

Report

Opportunities and Challenges: Informing a Strategy to Support, Strengthen, and Sustain the Community Health Worker and Promotor(a) Sector in Texas

June 2026

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1. Executive Summary

The Transformative Role of CHW/Ps in Texas

Community Health Workers and Promotores (CHW/P) are trustworthy individuals who share life experiences with the people they serve and have firsthand knowledge of the causes and impacts of poor health. They bridge the gap between communities and health care services. Evidence shows that CHW/Ps can improve health for the individuals they serve and can reduce costs.

Since emerging in the 1960s, the Texas CHW/P workforce has grown significantly, numbering 10,800 across 194 counties as of 2026. Despite this expansion, systemic barriers limit the reach of this workforce, and many Texans who would benefit from CHW/P services still lack access.

Goal of this Report

The Episcopal Health Foundation (EHF) recognizes the CHW/P workforce as a key part of a community-based approach to improving health outcomes and reducing preventable health differences in under-resourced communities. In order to realize this promise in a state as large and diverse as Texas, stakeholders across the state will need to take coordinated action to build capacity and address systemic barriers.

To inform a strategy and action plan, we review the CHW/P landscape within Texas and nationally to identify promising practices, barriers and the system level factors critical to long-term CHW/P sector sustainability. This report lays a foundation through:

- an examination of evidence of CHW/P impact,
- a review of the Texas CHW/P landscape, informed by 13 interviews with CHW/P leaders, allies, and policy experts,
- a review of the national landscape based on the literature and IMPaCT's experience working across 20 states, and
- a draft systems-level framework.

This landscape assessment will inform additional stakeholder engagement and strategic planning work.

Findings from the Texas and National CHW/P Landscapes

The review of the Texas and national landscapes focuses on three critical components of the CHW/P sector: ecosystem and stakeholders, financing and workforce development and support.

Challenges and best practices for financing and workforce development and support are presented, including:

Financing Takeaways - Promising Practices and Barriers

- New funding approaches are emerging (within Texas and nationally), but financial sustainability for CHW/P positions and programs remains a significant challenge. Policy refinement and infrastructure investment are necessary to overcome barriers that impede CHW/Ps and programs from unlocking financing (e.g., complex provider enrollment, contracting difficulties, and a narrow scope of covered benefits).
- Diversified, multi-payer and provider strategies offer promise, including integrating CHW/Ps into value-based models. At the same time, community-based and/or small programs face unique challenges to reimbursement and partnering with payers, which should be considered in strategies to support and sustain the workforce.
- Evidence proves that CHW/Ps are a workforce that can improve health outcomes, equity, and quality and reduce costs. To cultivate expanded financial commitment from payers, health systems, academic institutions, funders, and others, a customized business case that translates this impact for specific stakeholders may be needed.

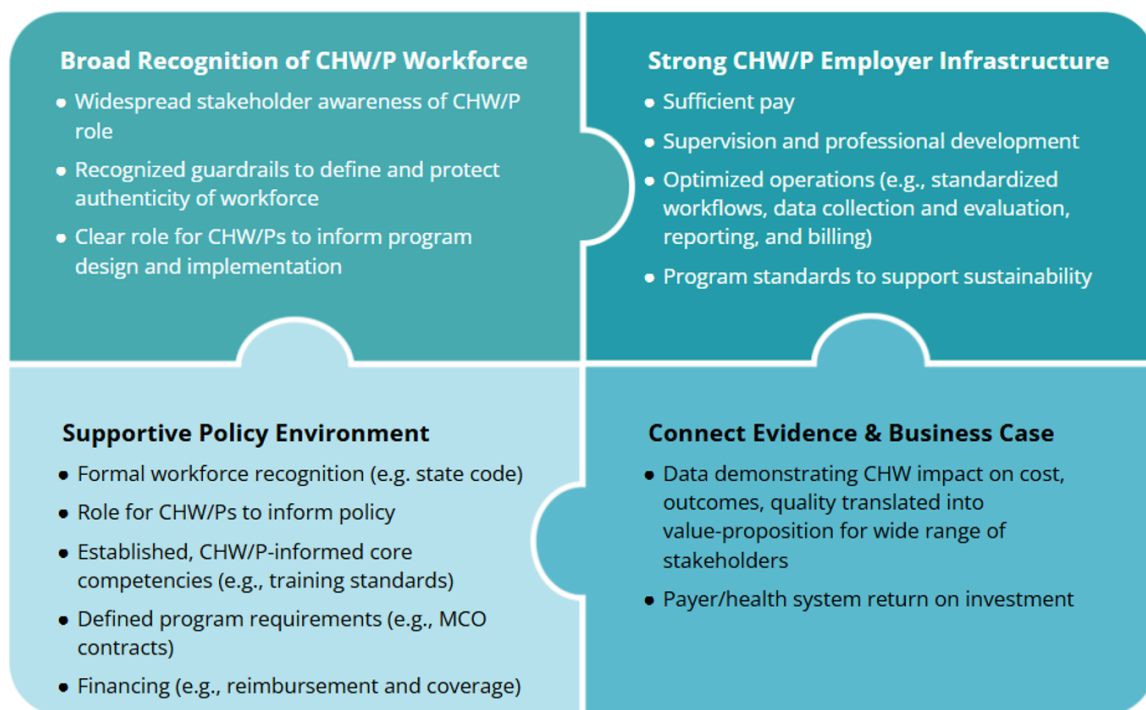
Workforce Development and Support Takeaways - Promising Practices and Barriers

- Policy development and implementation must be informed by CHW/Ps and should not create barriers to workforce entry, training or program sustainability. Recent developments in Texas (e.g., delays in CHW/P and training curriculum certification and the disbanding of the state's CHW Advisory Committee) have raised questions around stability of CHW/P policies and a clear role for CHW/Ps to advise the state.
- To sustain the workforce and high-quality programs requires scaling best practices for hiring, scope of work, professional development, supervision, career pathways and retention strategies (e.g., compensation). This workforce development and support should expand beyond training and certification and consider emerging approaches (e.g., program accreditation standards).
- Limited organizational infrastructure (e.g., technology, data systems, standardized workflows, billing systems, etc.) impedes standardized and sustainable delivery of high-quality service. Investment in infrastructure is critical to support the workforce and ensure program quality and impact long-term.

