**Community Health Workers: Priorities for Maximizing the Benefits of a Growing Workforce**

**ABSTRACT**

Healthcare reform innovations, including the Patient Protection and Affordable Care Act (PPACA) and state Medicaid redesign efforts provide opportunities for the Community Health Worker (CHW) workforce to expand, driven by robust evidence documenting their effectiveness in achieving better care, improving health and lowering costs. This article summarizes recent developments in the field and makes recommendations for advancing current health care landscape, and the CHW workforce. It aims to inform the integration of CHWs into health care teams while supporting the unique characteristics that make them effective. The authors recognize that advancing the CHW profession requires leadership from within the field. For this reason, the authors recommend the creation of a national association of CHWs to address the policy, practice, research and regulatory issues facing this rapidly growing field.

**INTRODUCTION**

Healthcare reform and the Patient Protection and Affordable Care Act (PPACA) recognize that the existing health care system is fragmented and ineffective at improving the health and wellbeing of our population while operating at exorbitant costs which threaten to bankrupt our nation. The PPACA has given rise to Medicaid redesign efforts ongoing in all but a few states that mandate changes in the way we finance healthcare from pay-per-encounter to pay-for-performance, shared risk and bundled payment models. In the context of this profound change, opportunities for the Community Health Worker (CHW) workforce are expanding, driven by increasingly robust evidence documenting CHW effectiveness, and especially in their ability to address the impacts of the social determinants of health. The CHW and public health communities seek to foster workforce expansion and effective delivery of CHW services while preserving the unique quality of their work (Campbell et al, 2015; Findley, Matos, Hicks, Chang, & Reich, 2014; Redding et al, 2015).

To address these issues, an advisory panel was convened by Sanofi US, Inc. on November 16th, 2014 during the American Public Health Association (APHA) annual meeting in New Orleans. The panel, composed of experienced CHWs and CHW thought leaders, met to identify opportunities, challenges and strategies to advance the CHW workforce nationally. This document summarizes advisory panel recommendations on how to broaden integration of the CHW workforce in the context of health care reform. Recognizing inherent challenges to integrating the CHW workforce into traditional medical care systems, the panel proposed an agenda to help the CHW community align workforce goals with those of other health care delivery stakeholders, including providers, policymakers, and payers.

The authors a) assume the holistic global understanding of health as complete physical, mental, and social wellbeing, and not merely the absence of disease (WHO, 1948); and b) recognize that CHWs promote health equity through contributing to the health and wellbeing of individuals and communities. The authors recognize that many CHWs work outside of what might traditionally be viewed as the health care sector, working in community-driven organizations, schools, faith-based, and other civic organizations.

**CHW WORKFORCE EXPANSION: OPPORTUNITIES AND BARRIERS**

The PPACA marked a watershed moment for the CHW workforce. The reach and cultural appropriateness, and effectiveness of services can be improved through expansion of the workforce and better integration into health care delivery systems. Specific PPACA provisions (Katzen & Morgan, 2014) raise the CHW profile and expand awareness of their value to prevention, health promotion, and treatment adherence. This acknowledgement has afforded CHWs greater opportunity to engage in policy discussions regarding their roles (Catalani, Findley, Matos, & Rodriguez, 2009; Findley et al, 2012). As health care delivery system innovations continue to evolve, the integration of CHWs can be expected to increase.

CHWs play multiple roles in both patient-centered and population-based approaches; however, obstacles remain regarding consensus on definition, training and certification standards, and a lack of policies for sustainable financing. Recent momentum from local-, state-, regional-, and national-level initiatives, combined with the increasing body of evidence documenting CHW contributions, will help overcome these remaining obstacles and enable a fuller inclusion of CHWs into mainstream innovations.

