

POLICY BRIEF OVERVIEW

The National Health Care for the Homeless Council recognizes the development and expansion of Community Health Worker (CHW) programs within Health Care for the Homeless projects as a significant opportunity to improve health and access to care for those experiencing homelessness. Starting in 2014, the Affordable Care Act expands Medicaid to those at or below 133% of the Federal Poverty Level, which offers an additional opportunity to utilize CHWs to provide outreach and assistance with enrollment. This publication is designed to complement other Council efforts to promote CHW programs, such as *Community Health Workers in Health Care for the Homeless: a Guide for Administrators*, by providing an overview of federal and state policies governing CHW programs and providing recommendations for how HCH projects can fully leverage public and private funds to implement CHW programs. A brief history of the CHW profession, financing options, training and certification models, opportunities in the ACA, three state case studies, considerations for HCH projects and recommendations are provided for a range of stakeholders will all be discussed.

Introduction

For many years, community health workers (CHW) have helped address disparities in health outcomes and access to care, but a formal definition has been relatively recent. The term “CHW” refers to many different job titles and roles (lay health worker, patient navigator, peer advisor, community health advocate, *promotores de salud*, and many others). Duties of the work vary and may include outreach, health education, benefit acquisition, system navigation, client advocacy, and other enabling services. The common thread among these positions is an ethnic, linguistic, cultural or experiential connection with the population served. This connection to the community allows CHWs to support medically underserved community members in ways that traditional medical professionals generally do not.

There is a developing body of evidence demonstrating CHW effectiveness. Most studies are focused on CHW interventions targeted at specific conditions such as diabetes or asthma, and these studies generally show improvement in health outcomes, health behaviors, and patient satisfaction.^{1, 2, 3, 4, 5} Other studies have demonstrated cost savings and improved outreach and enrollment into public benefits.^{6, 7, 8} Comprehensive reviews such as those conducted by the Health Resources and Services Administration (HRSA) and the Agency for Healthcare Research and Quality have found mixed results in the literature due to both design limitation and results. Improvement in health outcomes has a stronger body of evidence than cost savings in these reviews but further research into both areas is required.^{9, 10} This initial evidence provides sufficient cause to explore CHW policy and the opportunities programs may provide to HCH projects and patients.

Policy Background

Interest in CHW as a distinct profession has been building for years, with a specific definition contained for the first time in the Department of Labor 2010 Standard Occupational Classification system. In it, CHW job responsibilities are defined as:

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 as first aid and blood pressure screening. May collect data to help identify community health needs.¹¹

This definition is a significant step in the CHW profession but interest in CHWs started decades ago. One of the first formal CHW programs was the Community Health Representative (CHR) program started in 1968, first under the Office of Economic Opportunity and subsequently under the jurisdiction of the Indian Health Service. The CHR program worked with members of Native American communities to improve health knowledge and behaviors within those communities. This program continues to this day, employing over 1,400 CHRs from over 250 different tribes.¹²

In 1978, the World Health Organization recognized the use of CHWs as “an important policy to promote primary care.”¹³ This coincided with a proliferation of time-limited CHW programs in several states during the 1980s, with longer-term programs established in some jurisdictions in the 1990s. Formal training programs and scientific evaluation also increased leading to the first national CHW study by the Annie E. Casey Foundation and the University of Arizona in 1998.¹⁴

Since, interest in CHWs has continued to grow. Within the last ten years, the Institute of Medicine, the American Public Health Association and the National Conference of State Legislatures have all published accounts of the potential benefits of CHWs.^{15, 16, 17} Additionally, HRSA has published several reviews on CHWs, most recently a comprehensive workforce study in 2007.¹⁸ This national attention has increased state level activity and many states, such as Texas, Minnesota, and Massachusetts, now have well-developed CHW programs, regulations and public funding sources.

