

# Community Health Worker Grant Program Final Report

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## Clinic Perspectives and Patient Outcomes

Engrossed Substitute Senate Bill 5187; Section 211(44); Chapter 475; Laws of 2023

June 30, 2025

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# Table of contents

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Executive summary.....	5
Introduction.....	6
Why CHWs work so well.....	6
Legislative directive.....	6
CHW Grant and Tribal CHW Program.....	8
Tailored CHW roles.....	8
CHW services.....	8
Outreach.....	8
Informal counseling.....	9
Social support.....	9
CHW grant services.....	11
Table 1: Number of patients served by CHWs per clinic, January–December 2023.....	11
Table 2: Number of patients served by CHWs per clinic, January 2024–December 2025.....	11
Table 3: Comparison of number of EHR services provided by type, 2023–2024.....	12
Table 4: Comparison of number of K12 services provided by type, 2023–2024.....	12
Table 5: Comparison of number of 0–18 MCH services provided by type, 2023–2024.....	13
Table 6: Number of services provided by type, January–June 2025.....	13
CHW grant evaluation.....	14
Perspectives from the field.....	14
CHW recruitment and retention.....	14
CHW support and clinic integration.....	15
Figure 1: Evaluation of onboarding process - CHWs.....	16
Figure 2: Adequacy of CHW Training - CHWs.....	16
Role clarity.....	16
<b>Figure 3: Understanding of CHW role - CHWs</b> .....	17
<b>Figure 4: Understanding of CHW role - supervisors</b> .....	17
Family engagement.....	18
Implementing Culturally and Linguistically Appropriate Services (CLAS) standards.....	19
Figure 5: Preparedness for diverse populations - CHWs.....	20
Figure 6: Preparedness for diverse populations - supervisors.....	20
Figure 7: Delivery of translation services.....	21

Family reflections .....	21
Behavioral health (mental health and substance use disorder treatment) supports.....	21
Figure 8: Mental/behavioral health impacts .....	22
Social and community support.....	23
Cultural and linguistic appropriateness of CHW services.....	23
Inclusivity .....	23
Language and interpretation assistance.....	23
Figure 9: Equity, inclusion, and cultural sensitivity .....	24
Patient satisfaction with CHW services .....	24
Figure 10: Support level from CHW over past year.....	25
Figure 11: Likelihood to ask for CHW support again .....	25
Evaluating health outcomes.....	26
Demographics.....	26
<b>Table 7: Patient demographics and health care utilization</b> .....	27
Well-child visits.....	28
Table 8: Number of WCV for control group, CY 2023–2024 .....	28
Table 9: Number of WCV for treatment group (used CHW program), CY 2023–2024 .....	28
Emergency Department visits (ED).....	29
Table 10: Number of ED visits for control group, CY 2023–2024 .....	29
Table 11: Number of ED visits for treatment group (used CHW program), CY 2023–2024 .....	29
Mental health utilization.....	30
Table 12: Number of MH visits for control group, CY 2023–2024 .....	31
Table 13: Number of MH visits for treatment group (used CHW program), CY 2023–2024.....	31
CHW program impact on health care utilization.....	31
Analysis results .....	31
Table 14: Estimated program effects on health care utilization.....	32
Discussion.....	32
Limitations.....	34
HCA technical assistance .....	35
Establishing an Apple Health CHW benefit.....	36
Conclusion .....	37
Appendix: Evaluation methodology .....	38

## Executive summary

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The Community Health Worker (CHW) Grant Program has shown strong impact in improving access, equity, and family-centered care across Washington. Over two years, over 17,500 children and families were served, with CHWs delivering over 18,000 services ranging from health education to social support. Families expressed high satisfaction, with over 90% reporting that CHWs respected their values and made care easier to access.

Results show that CHW services led to meaningful improvements in health care utilization:

- Well-child visits increased 33% among children aged 3–18 years.
- Mental health visits rose 62%.
- Emergency department visits increased by 30% for children 16–36 months and 38% for those aged 3–18 years.

Together, these findings demonstrate that CHWs are effectively improving access to preventive and behavioral health care and helping families seek timely services when needed.

The program also surfaced important challenges:

- Clinics faced recruitment and retention difficulties toward the latter part of the grant, driven by funding uncertainty.
- Role clarity emerged as a critical issue, as CHW duties sometimes overlapped with other staff, creating confusion for families and clinical teams.
- Cultural and linguistic needs were not always fully met, with CHWs reporting gaps in culturally relevant educational materials and difficulties with interpretation services.
- Sustainability remains a key concern, as grant funding offered flexibility is not always available under Medicaid reimbursement.

With the transition to the Apple Health CHW benefit in July 2025, these lessons are now directly informing implementation. Sustaining this workforce through clear role definitions, robust training, cultural and linguistic support, and flexible funding mechanisms will be essential to realizing their full potential. **By carrying forward these insights, Washington is well-positioned to build a durable CHW infrastructure that advances health equity and strengthens outcomes for children, youth, and families.**

## Introduction

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Community Health Workers (CHW) play a pivotal role in primary care, acting as a vital link between health care providers and the communities they serve. With a focus on holistic well-being, CHWs bridge the gap between medical interventions and the social determinants that shape health outcomes. Their role encompasses:

- Health education
- Patient-advocacy
- Navigating complex health care systems
- Addressing health-related social needs

By building trust, demonstrating cultural competence, and offering personalized support, CHWs contribute to a patient-centered approach that extends beyond clinical treatments, ultimately promoting more comprehensive and equitable health care outcomes.

## Why CHWs work so well

A hallmark of CHWs contributions lie in their cultural congruence. CHWs possess an innate understanding of the diverse cultural backgrounds and linguistic nuances of the communities they serve. This cultural fluency allows them to communicate health information effectively, eliminating language barriers, and fostering trust.

When health disparities disproportionately affect marginalized populations, CHWs, due to their shared background, language, and experiences, can bridge the communication gap, ensuring all individuals, regardless of their background, receive equitable care.

It is important to recognize a potential caveat in the pursuit of complete cultural congruence. In some instances, achieving perfect alignment with a community's culture may prove challenging. Factors such as language barriers, diverse subcultures within a community, and the fluid nature of cultures can all pose obstacles to this goal. Cultural competency is a useful bridge when perfect congruence is not feasible.

**Supporting CHWs in developing cultural competency through training and ongoing support (e.g. quality supervision) is an important component to care.** CHWs are encouraged to commit to ongoing learning about the communities they serve. Professional development opportunities enhance CHWs' abilities to navigate cultural differences sensitively, adapt to evolving cultural contexts, and demonstrate respect for diverse backgrounds. This process of continuous education, adaptability, and relationship-building is fundamental to maintaining cultural competence.

## Legislative directive

In 2023, the Washington State Legislature directed the Health Care Authority (HCA) to implement the CHW grant program during the 2023 fiscal year (FY23) from January 1, 2023, through June 30, 2024. The grant program allows CHW services to be provided to patients and their families through primary care clinics. Patients may be up to age 18 with a mental, behavioral, or health related social need. During the

2024 legislative session, the directive was updated to continue the CHW grant program through June 30, 2025 while pursuing Center for Medicare and Medicaid Services (CMS) approval to cover CHW services under the Medical Assistance Program.

This report describes the results of the CHW grant during the 2024 and 2025 fiscal years, from July 1, 2023, through December 30, 2024, and satisfies the legislative reporting requirements in Engrossed Substitute Senate Bill 5187; Section 211(44).

HCA must provide a final report that includes:

- The quantitative impacts of the grant program;
- How many CHWs are participating in the grant program;
- How many clinics these CHWs represent;
- How many clients are being served;
- Evaluation of any measurable health outcomes identified in the planning period prior to January 2023; and
- The number of children who received community health worker services between June 1, 2023, and June 30, 2024.
- For the children who received CHW services within this period, compare the following data to children of the same ages and languages receiving coverage through Apple Health (Medicaid), including:
  - Well-child visits;
  - Mental health services when a need is identified; and
  - Emergency department utilization.

# CHW Grant and Tribal CHW Program

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In 2022, two expert committees—the Children and Youth Behavioral Health Work Group’s (CYBHWG) Behavioral Health Integration into Primary Care subgroup and the Washington Chapter of the American Academy of Pediatrics’ (WCAAP) First Year Families steering committee—provided a legislative priority recommendation to fund non-licensed professionals such as CHWs in pediatric primary care settings. This resulted in the legislative directive for HCA to create the CHW grant which provided funding for CHW salaries, benefits, supports, and resources in 21 pediatric primary care clinics across Washington state.

At the start of 2024, a total of 45 CHWs were employed, with 34 serving non-Tribal communities. Two clinics ended their contract, and five clinics reduced the number of CHWs at their clinic which resulted in a total of 38 CHWs employed at the end of the project period (11 Tribal clinics and 27 non-Tribal). Hiring challenges were cited as the primary reason for this decrease. Due to the time-limited nature of the grant program, clinics indicated concerns around establishing sustainable funding, though HCA communicated this factor during the initial grant application process.

## Tailored CHW roles

For the HCA CHW grant, two CHW roles were originally established to serve children birth through 18. After consulting with Tribal clinics, a third role was designed to allow CHWs and Community Health Representatives<sup>1</sup> (CHRs) to serve the entire 0–18 age range, ensuring cultural alignment and comprehensive coverage. This resulted in three distinct CHW roles:

- **Early relational health (ERH):** CHWs serving children from birth to age five and their families/caregivers
- **K12 mental health (K12):** CHWs serving children ages 5–18
- **Tribal 0–18 maternal and child health (0-18 MCH):** CHWs or CHRs serving children 0–18 and their families/caregivers

Currently, there are 19 CHWs fulfilling the ERH role, 15 performing as K12 CHWs, and 4 serving the entire age range. The CHWs are employed by pediatric primary care clinics in the regions of Greater Columbia, Great Rivers, King, Pierce, North Central, North Sound, and Thurston-Mason.

## CHW services

Aligned with the legislative directive, CHW services were defined as outreach, informal counseling, and social support. These services were provided to pediatric patients and their parents/caregivers with a focus on those enrolled in Apple Health (Medicaid).