**RECENT ADVANCES IN THE CHW WORKFORCE**

Published in 1998, the National Community Health Advisor Study (NCHAS), was the first national effort to identify CHW roles, skills and qualities. Recognizing the capacity of CHWs to improve health and healthcare access, the study was intended to describe and validate the CHW field. The study documents CHW effectiveness in the prevention and reduction of cultural and linguistic barriers to care and in their ability to help people navigate complicated systems of health and social services to improve the quality and cost-effectiveness of care.

The Community Health Worker Section of the American Public Health Association (APHA), has been active for more than twenty years, establishing a CHW definition built on consensus of the field and developing policy positions on CHW leadership and CHW training. Most recently (in 2014) APHA adopted a policy resolution urging all regulatory bodies charged with developing workforce standards for CHWs to include at least 50 percent CHW representation. The APHA defines CHWs as “frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables the CHW 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 CHW 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” (APHA, retrieved 2017).

In 2009, the Executive Office of the President published a new listing of US Department of Labor (DOL) standard occupational categories in which CHWs are listed for the first time as a distinct occupation. This federal standard promotes CHW understanding and recognition. The definition in the DOL classification of CHWs is as follows: (U.S. Bureau of Labor Statistics, 2016):

*Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such first-aid and blood-pressure screening. May collect data to help identify community health needs. Excludes “Health Educators”.*

This DOL definition focuses primarily on a medically oriented role for the CHW, and is currently undergoing revision. The CHW Section of APHA has launched a national campaign requesting that the DOL substitute the APHA definition because it was developed through consensus in the field and recognizes that many CHWs work outside of what traditional healthcare might be traditionally viewed as health care, in settings, in areas such as community organizing, early childhood development, safe neighborhoods, food security, education, and employment. Solidifying definitions and elevating recognition enhances CHW workforce credibility with employers, payers, regulators, and other stakeholders alike. (It should be noted that this federal definition is only for classification and enumeration purposes, and is not binding on employers or payers in a regulatory sense.)

In 2007, the Health Resources and Services Administration (HRSA) estimated that roughly 120,000 CHWs served communities throughout the US. (NCSL, 2008). At that time, the DOL projected that employment of CHWs would grow faster than the average for all occupations in the period 2014–2024. (U.S. Bureau of Labor Statistics, 2015). Adoption of the more inclusive APHA definition by the DOL is critical to acknowledge the depth and reach of CHW practice.

Building on the work reported by the National Community Health Advisor Study, the Community Health Worker Core Consensus (C3) Project offers contemporary recommendations for CHW core roles (scope of practice), core skills, and core qualities. Patterns of CHW employment have shifted since the time of the NCHAS, with increasing numbers of CHWs employed in health care systems and managed care organizations.  The C3 Project compared current workforce analyses from six “benchmark” states and used a participatory, iterative approach to refining these findings, with the intention of building common language about the workforce.  While the recommendations do not represent a “national standard,” they are intended to encourage more commonality in definitions across states by serving as a common starting point for consideration of standards and educational program design by CHWs and other stakeholders. The final report of the Community Health Worker (CHW) Core Consensus Project can be found here:<https://sph.uth.edu/dotAsset/28044e61-fb10-41a2-bf3b-07efa4fe56ae.pdf>.

On a state level, the New York State Community Health Worker Initiative in partnership with Columbia University Mailman School of Public Health, conducted rigorous community based participatory research, data analysis and market analysis to establish workforce standards, scope of practice, training recommendations and financing possibilities in NYS. The report titled, “Paving a Path to Advance the CHW Workforce in NYS”, was published in 2011 and presents a contemporary description of the CHW scope of practice, roles, tasks and qualities.

# *Who Are CHWs?*

This collective research, together with robust documentation in the scientific literature, indicates that CHW is an occupational designation that includes numerous job titles, including, but not limited to, outreach worker, community health representative, promotor(a) de salud, patient navigator, and peer educator. (CDC, 2013). CHWs within the healthcare sector serve as connectors between individuals and providers, and as agents of change to help traditional healthcare systems improve the quality and appropriateness of their services. Traditionally, CHWs have worked in oppressed communities, or with groups who lack sufficient access to healthcare or a voice to inform innovation. (CDC, 2013). At their core, CHWs strive for social justice and equity.