A Draft Strategic Framework for Sustaining and Scaling CHW/Ps

Together, learnings from the Texas and national landscape reviews point to system level factors critical for long-term CHW/P sector support. These factors span four focus areas: a supportive policy environment, broad recognition of the CHW/P workforce, strong CHW/P employer infrastructure, and connecting evidence and the business case (see figure 1).

Figure 1. Draft Systems-Level Framework to Support, Strengthen and Sustain the CHW/P Workforce



This draft systems-level framework presented in the report offers a roadmap for EHF and stakeholders as they align on priorities and develop a strategy and action plan to strengthen the CHW/P sector's long-term reach and impact across Texas.

2. Introduction: The Transformative Role of CHW/Ps in Texas

Community Health Workers and *Promotores* (CHW/P) are essential to transforming health care in Texas.¹ CHW/Ps are trustworthy individuals who share life experiences with the people they serve and have firsthand knowledge of the causes and impacts of poor health. They bridge communities and health care services, act as cultural mediators and deliver critical services, including health education, care navigation, skill building, self-advocacy and assistance accessing non-medical needs like housing, nutrition, and transportation.²

A Brief History

The history of CHW/Ps in Texas spans over six decades, beginning in the 1960s when *Promotores de Salud* first emerged in Latino communities along the Texas-Mexico border.³ This grassroots workforce subsequently expanded across the state to serve underserved or under-resourced communities. In the 1980s and 1990s, CHW/Ps played a key role in maternal and child health, chronic disease prevention, and connecting communities to preventive services (e.g., immunizations) and non-medical resources.⁴ Grassroots CHW/P organizations (like the South Texas Promotores Association) formed to share information and advocate for increased recognition of the workforce.⁶ Over time, CHW/Ps integrated more into community-based organizations, community clinics, faith-based networks, and public health departments, later expanding to federally qualified health centers (FQHCs), academic institutions, health systems and health plans.

The State of Texas formally recognized the role of CHW/Ps in 1999, making it the first state to do so. Since then, state officials and policymakers have enacted policies intended to support the formal integration and recognition of this workforce within health and social service systems. For example, the state established a statewide training and certification program and, more recently, created opportunities for Medicaid health plans to cover certain CHW/P services. Federal efforts also supported expansion. The state's Medicaid section 1115 waiver directed funding to safety net health systems, which supported CHW/P integration into care delivery.⁷ Federal legislation responding to the COVID-19 public health emergency resulted in more funding for training, supporting growth in the number of certified CHW/Ps.⁸ As of 2026, there were 10,800 CHW/Ps in 194 counties working across health systems, FQHCs, community based organizations, managed care entities and more.⁹

Today, at least eleven regional associations, a statewide association, and a network of CHW/P leaders work to elevate the critical role this workforce plays across Texas and advocate to ensure its long-term sustainability.¹⁰

EHF's Commitment to the CHW/P Workforce

The Episcopal Health Foundation's (EHF) work is rooted in the pursuit of equitable health for all Texans. EHF recognizes CHW/Ps as foundational to community-based approaches that improve health outcomes, remove barriers to health and advance health equity. For over a decade, EHF has invested in efforts to support, strengthen and sustain this workforce. This has included:

- funding to implement CHW/P models that have shown promise in other states (e.g., Pathways Community Hub and Texas Accountable Communities for Health Initiative (TACHI)),¹¹
- research, evaluations and statewide surveys of the CHW/P workforce,^{12 13}
- grants, research and community engagement to support passage of legislation that created a new Medicaid benefit for CHW/P services, and¹⁴
- partnering with state policymakers to provide technical assistance and supporting learning collaboratives to advance implementation of new CHW/P-related policies.^{15 16 17}

EHF is committed to further supporting the CHW/P sector as part of its 2025–2030 strategic framework, which identifies CHW/Ps as core to driving change.¹⁸

Goal of this Report

The Texas CHW/P workforce's size, reach and impact has expanded significantly over the past 60 years. However, CHW/P services are still not available to many of the Texans who would benefit from them. More work is needed to ensure expansion, scaling and sustainability of this workforce and CHW/P programs. Development of a strategy and action plan for the future requires understanding the current landscape, assessing what works and what does not, and identifying systems-level factors that impact success.

This report lays the foundation for a strategy and action plan. It has four sections. The first section summarizes evidence of CHW/P impact. The second section reviews the Texas CHW/P landscape, informed by 13 interviews with CHW/P leaders, allies, and policy experts. The third section provides an overview of the national landscape based on a review of the literature and IMPaCT's experience working across 20 states. Finally, landscape assessment findings are integrated into a systems-level framework. The framework can guide multi-stakeholder

engagement and the development of a strategic plan to further support, strengthen and sustain the CHW/P sector in Texas.

Goal: The goal of this work is to support, strengthen and sustain the CHW/P workforce, defined as:

- **Support.** Promote the CHW/P workforce and awareness of its vital role in improving health outcomes and reducing disparities through program support, research, advocacy and technical assistance.
- **Strengthen.** Equip CHW/P programs with the infrastructure required to deliver high-quality services, retain and support talented CHW/Ps and scale to serve more Texans.
- **Sustain.** Advance strategies that ensure long-term CHW/P employment, sustainable programs and access to high-quality CHW/P services.

