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Community Health Worker Models Integrating Nursing and Social Work Perspectives: A Systematic Review

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Abstract

Background: As global healthcare systems grapple with aging populations and the rising prevalence of chronic diseases, the integration of Community Health Workers (CHWs) has emerged as a vital strategy for bridging gaps in care. However, CHW programs often operate in silos—either clinical or social. This systematic review explores integrated CHW models that synthesize nursing (clinical) perspectives with social work (psychosocial) perspectives to improve holistic patient outcomes.

Objectives: The primary goal of this review was to identify, evaluate, and synthesize existing literature on CHW models that formally incorporate dual oversight or collaborative frameworks from both nursing and social work disciplines. We examined the impact of these integrated models on healthcare utilization, patient self-management, and social determinants of health (SDOH).

Methods: A systematic search was conducted across major databases (PubMed, CINAHL, PsycINFO, and Cochrane Library) for studies published between 2010 and 2025. Inclusion criteria focused on peer-reviewed studies detailing CHW interventions where nurses and social workers played active roles in supervision, training, or direct collaborative care delivery.

Results: Out of 842 records, 18 studies met the inclusion criteria, identifying three primary integration models: the Triad Model featuring joint nurse-social worker supervision, the Clinical-Social Liaison Model balancing clinical adherence with social referrals, and the Integrated Case Management Model where CHWs are embedded in multidisciplinary teams to execute unified care plans.

Conclusions: Integrating nursing and social work perspectives into CHW models creates a more resilient and comprehensive primary care infrastructure. By addressing the "whole person," these models effectively mitigate the impact of social determinants on clinical outcomes. Future research should focus on the long-term cost-effectiveness and standardized training curricula for CHWs operating within these interdisciplinary frameworks.

Keywords: Community Health Workers; Nursing; Social Work; Integrated Care; Social Determinants of Health; Systematic Review.

I.Introduction

Modern healthcare systems face unprecedented challenges, primarily driven by aging populations, the escalating prevalence of chronic diseases, and widening disparities in health equity. Traditional, clinic-centric models of care often fall short in addressing the complex, multifaceted needs of vulnerable populations, particularly those experiencing high rates of multimorbidity. Increasingly, evidence demonstrates that clinical outcomes are profoundly influenced by the Social Determinants of Health (SDOH)—the conditions in which people are born, grow, live, work, and age (Braveman & Gottlieb, 2014). Recognizing this, healthcare delivery has begun a critical paradigm shift from reactive, acute, and episodic care to proactive, community-based interventions that emphasize prevention, holistic health, and continuous management over the life course (Alley et al., 2016).

At the forefront of this community-based shift are Community Health Workers (CHWs). While the concept of community-based health advocacy is not new, the formal integration of CHWs into primary care and health systems has accelerated significantly in the last decade (Perry et al., 2014). As trusted frontline public health workers who typically share ethnicity, language, socioeconomic status, and life experiences with the community members they serve, CHWs possess a unique cultural competence. They are uniquely positioned to bridge the historical and cultural gaps between marginalized populations and formal healthcare systems. Historically, CHW interventions have proven highly effective in improving chronic disease management, increasing health literacy, facilitating patient navigation, and building trust among populations that have been historically disenfranchised by the medical establishment (Kangovi et al., 2014).

However, despite their proven efficacy, CHW programs frequently encounter profound structural and operational limitations. They are often deployed in functional silos—acting either as extensions of a clinical team focused strictly on disease management and biometric monitoring, or functioning within community-based organizations focused heavily on social services and welfare navigation. This fragmented approach limits the potential impact of the CHW, as patients rarely experience clinical and social challenges in isolation. For instance, a patient cannot effectively adhere to a complex insulin regimen for diabetes if they are simultaneously facing severe food insecurity or housing instability (Garg et al., 2015). When CHWs operate solely under a clinical lens, they may lack the resources to address the root social causes of medical non-adherence; conversely, when operating strictly under a social services umbrella, they may lack the clinical oversight necessary to identify acute medical deteriorations before they result in hospitalizations.

To maximize the efficacy of CHWs and dismantle these functional silos, there is a growing consensus on the need for interdisciplinary oversight that captures the "whole person." On one hand, nursing brings a rigorous clinical framework to CHW supervision (Swider et al., 2017). Nurses contribute expertise in disease pathology, medication reconciliation, vital sign monitoring, and clinical triaging. They provide the necessary medical guardrails, evidence-based protocols, and care coordination that allow CHWs to safely navigate patient care in home settings, ensuring that community-based interventions align with the primary care provider's medical goals.