The uniqueness of the CHW workforce creates opportunities to transform health care delivery as new models emerge under health care reform. As a practice that is “at once ancient and emerging” (Wiggins et al, 2013), CHW services have been documented in the U.S. as early as the 1950s, and the profession emerged more fully within the backdrop of the 1960s and 1970s anti-poverty and social justice movements (Perez & Martinez, 2008). Integrating CHW expertise into mainstream health care presents opportunities to promote a focus on both population health and patient-centeredness.

However, thorough understanding of the contributions CHWs bring to healthcare and social service systems is still not widespread. Stakeholders need to hear about the value of CHWs’ unique position and skills in terms of their ability to reduce healthcare costs. CHWs are learning to explain their value in making the case for expanded roles in healthcare.

“CHWs can reduce overall cost of care for high utilizers of emergency departments in both short-term and longer-term perspectives; that is to say, the short-term intervention can produce both short-term results and longer-term changes in behavior resulting in continued cost saving.” — Carl Rush

*Journal of Ambulatory Care Management*

**CHW ROLE IN THE CURRENT HEALTH CARE LANDSCAPE**CHW roles and responsibilities vary widely: CHWs may be paid employees of family-service organizations, advocacy groups, early childhood education programs, outpatient/ambulatory care centers, or physician offices. They may also be community volunteers working in association with the local healthcare system. CHWs may coordinate care and care transitions for community members, provide culturally appropriate health education related to chronic disease prevention and management, advocate for community members, provide informal coaching and counseling, and address health issues at a community level (Rural Health Information Hub, 2016). CHWs build individual and community capacity to improve healthcare systems, and mobilize community strengths and assets to address social and psychosocial determinants of health.

CHWs are uniquely qualified to create linkages between communities and healthcare providers. CHWs share life experiences (and often language and cultural heritage) with community members, and can both build trust and recognize culturally specific health behaviors and beliefs. Additionally, their role as advocate and educator goes in two directions. The role of CHWs in health education and communication of information from providers to community members is widely understood. But CHWs can also educate providers on the cultural and social context of health behaviors and help improve the quality of their services to address communities’ needs and preferences. These communication streams are subtle yet powerful. Cultural context is critical to communicating both disease-prevention strategies and obstacles faced in implementing those strategies back to providers. Therefore, workplace protocols for supporting this two-way communication are needed.

“CHWs can help people who are struggling to control their chronic disease. I worked for a diabetes program that performed a quasi-randomized control trial comparing the standard of care to a CHW intervention in the South Bronx. The CHWs were supported by the medical director and supervised in a very supportive way so they had a lot of freedom to engage patients as patients found appropriate. We found a full point drop in HbA1c level in the intervention group after six months of CHW intervention. We set up cooking groups and walking groups, and even a dance group. We helped people set achievable goals and celebrated their little successes, which we then leveraged to motivate them towards accomplishing larger goals. We were able to gain the support of the doctors once they saw us being successful with patients they had had a lot of trouble with.” – Romelia Corvacho, CHW

**CHW IMPACT ON CHRONIC DISEASE PREVENTION AND MANAGEMENT**

The US Department of Health and Human Services (HHS) estimates that 75% of the nation’s healthcare spending is attributable to chronic diseases, many of which are preventable (U.S. Department of Health and Human Services, 2013). Challenges to healthcare access, health equity, and disease prevention include cultural, linguistic, health literacy and socio-economic factors (Singleton & Krause, 2010). Out-of-pocket costs — such as co-payments, coinsurance, and deductibles — also discourage individuals from seeking preventive care services, creating downstream health consequences and higher long-term costs (U.S. Department of Health and Human Services, 2013).

