High-Impact Community Investments by Health Plans

Considerations for Health Plans Working with Community Health Workers to Address Non-Medical Drivers of Health and Resulting Health Inequities

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Report Summary: In order to improve clinical outcomes, health plans are increasingly investing in programs to address their beneficiaries' social determinants of health (SDOH) needs, including by leveraging community health workers (CHWs). To this end, the Association of State and Territorial Health Officials (ASTHO), in partnership with CVS Health®, conducted a research plan that included a literature scan and focus group interviews with health systems, state health departments, and organizations developing and deploying innovative CHW models and supporting the CHW workforce. This paper explores the results of that research and describes how an insurer-sponsored CHW program can address health plan members' SDOH needs.

Outlined in this paper are the findings from our research, which include:

- Health plans investing in SDOH initiatives, such as CHW-led programs, has documented positive value.
- CHWs' effectiveness in addressing non-medical drivers of health is well known and documented.
- CHWs' vast breadth of value is rooted in compassionate care and lived experience; they have the unique capability to provide person-centered care that accounts for the full family and community context.
- Organizational readiness, such as adequate infrastructure and support structures, is necessary for establishing effective and scalable CHW initiatives.
- Partnerships with CHWs and the organizations representing and supporting them will foster cohesion and shared vision-making when developing CHW-led programs.

In support of these findings, this paper outlines tactical ways health plans can address SDOH, the fundamental mechanisms for effectively financing SDOH programs, best practices for CHW program deployment as a tool for addressing SDOH, and the ways health plans should support CHWs (professionally, financially, and psychologically) to build out effective and sustainable programs. This paper also serves as a call to action for health plans to consider investing in robust, patient-centered SDOH initiatives that prioritize collaboration with providers, public health, and community-based organizations, and highlights why CHW workforce capacity is key for such investments.

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Introduction

The social determinants of health (SDOH), or the social, economic, and environmental conditions of one's life, account for approximately half of the variation in health outcomes in the United States. Furthermore, there is a strong correlation between the social, economic, and environmental conditions that marginalized communities face and health disparities among these populations.[1,2] Research shows that when you remove non-modifiable and often unmeasurable genetic factors, social, economic, and environmental factors account for 50% of overall health outcomes, whereas both access to and quality of clinical care contributed only 20%. This evidence suggests that improving social, economic, and environmental conditions can have a significant impact on improving health inequities.[3] As such, the nation has seen an increase in prioritizing health equity strategies promoted by HHS, the Centers for Medicare and Medicaid Services (CMS), and other federal agencies, as well as a subsequent increase in investments in a landscape of innovations in SDOH and health-related social needs - individual social and economic needs resulting from an individual's SDOH - spanning medicine, public health, social services and health plans.[4,5,6]

Public health and health care frequently utilize community health worker (CHW)-led programs are as an evidence-based model for addressing individual social needs. Aiming to provide empathetic and person-centered care, CHWs foster programs for people who are medically underserved and serve as a bridge between medical services, public health and other community and social service providers.[7,8] This workforce can be trained and fluent in topics such as cultural competency, health education, trauma-informed care, patient privacy, motivational interviewing, and disease-specific topic areas, among others, and often complement clinical practitioners as members of a care-team. CHWs bring a unique set of skills, often including lived experience, that help foster trust and rapport among historically-marginalized populations who often have significant, unmet SDOH needs that go unaddressed in traditional healthcare models. Several studies have demonstrated the impact of CHWs on improving clinical outcomes such as chronic disease control, quality of care, and mental health.[9,10,11] Additional evidence exhibits opportunities for CHWs to generate a positive return on investment, as well.[12,13] Due to their demonstrated effectiveness, CHWs are an essential workforce to integrate into healthcare systems to advance health equity.

Health Plan Actions to Address Social Determinants of Health

Disease-specific research highlights associations between food insecurity and diabetes, social isolation and stroke, and housing instability and emergency room usage.[14,15,16] Studies examining healthcare utilization and costs have identified how SDOH can negatively impact hospital stay length and readmission rates, while specific risk factors such as housing instability and unemployment have been directly associated with greater outpatient costs and service use per year, per patient.[17,18] These examples highlight the linear relationship between SDOH and adverse health outcomes, increased utilization of healthcare, and spending. As such, health plans should consider investing in lower-cost solutions to manage non-medical social drivers of health to reduce health disparities for their members and drive down higher-cost, unplanned medical expenses.

