How Managed Care Organizations Can Authentically Partner with Community Health Workers

Background

Community health worker, or CHW, is an umbrella term that includes promotores and promotoras de salud, community health representatives (CHRs), aunties, peers, outreach workers, and dozens of additional titles who share lived experience, trust, compassion, and culture with the communities where they live and serve. This trust and cultural alignment facilitates CHWs' roles as community educators, capacity builders, advocates, and liaisons between racially marginalized communities and health and social services systems (American Public Health Association [APHA], 2014). With over 60 years of research that documents and supports their roles and capacity (Association of State and Territorial Health Officials [ASTHO] and National Association of Community Health Workers [NACHW], 2020), Federal, state, and local governments, healthcare, academic, and other institutions are increasingly drawn to CHWs as an essential workforce. CHWs are widely recognized for their vital contributions to advance health and racial equity.

This brief offers practical guidance for managed care organizations (MCOs) that are interested in working with CHWs toward health and racial equity and improve outcomes for community members. It includes an overview of the CHW workforce and the value of their ability to link and build upon the existing capacity of individuals, communities, and systems. It also provides recommendations from NACHW on how MCOs and CHWs can work together to better integrate CHWs and care delivery systems, CHW financing, training, and workforce development.

The CHW Workforce

"I could be from Germany or Zimbabwe, Argentina or Cape Verde. I may be alive today, or I may have lived 600 years ago. People like me -- neighbors, friends, family members -- have been passing on health information and advice for as long as there have been communities. We are the aunties, the curanderos, the sobadores, the grandmothers" (Wiggins et al., 2022).

CHWs have been here since the very beginning. Throughout history and across the globe, communities have always had natural helping systems in which traditional or tribal healers and other trusted individuals played important, often life-saving roles. Today, these trusted community members are known by many different titles — CHWs, CHRs, promotoras, aunties, outreach workers, and many more. (NACHW, 2023)

The CHW profession's global history includes countless CHW figures from all communities, cultures, and identities throughout time. Among them are granny-midwives, whose use of ancestral wisdom and training to care for African peoples enslaved in the US throughout pregnancies, births, and their post-partum period can be traced back to the early 1600s (Robinson, 1984). During the mid-20th century, the Chinese village doctor program, Latin American promotores and promotoras de salud models, and the CHR Program in Native American tribal lands and organizations gained momentum and their recognition became more widespread, especially in the US. (Wiggins & Borbón, 1998 & National Association of CHRs, 2023). There have been many more CHW movements beyond these listed. Countless CHW stories, voices, and perspectives are not reflected in peer reviewed or other frequently cited works.

> "…long before doctors and hospitals, granny midwives were the incredible force that helped birth America" (Timeline, 2017).

While this rich history includes many triumphs, the CHWs who came before us also suffered profoundly. In racially minoritized communities historically and today, CHWs have endured in the face of the unnatural, inhumane conditions of systemic racism. In too many cases, oppressors tormented and killed CHWs for their contributions to community wellbeing and liberation (Wiggins et al., 2022). Nevertheless, CHWs have emerged and re-emerged throughout the ages, often directly in response to systematic exposure to multiple forms of violence toward their communities. Their legacy is a CHW profession, workforce, and movement that promotes the conditions in which all people have what they need to be well and live with ease—a world where the level of resilience that was once required for survival is no longer necessary.

Today, the US CHW workforce is diverse in race, ethnicity, language, identity, and lived experience. CHWs in the US are employed in a wide range of sectors and the majority are women and persons of color who work for community-based organizations (CBOs) and local government (NACHW, 2022, Higgins et al., 2021, US Department of Labor, 2022). CBOs operate outside of formal health care settings, and, like CHWs, local, culturally aligned CBOs may share a greater degree of trust within their communities than do the systems that have often harmed communities of color. Many CBOs are built and staffed by people

who are qualified to offer services and programs delivered in a manner specific to the culture and geography of the community they serve by way of shared racial or ethnic identities, language, or lived experience. CBOs that earn the respect of the participants they work with may even be considered a part of the community itself by some members, thus serving as critical leaders and partners in population health efforts.

The Value of CHWs: Critical Bridges Between Individuals, Communities and Systems

"You cannot understand the trust, commitment, expertise, or authenticity of Community Health Workers without considering the populations and communities from which they originate – those which have experienced historic and structural marginalization, othering, stigma, oppression and barriers to the social drivers of health and wellbeing. CHWs [are] the workforce we need for the world we want." - Denise Octavia-Smith, Executive Director, NACHW, 2023.

