

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (I-15)
Incorporating Community Health Workers into the US Health Care System
(Resolution 805-I-14)
(Reference Committee J)

EXECUTIVE SUMMARY

At the American Medical Association's (AMA) 2014 Interim Meeting, the House of Delegates referred Resolution 805, which asked the AMA to: 1) encourage the incorporation of community health workers into the US health care system and support legislation that integrates community health workers into care delivery models especially in communities of economically disadvantaged, rural, and minority populations; and 2) support appropriate stakeholders to define community health workers in order to define their required level of training and scope of practice and to legitimize their role as health care providers. The Board of Trustees assigned this issue to the Council on Medical Service for a report back to the House at the 2015 Interim Meeting.

The following report discusses the diverse roles that community health workers assume in the community and broader health care system, provides examples of community health worker programs and ethical guidelines, and outlines the current funding structure of community health worker programs. The Council developed this report consistent with the tone and scope of Policy H-373.994, Patient Navigator Programs, which the House established when it adopted the recommendations of Council on Medical Service Report 7-I-11. The Council's concerns and expectations with patient navigators mirror those regarding community health workers. Accordingly, the Council recommends that the broad principles in Policy H-373.994 should apply to community health workers as well.

Specifically, Policy H-373.994 states that the role of navigators is to enhance the patient's ability to make appropriate health care choices, that there needs to be communication between the navigator and the patient's medical team, that navigators should refrain from any activity that could be construed as clinical in nature, and that patient navigators should disclose their training and credentials, as well as any potential conflicts of interest. In addition to linking community health workers to these navigator principles, the Council offers a number of recommendations to further articulate AMA policy with respect to these non-clinical members of physician-led health care teams.

Community health workers are broadly defined as community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care.

Due to the diversity of roles and responsibilities of community health workers, it is challenging to identify a single set of guidelines applicable to all community health workers. The Council believes existing industry guidelines provide a strong framework for ensuring community health workers work properly to enhance and supplement the work of the physician-led health care team. Further, the Council believes that appropriate stakeholders must work to establish not only core competencies but also clear training and continuing education requirements.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-I-15

Subject: Incorporating Community Health Workers into the US Health Care System
(Resolution 805-I-14)

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee J
(Jeffrey P. Gold, MD, Chair)

1 At the American Medical Association’s (AMA) 2014 Interim Meeting, the House of Delegates
2 referred Resolution 805, “Incorporating Community Health Workers into the US Health Care
3 System,” submitted by the AMA Medical Student Section. Resolution 805-I-14 asked “that the
4 AMA: 1) encourage the incorporation of community health workers into the US health care system
5 and support legislation that integrates community health workers into care delivery models
6 especially in communities of economically disadvantaged, rural, and minority populations; and 2)
7 support appropriate stakeholders to define community health workers in order to define their
8 required level of training and scope of practice and to legitimize their role as health care
9 providers.” The Board of Trustees referred this issue to the Council on Medical Service (CMS) for
10 a report back to the House at the 2015 Interim Meeting.

11
12 The following report discusses the diverse roles that community health workers assume in the
13 community and broader health care system, provides examples of community health worker
14 programs and ethical guidelines, outlines the current funding structure of community health worker
15 programs, and recommends policy to help define the appropriate role of community health
16 workers as part of a patient’s health care team.

17
18 **BACKGROUND**

19
20 Community health workers (CHWs) are known as peer advocates, community health
21 representatives, and patient navigators, among many terms, and are broadly defined as “community
22 members who work almost exclusively in community settings and who serve as connectors
23 between health care consumers and providers to promote health among groups that have
24 traditionally lacked access to adequate health care.”¹ The Council is defining CHWs as public
25 health workers serving as intermediaries between health services and the community. This
26 definition encompasses non-clinical workers serving the community including those serving as
27 patient navigators. The scope of CHWs varies greatly depending on the sector and state in which
28 they work. CHWs are uniquely qualified as intermediaries between the populations they serve and
29 the health care system, because they live in, and speak the language of the community, and
30 recognize and understand cultural issues. CHW expertise is based on shared life experiences with
31 those they serve. The community health worker model has its origins in antipoverty programs and
32 in efforts to address health care disparities and improve health outcomes among underserved
33 populations. Since the 1960s, CHWs have helped patients navigate the health care system by

1 decreasing socioeconomic barriers to care. The US recently has seen increased attention to these
2 non-traditional health care workers and their potential value due to evidence that some
3 interventions involving CHWs have produced positive outcomes for management of diabetes,
4 hypertension, asthma, cancer, and HIV/AIDS.

