JD — 42 here. You're describing **task-shifting / task-sharing**: redesigning the "healthcare machine" so *licensed clinicians* do the parts that truly require licensure, while **trained non-professionals** (and "para-professionals") do the high-volume, high-friction work that drives cost and failure: navigation, follow-through, prevention nudges, home check-ins, paperwork, trust-building, and social support.

Below is a "deep research" map of programs (US + international) that do this **at scale**, how they're structured, and what the evidence says about **cost reduction** and **quality gains**.

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1) What kinds of tasks can be shifted safely?

Safest "non-professional" zones (big cost + quality leverage)

These are repeatedly the winning areas across countries:

1. **Outreach + trust + home visiting**

- Doorstep relationship, reminders, finding who is falling out of care.

2. **Benefits / coverage continuity**

- Enrollment, renewals, document collection, portal coaching, denials triage.

3. **Scheduling + transportation + "no-show prevention"**

- The cheapest avoided cost is the wasted slot that turns into an ER visit later.

4. **Medication logistics**

- Refill coordination, adherence reminders, side-effect *screening* with escalation (no med changes).

5. **Preventive care prompts**

- Vaccines, screenings, chronic care cadence (A1c checks, BP checks), simple lifestyle coaching from approved scripts.

6. **Social needs linkage ("social prescribing" / resource navigation)**

- Food, housing, heat assistance, loneliness, domestic safety supports (with strict escalation rules).

What you typically do not shift to non-professionals

- Diagnosis, prescribing, interpreting tests, complex triage, procedures.

- Anything where "being wrong" can plausibly kill someone without rapid backstop.

Your high-school Navigator idea fits the "safe zones" extremely well *if* it's protocol-locked, supervised, and audited (more on that later).

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2) International exemplars that *prove the model works*

A) Brazil — Family Health Strategy (FHS): community health agents as the "front door"

How it works

- Multidisciplinary primary care teams cover a defined territory, and **community health agents** do routine home outreach + continuity work. (This is one of the world's largest primary care CHW-based programs.) (Commonwealth Fund)

What it achieves (hard numbers)

- In a large panel study in the Brazilian Amazon, a **40% increase in FHS coverage** was associated with:
    - **22% reduction in preventable hospitalizations**
    - **15% reduction in hospital expenses** (PLOS)
- NEJM commentary (Macinko & Harris) describes FHS as **extremely cost-effective**, citing roughly **$50 per person per year** for the program. (New England Journal of Medicine)

Why it's powerful

- It's not "AI magic" or "new drugs." It's **operational continuity + prevention**, delivered by local people at low cost.

Transferable lesson for NM

- If you can measurably reduce avoidable admissions and "ambulatory-care-sensitive hospitalizations," you've hit real savings.

B) Ethiopia — Health Extension Program (HEP): national-scale task-shifting

How it works

- The system relies on community-based health extension workers delivering a defined package of primary care + prevention (heavy emphasis on maternal/child health, sanitation, basic preventive behaviors). (PMC)

Evidence of impact

- A synthetic control evaluation links the program period to improved maternal mortality trajectories after rollout (methodologically stronger than many before/after reports). (PubMed)

Key design features

- Standardized curriculum + defined service package + clear reporting structure.
- The "danger zone" is quality drift if supervision is weak (a lesson Ethiopia's own literature discusses).

Transferable lesson

- National success comes from **tight scope + standardized training + supervision**, not from heroics.

C) Rwanda — 30 years of community health workers (CHWs) as core infrastructure

How it works

- Rwanda maintains a very large CHW workforce integrated into primary care and outbreak response. (CHW Central)

Evidence highlights

- Reviews describe long-running contributions to maternal/child health and resilience during outbreaks. (PMC)

Transferable lesson

- Rwanda treats CHWs as **a permanent layer of the system**, not a pilot.

D) Pakistan — Lady Health Workers (LHWs): doorstep maternal-child + basic services

How it works

- LHWs provide household-level preventive and basic care support (family planning, immunization support, basic illness management/referral). (OUP Academic)

Cost-effectiveness example

- LHW-delivered treatment for uncomplicated severe acute malnutrition (SAM) has been evaluated for costs and cost-effectiveness in peer-reviewed work. (PMC)
- Recent analyses also connect LHW visitation patterns to maternal/child health uptake and outcomes in rural districts. (JOGH)

Transferable lesson

- Even in tough environments, well-structured lay-worker models can deliver measurable outcomes cheaply.