Cultural alignment and lived experience with similar issues and conditions as their ancestors make CHWs uniquely qualified to amplify community strengths and address community priorities (NACHW, 2023). Shared lived experience is a hallmark of the CHW profession; however, it is also one of several requisite qualities and unique characteristics of the profession that may not be fully understood by many employers and partners, including MCOs.

Even the principles that frame CHW competency development are distinct from other fields. For many professions, it is appropriate to pose that with training, anyone can "start from scratch." However, CHWs are not blank slates and completion of a CHW training program alone isn't what makes a CHW a CHW. In the CHW field, competencies are defined as a combination of qualities and skills. Qualities are specific to the human, and while they can be enhanced with training, they can't be manufactured. Connection to the community served through shared race, ethnicity, language, culture, or lived experience are examples of qualities. CHW qualities also include sincerity, empathy, determination, and open-mindedness. (Rosenthal et al., 2018).

The importance of shared lived experience as a requisite CHW quality cannot be overstated. MCOs and other employers can actively preserve and promote the fidelity of the CHW profession in several ways. For example, all employers can prioritize shared lived experience over formal education requirements for CHW positions. See Recommendations for more information.

"Qualities, such as connection to the community served, help to facilitate the trust and relationships CHWs need to be effective in their work with the individuals, families, and communities they serve." – CHW Core Consensus Project, 2018

CHWs' efficacy in working to improve health outcomes and reduce costs is well documented (ASTHO & NACHW, 2020). CHWs use a variety of strategies to promote health and wellbeing. On a day-to-day basis, interpersonal-level core CHW roles can often take the form of assessing and addressing the health-related social needs of participants and connecting individuals to housing, food, employment, and other community resources. Interpersonal-level core CHW roles also include provision of culturally appropriate health education and information; care coordination, case management, and system navigation; advocacy for individuals; individual capacity-building; direct service provision; and implementation of individual assessments.

In addition to working with individuals, CHWs also routinely work with entire communities to mobilize health-promoting policies, organize mobile testing and outreach events and programs, conduct assessments of community strengths and priorities, evaluate CHW programs, participate in research design, implementation, and dissemination, co-develop strategies and materials to address concerns, misinformation, and health beliefs in a culturally appropriate manner, and more. These organizational/institutional, community, and policy-level roles are part of what make CHWs a truly unique workforce who affect change across sectors and employment settings.

The American Public Health Association (APHA) recently adopted a policy statement that calls for training, programming, evaluation, and support for CHWs to address racism and prevent violence (APHA, 2022). As the policy statement explains, the socio-ecological model is a useful framework for understanding CHW roles in violence prevention (Dahlberg & Krug, 2002). Looking at the C3 core CHW roles and competencies and the socioecological model side by side, it is clear that a number of CHW core roles take place at the interpersonal level between CHWs and individuals, families, and small groups or classrooms. At the same time, many CHW core roles also apply at organizational/institutional, community, and policy levels (for example, advocating for individuals and communities, building individual and community capacity, implementing individual and community assessments, conducting outreach, and participating in evaluation and research). Many of the same CHW core roles also prevent and address multiple forms of violence, including systemic racism (APHA, 2023, Wennerstrom et al, 2018, Barbero et al., 2022).

Core CHW Roles

| 1. | Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems |
2.	Providing Culturally Appropriate Health Education and Information
3.	Care Coordination, Case Management, and System Navigation
4.	Providing Coaching and Social Support
5.	Advocating for Individuals and Communities
6.	Building Individual and Community Capacity
7.	Providing Direct Service
8.	Implementing Individual and Community Assessments
9.	Conducting Outreach
10.	Participating in Evaluation and Research

Figure 1: (McLeroy, 1988).

