COMMUNITY HEALTH WORKER
Policy Forum

Integration of Community Health Workers for a More Resilient U.S. Healthcare System through Policy Interventions

INTEGRATION OF COMMUNITY HEALTH WORKERS FOR A MORE RESILIENT U.S. HEALTHCARE SYSTEM THROUGH POLICY INTERVENTIONS

ABSTRACT

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This report - supported by Eli Lilly and Company (Lilly) - summarizes findings from a review of community health worker (CHW) policy literature and multiple working sessions that engaged local, state and nationally-based organizations with an interest in supporting CHWs to identify critical areas of CHW unmet need and to outline the policies needed to improve the sustainability and integration of CHWs into the U.S. healthcare system. The findings are reported in the following areas: Brief history of CHWs in the U.S.; renewed recognition of CHW impact; understanding of the CHW policy landscape; CHW community perspective on policy tensions and actionable policy solutions; and policy recommendations.

Shakata Norwood , CHW

This report was supported by Eli Lilly and Company

A recent peer-reviewed study

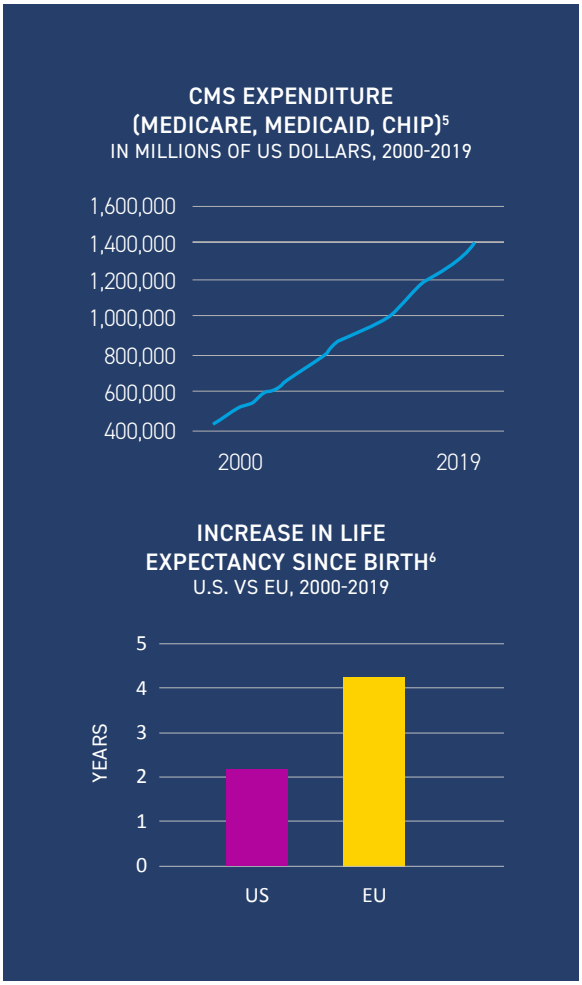
of 302 Medicaid beneficiaries or uninsured people living in high-poverty neighborhoods and diagnosed with at least two chronic conditions (i.e., diabetes, obesity, hypertension) demonstrated that CHW intervention improved health conditions of residents, reduced hospitalization, and yielded savings to the Medicaid program equal to $2.47 for every $1.00 invested in the CHW program.[1]

EXECUTIVE SUMMARY

Overview

The U.S. healthcare system is facing a multitude of challenges, with high costs and the number of individuals who are uninsured or inadequately insured growing — more than 40 percent of working-age adults in 2022 — resulting in far too many people delaying care or without affordable access to it.[2] This reality, coupled with Medicare and Medicaid spending accounting for more than 36 percent of total national health expenditures in the U.S. annually,[3] has led policymakers and overburdened health systems to explore innovative approaches. These approaches aim to increase access among groups that have been marginalized by strengthening treatment of underlying health conditions, addressing social determinants of health (SDOH)*, and, ultimately, improving health outcomes and reducing the cost burden to the healthcare system.

Against the backdrop of converging public health crises and a shifting health policy landscape, one model that has proven highly effective in lowering costs and improving health outcomes, while also addressing SDOH, is embedding CHWs in U.S. communities and clinics to provide social support, care coordination, and advocacy for communities that are under-resourced.[4] Given the need to address inherent shortcomings in the U.S. healthcare system, evidence supports the vital role CHWs can play in a reimagined and resilient healthcare system.



* Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. *(Source: U.S. Department of Health and Human Services. Healthy People 2030.)*

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While the U.S. continues to grapple with the lasting impacts of the COVID-19 pandemic and reflect on lessons learned, it is abundantly clear that federal and state policymakers and healthcare and public health advocates recognize the myriad inefficiencies in the U.S. healthcare system and a significant need to build capacity and develop the healthcare workforce swiftly. It is crucial to educate and mobilize policymakers to recognize CHWs as an essential component of the U.S. healthcare system. Policy solutions must to facilitate the recruitment, retention, education, and integration of CHWs into our clinics and communities.

The CHW Policy Forum, convened by Lilly, was comprised of the below organizations which provided input on the policy recommendations and the white paper.

ESKENAZI HEALTH

INCHWA
Indiana Community Health Workers Association
Building a Healthier Indiana

RICHARD M. FAIRBANKS SCHOOL OF PUBLIC HEALTH

PUTTING PATIENTS FIRST
NATIONAL HEALTH COUNCIL*

NBCSL
National Black Caucus of State Legislators

NHCSL
National Hispanic Caucus of State Legislators

PURDUE UNIVERSITY*
Center for Health Equity & Innovation

*Denotes CHW Policy Forum co-chair organizations

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Background

From Nairobi to Indianapolis, Lilly is collaborating with CHW advocacy groups and policymakers to create a supportive and sustainable ecosystem† to broaden the impact of CHWs and improve the health and well-being of communities.

As a starting point, Lilly reviewed the policy landscape to identify and assess policy issues related to CHWs, including reimbursement, federal and state funding, and scope of service, including addressing SDOH and workforce development. To vet findings and further review unmet needs and opportunities, Lilly assembled a group of experts – now called the CHW Policy Forum – to co-create a policy agenda designed to deliver long-term community support.

Forum participants include representatives from local, state, and national organizations, including the National Health Council; Center for Health Equity and Innovation; Purdue University; National Hispanic Caucus of State Legislators; National Black Caucus of State Legislators; Indiana Community Health Workers Association; Eskenazi Health; and the Indiana University Richard M. Fairbanks School of Public Health at Indianapolis.

Prior to the inaugural convening of the CHW Policy Forum, members were provided a brief survey, based on results of the CHW policy landscape review, and asked to complete a pre-meeting questionnaire to prioritize the policy discussion topics. This feedback was instrumental in structuring the conversation and driving dialogue during the first convening of the Forum.

Members indicated the policy tensions facing CHWs and the communities they serve – ranked in order of importance – are CHW reimbursement, federal and state government funding, CHW scope of service expansion, and CHW workforce development, including providing livable wages.

During the second convening of the Forum, members reaffirmed the difficulties of working within the current system of Medicaid reimbursement due to the unique, cross-cutting nature of CHWs' work. Acknowledging the shortcomings of current Medicaid reimbursement, the Forum determined that while the proposed policy changes outlined in this paper will address some of the challenges CHWs face, innovative solutions that reimagine and adequately contextualize the work of CHWs in addressing health inequities are necessary. The Forum believes policy changes made to benefit CHWs must take place along two axes: 1) policy change within the current system, as outlined in this paper; and 2) pioneering a new funding model for long-term, sustainable change that considers the unique nature of CHWs' work.

Informed by the CHW policy landscape review and anchored by expert opinion (via the CHW Policy Forum), this paper outlines a brief history of CHWs, the CHW community perspective on policy tensions, and actionable policy solutions, as well as puts forward a focused set of policy recommendations to address core issues facing CHWs.

