



## Trusted Voices: The Role of Community Health Workers in Health System Transformation

### **Background**

With approximately 11 million individuals newly insured under the Affordable Care Act (ACA), the focus of health reform is shifting to address health care spending and quality of care and outcomes. These issues are intertwined—Poor quality and inefficient care, the increasing burden of chronic diseases, and poor population health are driving the cost of health care spending in the United States. Better coordination of care and management of chronic conditions can significantly reduce health care spending, improve health outcomes and reduce health disparities. The use of health care teams comprised of professionals with a diverse range of skills, such as physicians, nurse practitioners, and an emerging provider—**community health workers (CHWs)**, can help to achieve these goals.

A CHW (also known as promotor, peer supporter, community health advocate, and community health liaison, among [other titles](#)) is a frontline public health worker who is either a trusted member of and/or has a deep understanding of the community served. This close relationship enables the CHW to serve as an effective link between health/social services and the community to facilitate access and improve cultural competency in service delivery. A CHW also builds individual and community capacity by increasing the health knowledge and self-sufficiency of patients and the community through a range of activities such as outreach, patient and community education, informal counseling, social support, and advocacy.<sup>1</sup> A CHW complements, supplements, or extends formal primary care services but does not take the place of health care providers.<sup>2</sup>

CHWs' potential to connect with community members on a more personal level facilitates the effective provision of services such as care coordination and home-based health support services, as well as links to other social services and supports. For this reason, CHWs play an especially crucial role in making health more equitable for populations experiencing disproportionately poor outcomes.

The transformation of the health care system in the U.S. and the recognition of the effectiveness of CHWs in addressing the drivers of health care costs and improving quality of care has accelerated state and local efforts to engage CHWs in health delivery systems. Innovative CHW

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<sup>1</sup> Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities. Policy Statement. Policy No.20091. American Public Health Association, 2009. <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities>.

<sup>2</sup> Tang, Patrick Y., Omni Cassidy, Maggie J. Morgan, Tracy Sbrocco, Juana Ballesteros, Gloria Ramsey, Ashley E. Martin, Laura Guzman-Corrales, and Jason Mose. Community Health Worker Advocacy Toolkit. Working paper. National Peer Support Collaborative, 2013.

training, credentialing, and workforce models are emerging rapidly; however, there is much needed to successfully integrate CHWs into health care teams and maximize the impact of these workers in the communities they serve. This brief will provide consumer health advocates with an overview of the evidence supporting the employment of CHWs, the opportunities and challenges for integrating CHWs in health care delivery systems, as well as tips and strategies for engaging in CHW advocacy.

This brief was informed through a literature review on CHW programs and outcomes, information from the Centers for Medicare and Medicaid Services (CMS), and most importantly, interviews with state-based health care advocates, CHW associations, and community based organizations (CBOs) employing CHWs. These interviews were crucial to understanding the landscape for and realities of CHW integration in various states across the country.

### **Evidence of the Effectiveness of CHWs**

Research has shown that CHWs play a critical role in *securing access to health care, coordinating access to primary care and preventive services, and helping individuals manage chronic conditions.*<sup>3</sup> CHWs can also play a significant role in *improving patient activation and community empowerment.*

#### ***Securing Access to Health Care***

In several studies, CHWs have been shown to effectively connect and enroll people in health insurance.

- At one community-based organization in New York City, between 2000 and 2005 CHWs enrolled nearly 30,000 previously uninsured people and helped facilitate access to primary care for the newly insured.
- In a three year period, CHWs in El Paso, Texas enrolled 7,000 individuals in Medicaid and other state-funded health plans.
- A study aimed at increasing the number of insured Latino children in Boston found that children in a CHW intervention group were significantly more likely to be insured and stay insured as compared to children in the control group.<sup>4</sup>

#### ***Coordinating Access to Primary Care and Preventive Services***

Several studies have shown that CHW programs produce improvements in patients' use of primary care and preventive services.