5
6 In 2002, the Institute of Medicine (IOM) recognized that CHWs offer promise as a resource to
7 increase racial and ethnic minorities' access to care while liaising between health care providers
8 and the community.² Subsequently, in 2010, both the US Department of Labor (DOL) and the
9 Affordable Care Act (ACA) expressly recognized both patient navigators and the broader
10 profession of CHWs.³ The DOL created a unique occupational code for CHWs, and the ACA
11 identified CHWs as members of the health care workforce who may be used to provide outreach,
12 promote positive health behaviors, and guide underserved populations to appropriate health care
13 resources. The ACA authorized the Centers for Disease Control and Prevention (CDC) to issue
14 grants to organizations utilizing CHWs although Congress never appropriated funding for the
15 grants.

16 17 CURRENT ROLE OF COMMUNITY HEALTH WORKERS

18
19 Consistent with the ACA's emphasis on community-based prevention, health care teams, and the
20 growing recognition of disparities in health outcomes across ethnic groups, CHWs represent a
21 developing resource to assist in providing care that is accessible and culturally competent.
22 Literature generally recognizes seven core roles of CHWs: those promoting cultural mediation
23 between communities and the health care system; those providing culturally appropriate and
24 accessible health education and information; those ensuring that people get the services they need;
25 those providing informal counseling and social support; those advocating for individuals and
26 communities; those providing direct services and administering health screening tests; and those
27 building individual and community capacity.⁴ These categories are not mutually exclusive, and
28 many CHW programs exhibit a number of these core values, which continue to guide the field.
29

30 Hundreds of programs across the country utilize CHWs in a variety of ways, and, when providing
31 services as an integrated member of the primary health care team, CHWs can have a positive effect
32 on the health outcomes of patients.⁵ CHWs serve as intermediaries between clinical services and
33 the community. The information CHWs gather about patients' health status and unique
34 socioeconomic barriers to health are relayed to the health care team to tailor the patient's care plan.
35

36 The Mississippi Delta Health Collaborative (MDHC), a state Department of Health initiative, aims
37 to provide leadership and guidance in the Delta region to improve the population's cardiovascular
38 health by using CHWs.⁶ All CHWs in the program are from the Delta region, are state health
39 department employees, and receive initial and ongoing competency and clinic-based training.
40 MDHC's CHWs are integrated into and receive referrals of patients with elevated blood pressure
41 from various sites such as health care providers at federally qualified health centers (FQHCs) and
42 rural clinics.⁷ CHWs follow an approach intended to establish and maintain links to the health care
43 system and maintain adherence to treatment protocol. CHWs help physicians with care
44 coordination by conducting home visits to monitor cardiovascular risk factors, helping patients
45 schedule appointments, and linking patients with transportation services to access health care.
46

47 A University of Pennsylvania Medicine program at two clinics incorporates CHWs into the
48 primary care team to improve the health of vulnerable patients dealing with chronic conditions.⁸
49 The CHWs are part of the Individualized Management for Patient-Centered Targets (IMPACT)
50 program where trained CHWs provide social support and health care system navigation assistance
51 to socioeconomically vulnerable patients. At the clinic, patients dealing with chronic conditions

1 discuss a specific health goal with their primary care provider, and CHWs help the patient carry out
2 that goal. Over a six-month time frame, patients work with a CHW to create a plan to achieve the
3 goal. Goals may include addressing food insecurity, economic issues like affording basic utilities,
4 creating a plan to increase medication adherence, or addressing addiction. The framework allows
5 for patients to receive holistic care and empower the patient to follow-through on their care plans
6 by addressing barriers to health that may be non-medical.

7
8 As part of the CDC Division of Diabetes Translation, the CDC partnered with Marshall University
9 to create the Appalachian Diabetes Control and Translation Project (ADCTP), which is aimed at
10 reducing the impact of diabetes on people living in high-risk counties in the Appalachian Region.⁹
11 As part of the ADCTP, groups of CHWs throughout the Appalachian Region are developing
12 partnerships and collaborating with community organizations to develop ways to promote healthier
13 lifestyles and increase prevention efforts. The ADCTP specifically targets economically distressed
14 adult populations disproportionately affected by type 2 diabetes.¹⁰ CHW-led projects include
15 education on healthy eating and exercise habits, health fairs, and support groups. CHWs also
16 provide instruction to patients on diabetes self-management.