## Outreach

Conducting or participating in community outreach allows CHWs to:

- Connect and foster relationships with the families served.
- Identify children, youth, and their families that may need CHW services.

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<sup>1</sup> CHRs are well-trained, medically guided, Tribal and Native community people who provide a variety of health services within American Indian and Alaska Native (AI/AN) communities.

- Build a network to strengthen streamlined referrals for families.

Many CHWs have organized or attended health fairs to provide health information and resources. However, the role of CHWs extends well beyond distributing health information. CHWs actively engage in cross-sector collaboration endeavors to increase awareness and address critical issues within communities. These collaborations include physical health care, mental/behavioral health, education, and social service systems.

## Informal counseling

CHWs teach essential health information and facilitate informed decision-making. CHWs help families understand complex medical information, ensuring patients comprehend diagnoses, treatment plans, medications, provider recommendations, and preventive measures.

ERH CHWs undertake the vital responsibility of promoting healthy developmental milestones. This encompasses activities like:

- **Conducting developmental screenings:** Using tools like ASQ-3 or SWYC to identify concerns early
- **Parent coaching:** Teaching caregivers how to play, talk, and read with their children.
- **Resource and system navigation:** Connecting families to Early Intervention, WIC, Head Start, or home-visiting programs, and guiding families through medical processes.
- **Health promotion:** Educating and encouraging well-child visits, early childhood vaccines, and appropriate developmental screenings.

K-12 CHWs deliver foundational mental health education by teaching children and teens about emotional awareness, stress management, and healthy coping strategies. They provide brief, goal-focused coaching and skill-building sessions that promote resilience, problem-solving, and positive peer relationships. K12 CHWs also address preventive health topics with students and families, including personal hygiene, immunization education, and the importance of recommended vaccines such as COVID-19, HPV, and other age-appropriate adolescent immunizations.

## Social support

CHWs provide care coordination and support for health-related social needs. They aid individuals in obtaining insurance coverage, affordable medications, and support services for needs such as:

- **Housing:** CHWs assist patients in securing stable housing by facilitating connections with housing agencies, helping patients understand eligibility criteria, and providing guidance through the application process.
- **Food security:** CHWs link patients to food assistance programs, ensuring access to nutritious meals by providing information about food banks, government assistance programs, and community resources.
- **Transportation:** Transportation can be a significant barrier to accessing health care, especially for those in underserved areas. CHWs address this challenge by aiding patients in identifying transportation options, such as public transit, ride-sharing services, or community transportation initiatives that provide resources like gas vouchers.
- **Employment:** CHWs are instrumental in connecting patients to employment opportunities, which can have a profound impact on patients' economic stability and overall health. They may

collaborate with local job training programs, help with resumes, and provide guidance on accessing job search platforms.

- **Disability services:** CHWs in Thurston, Mason, King, Skagit, and Pierce counties connect families to Early Supports for Infants and Toddlers (ESIT), Wrap-around with Intensive Services (WISe), and other programs designed to support individuals with disabilities (i.e. Special Education, Developmental Disabilities Administration, and Social Security Income), particularly in educational and developmental settings.

## CHW grant services

**Table 1: Number of patients served by CHWs per clinic, January–December 2023**

CHWs include ERH, K12, and 0-18 MCH. Small numbers are redacted by HCA to protect against reidentification.

Clinic name	Number of patients served
Child & Adolescent Health Center	245
Community Health	883
Harborview	174
Hope central	322
Lake Chelan	669
Northwest Pediatrics	732
Pediatrics Northwest	1112
Seahurst	260
SeaMar	1450
South Sound	195
Summit Pacific	577
UW Medicine	542
Valleyview	504
Yakima Neighborhood	153
Lummi Nation	37
Makah Tribe	*
Port Gamble	61
Tulalip Tribe	*
Yakama Nation	139
<b>Total</b>	<b>8,067</b>

Source: Health Care Authority, Enterprise Analytics Research and Reporting, Oct 2023

**Table 2: Number of patients served by CHWs per clinic, January 2024–December 2025**

CHWs include ERH, K12, and 0-18 MCH.

Clinic name	Number of patients served
Child & Adolescent	632
Colville Tribe-Lake Roosevelt Heath Center	67
Community Health	820
Harborview	562
HopeCentral	318
Lake Chelan	603
Lummi Nation	106
Makah Tribe	30
Northwest Pediatrics	214

Pediatrics Northwest (All sites)	2503
Port Gamble	101
Quileute Tribe	104
Seahurst	191
SeaMar (All sites)	1460
SouthSound	282
Summit Pacific	927
Tulalip Tribe	76
UW Medicine	732
Valleyview	1278
Yakama Nation	494
Yakima Neighborhood	326
<b>Total</b>	<b>11,826</b>

Source: Health Care Authority, Enterprise Analytics Research and Reporting, October 2, 2025

**Table 3: Comparison of number of EHR services provided by type, 2023–2024**

Service Type	Q1-Q2 2023	Q3-Q4 2023	Q1-Q2 2024	Q3-Q4 2024	Grand total, 2023–2024
<b>Social support</b>	844	1,857	1,932	1,838	<b>6,471</b>
<b>Informal Counseling</b>	158	496	492	350	<b>1,496</b>
<b>Outreach</b>	575	547	552	976	<b>2,650</b>
<b>Others</b>	178	317	1,009	196	<b>1,700</b>
<b>Totals</b>	<b>1,755</b>	<b>3,217</b>	<b>3,985</b>	<b>3,360</b>	<b>12,317</b>

Source: HCA, Enterprise Analytics Research and Reporting, Oct 2023; Oct 2024 Program Implementation, Assessment & Quality Improvement

**Table 4: Comparison of number of K12 services provided by type, 2023–2024**

Service Type	Q1-Q2 2023	Q3-Q4 2023	Q1-Q2 2024	Q3-Q4 2024	Grand total, 2023–2024
<b>Social support</b>	936	2,135	2,974	1,904	<b>7949</b>
<b>Informal Counseling</b>	407	927	1,016	558	<b>2908</b>
<b>Outreach</b>	404	632	562	248	<b>1846</b>
<b>Others</b>	99	265	98	121	<b>583</b>
<b>Totals</b>	<b>1,846</b>	<b>3,959</b>	<b>4,650</b>	<b>2,831</b>	<b>13,286</b>

Source: HCA, Enterprise Analytics Research and Reporting, Oct 2023; Oct 2024 Program Implementation, Assessment & Quality Improvement

**Table 5: Comparison of number of 0–18 MCH services provided by type, 2023–2024**

Note: 0–18 MCH data begins in Q3–Q4 of 2023 because Tribes weren't yet fully signed on during Q1–Q2 2023.

Service type	Q3-Q4 2023	Q1-Q2 2024	Q3-Q4 2024	Grand total, 2023–2024
<b>Social support</b>	36	49	53	<b>138</b>
<b>Informal counseling</b>	40	20	36	<b>96</b>
<b>Outreach</b>	39	4	2	<b>45</b>
<b>Others</b>	120	55	444	<b>619</b>
<b>Totals</b>	<b>235</b>	<b>128</b>	<b>535</b>	<b>898</b>

Source: HCA, Enterprise Analytics Research and Reporting, Oct 2023; Oct 2024 Program Implementation, Assessment & Quality Improvement

**Table 6: Number of services provided by type, January–June 2025**

Service Type	ERH	K12	0–18 MCH	Grand total, Q1–Q2 2025
<b>Social support</b>	3,083	4,102	72	<b>7,257</b>
<b>Informal Counseling</b>	814	1,979	30	<b>2,823</b>
<b>Outreach</b>	995	835	8	<b>1,838</b>
<b>Others</b>	1,097	161	275	<b>1,533</b>
<b>Totals</b>	<b>5,989</b>	<b>7,077</b>	<b>385</b>	<b>13,451</b>

Source: Health Care Authority, Enterprise Analytics Research and Reporting, January 2024-2025 Program Implementation, Assessment & Quality Improvement

## CHW grant evaluation

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In 2024, Colehour+Cohen Inc. (C+C) was contracted to conduct an evaluation of the CHW program using a two-phased, mixed-methodology approach of gathering feedback from CHWs, CHW supervisors, and families served. C+C conducted one-hour, one-on-one interviews over Zoom with parents who received CHW services in the previous year. They conducted a total of eight interviews (six in English and two in Spanish). For the CHW and supervisor study, each group included two to five participants randomly selected from a list of CHWs and supervisors. A follow-up quantitative survey was administered to families, CHWs, and supervisors to capture more detailed feedback on their experiences.

### Perspectives from the field

Phases one and two of the C+C evaluation focused on perspectives from the field, gathering insights from CHWs, CHRs, and supervisors. Phase one included six focus groups conducted with three groups of CHWs and three groups of supervisors. Each group included two to five randomly selected participants of supervisors and CHWs representing both K12 and ERH.

A separate phase one focus group was conducted for CHRs and supervisors participating in the Tribal program, serving the entire age range 0-18. This effort ensured proper representation and captured the unique experiences of Tribal CHRs for a more comprehensive understanding of their distinct perspectives, challenges, and contributions within their communities.

Phase two included a quantitative survey administered to all 39 CHWs and 26 supervisors to capture detailed feedback on experiences within their program. This included program effectiveness, challenges, satisfaction with resources and training, and cultural and linguistic appropriate standards (CLAS) of CHW services.

### CHW recruitment and retention

Integrating CHWs and building a strong and sustainable CHW workforce begins with recruitment. Both lived experience and training were honored throughout a few of the clinics' hiring processes by recruiting candidates with shared languages, cultures, and experience navigating similar challenges. Tribal communities took a culturally grounded approach, adhering to the Native hiring preference policy and ensuring CHWs share cultural and linguistic backgrounds with the populations they serve.

Recruitment for CHW roles did not present significant issues in the first 18 months of the program, with all CHWs hired and onboarded prior to the start of the grant in February 2023. During this evaluation, more than half of supervisors reported it was "not very difficult" to recruit CHWs. However, challenges became more prominent in the latter half of the grant period due to shortened timelines and uncertainty around future funding. Data showed that 32% of supervisors found recruitment to be at least somewhat difficult during this time.