3. The Growing Evidence-Base: Evaluations of CHW/P Impact

For over 70 years, CHW/Ps in the United States have addressed the social and health needs of the communities they serve. They have become an essential component of the health care workforce.¹⁹ A pivotal 1998 study defined the core roles and competencies of CHW/Ps (e.g., outreach, health education, advocacy and system navigation) and affirmed their effectiveness. This study included recommendations to inform workforce development, program evaluation and policy decisions, generating formal recognition of this workforce by the health care system and policymakers.²⁰

Since then, a growing body of research shows that CHW/Ps can improve outcomes, reduce costs and generate a return on investment (ROI).²¹ Studies demonstrate that CHW/Ps can enhance engagement in primary care²² and preventive services (e.g., cancer screenings²³ and vaccinations²⁴), improve mental health, support management of chronic diseases (including cardiovascular disease,²⁵ blood pressure,²⁶ and diabetes²⁷) and reduce costs.²⁸

Evaluations of national models show that CHW/P impact is scalable. Two randomized controlled trials (RCTs) of the IMPaCT intervention—a person-centered, structured CHW/P model implemented in over 20 states—found that uninsured or publicly insured adults with two or more chronic conditions who received six months of CHW/P support had improved mental health and chronic disease control (including A1c levels), as well as fewer hospital days and a lower likelihood of readmission.²⁹ A third RCT showed that patients who engaged with IMPaCT CHW/Ps during hospitalization and post-discharge had increased primary care engagement and improved mental health.³⁰ A Patient-Centered Outcomes Research Institute (PCORI) evaluation of implementation of the IMPaCT model across five sites, including rural and urban communities, found that individuals who worked with CHW/Ps had fewer inpatient admissions and hospital days and a higher likelihood of primary care visits.³¹

Evaluations also show that CHW/Ps deliver savings. An economic analysis found the IMPaCT model delivered a \$2.47 return on investment for every dollar invested by a Medicaid payer within the fiscal year.³² Evaluations of the Center for Medicare and Medicaid Innovation's (CMMI) Accountable Health Communities (AHC) Model provide evidence that navigation services benefit health care spending and utilization. The 5-year model, implemented by 28 organizations across

21 states, tested screening Medicare and Medicaid beneficiaries for health-related social needs and connecting them to community resources through patient-centered navigation services. The final evaluation shows that this scaled approach screened 1.1 million Medicare and Medicaid beneficiaries for health-related social needs and generated \$200 million in net savings. Notably, Medicare and Medicaid enrollees who received both screening and navigation had lower total health care expenditures, with Medicaid enrollees specifically showing lower inpatient admissions and unplanned readmissions compared to those who received screening only.³³

However, not all evaluations show consistent impact. A 2023 review of the evidence, including RCTs, found mixed findings on cost savings³⁴ and patient satisfaction.³⁵ Comparing results across interventions presents a challenge because CHW/P programs vary widely in disease focus, design and approach to hiring and supervision.³⁶ Consistent, effective programs at scale require adherence to evidence-based practices, both in the intervention itself and in policies that support the workforce (e.g., hiring, compensation, supervision).³⁷

In Texas, evaluations of CHW/P programs show promising yet mixed results, consistent with national findings. For example, between 2018 and 2023, four sites implemented the Pathways Community Hub Institute (PCH) Model, which has been scaled across 19 states.³⁸ Mixed methods evaluations across the four sites demonstrate varied impact on savings and health outcomes.³⁹ An evaluation found that these programs effectively engaged high-risk pregnant mothers and clients (primarily from Hispanic/Latino and Non-Hispanic Black communities), though the impact on utilization, outcomes and savings varied. The evaluation, which used semi-structured interviews and client encounter data, found that while the majority of pregnant clients received inadequate prenatal care, birth outcomes at two sites were above county-level averages within the Medicaid population. The intervention was cost neutral at two sites.⁴⁰ A separate evaluation of the Williamson County PCH found that the intervention favorably impacted birth outcomes.⁴¹ Conversely, a retrospective matched cohort evaluation of the Bexar County Health Collaborative PCH in San Antonio found that mothers who completed the program had significantly more emergency department (ED) visits and higher pharmacy and delivery costs compared to matched controls.⁴²

Other evaluations of local or regional Texas-based CHW/P programs have shown positive impact. A pre/post observational study of Memorial Hermann Health System's patient navigation program found that certain patients who worked with bilingual CHW/Ps had decreased odds of returning to the ED, and the model generated savings.⁴³ Other studies demonstrate that CHW/P programs improve access, adherence and outcomes, but findings on savings or cost-effectiveness

are limited. For example, a prospective quasi-experimental study of a combined navigator/promotora program for predominantly Hispanic women with abnormal breast cancer screenings in San Antonio found that navigated women had significantly shorter times from definitive diagnosis to initiation of therapy.⁴⁴ An RCT of a CHW-led patient navigation program for Latino Medicare enrollees found modestly higher colorectal cancer screening adherence compared to those receiving mailed education materials.⁴⁵ A longitudinal study of the Salud y Vida program, which integrates home visits from CHW/Ps into a chronic care management model, found significant reductions in systolic and diastolic blood pressure among Hispanic adults with comorbid, poorly controlled diabetes and hypertension. Reductions were sustained through 15 months among those with higher program engagement.⁴⁶ Finally, a dissemination and implementation study of the evidence-based Tu Salud ¡Sí Cuenta! program found that low-income Latinos along the Texas-Mexico border with higher exposure to CHW/P home visits had significantly greater daily fruit and vegetable intake and weekly physical activity compared to lower exposure participants.⁴⁷

This research confirms that CHW/Ps have the potential to improve health and wellness and deliver health care savings, but real-world performance of these programs has been inconsistent to date. To support, strengthen and sustain the CHW/P sector and achieve consistent impact at scale, it is essential to identify the systems-level factors that drive success.

