PEC Innovation 6 (2025) 100397

Contents lists available at ScienceDirect

PEC Innovation

journal homepage: www.elsevier.com/locate/pecinn

The role of community health workers in enhancing home and community-based services in American Indian communities

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ARTICLE INFO

Keywords:
Community health worker
American Indian
Indigenous
Health promotion

ABSTRACT

Objectives: Describe the role and benefit of Community Health Workers in American Indian communities as a novel solution to meeting home and community-based service (HCBS) needs.
Methods: Short communication based on extant literature and current policy challenges.
Results: Community health workers (CHW) play an essential role in various healthcare settings particularly in American Indian (AI) communities working to close gaps in preventive and comprehensive healthcare accessibility. CHWs close these gaps through providing expertise in culturally oriented and familial support, educating communities on acute and chronic illnesses and wellness, and dispelling misinformation regarding health issues. However, integration and application of CHWs into home- and community-based services has limited recognition and utilization in healthcare systems and healthcare payment. Robust training/credentialing pathways and sustainable funding streams are essential for the integration of CHWs into the formalized healthcare provider team. Barriers that prevent this integration include inconsistencies in documentation, lack of stable funding, and a lack of formal professional recognition.
Conclusions: Previously successful models of CHW integration promote formalized training programs, professional development opportunities, earning certifications, and promoting collaboration between CHWs and providers.
Innovation: Applying CHW use in HCBS can increase community wellness while mitigating impacts of health disparities in HCBS for an often-under-resourced set of communities – our nation's American Indian communities.

1. Introduction

Community health workers (CHWs), officially recognized as a distinct labor category by the US Department of Labor in 2010, play a vital role in healthcare delivery, particularly in underserved communities [1,2]. During the COVID-19 pandemic, they proved essential in disseminating health information and connecting marginalized communities to healthcare services [3].

In American Indian and Alaska Native (AI/AN) communities, a variation on CHWs called Community Health Representatives (CHRs) has operated since 1968 [4]. Currently, over 1700 CHRs representing 264 tribes work closely with the Indian Health Service [5]. In Arizona, which has the third-largest AI/AN population in the US, 19 of 22 AI tribes operate CHR programs, employing about 250 CHRs [4]. These programs are notable and helpful given the health disparities in AI/AN communities. For example, diabetes rates are significantly higher among AI/AN populations (50 %) compared to other ethnic groups (ranging from 7.4 % to 14.5 %) [6,7]. CHRs are effective in addressing these disparities through culturally-appropriate education and healthcare system navigation. One meta-analysis showed improvements in blood glucose management and weight loss across various groups, while another clinical trial revealed notable health improvements among Navajo Nation members with diabetes who participated in CHW-staffed programs [6,8].

The US healthcare system has been shifting toward home- and community-based services (HCBS) to reduce costs and increase access. This change has implications for AI/AN communities, as they are more likely to use tribally affiliated services [9]. While HCBS shows promise in improving care accessibility and quality of life for AI/AN individuals, both AI/AN and non-AI communities face a significant direct care

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https://doi.org/10.1016/j.pecinn.2025.100397
Received 23 October 2024; Received in revised form 21 March 2025; Accepted 29 April 2025
Available online 30 April 2025
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workforce shortage that predates the COVID-19 pandemic. CHWs could help address this gap with proper preparation and recognition [10].

1.1. Current models of care

The Indian Health Service (IHS) provides healthcare to over 2.8 million AI/AN people, though chronic Congressional underfunding limits its effectiveness [11]. Like elsewhere in the US, long-term services and supports remain underfunded and fragmented, leading to heavy reliance on family care. AI/AN communities have recognized the need for community health professionals to bridge cultural gaps with non-AI healthcare systems [4]. Another model is the Promotora program, which emerged in the 1980s along the US-Mexico border through academic/community partnerships. This evidence-based program is now overseen by the Arizona Department of Health Services and implemented by CHWs across various agencies [4].