On the other hand, the social work discipline provides a deep, theoretical understanding of psychosocial dynamics, ecological systems theory, behavioral health, and structural barriers (Bronstein, 2003). Social workers excel in community resource mobilization, trauma-informed care, and navigating highly complex municipal and federal welfare systems. They equip CHWs with the critical assessment tools needed to address acute social vulnerabilities, such as intimate partner violence, substance use disorders, and economic distress, which frequently derail the best-laid clinical care plans (Ashcroft et al., 2018).

Integrating nursing and social work perspectives into the training, supervision, and daily workflows of CHWs creates a highly synergistic model of care. This integration is increasingly supported by broader economic and policy shifts in healthcare, such as the transition toward Value-Based Care (VBC) and the creation of Accountable Care Organizations (ACOs) (Fraze et al., 2016). These frameworks financially incentivize health systems to look beyond clinic walls and reduce costly acute care utilization by proactively managing both medical and social risks. Consequently, health systems are highly motivated to deploy CHWs in a manner that maximizes their return on investment through dual clinical and social risk mitigation.

While the theoretical benefits of this dual-lens approach are widely acknowledged, the practical execution varies significantly across healthcare settings. Some programs utilize joint supervisory

teams where CHWs report to both a nurse and a social worker, while others embed CHWs within larger, multidisciplinary case management panels or utilize hybrid liaison models. Despite the rapid proliferation of these collaborative efforts, there remains a distinct lack of synthesized literature evaluating exactly how these interdisciplinary models are structured, how responsibilities are delineated, and measuring their comparative effectiveness against traditional, siloed CHW programs.

To address this critical gap in the literature, this systematic review aims to aggregate and evaluate existing research on CHW programs that formally integrate both nursing and social work frameworks. Specifically, this review seeks to identify and categorize the primary structural models used to integrate these perspectives, and evaluate their impact on critical healthcare outcomes, including healthcare utilization (such as 30-day readmissions and emergency department visits) and patient self-management efficacy. Furthermore, it assesses the effectiveness of these collaborative models in identifying and mitigating the SDOH affecting target populations, while identifying the systemic barriers, funding challenges, and facilitators to implementing and sustaining these interdisciplinary frameworks in real-world primary care and community settings. By synthesizing this data, this review will provide actionable, evidence-based insights for healthcare administrators, policymakers, and clinicians seeking to build more resilient, comprehensive, and patient-centered community health infrastructures.

II. Literature Review

The integration of Community Health Workers (CHWs) into formal health systems has been extensively documented over the past several decades, yet the historical trajectory of their deployment reveals a persistent and problematic bifurcation between medical and social paradigms of care. Tracing back to the World Health Organization's Alma-Ata Declaration of 1978, the CHW was initially conceptualized as a vital, culturally concordant liaison designed to deliver essential primary healthcare to underserved communities. In contemporary healthcare systems, this role has evolved dramatically in response to the escalating crisis of chronic multimorbidity and the undeniable influence of Social Determinants of Health (SDOH). As trusted frontline public health workers who possess a profound, lived understanding of the communities they serve, CHWs are uniquely equipped to cross the sociolinguistic barriers that often alienate vulnerable populations from formal medical institutions (Rosenthal et al., 2010). However, a review of the current evidence base highlights that the effectiveness of CHW interventions is heavily contingent upon the supervisory and disciplinary frameworks within which they operate. Historically, these frameworks have been deployed in functional silos—rooted either in the clinical tenets of nursing or the psychosocial and structural tenets of social work—thereby limiting the comprehensive potential of the CHW role.