4. Overview of the Texas CHW/P Landscape

The CHW/P workforce has served Texas communities for over six decades. Efforts to support, strengthen and sustain this vital workforce into the future require a review of the state's landscape to identify both what works and systemic barriers impeding success. This review focuses on three critical components: the CHW/P ecosystem and stakeholders, financing strategies, and workforce development and support. Here, we provide a snapshot of promising practices and barriers related to financing and workforce development.

A review of publicly available surveys, literature, and 13 key informant interviews with CHW/P leaders, allies and policy experts grounds this report. This review is not intended as an exhaustive catalog of all related activities.

A. Texas CHW/P Ecosystem and Stakeholders

A diverse, interconnected network of stakeholders (many of whom operate locally or regionally) shapes the CHW/P ecosystem in Texas. To successfully support and sustain this workforce will require inclusive strategies that engage key actors, including:

- CHW/Ps and CHW/P Associations
- CHW/P Allies
- Populations and Communities served by CHW/Ps
- Certified CHW/P Training Centers
- CHW/P Employers/Service Providers (e.g., community-based organizations, health systems, federally qualified health centers, clinics, faith-based organizations, and more)
- Academic Institutions (e.g., higher education and community colleges that support research, employment and training)
- State Government
- Payers (e.g., Medicare Advantage, Medicaid managed care plans)
- Funders

Below is a snapshot of these stakeholder groups, their reach and impact.

CHW/P Workforce Snapshot

The Texas CHW/P workforce is the third largest in the country⁴⁸ and has expanded significantly, growing from approximately 3,750 certified CHW/Ps in December 2020 to 10,800 in February 2026.⁴⁹

- Demographics. As of 2024, most CHW/Ps are women (86%). The majority of CHW/Ps are Hispanic (59%), with the remainder being Black (22%), White (14%), and Asian (3%) individuals.⁵⁰
- Geographic Distribution. Certified CHW/Ps are spread across 194 counties with the most CHW/Ps in Harris, Dallas, Bexar, Tarrant and El Paso counties.⁵¹
- Employment. While 70% of employers hired CHW/Ps full-time, only 45% worked under the title CHW/P.⁵² This discrepancy may be caused by a shortage of stable CHW/P positions (as highlighted in key informant interviews) or by certified CHW/Ps working in other fields. More research is needed to pinpoint the factors.
- Core Services.⁵³ CHW/Ps primarily provide health education and promotion (85.7%), information and referral to services (82.3%), system navigation/access to services (74.8%), and individual and community advocacy (63.9%). The vast majority of these services (77.6%) are delivered in community-based settings.⁵⁴

CHW/P Associations

Texas is home to a network of CHW/P associations, with at least 11 regional associations as of December 2021.⁵⁵ Interviewees indicate that these regional and local associations operate independently and often in a siloed manner. In 2019, the Texas Association of Promotores & Community Health Workers (TAPCHW) was created with the mission to “support and expand opportunities for the CHW profession at the state and local level through advocacy, education, employment, empowerment, and policy.” There is no formal connection between the regional association, TAPCHW and the Texas Department of State Health Services.

CHW/P Allies

Several organizations play a role in convening members of the CHW/P workforce to provide professional development and advocacy support. For example, the National C3 Council (C3 Council) is based out of Texas Tech University Health Sciences Center and is composed of CHW/P and allies, researchers and advocates. The C3 Council works to foster unity within the field and enhance the visibility of this workforce. It developed a nationally-recognized, consensus based set of CHW/P roles and core competencies that is broadly adopted, including by the Centers for Medicare and Medicaid Services, which referenced C3 in its Medicare payment rule on

Community Health Integration (CHI) services.⁵⁶ Another CHW/P ally organization is the Responsive Trust Network, based out of the University of Houston Community Health Workers Initiative, which aims to support CHW/Ps and their community partners in Houston through research opportunities, training and mentorship.⁵⁷

Populations and Communities Served by CHW/P

CHW/Ps serve diverse populations, including individuals with chronic diseases, behavioral health needs,⁵⁸ mothers and children, those facing social barriers, individuals in rural communities, the uninsured, and more.⁵⁹ A 2021 survey of Texas CHW/P employers offers insight into the needs of individuals served by CHW/Ps and the services they receive. The most common health challenges are diabetes (67.9%), hypertension (57.7%), and mental and behavioral health challenges (55.1%). These populations also face multiple, non-medical barriers to health, including: transportation (89.7%), lack of health insurance (89%), need for connection to health resources (87.7%). Other significant barriers are limited English skills (80%), food insecurity (75.5%), housing (74.8%), and homelessness (56.8%).⁶⁰

Certified CHW/P Training Centers

Texas was the first state to establish a statewide, voluntary CHW/P training and certification program in 2001. The establishing law requires certification for paid CHW/Ps.⁶¹ The Department of State Health Services' (DSHS) Community Health Worker (CHW) or Promotor(a) Training and Certification Program oversees training and certification of CHW/Ps, CHW/P Instructors (CHWIs) and training centers.⁶² As of early 2026, 66 DSHS-certified training programs operated in 21 counties across the state, run by a variety of entities including academic institutions, Area Health Education Centers (AHECs), federally qualified health centers (FQHCs), health systems, community-based organizations (CBO), and health plans.⁶³

CHW/P Employers/Service Providers

As of 2024, the largest employers of CHW/Ps in Texas were health care entities (17.5%; including clinics, hospitals and emergency services), community health centers (16.7%), CBOs (12.6%), and educational institutions (11.3%).⁶⁴ Payers accounted for 9.5% of CHW/P employment, and social/community services accounted for 8.8%. Notably, 52% of CHW/Ps were not working with a clinical team, reinforcing their position in the community but potentially making it more challenging to tap into clinical payment sources.⁶⁵

