Community Health Workers (CHWs) are frontline public health workers who serve as liaisons between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care, according to the US Centers for Disease Control and Prevention. By sharing the same community, or personal, cultural, linguistic, and other characteristics—sometimes including a medical condition—with those they serve, CHWs work to facilitate access to services and to improve the quality and cultural competence of service delivery.

There are currently more than 50,000 Community Health Workers in the United States, according to the Bureau of Labor Statistics.

PCORI Answers Critical Questions

Much remains unknown about the specific roles of CHWs in promoting access to care and garnering better health outcomes. PCORI funds studies that seek to help patients, clinicians, and others answer questions they might have about CHWs, such as:

**DOCTOR**
My clinic serves an area with a large Asian-American population. Is there any research that shows how to effectively deploy CHWs in this population to improve outcomes?

**HOSPITAL ADMINISTRATOR**
How can CHWs help to improve care delivery and health outcomes for cancer patients?

Comparing Care Coordination Models to Help Underserved Populations Avoid Hospitalization

Health interventions that seek to meaningfully reduce disparities should consider patients' medical and social needs. This study will fill important gaps in evidence concerning the effects of three diverse care coordination models on hospitalization rates for a socioeconomically disadvantaged population at increased risk of hospitalization. The first model is a commonly implemented care coordination model in which high-risk patients have access to nurse care coordinators who seek to manage these patients' care across the continuum. The second model, the Comprehensive Care Physician (CCP) program, offers high-risk patients integrated care from the same physician in the inpatient and outpatient settings so that they can benefit from the advantages of continuity in the doctor-patient relationship. The third model builds on the CCP by adding systematic screening of unmet social needs, access to a community health worker, and access to a community-based arts and culture programming. More information about this project can be seen at [www.pcori.org/Meltzer306](http://www.pcori.org/Meltzer306).

Enhancing Care Transitions Intervention with Peer Support to Reduce Disparities

Unplanned hospital readmissions are extremely costly to patients and the healthcare system. Hospital readmissions are particularly common in older adults. Further, racial and ethnic minority older adults continue to suffer disproportionately high readmission rates. This study seeks to understand whether peer support will increase the effectiveness of a well-known nonclinical coaching strategy called Care Transitions Intervention (CTI) in African-American and Latin/Hispanic older adults. CTI occurs in the hospital, home, and via telephone for 28 days after discharge from the hospital, with the goal of ensuring the safe and effective transition from the hospital setting to the community. Researchers will compare usual care, CTI alone, and CTI enhanced with peer support to understand the best way to reduce unplanned hospital readmissions in this particularly vulnerable group of patients. Further details about this project are at [www.pcori.org/Conner305](http://www.pcori.org/Conner305).
As of November 2020, PCORI has funded nearly $278 MILLION TO FUND 78 active or completed comparative clinical effectiveness research studies that use community health workers in an intervention.

BY THE NUMBER OF PROJECTS

Top Condition Categories

*By number of projects. A project may study more than one condition.

Areas of Care Addressed

- Treatment
- Prevention
- Other
- Screening
- Post-Treatment Survivorship