Originally slated to run from January 2023 through January 2025, the CHW grant was later extended by six months to end in June 2025, aligning with the anticipated launch of the Apple Health CHW benefit in July 2025. Despite the extension, clinics faced decision making under uncertainty (e.g., whether the benefit would fully cover staffing costs and activities), leading some to pause hiring, tighten criteria, or retire CHW positions. **This dynamic shifted the primary challenge from initial recruitment to maintaining the CHW workforce (role continuity and retention).** With limited time remaining under the grant, some clinics

reported having to alter hiring criteria or even retire CHW roles due to uncertainty in funding and workforce planning, though this was a known factor at the initiation of the grant program.

While the current Medicaid benefit creates a longer-term reimbursement path, many clinics noted that grant dollars provide essential flexibility that fee-for-service or capitated Medicaid payments may not fully support. Grant funds enable CHWs to:

- Serve uninsured and commercially insured patients.
- Conduct community outreach and prevention activities not reimbursable under Medicaid.
- Cover upfront staffing and infrastructure needs.

Maintaining dual funding streams would help clinics preserve the full scope of CHW services and better meet diverse community needs.

## **CHW support and clinic integration**

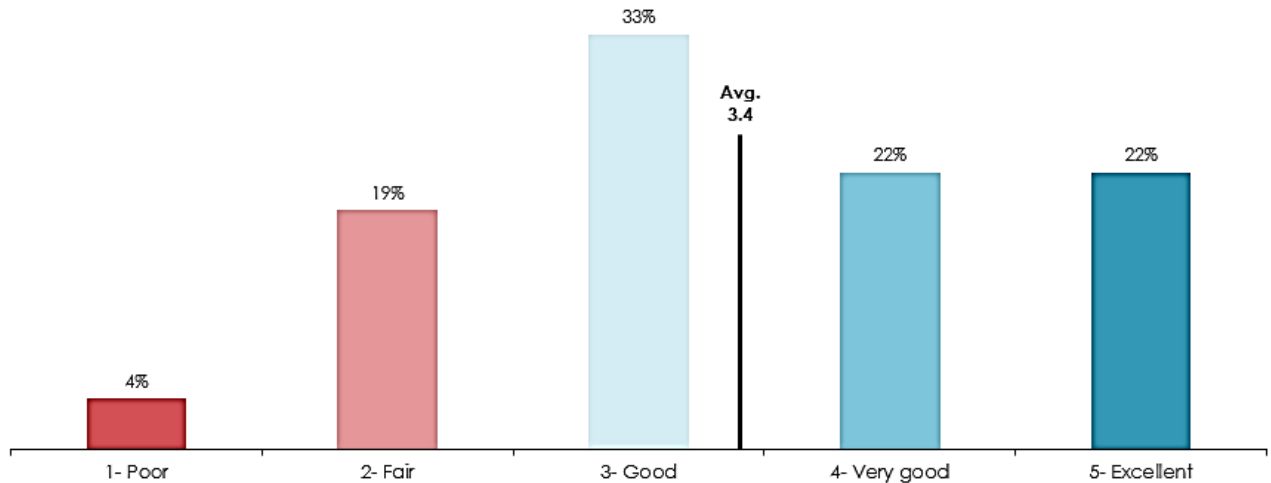
Throughout the grant, supervisors and CHWs had access to a variety of supportive tools and resources to perform the CHW role effectively. These tools, coupled with a positive relationship between CHWs and their supervisors, play a critical role in fostering a supportive work environment. CHWs and supervisors both expressed the importance of a healthy working dynamic and how critical the relationship is to success. Eighty-one percent of CHWs reported their supervisor's support was either "very" or "extremely" important to their success, highlighting the importance of having guidance, feedback, and someone who actively listens to their concerns. CHWs indicated that one-on-one supervision allowed broader conversations on workflow, caseload, and performance to effectively and collaboratively address issues.

Successful integration of the CHW into clinic practice is a two-way approach:

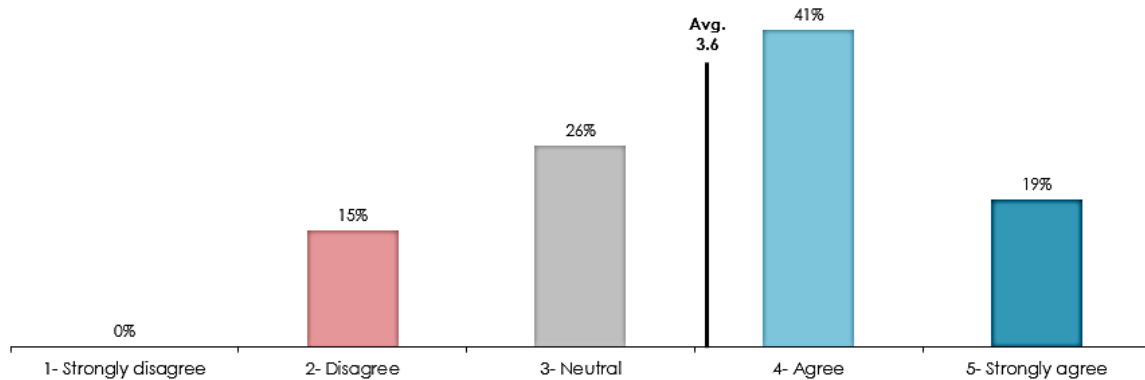
1. For the CHW to attend team meetings, participate during patient appointments, and network with community partners.
2. Ensure CHWs are fully integrated as a valuable member of the clinical team's education and collaboration.

Clinical teams are encouraged to educate themselves on the CHW role and workforce and to create an environment that encourages collaboration by inviting CHWs to team meetings or patient appointments. This fosters open communication and provides flexibility for outreach and networking.

**Figure 1: Evaluation of onboarding process - CHWs**



**Figure 2: Adequacy of CHW Training - CHWs**



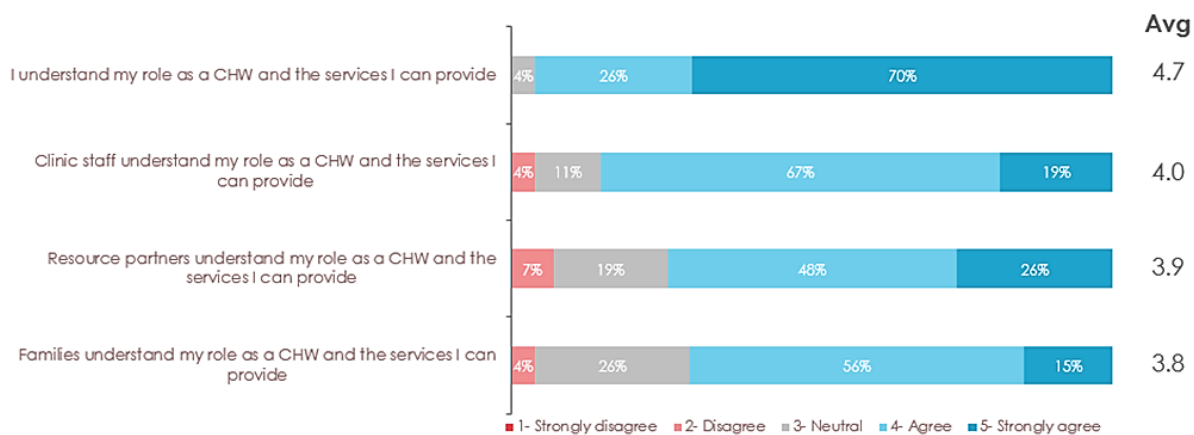
## Role clarity

As the CHW workforce has grown in response to rising demand, the need for clear role definitions has become increasingly apparent to ensure CHWs meet both community and organizational expectations. Similarities to other provider types—such as health educators, social workers, and care coordinators—can sometimes lead to confusion about the role of CHWs when job responsibilities overlap. For example, providing health education or connecting families to resources may be performed by multiple provider types making it unclear who is responsible for the task.

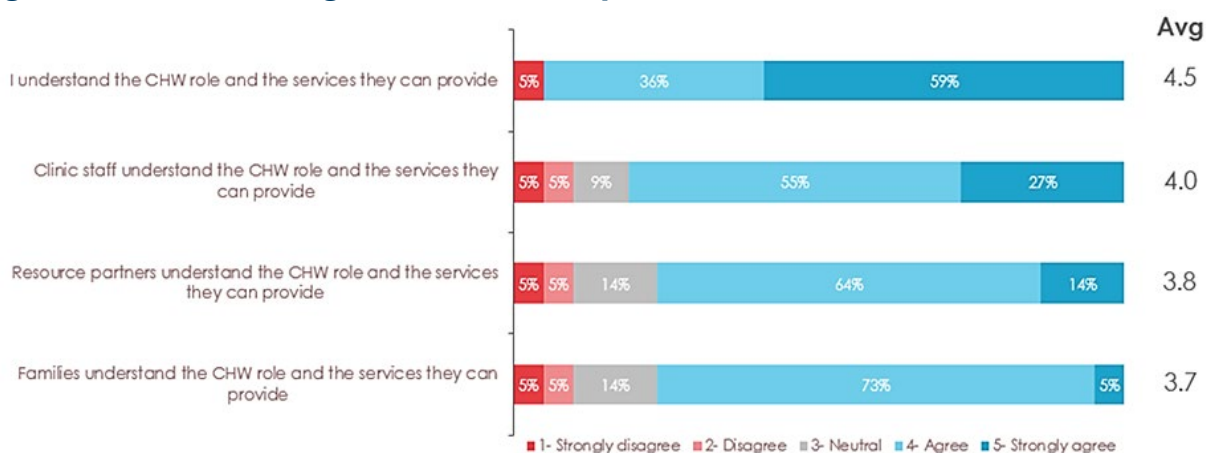
Both CHWs and their supervisors were asked to define the CHW role. Responses indicated CHWs and their supervisors were generally aligned in their view of the CHWs role. Ninety-six percent of CHWs and 95% of supervisors “agree” or “strongly agree” that they understand the community health worker role. Both CHWs and supervisors agreed with the definition CHW services including a balance of health care and community support. Alternatively, CHWs and supervisors indicate that relatively few “strongly agree” that clinic staff and resource partners understand the CHW role (figures 3 and 4). Some CHWs mentioned that

providers often think they are trained to assist in crisis scenarios. These results indicate a need for clearer communication about the scope of CHWs and CHW provided services.