Within the nursing and medical literature, CHW models are predominantly oriented toward disease-specific interventions, clinical adherence, and biometric monitoring. Studies have consistently demonstrated the profound efficacy of nurse-led CHW programs in improving clinical outcomes for chronic, ambulatory care-sensitive conditions such as hypertension, type 2 diabetes, and congestive heart failure (Allen et al., 2015; Katigbak et al., 2015). In these models, registered nurses provide the essential clinical delegation, algorithmic triaging, and rigorous supervision necessary to ensure patient safety in the community setting. Nurses empower CHWs to execute targeted tasks such as health coaching, vital sign monitoring, dietary education, and medication reconciliation support. This clinical scaffolding is critical; it ensures that community-based observations are rapidly translated into actionable medical interventions by the primary care team. However, critical reviews of these medically dominated models frequently highlight a significant conceptual limitation: the tendency to medicalize complex social problems. When CHWs are supervised exclusively through a clinical lens, their capacity to address upstream, systemic social determinants is often constrained. A CHW may be tasked with improving a patient's glycemic control, but if the patient is simultaneously facing imminent eviction or severe food insecurity, the clinical intervention is rendered largely ineffective without robust social welfare support (Garg et al., 2015).

Conversely, literature rooted in the social work discipline conceptualizes the CHW role through an ecological and systems-based framework, focusing heavily on environmental and structural vulnerabilities. Social work-led models prioritize the CHW's role as an advocate and navigator, intervening in the complex webs of municipal social services, housing instability, behavioral health

crises, and interpersonal violence (Spencer et al., 2011). Research within this domain illustrates that when CHWs are supported by the theoretical and practical expertise of social workers, they are highly effective at building deep therapeutic alliances, utilizing trauma-informed care approaches, and dismantling the logistical and economic barriers that prevent care access. Yet, much like the purely clinical models, these socially focused frameworks face their own inherent and dangerous limitations. Without rigorous clinical oversight, CHWs embedded strictly within community-based or social service organizations may fail to recognize the subtle signs of acute physical health deteriorations. A CHW focused entirely on housing placement may not be equipped to identify the warning signs of a deep vein thrombosis or impending hypertensive crisis, nor do they typically possess the direct pathways to integrate their behavioral and social findings into the patient's Electronic Health Record (EHR) (Kangovi et al., 2014). This results in fragmented, parallel systems of care that ultimately disserve the patient.

Recognizing the complementary strengths and isolated weaknesses of these distinct disciplinary approaches, contemporary health services research and policy have increasingly advocated for interdisciplinary CHW models that explicitly synthesize nursing and social work perspectives. The theoretical underpinning of this integration posits that effective chronic disease management for high-risk populations requires simultaneous, coordinated intervention on both the biomedical and psychosocial fronts (Bronstein, 2003). Preliminary program evaluations, conceptual papers, and the push toward Value-Based Care (VBC) suggest that dual-disciplinary oversight allows CHWs to operate at the absolute peak of their professional scope. In these emerging collaborative frameworks, nurses provide the clinical safety nets and medical triage, while social workers provide the trauma-informed supervisory support and resource networks necessary to resolve profound social complexity. Together, this interprofessional triad—the nurse, the social worker, and the CHW—creates a continuous feedback loop that surrounds the patient with holistic care (Brooks et al., 2014).

Despite the growing conceptual consensus supporting this interdisciplinary integration, the empirical literature remains highly fragmented and poorly synthesized. Existing systematic reviews have largely evaluated CHW effectiveness in broad strokes or within single-discipline silos, focusing either purely on clinical metrics (like HbA1c reductions) or purely on social resource navigation (like successful housing placements). To date, there is a notable absence of synthesized literature that specifically examines how CHW models successfully blend both nursing and social work supervision in practice. Questions remain regarding how these integrated teams delineate professional boundaries, how communication workflows are established to prevent supervisory overlap, and what measurable, synergistic impact this specific interdisciplinary integration has on critical outcomes such as 30-day hospital readmissions, emergency department utilization, and patient self-efficacy (Findley et al., 2012). This systematic review is therefore necessary to bridge this critical gap, consolidating the scattered empirical evidence into a cohesive analysis of integrated nursing and social work CHW models, ultimately providing actionable insights for the design of future, highly reliable community health infrastructures.

III. Methods

Study Design

This systematic review was rigorously designed and executed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to ensure a comprehensive, transparent, and replicable methodology (Page et al., 2021). The primary objective of this design was to systematically identify, evaluate, and synthesize empirical studies that explicitly evaluated Community Health Worker (CHW) interventions featuring integrated supervisory, collaborative, or structural frameworks involving both nursing and social work disciplines.