Public Policy
Community
Institutional
Interpersonal
Individual
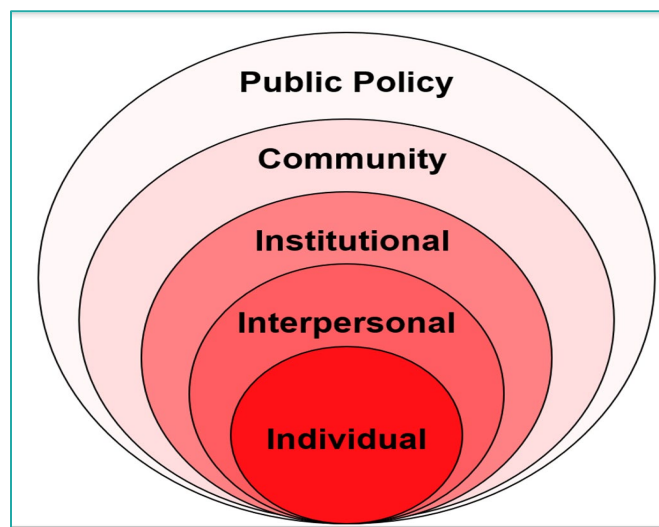
Figure 2: (Rosenthal et al., 2014-2022).

What does CHW-Medicaid integration currently look like?

CHWs' unique qualifications have sparked the interest of state Medicaid offices and MCOs since the 1960s-70s (Cauffman et al., 1970 & Rosenthal et al., 1998). In recent years, a growing number of MCOs have begun to integrate CHWs in their approaches to address social determinants of health (SDoH) (Wennerstrom et al., 2023, Wennerstrom et al., 2022, Sabo et al., 2021). In nearly a quarter of states where MCOs exist, MCOs are required to offer CHW services to members, and additional states have reported they plan to follow suit next

year (Hinton & Raphael, 2022). For example, Oregon's Medicaid office classifies CHWs as one of six Traditional Health Worker (THW) types, among doulas, peer support specialists, peer wellness specialists, navigators, and tribal health workers. The law that established Oregon's Coordinated Care Organization (CCO) system authorized CCOs to provide access to THW services for members (State of Oregon, 2011). The 2020-2024 round of CCO contracts feature a detailed section on SDoH and health equity where CCOs describe their "THW integration and utilization plans" (Oregon Health Authority, 2019).

While this growing interest in CHWs is encouraging on many levels, it may also present challenges for the CHW workforce. There is a growing evidence base that indicates CHWs employed by MCOs may be supported to enact a somewhat constricted range of core CHW roles (George et al., 2020, Sabo et al., 2021, Wennerstrom et al., 2022, Wennerstrom et al, 2023). For example, a 2021 study concluded MCO CHW employment settings "...appear to focus on supporting clinical care and making referrals for social issues, rather than addressing community-level concerns," (Wennerstrom et al., 2023). Similarly, of Oregon's 16 CCOs, 13 had CHW programs in 2017, all of which reported engaging CHWs in interpersonal-level core roles (care coordination and systems navigation); however, few CCOs engaged CHWs in community-level roles (capacity building and advocacy) (George et al., 2020).

The extent of the differences between CHWs employed by MCOs and CHWs employed by CBOs and other settings is not yet clear. Further research and evaluation is needed to determine the extent to which requiring MCOs to work with CHWs and/or CBO employers:

1) Adds value for members.
2) Achieves goals related to racial equity.
3) Benefits the professional development and job satisfaction of CHWs.

The successes and challenges of MCO-led CHW integration efforts hold important lessons learned for future CHW-Medicaid integration initiatives.

Recommendations

NACHW envisions CHWs united nationally in achieving health, equity, and social justice and advocates for CHWs' professional autonomy in all employment environments. NACHW approaches advocacy from an equity and social justice stance and prioritizes the lived experience of CHWs.

In 2021, NACHW released its first (NACHW, 2021). In September 2022, NACHW issued recommendations to the Centers for Medicare & Medicaid Services (CMS) informed by the experiences and input of CHW members from a diverse range of employment sectors, including clinical, behavioral health, social, and CBOs (NACHW, 2022).

Recommendations for CHW employers and policymakers:

A. Adopt the full APHA CHW definition and use the C3 findings and recommendations to develop CHW position descriptions, services, and training requirements.
B. Pay CHWs equitably, including for their lived experience.
C. Promote consistent, CHW-led measurement of CHW and community wellbeing and consult the recommendations and findings from the National CHW Common Indicators (CI) Project.
D. Eliminate funding barriers for CBOs that employ CHWs (Farjado et al., 2021).

Recommendations and policies that are already endorsed nationally within the CHW field remain relevant and should be applied across Medicaid and Medicare programs and services. NACHW offers the following recommendations for MCO leaders that endeavor to work in solidarity with CHWs in pursuit of health and racial equity:

Workforce Sustainability

- Pay CHWs a thriving wage (Friese, 2022), comprehensive benefits, paid time off, access to self-care support, and overtime and sick pay.
- Ensure CHW funding sustains a full range of core CHW roles, including those that address community-level priorities and strengths as well as the health and well-being of individuals and families.
- Support the growth of CHW employment in a variety of sectors, not just in health care payer and/or provider organizations.