1.2. Value of CHWs in AI/AN communities

CHWs are trained to be effective communicators and collaborators with empathetic and relational skills and their understanding of community dynamics as they are often themselves part of communities they serve [3,12]. This pre-established rapport originating from shared culture, language, and life experiences, allow CHWs to work on client empowerment and advocacy between clients and healthcare providers. CHWs also adopt a multifunctional approach to addressing health disparities by delivering culturally conscious health information and services and offering social support and advocacy for their patients. This advocacy and social support are exemplified by regular home visits in AI/AN communities that blend western and Native healthcare approaches, supporting holistic community health [3].

CHWs provide critical support for monitoring and identifying high-risk patients. An IHS CHR Evaluation Report highlights that 70 % of CHW-provided services focuses on chronic disease management, leading to fewer emergency room visits and hospitalizations [13]. CHW interventions have been shown to lower annual healthcare costs per patient by $82 and yield a 1.8 return on investment [14,15]. Another CHW program showed financial return on investment was on average $2.47 for each dollar spent on community health workers to meet social needs [16]. Readmissions rates were lowered using similar roles as part of healthcare teams [17]. Additionally, a meta-analysis of 36 randomized-control trials further confirms that CHWs significant decrease ED visits, hospitalization, and urgent care utilization. [15]

Despite their numerous advantages, CHWs face challenges in community-clinical integration [10]. Barriers to integration of CHWs into the community-clinical landscape include health record documentation inconsistencies, particularly for those regions that do not have access to unified Electronic Health Records, insufficient funding streams for program sustainability, and lack of widespread recognition of the importance of their role or designation as a formal health profession [3,18]. Furthermore, the lack of comprehensive evaluations on the effectiveness and cost efficiency of CHR programs makes it difficult to measure CHWs' full impact, sustain funding, and advocate for policy changes [13]. This reinforces a need for standardized data collection, improved reporting systems, and expanded reimbursement models. These factors contribute highly to the disjunction that currently exist in the use of CHW.

Limited funding jeopardizes the means for CHWs to gain access to adequate training, supervision, and other professional development opportunities, which constrains their ability to serve those needing their support. In 2021, an estimated 2470 CHWs left their jobs, while another 5073 transferred to different positions, accounting for nearly 12 % of the CHW workforce – a turnover rate notably higher than the 9.3 % average for all other US occupations. [19] It is essential to adopt a multidisciplinary and comprehensive approach to address the exacerbation of these barriers through the intentional integration of CHWs across clinical, preventive, and public health programs along with other providers that are already recognized in the formal health professions [2].

1.3. Pathway for CHW integration

Integrating CHWs into healthcare systems entails navigating diverse models that cater to distinct roles, contexts, and needs. Several existing organizations are committed to building robust community health services within AI/AN communities. An example is the COPE Program (Community Outreach and Patient Empowerment), which has formal partnerships with the Navajo Nation CHR Program and clinical facilities that serve the Navajo Nation and has improved utilization of outpatient healthcare services and clinical outcomes among patients living with diabetes [20].

Additionally, states like Massachusetts, North Carolina, and Minnesota have taken proactive measures to enhance CHW integration. For example, Massachusetts and North Carolina have established a certification program for CHWs, offering core competency training and improving recognition of the workforce [20,21]. North Carolina has established early thinking on how to fund CHWs through Medicaid [22]. Minnesota developed a new and innovative State Plan Amendment to provide reimbursement for diagnosis-related CHW services as part of Medicaid transformation [3,12]. This has created a more sustainable funding landscape for CHW services.

The IMPaCT model at the University of Pennsylvania Health System exemplifies a fully integrated approach with CHWs working closely with healthcare providers (i.e., attending clinical rounds, participating in patient appointments) [23]. The IMPaCT model has been shown to reduce hospital stays by 65 %, improving chronic disease management, and increasing patient satisfaction [16]. Robust training and credentialing pathways are crucial for the full integration of CHWs into existing healthcare systems. These training and credentialing pathways range from community college education, on-the-job training, and state-level certification [24].