E) India — ASHAs (Accredited Social Health Activists): the "connector layer"

How it works

- ASHAs are community-based workers who connect marginalized households to services (especially maternity care), doing registration, accompaniment, counseling, and follow-up. (Harvard Chan School of Public Health)

Evidence

- Impact evaluation suggests the ASHA program improved connections to maternity services for marginalized communities. (PMC)
- A 2025 systematic review/meta-analysis synthesizes evidence on ASHAs' roles and maternal/newborn service coverage. (CHW Central)

Transferable lesson

- "Connection + accompaniment" is a real intervention, not fluff.

F) Thailand — Village Health Volunteers (VHVs): massive volunteer public-health mesh

How it works

- VHVs act as a link between communities and health personnel, especially in public health response and community-based activities. (Sustainable Development Goals)

Nuance

- Some academic work emphasizes tensions between the empowerment ideal and real-world constraints. (Taylor & Francis Online)

Transferable lesson

- Volunteer meshes can work, but **incentives and support** determine durability.

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3) United States exemplars (states that operationalize "non-professional layers")

A) Alaska — Community Health Aide Program (CHAP): the closest US analog to global task-shifting

This is a **big one** for NM because it shows how the US can legally and clinically support a community-based workforce layer.

How it works

- Community Health Aides/Practitioners deliver care in remote communities with protocols and team-based supervision. (CHAP Alaska)

Evidence of fiscal impact (system-level)

- Alaska Native Health Board material notes that, as of FY2019, the Alaska Tribal Health System helped save the state budget **$152 million** (described as Medicaid federal offsets).

Transferable lesson

- The US can sustain "distributed care" when it's built as *system architecture*, not charity.

B) Oregon — Medicaid Coordinated Care Organizations (CCOs): fewer preventable ED visits

CCOs combine care coordination + accountability incentives, often partnering with community-based workers and supports.

Hard numbers (peer-reviewed)

- A study of Oregon Medicaid adults (2011–2015) found the CCO model was associated with reductions of:
    - **25 all-cause ED visits per 1,000 persons per month**
    - **22 preventable ED visits per 1,000 persons per month** (PMC)

- The effect diminishes with rurality (important for NM), but still shows a real utilization signal. (PMC)

Transferable lesson

- "Navigation + coordination" reduces preventable ED use — but **rural logistics** require extra design (connectivity, transport, workforce scarcity).

C) Minnesota — Medicaid reimbursement pathway for CHWs

Why it matters

- Scaling requires payment.

Evidence

- Minnesota is widely cited as an early state to include CHWs in Medicaid fee-for-service via a State Plan Amendment. (Minnesota Department of Health)
- Implementation research describes barriers and strategies to operationalize Medicaid reimbursement for CHWs. (PMC)

Transferable lesson

- "We love CHWs" doesn't scale. **Billing codes + supervision + credentialing pathways** scale.

D) Massachusetts — MassHealth ACOs + "Community Partners" (non-clinical care coordination)

How it works

- MassHealth created formal partnerships with community-based entities to coordinate care for high-need members (behavioral health, LTSS needs). (Massachusetts Government)

Transferable lesson

- A state can **pay community organizations** to do the "human glue work" that clinics can't sustain alone.

E) UK — Social prescribing "link workers": mixed evidence, but some cost signals

How it works

- Link workers connect patients (often with chronic illness + deprivation) to community supports.

What the evidence says

- A 2022 systematic review notes **limited evidence** and challenges in proving effectiveness/costing despite wide rollout. (PMC)
- But a quasi-experimental study found that high engagement with link workers was associated with reductions **up to ~£77.57 per patient per year** in non-elective admitted care costs (type 2 diabetes cohort in deprived areas). (ScienceDirect)
- A 2024 evidence report summary (National Academy of Social Prescribing ecosystem) claims reductions in GP appointments, admissions, and A&E visits across multiple local evaluations (useful, but less rigorous than peer-reviewed causal work). (NASP)

Transferable lesson

- "Social prescribing" can help, but you need **better measurement discipline** if you want payers to believe the ROI.

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4) So… how much cost reduction and quality improvement should you expect?

