Penn Center for Community Health Workers

2026 Latino Health Collective Retreat

Mission: Advancing health equity through person-centered care and partnerships.

Jovan Bennett, Senior Director

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From Community Insights to the Penn Center

- **2011**: **IMPaCT Launched**: Developed through more than 100 interviews with residents of West and Southwest Philly to understand what they believed they needed to improve their health.

- **2013**: **PCCHW Established**: The Penn Center for Community Health Workers was formally established to support the model's continued development and expansion.

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What We Heard: The Gap Between Healthcare and Everyday Life

Disconnect between clinical advice and everyday life

“ They can give you advice, like here’s the kind of medicine you need. But they don’t really know how it works in the real world.”

Barriers to accessing care

“I can’t get what I need from the clinic so I have to go to the ER.”

Unrealistic expectations

“Set up to fail.”

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Designed Differently From the Start

COMMON CHW PROGRAM CHALLENGES	The IMPaCT APPROACH
Staff Turnover	Specialized CHW Recruitment
Poor Infrastructure	Standardized Training, Work Practice, & Supervision
Disconnected from Healthcare	Integrated into Health Systems
Disease Focus	Whole-Person Focus
Not Measured	Scientifically Proven

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Local Talent. Lasting IMPaCT.

- Employing **trusted Philadelphia residents** as community health workers since **2013** to build rapport and provide tailored, community-based care.

- **Fully-funded by Penn Medicine**, PCCHW reflects the health system's sustained commitment to investing in and supporting one of the region's largest CHW programs.

Building a Skilled & Supported CHW Workforce

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From Innovation to Scale: PCCHW Today

30
CHWs

>28,000
Patients Served

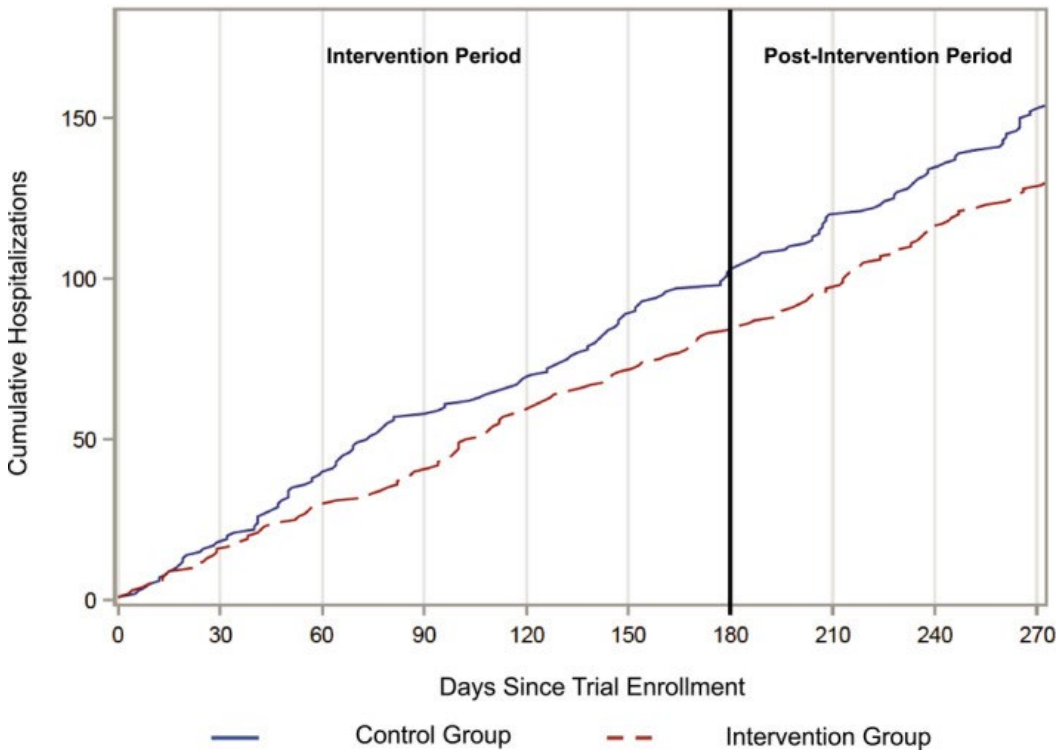
>40
Clinical Sites

>100
ZIP Codes

How IMPaCT Has Evolved

- **Expanded across care settings**: Extended work beyond its initial implementation into hospitals, primary care, and community-based services.
- **Broadened patient engagement**: Expanded how CHWs connect with patients at the bedside, in clinics, during home visits, and through telephonic outreach.
- **Strengthened care integration**: CHWs collaborate with clinical teams to coordinate care and address barriers beyond the clinical setting.
- **Maintained a person-centered approach**: The model continues to prioritize patient-defined goals, trusted relationships, and whole-person care.

CHWs improve patient health, experience, and reduce health care costs



- **↓34%** reduction in total hospital days
- **13%** increase in post-hospital primary care follow-up
- Improvements in **mental health** and control of **chronic health** conditions
- Increased patient-reported **quality of care** (CAHPS/HCAHPS)
- ★ ★ ★ **9.8**/10 likelihood to recommend

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Addressing health and social needs in FY26

2,614 **health-related social needs** addressed

1,842 **primary & specialty care** navigation needs addressed

421 **transportation barriers addressed** via Uber Health

321 **grocery boxes distributed** to food insecure patients

64% **post-hospital primary care** appointments completed

60% **lower likelihood of hospital/observation visit** among patients with CKD

CHWs provide person-centered, holistic support

"One of the many compassionate CHWs assisted one of our most vulnerable patients into **stable housing** in an independent senior apartment complex. He is very hard to connect with due to losing his phone. Yesterday she spent many hours at his bedside, helping him with a **new phone**. **His joy having a connection to his world was palpable in the room.** She assisted him with **securing a new PCP** [and] follow up appointment; he had not followed up since 2016 and has used our ED as his PCP for years. She also confirmed and secured a PCA assessment to get him evaluated for **HHA services**. All of these important **life-changing opportunities** may help us help him take more responsibility for his health." – *HUP Clinical Resource Coordinator*

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