**Figure 3: Understanding of CHW role - CHWs**



**Figure 4: Understanding of CHW role - supervisors**



Further, focus group participants reported that families often confuse CHWs with social workers, nurses, or case managers. Role clarity may be just one piece of the puzzle, but it is a cornerstone for successfully integrating CHWs into care teams and ensuring their effectiveness. A lack of role clarity can have an impact on CHWs ability to perform their responsibilities, directly influencing their outreach efforts, client prioritization, and engagement with families.



Sometimes families who are unfamiliar with the role will ask about medications assuming that the role is similar to a nurse or will assume that the role is that of a social worker. It can start to feel like a catchall when there is not a clear understanding of the role.”

**CWH survey response**

Bringing familiarity with the clinic team may take ongoing training, encouraging collaboration, and consistent conversations over time with the CHW and care team members to ensure alignment across the team, foster mutual understanding, and reduce tension and burnout.

## Family engagement

Fostering connections and trust with families is a core skill for CHWs and developing meaningful relationships takes time. For many CHWs, the first point of contact with a family is initiated during the office visit via a warm hand off commonly from a referring provider or clinical staff. Some families may reach out directly if familiar with CHW support. Once a referral is received, CHWs prioritize families based on urgency or severity of needs (62%), timing of the referral (43%), and provider input (36%).

Follow-up contact is a critical factor in the effectiveness of CHW service delivery, helping to maintain ongoing connections and build trust with families. To ensure access to services, CHWs provided services and support in various ways:

- In-person at the clinic (72%)
- Phone calls (56%)
- Text messages (35%)
- Video call (2%)
- Other in-person encounters such as meetings at local public settings or via home visits (19%)

Over 20% of CHWs under the grant report they “always” follow up with families, while 59% indicated they often do so. These follow-ups help bring awareness of CHW services, reinforce family engagement, and help address evolving needs.

In-person meetings with families are the most common engagement strategy, but CHWs also rely on phone calls, text messaging, and, when necessary, home visits to ensure families’ access. With these methods in place, CHWs and their care teams have been able to maintain the confidentiality of the client while also meeting the client where they are to address their needs. Nearly all CHWs and supervisors rate the confidentiality provided for families at their clinic as “very good” or “excellent.” This highlights strong efforts to maintain privacy and uphold commitment to addressing the needs of the families. By engaging families in these intentional and adaptive ways, CHWs foster relationships that are critical for addressing social and health related needs.

To strengthen family engagement, teams must adopt practices that prioritize inclusivity and communication. This includes:

- Implementing family-centered care models that encourage active participation and shared decision making.
- Providing or supporting CHWs by identifying tools and resources, including culturally appropriate and relevant training to the population served, to better address families’ needs and improve health outcomes.
- Establishing clear follow-up protocols to ensure families are engaged in their plan of care.
- Utilizing multiple communication methods including phone calls, texts, in person, and video calls to ensure connection between families and their care team.

## Implementing Culturally and Linguistically Appropriate Services (CLAS) standards

CLAS standards are essential for ensuring equitable and effective health care services, particularly in diverse communities. Clinics were expected to work towards incorporating CLAS standards to align with HCA's mission to advance equitable, patient-centered care. CHWs have been key contributors to advancing health equity, using their lived experience to fill gaps between health care and social service systems and the community. There are 15 CLAS standards, organized under three themes:

- Governance, Leadership, and Workforce (standards 1-4)
- Communication and Language Assistance (standards 5-8)
- Engagement, Continuous Improvement, and Accountability (standards 9-15)

By implementing the CLAS standards, clinical teams were able to ensure their health care services met the cultural and linguistic needs of all patients by:

- Offering services that respect diverse cultural health beliefs and practices.
- Providing language assistance via interpreters or bilingual staff for patients with limited English proficiency.
- Ensuring clear communication and understandable information for all patients.
- Involving community members in health care decisions to reflect their needs.

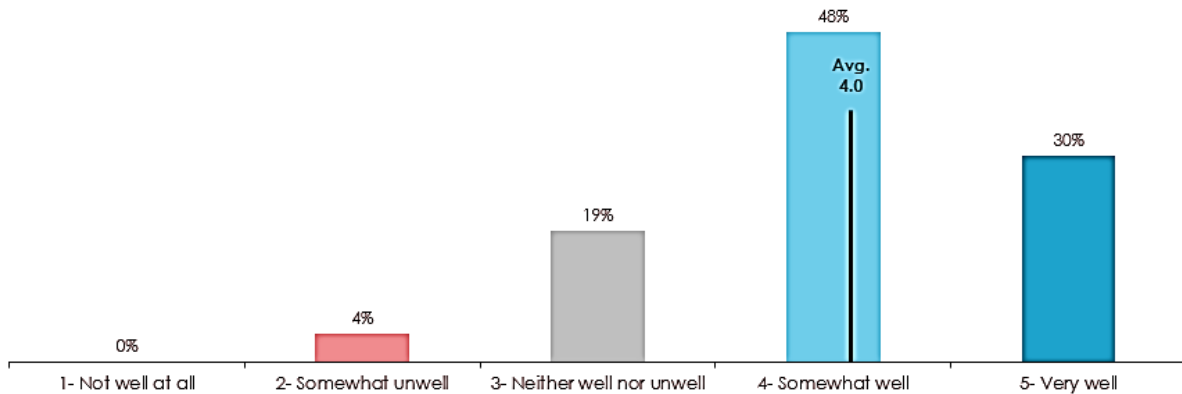
In October 2024, C+C surveyed CHWs and their supervisors to better understand their thoughts on the CLAS standards and their progress toward implementing the standards. According to the survey, both CHWs and supervisors "generally agree" that their clinics provide culturally appropriate services, with 78% of surveyed CHWs and 82% of supervisors confirming this belief.

Implementing the CLAS standards is a different experience for Tribal communities as their services and resources are inherently tailored to meet the unique needs of their community. There are special situations where additional coordination may be necessary such as situations where a child may be adopted by non-Tribal parents or encounter an individual from another Tribe. In these situations, the clinical teams recognize the importance of ensuring culturally sensitive care and coordinating with the appropriate tribe if necessary.

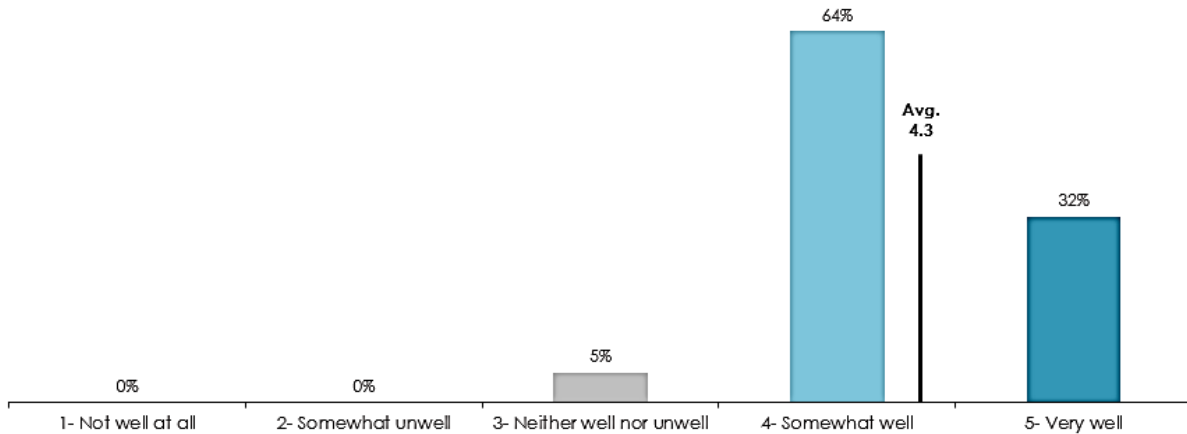
Effectively addressing cultural needs takes lived experience and training. Many CHWs under the grant had shared cultural, linguistic, or situational lived experience. CLAS standards training included education during the CHW huddle and quarterly all clinic calls with the supervisors. Online trainings materials were also provided for continuation with the combined use of any cultural competency training required by the clinical sites for all employees. Over 40% of CHWs and 30% of supervisors cited their preparedness for working with diverse populations as "very well." CHWs and supervisors also feel that training has prepared CHWs at least "somewhat well" to work with diverse populations (figures 5 and 6).

However, cultural challenges persist, with approximately two-thirds of CHWs reporting difficulties in addressing cultural needs, often due to a lack of culturally relevant educational materials. These findings highlight the need for enhanced resources and training to better equip CHWs to meet the unique cultural needs of the families they serve.

**Figure 5: Preparedness for diverse populations - CHWs**



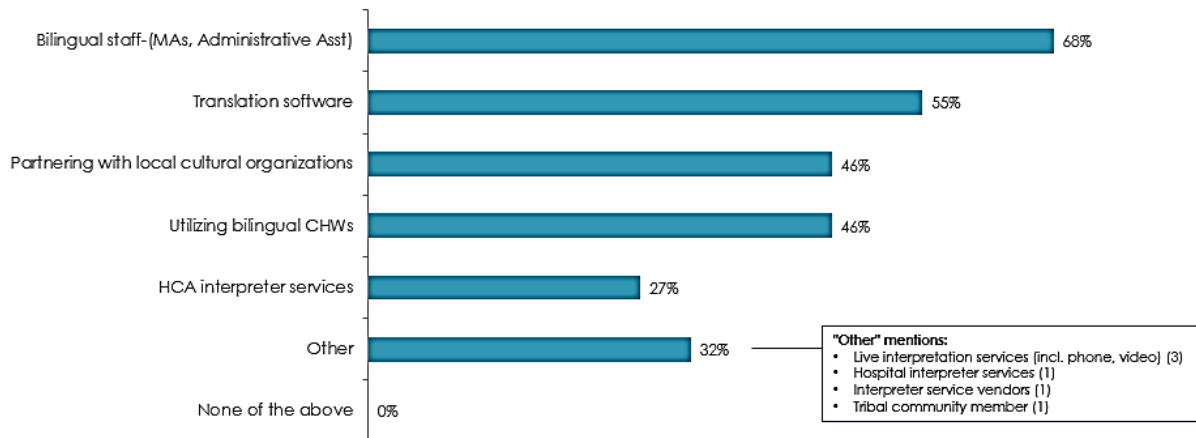
**Figure 6: Preparedness for diverse populations - supervisors**



Although both supervisors and CHWs agree that there could be more training opportunities to support the CLAS standards, providing culturally relevant information is not as much of an issue as addressing language barriers. Clinics address Limited English Proficiency (LEP) needs primarily through bilingual staff and translation software with which 63% of CHWs report being at least “somewhat satisfied.” Supervisors report being largely satisfied with each interpretation/translation service their team has used but have found most satisfaction with utilizing bilingual CHWs and other bilingual staff.