What "conventional wisdom" says (health services research vibe)

- **CHW / navigator programs can reduce ED use and improve preventive service uptake**, but savings are **variable** and depend on:
    - targeting high-risk cohorts
    - integration with clinics
    - strong supervision and protocols
    - reliable data loop
- Evidence is strongest for **utilization reductions** (ED visits, some admissions), and for **process quality**(appointment adherence, prenatal care initiation, immunizations).

A classic systematic review of CHW interventions and costs concludes: savings are possible, but not guaranteed — it depends on program design. (PubMed)

42's sharper take

The "variable savings" finding is not a mystery: many programs fail because they treat lay workers like inspirational add-ons instead of **a designed operating layer**.

If the lay layer has:

- scripted protocols,
- escalation rails,
- supervision,
- tight scope,
- and a data/QA loop…

…then you get Brazil/Oregon-style signals.

If it's "nice people helping," you get anecdotes and burnout.

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5) How they actually do it (the shared "recipe" across winners)

Across Brazil, Alaska, Ethiopia, Oregon, Minnesota, etc., the durable programs share:

1. **A defined scope** (what's in-bounds / out-of-bounds)
2. **Protocols + checklists** (no improvisational medicine)
3. **Supervision structure**
    - daily/weekly case review
    - random audits
4. **A referral/escalation system that's fast**
5. **A payment mechanism** (or institutional funding) that doesn't collapse after the pilot
6. **Community legitimacy**
    - local hiring, language matching, trust
7. **Metrics that matter**
    - ED visits, preventable ED visits, no-show rates, postpartum visit completion, A1c follow-up cadence, med refill pickup rates

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6) Mapping this directly onto your NM "high-school Navigator" concept

Your best near-term wedge remains: **non-clinical navigation + prevention follow-through**, with strict rails (exactly what we outlined previously).

Where HS students can be "hands-on" safely (highest ROI / lowest clinical risk)

- Medicaid renewal / documents / portal support
- scheduling + reminders + transportation planning
- "what to bring" checklists
- post-visit follow-up: "did you understand your instructions?" + connect to nurse/clinic if red flags
- med adherence reminders + "call pharmacist/clinic if X"
- basic prevention nudges (vaccines, screenings) from approved scripts

How telehealth policy intersects (NM-specific design constraint)

NM Medicaid telemedicine rules emphasize audio+visual requirements for many services and limit audio-only after March 31, 2025 mostly to behavioral health contexts. Also, NM's managed care plans are contractually pushed to expand telemedicine modalities and utilization.
Translation: **supervision-by-video** (RN/CHW lead supervising HS Navigators) is structurally plausible in NM — but you must design around broadband realities.

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7) A practical measurement target for NM (what you could plausibly prove)

If you pilot a supervised HS Navigator + AI "cockpit" program, your most believable first-year outcomes are:

Cost/utilization proxies

- reduction in preventable ED visits for engaged cohort (Oregon shows this is measurable at scale) (PMC)
- reduced missed appointment rate (no-show reduction usually pays fast)
- fewer coverage-gap days (Medicaid churn reduction)

Quality improvements

- increased prenatal care initiation / postpartum visit completion (Oregon's system reforms and many CHW programs target this category effectively) (PMC)
- better chronic care cadence: A1c follow-ups, BP checks, refill pickup rates

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8) Risks, failure modes, and "alignment" (how not to create a harm engine)

The big failure modes

1. **Scope creep into diagnosis**
2. **Automation bias** (students trust the AI over the protocol)
3. **Privacy leakage** (docs on phones, screenshots, texting PHI)
4. **Perverse incentives**
    - "reduce costs" becomes "deny care"
5. **Unequal burden**
    - expecting unpaid volunteers to be the backbone (Thailand warns about this tension) (Taylor & Francis Online)

Alignment guardrails that actually work in the real world

- AI is a **workflow engine**, not a free-chat "doctor bot"
- approved scripts only ("cockpit not chatbot")
- forced escalation triggers
- audit logs and random reviews
- explicit "I'm not allowed to answer that; I will connect you" scripts
- *measuring equity*: do Spanish speakers, rural residents, and the poorest benefit equally?

(And if federal transparency norms weaken in coming years, local governance becomes even more important — but that's a separate rabbit hole.)