Health plans are uniquely positioned to make meaningful improvements to health disparities resulting from such risk factors, as they have the opportunity and means to:

1. Incorporate allowable CHW services into benefit design.
2. Incentivize providers to screen and refer for SDOH needs.
3. Establish cross-sector partnerships with health and social service providers to coordinate care provision.

Paying for Allowable Services

Recent regulations, federal prioritization, and state led initiatives have made it easier and more necessary for health plans to fund SDOH initiatives. These changes require health plans to incorporate non clinical services into their benefit design and test the effectiveness of such interventions on improving health outcomes and reducing care costs.[19]

Medicaid authorities for investing in social determinants of health

There are ample opportunities for addressing SDOH through various Medicaid funding levers, including state plan amendments, waivers, and managed care, with recent CMS guidance increasing the options available to states through managed care authority and Section 1115 waiver demonstrations.[20]

State Medicaid programs may use various state plan and waiver authority (e.g., 1905[a], 1915[i], 1915[c]) to cover non-medical services for older adults and people with disabilities . To include service provisions for all other Medicaid members, states may also add non-clinical benefits via Section 1115 waivers, as seen in recent waiver approvals for health related social need service provision (e.g., housing supports, nutrition services, case management, employment support) in states such as Arizona, Arkansas, California, and Oregon.[21,22,23] These waivers are addressing members' health related social needs (their unmet, adverse social and economic conditions that contribute to poor health conditions—such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities) through pilot approaches addressing SDOH, such as temporary housing and medically-tailored meals programs.

For states where Medicaid is delivered via managed care, health plans that are contracted to serve as Medicaid managed care organizations have additional options for SDOH benefit design. One avenue available through managed care authority is the result of recent federal rulings allowing managed care organizations to provide "in-lieu-of" services that may substitute standard Medicaid benefits for non-medical services.[24]

State examples of this flexibility aimed at addressing SDOH include New York's coverage of medically-tailored meals, California's Medi-Cal Community Supports benefits, and Kansas' KanCare program providing medical nutrition therapy. Managed care organizations may also voluntarily include "value-added" non-medical services outside of covered contract services and may leverage their procurement strategies to develop quality requirements linked to SDOH.[25]

Medicare Advantage plan options for investing in social determinants of health

The 2018 Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act paved the way for Medicare Advantage plans to cover additional services for a subset of beneficiaries with complex needs as of 2020.[26] In a letter to Medicare Advantage organizations, CMS broadly identified examples of allowable supplemental benefits, including meals (beyond a limited basis), food and produce, transportation for non-medical needs, and social needs benefits (e.g., access to community or plan-sponsored programs and events to address enrollee social needs).[i]

Medicare Part B also covers community health integration services to address individual social needs that may affect a provider's diagnosis and treatment of a patient's medical problem.[27] These services include care assessments to better understand individual circumstances, care coordination, health education, patient self-advocacy training, health system navigation, and social-emotional support.

Community Health Worker-Led Programs as a Vehicle for Health Plans to Address Social Determinants of Health

Health plans should develop comprehensive programs that shift how providers address social needs beyond simply referring patients to social services in order to ensure follow through and uptake of needed services in alignment with new HEDIS SDOH quality metrics and improved quality of care for patients. These programs should instead include integration of emotional support opportunities, improved healthcare service utilization, and individually tailored clinical care to address social risk, as proposed by recent literature that explores the evidence of increased awareness and coordination of social conditions among the health care sector.[28] CHW-led programs offer a prime opportunity for sweeping interventions such as these and provide maximum individual impact and organizational value.[29]

Health plans can provide individuals with comprehensive support and service provision to address multi-faceted needs that account for the full family and community context by incorporating CHWs into benefit design and program implementation in the following CHW employment models:

1. Hiring CHWs directly.
2. Contracting with CHW employers, including community-based organizations (CBOs)
3. Instituting a "hub" model where an agency works as a single point of contact between healthcare entities (including payers or provider organizations) and a network of CBOs that provide social services.[ii]

[i] Private insurance companies have a wide breadth of options for investing in SDOH services in beneficiary benefit design, but there is limited evidence on best-practice frameworks for these investments due to the state-specific regulations for private insurers. Recent literature assessed social spending among the top 20 U.S. health insurers by market share and found that cumulatively, these organizations invested at least $1.87 billion in SDOH. Funding primarily went to housing ($1.2 billion) and food security ($238 million).