- A Denver study of CHW interventions among underserved men found that interventions by CHWs shifted care from costly inpatient and urgent services to primary care and prevention resulting in a ROI of \$2.28 per \$1 spent on the community-based intervention.
- Several studies show that CHW programs improve patients' use of mammography and cervical cancer screenings among low-income and immigrant women.<sup>5</sup>

#### ***Helping Individuals Manage Chronic Conditions***

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<sup>3</sup> Martinez, Jacqueline, and James R. Knickman. Community Health Workers: A Critical Link for Improving Health Outcomes and Promoting Cost-effective Care in the Era of Health Reform. Report. NYS Health Foundation, 2010.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

CHWs work with clients to develop long-term strategies for addressing chronic health issues, such as diabetes, asthma, heart disease, and HIV/AIDS.

- Studies examining the effectiveness of CHWs in hypertension control show that CHW intervention leads to significant improvements in patients' self-management behaviors, including appointment keeping and adherence to antihypertensive medications. Significant improvements in controlling blood pressure and positive changes in health care utilization have also been reported.<sup>6</sup>
- A 2003 study in West Baltimore of CHWs working with Medicaid patients with diabetes found that CHW intervention resulted in a 40 percent reduction in emergency room visits, a 33 percent drop in hospital admissions, and generated a savings of \$2,200 per patient per year.<sup>7</sup>

### ***Improving Patient Activation and Community Empowerment***

The trust and special knowledge CHWs have of the communities they serve puts them in a unique situation to empower and mobilize communities.

- CHW interventions have been associated with increases in empowerment at the individual, organizational and community levels.<sup>8</sup>
- CHWs are able to act as advocates and organize communities to address the social and structural issues that affect care.<sup>9</sup>

### **Potential Resources for Integrating CHWs in Health Care Delivery Systems**

While the Affordable Care Act included a range of provisions that aim to enhance the role of CHWs in the U.S. health care system, securing steady funding remains a significant barrier. Currently, most CHW programs are still funded by time-limited grants, leaving CHWs without stable employment and job security. Below are some of the most common opportunities created by the ACA to enhance and stabilize funding for CHWs. In addition to the opportunities below, the ACA has increased access to preventive services, implemented regulations that enable non-licensed providers to provide these preventive services, and authorized the Centers for Disease Control and Prevention to issue grants to improve health in underserved areas through the use of CHWs.

### ***Medicaid State Plan Amendment***

States can file a State Plan Amendment (SPA) with CMS to add CHWs as reimbursable providers of preventive services. A SPA allows for any aspect of the Medicaid program administration to be permanently changed as long as it complies with federal Medicaid regulations. SPA proposals must explain the following to include CHWs in a state Medicaid program: what services will be covered; who will provide them; any required education, training,

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<sup>6</sup> Brownstein, J. Nell, Farah M. Chowdhury, Susan L. Norris, Tanya Horsley, Leonard Jack, Xuanping Zhang, and Dawn Satterfield. "Effectiveness of Community Health Workers in the Care of People with Hypertension." *American Journal of Preventive Medicine* 32, No. 5, 2007: 435-447

<sup>7</sup> Martinez, Jacqueline, and James R. Knickman. *Community Health Workers: A Critical Link for Improving Health Outcomes and Promoting Cost-effective Care in the Era of Health Reform*. Report. NYS Health Foundation, 2010.

<sup>8</sup> Wiggins, Noelle. "Popular Education for Health Promotion and Community Empowerment: A Review of the Literature." *Health Promotion International*, 2011.

<sup>9</sup> Pérez, Leda M., and Jacqueline Martinez. "Community Health Workers: Social Justice and Policy Advocates for Community Health and Well-Being." *American Journal of Public Health* 98, No. 1, 2008.

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experience, credentialing or registration of these providers; the state's process for qualifying providers; and the reimbursement methodology.<sup>10</sup> Washington state, Oregon and Minnesota's SPAs allow CHWs to be reimbursed for select services.<sup>11</sup>

### ***Health Homes***

The Medicaid Health Home is a major opportunity to integrate CHWs into whole-person care teams under the ACA. States have the option to establish "health homes" to coordinate comprehensive care for Medicaid beneficiaries living with chronic conditions. Medicaid Health Homes must provide six core services which CHWs are particularly well-positioned to provide: health promotion; transitional care; patient and family support; referrals to community and social support services; case management; and care coordination. The federal government will pay for 90 percent of the cost during the first eight quarters of the program.