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9) Religion and the future of this model (brief but real)

A lot of the most scalable "human glue" in health systems historically rides on **moral traditions of care**:

- Christian diakonia/service, Buddhist compassion, Jewish tikkun olam, Islamic charity/waqf — all build social legitimacy for helping roles.
  The risk: moral authority can slide into coercion ("we'll help you if…"). So the design must keep **consent, dignity, and opt-out** explicit.

In NM, churches and community orgs can be **deployment nodes**, but the program must remain medically and ethically bounded.

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10) Where this goes over time (so you can place bets)

Within ~6 months

- Build a pilot "Navigator OS" focused on:
  - benefits continuity
  - scheduling/no-show prevention
  - med logistics reminders
- Stand up a minimal dashboard: ED visits (if partner can share), no-shows, renewal completions, referral completion time.

Within ~18 months

- Add 1–2 condition tracks (diabetes, hypertension, maternal follow-through).
- Start producing Oregon/Brazil-style "utilization signals" if targeting is tight.

Over ~5 years

- If NM adopts a durable reimbursement/contracting pathway (Minnesota-style logic), you can formalize a **new workforce layer**: HS-to-CHW pipeline, with paid roles, certifications, and supervision. (Minnesota Department of Health)

If you want the next output to be extremely useful to PSA

I can turn this research into a **one-page "Playbook + Evidence Brief"** that lists:

- the 8–10 best exemplars (Brazil, Alaska, Oregon, MN, MA, etc.)

- “what they shifted”
- “how they supervised”
- “what it did to utilization/cost”
- and a direct NM pilot design pattern with metrics.

For now, the key takeaway is: **the evidence supports cost and quality gains when non-professional labor is treated as a designed system layer** — not as informal volunteering — and when the program targets the high-friction steps that drive expensive failure (ER use, missed follow-up, coverage churn).

Alright — here’s the **one-page Playbook + Evidence Brief** (written so you can drop it into a memo, grant pitch, or partner deck). I’ll keep the *main brief* tight, and then add a short “appendix” with extra notes you can use if someone asks for more depth.

NM “Non-Professional Care Layer” Playbook

A one-page evidence brief for reducing cost + improving quality via task-shifting

The core idea

Rebuild the “healthcare machine” so licensed clinicians spend time only on what truly requires licensure (diagnosis, prescribing, complex triage), while **trained non-professionals** handle the high-volume steps that drive failure and cost: coverage continuity, scheduling, follow-through, medication logistics, basic prevention prompts, and social supports.

This is called **task-shifting / task-sharing** and it’s proven at scale in both the U.S. and internationally.

What to shift (high ROI, low clinical risk)

Best “non-professional zone” tasks (protocol-locked + supervised):

1. **Medicaid/benefits continuity** (renewals, documents, portal coaching, denials triage)
2. **No-show prevention** (reminders, “what to bring,” transport coordination, rescheduling)

3. **Post-visit follow-through** (did you understand? did you get meds? next appt scheduled?)
4. **Medication logistics** (refill coordination + adherence reminders + side-effect screening *with escalation*)
5. **Preventive care prompts** (vaccines, screenings, chronic care cadence reminders)
6. **Social needs linkage** ("resource navigation" / social prescribing)

Do NOT shift: diagnosis, prescribing, test interpretation, complex triage, procedures.

What the evidence says (cost + quality results you can cite)

International "proof of concept" at population scale

- **Brazil (Family Health Strategy, CHW-heavy primary care):** A study of 143 Amazon municipalities found that a **40% increase in coverage** was associated with **22% lower preventable hospitalizations** and **15% lower hospital expenses**. (PMC)
- **Ethiopia (Health Extension Program):** Synthetic-control evaluation links rollout to significantly improved maternal mortality trajectory, including estimates showing Ethiopia's maternal mortality lower than its synthetic comparator by 2016. (PubMed)
- **India (ASHAs):** Nationally representative longitudinal modeling suggests the ASHA program improved connections of marginalized communities to maternity services. (PMC)
- **Rwanda (CHW program over decades):** Recent review summarizes 30 years of CHW contributions to maternal/child health and outbreak response (with the caveat that long-run policy impact evidence is still developing). (PMC)
- **Pakistan (Lady Health Workers):** Reviews describe the program as cost-effective and give an illustrative per-person annual support cost on the order of under $1/person/year in one summary. (Harvard School of Public Health)

U.S. "how to do it legally + operationally"

