Some states offer training and certification. <sup>49</sup> Typically funded by time-limited categorical grants and contracts. <sup>50-52</sup>
Common principles of the disciplines	Social justice. Client and community empowerment. Cultural competence. Advocacy for individuals and communities. Promotion of self-determination. <sup>40</sup>	Work either for pay (sometimes part-time) or as volunteers. <sup>53</sup>
Characteristic principles of the discipline	Biopsychosocial and spiritual perspectives in working with clients. Person-in-environment framework, which entails understanding clients' experiences within the contexts of physical and social environments. Focus on clients' strength and resilience. Promote the value of social work research. <sup>48</sup>	Sharing social identity (such as race, ethnicity, and/or socioeconomic status) and cultural values with community members. Trusted member of the community served. <sup>2</sup> Shows the patient 'someone who cares.' <sup>43,44</sup> Cultural humility. <sup>54</sup>

*Note*

<sup>a</sup>Based on information reviewed from the literature.

**Box 3.**

**PERSPECTIVES FOR COMMUNITY HEALTH WORKER SERVICES CONTRIBUTIONS TO THE HEALTH SYSTEM AND PATIENTS**

Contribution	Perspective	Direct Quotes
To the health system	System Director of Case Management, from the Department of Social Services	<p>“The Community Health Workers have been a tremendous asset to the inpatient and emergency department social workers. It has been a comfort to know when a patient is going home that there will be a caring, compassionate, and well-versed individual that can assist with navigating the health and social needs for our patients.”</p>
To patients	Community health worker	<p>“I called a patient the other day, he said he was feeling ill and in pain. He sounded like he was in a lot of pain—so much pain that he was crying. It scared me a little bit! I told him he needed to call 911 if he was in this much pain. So, he did, and then he called me back while the ambulance was coming to get him. I called him a couple days later, and I found out he had had a stroke as we were talking! He didn’t even know it at the time. They did a procedure on his back, and he sounded upset. I let him talk a bit, to vent, and I provided emotional support. He says he will call me when he’s back home. I’ll follow up again with him next week.”</p> <p>“I’m working with this older lady who was just diagnosed with diabetes. She needed help with everything. She knew how to check her blood sugar, but she didn’t know how to get a device. She didn’t know what she should be eating, and she needed to know much more to be able to control her disease. She was experiencing early vision loss. So, I connected her with the Center for Diabetes and Endocrinology, and she talked with a staff member there. She’s not mobile, so we were trying to figure out how to get her there. I’m planning on connecting her with transportation resources. She was eager to go and very happy.”</p> <p>“I have a patient who doesn’t really have any unmet social needs anymore. Last week, when I called, I told her that this would be the last call I’ll be making. She was like, ‘Why?! No!! It’s so nice to talk to you every week.’ So, I told her, ‘You have my number—if you have needs that come up, you can give me a call.’ Many patients really appreciate the emotional support we offer them, but after a certain point we need to help them be independent, and I have to move on to other patients.”</p>


the largest privately-owned safety-net hospital system in Illinois. Sinai's communities have been historically marginalized and under-resourced. These communities face significant socioeconomic challenges as well as health inequities relative to Chicago's remaining communities. Sinai's predominantly Black and Latinx patient base is also overwhelmingly uninsured or underinsured.<sup>47</sup> Sinai Urban Health Institute's CHWs are hired from Sinai's communities through outreach events specifically aimed at community members and referrals from other experienced CHWs and community-based partners. They are trained in CHW core skills and paired with experienced CHWs for additional experiential learning before working independently.

In 2018, SUHI developed a program to address unmet social needs of victims of non-fatal gun violence. SUHI's CHWs approached patients at Mount Sinai Hospital's ED. After the initial implementation phases, we learned that placing CHWs in ED trauma situations created a host of challenges and was not conducive to successful SDoH screening. The challenges in this initial program, however, sparked a partnership with Sinai SWs to improve care for patients with complex needs. As a result, CHWs started visiting hospitalized patients with Sinai SWs, which led to the development of a referral process from SWs to CHWs for high-risk patients in the ED and on the inpatient units of both Sinai hospitals, Mount Sinai and Holy Cross hospitals. Additionally, as the COVID-19 pandemic erupted during the span of this program, referrals began to become virtual, and SWs began referring patients discharged with COVID-19 to CHWs.