Research shows that prevention is key to both cost containment and better health outcomes. The “Triple Aim” addresses the cost/quality balance (Institute for Healthcare Improvement, 2017):

* Improve the patient experience of care, including quality of care
* Improve the health of populations
* Reduce the per capita cost of healthcare

The PPACA mandates preventive care, including screening, for persons at high risk for chronic diseases (U.S. Department of Health and Human Services, 2010). High-cost chronic conditions, including asthma and diabetes, often disproportionally impact certain racial and ethnic groups, and underserved and/or economically disadvantaged communities (U.S. Department of Health and Human Services, 2011; Levine, 2011; Akinbami, 2012). To effectively address prevention and management of conditions known to impact these communities, system changes, including consumer empowerment, are critical.

Increasing healthcare coverage coupled with an aging population has created a greater demand for healthcare services. The associated costs are expected to further strain resources and challenge priorities in resource allocation. Furthermore, the financial and social burden of chronic conditions such as diabetes also continues to grow (Bovbjerg, Eyster, Ormond, Anderson, & Richardson, 2013).

CHWs can appreciate the challenges of both living with and managing chronic conditions under difficult socioeconomic circumstances. This is especially important for aging individuals with multiple chronic diseases or those who are at risk of developing additional chronic conditions.

Given appropriate support, CHWs can implement prevention strategies at multiple levels, from individual coaching for diet and physical activity to population-level interventions on environmental challenges to health, such as the lack of access to nutritious food or safe streets. Importantly, CHWs also have the potential to impact the design of disease-prevention strategies, making them more relevant, achievable, and appropriate.

***Emerging Healthcare Delivery Systems***

Emerging healthcare delivery models, including accountable care organizations, medical villages, accountable health communities, patient-centered medical homes, and health homes, must aim to provide more cost-effective and person-focused care than traditional-delivery models. This drive toward care coordination could benefit from increased integration of CHWs into healthcare delivery teams. CHWs can bridge language and cultural barriers that can impede optimal care. States are using Delivery System Reform Incentive Payment (DSRIP) waivers to establish financing models which support team-based care, bundled payments, and value-based purchasing.

As trusted community members, CHWs are often the “first ear” for high-value contextual information that could benefit decision-making within a patient-care team that might otherwise have incomplete or inaccurate information. CHWs can elicit more candid responses from patients, overcoming reticence due to stigma or fear of disapproval from a clinician as an authority figure. This candor can help lead to more efficient diagnosis and progress on adherence to treatment.

CHWs are also in a unique position to observe, investigate, and act upon root causes of chronic diseases. For example, in areas with high obesity rates, CHWs may counsel on dietary choices, but also help people learn how to make healthier food choices within their community. CHWs often function as community organizers galvanizing people to collectively advocate for improved environments. Mitigating the impacts of complex social determinants of health are the “wheelhouse” of the CHW. Better utilization of CHW skills can establish a more holistic understanding of health by providers.

**FUTURE DIRECTIONS**

Considering the opportunities for and challenges to the CHW workforce in the health reform era, the advisory panel developed key recommendations for workforce expansion. These recommendations fall squarely within the focus of health reform on chronic disease prevention and management, areas where the impact from the CHW community is well documented.

***Create a National Organization***

Growing recognition of CHWs’ contributions to emerging healthcare models suggests a compelling need for a national-level organization to represent the workforce.

A national professional association could safeguard the core CHW values of social justice and equity, while helping to integrate CHWs within the healthcare system with dignity and respect.

“In this time of expansion in the CHW workforce, it is imperative that CHWs develop a national professional association to guide the development of the practice to preserve the integrity and value of their work.”

***Workforce Development and Standards***

The policy infrastructure to support the CHW workforce requires attention to:

1. Definitions and standards for the occupation; (2) workforce
2. Workforce-development strategies, including training resources and career-development pathways
3. Sustainable financing mechanisms (not limited to healthcare funding)
4. Documentation and evaluation practices

An interesting and contemporary approach to the training and certification of CHWs is emerging in a number of states that are implementing apprenticeship programs. This method seems to offer a different perspective for consideration of CHWs as a “trade”. The culture of the trades embraces self-determination and self-governance. The CHW apprenticeship model appropriately differentiates their work from that of the clinical tasks performed by medical professionals.