17 18 FUNDING

19
20 While some CHWs are volunteers, the majority of CHW programs rely on paid CHW positions.¹¹
21 Because the profession lacks broad recognition and acceptance, there is difficulty establishing and
22 maintaining CHW program funds. Current CHW program funding sources vary and many are
23 mixed. About two-thirds of all CHW programs use multiple funding streams from a combination of
24 both public and private sources.¹² Generally, funding sources are grouped into one of three
25 categories: time-limited grants, state and local funds, and public or private insurance.

26 27 *Time-Limited Grants*

28
29 Most programs rely, at least in part, on time-limited grants. Time-limited grants may be as short as
30 a year or as long as three years, and come from sources like private foundations and government
31 agencies. Many grant programs target a specific condition or population, such as asthmatic children
32 in an underserved community. While there is relative availability of grants, most are not renewable,
33 so CHW programs are at high risk of disruption and termination when the grant terminates.

34 35 *State and Local Funds*

36
37 CHW programs funded through state and local funds are allocated each budget cycle and make
38 funding of CHWs directly available.¹³ Under this model, the funds may either pay CHW salaries
39 directly or be designated to an organization that administers the program. Of course, the nature of
40 these funds makes them susceptible to budget restrictions and cuts. Additionally, such funding is
41 highly dependent on each state and locality's budget and political situation.

42 43 *Private or Public Insurance*

44
45 Both private and public insurance have played a role in the funding of CHW positions.¹⁴ Insurance
46 plans may fund CHW positions in a number of ways either through direct reimbursement, indirect
47 payment, or capitation. Some health plans are paying CHWs via capitation as part of the health
48 care team. Public insurance such as Medicaid has been used by a number of states to fund their
49 CHW programs and has emerged as relatively stable since it accesses an existing health care
50 financing mechanism. Medicaid managed care organizations may use capitated payments to
51 employ CHWs or organizations such as federally qualified health centers can be reimbursed for

1 Medicaid administrative costs performed by CHWs.¹⁵ Also, Medicaid Section 1115 waivers permit
2 states to implement demonstration projects to further the goals of Medicaid, and a number of states
3 have utilized section 1115 waivers as a means of financing their CHW initiatives.¹⁶

4 5 COMMUNITY HEALTH WORKERS PROGRAMS AND STANDARDS

6
7 The community health worker's role varies considerably and depends on the sector in which they
8 work. The skills and competencies for a CHW working to promote nutrition and immunization
9 differ from those of a CHW working to connect patients with clinical services. Because each
10 community's needs differ and the skills required for any particular CHW program vary, it is a
11 challenge developing standardized training or certification. A 2002 IOM report identified barriers
12 to the effective use of CHWs in multidisciplinary health care teams including inconsistent CHW
13 scope of practice, training, and qualifications.¹⁷

14
15 As the role of CHWs in the health care system increases, so too does interest in formalizing and
16 standardizing workforce training requirements. Five states have laws or regulations establishing a
17 certification program, seven states have no law but have established a state-led training or
18 certification program, while others have remained silent on the issue altogether leaving requisite
19 training or certification requirements the responsibility of the CHW program.¹⁸

20
21 Texas enacted legislation requiring the Department of State Health Services (DSHS) to establish a
22 CHW training program, which is mandatory for those CHWs who are compensated for their
23 services.¹⁹ To become a certified CHW, an individual must be at least 18 years old and complete a
24 DSHS-approved 160 hour competency-based training program or prove the completion of at least
25 1,000 hours of CHW services within the last 6 years.²⁰ The established core competencies include
26 communication skills, interpersonal skills, organizational skills, and knowledge of specific health
27 issues. Certified CHWs are required to renew their certification and complete continuing education
28 biannually.²¹

29
30 Indiana does not have legislation establishing CHW certification; rather, certification is
31 department-established. The Indiana Division of Mental Health and Addiction and the Department
32 of Health jointly established a training and certification program for CHWs. In order to be eligible,
33 individuals must be at least 18 years old and have a high school diploma or equivalent. The training
34 program is three-days and ends with a final exam. The program is module-based and covers topics
35 such as communication skills, cultural understanding, prevention, chronic illness, behavioral
36 health, and outreach. Upon completion of the training, certified CHWs may serve in a variety of
37 settings including hospitals, clinics, and community centers.