Academic institutions

Academic institutions across Texas serve as important sites for CHW/P training, employment, research and advocacy. Examples of institutions that have approved CHW/P training programs and/or robust CHW/P initiatives include the University of Texas at Tyler, Dallas College, University of Houston, Texas Tech University, University of Texas Health Science Center at Houston, the University of North Texas Health Science Center, University of Texas at Arlington, and Texas A&M, University of Texas Health San Antonio, Texas Southern University.⁶⁶

State government

Two state agencies play a central role in development and implementation of policies impacting the CHW/P workforce. The DSHS Community Health Worker (CHW) or Promotor(a) Training and Certification Program oversees training and certification, CHW/P instructors (CHWIs) and CHW/P training centers. A statewide CHW Advisory Committee (2011–2025) previously advised DSHS, providing CHW/P leaders with a formal voice in workforce policy. Following its disbandment in late 2025, DSHS is in the process of establishing a new partnership model (Texas CHW Partnership). The Health and Human Services Commission (HHSC) is the single state Medicaid agency, responsible for administering the Medicaid program. In this role, HHSC oversees all aspects of the new CHW/P Medicaid benefit, including benefit design, reimbursement, provider enrollment and managed care contracts.

Payers

A range of Medicaid, Medicare, commercial and employer sponsored health plans operate across Texas, including national and local payers. In a 2025 survey of Medicaid MCOs in Texas, most plans reported employing CHW/Ps.⁶⁷ Some plans run certified training programs, employ CHW/Ps, and support CHW/P research and program implementation. For example, Aetna and United Healthcare contributed funding to implement the Texas Pathways Community Hub (PCH) program.⁶⁸ Other payers, including Cigna,⁶⁹ have funded community-based CHW/P initiatives.⁷⁰

Funders

Private foundations have invested in Texas CHW/P programs, evaluation and advocacy. Investment by large foundations—including the Houston Endowment, St. David's Foundation, and Methodist Healthcare Ministries of South Texas—demonstrate a strong, growing recognition of the CHW/P workforce's vital role across the state.

B. Texas CHW/P Financing

Financial sustainability is a critical challenge for CHW/P programs in Texas. Historically reliant on braided funding approaches, CHW/P programs continue to struggle with funding despite expanding payment models and reimbursement opportunities. Over 50% of CHW/P employers identified long-term financing mechanisms as a key workforce development need in a 2021 survey.⁷¹ A 2024 survey found similar results: 54% of CHW/P respondents had grant funded positions.⁷² These findings were echoed in key informant interviews.

Financing strategies vary significantly among CHW/P employers and are dependent on the entity type (e.g., CBOs, FQHCs, health systems, academic institutions, etc.) and size, population served and services provided. This section outlines the non-grant-based or timeline-limited financing mechanisms available in Texas, examining both successful use cases and implementation challenges.

Medicaid Coverage

In 2023, Texas' legislature enacted several bills to expand Medicaid coverage for CHW/P services. Most notably, House Bill (HB) 1575 established case management services for children (up to age 20 with a health condition or at risk of a medical condition, illness or injury) and high-risk pregnant women (CPW) to address non-medical needs.⁷³ The law allows DSHS-certified CHW/Ps to enroll as Medicaid providers and serve as "case managers" able to provide these services to the CPW population.⁷⁴ A 2025 Milliman report estimated that between 2019 and 2021, 31%-37% of 410,152 pregnancies covered by the Texas Medicaid managed care program were high risk.⁷⁵

Also in 2023, legislators enacted HB 113, allowing Medicaid managed care plans (MCOs) to categorize CHW/P services as quality improvement activities for Medical Loss Ratio (MLR) calculations, enabling funding for CHW/P services to count toward care rather than administrative overhead.⁷⁶

Although HB 1575 created a Medicaid payment pathway for CHW/P services, significant implementation challenges limit its impact. Key barriers identified by informants (and reiterated in a survey of health plans)⁷⁷ include:

- Provider Enrollment Complexity. Despite technical assistance from CHW/P associations, training centers and funders, CHW/Ps and their employers face significant challenges with the complex and lengthy Texas Medicaid & Healthcare Partnership (TMHP) provider enrollment process, which often requires back and forth with the state.

- Infrastructure Limitations. Reimbursement favors institutions with existing billing infrastructure and staffing capacity to support CHW/P provider enrollment (e.g., FQHCs) and disadvantages community-based programs that have not traditionally billed for services (e.g., CBOs).⁷⁸
- MCO Contracting Challenges. CHW/Ps have had difficulty contracting with Medicaid MCOs who may view CHW/P services as duplicative of other covered services.⁷⁹

Medicare Billing

In 2024, Medicare began reimbursing for CHW/P services using Community Health Integration (CHI) codes. Although limited data exists on uptake of these codes in Texas, they offer programs serving Medicare populations an opportunity to generate additional revenue.

Payer Initiatives

A 2024 study found that payers account for 9.5% of CHW/P employment, signaling growing payer investment in the workforce.⁸⁰ A 2025 survey of Medicaid MCOs in Texas found that most plans reported employing CHW/Ps.⁸¹ For example:

- Aetna Medicare runs a CHW/P program that serves Medicare members post-discharge with the goal of preventing readmissions.⁸²
- An Elevance Health-affiliated Medicaid plan runs a CHW/P program that aims to improve health and quality for Medicaid members who could benefit from additional support. An evaluation of the program found it successfully increased appropriate outpatient utilization.⁸³
- A number of payers, including Cigna,⁸⁴ Community First,⁸⁵ and United HealthCare⁸⁶ have funded community-based CHW/P pilots, but this funding has largely been time-limited.

Evolving Financing Strategies

CHW/P programs have historically relied on braided funding (a mix of grant funding, dedicated operational dollars, and hospital community benefit dollars, among other sources) and these approaches continue to evolve.

Key informants shared examples of organizations transitioning programs away from time-limited sources to operational budgets. Baylor Scott & White, for example, used Medicaid Section 1115 Demonstration Waiver funding to support its CHW/P program and moved it into its core operating budget after recognizing significant patient benefits. One FQHC initially used grant dollars to fund a behavioral health CHW/P and then built the program into the clinic's core budget.