† Sustainable refers to systems sustainability that includes staff retention, resiliency, and long-term capacity, as well as economic and social sustainability. *(Source: American College of Healthcare Executives, Healthcare Sustainability, 2021. Available at www.ache.org/blog/2021/designing-for-healthcare-sustainability-a-framework.)*

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BRIEF HISTORY OF CHWS

In the U.S., the CHW workforce was explicitly created to reduce racial, ethnic, economic, and geographic disparities in essential care.[7] CHWs bring inherent and unmatched value to the communities they serve and can build trust with their patients and leverage relationships with community members to break down SDOH and improve health outcomes. Going beyond just addressing acute medical needs, CHWs are from the communities they serve and evidence shows they improve health literacy by providing education on chronic illnesses, nutrition, hygiene, preventive medications, and family planning, using jargon-free communication, local idioms, and storytelling.[8] Furthermore, CHWs have demonstrated the ability to motivate individuals to engage in lifestyle modifications using empathy, patience, and persistence in a culturally appropriate manner.[9]

Even as CHWs have a documented history of assisting communities that are underserved, driving healthcare costs down, and improving health outcomes for more than six decades, the number of practicing CHWs in the U.S. is exceedingly low. Compared to more than 3 million registered nurses in the workforce, as of 2021, there were roughly 61,000 CHWs in the U.S., and approximately only 1,000 of those CHWs working in state or local health departments, or about 2% of the public health workforce.[10,11,12]

A Community Health Worker

is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the Community Health Worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A Community Health Worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy."[13]

165,000
PREMATURE DEATHS PREVENTED

$545 B
IN LONG-TERM ECONOMIC VALUE

"The results suggest that the relatively small community social workforce of 650,000 people helped prevent 165,000 premature deaths (equivalent to 6.3 percent of all U.S. deaths in 2015), and, when based upon a conservative estimate of the value of a single life, yielded an estimate of $545 billion in long-term economic value."[14]

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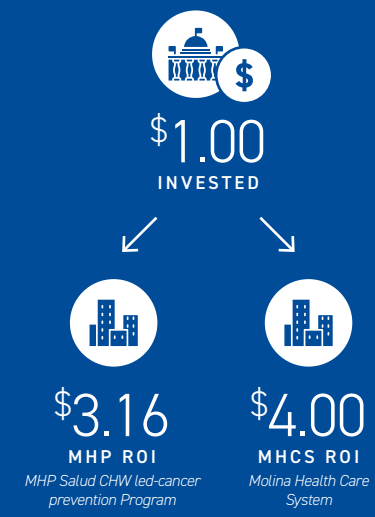
CASE STUDY: Validating Return on Investment Data

CHW programs have been associated with cost savings in numerous Return on Investment (ROI) studies.[4] In a recent peer-reviewed study of 302 Medicaid or uninsured patients living in high-poverty neighborhoods and diagnosed with at least two chronic conditions (diabetes, obesity, tobacco dependence or hypertension), CHW intervention improved health conditions of residents, reduced hospitalization, and yielded savings to the Medicaid program equal to $2.47 for every $1.00 invested in the CHW program.[4] Similarly, in 2018, MHP Salud's CHW-led cancer prevention program demonstrated an ROI of $3.16 for every dollar invested, and a program for Medicaid-eligible adults, instituted by the Molina Health Care System of New Mexico, reported a $4.00 return for every dollar invested.[15]



FEDERAL FUNDING INDICATES RENEWED IMPACT OF CHW EFFECTIVENESS

Despite substantial evidence demonstrating the effectiveness of the CHW model in many healthcare settings, deployment of CHWs has been limited in the U.S.[15,16] However, as the COVID-19 pandemic surged, the value of the CHW workforce as part of the healthcare system was rediscovered, evidenced by a significant expansion of short-term federal funding.[17] As the pandemic moved into its second year, Congress passed the American Rescue Plan Act, allocating $7.4 billion for the public health workforce to better support pandemic relief efforts and allocating $250 million for community-based organizations to mitigate the effects of the pandemic.[18] Through the passage of this federal law, federal policymakers and Congress renewed their recognition of the vital role community-grounded solutions – including CHWs – play in the healthcare delivery system, especially in times of crisis.

In addition to congressional action, federal agencies also renewed their focus and support for CHWs. In 2021, the Centers for Disease Control and Prevention (CDC) announced more than $300 million in funding for CHWs.[19] Funded through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan Act of 2021, this funding provided critical support to states, localities, and territories to implement CHW-led programs and initiatives.