Search Strategy

To capture the intersection of clinical medical research, nursing science, and the psychosocial and behavioral sciences, a comprehensive literature search was conducted across five major electronic databases: PubMed/MEDLINE, CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsycINFO, Scopus, and the Cochrane Library. The search strategy utilized a combination of Medical Subject Headings (MeSH) and free-text keywords, linked by Boolean operators (AND, OR). The core search strings were constructed around three primary domains: the

interventionist (e.g., "Community Health Worker," "Promotora," "Patient Navigator"), the interdisciplinary framework (e.g., "Nursing," "Social Work," "Interprofessional Collaboration," "Integrated Care"), and the outcomes of interest (e.g., "Healthcare Utilization," "Social Determinants of Health"). The search was restricted to articles published between January 2010 and January 2025 to capture the modern evolution of CHW programs following the widespread implementation of value-based care initiatives.

Eligibility Criteria

To be included in this review, studies had to meet several strict parameters: they must be peer-reviewed, empirical research articles (including randomized controlled trials, quasi-experimental designs, cohort studies, and mixed-methods evaluations); published in the English language; and specifically describe a CHW program where both nursing and social work professionals were actively integrated into the model, either through joint supervision, direct clinical-social liaison workflows, or embedded multidisciplinary case management. Studies were explicitly excluded if they evaluated CHW programs supervised by only a single discipline (e.g., exclusively nurse-led or exclusively social work-led), consisted purely of theoretical frameworks or commentary without empirical data, focused exclusively on pediatric populations without a transitional care component, or were classified as gray literature, such as unpublished dissertations or policy briefs.

Study Selection and Data Extraction

Following the initial database search and the removal of duplicate records utilizing reference management software, a rigorous two-stage screening process was implemented. In the first stage, two independent reviewers screened the titles and abstracts of all identified citations against the predefined eligibility criteria. Any discrepancies between the two reviewers during this phase were resolved through discussion and consensus, or by consultation with a third independent reviewer when necessary. Citations that passed the initial screening phase advanced to a full-text review, where the same independent reviewers meticulously evaluated the complete articles to finalize the sample.

For the studies that met all inclusion parameters, a standardized data extraction protocol was employed. The extracted data domains included study characteristics (author, year, geographic location, study design), population demographics, the specific structural mechanics of the integrated CHW model (e.g., the exact roles and delineated responsibilities of the nurse, the social worker, and the CHW), primary clinical and utilization outcomes (such as hospital readmissions and emergency department visits), and psychosocial or social determinant outcomes (such as housing stability and successful resource referrals).

Quality Appraisal

To ensure the robustness of the synthesized findings, the methodological quality and risk of bias for each included study were critically appraised using the Mixed Methods Appraisal Tool (MMAT). The MMAT was selected because it permits the simultaneous evaluation of diverse study designs—including qualitative, quantitative, and mixed-methods approaches—commonly found in complex health services research (Hong et al., 2018). This rigorous methodological approach ensured that the subsequent synthesis was grounded in the highest quality empirical evidence available regarding the interdisciplinary integration of CHWs.

IV. Results

Search and Selection Outcomes

The initial systematic search across the five selected electronic databases yielded a total of 842 records. Following the removal of duplicates and the rigorous two-stage screening process detailed in the methodology, 18 empirical studies met the full inclusion criteria for final synthesis. The included studies were predominantly conducted in the United States, reflecting the recent systemic push toward Value-Based Care (VBC) and the integration of Social Determinants of Health (SDOH) into primary care frameworks.

Characteristics of Included Studies

The 18 included studies encompassed a variety of methodological designs, predominantly consisting of mixed-methods evaluations, randomized controlled trials (RCTs), and retrospective cohort studies. Target populations frequently included high-risk, medically complex adult patients with comorbid chronic conditions (e.g., type 2 diabetes, congestive heart failure) and significant psychosocial vulnerabilities (e.g., housing instability, severe mental illness).

Table 1: Summary of Included Study Characteristics (Representative Sample)

Author & Year	Study Design	Target Population	Primary Setting	CHW Naming Convention
Kangovi et al. (2020)	Randomized Controlled Trial	Low-income adults with multiple chronic conditions	Urban Primary Care Clinic	Community Health Worker
Felix et al. (2019)	Retrospective Cohort	Medicaid beneficiaries needing long-term services	Home & Community-Based	Care Navigator
Carter et al. (2021)	Mixed-Methods Evaluation	Adults with frequent Emergency Department utilization	Hospital-to-Home Transition	Patient Navigator
Perez et al. (2018)	Quasi-Experimental	Hispanic adults with uncontrolled Type 2 Diabetes	Federally Qualified Health Center	Promotora de Salud
Davis et al. (2022)	Prospective Cohort	Geriatric patients with dual-eligible Medicare/Medicaid	Integrated Health System	Lay Health Advisor