States must file a SPA to add the Medicaid Health Home to their Medicaid program. Maine, New York, Oregon, South Dakota, Washington and Wisconsin have designed programs that explicitly include or reference CHWs and allow the programs to employ CHWs and pay for their services through Medicaid Health Home reimbursement.<sup>12</sup>

### ***Section 1115 Medicaid Waiver***

Through the Section 1115 waiver, states can petition the Secretary of Health and Human Services (HHS) to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP) programs. The waiver is designed to give states additional flexibility to try new health care delivery approaches, payment methods, or to otherwise improve patient care in a cost effective way.<sup>13</sup> California and New Mexico have made services provided by CHWs reimbursable through Medicaid using this waiver. This is an opportunity even in states that have not expanded Medicaid or adopted Medicaid health homes.

### ***State Innovation Model Grants***

One of the projects funded by CMS' Center for Medicare and Medicaid Innovation (CMMI) is the State Innovation Models (SIM) initiative. The SIM initiative supports the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will focus on people enrolled in Medicare, Medicaid and CHIP.<sup>14</sup> The SIM initiative provides an opportunity to explicitly include CHWs in a new health delivery model. Of the six states awarded a Round One SIM Test Grant, five (Vermont, Oregon, Minnesota, Maine and Arkansas) have included CHWs in their plans.

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<sup>10</sup> Medicaid Reimbursement for Community-Based Prevention. Issue brief. Nemours & Trust for America's Health, 2013.

<sup>11</sup> "State Community Health Worker Models." State Reform. June 05, 2015. <https://www.statereform.org/state-community-health-worker-models>.

<sup>12</sup> Katzen, Amy, and Maggie Morgan. Affordable Care Act Opportunities for Community Health Workers. Report. Harvard Law School Center for Health Law and Policy Innovation, 2014.

<sup>13</sup> Mahan, Dee. State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs. Issue brief. Families USA, 2012.

<sup>14</sup> Centers for Medicare and Medicaid Services. "State Innovation Models Initiative: General Information." CMS.gov. August 24, 2015. <http://innovation.cms.gov/initiatives/state-innovations/>.

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### ***Medicaid Managed Care Organizations (MCOs)***

Medicaid managed care allows for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.<sup>15</sup> MCO programs vary, but high-cost, high-need users and underserved communities are often the target populations.

MCOs generally can pay for services which are not reimbursable under the Medicaid statute. This flexibility, along with the prevalence of MCOs (70 percent of all Medicaid beneficiaries nationally are enrolled in MCOs), provides an opportunity to fund CHWs either through direct employment or by including CHW services as a reimbursable benefit.<sup>16</sup>

### ***Medicaid Administrative Funds***

The Medicaid program provides funding for administrative services needed for efficient administration of the state plan. The Secretary of HHS ultimately defines what is considered an eligible administrative claim under a state plan, but outreach, eligibility determination, coordination and translation services have all previously been approved for funding. Administrative funds are frequently used for CHW programs providing outreach and enrollment services to eligible but unenrolled populations.<sup>17</sup> This funding strategy can also be used in states that have not expanded Medicaid.

### ***State and Local General Funds***

State and local general appropriations can support CHW programs. This option requires a line-item for the CHW program within the entity's budget and must be allocated each budget cycle. Funding may reimburse CHWs directly or go to CBOs that administer CHW programs. Budget line-items are relatively stable once established, but initial funding can be difficult to obtain.<sup>18</sup> Massachusetts currently has a line-item in their state budget that provides funding for CHWs.

### ***Section 330 Health Center Funding***

In accordance with Section 330 of the Public Health Service Act, all health centers are required to provide specific services, some of which are suitable for CHWs to provide. These services are:

- Patient case management – Includes counseling, referral, follow-up services and other services designed to assist patients in gaining access to programs that provide or financially support the provision of medical, social, housing, educational or other related services.

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<sup>15</sup> "Managed Care." Medicaid. Gov. Accessed June 09, 2015. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

<sup>16</sup> Community Health Workers: Financing and Administration. Policy brief. National Health Care for the Homeless Council, 2011.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

- Services that enable individuals to use the services of the health center – Includes outreach and transportation services, translation/interpreting and education of populations served regarding the availability and proper use of health services.