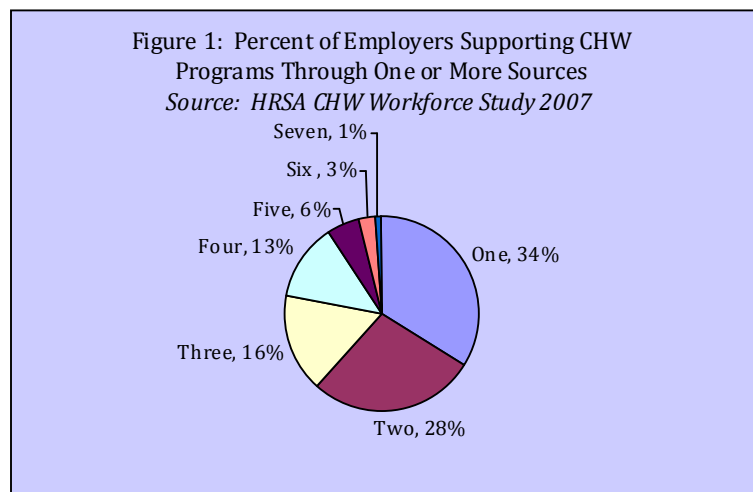
The first federal effort authorizing CHW programs – the *Patient Navigator Outreach and Chronic Disease Prevention Act* – passed in 2005. The legislation authorized \$25 million in HRSA-administered grants for patient navigator (a type of CHW) programs to coordinate health care services, provide health screening and health insurance information, conduct outreach to medically underserved populations, and perform other duties common to CHWs.¹⁹ This program was reauthorized in 2010 under the Patient Protection and Affordable Care Act (ACA; also known as health reform) as well as numerous other opportunities to expand and further integrate CHW programs into the health care system.²⁰

CHW Financing

The large majority of CHW programs rely at least in part on paid CHW positions. As such, funding is essential but can be difficult to obtain reliably. Two-thirds of all CHW programs use multiple funding streams from a variety of public and private sources (see figure 1).²¹ Funding opportunities differ by community but those of interest to HCH projects generally fall into one of four categories: time-limited grants, state and local general funds, Section 330 health center grants and Medicaid.

→ Time-limited Grants

Grants from private foundations or governmental agencies are the most prevalent CHW funding sources.²² These grants usually target specific health conditions or populations and rarely last more than three years, although some are renewable. An accurate index of all available CHW grants has not been compiled but private organizations such as the Robert Wood Johnson Foundation, the Annie E. Casey Foundation and the Blue Cross Blue Shield Foundation of Massachusetts have supported CHW initiatives. Many different governmental agencies and programs have also provided grants such as the National Institutes of Health; the Centers for Disease Control and Prevention; Temporary Assistance for Needy Families; the Center for Medicare and Medicaid Services (CMS); and



HRSA through the Bureau of Primary Health Care, the Maternal and Child Health Bureau, and the HIV/AIDS Bureau.^{23, 24, 25}

The primary advantage of these funding sources is their relative availability, with most CHW programs beginning with one grant and patching together additional grant opportunities over time. However, there are numerous disadvantages. Both the CHW positions and the relationships built with patients can be disrupted when short-term grants end. While other funding sources might be available, these often have different requirements and goals than the previous grant, which can cause service fragmentation. Frequent applications and progress reports can burden administrative staff. Lastly, a subsequent funder may choose a new target population or health condition that the community may not identify as a priority need. Despite these drawbacks, private or public grants are still immensely important to CHW programs.

→ State and Local General Funds

Supporting CHW programs through state and local general appropriations entails a line item for the CHW program within the entity's budget and must be allocated each budget cycle. This funding may pay CHW salaries directly or go to community-based organizations that administer the CHW program. Local Departments of Public Health in San Francisco, Fort Worth and elsewhere are examples of municipalities with this funding arrangement, and the Kentucky Homeplace program is an example of a CHW program funded through direct state appropriation.²⁶ Budget line items are advantageous because they are relatively stable once established, but initial funding can be difficult to obtain. Significant advocacy, public champions, and compelling evidence are often necessary to establish the program. CHW programs also remain vulnerable to budgetary reductions, especially during economic downturns.