One CBO that relies primarily on grant funding has developed a successful approach to ensuring financial sustainability through training its CHW/Ps to work across programs, allowing for staff reassignment if specific program funding ends.

Key informants also provided recommendations to expand funding and sustainable financing for the CHW/P workforce and programs in Texas. Recommendations include:

- Expand Coverage and Payment for Services. The scope of covered CHW/P services should be expanded to include more services and populations. Recommended strategies included a Medicaid state plan amendment and integration of expanded CHW/P services by more payers. Even where Medicaid coverage exists, challenges are impeding uptake. Informants emphasized the need to ensure policies and systems are designed to enable reimbursement to reach CHW/Ps delivering services across a range of settings (e.g., CBOs, FQHCs).
- Demonstrate the Value-Proposition of the CHW/P Workforce and Programs. To secure sustainable, multi-stakeholder funding requires clearly demonstrating the CHW/P value proposition. This means leveraging national and Texas-specific evaluations of CHW/P impact on outcomes, cost and return on investment (ROI) to build a sector-specific business case (e.g., distinct for health systems, payers, and funders). Quantitative data should be paired with compelling qualitative examples of the unique role CHW/Ps play with the individuals and communities they serve.
- Sustain Funding for Core CHW/P Functions. Blended funding from public health, community-based sources, and philanthropy will continue to be important for populations (e.g., uninsured) and services (e.g., transportation) not covered by existing payment models. Some interviewees emphasized that sustainable funding models should take these into account.

Financing Takeaways - Promising Practices and Barriers

- New funding approaches are emerging (e.g., the Medicaid CPW benefit and Medicare billing codes), but financial sustainability remains a significant challenge for CHW/P positions and programs, and reimbursement alone is insufficient. Policy refinement and infrastructure investment should address operational challenges that impede

CHW/P providers and programs from accessing funding (e.g., complex provider enrollment, contracting difficulties, and a narrow scope of benefits).

- Diversified strategies that include multiple payers and providers offer promise. Expanded engagement with payers and health systems should focus on identifying best practices that can be scaled, such as integrating CHW/Ps into value-based initiatives. At the same time, community-based and/or small CHW/P programs face unique challenges to unlocking reimbursement and partnering with payers. This should be considered in strategies to support and sustain the workforce.
- Evidence demonstrates CHW/P impact. To cultivate expanded financial commitment from payers, health systems, academic institutions, funders, and others, a customized business case may be required. Business cases should be explicit about the CHW/P role and opportunities to improve sector- or organization-specific outcomes, costs and ROI.

C. Texas CHW/P Workforce Development and Support

Although Texas has prioritized CHW/P training and certification, surveys and key informant interviews reveal persistent gaps in ongoing workforce development and support.⁸⁷

Certification

Texas was the first state to formalize CHW/P certification.⁸⁸ The process, overseen by DSHS' Community Health Worker (CHW) or Promotor(a) Training and Certification Program, requires completion of a DSHS-certified, 180-hour (previously 160 hours) competency-based training program or having at least 1,000 cumulative hours of services within the last three years.

Certification is recognized as a key strength of the Texas CHW/P workforce, defining a professional scope of practice and core competencies. However, informants voiced a critical concern: despite criteria alignment with the C3 Council standards, individuals who are not "authentic CHW/Ps" are gaining certification. Without guardrails to ensure community connection and accountability, the certification process risks failing its intended purpose and moving the workforce away from its core, community-embedded practice.

Key informant interviews highlighted the following emerging challenges with DSHS certification and practices.

- Gaps in CHW/P Voice in Policy Development. Between 2011 and 2025, DSHS was advised by a statewide Promotora and CHW Training and Certification Advisory Committee,

enabling CHW/P leaders to provide input on certification, regulation, employment, funding and sustainability impacting the workforce.⁸⁹ DSHS disbanded the CHW Advisory Committee at the end of 2025, eliminating the formal channel for CHW/P leaders to provide policy input. Although DSHS is convening a new body (the Texas CHW Partnership (TX CHWP)), this change raised stakeholder concerns about the future role of CHW/P voices in policy development.⁹⁰ As of May 2026, DSHS was accepting applications for the TX CHWP, but next steps and timelines were not publicly available.

- Updated Core Competency Requirements.⁹¹ In February 2026, DSHS expanded the CHW/P competency-based training to 180 hours, adding "Evaluation and Research Skills" to align with C3 standards.⁹² Key informants reported mixed reactions to this change. In general, certified training centers affiliated with academic institutions see this as enhancing credibility and CHW/P participation in research, while smaller or community-based centers are concerned about the capacity to comply.
- Administrative Delays in Certification. Key informants reported significant delays in DSHS review and approval of training center curriculums and individual CHW/P certifications. One training center reported waiting over 6 months for a decision on training curriculum updates. These delays create widespread negative effects: disrupting training center revenue, threatening employment for CHW/Ps who have completed training, and impeding employer program expansion.
- Focus on Certification without CHW/P Job Creation. Interviewees indicated that certification has not resulted in employment, highlighting a critical mismatch between investment in certification and creation of new CHW/P positions and programs. For example, a 2022-2025 influx in federal funding⁹³ increased the number of certified CHW/Ps but failed to support new jobs.⁹⁴ This lack of job opportunities risks causing authentic CHW/Ps to leave the profession.

Support for the CHW/P Workforce

Low compensation, inadequate supervision and limited professional development are critical challenges threatening the sustainability and retention of the Texas CHW/P workforce.

A joint initiative by the Health Equity Collective (HEC) and the Houston Health Department engaged local stakeholders to identify key workforce barriers. Major issues identified included unstable grant-based funding, low pay, poor integration of CHW/Ps into clinical teams and a lack of specialized training or clear career advancement pathways.⁹⁵ Other surveys and key informant interviews echo HEC's findings, reinforcing the need to address the following challenges.