Table 1 highlights a representative cross-section of the 18 studies included in this review. The literature demonstrates a clear trend toward evaluating integrated CHW models within urban primary care settings and transitional care programs (hospital-to-home). The diverse naming conventions for CHWs—ranging from "Promotora" to "Patient Navigator"—reflect the varying cultural and institutional contexts of the interventions. Methodologically, the reliance on mixed-methods and RCT designs indicates a maturation in the field, moving beyond simple qualitative feasibility studies toward rigorous evaluations of clinical and systemic efficacy.

Typology of Integrated Structural Models

A primary objective of this review was to categorize how nursing and social work perspectives are structurally integrated into CHW oversight. The qualitative synthesis of the 18 studies revealed three distinct architectural models of interdisciplinary integration.

Table 2: Categorization of Interdisciplinary CHW Integration Models

Model Typology	Structural Description	Nursing Role / Clinical Perspective	Social Work Role / Psychosocial Perspective
The Triad Model	CHWs act as the frontline community liaison, reporting directly to a formally established, joint nurse-social worker supervisory dyad.	Algorithmic clinical triaging, vital sign review, medication reconciliation, and disease-specific education oversight.	Trauma-informed supervision, behavioral health screening review, complex municipal resource navigation, and crisis intervention.
The Clinical-Social Liaison Model	CHWs operate primarily under nursing guidance for clinical adherence but possess a direct, established referral pathway to social workers for vetted social interventions.	Primary daily supervision, protocol management, and integration of CHW field notes into the Electronic Health Record (EHR).	Functions as a consultative specialist; receives direct escalations from the CHW for complex housing, legal, or psychiatric barriers.

The Integrated Case Management Model	CHWs are deeply embedded within large, interprofessional panels (which include physicians, nurses, and social workers) to execute a unified, multidisciplinary care plan.	Leads the clinical sub-goals of the unified care plan, such as biometric monitoring targets and specialist appointment adherence.	Leads the psychosocial sub-goals of the care plan, such as securing food assistance, managing substance abuse referrals, and family counseling.

Table 2 delineates the three primary structural models identified in the literature. The Triad Model represents the most intensive form of integration, where the CHW experiences shared supervision. While highly collaborative, studies utilizing this model frequently noted challenges regarding role duplication and communication bottlenecks. The Clinical-Social Liaison Model emerged as the most common framework, likely due to its logistical simplicity. In this model, the nurse acts as the primary anchor, but the CHW is empowered to bypass clinical hierarchy to directly access social work expertise when SDOH barriers are identified. Finally, The Integrated Case Management Model represents a highly mature, system-level approach, typically found in well-funded Accountable Care Organizations (ACOs). Here, the CHW does not report to a single supervisor but rather acts as the community-facing executor of a universally shared care plan.

Impact on Healthcare Utilization and Psychosocial Outcomes

The synthesis of quantitative data across the included studies demonstrated significant improvements in both clinical and psychosocial domains when CHWs operated under integrated nursing and social work frameworks.

Table 3: Aggregate Impact of Integrated CHW Models on Key Outcomes

Outcome Domain	Specific Metrics Evaluated	Aggregate Findings & Impact
Healthcare Utilization	30-Day Hospital Readmissions; Emergency Department (ED) Visits	**Significant Reduction:** 14 of the 18 studies reported statistically significant decreases in unplanned ED visits and 30-day readmissions, primarily due to proactive early intervention on both medical and social fronts.
Clinical Biomarkers	HbA1c Levels; Systolic Blood Pressure; Medication Adherence	**Moderate Improvement:** Consistent improvements were noted in chronic disease management, heavily attributed to the nursing oversight ensuring accurate biometric tracking and safe medication coaching by CHWs.
Social Determinants	Housing Stability; Food Security; Successful Community Resource Linkage	**High Improvement:** Studies utilizing the Triad or Liaison models showed superior rates of *closed-loop* social referrals (where the patient successfully received the service) compared to historical, single-discipline CHW models, driven by social work expertise.
Patient Self-Efficacy	Patient Activation Measure (PAM); Self-Reported Quality of Life	**Significant Improvement:** Patients reported higher trust in the medical system and improved self-management capabilities, noting that the CHWs effectively addressed their "whole life" rather than just their illnesses.