→ Section 330 Health Center Funding

Section 330 funding is especially relevant for HCH projects since the health center and HCH program is authorized and funded through Section 330 of the Public Health Service Act [the HCH program is funded through Section 330(h)]. This legislation and the regulations that followed specified the requirements for the health center program and authorized grant funding to carry out these requirements. The following is an excerpt from the statute outlining required services that may be appropriate for CHWs:

- (iii) patient case management services** (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services;
- (iv) services that enable individuals to use the services of the health center** (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services or appropriate personnel fluent in the language spoken by a predominant number of such individuals); and
- (v) education of patients and the general population** served by the health center regarding the availability and proper use of health services.²⁷

These are required services for all health centers but the manner each health center provides them is established in the grantee's scope of project application. CHW programs could be established to provide many of these services either through inclusion in an original grant application by a prospective health center, a grant application for service expansion, through the change of scope process, or by notifying HRSA of the change in their annual report.²⁸ *Promotores de salud* programs in migrant health centers are supported in this manner. Section 330 grants offer the distinct advantage of ongoing funding once awarded, presuming sufficient appropriations for the health center program.

→ Medicaid

Just over 25% of HCH clients had Medicaid in 2010, but many more will qualify after the Medicaid expansion to childless adults in 2014 (or earlier at state option).²⁹ CHW programs are not recognized as reimbursable providers under Medicaid statute but other avenues for Medicaid funding are available through Medicaid administrative funds, Medicaid Managed Care Organizations (MCOs), and Section 1115 waivers.

Medicaid Administrative Funds: The Medicaid program not only provides funding for services but also for administrative services needed for “the proper and efficient administration of the state plan.”³⁰ The Secretary of Health and Human Services (HHS) ultimately defines what is considered an eligible administrative claim under a state plan but outreach, eligibility determination, coordination and translation services have all previously been approved. Public Health Departments and community groups throughout the country use administrative funds for CHW programs providing outreach and enrollment services to eligible but unenrolled populations. To the extent that CHW programs focus on administrative services identified under the state plan, they can be reimbursed by Medicaid as administrative costs.

Medicaid MCOs: Managed care is an insurance model intended to improve quality and reduce cost through care coordination, flexible benefit design, and incentives. The MCO usually receives a single payment (known as capitated payment) for each enrollee and provides reimbursement to providers for services rendered.

Currently 70% of all Medicaid beneficiaries nationally are enrolled in MCOs, and this proportion has been rising significantly over time. In fact, all but two states offer some MCO coverage arrangements and seventeen mandate MCO coverage throughout the state, with exceptions for certain populations.³¹ The prevalence of Medicaid MCOs provides an opportunity for innovative models such as CHW programs because they can generally decide how to use their funds once certain stipulations are met; some have chosen to fund CHW programs, either through direct employment by the MCO or through including CHW services as a reimbursable benefit. Specific MCO program designs will vary, but frequent users of health services and medically underserved communities are often the target populations.³² CHW programs targeting homeless populations could be of interest to Medicaid MCOs, especially as more become eligible for Medicaid.

Section 1115 Waiver: States have significant flexibility in developing their individual Medicaid state plan. There are certain mandated benefits that must be offered and many optional benefits listed in statute that a state can include in its Medicaid plan through the submission of a state plan amendment. A state can also petition the HHS Secretary to waive certain Medicaid program requirements for the purposes of research and demonstrations through a Section 1115 waiver (named for Section 1115 of the Social Security Act). Seeking an 1115 waiver is more difficult for states than submitting a state plan amendment, but the waiver allows for innovative care delivery and payment systems not eligible under statute as long as the federal government would not be spending more than it would absent the waiver (known as “budget neutrality”).³³

MEDICAID: THE BASICS

- Provides health insurance coverage to 60 million Americans
- Seniors, individuals with disabilities, pregnant women, and children are historically eligible
- Adults without dependant children have historically not been eligible
- Means tested, with different groups having different income thresholds
- Medicaid is an entitlement: everyone who qualifies receives coverage
- Financed through a federal-state partnership, with the federal government paying 50-75% of costs depending on the state
- Cost sharing is restricted so coverage remains affordable
- Statute mandates certain benefits but each state develops a State Plan with broad flexibility in benefits design and payment rates
- States administer the program
- Eligibility determination can be a barrier for some populations (like homeless)