Currently, as part of the discharge planning process, Sinai SWs assess patients for their risk of hospital readmission by administering an assessment tool called the *Case Management Department Readmission Screening Tool* (Figure 1) that assesses the need for Community Case Management (CCM). Social workers assess all patients discharged from the ED and inpatient units of both Sinai hospitals with this tool, and those determined to be high- or medium-risk for readmission are then referred to SUHI's CHW program. SUHI's CHWs then contact the patients to administer the SDoH questionnaire (Figure 2) and refer patients to Sinai's in-house services or community resources for any identified needs. Figure 3 describes the referral process.

Community health workers explain discharge instructions to patients; make sure patients understand their responsibilities; provide emotional and instrumental support; reach out to providers to clarify discharge instructions or ask questions on behalf of the patients; make appointments; and participate in appointments between providers and patients as needed. In Box 3, we describe examples of CHW services as described by a health system leader and CHWs.

The integration of CHWs into Sinai's system embodies elements from both the community partner model (initially) and in its current practice, resembles most the direct service model (described in Box 1).<sup>38</sup> Our CHWs are employed by SUHI (a component of the system) and receive referrals from Sinai SWs. In our partnership, CHWs are truly integrated into patient care and function as a member of the health care team. We have established mechanisms to ensure frequent bidirectional flow of information among our CHWs, SWs, and providers. Community health workers document their findings in Midas Case Management Platform which is embedded in the electronic health record (EHR) and accessible to SW and providers. In the initial phases of the



**SINAI**  
Sinai Health System  
Hospital to Home

Community Care Management Program

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Admission Date: \_\_\_\_\_  
Discharge Date: \_\_\_\_\_

Consent: Patient has given verbal consent for Care Management on: \_\_\_\_\_  
Community Primary Care Provider: \_\_\_\_\_  
Date of Last Visit: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Reason for admission: \_\_\_\_\_

Needs help with appointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transportation Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty paying for medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self-health rating of fair or poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospitalizations for CHF, CAD, Asthma, COPD, DM substance abuse*		
2 or more hospitalizations in the last 12 months*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3 or more ED visits in the last 6 months**	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feeling down, depressed, hopeless in the last 2 weeks and not in active treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol or drug use and feeling they should cut down and not in active treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Alcohol status		
• Drug use status		
Smokes cigarettes or cigars and refuses Smoking Cessation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Tobacco status		
Homeless/shelter		
• Current residential status		
Does not feel safe at home*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Needs help with food, clothing, housing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnant, no prenatal care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other		

High intensity = \* or 6 or more factors  
Medium intensity = \*\* or 4-5 factors  
Low intensity – 1-3 factors

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Figure 1. Case management department readmission screening tool to assess the need for community case management.

## Social Determinants of Health Questionnaire

I'm going to ask you some personal questions about yourself and your life. We will use the information to connect you to services if you're interested. You do not have to answer any questions that you don't want to. NOTE: The Social Determinants of Health Questionnaire is administered to identify patient needs. While we will try to assist you in fulfilling those needs, we cannot guarantee that we will provide any resources, referrals, or other services.

**Primary Care**

Do you have a doctor (primary care physician) that you see regularly?

Yes     No     Don't know     Refused

**Insurance**

Do you have health insurance or a medical card?

Yes     No     Don't know     Refused

**Housing**

Do you currently have a place to stay/live?

Yes     No     Don't know     Refused

In the next two months, will you have a place to stay/live?

Yes     No     Don't know     Refused

**Food**

In the last 12 months, have you worried that your food will run out before you have money to buy more?

Yes     No     Don't know     Refused

In the last 2 months, have you run out of food that you bought and didn't have money to get more?

Yes     No     Don't know     Refused

In the last 12 months, have you not been able to afford to eat balanced meals?

Yes (I have not been able to afford balanced meals)  
 No (I have been able to afford balanced meals)  
 Don't know  
 Refused

In the last 12 months, have you cut the size of your meals or skipped meals because there wasn't enough money for food?