Beyond the pandemic, some indications suggest that Congress remains focused on providing bipartisan support to bolster the CHW workforce to recruit, train, and develop sustainable career pathways.[20] Additionally, Congress has focused on expanding the scope of services rendered by CHWs and the types of services that federal and state healthcare programs, including Medicare and Medicaid, can reimburse. While federal funding of CHWs was renewed against the backdrop of the COVID-19 pandemic, these funding vehicles are short-term and lack the sustained commitment required to support long-term, holistic, patient-centered approaches.[21] These forms of short-term funding exacerbate recruitment and retention challenges by discouraging labor participation and, ultimately, limits the healthcare system's commitment to CHW training and career development.[21]

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CHW POLICY REVIEW

UNDERSTANDING THE COMMUNITY HEALTH WORKER POLICY LANDSCAPE

In 2022, Lilly conducted a targeted CHW policy review, including screening of both published and grey literature, to determine the current U.S. CHW policy landscape, to better understand unmet policy needs of CHWs – at the federal and state levels – and to determine barriers that impede CHWs' ability to assist community members in improving overall health and well-being, including their ability to address factors of SDOH.

The targeted CHW policy review uncovered areas of unmet need and segmented the current U.S. CHW policy landscape into four areas of regulatory and policy categories, including reimbursement (Medicaid), federal and state funding, the scope of service (e.g., reimbursement for SDOH), and workforce development (e.g., education, training, career pathways, and livable wages).

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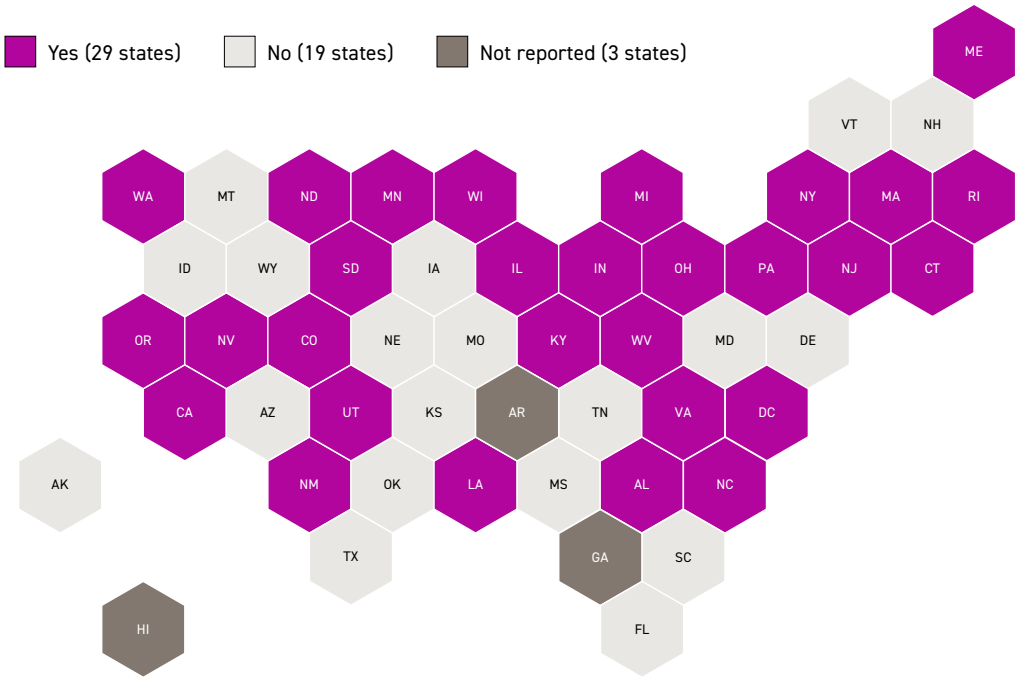
1. UNSUSTAINABLE STATE FINANCING OF CHW PROGRAMS LEADS TO UNEVEN CHW REIMBURSEMENT

Reimbursement of CHW services is inconsistent state-by-state and lacks uniformity across state financing models, contributing to uneven access to the communities they serve. While some state and local health agencies utilize federal grants and flexible payment models (e.g., Medicaid 1815 funds, Health Resources and Services Administration (HRSA)), others rely on health systems and providers *(i.e. managed care organizations (MCOs))* to fund the scope of service for CHWs. Today, 15 state Medicaid programs directly reimburse CHW organizations for their services; 10 state Medicaid programs do not cover CHW services at all and 27 states utilize managed care plans for CHW services or implementation.[22]

Across U.S. states, there are many sources of healthcare funding, including Medicare, Medicaid, the Children's Health Insurance Program, the Health Insurance Exchange, and employer-sponsored insurance. Of these sources, state Medicaid offers four primary financing models that support programs to implement training, certification, and integration of CHWs into communities and local healthcare systems.[23] These funding pathways show the most promise for potential policy change at the state and/or federal level.