38
39 Kentucky lacks legislation establishing CHW certification and does not require CHW certification.
40 Any CHW certification largely occurs at individual CHW programs. For example, the Kentucky
41 Homeplace Program, a CHW program delivering education on prevention and disease self-
42 management, requires certification to work in the program. Certification requires CHWs to have a
43 high school diploma or equivalent and complete 40 hours of training on chronic disease
44 management, cancer prevention, in-home visiting safety, communication, and liability and legal
45 instruction.²² Additionally, the certification requires three months of shadowing an experienced
46 CHW wherein CHWs meet the community providers with whom they will work.²³ After the
47 certificate is earned, there are continual trainings on various topics such as communicable diseases
48 and child abuse.²⁴

1 *Ethical Standards*

2
3 The Community Health Worker Code of Ethics is based on and supported by the core values
4 adopted by the American Association of Community Health Workers (AACHW), a national
5 professional CHW group. The Code of Ethics provides a framework for CHWs, supervisors, and
6 employers of CHWs to guide the discussion of ethical issues facing the profession. Not only are
7 employers encouraged to consider this Code when creating CHW programs, but also, numerous
8 states, including Indiana and Massachusetts, have developed ethical standards using the CHW
9 Code as a model.

10
11 The CHW Code of Ethics is based upon commonly understood principals that apply to all health
12 and social service professionals including the promotion of social justice, improved health, and
13 dignity. The core of the CHW Code is that the responsibility of all CHWs is to strive for excellence
14 by providing quality service and the most accurate information available to individuals, families,
15 and communities. It includes sections on confidentiality, equitable relationships, rights and
16 responsibilities, and the scope of ability and training. The CHW Code specifically directs CHWs to
17 disclose qualifications, training, experience, and credentials. The CHW Code, however, does not
18 address all ethical issues facing CHWs and states that the absence of a rule does not imply that
19 there is no ethical obligation present. As professionals, CHWs are encouraged to reflect on the
20 ethical obligations that they have to the communities that they serve.

21
22 **RELEVANT AMA POLICY**

23
24 Policy D-165.975 directs the AMA to highlight the need for improved access to quality health care
25 for all disadvantaged, working with the private sector and government at all levels to improve
26 health care access for this population.

27
28 Policy H-373.994, established with CMS Report 7-I-11, addresses patient navigators, who are non-
29 clinical patient advocates whose role is encompassed in the broader term of community health
30 workers. The Council's concerns and expectations with patient navigators mirror those regarding
31 CHWs. Policy H-373.994 recognizes that patient navigator services may help improve access to
32 care and help patients manage aspects of the health care system and that information provided by
33 the patient navigator enhances a patient's ability to make appropriate health care choices. The
34 policy provides guidelines to patient navigator programs to ensure patient navigators foster patient
35 empowerment while explicitly refraining from any activity that could be construed as clinical in
36 nature. Policy states patient navigator programs should establish procedures to ensure direct
37 communication between the navigator and the patient's health care team. The policy emphasizes
38 that patient navigators should fully disclose relevant training, experience, credentials, and potential
39 conflicts of interest. The policy also calls for the AMA to work with other organizations to ensure
40 patient navigators are free of bias and do not usurp the physician's role or responsibility for patient
41 education or treatment planning.

42
43 The AMA has extensive policy related to individuals who work with patients as part of a health
44 care team. Several policies reinforce the concept of physicians bearing the ultimate responsibility
45 for care and advocate that allied health professionals such as nurses and physician assistants
46 function under the supervision of a physician (e.g. Policies H-35.970, H-45.973, H-35.989).
47 Policy H-160.912 advocates that all members of a physician-led team be enabled to perform
48 medical interventions that they are capable of performing according to their education, training and
49 licensure, and the discretion of the physician team leader. Policy H-160.938 promotes a physician-
50 led team approach to disease-specific patient care and self-management programs. Policy H-35.996
51 states that hospital medical staffs should have the authority to determine what functions and

1 services should be made available for patient care by members of “emerging or expanding health
2 professions.” Policy H-160.906 defines “physician-led” in the context of team-based health care as
3 the consistent use by a physician of the leadership, knowledge, skill, and expertise necessary to
4 identify, engage, and elicit from each team member the unique set of training, experience, and
5 qualifications needed to help patients achieve their care goals, and to supervise the application of
6 those skills.