However, both groups identify key challenges with interpretation services. The most common issue is technological difficulties while using remote interpretation tools. Additionally, the lack of available interpreters and limited access to required languages are notable barriers. According to survey data, quality of interpretation is not perceived as a widespread issue, with only 26% of CHWs and 18% of supervisors identifying it as a concern. To ensure accuracy and quality, most supervisors report taking proactive measures. These include providing ongoing training (50%), incorporating feedback from patients (30%), shadowing interpreter sessions (30%), and gathering supervisor feedback (30%). **These strategies underscore the commitment to maintaining high standards in interpretation services, although gaps in availability and technology must still be addressed.**

**Figure 7: Delivery of translation services**



## Family reflections

Between April and December 2024, C+C implemented a two-phase approach, interviewing and surveying the families of the patients served by the pediatric CHWs. Randomized selection was used identifying participants from the 350 patients across all participating clinics. Patients were selected based on the criteria that they were Washington state residents, 18 years of age or older, a parent or caregiver (for children under 18), are enrolled in Apple Health (Medicaid), received CHW services, and with a primary language was English or Spanish.<sup>2</sup>

Phase one consisted of 60-minute interviews with parents and caregivers of the pediatric clients (0-18), and phase two included an online 15–20-minute survey administered to families for feedback on their experiences with the program. Participants were invited to complete the survey by email and flyer from the clinical teams, primarily the CHW and supervisors. Families who completed the survey received compensation in the form of a gift card. C+C received 118 complete surveys.

## Behavioral health (mental health and substance use disorder treatment) supports

The word “community” in community health worker carries profound weight, embodying the lived experience, deep-rooted knowledge, and trusted relationships that makes these professionals invaluable connectors and advocates with their communities. Referrals to CHWs included support for accessing mental/behavioral health services and resources. In the third and fourth quarters of the first year of the grant, 2023, our CHWs connected with 4,963 clients of whom 1,989 were Apple Health/Medicaid clients. Of the 1,989 clients, 1,158 received support for mental and behavioral challenges for the focus on the grant, referrals were often initiated primarily to address the principal illness, the mental or behavioral health need.

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<sup>2</sup> Languages were limited to English and Spanish due to funding capacity for additional interpretation services.

Families seeking support for mental/behavioral health challenges often express challenges with identifying resources or the appropriate next steps after receiving a diagnosis:

- Long waitlist for programs and services (50%)
- Challenges finding services covered by health insurance (43%)
- Difficulty with application process (21%)
- Difficulty making appointments (7%)

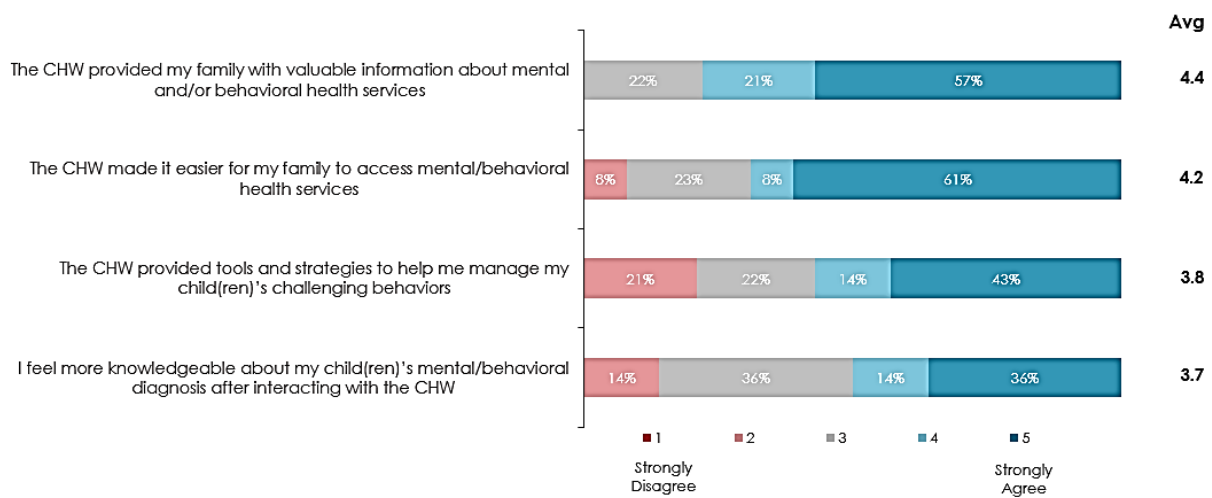
Twenty-one percent of families reported facing two related barriers—difficulty securing a therapist and an unclear or absent diagnosis—often because they lacked ongoing mental health care or relied on emergency department (ED) visits that didn’t yield a formal evaluation. CHWs also provided informal counseling (non-clinical emotional support and guidance) to assist families with understanding recommendations and diagnoses from their providers. CHWs also performed care coordination and outreach to ensure families were connected to mental health therapy, Applied Behavioral Analysis (ABA), and support for health-related social needs. When surveyed, the data found:

- 78% of survey respondents agree CHW provided them with valuable information about these services (Figure 8).
- 69% agree the CHW made the services easier to access (Figure 8).

Parents also shared many examples in the interviews about how CHWs made phone calls on their behalf to gather information and assist with every step of the referral process. This was reflected in the data: 61% of families “strongly agreed” when asked if they found it easier to access mental and behavioral health resources with the support of a CHW. Several parents also shared that with proper support, they have witnessed noticeable improvements in their child’s behavioral and social skills.

While the data demonstrates the strength in CHWs navigation skills it also indicates areas of improvement when ensuring CHWs have the tools and resources needed to aid families. Only 43% of families reported that they strongly agreed that CHW provided tools and resources to help manage their child’s conditions.

**Figure 8: Mental/behavioral health impacts**



## Social and community support

Addressing social needs is a critical role for the CHW roles as many of these issues were often more immediate than the principal illness that initiated the referral or essential to effectively managing the principal illness. Food insecurities, legal assistance related to immigration, housing and utility assistance, and transportation were some of the most common challenges to navigate due to limited resources and sometimes limited knowledge of the resources by the CHWs. When asked about the value and impact of CHW support with navigating resources and services for social issues, 84% agreed that the information provided to them on how to apply for assistance and benefit programs was valuable. Over 75% of the families surveyed agree or strongly agreed that CHWs made it easier to apply for assistance and benefit programs. **An overwhelming majority of the families also strongly agreed that the CHW helped connect them to resources and programs that were valuable in supporting their families.**

## Cultural and linguistic appropriateness of CHW services

Providing culturally and linguistically appropriate services ensures that families are included in the decisions regarding their or their child's plan of care, that any information provided is accurate, relevant, and easy to understand for clarity, and that language and interpretation services are available for those with a limited English proficiency. This portion of the survey was to determine if CHWs were successfully meeting the national CLAS Standards. Overall, families expressed high levels of satisfaction with the cultural and linguistic appropriateness of CHW interactions:

- 93% agree the CHW treats them fairly.
- 91% agree the CHW listens to their concerns.
- 91% agree the CHW respects their family's cultural values and beliefs.
- 88% agree the CHW does everything possible to ensure they feel comfortable when discussing health concerns.

## Inclusivity

To make families feel heard, respected, and included in their health care journey, it takes empathy, cultural humility, and skills in active listening. Survey results show 90% of families agree that their CHW asks about their opinions and preferences and 89% agree the CHW involves them in the process of choosing resources and services. These practices reflect the CLAS standards of engaging patients in their care decisions, fostering a sense of empowerment, and collaboration. One parent shared during their interview that while working with the CHWs, the CHW also helped with establishing developmental goals for their children, showcasing the value of co-creating personalized care plans. By actively listening and tailoring services to meet individual and cultural needs, CHWs can build trust and encourage patient/family involvement, regardless of background, in their health care journey.

## Language and interpretation assistance

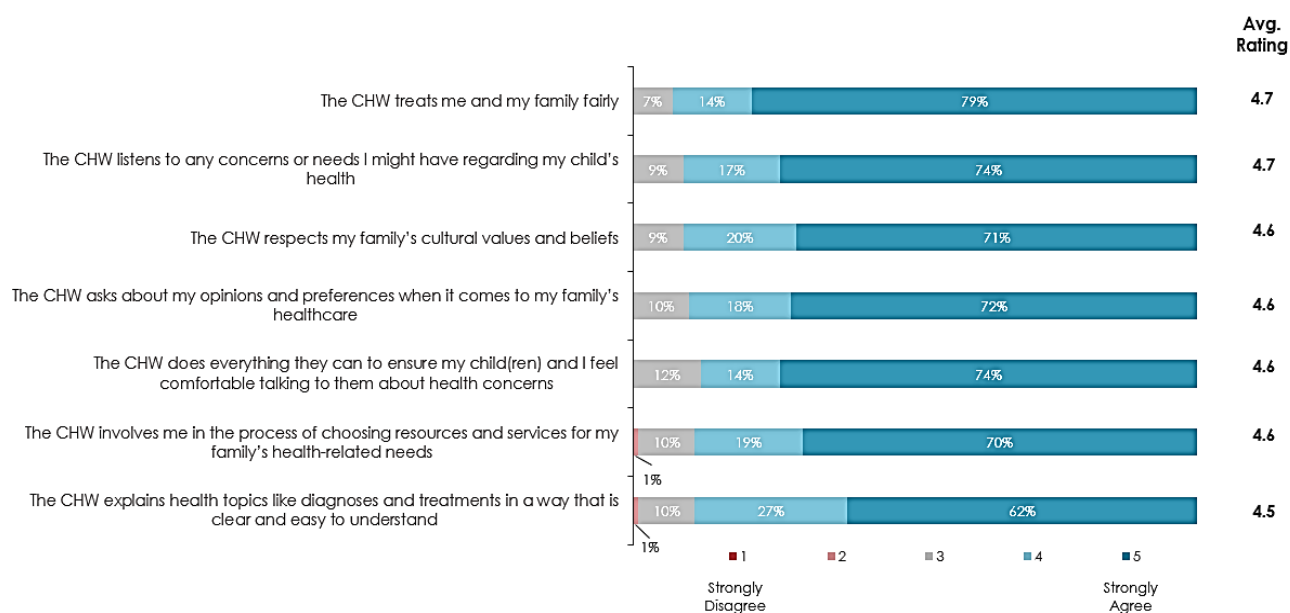
Addressing language barriers and prioritizing effective communication, CHWs help families navigate complex health systems and overcome potential misunderstandings, ensuring equitable access to care for all, regardless of linguistic background. Among both survey and interview respondents, all report their CHW has provided some form of language support, and all have been satisfied with their experience.