STATES THAT ALLOW MEDICAID PAYMENT FOR SERVICES PROVIDED BY COMMUNITY HEALTH WORKERS (CHWS) AS OF JULY 1, 2022[24]



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STATE PLAN FUNDING

Under the state plan, individual states require MCOs to offer CHW-delivered services or employ CHWs as an administrative cost.[25] In these cases, Medicaid payments are generally allowable for specific services determined by the agreements between MCOs, the Centers for Medicare and Medicaid Services, and the state.[26]

States that employ a Medicaid plan for funding CHWs include Indiana, Kentucky, Minnesota, North Dakota, Oregon, and South Dakota.[27]

HEALTH HOME PROGRAMS

Currently, only a handful of states allow the implementation of CHWs in their health home programs as part of a care team. Under this model, reimbursable CHW responsibilities include meeting regularly with the care team to plan care and discuss patient cases, identifying and providing referrals to community social supports and resources for the patient, and providing education on health conditions and strategies to implement care plan goals.[28]

States that allow the employment of CHWs in their health home programs include California, Maine, Michigan, Washington, and West Virginia.[29]

DEMONSTRATION APPROACHES

Section 1115 of the Social Security Act gives the the Secretary of the U.S. Department of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. Section 1115 demonstrations that look to accomplish payment and delivery system reform for CHWs include delivery system reform incentive payment (DSRIP) or DSRIP-like programs.[28]

Several states have integrated CHWs into interdisciplinary networks of providers eligible for performance-based funding or invested in building the capacity of the CHW workforce,[24] including California, Massachusetts, and Washington.

MANAGED CARE ORGANIZATION APPROACHES

Some states are financing and delivering CHW services through their Medicaid managed care arrangements, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS), and in some cases requiring it.[24]

States that mandate or require Medicaid MCOs to provide CHW services include Michigan, New Mexico, and Oregon. Other states, such as Florida and Texas, encourage or provide a specific option for MCOs to use CHWs for certain services or interventions or as members of care teams but do not require them to do so.[28]

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2. LACK OF SUSTAINED FEDERAL FUNDING FOR TRAINING AND DEVELOPMENT DISINCENTIVIZES PROFESSIONAL CHW WORKFORCE DEVELOPMENT AND CAPACITY BUILDING

As is the case with many industries impacted by COVID-19, the pandemic has exacerbated existing shortages in healthcare professionals, including the under-implementation of CHW skills and the underrepresentation of CHWs in communities that are medically underserved. To better address the shortage in the healthcare workforce, some states are leveraging one-time federal funds from the American Rescue Plan Act to bolster the availability of CHWs, providing new opportunities for professional advancement and retention incentives while also enhancing the practice of expanded credentialing, accreditation, and certification of CHWs.

Specifically, some states are utilizing federal funds to enhance training and support beyond initial requirements,

including incentives for higher wages pending additional training completed, standardizing credentials and training modules that establish CHWs within the healthcare workforce, and developing structures for family caregivers to be paid as part of the healthcare structure. Additionally, several states have implemented voluntary CHW certification systems intended to support CHWs who are interested in transitioning to working in integrated health and social systems of care. Other states have put statewide certification discussions on hold, instead opting to focus on other strategies for CHW workforce development, including expanding opportunities for training to cultivate professional citizenship, leadership, community mobilization, facilitating community-based research, and making the financing of CHW positions sustainable. The current state policy landscape for CHWs does not necessarily suggest that statewide CHW certification is a prerequisite for sustainable financing, but more research on this topic is needed.[29,30]

Coupled with federal funding via the American Rescue Plan Act, in April 2022, HHS, through HRSA, announced the availability of $226.5 million in American Rescue Plan Act funding to launch the Community Health Worker Training Program.[31] This new program, part of the Biden Administration's commitment to building a robust public health workforce, will increase the number of CHWs and, according to the administration, assist in "connecting people to care, including COVID-19 care, mental health and substance use disorder prevention, treatment and recovery services, chronic disease care, and other important health services."[32]