Yes     No     Don't know     Refused

In the last 12 months, have you not eaten for a whole day because there wasn't enough money for food?

Yes (I have not eaten for a whole day because of money issues)  
 No (I have eaten every day)

1

Figure 2. Social determinants of health (SDoH) questionnaire screening tool used to identify social needs in patients.

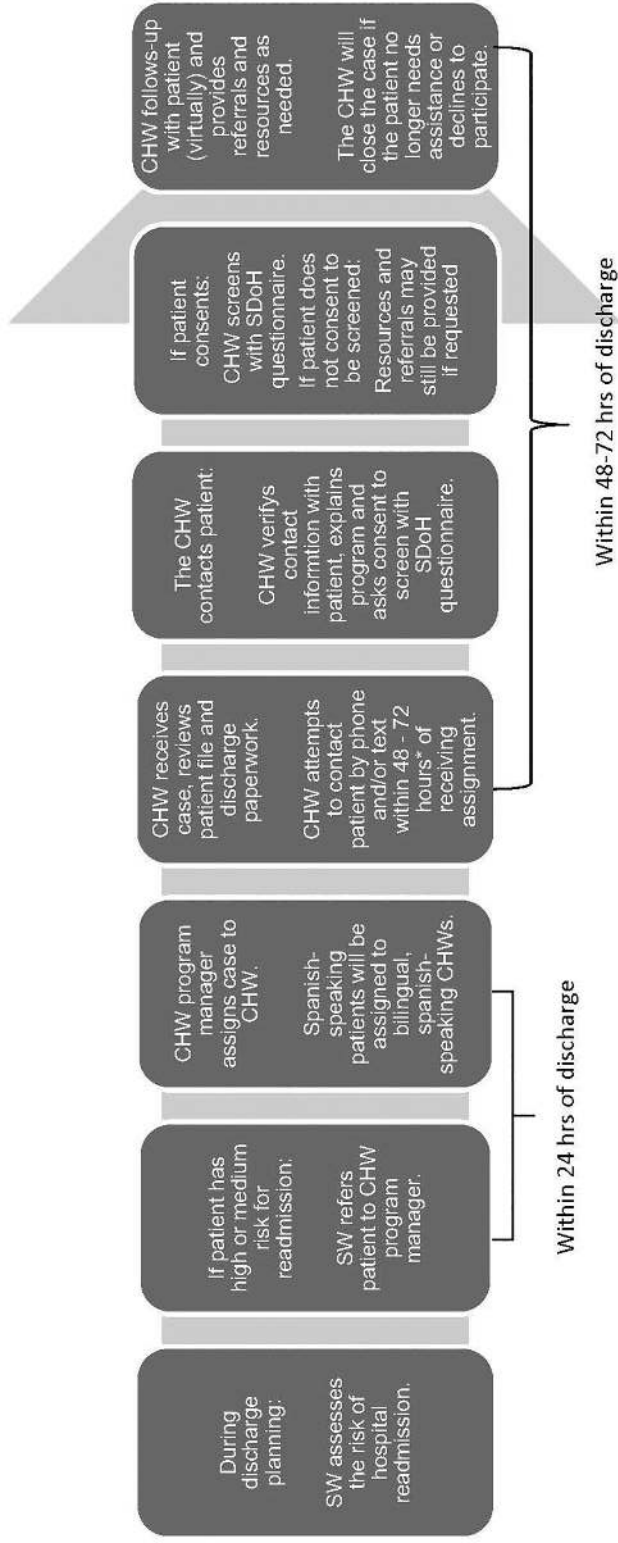


Figure 3. Program process workflow and referral timeline.<sup>8</sup>

Notes:

<sup>a</sup>The CHW will call and/or text the patient twice weekly until contact is made. If the patient does not answer the phone, CHWs will leave a voice message as well as a text message, making sure to include the CHW's name and contact information. If the patient still has not responded after calling and texting twice weekly for two weeks, CHWs can stop reaching out and consider the case closed.