Source: Kaiser Family Foundation (Aug. 2010).
Medicaid: A Primer 2010

Section 1115 waivers have been used extensively by states for many initiatives, with some covering CHW programs. States such as Alaska, California, and Minnesota have received waivers to deem CHW programs as reimbursable providers, and others such as Texas are exploring this option.^{34,35} The stability of the funding is the key advantage of Medicaid reimbursement, but meeting the requirements of an 1115 waiver can be burdensome due to extensive clinical reporting, budget neutrality requirements, and certification needs.

CHWs in the Patient Protection and Affordable Care Act (ACA)

HCH grantees and consumers have a significant stake in the expansion of Medicaid health insurance coverage and the investment of \$11 billion dollars in the health center program provided in the ACA. In addition, a myriad of other initiatives and funding opportunities are authorized, which can aid HCH projects improve care for those experiencing homelessness. CHW programs can play a significant role in many of these efforts.

Medicaid Expansion

Starting January 1, 2014 (or earlier at state option), Medicaid eligibility will expand to include all individuals with income at or below 133% of the Federal Poverty Level, which will include most individuals experiencing homelessness.³⁶ The Congressional Budget Office estimates this will result in 16 million new enrollees by 2019 but also leave 10 to 11 million of those eligible for Medicaid uninsured.³⁷ A Kaiser study, however, estimated aggressive outreach efforts by federal, state, and community-based organizations could result in up to 23 million new enrollees, leaving 3 to 4 million individuals eligible but not enrolled.³⁸

Figure 2. Vulnerable populations specified in the ACA:

- Children
- Unaccompanied Homeless Youth
- Children with Special Health Care Needs
- Pregnant Women
- Racial and Ethnic Minorities
- Rural Populations
- Victims of Abuse or Trauma
- Individuals with Mental Health or Substance Abuse Disorders
- Individuals with HIV/AIDS

Source: PPACA Section 2201(F)

Homeless persons are among the populations most in need of outreach and assistance to enroll in Medicaid. CHW programs based in HCH projects are uniquely suited for this effort thanks to CHW connection with the community served and likely knowledge of community benefits. The ACA requires states to establish procedures for outreach to vulnerable populations (see figure 2) but guidance from the Centers for Medicare and Medicaid Services (CMS) on how such activities will be funded and administered has not been developed to date.³⁹ The Children's Health Insurance Program Reauthorization Act and the Massachusetts state health reform law both authorized outreach and enrollment grants and enhanced Medicaid administrative funds have also been used to provide Medicaid enrollment outreach.^{40,41} Either of these proven strategies could be used to implement the ACA.

Patient Centered Medical Home/Health Home

Several provisions included in the ACA intend to improve care and lower cost through innovative health care delivery models such as Patient Centered Medical Homes (PCMH)/Health Homes. According to the Agency for Healthcare Research and Quality, the PCMH model of health care delivery provides care that is patient-centered, comprehensive, coordinated and accessible, among other characteristics.⁴² Fidelity to the PCMH model requires additional attention to cultural competence and health navigation, abilities effectively filled by CHWs.

The ACA establishes several opportunities to establish PCMH. One provision establishes a state option to provide health homes for Medicaid beneficiaries with chronic conditions. The health home would consist of a team of providers responsible for comprehensive care management, health promotion, patient and family support, and referrals to other appropriate social services, among other duties. Mental health and substance abuse disorders are considered chronic conditions under this provision. CHWs are not directly identified as eligible members of the health home team, but can be designated as appropriate by the state.⁴³

A second provision under the ACA establishes Community Health Teams (CHTs) to support PCMH. Grants may be provided to states or state-designated entities to fund interdisciplinary teams that support patients and providers using the PCMH model. The CHT would supplement primary medical care with community-based prevention, patient education and care management. CHWs are not listed as eligible members of CHT, but the professions listed in statute are not exclusive. This program has not been funded to date.⁴⁴