Authentic Partnership

- Prioritize CHW leadership and contract with your local CHW network or association to co-design the approach to MCO-CHW integration from the start; commit to following where CHW values lead these efforts.
- Respect and partner with CHWs as members of a recognized, self-determined profession and leaders of health and racial equity efforts.
- Require CHW-related working groups within your organization and partnerships to be comprised of at least 50% of CHW workforce members from a diverse range of geography, backgrounds, and identities.

CHW Recruitment

- Contract with trusted CBOs and CHW Networks that are already skilled in CHW employment practices and services as an alternative or complement to hiring CHWs directly.
- Collaborate with CHW Networks on how to approach contracting and workforce capacity.
- If MCOs hire CHWs directly, prioritize CHWs' lived experience and qualities required to succeed in the role, versus formal educational qualifications or similarities with previous or current job duties alone.
- In states where a CHW certification program exists, support CHW employees and partners to complete training for certification upon hire, rather than require CHW certification as a minimum qualification in CHW position descriptions.
- Support CHW partners and employees to lead development, implementation, and evaluation of organizational hiring and contracting processes and policies.
- Carefully determine whether candidates for CHW positions possess the necessary shared lived experience for the community served, including internal candidates and staff with similar/related job duties who may be cross trained as CHWs.

Training and Professional Development Opportunities

- Consider training opportunities for CHWs as part of recruitment and retention strategies. For example, if an MCO seeks to expand their CHW reach in a particular region, they may invest in local CHW training sites or fund training scholarships for CHWs.
- Ensure CHW employees and partners have access to professional development and career advancement or promotion opportunities.

CHW Core Roles and Services

- Integrate the 10 CHW core roles into CHW job descriptions, hiring processes, and work responsibilities according to the recommendations of the C3 Project.
- Support CHW employees and partners to enact a full range of core roles across all levels of the socio-ecological framework.
- Engage CHW employees and partner to evaluate the extent to which CHWs employed by your organization and provider network are supported to enact a full range of core CHW roles. If needed, make organizational policy changes to better support CHW employees and partners to work at the top of their experience and range of core roles.

Evaluation, Research, and Quality Assurance

- Note: if CHW work practice standards are to be developed, it must be a CHW field-wide collaborative effort initiated and led by CHWs through a national consensus-driven process that would likely take several years or more. These efforts have only recently begun and are currently incomplete.
- Focus quality assurance efforts on consistent CHW-led measurement of CHW and community experiences and wellbeing. Engage CHW employees and partners to measure the processes and outcomes of CHW positions, programs, and capacity-building efforts supported by your organization.
- Use process and outcome indicators developed through an evidence-informed, national consensus-driven process led by CHWs, including the findings and recommendations from the CI Project (CI Project, 2023).

Financing

- Intentionally focus on the distribution and re-distribution of resources and funding to support the strengths and priorities of existing CHW employers like local CBOs, where funding is often especially precarious.
- In states where there is interest to add CHW coverage to their Medicaid programs, MCOs can support with thought partnership specific to state plan amendments (SPAs), 1115 waiver program design, and other Medicaid mechanisms to reimburse and cover CHW services.
- When planning for how to design and implement Medicaid coverage for CHW services, states and MCOs should engage CHW networks and associations to co-create solutions that will meet support the CHW workforce, meet member needs, and meet the mission and goals of Medicaid.
- Understand that established rates (where reimbursement for CHW services exists) are the minimum, not the only rate that MCOs can use to cover services. MCOs may have the flexibility to establish higher reimbursement rates when appropriate.

Increasing Knowledge and Awareness

- Promote anti-racist payment reform (Singletary & Chin, 2023).
- Be aware of your own intersections of privilege and oppression and leverage your unique positionality to work in solidarity with the CHWs of the past, present, and future.
- Learn about the global history of the CHW profession and be able to explain CHW paradigms and values like self-determination and anti-racism to colleagues.
- Adopt and promote the policy recommendations to respect, protect, and partner with CHWs within the NACHW National Policy Platform (NACHW, 2021).

- Adopt and promote the APHA CHW Section policies concerning CHW contributions to health in the US, CHW leadership and self-determination, CHW definition, and support to prevent violence and address systemic racism (APHA, 2001, APHA, 2009, APHA, 2014, APHA, 2023).