While this funding and other similar efforts are to the great benefit of CHW's across the country, they critically fail to solve an important issue CHW programs have faced before the onset of the pandemic: inconsistent funding. In addition to the recruitment and retention challenges surfaced by short-term funding, trust between patients and their health systems can suffer under short-term and inconsistent funding arrangements. Consistency in the services provided and the quality of those services can serve to strengthen trust between patients and their healthcare providers, creating healthier behaviors and improving community resilience over time.[33]

3. NARROW SCOPE OF SERVICE FAILS TO EMPOWER THE FULL RANGE OF CHW TREATMENT

As the CHW model continues to be supported by public health experts and policymakers across the local, state, and federal landscape, states have leveraged CHWs who can offer critical services regardless of their currently defined scope. Expanding CHW scope of service is crucial to ensuring CHWs and their organizations are properly reimbursed. While the core responsibilities of CHWs range from providing health education and resources to administering some direct care such as first aid and blood pressure screening, some states have addressed a critical unmet need by expanding CHWs' scope to focus their efforts on the underlying factors that impact a person's health, including SDOH.

In 2022, CMS approved California's Medicaid State Plan Amendment (SPA) proposal to expand CHW scope of service in the state to include, but not limited to, factors that contribute to SDOH, environmental and climate-sensitive health issues, aging, domestic violence, and violence prevention.[34] Other states have also taken proactive measures to leverage Medicaid's SPA to expand the scope of services offered by CHWs, including Indiana, Louisiana, Minnesota, Oregon, Rhode Island and South Dakota.[24] The expansion of services covered in those states ranges from underlying factors that contribute to SDOH to cultural brokering between a community member and their health team.

Although expansion of scope of service would help to solve some of the problems associated with CHW reimbursement, it notably may also raise challenges for some CHWs and CHW organizations if approached too rapidly or without CHW input. For example, if scope expansion were to occur beyond the current training and certification capabilities provided to CHWs, organizations that provide those certifications must also expand the scope of practice or implement specialty trainings to meet those needs, Additionally, without a commensurate rise in the wages afforded to CHWs, it is possible that an expansion of scope would stretch CHW's beyond their capacity to provide high-quality care.

A patient of mine didn't have the finances

to turn his utilities back on after they were shut off, which meant he was also unable to take his insulin – as it needs to be stored in a refrigerator. I connected him to a community center that helped pay those utilities so that he could continue his medication."