Specific Public Health Grants

CHW programs have a role to play in many grants and initiatives authorized under the ACA. The Patient Navigator program originally enacted in 2005 was reauthorized through 2015 under the ACA, as well as a number of initiatives designed to improve public health such as the Incentives for Prevention of Chronic Disease in Medicaid provision. This initiative appropriates \$100 million over five years in grants to states to reduce the incidence of chronic disease in Medicaid beneficiaries through improvements in cholesterol, blood pressure, tobacco use, and other health indicators.⁴⁵ Additionally, the ACA establishes the Prevention and Public Health Fund, allocating \$1 billion in FY12 and increasing each year to \$2 billion by FY15 and each year after to fund initiatives designated by Congress and the Secretary of Health and Human Services. Many of the activities likely to receive funding are appropriate for CHWs, such as Community Transformation Grants, Immunization Programs, and Education and Outreach Campaigns.⁴⁶

One set of grants of particular importance are Grants to Promote the Community Health Workforce. These grants mention CHWs specifically and provide preference to eligible entities who have experience working with the underserved, whose population has a high proportion of individuals eligible for insurance but unenrolled, and whose population has a high incidence of chronic disease. Federally Qualified Health Centers (FQHCs) are deemed eligible and HCH projects certainly serve a population that meets the preferred criteria. No funds have yet been appropriated but they are authorized through FY14.⁴⁷

Threats to the ACA

The goals and provisions of the ACA are dependent on Congressional support and judicial review. Reducing or eliminating funding for initiatives that improve access to care would be harmful to HCH projects, their patients, and the effort to reduce health disparities. Maintaining funding appropriated through the ACA itself and allocating funds to programs authorized but not appropriated under the ACA should be a priority of lawmakers and the HCH community alike.

Administration, Certification, & Training

The degree of administration, certification, and training requirements for CHWs vary considerably between states. Some states have state-regulated training and certification requirements for CHWs that must be met in order to practice and receive reimbursement for CHW services. These training programs are often offered at community colleges or regional training centers and can require a year or more of classes and clinical experience to complete. The regulation of such programs also varies with state agencies, local agencies, or nongovernmental professional boards administering the program requirements. Other programs require little public certification, allowing on-the-job training instead.⁴⁸

There are differing views within the CHW field regarding what degree of professional certification is appropriate for CHWs. There is some fear that excessive regulation and training requirements might make the profession less accessible to members of underserved communities whose skill set lies more with knowledge of the community than with advanced education. On the other hand, professional accreditation offers more accountability, standards for outcome measurement, and potential for development. Stable funding through Medicaid or state appropriations will invariably require standard administration and certification.

State Examples

While there is variability between CHW programs, some states have well-developed programs that illustrate promising strategies for CHWs. This policy brief highlights Texas, Minnesota and Massachusetts based on their diverse funding and administration models.

TEXAS: State and Local General Funds:



CHW and *promotores de salud* programs have been serving the large population of medically underserved Spanish-speaking residents in Texas for decades but state legislation regarding CHW first passed in 1999, establishing a Promotor(a) Program Development Committee. Recommendations by this committee and subsequent legislation led to a state-regulated training and certification program and a training and certification advisory committee that regularly reports to the Department of State Health Services. Paid CHWs must complete a state-approved 160-hour training program and maintain certification through continuing education. CHW instructors and curricula are also subject to state certification. State and local agencies are the primary employers of CHWs, providing general funds through the Department of State Health Services and local health departments. Currently 1,300 CHWs are certified and all regions of the state use CHWs in some way.⁴⁹ Recent legislation commissioned a study on the effectiveness of CHW, the desirability of expanding their roles and identifying funding methods which could further expand the program. The study is to be submitted to the state legislature by December 1, 2012.⁵⁰