Conclusion

CHWs have always used a variety of methods to pursue racial equity and liberation for all people. CHWs are by and large employed by CBOs that operate outside health care delivery settings, making them well positioned to serve communities most impacted by racial and health disparities. MCOs and other institutions should partner with CHWs, CHW networks, and CBOs locally, and evaluate the extent to which their organizations currently support CHWs to enact a full range of core roles and services.

References

American Public Health Association (APHA). (2001). Recognition and Support for Community Health Workers' Contributions to Meeting our Nation's Health Care Needs. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/15/13/24/recognition-and-support-community-health-workers-contrib-to-   meeting-our-nations-health-care-needs%C2%A0

American Public Health Association (APHA). (2009). Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/15/13/24/recognition-and-support-community-health-workers-contrib-to-meeting-our-nations-health-care-needs%C2%A0

American Public Health Association (APHA). (2014). Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/15/support-for-community-health-worker-leadership%C2%A0

American Public Health Association (APHA). (2023). A Strategy to Address Systemic Racism and Violence as Public Health Priorities: Training and Supporting Community Health Workers to Advance Equity and Violence Prevention. Retrieved from https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2023/01/18/Address-Systemic-Racism-and-Violence

American Public Health Association. (2014, November 18). Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing. https://www.apha.org/policies-and-advocacy/public-health-policy-

statements/policy-database/2015/01/28/14/15/support-for-community-health-worker-leadership%C2%A0

Association of State and Territorial Health Officials & National Association of Community Health Workers. (2020). Community Health Workers: Evidence of their Effectiveness. https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf

Barbero, C., Hafeedh Bin Abdullah, A., Wiggins, N., Garrettson, M., Jones, D., S Guinn, A., Girod, C., Bradford, J., & Wennerstrom, A. (2022). Community Health Worker Activities in Public Health Programs to Prevent Violence: Coding Roles and Scope. American journal of public health, 112(8), 1191–1201. https://doi.org/10.2105/AJPH.2022.306865

Cauffman, J. G., Wingert, W. A., Friedman, D. B., Warburton, E. A., & Hanes, B. (1970). Community health aides: how effective are they?. American journal of public health and the nation's health, 60(10), 1904–1909. https://doi.org/10.2105/ajph.60.10.1904

CHW Common Indicators Project. (2023). Proposed Indicators for Priority Constructs (version 02-18-2023). Retrieved from https://cdn.ymaws.com/www.nwrpca.org/resource/resmgr/chw_webpage/2023-02-18_chw_common_indica.pdf

Dahlberg LL, Krug EG. Violence: a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1-21. https://www.cdc.gov/violenceprevention/about/social-Ecologicalmodel.html

E.L. Rosenthal; P. Menking; and J. St. John. The Community Health Worker Core Consensus (C3) Project: A Report of the C3 Project Phase 1 and 2, Together Leaning Toward the Sky A National Project to Inform CHW Policy and Practice Texas Tech University Health Sciences Center El Paso, 2018. Retrieved from https://www.c3project.org/_files/ugd/7ec423_2b0893bcc93a422396c744be8c1d54d1.pdf

Farjado, A., Quinn, A., White, A., Gines, V., & Octavia Smith, D. (2021, November 15). Addressing Systemic Inequities and Racism in Community-Based Organization Funding. https://vaccineequitycooperative.org/news/blog_cbo_funding/

Friese, G. (2022, January 10). Pay paramedics a thriving wage to end the retention crisis. Retrieved from https://www.ems1.com/recruitment-and-retention/articles/pay-paramedics-a-thriving-wage-to-end-the-retention-crisis-68xRW8ONK5rmnMvM/

George, R., Gunn, R., Wiggins, N., Rowland, R., Davis, M. M., Maes, K., Kuzma, A., & McConnell, K. J. (2020). Early Lessons and Strategies from Statewide Efforts to Integrate Community Health Workers into Medicaid. Journal of health care for the poor and underserved, 31(2), 845–858. https://doi.org/10.1353/hpu.2020.0064

Higgins, E., Chhean, E., Wilkniss, S., & Tewarson, H. (2021, December). Lessons for Advancing and Sustaining State Community Health Worker Partnerships. Retrieved from https://nashp.org/lessons-for-advancing-and-sustaining-state-community-health-worker-Partnerships/