- Low Compensation. Texas CHW/P salaries are among the lowest in the country, posing a significant challenge to workforce sustainability.⁹⁶ In 2024, the mean annual salary in Texas for CHW/Ps was \$48,500, compared to \$55,970 at the national level.⁹⁷
- Gaps in Standards and Training for Supervision. Employer surveys and key informant interviews highlight a strong need for role-based training and clear standards for CHW/P supervisors. A 2021 survey of employers found that approximately 45% reported a need to train supervisors and 46% reported the need for training on the CHW/P role and its benefits to clients and care teams. The same survey found that nearly 30% of employers had limited or no capacity to apply supervision standards.⁹⁸ Key informants reiterated these findings. They shared that employers and colleagues often lack awareness of the role of CHW/Ps and what they do. This is particularly pronounced when CHW/Ps are embedded in clinical or academic settings.
- Limited Professional Development and Career Pathways. Workforce development gaps threaten retention and sustainability. In the 2021 survey, CHW/P employers identified a need for specialized continuing education (52%) and training to develop new or reinforce initial skills (56%). Nearly 70% of employers reported limited capacity to develop career pathways for CHW/Ps.⁹⁹ Key informants reiterated this, citing the need for greater job security and for more employers to invest in career ladders and workforce retention strategies.

Despite systemic gaps, several Texas programs demonstrate best practices for career growth and retention. Baylor Scott and White instituted career advancement opportunities for CHW/Ps, with three levels for the CHW/P role. The organization also has a CHW Development Council.¹⁰⁰ El Buen Samaritano in Austin has three levels of the CHW/P role and a compensation floor for these positions. The Williamson County Pathways Community Hub offers ongoing CHW/P professional development that includes monthly training on topics including mental health, first aid and clinical screenings.¹⁰¹

Operational Capacity

Key informant interviews and the literature indicated significant variation in CHW/P program infrastructure. Informants reported that CHW/P programs frequently lack systems to support:

- workflows that enable effective service delivery and documentation (e.g., screenings, care management, coordination and referrals);
- standardized data collection, reporting and evaluation; and
- provider enrollment, MCO contracting and claims submission.

These functions are critical to deliver high-quality, standardized client services, evaluate program impact and unlock sustainable financing for CHW/P programs.

One key informant reported that maintaining data collection and reporting systems requires significant financial resources, and funders rarely cover administrative expenses. This creates a challenge for many CHW/P organizations seeking to track and demonstrate impact. Another reported challenge is that data collection and evaluation often omit the patient-centered aspects of care that CHW/Ps provide, such as person-centered assessment, goal setting, outreach and follow-up and support meeting social needs. Another challenge mentioned in interviews is limited access to telehealth, broadband and tools (e.g., laptops, ipads, phones) that enable CHW/Ps to connect with other members of the care team or resources (e.g., food supports) in real time. This is particularly critical in rural areas.¹⁰²

Workforce Development and Support Takeaways - Promising Practices and Barriers

- Recent challenges (e.g., delays in CHW/P and training program curriculum certification and the disbanding of the CHW Advisory Committee) have created barriers to entry, threatened training programs, and caused uncertainty about CHW/P policy input. CHW/P leader engagement is critical to developing policies and programs that strengthen, support and sustain the workforce.
- Although Texas leads in CHW/P certification, certification does not translate into job opportunities or sufficient compensation and enables individuals who may not be authentic CHW/Ps to become certified. To sustain the workforce requires moving beyond certification to scale promising practices for supervision, career pathways, and retention strategies. Beyond training supervisors, educating care team members (e.g., clinicians, social workers) on the CHW/P role can ensure that CHW/Ps practice within their scope and clinicians practice at the top of their license.
- Limits in organizational infrastructure (e.g., technology, data systems, standardized workflows, billing systems) impede the effective and sustainable delivery of high-quality service.

5. Overview of the National CHW/P Landscape

A. National CHW/P Ecosystem

Nationwide, the CHW/P workforce is expanding, fueled in part by demonstrated impact on health outcomes and innovative financing.

As of 2024, there were 65,100 CHW/Ps in the US, a number projected to increase by 11% by 2034. This workforce is embedded across sectors, with the largest U.S. employers being ambulatory healthcare services (21%), social service providers (20%), and local government (18%). Hospitals and religious, grantmaking, civic and professional organizations each employed about 10% of the workforce. As of March 2026, approximately 30 states had integrated CHW/P coverage into their Medicaid programs, and, in 2024, Medicare began paying for CHW/P services for the first time through new CHI codes.

An analysis of national trends, including successful strategies and systemic hurdles, is vital to shaping stakeholder engagement and building a scalable, sustainable CHW/P strategy for Texas.

B. National CHW/P Financing

While CHW/P programs historically relied on braided, often time-limited funding from federal, state, and philanthropic sources, more funding strategies are emerging through Medicaid and Medicare reimbursement and integration of CHW/Ps into payer initiatives and value-based payment models.

Medicaid

Over half of states covered some CHW/P services under their Medicaid programs as of March 2026.¹⁰³ These efforts are often part of state strategies to extend the reach and capacity of the health care workforce, improve population health outcomes and reduce costs. States typically implement coverage through a State Plan Amendment (SPA), MCO contracts, or a Medicaid Section 1115 Demonstration waiver.¹⁰⁴ A number of states, like California, Oregon, New Mexico and Washington, use multi-pronged approaches to coverage and payment and combine a SPA, MCO contract requirements, and a Section 1115 waiver.

State Plan Amendments (SPA)

At least 20 states have an approved SPA authorizing Medicaid payment for a defined set of CHW/P services for a specific population.¹⁰⁵ SPAs integrate covered services into state Medicaid benefits and create fee-for-services (FFS) billing codes that can also support MCO capitation rate development.