Developing a national-level CHW organization presents opportunities to create national discourse and consensus on training and certification standards while preserving the integrity of the CHW’s identity and values. In 2013, the Centers for Disease Control and Prevention (CDC) reviewed state-level CHW regulations, including information on training and certification, as well as reimbursement policies (CDC, 2013). Although this information describes the regulatory landscape concerning CHWs, it is important to consider that while healthcare systems are deeply rooted in the medical model, current health reform seeks innovative efforts to address the social determinants of health.

Widely accepted training standards and guidelines can help raise the credibility of CHWs. Standardization, however, carries the risk of redefining the community perception of the CHW and eroding their valued societal position of trust.

***Leadership Development***

As CHWs achieve greater recognition and more prominent roles, leadership development within the field is essential. A national-level organization can create leadership development programs, including both formal training and action-oriented/experiential opportunities.

***Sustainable Workforce Financing***

Historically, financing for CHW services has relied on short-term grants and contracts. In the move to create more sustainable financing for CHWs in the current cost-saving environment, payers expect CHW qualifications to be specified to justify payment. These standards, however, must not lead to a narrowing of the CHW scope of practice. Integration of CHWs into team-based care allows them to be included in newly created financing mechanisms such as bundled/global payments, value-based purchasing, and shared risk. However, many institutions lack expertise on including CHW positions in such payment models. A national organization could support dialogue with policymakers and design of payment demonstrations involving CHWs. A national CHW association will also safeguard the community-centric, grassroots nature of the CHW workforce as these innovative healthcare financing mechanisms emerge.

***CHW-led State Policy Development***

Decisions are being made at the state level on the development of a public policy infrastructure to support CHWs. Sustainable financing of CHW employment will inevitably rely heavily on public funding streams, and will probably involve Medicaid. Acceptance of standards for Medicaid participation will be needed from state governments. State governments may need to invest in CHW workforce development and to include CHW activities in standards for data collection in public health and healthcare programs.

This picture is complicated by several factors:

1. Strong anecdotal evidence suggests that few state government officials fully appreciate the unique nature and value of CHWs, and therefore are unable to adequately consider these factors when developing sound public policy
2. Several states are currently proceeding with CHW policy development driven by healthcare-related interests. These efforts should include the meaningful participation of state-level CHW networks and associations, and should follow other recommended practices to assure alignment with the unique nature of the CHW workforce. At least 30 states are at some stage of CHW policy development, often with minimal participation by CHWs. The National Academy for State Health Policy (NASHP; NASHP, 2015) and the Association of State and Territorial Health Officials (ASTHO) have begun tracking state policies regarding CHWs. The CDC has published several CHW policy-guidance papers to assist states (CDC, 2014; CDC, 2015). In parallel with the top priority efforts to build national and state CHW associations, it is vital to exert influence on ongoing state policy initiatives to remind other stakeholders of key values and principles, such as CHW self-determination.
3. Despite this growth in state CHW policy development, challenges remain in communicating best practices and sharing of relevant information. Currently, each state exploring such policies is more or less on its own. More experienced states like Massachusetts, Texas, New Mexico, and Minnesota can contribute lessons learned (both positive and negative), but state government employees may not have the time to assist other states. Officials of the National Conference of State Legislatures, the National Governors Association (NGA) and ASTHO have agreed that resource-sharing on policy development would help avoid “reinventing the wheel.”

***State CHW Policy: Recommendation***

A resource exchange on state CHW policy development could provide important support to state governments, CHW networks, and stakeholder coalitions. The exchange would promote recommended practices and strategies in policy development and prevent state governments from taking shortcuts which can compromise the unique grassroots contributions CHWs make.