- Shanyra Zapata,
Community Health Worker, Indianapolis

PRIORITIZATION OF

POLICY TENSIONS & ACTIONABLE SOLUTIONS

INFORMED BY THE CHW POLICY FORUM

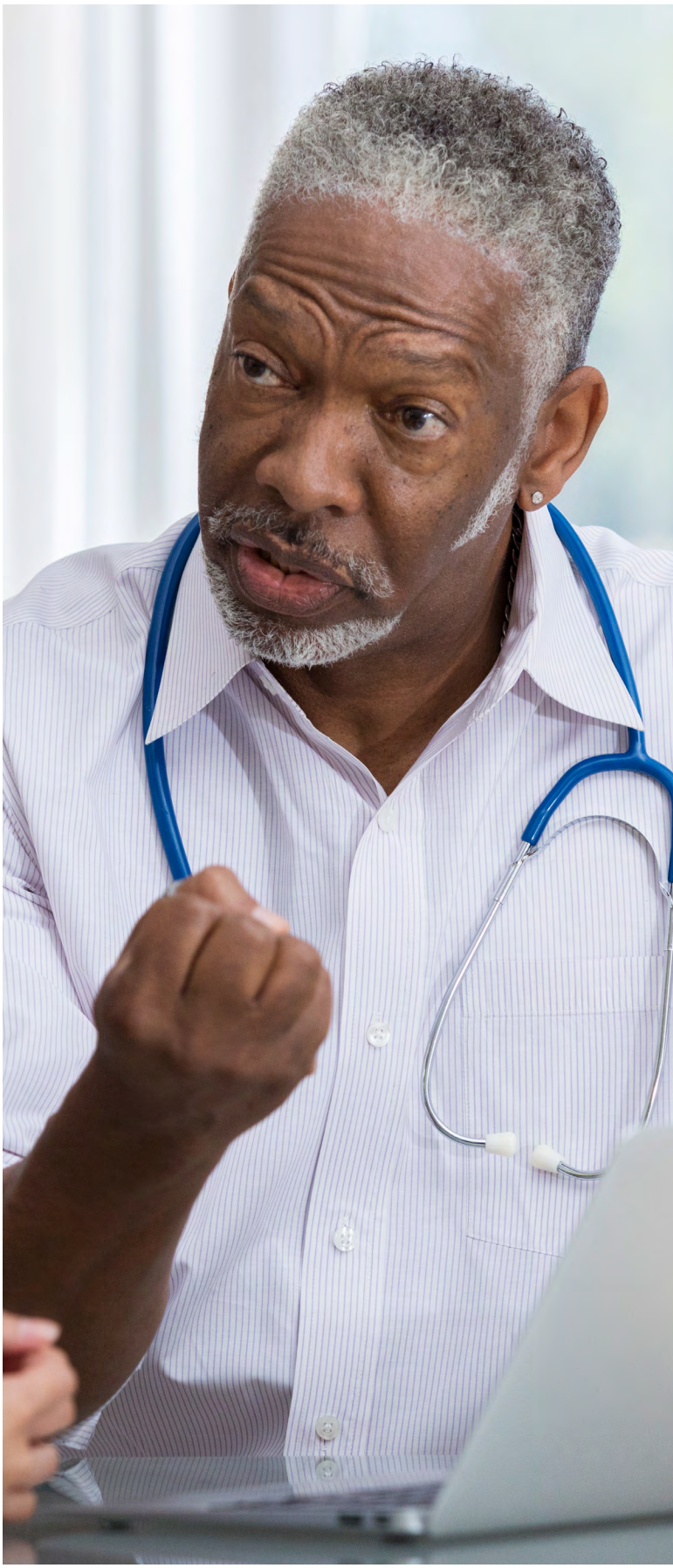
Against the backdrop of the CHW policy assessment, CHW Policy Forum has shared their vast experience working within the U.S. healthcare system and the importance of establishing long-term, sustainable funding to facilitate the vitality of CHW programs and increase the scope of reimbursable CHW services. Federal and state actionable policy solutions were segmented across four policy areas while recognizing there is some overlap between state and federal policy solutions:

1) CHW REIMBURSEMENT

2) FEDERAL AND STATE FUNDING

3) WORKFORCE DEVELOPMENT AND PROGRAMS

4) EXPANSION OF CHW SCOPE OF SERVICE



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1) CHW REIMBURSEMENT

- The top priority for the CHW community is securing **consistent and sustainable funding sources.**
- The **lack of uniformity in services eligible for reimbursement could be made more efficient.** Updated and streamlined utilization of reimbursement codes would ensure CHWs and health systems can submit clinical and non-clinical CHW services for reimbursement.
- There is a critical need to establish CHW funding and reimbursement frameworks and make them accessible through community-based organizations and partners. Many organizations that have established community trust and employ CHWs need to be equipped to meet federal or state billing requirements.
- **Federal and state definitions** of the CHW profession and the services they offer are inconsistent and imprecise, which cause reimbursement tension between other healthcare providers and payers and lead to inconsistent reimbursement.
- **Healthcare provider-focused value payment models** should be explored as they offer more flexible payments that allow for long-term outcomes, providing more incentives to providers (e.g., doctors, nurses) and MCOs to invest in CHW/community needs.

2) FEDERAL AND STATE FUNDING

- Federal and state **funding mechanisms** for CHW programs need to be more sustainable and structured for long-term implementation. Success metrics are skewed to prioritize reactionary, service-focused care rather than proactive, outcomes-based care.
- **"Hub Models" have been implemented in a handful of states** (e.g., Indiana, Michigan, Ohio, Washington) using crowdsourced funding across organizations to support CHW programs; these hub models provide the infrastructure to track risk factors from identification through mitigation and link payment directly to outcomes.[35]
- For communities that face barriers to accessing federal or state funds, **micro-funding could be an alternative** option to tap financial resources and has been a proven model to unlock additional funds to support CHWs.[36]

3) WORKFORCE DEVELOPMENT AND PROGRAMS

- There is a fundamental need to **educate health systems on the proper implementation of CHWs** in the healthcare system and how to best integrate and leverage the valuable skills CHWs bring to healthcare practices.
- Policy language needs to be standardized across states and in the federal government to better define the CHW profession.
- Critically, there must be an **increase in the federal Physician Fee Schedule** (PFS), and programs must provide a sustainable living wage for CHWs.