7
8 **DISCUSSION**

9
10 The general concept of community health workers is consistent with the patient-centered medical
11 home model, which emphasizes physician-led, team-based care that is coordinated and integrated
12 across all elements of the health care system and the patient’s community (Policy H-160.919).
13 Providing open communication and serving between health systems and communities facilitates
14 access to and improves the quality and cultural competence of care. Conversely, to the extent CHW
15 services have the potential to restrict care or interfere with the patient-physician relationship by
16 interfering with and contradicting treatment plans, it is important that our AMA be prepared to
17 confront this potential intrusion. To mitigate risk of interference, the Council believes CHWs
18 should work under a protocol developed by the physician-led health care team regarding any
19 activity relating to clinical matters. Because CHWs encompass the role of patient navigators, the
20 Council recommends Policy H-373.994, Patient Navigator Programs, be amended and apply to
21 community health workers.

22
23 Because of the diversity of roles and responsibilities of community health workers, it is challenging
24 to identify a single set of guidelines applicable to all CHWs. The Council believes that the CHW
25 Code of Ethics, supported by the AACHW, provides a strong framework for ensuring CHWs work
26 properly to enhance and supplement the work of the physician-led health care team. The CHW
27 Code specifically calls for cooperation among other health care providers and recognizes
28 limitations on the services they can provide. The Council finds these principles imperative, and
29 believes it is important the CHWs refrain from any activity that could be construed as clinical in
30 nature, including interpreting test results, diagnosing illness or disease, or making treatment
31 recommendations. Where appropriate, CHWs may use clinical experience or training to help
32 patients better understand information provided by their physician or other members of their health
33 care team.

34
35 The CHW Code directs that all CHWs be truthful and forthright in presenting their background and
36 training to health care providers and be truthful about qualification and competencies to
37 individuals, families, and communities. Though not stated in the CHW Code, the Council believes
38 it is in the interest of patients for CHWs to be subject to background checks as they will have
39 contact with patients and may have access to personal and medical information. The role of the
40 CHW is built on trust, and full disclosure of background and training allows patients to determine
41 which services the CHW is qualified to perform.

42
43 CHWs serve in a wide variety of roles within the health care system, and there is a lack of
44 specificity regarding distinct roles and responsibilities. The Council believes the current absence of
45 standardized core competencies and standardized training contributes to this lack of professional
46 acceptance. The Council believes that appropriate stakeholders must work to establish not only a
47 set of defined core competencies and skills but also establish clear training and continuing
48 education requirements. CHWs have the capacity to be valuable members of the health care team.
49 To do so, their roles and responsibilities must be clarified, and their training must be standardized
50 as appropriate for the services they provide.

1 The lack of sustainable funding disrupts the services CHWs provide and prevents health care teams
2 from realizing their full potential. The expanding evidence base for CHW programs suggests their
3 strong potential for improving health outcomes; however, programs are often not sustained due in
4 large part to limited and time-sensitive funding mechanisms. Establishing sustainable funding
5 mechanisms supports the integration of CHWs into the care team. In particular, public and private
6 insurance payers could provide pathways to a sustainable financing structure. The Council believes
7 sustainable funding mechanisms that do not come out of that allocated physician payment should
8 be pursued.

9
10 RECOMMENDATIONS

11
12 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
13 805-I-14 and that the remainder of the report be filed:

- 14
15 1. That our American Medical Association (AMA) amend Policy H-373.994 by addition of a
16 new recommendation that specifies that the policy provisions for patient navigators are
17 also relevant for community health workers and other non-clinical public health workers.
18 (Modify HOD Policy)
- 19
20 2. That our AMA encourage states and other appropriate stakeholders to establish that
21 community health workers work under a strict protocol for any activity that relates to
22 clinical matters and that this protocol be developed by the physician-led health care team.
23 (New HOD Policy)
- 24
25 3. That our AMA encourage states and other appropriate stakeholders to conduct background
26 checks on community health workers prior to the community health worker providing
27 services and take the background check results into appropriate consideration. (New HOD
28 Policy)
- 29
30 4. That our AMA encourage states and other appropriate stakeholders to develop a set of
31 defined core competencies and skills of community health workers. (New HOD Policy)
- 32
33 5. That our AMA encourage states to support or establish the training, certification, and
34 continuing education of community health workers that allow for multiple points of entry
35 into the profession. (New HOD Policy)
- 36
37 6. That our AMA encourage health insurers and other appropriate stakeholders to promote
38 sustainable funding mechanisms such as public and private insurance to finance
39 community health worker services and that this funding not be part of funds allocated for
40 physician payment. (New HOD Policy)
- 41
42 7. That our AMA encourage states and other appropriate stakeholders to engage in
43 collaborative efforts with community health workers and their professional organizations
44 in the development and implementation of policies related to community health workers.
45 (New HOD Policy)
- 46
47 8. That our AMA encourage states to consider privacy and liability issues related to the
48 inclusion of community health workers in the physician-led health care team. (New HOD
49 Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Witmer A. Community Health Workers: Integral Members of the Health Care Work Force. *Am J Public Health*. 1995;85:1055.
- ² Institute of Medicine. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.
- ³ National Health Care for the Homeless Council. (2011). *Community Health Workers: Financing and Administration*. Available at <http://www.nhchc.org/wp-content/uploads/2011/10/CHW-Policy-Brief.pdf>.
- ⁴ Rosenthal, E. L., Wiggins, N., Brownstein, J. N., Johnson, S., Borbon, I. A., & De Zapien, J. G. (1998). A summary of the national community health advisor study: Weaving the future. A policy research project of the University of Arizona. Summary coordination by E. Koch. Tucson, AZ: University of Arizona, Rural Health Office.
- ⁵ Pittman M et al. *Bringing Community Health Workers into the Mainstream of U.S. Health Care*. February 2015. Available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Wkfrce3_CHW_IOM_Paper.pdf.
- ⁶ *Addressing Chronic Disease through Community Health Workers*. Available at http://www.cdc.gov/dhdsp/docs/chw_brief.pdf.
- ⁷ Id.
- ⁸ <http://chw.upenn.edu/impact>.
- ⁹ <http://www.cdc.gov/diabetes/programs/appalachian.html>
- ¹⁰ http://www.bms.com/Documents/together_on_diabetes/marshall-press-release-01222013.pdf
- ¹¹ Dower C et al. *Community Health Worker Practice and Utilization: The Focus on Financing*. Available at http://futurehealth.ucsf.edu/Content/29/2006-12_Advancing_Community_Health_Worker_Practice_and_Utilization_The_Focus_on_Financing.pdf
- ¹² *Advancing Community Health Worker Practice and Utilization The Focus on Financing.pdf*
- ¹³ Dower C et al. *Community Health Worker Practice and Utilization: The Focus on Financing*. Available at http://futurehealth.ucsf.edu/Content/29/2006-12_Advancing_Community_Health_Worker_Practice_and_Utilization_The_Focus_on_Financing.pdf
- ¹⁴ Id.
- ¹⁵ *Financing Community Health Workers: Why and How*. Available at http://pscinc.com/LinkClick.aspx?fileticket=Vu_X9O_UHHg%3D&tabid=65.
- ¹⁶ Dower C et al. *Community Health Worker Practice and Utilization: The Focus on Financing*. Available at http://futurehealth.ucsf.edu/Content/29/2006-12_Advancing_Community_Health_Worker_Practice_and_Utilization_The_Focus_on_Financing.pdf
- ¹⁷ *Community Health Workers: Financing and Administration*. Available at <http://www.nhchc.org/wp-content/uploads/2011/10/CHW-Policy-Brief.pdf>.
- ¹⁸ Institute of Medicine. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.
- ¹⁹ <http://www.astho.org/public-policy/public-health-law/scope-of-practice/chw-certification-standards/>
- ²⁰ Id.
- ²¹ Id.
- ²² *Community Health Workers in Utah: An Assessment of the Role of CHWs in Utah and the National Health Care System*. Available at http://cppa.utah.edu/CHW_Appendix_2_National-assessment.pdf.
- ²³ Id.
- ²⁴ Id.