SW=Social Worker;

CHW= Community Health Worker

SDoH= Social Determinants of Health

program, there were some challenges stemming from a lack of understanding among the clinical team about the CHW role and how they can best be used to improve clinical workflow and address patient needs. Therefore, in the program development phase, CHWs attended monthly meetings with providers and shared their expertise about adverse SDoH affecting Sinai's patients and available services. The program manager continues to meet bi-weekly with SW lead and department directors to check in and discuss possible programmatic modifications. Each month, the program manager generates a report card including the number of referrals made by each SW and characteristics of the referrals and outcomes, and shares the report card with the SW lead.

**Program evaluation process and outcomes.** Sinai EHR and program records, managed in a REDCap database, are currently used to evaluate the effectiveness of the partnership. This includes data on patients' demographics; hospitalization and ED visit history; self-rated health; mood; substance and tobacco use; transportation issues; housing status; personal safety concerns; and ability to obtain medical care, food, and clothing (see Tables 1 and 2). Community health workers also record community resources referrals and type and length of patient conversations. We also collect qualitative data on CHW patient highlights, program challenges, and expansion efforts within and outside of our health system (Box 3).

In Table 1, we present the characteristics of visits from July 1, 2020, to June 30, 2021, corresponding with the most recent version of the program described in Figure 3. Table 2 describes early outcomes of patients screened by CHWs for social risk factors from July 1, 2020, through June 30, 2021. We calculate program reach (percentage of patients screened out of those referred by SW) and program fidelity (percentage of patients provided resources out of patients with a need). A large majority (66%) of screened patients had at least one or more identified needs. The most common needs (calculated from a percentage of patients with any needs) were food insecurity (26%), need for behavioral health and emotional support (23%), and housing insecurity (15%), among other needs. One of our more promising metrics is in preliminary 30-day patient readmission rates, with screened patients showing a 35% lower risk of readmission compared with non-screened patients.

**Future evaluation and direction.** Our program demonstrates much promise, especially in reducing unnecessary hospital readmissions. We anticipate adding to our program in the following areas:

*Effectiveness and cost-effectiveness.* We plan to compare same hospital 30-day readmissions for screened patients compared with non-screened patients and patients who were not referred to our program, controlling for patients' sociodemographic and clinical characteristics. We will also calculate cost of CHWs' times and total program costs per patient screened and per patient connected to services.

*Patient satisfaction.* We are planning an expansion of this program with the target goal of improving patient satisfaction and experience.

*Highest-risk patients.* We plan to better characterize and address the needs of a high-risk patient population with multiple readmissions, so that we can offer a more focused and intensive intervention specifically designed to meet the needs of this subset of individuals.

*Prevention and predictive modeling.* While our current CHW intervention is methodi-

**Table 1.**

**CHARACTERISTICS OF UNIQUE PATIENTS AND REFERRALS BY SOCIAL WORKERS (SW) AND SCREENED BY COMMUNITY HEALTH WORKERS (CHW) FOR UNMET SOCIAL NEEDS FROM JULY 1, 2020, THROUGH JUNE 30, 2021 (N=1,023)**

Characteristics <sup>a</sup>	Referred by SW	Screened by CHW
Total referrals (non-unique)	1023	534
Referral reason		
High or medium risk of ED readmission	892 (87%)	453 (85%)
Patient discharged after COVID-19 diagnosis	114 (11%)	76 (14%)
Missing	17 (2%)	5 (1%)
Unique patients	877	484
Race and ethnicity		
Non-Hispanic Black	583 (66%)	322 (66%)
Non-Hispanic White	34 (4%)	18 (4%)
Non-Hispanic other <sup>b</sup>	20 (3%)	9 (2%)
Hispanic of all races	175 (20%)	119 (25%)
Missing	65 (7%)	16 (3%)
Gender		
Female	394 (45%)	235 (49%)
Male	445 (51%)	238 (49%)
Other	1 (0%)	1 (0%)
Missing	37 (4%)	10 (2%)
Age		
Ages <=18	0 (0%)	0 (0%)
Ages 19–33	66 (8%)	27 (6%)
Ages 34–48	120 (14%)	68 (14%)
Ages 49–64	314 (36%)	177 (37%)
Ages 65–78	218 (25%)	137 (28%)
Ages >=79	84 (10%)	47 (10%)
Missing	75 (9%)	28 (6%)

*Notes*

<sup>a</sup>Patient insurance was collected after the reporting period, about 10% of patients screened by CHWs were uninsured 47% had Medicaid or other public insurance, 38% had Medicare or private insurance, and the remaining 5% were missing.