CHWs who engage with community college education – the source of much CHW education – not only gain valuable skills but are supported in their professional growth, enabling them to expand their knowledge base and contribute more meaningfully to patient care [10]. Additionally, healthcare agencies that provide on-the-job training have reported improved retention rates among CHWs as this approach links structured educational curricula with practical job training. This ensures that CHWs have a solid foundation in care standards, resulting in improved health outcomes and an increased reliance on their hard-earned competencies [10]. State-level certification programs further enhance recognition and provide financial and professionalization incentives for CHWs, which ultimately improves recognition of their value in promoting community health and alleviating health disparities.

2. Discussion and conclusion

Table 1 includes perennial HCBS challenges and how the CHW model can meet those challenges – especially for the AI/AN populations – by providing cultural competencies, community rapport, accessibility, holistic care, and equitable services.

2.1. Innovation

CHW models – and the community health representative model of the CHWs, in particular – are an elegant and logical answer to supporting AI/AN people in their communities and at home. Expanding CHWs within the HCBS context in AI/AN communities is innovative because it applies a proven public health approach to address the unique cultural, geographic, and healthcare barriers faced by AI/AN communities. These roles can be filled by those from the community who have shared understandings of community challenges, knowledge of cultural and family characteristics, and similar lived experience in AI/AN

Table 1
Challenges in Home and Community Based Services & How Community Health Workers Are An Innovative Response [28-30].

Challenges in HCBS	Innovations the CHW model offers
Lack of cultural awareness	Cultural Competencies – Deeper understanding of cultural norms, traditions, language, and family dynamics
Lack of community trust and rapport	Community integration – Approachable, trustworthy, and effective at disseminating community health information. Bridges gap between community and professional services.
Inaccessible (i.e., geographically isolated)	Accessible and Reliable – Local and longstanding presence in community builds trust and accessibility.
Comprehensive care	Holistic care – Comprehensive care integrating social, economic, and cultural factors.
Racial inequalities	Advocacy – Empower and assist community members with navigating healthcare systems, ensure that individuals receive quality services.

communities. CHWs, with deep cultural ties, provide culturally competent care, bridging gaps for American Indian populations facing health disparities. They offer preventive care, chronic disease management, and education, reducing hospitalizations and increasing patient compliance.

Diabetes prevalence among AI/AN communities is roughly 14.7 %, nearly double the U.S. national average [25]. Yet approximately 40 % of AI/AN individuals live in rural areas, often living far from the nearest healthcare facility [26]. Enhancing collaboration between remote CHWs and clinic-based providers in more urban centers facilitates a more cohesive approach to addressing health disparities. This process can more effectively identify individuals with unmet LTC needs, connecting them with HCBS resources, and reducing the need for higher cost care at a distance [27].

Given the new challenges in post-pandemic healthcare and shifting Medicaid policies under a new presidential administration, future research should explore how CHW programs may be impacted and identify policy solutions to sustain these roles. By leveraging cultural competency and deep community connections, CHWs represent a transformative approach to healthcare that bridges traditional medical services with culturally informed care.

CRediT authorship contribution statement

Zavera K. Basrai: Writing – review & editing, Writing – original draft, Resources, Investigation, Data curation, Conceptualization. **Caroline Y. Yoon:** Writing – review & editing, Writing – original draft, Software, Resources, Data curation, Conceptualization. **Valerie Tsosie:** Writing – review & editing, Validation, Resources, Investigation, Data curation. **Ronny A. Bell:** Writing – review & editing, Validation, Resources, Methodology, Investigation, Conceptualization. **Nathan A. Boucher:** Writing – review & editing, Writing – original draft, Supervision, Resources, Methodology, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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