[ii] The Pathways Community Hub is a prolific example of a CHW hub model.

Person-centered care is pivotal to effectively addressing root causes of health problems; however, all focus groups underscored the need for person-centered care that goes beyond only addressing commonly defined health related social needs (e.g., food insecurity, housing needs) that are often the focus of SDOH interventions or screening tools. A narrow SDOH focus can entirely miss a patient's most pressing need (e.g., managing a family member's chronic health conditions, a challenge rooted in a broader community context).

As such, CHWs can fill an important gap in by assessing the full range of a patient's care needs accurately and compassionately and understanding concerns that a patient may not share or present during a healthcare visit. Focus group participants highlighted that CHWs are often especially valued and trusted because of their lived experience—the knowledge they carry from a shared personal identity, history, or life event, such as a certain medical condition, poverty, trauma, marginalization, or prejudice—which provides them with the unique ability to understand their clients' circumstances. CHWs can empathize with potentially complex circumstances, have the community context to identify available services, and can provide culturally competent care.

How Health Plans Can Engage with Community Health Workers

For health plans considering investing in or otherwise engaging with CHWs, it is important to understand what roles and services CHWs are well-suited to provide and which populations they can markedly impact. Affirmed by the National Association of Community Health Workers, the Community Health Worker Core Consensus Project offers the CHW-vetted roles and competencies listed below to ensure enhanced support for and sustainability of the workforce in all settings.[30,31] Although these competencies have been adapted and adopted by different states, they can provide an important benchmark for defining the CHW workforce.

Community Health Worker Core Roles and Competencies	
• Cultural mediation among individuals, communities, and health and social service systems • Providing culturally appropriate health education and information • Care coordination, case management and system navigation • Providing coaching and social support • Advocating for individuals and communities • Building individual and community capacity • Providing direct services • Implementing individual and community assessments • Conducting outreach • Participating in evaluation and research	• Communication • Interpersonal and relationship building • Service coordination and navigation • Capacity building • Advocacy • Education and facilitation • Individual and community assessment • Outreach • Professional skills and conduct • Evaluation and research • Knowledge base

While CHWs are well suited to deliver services to all individuals in need of system navigation, research has shown that CHW-led interventions are particularly effective among economically or socially marginalized communities, racial and ethnic minority communities, and medically underserved communities, including people living in rural areas, those with multiple chronic conditions, and individuals who are high healthcare utilizers (see Appendix A).[32,33]

Authentic Partnership with Communities to Address Social Determinants of Health

SDOH programs, including CHW-led interventions, should consider the expertise of all stakeholders to develop a program that maximizes community benefit. A range of perspectives is necessary to make meaningful change and truly understand both a patient's needs and the community or cultural context that also impacts their health. Health plans that are considering launching SDOH or CHW programs should prioritize developing an authentic partnership with community members and representatives to reduce duplication, minimize patient handoffs, and leverage existing community expertise.[34]

This work can include ongoing dialogue with public health departments and support to CBOs. For instance, public health departments can bring macro population health level awareness of community context, complementing health plans' own unique insight into individual patient needs.[iii] Further, CBOs are existing community experts and central employers of CHWs that are traditionally nonprofit local organizations providing services to communities and certain target audiences to improve health and well-being. CBOs include Area Agencies on Aging, food banks, interpersonal violence shelters, housing assistance agencies, and rural health networks.

Shared vision-setting across partners and sectors

As health plans consider building and scaling CHW programs, they may want to have conversations with public health, CHWs and other CHW employers to identify a shared vision of collective impact and strategies for addressing the wide range of SDOH and fostering healthier communities. This cross-sector engagement and collaboration should lead to formalized processes for assessing organizational assets (like capacity, expertise, and funding) and areas for joint momentum and for developing a partnership plan and established infrastructure for areas of ownership, influence, and input of service provision between community stakeholders and health plans. This would allow CHWs to comprehensively address both patient and community needs. In practice, this may include health plans developing advisory councils/groups and taskforces with representation from community members, CHWs and CHW employers.