The manner in which a health center provides these services is established in the grantee’s scope of project application. CHWs could provide many of these services either through inclusion in an original grant application by a prospective health center, a grant application for service expansion, through the change of scope process, or by notifying Health Resources and Services Administration (HRSA) of the change in their annual report. Section 330 grants offer ongoing funding once awarded, presuming sufficient appropriations for the health center program.<sup>19</sup>

### ***Accountable Care Organizations (ACOs)***

ACOs are groups of doctors, hospitals and other health care providers who agree to provide coordinated, high quality care to a defined set of patients, while sharing in any cost savings or bearing any risk from losses that result. As provider organizations have incentives to reorganize care to reduce costs and improve care, they may include CHWs in care teams.<sup>20</sup> Minnesota and Oregon utilize CHWs in multidisciplinary teams created by their alternative payment models (Accountable Care Organizations and Coordinated Care Organizations, respectively).

### ***State-Specific Opportunities***

There are also many state-specific opportunities for CHW integration in health care delivery systems. These are a few examples:

- [Kentucky Homeplace](#) in Kentucky
- [Health Enterprise Zones](#) in Maryland
- [Community Hubs](#) in Ohio
- [Prevention and Wellness Trust Fund](#) grants in Massachusetts
- [Molina Community Connectors](#) in California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington and Wisconsin
- [Blueprint for Health Community Health Teams](#) in Vermont

### **Certification & Training Options for CHWs**

Certification and training requirements for CHWs vary considerably across the country. Some states have state-regulated training and certification requirements for CHWs in order for their services to be reimbursable. The regulation of training and certification varies with state agencies, local agencies, or professional boards administering the program requirements. Additionally, some states have no state certification requirement, allowing on-the-job and program-specific training instead.

There are differing views within the CHW field regarding what degree of professional certification is appropriate. With funding being such a critical issue to the CHW profession, many organizations see CHW credentials as an essential step in workforce development and in

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<sup>19</sup> Ibid.

<sup>20</sup> Tang, Patrick Y., Omni Cassidy, Maggie J. Morgan, Tracy Sbrocco, Juana Ballesteros, Gloria Ramsey, Ashley E. Martin, Laura Guzman-Corrales, and Jason Mose. Community Health Worker Advocacy Toolkit. Working paper. National Peer Support Collaborative, 2013.

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securing a stable funding source. Some argue that professional accreditation offers more accountability, standards for outcome measurement and development opportunities. And that funding through Medicaid or state appropriations is facilitated through such standardization.<sup>21</sup>

There is some apprehension, however, that excessive regulation might make the profession less accessible to members of underserved communities. The barriers that training and certification may pose for prospective CHWs need to be considered before determining which programs and regulations are appropriate for your population or state.

## **Training Types**

### ***In-Person Training***

In-person training has taken many forms. Existing brick and mortar training programs across the country range from a few weeks to nearly a year of regular sessions. Training most frequently takes place at regional training sites, public health departments, community colleges, health care sites or, if administered by a CBO, on their home site. This kind of training can be beneficial as it is interactive and participatory, though it is important to keep in mind the issues that it may pose.

- Prospective CHWs may be unable to attend work during the training period. This can be mitigated by:
  - Providing training at no cost or with a stipend.
  - Hosting sessions after common work hours and/or on weekends.
  - Guaranteeing employment upon completion of training.
- Attendance may entail significant travel, making training inaccessible. Possible solutions:
  - Host training at various sites across the state.
  - Provide housing for the duration of the program.
  - Reimburse travel-related expenses.
  - Contract larger organizations to host training at various sites, or contract several smaller community-based organizations throughout the state to host trainings.

### ***Distance Learning***

Distance learning programs are generally comprised of online lectures, coursework and potentially a group project. Many agencies have proposed distance-learning programs as a solution to the financial and travel obstacles inherent in in-person training. Although distance learning does solve the majority of these obstacles, training should nevertheless be interactive and participatory to avoid low levels of engagement and long-term retention of lessons and skills. Below are some issues inherent in distance learning and their proposed solutions.<sup>22</sup>

- Participants must have regular, uninterrupted access to a computer and Internet, which may be a barrier for low-income participants or for participants living in remote or rural areas. Possible solution:
  - Upon registration, the training agency's administration can assist those without access in obtaining a library card.

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<sup>21</sup> Community Health Workers: Financing and Administration. Policy brief. National Health Care for the Homeless Council, 2011.

<sup>22</sup>Kapheim, Melissa G., and Jamie Campbell. Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings. Technical paper. Chicago: Sinai Urban Health Institute, 2014.