Among survey respondents, 77% state that their CHW speaks their preferred language and thereby assists directly with interpretation and translations. One family shared specific details on how their CHW spent

hours assisting the family with applying for benefits while providing helpful interpretations and translation services through the process to include the family.

When asked if they faced any language barriers at the clinic, 65% of survey respondents stated that they “rarely or never” experienced language barriers and reflecting the strong language support. However, data also shows that there are areas for improvement when 23% of the survey respondents reported they “often” experienced communication barriers. In the clinics, interpretation and translation services can be offered via bilingual staff, third-party interpreters, or through electronic devices. Most families cited the issues connected with video interpretation and a few poor experiences with interpreters.

**Figure 9: Equity, inclusion, and cultural sensitivity**



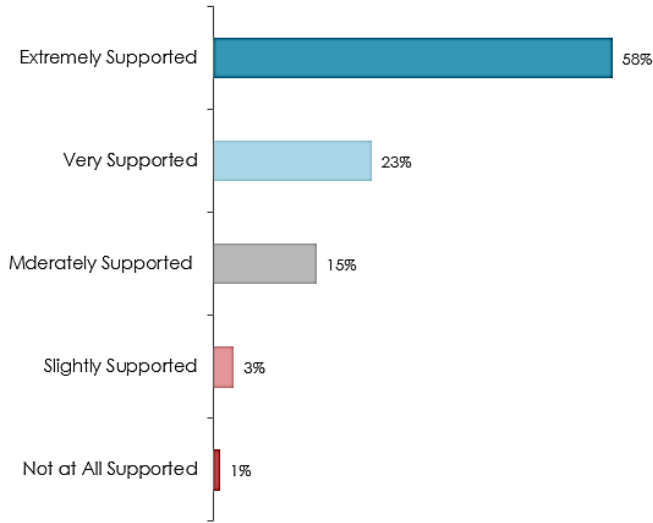
## Patient satisfaction with CHW services

At the conclusion of both the interview and surveys, families were asked general questions to better understand families’ overall satisfaction with the CHW services. The first questions were regarding familiarity with the CHW role and the CHW program:

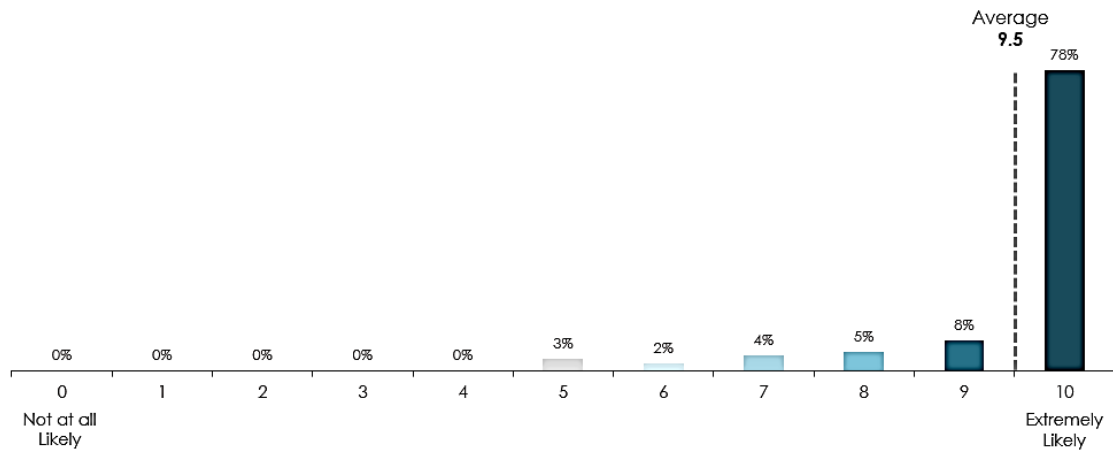
- 84% of the participating families expressed having some knowledge of the CHW program.
- 76% of respondents found the CHW's explanation of their role and services to be very or extremely clear.

Across the various supports offered to families, overall families were highly favorable of the CHW support with 78% reporting that they were more likely to recommend CHW services to other families. When asked about overall interaction with CHWs including the time and space of services, majority of respondents reported satisfaction with their time with their community health workers. Families also reported feeling very satisfied with the level or privacy during their visit (85%) and the amount of time they were able to work with their community health worker (82%).

**Figure 10: Support level from CHW over past year**



**Figure 11: Likelihood to ask for CHW support again**



## Evaluating health outcomes

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HCA conducted an internal evaluation to assess the impact of CHWs on the health outcomes of pediatric patients in primary care. This study evaluates how CHWs impact health care utilization by comparing children who received CHW services (referred to as the “treatment group”) to similar children who did not (referred to as the “control group”). For this evaluation we tracked well-child visits, ED visits, and mental health visits before and after CHW involvement to measure program effectiveness.

The analysis included 2,376 children aged 0–18 who received CHW services in 2023 (treatment group) and 9,504 matched children who received care at the same clinics but did not receive CHW services (control group). We used a 1:4 matching ratio based on demographic characteristics, health conditions, and baseline health care utilization patterns.

### Demographics

The overall sample included 9,504 controls and 2,376 treatment children. The population was racially and ethnically diverse (tables 7.3 and 7.4). Health care utilization patterns show that children receiving CHW services had more ED and MH visits both pre- and post-intervention compared to controls (e.g., ED 1+ visit post: 73% vs. 56%; MH 10+ visits post: 13% vs. 7%). This pattern suggests that CHW-engaged children may have higher baseline needs and experienced increased connection to care following intervention.

Children served in the Washington CHW Program were largely in the 3–18-year age group, making up about three-quarters of both the control (75%) and treatment (76%) groups, with smaller proportions in the 16–36-month (15–16%) and 0–15-month (9%) age groups. Across age groups, the mean age was consistent between control and treatment groups, with slightly higher average ages in the treatment group (0.87 vs. 0.81 years for 0–15 months, 2.51 vs. 2.50 years for 16–36 months, and 9.6 vs. 9.5 years for 3–18 years).

Gender distribution was balanced, with males and females nearly evenly split across all age groups. Visit counts showed increased engagement post-intervention for treatment children, particularly in well-child visits (WCV) and mental health (MH) visits. For example, children receiving CHW services had a higher proportion of at least one WCV (40% vs. 31%) and MH visits (48% vs. 27%) after intervention compared to controls, suggesting improved preventive and behavioral health utilization.

**Table 7: Patient demographics and health care utilization**

**7.1: Age**

	Sample size	Mean age	Standard deviation	Median	Median Q1	Median Q3	Minimum age	Maximum age
Control	9,504	7.6	4.7	7.0	4.0	11.0	0.0	17.0
Treatment	2,376	7.7	4.8	7.0	4.0	12.0	0.0	17.0

**7.2: Gender**

	Sample size	Female (count)	Female (%)	Male (count)	Male (%)
Control	9,504	4,675	49%	4,829	51%
Treatment	2,376	1,177	50%	1,999	50%

**7.3: Race**

	Sample size	American Indian / Alaska Native	Asian	Black	Multi-racial	Native Hawaiian / Pacific Islander	White	Other
Control	9,504	549 (5.8%)	251 (2.6%)	820 (8.6%)	356 (3.7%)	313 (3.3%)	4,633 (49%)	2,582 (27%)
Treatment	2,376	133 (5.6%)	50 (2.1%)	240 (10%)	83 (3.5%)	79 (3.3%)	1,101 (46%)	690 (29%)

**7.4: Ethnicity**

	Sample size	Hispanic (count)	Hispanic (%)	Not Hispanic (count)	Not Hispanic (%)
Control	9,504	4,264	45%	5,240	55%
Treatment	2,376	1,073	45%	1,303	55%

## Well-child visits

A well-child visit means that a child had at least one routine check-up during the year. This can include any scheduled well-child appointment or other encounter where the purpose was preventive care. Routine lab-only visits don't count toward this measure — the visit must include a full well-care service.

See the [Appendix](#) for HCA's calculation methodology and an expanded data table that includes the rate of change in WCV for both the control and treatment groups. A summary of that data is as follows:

**0-15 months:** Among infants aged 0–15 months, both the control and treatment groups experienced a decline in well-child visit (WCV) rates after the implementation of the CHW program.

- The control group's WCV rate decreased by 26%.
- The treatment group's WCV rate decreased by 20%.

**16-36 months:** For the 16–36 months age group, trends diverged.

- The control group's WCV rates decreased by 3%, suggesting a nearly stable rate.
- The treatment group's WCV rate increased by 9%.

**3-18 years:** The most notable change was observed in the 3–18 years age group

- The control group's WCV rates modestly increased by 7%.
- The treatment group's WCV rates substantially increased by 42%.

These findings suggest that the CHW program may have been particularly effective in improving preventive care utilization in older children.