Properly valuing and supporting community-based organizations

CBOs—and the CHWs they employ—often face significant financial uncertainty due to reliance on ever-changing grant funding that is often siloed and tied to specific populations, health conditions, or public health events. Even as new financing opportunities arise in Medicare or Medicaid, CBOs and other CHW employers do not typically have the necessary resources and infrastructure to track these revenue options or to contract and bill for Medicaid and Medicare reimbursements. These funding and capacity challenges have an impact on CHW workforce retainment. CHW burnout is common in the field. CBOs offer significant value to healthcare plans whose beneficiaries live in the local community, including longstanding relationships and community trust, but they need additional supports from healthcare plans to build or maintain staffing and infrastructure to effectively deploy CHWs.

[iii] As mentioned by Sherri Ohly from Envision Equity during focus group.

If health plans decide to enter into contracts with CBOs to address SDOH needs for their health plan beneficiaries, it is essential to build a dynamic, collaborative relationship and to approach CBOs as valued partners with equal expertise rather than as small-scale contractors. Health plans should take time to understand the capacity constraints that CBOs may face and proactively work with CBOs to set them up for success in their contracts. Examples include offering in-kind support or infrastructure grants to facilitate the contractual process and offset startup costs for increased service provision. Health plans should also consider alternative payment models such as fixed priced, bundled payments or value-based payments with CBOs, other CHW employers, or CBO networks to contract with these organizations as a system for SDOH benefit design and CHW engagement, rather than fee-for-service payments for CHW services only.[35] This provides more sustainable financial support for these organizations and offers the opportunity for health plans to leverage the full extent of CBO expertise and service provision for members.

Supporting the CHW Workforce within a Healthcare Organization

To effectively build and scale a robust CHW program that is impactful for members, health plans must recognize the need to adequately support this workforce. CHWs should be valued for their unique qualifications and expertise on care teams, most notably their lived experience. True recognition of this value requires equitable pay, sufficient social-emotional support, and comprehensive training and professional development opportunities.

Organizational Readiness Needed for Effective and Scalable Community Health Worker Initiatives

Effective CHW programs include comprehensive support, such as training, efficient workflows, and social-emotional care for CHWs themselves.

Equipping community health workers with technical skills and supporting career advancement

Consistent training opportunities for CHWs, rooted in core competencies, can ensure CHWs are prepared to care for patients with specific conditions, learn data collection skills, and understand how to use the electronic medical record. Additionally, programs should provide training opportunities for transferable skills, such as basic life support, cardiopulmonary resuscitation, motivational interviewing, and Mental Health First Aid. Providing these transferable training opportunities can "upscale" the CHW profession, allowing CHWs to pursue additional career opportunities of interest.

Prioritizing community health workers' time

CHW programs should develop workflows that minimize CHW's time on administrative tasks and increase available time for patient interactions. Workflows can include how a care team plans to engage CHWs in patient care when a social need is identified and how to prioritize responding to community needs to allow CHWs to practice to their fullest extent.

Additionally, CHWs are often required to document their patient interactions in electronic medical records, which can limit the way CHWs report their patient interactions, thus losing the full story of the patient needs the CHW is seeing. Therefore, health plans should consider how CHWs report and document information to allow for a broader understanding of patient and community context.

Social and emotional support for community health workers

CHWs engage daily with patients who have complex health and social needs, which can be emotionally burdensome. Programs should include peer-support opportunities for CHWs to connect with each other, discuss their experiences, and feel supported in their complex work environment. For example, a program could host sessions for CHWs, without any supervisors or external participants, so they can process their caseloads with each other. Additionally, programs should include conversations about self-care and managing stress in the CHW recruitment process. This can ensure CHWs feel supported and valued in their roles, both on the care team and in the community.

Program Infrastructure

In addition to workforce needs, components of program infrastructure that can allow CHWs to be more effective in caring for their patients include adequate supervision, supportive employment policies, and integrating CHWs into clinical care teams.

Thoughtfully managing community health workers and supporting supervisory opportunities

CHW programs with supervisors who have experience as CHWs, or who understand CHWs' value and scope of work, will be more successful in supporting CHWs themselves. Programs should be intentional about appointing management and supervision staff. In health systems, supervisors who provide in-person direction related to chart reviews, observing patient interactions, and monitoring service quality, can best allow CHWs to grow and effectively care for their patients. Supervisors working with CHWs can also help them identify career goals, ask how CHWs are doing, and identify areas of potential growth or additional support, to reduce potential for burnout. Group supervision should also be considered, to minimize feelings of isolation and maximize peer-to-peer learning.