Such a resource exchange could create and/or disseminate:

* Practice-informed recommendations for policy, leadership and workforce organizing, news of recent policy developments, and contact information for state officials, policy coalition leaders, and CHW networks
* Specialized policy studies as requested by multiple states
* Direct technical assistance to state governments and stakeholder coalitions

***Expanded Awareness of CHWs and Their Value***

“Elevating the perceived value of CHWs is key to broadening adoption in the current health care system.”

As new healthcare delivery models emerge, opportunities to realize the full potential of CHWs hinge on raising awareness of CHW impact on increasing access, lowering costs, and improving outcomes. Yet many stakeholders have limited understanding of the unique scope of the work of CHWs.

Many CHWs are unaware that they are part of a larger CHW workforce due to their historic marginalization, the proliferation of job titles, and the tendency of some CHWs to identify more strongly with a specific health issue than with a broader occupational identity.

There is broad consensus on the need to build awareness of CHW professional identity to facilitate meaningful policy change; media opportunities could be leveraged to help meet this need. The CHW’s role as advocate for individual and community health needs has broad appeal. Furthermore, the unique potential of CHWs in helping to address the social determinants of health is essential to the goals of healthcare reform. The “high-touch” approach CHWs apply on a personal level, and the change they ignite at a macro community level, are unique points to emphasize in showcasing CHWs. Healthcare industry media are also drawn to CHWs’ ability to reduce healthcare costs.

A focused identity campaign could expand awareness for both CHWs and other stakeholders. A national-level organization could lead development of consistent messaging that reflects the goals and needs of the CHW occupation at large. A wide variety of media platforms could be leveraged, including print, scientific publications, radio, websites, and social media.

***Improving Chronic Disease Management and Medication Adherence***

“Reductions in hospitalizations and emergency department visits are overwhelmingly reported to be the key drivers of declining health care costs associated with improved medication adherence.” –Roebuck et al. 2011, *Health Affairs*

A key area of research requiring more evidence is the role of CHWs in chronic disease prevention and medication adherence.

Addressing the research gap regarding impact of CHWs on chronic disease prevention has challenges; immediate cost savings may not be generated, and better outcomes may not lead to cost reductions. However, quality outcomes are aligned with healthcare reform initiatives and longer-term studies may support cost containment. Literature shows that CHWs significantly impact projected costs of chronic diseases such as asthma, diabetes, and hypertension. Future studies should consider quality metrics to quantify the impact of interventions.

Research shows that medication adherence leads to lower healthcare costs due to reductions in hospitalizations and emergency department visits (Roebuck, Liberman, Gemmill-Toyama, & Brennen, 2011). It also lowers the cost of tertiary treatments and procedures, and treatment of end-organ damage. Finally, medication adherence increases life expectancy and quality of life, so that individuals can be productive members of their communities. Behavioral, cultural and socioeconomic factors are strong influencers on medication adherence. In the eyes of payers and other stakeholders, the impact of CHWs on medication adherence is a key step in increasing their value.

**CONCLUSION**

The work of CHWs has recently attracted significant attention, primarily driven by efforts to address inequities in population health, especially for those living with multiple chronic conditions. This interest is also fueled by increasingly robust published evidence of CHW effectiveness in improving outcomes and lowering costs for people with chronic conditions. Furthermore, the focus of emerging innovations on team-based care and linkages to community-based services has raised awareness of the CHW role in coordinating care across providers and systems.

This paper examines the evolving roles of CHWs, and the elements that contribute to their success. It aims to inform the integration of CHWs into healthcare teams while urging support for the unique characteristics that make them successful. Preserving the character of the work of CHWs is increasingly critical as attempts are made to define and regulate the workforce. The authors recognize that advancement of the CHW profession requires leadership and structure from within the field, and therefore urge the creation of a national association of CHWs. This association would facilitate consensus related to workforce standards and sustainable financing mechanisms, as well as foster leadership development, to support the work of CHWs. Additional future directions include advancing state-level policy, expanding awareness of the profession, and, finally, driving a research agenda which articulates the true impact of this workforce on improving the prevention and management of chronic disease while advancing population health efforts.

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