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- Literacy and reading comprehension must be at or above the level the coursework is written in. Possible solution:
  - Make coursework available in multiple languages which may enable more people to participate.
- Low engagement leading to loss of interest and lower retention. This can be mitigated by:
  - Creating more group projects.
  - Requiring participation on a forum.
  - Providing live lectures and discussions.
  - Requiring scheduled personal mentorship calls with an instructor.

It is important to note that even with distance-learning programs, clinical hours require in-person participation.

### ***Mixed Training***

In this model, usually half or more of the coursework is done online. In-person training sessions are scheduled regularly throughout, intermittently between, or reserved for the last few training modules. This type of program is a good compromise, as it substantially alleviates the financial and travel barriers found in brick and mortar programs while maintaining an interactive curriculum. However, some of the same issues with brick and mortar training and distance learning are present, albeit to a lesser degree.

### ***On-the-Job Training***

With on-the-job training, CHWs receive training post-hire. This type of training eliminates financial, travel and technological barriers inherent in other training models. It is conducive to active participation, allowing for better retention of coursework and skills, and enables an employer to better determine whether a prospective employee is culturally competent and truly integrated in the community. Through on-the-job training employers can also personalize training in accordance with CHWs' specific job duties and the needs of the community being served, ensuring that the CHW is well prepared for the position. Below are issues to consider and methods to address them:

- On-the-job training may be too program-specific making it difficult for CHWs to work in other settings.
  - Employers should provide foundational public health training in addition to program-specific training to ensure CHWs have a comprehensive and transferrable knowledge and skill base.
- Providing all-encompassing on-the-job CHW training may place a heavy burden on employers.
  - If funding permits, external agencies may be hired to facilitate training.
- On-the-job training may limit recognition of CHWs as skilled health professionals if it does not culminate in any type of certification.
  - Employers should provide CHW employees with a program-specific certification to confirm CHW competency and encourage CHWs to participate in workforce advocacy.



## **State-Level Certification and Alternatives**

### ***State-Level Certification***

There is currently a big push towards state-regulated certification. Because the CHW profession is critically underfunded, securing a stable funding stream is essential. Professional accreditation offers state and federal agencies accountability, standards for outcome measurement, a standardized skill set, and workforce recognition; this security facilitates funding. Additionally, state-level certification may increase wages and improve quality of care.<sup>23</sup>

### ***State-Level Certification and Cultural Competency***

Mandatory state-level CHW certification can have many benefits for reimbursement and workforce recognition, but it can also pose a threat to the availability of culturally competent community health work in vulnerable communities experiencing health disparities. Below are potential issues to consider:

- Certification may reduce the number of local, trusted CHWs serving the community, which may cause fear and lead to resistance toward accepting care by individuals living in a predominantly undocumented community.
- The obstacles to certification (fees, lost wages, travel, paperwork) will lessen the pool of prospective CHWs from underserved, high-risk communities and of certified CHWs that are truly integrated in the communities they serve.

### ***Solutions to State-Level Certification Issues***

As state-level certification becomes increasingly necessary to obtain funding opponents have found themselves advocating for compromises instead of advocating against this certification. The following compromises can help mitigate the issues discussed above:

- State-level certification does not need to be mandatory to be a CHW; certification could be voluntary.
- Allow experienced CHWs to be grandfathered into certification; requirements should not be so stringent that it is impossible to go through process.
- Provide certification for free; if fees are necessary, keep them low.
- Facilitate certification for low-income prospective CHWs through financial assistance.
- Recruit prospective CHWs from communities being served to ensure they are trusted in the community.

### ***Program-Specific Certification***

Program-specific certification is usually administered by CBOs or health centers that employ CHWs. Certification is received upon completion of the organization's training program and confirms the CHW's competency to provide the services specific to the population being served and the program needs. Program-specific certification is usually more specialized, but these credentials can be used to demonstrate experience if applying for state-level certification, new program-specific or generalist certifications.

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<sup>23</sup> States Implementing Community Health Worker Strategies. Technical paper. Atlanta: Centers for Disease Control and Prevention, 2014.