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4) EXPANSION OF CHW SCOPE OF SERVICE

- Because coding rules for reimbursement do not cover the full scope of CHW services, **organizations may sometimes choose not to seek financial reimbursement for CHW work.** Therefore, it is essential to prioritize additional reimbursable services or reforms to existing reimbursement coding rules to permit CHWs to address SDOH and interventions that improve health outcomes.
- Increasing **awareness and education around pathways to a sustainable and lucrative career** as a CHW could improve recruitment and retention.
- It is imperative to **identify additional shared opportunities for experience-based cross-training** for CHWs, as well as nurses, health coaches, community health centers, and others, as well as to implement greater institutional flexibility for clinic- and community-based CHWs to be interchangeable and serve both patient populations – within the clinic and in the community.

Ron Rice, Community Health Worker

This report was supported by Eli Lilly and Company

COMMUNITY HEALTH WORKER
Policy Forum

CHW POLICY RECOMMENDATIONS: PART 1

CHW Policy Forum members have set forth the following list of immediate policy recommendations to support CHWs and improve access to equitable healthcare:

Develop a sustainable and dedicated CHW federal funding pathway through congressional appropriations *(Annual Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill)* that enables the HRSA to support CHW programming.

Establish section 1115 (Medicaid waivers) policy principles and criteria to ensure that section 1115 waivers expand Medicaid coverage to reduce health disparities through CHWs, including addressing health-related social needs (HRSN), also referred to as SDOH.

Increase utilization of Medicaid SPA by states to ensure authorization for CHWs to administer preventive health services and address SDOH to Medicaid beneficiaries, including, but not limited to, health education and coaching, health navigation and care planning, screening and assessment, housing nutrition, and mental and behavioral health skills — ensuring that CHWs and their organizations receive reimbursement for the holistic health services they provide.

Implement uniform federal and state definitions of CHWs and scope of service, including an emphasis on the qualification of CHWs to have lived experiences that align with and provide a connection between the CHW and the community being served. Additionally, definitions must recognize the role of CHWs in approaching the holistic wellness of patients in their communities through avenues sometimes understood as outside traditional care, including volunteer work, coalition building, and public health.[37]

Authorize a federal campaign (public service announcement) by HHS to **increase awareness of CHWs, pathways to a sustainable career and educate health systems about the proper implementation** of CHWs in the healthcare system.

COMMITMENT TO EXPLORING LONG-TERM SOLUTIONS TO CHW FUNDING: PART 2

CHW Policy Forum members have identified the need to explore **innovative CHW healthcare delivery and payment models to achieve effective, efficient, and sustainable implementation of CHW programs in the long term.** The CHW Policy Forum recognizes that many of the most innovative changes to Medicare and Medicaid reimbursement systems are developed and implemented by the Center for Medicare & Medicaid Innovation (CMMI), and believes there is potential for a demonstration project through CMMI to deliver a new, innovative model for CHW funding.

This report was supported by Eli Lilly and Company

CONCLUSION/NEXT STEPS

In September 2022, the Biden administration announced funding to recruit, train, and deploy over 13,000 CHWs, and Congress has signaled that CHWs are critical to building capacity in our health infrastructure.[17] We collectively recognize the unique role of CHWs and must provide them with the tools to support the health of our communities through adequate reimbursement and funding for CHW programs. CHWs are cost-effective and evidence-based in improving access to healthcare and health literacy, reducing barriers that impede equitable care, and filling the provider gap within medically under-resourced communities. Evident through the lessons learned during the COVID-19 pandemic, one-size-fits-all approaches to healthcare often fail to account for the nuanced issues facing our communities and the root issues of equitable access and affordability of healthcare.

As we identify new solutions to old problems and prepare for future public health emergencies, it is critical that we address local health issues with local solutions ensuring healthcare professionals are reflective of the communities they serve by supporting CHWs through adequate reimbursement to address underlying causes of suboptimal health outcomes and creating a sustainable career pathway.

Working with CHWs, CHW partners, and policymakers, the CHW Policy Forum believes necessary policy solutions will sustain CHW career pathways and provide CHWs the resources for increased application of CHW skills and broader integration into the U.S. healthcare system are needed.

This report was supported by Eli Lilly and Company

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