**Table 8: Number of WCV for control group, CY 2023–2024**

Age Group	Sample size	WCV in CY 2023	WCV in CY 2024	Percent change
0–15 months	864	754	555	-26%
16–36 months	1,481	728	706	-3%
3–18 years	7,159	4,219	4,512	+7%

**Table 9: Number of WCV for treatment group (used CHW program), CY 2023–2024**

Age Group	Sample size	WCV pre-CHW	WCV post-CHW	Percent change
0–15 months	219	178	143	-20%
16–36 months	356	187	204	+9%
3–18 years	1,801	1,201	1,708	+42%

## Emergency Department visits (ED)

ED use was counted by the number of times a child went to the ED during the year, no matter how long they stayed or how serious the visit was. If a child went to the ED more than once on the same day, it is counted as a single visit. Visits that led to a hospital stay or an observation stay are not included, since those are counted separately.

See the [Appendix](#) for HCA’s calculation methodology and an expanded data table that includes the rate of change in ED visits for both the control and treatment groups. A summary of that data is as follows:

**0-15 months:** For infants aged 0–15 months, both control and treatment groups saw a decrease in ED visit rates.

- The control group’s ED visit rate decreased by 33%.
- The treatment group’s ED visit rate decreased by 27%.

**16-36 months:** In the 16–36 months age group, the patterns diverged.

- The control group’s ED visit rate slightly decreased by 4%, suggesting minimal change.
- The treatment group’s ED visit rate increased by 28% after following the CHW program.

**3-18 years:** Among children aged 3–18 years, the patterns continued to diverge.

- The control group’s ED visit rate decreased by 5%.
- The treatment group’s ED visit rate increased by 32% following the CHW program.

See the [Discussion](#) section for analysis on why ED visits may have increased following the CHW program.

**Table 10: Number of ED visits for control group, CY 2023–2024**

Age group	Sample size	ED visits, CY 2023	ED visits, CY 2024	Percent change
<b>0–15 months</b>	864	3,459	2,311	<b>-33%</b>
<b>16–36 months</b>	1,481	4,104	3,960	<b>-4%</b>
<b>3–18 years</b>	7,159	34,272	32,689	<b>-5%</b>

**Table 11: Number of ED visits for treatment group (used CHW program), CY 2023–2024**

Age group	Sample size	ED visits pre-CHW	ED visits post-CHW	Percent change
<b>0–15 months</b>	219	1,160	842	<b>-27%</b>
<b>16–36 months</b>	356	1,072	1,368	<b>+28%</b>
<b>3–18 years</b>	1,801	9,218	12,182	<b>+32%</b>

## Mental health utilization

For the mental health evaluation component of the study, members included those who receive at least one outpatient mental health service that meets specified procedure, provider, and diagnosis criteria within the measurement year. This includes:

- Psychotherapy and counseling services.
- Visits with mental health providers (such as psychiatrists, psychologists, and social workers) tied to a mental illness diagnosis.
- Behavioral health counseling encounters that include a mental illness diagnosis.
- Established patient visits with a mental health provider for any mental health condition.

Primary care visits are also included when mental illness is the primary diagnosis, ensuring capture of care delivered outside specialty behavioral health settings. Procedure code H0046 is counted when not marked as a service request. The criteria are intentionally overlapping to ensure a comprehensive view of access to outpatient mental health services across both specialty and primary care settings.

See the [Appendix](#) for HCA's calculation methodology and an expanded data table that includes the rate of change in MH visits for both the control and treatment groups. A summary of that data is as follows:

**0-15 months:** For the youngest age group (0–15 months), both the control and treatment groups saw a notable decrease in mental health (MH) visit rates following the CHW program.

- The control group's MH visit rate decreased by 70%.
- The treatment group's MH visit rate decreased by 41%.

**16-36 months:** In the 16–36 months age group, the patterns diverged.

- The control group's MH visit rate decreased by 6%
- The treatment group's MH visit rate increased by 24%.

**3-18 years:** Among older children aged 3–18 years, a similar pattern was observed.

- The control group's MH visit rate decreased by 6%.
- The treatment group's MH visit rate significantly increased by 44%.

These findings suggest that the CHW program may have contributed to increased engagement with mental health services among treatment group children aged 16 months and older, particularly those in the 3–18-year range. In contrast, among infants (0–15 months), mental health visit rates declined across both groups, potentially due to developmental appropriateness or fewer MH service needs at that age.

**Table 12: Number of MH visits for control group, CY 2023–2024**

Age Group	Sample size	MH visits, CY 2023	MH visits, CY 2024	Percent change
0–15 months	864	343	103	-70%
16–36 months	1,481	647	605	-6%
3–18 years	7,159	26,960	25,466	-6%

**Table 13: Number of MH visits for treatment group (used CHW program), CY 2023–2024**

Age Group	Sample size	MH Visits pre-CHW	MH visits post-CHW	Percent change
0–15 months	219	95	56	-41%
16–36 months	356	97	120	+24%
3–18 years	1,801	7,486	10,779	+44%

## CHW program impact on health care utilization

To see if the CHW program is linked to health care use, HCA ran a statistical test called a negative binomial model. If a result is **statistically significant**, it means the link is unlikely to be due to random chance. If a result is **not statistically significant**, it means the link we see could simply be due to random variation.

**Important:** This analysis shows an **association** between the CHW program and health care use, but it does **not prove that the program caused the changes**.

## Analysis results

After adjusting for age, gender, and race, the analysis of program effects on health care utilization revealed significant increases in service use among children who received CHW services, particularly in older age groups.

### Well-child visits:

- For children aged 0–18 years, the CHW program was associated with **a statistically significant** 33% increase (IRR = 1.33, 95% CI: 1.14–1.55,  $p < 0.001$ ).
- For younger children—those aged 0–15 months and 16–36 months—the increases in well-child visit rates (IRRs of 1.13 and 1.15, respectively) were **not statistically significant**, as their confidence intervals included 1 and p-values were well above 0.05.

### ED visits:

- There were **statistically significant** increases in older age groups. Children aged 16–36 months experienced a 30% increase (IRR = 1.30, 95% CI: 1.07–1.58, p = 0.009). Those aged 3–18 years saw a 38% increase (IRR = 1.38, 95% CI: 1.25–1.52, p < 0.001).
- In contrast, the 0–15-month age group showed a smaller increase (IRR = 1.09), which was **not statistically significant** (p = 0.40).

**MH visits:**

- Among children aged 3–18 years, a **statistically significant** 62% increase was observed (IRR = 1.62, 95% CI: 1.30–2.02, p < 0.001).
- While MH visit rates also rose for younger children aged 0–15 months and 16–36 months, these increases were **not statistically significant**. The confidence intervals for these groups were wide (e.g., IRR = 1.89, CI: 0.81–4.40 for 0–15 months), indicating greater uncertainty in the estimates—likely due to smaller sample sizes or lower baseline utilization.

**Table 14: Estimated program effects on health care utilization**

Understanding this table:

- The Incidence Rate Ratio (IRR) measures the relative change in healthcare visits associated with CHW services. An ideal IRR value is close to 1.0.
- The confidence interval (CI) measures the range of plausible values for each IRR estimate. An ideal CI is narrow, showing higher precision. A low CI means greater confidence in the estimate; a high CI means more uncertainty.
- The p-value measures statistical significance. A p-value ≤ 0.05 means the result is statistically significant; a p-value > 0.05 means it is not statistically significant

Visit Type	IRR	95% CI (Lower)	95% CI (Upper)	p-value	Statistically significant
Well-child visit: 0–15 months	1.13	0.80	1.59	0.50	No
Well-child visit: 16–36 months	1.15	0.82	1.61	0.40	No
Well-child visit: 3–18 years	1.33	1.14	1.55	<0.001	Yes
ED visit: 0–15 months	1.09	0.88	1.33	0.40	No
ED visit: 16–36 months	1.30	1.07	1.58	0.009	Yes
ED visit: 3–18 years	1.38	1.25	1.52	<0.001	Yes
MH visit: 0–15 months	1.89	0.81	4.40	0.14	No
MH visit: 16–36 months	1.15	0.54	2.48	0.70	No
MH visit: 3–18 years	1.62	1.30	2.02	<0.001	Yes

## Discussion

Our analysis of Washington’s CHW program reveals both promising impacts and areas requiring further improvement. Notably, the 33% increase in well-child visits among children aged 3–18 years is a testament to the dedication of the CHWs and their teams in engaging families and increasing awareness

of preventive care. Through consistent outreach, education, and relationship-building, CHWs likely helped navigate the health care system for many families, reinforcing the importance of routine check-ups even in the absence of illness.

Older children may have particularly benefited from CHWs' efforts due to increased opportunities for school-based communication and greater patient autonomy in scheduling appointments compared to families with infants or toddlers. Adolescents generally have greater patient autonomy—they can describe needs and often request or schedule visits themselves (e.g., via portals or school-based clinics)—whereas infants and toddlers are fully dependent on caregivers, making appointments contingent on adult work schedules, childcare, and transportation.

In contrast, younger age groups (0–36 months) did not show statistically significant improvements in well-child visits. This may reflect the unique challenges of engaging families with very young children, including competing caregiving demands, transportation barriers, or limited flexibility in scheduling. Additionally, both CHWs and families experienced difficulties in identifying and accessing some resources, which likely limited the program's impact. For CHWs that barrier is due to limited time for outreach, while families cited social challenges and long waitlists as the barriers to care. Another barrier frequently mentioned by CHWs in focus groups was the challenge of balancing their role in providing resources with respect to families' autonomy. Indeed, 82% of CHWs emphasized that the ultimate responsibility for seeking assistance lies with the families themselves — a dynamic that can be difficult to navigate when families are hesitant or unresponsive to outreach efforts. It's also possible that parents of infants were already more engaged in routine care (e.g., immunizations), limiting the room for additional improvement. To better support this group, CHWs may need longer, higher-touch engagement—home-based outreach, parent coaching at well-child visits, and direct linkages to early-childhood programs and services (e.g., Early Support/Early Head Start)—rather than expecting large gains in visit counts.