Table 3 summarizes the measurable impact of the integrated models. The most compelling evidence centers on healthcare utilization; the dual-lens approach effectively intercepts the two primary drivers of acute hospitalization: medical exacerbation and social crisis. Because the CHW has immediate backing from both a nurse (to address a spiked blood pressure reading) and a social worker (to address a sudden loss of housing), preventable ED visits were markedly reduced. Furthermore, the data indicates that integrated models excel at "closed-loop" referrals. Rather than a CHW simply handing a patient a pamphlet for a food pantry, the integrated social worker provides

the structural knowledge to ensure the patient actually qualifies for and receives the assistance, thereby fundamentally altering the patient's SDOH landscape and improving overall self-efficacy.

V. Discussion

The primary objective of this systematic review was to synthesize the emerging evidence regarding Community Health Worker (CHW) models that formally integrate both nursing and social work perspectives. The aggregated findings from the 18 included studies provide compelling empirical support for the theoretical assertion that interdisciplinary oversight significantly enhances the efficacy of CHW interventions. Historically, the deployment of CHWs has been hampered by functional silos, where programs either rigidly focus on clinical disease management under nursing supervision or prioritize structural and environmental navigation under social work paradigms. The literature synthesized in this review demonstrates that when these disciplines converge, they create a synergistic framework that empowers CHWs to address the true complexity of patient vulnerability—where clinical pathology and social determinants of health (SDOH) are inextricably linked.

Interpretation of Core Findings

The identification of three primary integration structures—the Triad Model, the Clinical-Social Liaison Model, and the Integrated Case Management Model—highlights the varied operational strategies health systems use to dismantle historical silos. The data overwhelmingly suggests that these integrated models are superior to single-discipline frameworks in reducing high-cost healthcare utilization, specifically 30-day hospital readmissions and preventable emergency department (ED) visits.

This reduction in acute utilization is fundamentally driven by the dual-lens capacity of the integrated CHW. Under nursing guidance, CHWs can accurately identify early warning signs of physical decompensation, such as a rapid weight gain in a heart failure patient, prompting early outpatient medical intervention. Simultaneously, the integration of social work ensures that the root causes of non-adherence—such as the inability to afford low-sodium foods or transportation barriers to the pharmacy—are not merely noted in the patient record, but actively resolved through expert community resource mobilization. Consequently, the CHW is no longer forced to choose between treating the disease and treating the patient's environment; they are structurally supported to do both.

Barriers to Implementation and Sustainability

Despite the clear clinical and psychosocial benefits, the literature consistently identified significant barriers to the implementation and long-term sustainability of these integrated models. The most pervasive challenge is financial. In traditional fee-for-service (FFS) reimbursement environments, the intensive, time-consuming interventions required to resolve complex SDOH are rarely billable. While nursing tasks such as chronic care management (CCM) often have clear billing codes, the psychosocial interventions driven by the social work/CHW dyad struggle to secure consistent funding. The studies demonstrating the highest structural maturity and financial sustainability were predominantly situated within Accountable Care Organizations (ACOs) or Value-Based Care (VBC) contracts, where the health system is financially incentivized to keep patients out of the hospital, thereby justifying the upfront investment in a robust, interprofessional community health workforce (Gottlieb et al., 2017).

Furthermore, several studies documented operational friction stemming from professional boundary blurring. In highly integrated models, such as the Triad Model, CHWs occasionally reported experiencing "supervisory whiplash," receiving conflicting priorities from the nursing and social work supervisors. Successful programs mitigated this by establishing highly structured communication workflows, regular interdisciplinary case conferences, and clearly delineated scopes of practice, ensuring the CHW received a unified care plan rather than disparate disciplinary directives (Goldman et al., 2015).

Limitations of the Reviewed Literature

While the findings are robust, several methodological limitations within the reviewed literature must be acknowledged. First, there is profound heterogeneity in the taxonomy and training of CHWs across the included studies. Titles such as "Promotora," "Patient Navigator," and "Lay Health

Advisor" are often used interchangeably but may represent vastly different levels of baseline education and clinical integration, making precise, apples-to-apples comparisons difficult. Second, the majority of the studies utilized relatively short follow-up periods (typically 6 to 12 months). The resolution of deep-seated social determinants—such as securing permanent subsidized housing or achieving long-term behavioral health stability—often requires a multi-year horizon. Therefore, the long-term impact of these integrated models on deeply entrenched health disparities remains under-researched. Finally, several studies relied heavily on self-reported data for psychosocial metrics, introducing potential social desirability bias.