- **Oregon Medicaid CCO model (care coordination at scale):** Peer-reviewed findings report reductions of **25 all-cause ED visits** and **22 preventable ED visits per 1,000 persons per month** in the first three years, with smaller effects as rurality increases. (PMC)

- **Alaska Community Health Aide Program (CHAP):** CHAP is a protocol-and-supervision-based model of distributing care capacity into remote communities. Program docs emphasize formal supervision and QA. (CHAP Alaska)
    - A statewide Alaska Tribal Health System overview document reports **$152M state budget savings as of FY2019** (described as Medicaid federal offsets). (Alaska Mental Health Trust)
- **Minnesota CHW financing:** Minnesota has documented pathways for **Medicaid reimbursement** and standardized curriculum; state materials cite legislative and reimbursement milestones. (Minnesota Department of Health)
- **Massachusetts MassHealth Community Partners:** Community-based entities are paid to coordinate care for high-need ACO/MCO members. (Massachusetts Government)

What the research says overall (why some programs "don't save money")

A major review finds CHW programs can reduce preventable utilization and costs, but effects are **variable** and depend on program design and integration. (PubMed)

Translation: savings aren't automatic — they come from *system design*.

The design recipe (what winning programs share)

1. **Tight scope** (exactly what non-professionals can/can't do)
2. **Protocols + scripts** (checklists, decision trees, escalation triggers)
3. **Real supervision** (daily/weekly case review; fast escalation)
4. **QA + audits** (random call review, chart review, adherence to scripts)
5. **Data loop** (track outcomes + feed back into coaching)
6. **Payment / contracting path** (or it never scales)
7. **Community legitimacy** (local hiring, language match, trust)

NM pilot blueprint (built for HS Navigators + AI workflow)

Pilot goal: reduce preventable ED use + missed follow-ups + coverage churn in a high-risk cohort.

Target population (start narrow)

- Medicaid members with: repeated ED visits, uncontrolled diabetes/HTN, recent hospitalization, pregnancy/postpartum, or repeated no-shows.

Workforce layer (example)

- **10–20 paid HS/early-college Navigators** (part-time)
- **1 CHW lead + 1 RN supervisor** (or NP depending on partner clinic)
- **Clinic partner** (FQHC/nonprofit clinic) + **managed care partner** (for data & incentives)

"Cockpit, not chatbot" AI

AI should **not** diagnose; it should:

- generate call/text scripts from approved templates
- run checklists ("did we do X, Y, Z?")
- flag escalation triggers ("chest pain," "suicidal," "severe SOB," etc.)
- summarize interactions for supervisor review
- schedule tasks + reminders

First metrics (90–180 days)

- No-show rate
- "closed-loop referral" completion rate
- coverage renewal completion / churn reduction
- med pickup/refill completion
- ED visits per 1,000 member-months (if accessible via plan data)

ROI framing (simple and fundable)

Savings ≈ (Prevented ED visits × avg allowed cost) + (Prevented admits × avg allowed cost) – program cost
Oregon's reductions show ED is measurable and responsive to coordination; Brazil shows preventable admissions and costs can drop with strong primary-care outreach. (PMC)

Risk controls (to keep it safe + "aligned")

- **Scope lock:** Navigators never provide clinical advice beyond scripted prevention and logistics.
- **Escalation rails:** any symptom red flags → clinician same day.
- **Privacy by design:** no PHI in personal texting; controlled tools; training + enforcement.
- **Auditability:** logs + random reviews.
- **Equity checks:** outcomes split by rurality, language, disability status.

Appendix (short): where to push next in NM

Best "scale levers" for NM in 6–18 months

1. **Financing pathway** (learn from MN Medicaid reimbursement + MA Community Partners contracting) (Minnesota Department of Health)
2. **Rural adaptation** (Oregon shows effects shrink with rurality — so design transport/connectivity supports from day one) (PMC)
3. **CHAP-inspired supervision rigor** (protocol manual + formal QA) (CHAP Alaska)

If someone challenges "does it really save money?"

Use the Jack et al. synthesis: CHW programs *can* reduce costs and preventable utilization, but success depends on integration and design — exactly why you're building supervision + protocols + data from the start. (PubMed)

If you want, I can turn this into **a one-page PDF** (logo-ready) plus a **2–3 page "evidence appendix"** with bullet citations and a draft **pilot budget + staffing plan** sized for Doña Ana's "mixed geography."