MINNESOTA: Medicaid Reimbursement



Minnesota is one of the few states that provide Medicaid fee-for-service reimbursement for CHWs and can be a model for others. Minnesota first established a standardized CHW curriculum and certification program in 2003 through a partnership between the State and the Blue Cross and Blue Shield Foundation of Minnesota – a partnership that continued with a study on sustainable financing of CHWs.⁵¹ In 2007, Minnesota obtained an 1115 Medicaid Waiver to allow state-certified CHWs to receive fee-for-service reimbursement under the state Medicaid plan. Minnesota Health Care Program (MHCP; the different Minnesota Medicaid programs) beneficiaries can receive patient education and care coordination services from CHWs who have been accredited and are under the supervision of a physician, advanced-practice nurse, dentist, or public health nurse. To become accredited, a CHW must complete the 11-credit state certification program managed by the Minnesota State Colleges and Universities System. The Medicaid reimbursement does not go directly to the CHW but rather to the eligible billing provider. The billing provider can either be the supervisory provider or an eligible health clinic, to include health centers/HCH projects. The 1115 Waiver only applies to fee-for-service MHCP beneficiaries; Medicaid MCOs operating in Minnesota have the discretion to fund or not fund CHWs.⁵²

MASSACHUSETTS: Time-limited grants**Massachusetts**

In 2006, Massachusetts passed *An Act to Provide Affordable, Quality, Accountable Health Care* – expanding health insurance coverage to 400,000 additional residents and lowering the uninsured rate to less than 3%.⁵³ These successes were achieved in part by the extensive use of CHWs in the state’s outreach and enrollment efforts. In addition to coverage expansions, the legislation also recognized the value of CHWs to improve access and reduce disparities and required a study on developing the workforce. Beyond this explicit mention of CHWs, the legislation also provided for Outreach and Enrollment Grants for community organizations to assist enrolling uninsured and underinsured residents into the new coverage options established in the law. Most grantee organizations used CHWs, and 164,000 individuals were enrolled into either state Medicaid or subsidized private insurance. These grantees have assisted almost 50,000 individuals in retaining their insurance during the annual renewal period.⁵⁴ Unfortunately, the grant period has elapsed, and no new grant funding has been identified.

Despite using CHWs during health coverage expansion, a 2010 report to the state legislature by the Department of Public Health and the Massachusetts CHW Association outlined significant barriers for CHW programs. As is the case nationally, CHWs in Massachusetts are usually funded through time-limited and targeted grants. The Outreach and Enrollment Grants that funded CHW programs following the Massachusetts health reform law are examples of this type of funding. Public and private payers have provided numerous grants for CHW in Massachusetts, demonstrating interest within the state, but periodic and unreliable funding still cause disruption in CHW programs and workforce. The lack of statewide certification criteria causes further obstacles for CHW program development, complicating both funding and professional development.⁵⁵ This has been a long-standing concern, however, and 2010 legislation established a CHW board of certification to develop standard, statewide criteria.⁵⁶

Discussion of CHWs & HCH Projects: A Need and an Opportunity

Individuals experiencing homelessness have many characteristics appropriate for CHWs: disproportionate incidence of disease, limited access to health care, limited health literacy, lack of comfort with traditional service providers, and distinct cultural and community experiences. In fact, the most comprehensive study of the CHW workforce, conducted by HRSA in 2007, found that over 40% of CHW programs target homeless populations.⁵⁷ Further integration of CHWs into HCH projects could help improve health outcomes, help offset workload for clinical providers, and build the capacity and independence of HCH consumers.

Consumers and Consumer Advisory Boards can be a resource in the development of CHW programs.

Empowering those experiencing homelessness is a central part of the mission of HCH projects, and participation in CHW programs, either as the CHW staff themselves or in a consulting role, is an effective way to further this mission. Individuals who have experienced homelessness offer a unique set of skills and experiences that make them well-suited to relate to the community served and maximize the benefit of CHW programs, although additional support may be needed to succeed as HCH staff.⁵⁸

Beyond the benefit of CHW programs to HCH patients in general, the 2014 Medicaid expansion as a result of the ACA makes the development of CHW programs all the more timely. CMS will likely encourage states to partner with community-based organizations to ensure adequate outreach and enrollment to vulnerable populations. Administrators of HCH projects should work at the state level to ensure resources are identified to assist homeless populations. CHW programs at HCH projects could be very effective at conducting outreach and enrollment

assistance. Please visit *Community Health Workers in Health Care for the Homeless: a Guide for Administrators* for more information on the project-level implementation of such programs.⁵⁹

Policy Recommendations

The CHW profession and its infrastructure have grown tremendously in recent years but there remain areas to strengthen.^{60, 61} A wide range of stakeholders all have opportunities to address these needs, enhance service and benefit access, reduce public costs and ultimately improve health.