Effectively integrating community health workers into clinical care teams

CHW programs have been successful when they educate the clinical care team, prior to a CHW's arrival, on the CHW's role and the types of services that CHWs can provide. Additionally, including CHWs in care team-wide meetings to discuss patient caseloads can ensure that CHWs are valued members of the team and included in decision-making. Workflows should also include considerations for how to screen patients for social needs in order to reduce screening fatigue for the patient and ensure that CHWs are notified if patients screen positive for certain needs.

Conclusion

This paper underscores the need for health plans to make meaningful investments in the CHW workforce as part of comprehensive programming in support of addressing health disparities caused by SDOH. CHWs' value is rooted in compassionate care and lived experience, which allows them to have an unmatched ability to comprehensively address patients' non-medical drivers of health. Properly deploying CHWs to clinical care teams should be considered a necessary component of patient-centered care approaches to address the wide range of patient needs, and investing in this workforce is a ripe opportunity for health plans to help address systemic health inequities. However, it is also important to understand and implement the infrastructure and supports CHWs and CHW employers need to ensure cohesive programming, a valued workforce, and scalable initiatives.

The CHW workforce has a large network of advocates, well-known evidential support of their efficacy, and a growing body of work underscoring the best practices for engaging with them. This paper adds to the field by amplifying CHWs' value in health plans' SDOH-related investments, recognizing that it is not enough to simply hire CHWs to solve the social needs of patient populations, but rather it's essential to build the infrastructure from the ground up for robust, patient-centered programs. This includes cohesive vision setting and authentic partnership building with CHWs and the stakeholders with a vested interest in and knowledge of the workforce; adequate employment practices to ensure readiness to hire or otherwise engage with CHWs; and pathways for proper training, professional development, and career progression for CHWs.

Appendix A: Examples of Community Health Worker Models Demonstrating Effectiveness in Delivery of Culturally Competent Care

ASTHO conducted a literature review to document specific community health worker (CHW) programs with a demonstrated positive impact on clinical outcomes or cost savings relevant for health plans. Criteria for abstract review of peer reviewed literature included various combinations of the following terms:

- Community health worker(s)
- Insurance
- Medicaid
- Medicare
- Health plan
- Payers
- Healthcare delivery
- Clinical care
- Operations
- Infrastructure
- Training
- Model
- Population
- Case study
- Return on investment
- Social determinants of health (SDOH)
- Health related social needs

Only peer-reviewed literature published in the last 10 years was considered for further review. Additionally, ASTHO did a scan of the grey literature to find case studies and final reports of research-proven program models.

Providing Culturally Competent Care to Ethnic Minority Groups

Across ethnic minority groups, and among individuals with limited English proficiency, CHW programs can improve clinical outcomes through targeted interventions aimed at increasing health literacy, improving health behaviors, and increasing healthcare screening uptake. The promotora de salud/lay health worker model has resulted in positive health outcomes within culturally diverse populations.[36,37] This model, often used in Latin America and the U.S. to reach Hispanic/Latino communities, leverages CHWs, or promotores, as members of the population who share similar social, cultural, and economic characteristics with their clients and provide clients with advocacy, education, mentorship, outreach and translation. Case studies of this model, such as the Salud es Vida cervical cancer education program in rural Southern Georgia and Vivir Mejor! (Live Better!), system of diabetes prevention and care in Mariposa County, Arizona, resulted in improved clinical outcomes and expanded service provision. This model has also seen successes in increasing health insurance enrollment, as exemplified in this New York State Health Foundation grant report. The report highlights the impact of the Make the Road New York promotora training program, which helps New York City immigrants find and access health insurance and healthcare.

In another program, researchers aimed to improve cancer awareness and screening among Vietnamese American women in a low-income community of San Francisco. CHWs led small group sessions and provided translated materials to participants. Results showed that participants had an increased level of awareness of cancer screening and a higher likelihood of cancer screening participation.[38]

Serving the Medically Underserved in Rural Communities

CHW programs can also improve care provision for Medically underserved groups. This includes rural communities, where access to care remains problematic. Promotora models in the rural United States are used to improve the health of migrant and seasonal farmworkers and their families. Additional program models have seen success in rural communities, where shortages of health professionals and medically underserved communities are uniquely in need of CHWs to act as connectors to other providers and services. A CHW-based chronic care management model in rural Appalachia resulted in reductions of hemoglobin A1c scores, emergency department visits, and hospitalizations.[39] CHWs working in drug and alcohol treatment settings in western Pennsylvania have also helped reduce emergency department visits and readmissions for patients with concurrent substance use disorder and chronic healthcare issues.[40]