Hinton, E. & Raphael, J. (2022). Kaiser Family Foundation. 10 things to know about Medicaid managed care 2022. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. Health education quarterly, 15(4), 351–377. https://doi.org/10.1177/109019818801500401

National Association of Community Health Representatives (NACHR). (2023). Definition of Community Health Representative. Retrieved from https://www.nachr.net/

National Association of Community Health Workers (NACHW). (2021). NACHW National Policy Platform. Retrieved from https://nachw.org/policies/

National Association of Community Health Workers (NACHW). (2023). The Six Pillars of Community Health Workers. Retrieved from https://nachw.org/the-six-pillars-of-community-health-workers/

National Association of Community Health Workers (NACHW). 2022. Membership Data 2022. https://nachw.org/wp-content/uploads/2022/08/NACHW-Membership-Data-2022.pdf

Oregon Health Authority. (2019). Coordinated Care Organizations 2.0 Request for Applications (RFA) RFA OHA-4690-19. Retrieved from https://www.oregon.gov/oha/OHPB/CCODocuments/01-CCO-RF-4690-0-Final.pdf

Robinson, S. (1984). A historical development of midwifery in the Black Community: 1600–1940. Journal of Nurse-Midwifery, 29(4), 247–250. https://doi.org/10.1016/0091-2182(84)90128-9

Rosenthal EL, Menking P, St. John J, Fox D, Holderby-Fox LR, Redondo F, Hirsch G, Lee L, Brownstein JN, Allen C, Haywood C, Ortiz Miller J, Ibarra J, Cole M, Huxley L, Palmer C, Masoud S, Uriarte J, Rush CH. The Community Health Worker Core Consensus (C3) Project Reports and Website. Texas Tech University Health Sciences Center El Paso. 2014-2022. https://www.c3project.org/

Rosenthal EL, Wiggins N, Brownstein N, et al. A summary of the national community health advisor study. Baltimore, MD: Annie E. Casey Foundation, 1998. Available at: https://crh.arizona.edu/sites/default/files/pdf/publications/CAHsummaryALL.pdf

Sabo S, Wexler N, O'Meara L, et al. (2021). Organizational readiness for community health worker workforce integration among Medicaid contracted health plans and provider networks: an Arizona case study. Front Public Health 2021;9:601908. Retrieved from https://www.frontiersin.org/articles/10.3389/fpubh.2021.601908/full

Singletary, K. & Chin, M. (2023). American Medical Association Journal of Ethics. 2023;25(1):E55-65. doi: 10.1001/amajethics.2023.55.

State of Oregon. (2011). House bill 3650. https://olis.oregonlegislature.gov/liz/2011R1/Measures/Overview/HB3650

Timeline. (2017). The story of the granny midwives, who birthed untold numbers of babies in the rural South. Vimeo. The story of the granny midwives, who birthed untold numbers of babies in the rural South. Retrieved from https://vimeo.com/211012543

United States Department of Labor. (2021). Occupational Employment and Wages: Community Health Workers, May 2022. Retrieved from https://www.bls.gov/oes/current/oes211094.htm

Wennerstrom A, Haywood CG, Smith DO, Jindal D, Rush C and Wilkinson GW (2023) Community health worker team integration in Medicaid managed care: Insights from a national study. Front. Public Health 10:1042750. doi: 10.3389/fpubh.2022.1042750

Wennerstrom, A., Haywood, C., Wallace, M., Sugarman, M., Walker, A., Bonner, T., Sutton, Y., Keller, B. L., Lewis, M., Springgate, B., & Theall, K. (2018). Creating Safe Spaces: A Community Health Worker-Academic Partnered Approach to Addressing Intimate Partner Violence. Ethnicity & disease, 28(Suppl 2), 317–324. https://doi.org/10.18865/ed.28.S2.317

Wennerstrom, A., Haywood, C.G., Smith, D.O., Jindal, D ., Rush, C., Wilkinson, G. W. (2022.) What Are the Roles of Community Health Workers in Medicaid Managed Care? Results from a National Study. Population Health Management. Dec 2022.763 770. http://doi.org/10.1089/pop.2022.0191

Wiggins, N., & Borbón, I. A. (1998). Core roles and competencies of community health workers. In Final report of the National Community Health Advisor Study (pp. 15–49). Baltimore, MD: Annie E. Casey Foundation. Retrieved from https://www.orchwa.org/resources/Documents/Chapter-3-from-CH-Advisor-Report-Wiggins0001.pdf

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