CHW Programs

- ❖ **Document health outcomes and cost savings** to the extent possible and use this information in discussions with potential funders.
- ❖ **Standardize professional definitions and research methodologies** through collaboration with state and national membership organizations and institutions.
- ❖ **Publicize the unique skill set and benefits of CHWs** through partnerships with other health care providers, national and state CHW membership organizations, and the media in order to raise the profile and credibility of the profession.

HCH Projects

- ❖ **Explore public and private funding opportunities for CHW programs** in your state and local community.
- ❖ **Engage in discussions with your state Medicaid agency and/or health reform coordinating body** to ensure that the unique needs of homeless persons are considered when planning for Medicaid expansion. Offer to be a partner in this effort and apply for any available Medicaid funds for outreach and enrollment efforts should they be available.
- ❖ **Maximize HRSA health center funding** to incorporate a CHW program into your program. Expanded services grants or changes in scope are both appropriate avenues.
- ❖ **Consider the use of consumers or former consumers in CHW programs**, although many others in the community may have the requisite understanding of the population to be served.

State Policy Makers

- ❖ **Take steps to provide reliable funding for CHW programs.** Depending on the state, this may first involve establishing an advisory committee, conducting an evaluation, passing legislation, or applying for waivers. Each state will have to consider the benefits and drawbacks to further accreditation and professionalization of CHWs. Ongoing funding through Medicaid or state funds is advantageous.
- ❖ **Develop a plan to ensure maximum enrollment in Medicaid starting in 2014 (or earlier at state option),** to include allocating sufficient resources and obtaining community input on the outreach needs of different communities. The needs of vulnerable populations such as individuals experiencing homelessness must be addressed and HCH projects will prove to be helpful partners in the effort.
- ❖ **Identify resources to conduct outreach and enrollment** by applying for federal grants, developing partnerships with private funders, and partnering with community organizations.
- ❖ **Replicate successful CHW models**, such as those that enhance enrollment in the Children's Health Insurance Plan and the Massachusetts state health reform implementation.

Federal Policy Makers

- ❖ **Support current Medicaid programs as well as the provisions of the ACA to extend health insurance to childless adults, many of whom need assistance applying for benefits.** Medicaid is a cost-efficient program that assists vulnerable populations and saves public expenditures through better health and appropriate use of health services.

- ❖ **Provide guidance and funding for Medicaid outreach and enrollment** that considers the unique needs of vulnerable populations. Ensure that significant community outreach occurs in underserved areas, and partner with community groups and HCH projects to accomplish the effort.
- ❖ **Maintain funding for the expansion of health centers** to ensure those newly insured through the ACA have access to quality, comprehensive and community-based care.

Conclusion

A variety of opportunities to improve the health of those experiencing homelessness are on the horizon and HCH projects and CHWs are well-positioned to be at the center of many of them. Much work needs to be done in order to fully maximize the goals of the ACA and other policy initiatives and opportunities. Innovative practice, community partnerships, and persistent advocacy with public officials are the best ways to reduce disparities in health access and health outcomes for those experiencing homelessness.

ACCESS MORE RESOURCES ONLINE:

- National Health Care for the Homeless Council | Health Care Reform | <http://www.nhchc.org/healthcarereform.html>
- National Health Care for the Homeless Council | Medicaid Tool Kit | <http://www.nhchc.org/medicaidadvocacytools.html>
- Community Health Workers in Health Care for the Homeless | <http://www.nhchc.org/Publications/CHWguide.pdf>

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