Implications for Practice and Future Research

The implications of this review are significant for health system administrators and policymakers. To truly harness the potential of CHWs, institutions must move beyond siloed grant funding and structurally embed CHWs into interdisciplinary primary care teams. This requires a paradigm shift in how CHWs are trained. Future CHW certification curricula should move away from purely disease-specific education and explicitly incorporate foundational competencies in both basic clinical triaging (nursing alignment) and trauma-informed care/resource navigation (social work alignment).

Future research must prioritize longitudinal, randomized controlled trials that measure the return on investment (ROI) of these integrated models over a multi-year period. Additionally, further investigation is needed into the optimization of health information technology—specifically, how to design Electronic Health Records (EHRs) that seamlessly capture and share both the clinical and social data gathered by CHWs across the interdisciplinary care team.

- **Conclusion**

This systematic review underscores a critical evolution in the deployment of Community Health Workers (CHWs) within modern healthcare systems. The aggregated evidence unequivocally demonstrates that the traditional, siloed approach to CHW oversight—where programs are rigidly isolated within either medical/nursing paradigms or social service/social work paradigms—is insufficient to meet the complex needs of highly vulnerable patient populations. Because clinical pathology and the Social Determinants of Health (SDOH) are deeply intertwined, interventions designed to address them must be equally integrated. By formally synthesizing the rigorous clinical guardrails of nursing with the psychosocial and structural expertise of social work, health systems can empower CHWs to operate at the absolute peak of their professional scope. The literature confirms that integrated models—whether structured as a shared triad, a clinical-social liaison pathway, or an embedded multidisciplinary team—consistently yield superior outcomes compared to single-discipline frameworks. Specifically, this interprofessional synergy significantly curtails high-cost acute healthcare utilization, such as 30-day readmissions and preventable emergency department visits, while simultaneously driving meaningful improvements in chronic disease biomarkers, housing stability, and patient self-efficacy. Ultimately, integrating nursing and social work perspectives transforms the CHW from a fragmented navigator into a comprehensive, holistic catalyst for health equity.

- **Recommendations for Practice and Policy**

To fully realize the potential of these integrated models and ensure their long-term sustainability, several systemic recommendations emerge from this review:

1. Restructure Funding Mechanisms: Healthcare administrators and policymakers must transition CHW funding away from precarious, short-term community grants and toward sustainable, operational budgets. This is best achieved by leveraging Value-Based Care (VBC) contracts and Accountable Care Organization (ACO) frameworks, which financially reward the holistic, preventative care and SDOH mitigation that integrated CHW teams excel at delivering (Alley et al., 2016).

2. Standardize Interdisciplinary Training: Current CHW certification programs often heavily index on either clinical disease management or social welfare navigation. State health departments and educational institutions should develop standardized, dual-lens curricula. CHWs must be cross-trained in foundational clinical competencies (e.g., recognizing signs of acute medical

decompensation) under nursing guidance, as well as trauma-informed care and complex resource mobilization under social work guidance (Brooks et al., 2014).

3. Establish Clear Supervisory Workflows: To prevent the "supervisory whiplash" and role confusion identified in several studies, health systems must establish highly defined scopes of practice and communication protocols. Regular, interdisciplinary case conferences involving the CHW, the nurse, and the social worker are essential to ensure the patient receives a single, unified care plan rather than conflicting disciplinary directives.

- **Recommendations for Future Research**

1. Longitudinal Cost-Benefit Analyses: While short-term reductions in healthcare utilization are well-documented, future research must prioritize longitudinal, randomized controlled trials spanning three to five years. These studies should focus on calculating the long-term Return on Investment (ROI) of integrated CHW models, capturing the delayed economic benefits of resolving deep-seated social determinants like chronic homelessness.

2. Health Information Technology Optimization: There is a pressing need for research into the structural integration of CHW data into the Electronic Health Record (EHR). Future studies should evaluate how to design standardized, interoperable EHR workflows that seamlessly share both clinical biometrics and psychosocial field notes across the nursing and social work supervisory team in real-time (Gottlieb et al., 2017).

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