<sup>b</sup>Non-Hispanic other category includes American Indian & Alaska Native, Native Hawaiian and Other Pacific Islanders, and Asian.

ED = Emergency Department; SW = Social Work; CHW = Community Health Worker

cally structured, SDoH data collected by our program is not integrated into the Sinai’s EHR. As a result, a systematic approach of early identification of high-risk patients for future admissions is not possible. Through an emerging academic partnership, we plan to use data analytics and predictive modeling to identify high-risk patients for hospital admissions and administer interventions with a focus on prevention.

**Table 2.****SOCIAL DETERMINANTS OF HEALTH (SDOH) REFERRALS, SCREENINGS, & OUTCOMES FROM JULY 1, 2020, TO JUNE 30, 2021**

	Referrals N (%)	Unique patients N(%)
Referrals from social work <sup>a</sup>	1023	
Unique patients referred from social work <sup>b</sup>		877
Referrals screened by CHWs of total referrals <sup>c</sup>	534 (52%)	
Unique patients screened by CHWs of unique patients referred		484 (56%)
Positive screenings from referrals screened by CHWs with any identified needs	342 (64%)	
Unique patients screened by CHWs with any identified needs		321 (66%)
Type of need identified of positive screenings by CHWs (n=342)		
Food insecurity	88 (26%)	
Behavioral health and emotional support needs	79 (23%)	
Housing insecurity	53 (15%)	
Lacking primary care provider	46 (13%)	
Follow up assistance needs	40 (12%)	
Lacking health insurance	38 (11%)	
Unemployed <sup>d</sup>	209	
Unemployed & seeking work	37 (11%)	
Unemployed & not seeking work <sup>d</sup>	172	
Utility difficulties	31 (9%)	
Transportation challenges	27 (8%)	
Prescription support needs	20 (6%)	
Bill assistance needs	18 (5%)	
Diabetes care needs	17 (5%)	
COVID-19 needs	16 (5%)	
Substance use needs	15 (4%)	
Other needs	90 (26%)	
Referrals connected to services of positive screenings by CHWs (n=342)	267 (78%)	
Unique patients connected to services		254 (79%)
Average number of resources provided per referral connected to services	1.57	—
30-day readmission rate for all referrals from social work (n=1023)	35%	
30-day readmission rate among referrals not screened by CHWs (n=489)	43%	
30-day readmission rate among referrals screened by CHWs (n=534)	28%	

*Notes*

<sup>a</sup>All referrals are of Sinai Chicago patients who have either been pre-screened to be at a high/medium risk for readmission or are discharged after a COVID-19 diagnosis; referrals count the same patient multiple times if they are referred to the program again.

<sup>b</sup>Unique patients only include patients who have not previously been referred to the program in the given period—i.e., return patients are not counted twice. For example, there were 1023 referrals from July '20 through June '21, but only 877 unique patients because 146 of the referrals were of return patient.

<sup>c</sup>Of the total referrals not screened (n=489), 293 were not accessible, 85 declined screening, 18 were in a nursing home, 20 listed a wrong number, and 73 were not screened for other reasons.

<sup>d</sup>Only being asked since November '20; does not qualify as a need.

## Conclusions

We describe the collaborative development of a partnership between SW and CHW programs to address SDoH that affect patients who visit the ED, are admitted to the hospital, and/or are discharged with a COVID-19 diagnosis. As we continue to refine this program, we will standardize the process and more rigorously assess the value of the partnership between CHWs and SWs within the health system to improve patient outcomes. Thus far, readmission outcomes show great promise and are a focus area as Sinai expands the integration of its CHW programs. We believe our program to be scalable and to have the potential for replication in different hospital settings, further illustrating how hospital systems can use CHWs to improve patient outcomes.

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