Serving Publicly Insured Medicaid Members

CHWs can also play an important role for Medicaid members, who historically have greater difficulty accessing appropriate care than individuals with private insurance. An observational analysis showcasing the positive impact of a non-disease specific health plan-led CHW program on Medicaid member outpatient utilization.[41] Similarly, a randomized program evaluation of healthcare utilization and costs between Medicaid beneficiaries randomly assigned to usual services versus a CHW program resulted in decreased acute care use (emergency department visits), and increased ambulatory care (primary care and subspecialty medical) use.[42] For health plans that serve as managed care organizations across states, this is a prime opportunity to bolster service provision to your Medicaid members.

Assisting Clinical Care Among High Healthcare Utilizers

Finally, when considering the opportunity for ROI, it is important to recognize the value of CHWs for individuals with multiple chronic conditions, and/or those with high degree of healthcare utilization. Researchers have studied the role of CHWs trained in patient navigation in reducing hospital utilization for "super-utilizers" in a low-income area of Memphis, Tennessee.[43] Results showed that as compared to the control group, super-utilizers working with a CHW had reductions in hospital encounters (13%) and total hospital days (8%), as well as an increase in time between hospital encounters (9%). In addition, a study measured the success of CHW intervention on improved outcomes in a low-income population with multiple chronic conditions in Philadelphia.[44] Results from the randomized clinical trial showed that CHW support resulted in improvements in several chronic disease measures, including body mass index, cigarettes per day, blood pressure, hemoglobin, as well as overall self-reported quality of care and self-rated mental health. This research exhibits the usefulness of CHW programs as a tool for population health management across disease areas.

Appendix B: Focus Group Contributors

ASTHO thanks the wide range of partners who contributed thought leadership in the series of focus group interviews that informed this white paper.

- **American Public Health Association's CHW Section:** Floribella Redondo-Martinez, AzCHOW President and CEO
- **Envision Equity:** Sherri Ohly, Co-Director, Development
- **IMPaCT Care:** Dawn Alley, Head of Scale
- **Meharry Medical College:** Patricia Matthews-Juarez, Senior Vice President, Office of Strategic Initiatives and Innovation
- **Montefiore's CHW Institute:** Renee Whiskey, Director of Community Partnerships
- **National Association of Community Health Workers:** Aurora Grantwingate, Member and Partner Engagement Manager
- **New Jersey Department of Health:** Nashon Hornsby, Assistant Commissioner, Division of Community Health Services
- **North Carolina Department of Health and Human Services:** Moneka Midgette, State CHW Program Coordinator, and Maggie Sauer, Director of the Office of Rural Health
- **Rhode Island Department of Health:** James Day, Health Program Administrator, CHW/COVID Response and Resilient Communities
- **RUSH University Medical Center's CHW Hub:** Lexi Artman, System Manager, Community Health Strategy and Programs
- **Sinai Chicago Urban Health Institute's Center for CHW Research, Outcomes and Workforce Development:** Stacy Ignoffo, Director of Community Health Innovations
- **Southeastern Michigan Health Association:** Arthur Hampton, Director of Health Equity

Appendix C: CHW Financing Levers

Historically, CHWs have relied on time-limited grant funding to support their community work. As COVID-19 pandemic-related funding runs out, CHWs and CHW programs are looking to other financing strategies, such as through Medicare and Medicaid, to ensure they can continue to work with patients and communities.[45] The following resources discuss these financing strategies and how states have used them to sustain the CHW workforce.

- Sustainable Financing of Community Health Worker Employment (report)—National Association of Community Health Workers
- Sustainable Financing of Community Health Worker Employment: Key Options for States to Consider (report)—National Association of Community Health Workers
- State Community Health Worker Policies (state tracker)—National Academy for State Health Policy
- Financing Community Health Workers Through Medicaid (blog)—ASTHO
- State Policies Bolster Investment in Community Health Workers (blog)—ASTHO
- Changes to 2024 Medicare Physician Fee Schedule for CHI Services (fact sheet)—ASTHO

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