The increase in emergency department (ED) visits, particularly among children aged 16 months and older, is a more complex finding. While it may seem counterintuitive, this trend could reflect improved access to care overall, including families' increased comfort in navigating the health care system. CHW engagement may have made families more aware of symptoms needing medical attention or reduced hesitation in seeking urgent care. Alternatively, increased ED use may signal unmet needs that surfaced through CHW interactions—needs that couldn't be resolved through primary care alone. **These findings underscore the importance of pairing CHW outreach with stronger care coordination and access to timely, appropriate non-emergency services.**

For mental health services, the significant 62% increase among children aged 3–18 years points to an especially important impact of the CHW program. Mental health concerns in this age group may be more visible—through school performance, behavior, or peer relationships—and more readily discussed during CHW visits or outreach. CHWs likely served as trusted intermediaries who reduced stigma, explained options, and connected families to mental health resources they otherwise may not have accessed. That no significant increase was observed in younger age groups may be due to a combination of lower baseline need, limited provider availability for very young children, and difficulty in recognizing or expressing symptoms in early development.

## Limitations

Several important limitations should be considered when interpreting these results. Most critically, children were not randomly assigned to receive CHW services—families were referred based on clinical judgment and identified needs, meaning CHW recipients may have systematically differed from non-recipients in ways that affect health care utilization. While we used propensity score matching to address this selection bias by comparing CHW recipients to children with similar demographic characteristics and health conditions, **we cannot fully account for unmeasured factors that influenced CHW referral decisions, such as family motivation, social circumstances, or care-seeking behaviors.**

The relatively short follow-up period limits our ability to assess longer-term program effects, as some changes in health care utilization may take more time to fully emerge. Additionally, using visit counts alone does not capture the quality, intensity, or appropriateness of care received. The observed increases in ED and MH visits may reflect improved awareness of available services, better access to care, or identification of previously unmet health care needs rather than negative outcomes. Some confidence intervals are wide, particularly for mental health visits, indicating uncertainty around the precise magnitude of effects.

Finally, findings are specific to this population and health system and may not generalize to other states, health care systems, or populations with different demographics or socioeconomic conditions. **These results should be interpreted as associations rather than definitive causal effects, and policymakers should consider these methodological limitations alongside the program's broader goals.**

## HCA technical assistance

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Prior to the CHW grant starting, HCA sought input from CHWs around key considerations and strategies to support the success of the CHW grant. A recommended strategy that CHWs elevated as an essential factor to success is the role of a program manager with experience as a CHW to offer technical assistance and support to CHWs and the clinics they would be working within.

HCA's Community Health Integration Program Manager is responsible for both the contract management and technical support to ensure the successful integration of CHWs within pediatric primary care. This role provides both individual and cohort opportunities to provide project updates and education, explore successes and challenges, and encourage the opportunity for peer-to-peer support. Additionally, bi-annual site visits provide clinics with a personalized approach for receiving technical assistance to assess clinics' progress with integrating CHWs into their workflows. This support for CHW integration included:

- Identifying successes and challenges.
- Monitoring clinical progress with adopting the Culturally and Linguistically Appropriate Services (CLAS) standards.
- Providing tailored resources.

Finally, the program manager provides learning opportunities to ensure CHWs were equipped with the skills, knowledge, and resources needed to perform their role through monthly CHW team huddles. Each meeting is focused on different child health initiatives, programs, and services available throughout the community for the pediatric population and their families. Each call consists of a speaker from respective organizations to provide education and resources to CHWs, strengthening the coordination of care for families in need of support for mental, behavioral, and health-related social needs. The huddles serve as an additional function for networking and resource sharing. CHWs also are encouraged and supported in providing peer-to-peer support.

HCA continues to provide weekly technical assistance on implementation and billing via standing office hours, targeted webinars, and one-on-one case reviews with clinics and managed care plans to support post-grant adoption, clarify documentation/coding standards, troubleshoot claims and denials, and align CHW workflows with billing teams to optimize impact within Apple Health.

## Establishing an Apple Health CHW benefit

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In October 2024, HCA submitted a state plan amendment (SPA) to Centers for Medicare and Medicaid Services (CMS) adding community health worker services as new benefit within the Preventive Services section of the Medicaid State Plan. CMS approved the SPA on November 27, 2024, allowing Apple Health to cover services provided by CHWs under a licensed provider, including:

- Person-centered assessments
- Care coordination and health system navigation
- Behavior change facilitation
- Health education and promotion

CHW services were also carved into managed care contracts allowing coverage for managed care clients. HCA completed rulemaking and established the regulatory framework for a benefit, including the scope of CHW services, provider qualifications, and reimbursement requirements. A billing guide has also been published to ensure clear guidance on documentation, coding, and claims submission for CHW services. HCA will continue to provide technical assistance to ensure a smooth adoption and transition from the grant, addressing billing questions, and optimizing CHWs impact within the Apple Health.

The CHW services will be available when recommended by a physician or other licensed practitioner and can be billed by qualifying CHWs or CHR. CHWs or CHRs must have lived experience, 2,000 supervised working hours, and obtain either a CHW/CHR Certificate or Supervision Attestation from Medicaid-enrolled licensed supervisor.

## Conclusion

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The Community Health Worker (CHW) Grant Program has shown strong impact in improving access, equity, and family-centered care across Washington. Sustaining and scaling CHW integration will be key to maintaining these gains and reducing gaps in care for children across Washington. By carrying forward insights from our findings, Washington is well-positioned to build a durable CHW infrastructure that advances health equity and strengthens outcomes for children, youth, and families.

## Appendix: Evaluation methodology

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When evaluating rates of well child, emergency department, and mental health visits, (Tables 7–9, respectively), HCA used propensity score matching (PSM) to ensure that the Control group had a similar age distribution to the Treatment group (those who engaged with CHWs) at enrollment. For each child, we defined the reference (index) date as their enrollment date and measured visits within one year before and one year after that date. Each child contributed up to 12 months of data in both periods; however, if a child was enrolled at 6 months of age, only 6 months of data were available for the pre-period. This same approach was applied consistently to both groups to maintain comparability.

### Data Sources: Primary Data Systems

- Source\_P1 (SP1): Primary Medicaid database containing member enrollment, claims, and eligibility data
- Enterprise Data Mart (EDM): Dimensional modeling database built on SP1 for streamlined access to commonly used data elements
- Enterprise Data Warehouse (EDW): Comprehensive data warehouse housing SP1, EDM, and additional data sources

**Data Collection Period:** Baseline demographic, utilization, and coverage data were extracted for each member across 12-month pre- and post-treatment periods. Qualitative variables were consolidated using the most recent or maximum value within each period, while quantitative utilization metrics were averaged across the respective time frames.

### Time Period Definitions

- **Treatment Group:**
  - Pre-period: 12 months before first CHW contact
  - Post-period: 12 months after first CHW contact
- **Control Group:**
  - Pre-period: Calendar year 2023
  - Post-period: Calendar year 2024
  - Reference treatment date: January 1, 2024

### Study Population and Inclusion Criteria

- **Inclusion Requirements:**
  - Continuous enrollment: 12 months before and after treatment date for treated group; calendar years 2023 and 2024 for control group
  - Age: 0-18 years at time of analysis
  - Geographic location: Washington State residents only
  - Complete data: No missing data on key matching variables
- **Exclusion Criteria:**
  - Third Party Liability (TPL): Members with additional insurance coverage that could result in incomplete Medicaid claims data
  - Dual eligibility: Medicaid/Medicare dual-eligible members due to potential incomplete claims
  - Missing data: Any member with incomplete information on matching variables
  - Geographic: Members residing outside Washington State

**Table 15: WCV rates before and after CHW program compared to control group, CY 2023–2024**

The visit rate is per 1,000 members. If the post/pre ratio is greater than 1, then visits increased; a ratio of less than 1 is a decrease in visits.

Age Group	Group type	Sample size	# of WCV (Pre)	# of WCV (Post)	WCV rate (Pre)	WCV rate (Post)	Post/Pre Ratio
<b>0–15 months</b>	Control	864	754	555	873	642	0.74
<b>0–15 months</b>	Treatment	219	178	143	813	653	0.80
<b>16–36 months</b>	Control	1481	728	706	492	477	0.97
<b>16–36 months</b>	Treatment	356	187	204	525	573	1.09
<b>3–18 years</b>	Control	7159	4219	4512	589	630	1.07
<b>3–18 years</b>	Treatment	1801	1201	1708	667	948	1.42

**Table 16: ED rates before and after CHW program compared to control group, CY 2023–2024**

The visit rate is per 1,000 members. If the post/pre ratio is greater than 1, then visits increased; a ratio of less than 1 is a decrease in visits.

Age Group	Group type	Sample size	# of ED Visits (Pre)	# of ED Visits (Post)	ED Visit rate (Pre)	ED Visit rate (Post)	Post/Pre Ratio
<b>0–15 months</b>	Control	864	3,459	2,311	4,003	2,675	<b>0.67</b>
<b>0–15 months</b>	Treatment	219	1,160	842	5,297	3,845	<b>0.73</b>
<b>16–36 months</b>	Control	1,481	4,104	3,960	2,771	2,674	<b>0.96</b>
<b>16–36 months</b>	Treatment	356	1,072	1,368	3,011	3,843	<b>1.28</b>
<b>3–18 years</b>	Control	7,159	34,272	32,689	4,787	4,566	<b>0.95</b>
<b>3–18 years</b>	Treatment	1,801	9,218	12,182	5,118	6,764	<b>1.32</b>

**Table 17: MH visit rates before and after CHW program compared to the control group, CY 2023–2024**

The visit rate is per 1,000 members. If the post/pre ratio is greater than 1, then visits increased; a ratio of less than 1 is a decrease in visits.

Age Group	Group Type	Sample size	Total MH Visits (Pre)	Total MH Visits (Post)	MH Visit rate (Pre)	MH Visit rate (Post)	Post/Pre Ratio
<b>0–15 months</b>	Control	864	343	103	397	119	<b>0.30</b>
<b>0–15 months</b>	Treatment	219	95	56	434	256	<b>0.59</b>
<b>16–36 months</b>	Control	1,481	647	605	437	409	<b>0.94</b>
<b>16–36 months</b>	Treatment	356	97	120	272	337	<b>1.24</b>
<b>3–18 years</b>	Control	7,159	26,960	25,466	3,766	3,557	<b>0.94</b>
<b>3–18 years</b>	Treatment	1,801	7,486	10,779	4,157	5,985	<b>1.44</b>