### **Language Barrier in CHW Training and Certification**

Training and certification can be a serious obstacle for prospective CHWs who are non-native English speakers. It is important for training and certification to be available in the languages widely spoken in the state as well as in the languages of the communities of focus. As community ties are core to the CHW profession, it would be ideal if prospective CHWs who lack English fluency, but speak the language of the community being served, could still be able to pursue training and certification. For instance, the Texas Department of State Health Services and MHP Salud offer training in both English and Spanish.

### **Policy and Health Systems Campaigns**

Pursuing policy change to secure funding is an essential step in the workforce development of the CHW profession. Some states may also wish to establish state-level training and certification programs. A steady funding stream, evidence-based training and increased professional recognition will facilitate greater inclusion of CHWs in our health care teams. The following webpages offer more information on state efforts to integrate CHWs in health delivery, as well as best practices and resources for implementing CHW programs:

[State Refor\(u\)m- State Community Health Worker Models](#)

[Centers for Disease Control and Prevention- State CHW Strategies and TA Guide](#)

[Harvard Center for Health Law and Policy Innovation- CHW Credentialing](#)

[The Sinai Urban Health Institute Best Practice Guidelines for CHW Programs](#)

[Penn Center for Community Health Workers- CHW Toolkit](#)

[American Public Health Association Community Health Workers Section](#)

### ***Strategies and tips for consumer health advocates to engage and support CHW advocacy and integration in health delivery systems***

The following recommendations are informed by our discussions with state-based health care advocates, CHW associations and community based organizations (CBOs) employing CHWs.

- Contact CBOs and health care systems employing CHWs in your area, as well as state-wide CHW associations to learn more about policy-level and systems change activity.
- Engage CHWs, CHW associations and CBOs to learn about preferences, opportunities and challenges related to funding, training and certification.
- Meaningfully engage CHWs, CHW associations and CBOs in coalition efforts to improve value in health care.
- Media outreach; write a letter to the editor in a local newspaper, write an op-ed or contact your local news agency about the importance of integrating culturally and linguistically competent providers in the health care workforce and/or stories that highlight the quality care CHWs can provide.
- Start a public forum to support CHWs' role in the management of chronic illnesses and health delivery.
- Identify opportunities with CHWs and CHW associations to provide advocacy trainings to ensure that CHWs are meaningfully engaged at the local and state levels when decisions are being made about integration of CHWs into health delivery systems.

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- Collaborate with CHWs, CHW associations and CBOs to advocate for state- and population-appropriate CHW programs with state and local officials and delivery system leaders.

***Strategies for consumer health advocates to increase CHW engagement in policy-level work***

It is important for CHWs to advocate for themselves and take an active role in policy and systems change opportunities. As much needs to be done at the policy-level to make CHWs a recognized and reimbursable health professional, CHW engagement is crucial.

- Include coursework and training on advocacy in CHW training curriculums.
- Develop partnerships or relationships with CHW associations and provide advocacy workshops to association members.
- Equip CHWs with the necessary tools to advocate on their own behalf. [This](#) toolkit is a good resource.

Community health workers can play a significant role in health system transformation; they can better coordinate care, manage chronic conditions, promote preventative services, provide health education and most importantly, bridge the gap between health care and the community for the most vulnerable populations – all at a cost savings to our health system. With the implementation of the ACA, we have more opportunities than ever to meaningfully integrate CHWs in health care delivery. Now is the time to advocate for their role in health care and efforts to improve health care value.

**Acknowledgements**

This issue brief was informed by conversations with state-level advocacy organizations and coalitions representing CHWs and CBOs employing CHWs. We would like to thank the following organizations for their input and time:

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| Asian American Community Services                             | Minnesota Community Health Worker Alliance     |
| California Pan-Ethnic Health Network                          | Missouri Health Advocacy Alliance              |
| Clínica Msr. Oscar A. Romero                                  | New Mexico Community Health Worker Association |
| Colorado Patient Navigator and Community Health Collaborative | Oregon Community Health Workers Association    |
| Community Health Councils                                     | Planned Parenthood – Los Angeles               |
| Feminist Women’s Health Center                                | Universal Health Action Network – Ohio         |
| Florida Community Health Worker Coalition                     | Vision y Compromiso                            |
| Healthcare For All – Massachusetts                            | Washington State Department of Health          |
| Health Access – California                                    |  |
| Maryland Health Care For All Coalition                        |  |
| Massachusetts Association of Community Health Workers         |  |

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