SPAs for CHW/P services vary from limited to more comprehensive policies. For example, Georgia's SPA covers CHW/P services for a narrow population (e.g., individuals with mental illness and substance use disorders), which limits access to a small subset of the Medicaid beneficiaries who would benefit from CHW/P services.¹⁰⁶ In contrast, New Mexico's SPA is broad, covering CHW/P provided health promotion/coaching, health systems navigation, and clinical support (e.g., supporting compliance with medical treatment plans, providing feedback to medical providers and coordinating care) to most Medicaid-eligible individuals.¹⁰⁷ To further support access, New Mexico has a standing order that grants CHW/Ps more autonomy, enabling them to provide covered services without a provider order. This is crucial for CHW/Ps to reach individuals who lack a regular source of care or face barriers to appointments.¹⁰⁸

CHW/P benefit design and payment operations matter and can have big impacts on service accessibility.¹⁰⁹ For example, a study of Medicaid billing across nine states found low uptake of CHW/P billing and cited barriers such as complex provider enrollment and billing processes, delays in payment and payment levels that are too low to support the workforce and program sustainability.¹¹⁰ In South Dakota, the state experienced slow uptake in billing after implementing coverage. In response to feedback from CHW/Ps and employers, the state increased reimbursement rates.¹¹¹ However, in 2025, only 1,250 Medicaid beneficiaries received reimbursed CHW/P services (approximately 1% of the state's Medicaid population), indicating barriers to access may still be an issue.¹¹²

MCO Contracts. About 20 states, some of which also have a SPA, require or encourage Medicaid MCOs to integrate CHW/P services into care for members.¹¹³ This approach offers states flexibility and does not require the same process or oversight as a SPA or a Section 1115 waiver (see below). While MCO requirements can drive accountability at scale, their effectiveness hinges on contract design and whether states mandate CHW/P integration.¹¹⁴

Oregon's Coordinated Care Organization (CCO) contract offers a promising approach. The state requires CCOs to integrate CHW/Ps (referred to as Traditional Health Workers (THW)) into care delivery and develop sustainable payment strategies for this workforce. The Oregon Health Care

Authority helps CCOs build organizational capacity to deliver THW services through adoption of best practices: contracting with CBOs that employ THWs, ensuring THW support and supervision, and clarifying the THW scope of practice. CCOs are also required to collect data to measure THW integration and utilization.¹¹⁵ Nevada's Medicaid MCO contract enables CHW/Ps to serve as Care Coordinators for certain lower-risk plan members. This moves beyond simply covering CHW/P services to recognizing the CHW/P role as part of the care team.¹¹⁶

Section 1115 Waivers. Fifteen states have integrated CHW/P services or programs into Section Medicaid Section 1115 Demonstration Waiver initiatives.¹¹⁷ These waivers enable states to fund services not otherwise permitted under Medicaid statute. However, they are not a viable option for long-term sustainability because they are time-limited, require federal approval and must be budget neutral.¹¹⁸ Although some states (including Texas) used Delivery System Reform Incentive Payment (DSRIP) and Health-Related Social Needs (HRSN) waivers to expand the CHW/P workforce, the current administration will not approve these types of waivers.¹¹⁹ A recently emerging trend is inclusion of CHW/Ps in re-entry initiatives piloted under waivers. As of October 2025, seven states incorporated CHW/P services into pre-release services for incarcerated individuals through a Section 1115 waiver.¹²⁰

Medicare

In January 2024, Medicare began reimbursing for CHW/P services through new CHI codes.¹²¹ Under these codes (G0019 and G0022), CHW/Ps provide crucial support to Medicare beneficiaries with a non-medical upstream driver that a provider has identified as a barrier to diagnosis or treatment of an illness or injury. CHI services include person-centered assessment, health navigation, behavioral change support and health education.¹²² While the introduction of CHI codes is a promising development for the CHW/P workforce, initial uptake has been slow.¹²³ A study that examined Medicare reimbursement for HRSN services in the first year they were available reported low utilization, including high denial rates for CHI claims (a 28% denial rate) with Medicare approving only 41,362 claims. The study authors suggest complex documentation requirements and lack of established, standardized workflows for CHW/Ps as potential causes.¹²⁴

One strategy emerging to boost utilization of CHW/P codes is alignment of Medicaid and Medicare codes. As of March 2026, states like California, Minnesota and Washington have adopted Medicare CHI codes within their Medicaid programs.¹²⁵

Federal Funding

Although federal funding opportunities for the CHW/P workforce have expanded, they tend to be short-term. This can be a great opportunity for building CHW/P infrastructure, but their time-limited nature means they aren't well-suited for long-term sustainability. One recent federal policy that is directing resources to the CHW/P workforce and programs is HR 1, which Congress passed in July 2025. HR 1 established the Rural Health Transformation Program (RHTP) and allocated \$50 billion in federal funding. Nearly 40 states plan to invest RHTP funds in the CHW/P workforce through initiatives ranging from expanding training to integrating CHW/Ps into value-based models.¹²⁶ Separately, several states have leveraged Opioid Settlement Funds for CHW/P initiatives, such as expanding peer-led recovery services in rural communities, strengthening engagement and retention in outpatient opioid treatment services and implementing mobile outreach programs.¹²⁷

It is important to note that often federal funds are used to support workforce expansion by funding CHW/P positions or training. However, these efforts are not sustainable unless the investment includes long-term infrastructure (e.g., systems for billing, data collection, evaluation, professional development and program quality). Without this, funding often fails to create lasting programs or retain the CHW/P workforce.

State Funding

Some states are allocating state funds to expand CHW/P programs, often as a preparatory step for permanent policies like a SPA or MCO contract requirements. For example, Tennessee allocated \$8 million for 2-year grants to build CHW/P employer infrastructure. This investment scaled IMPaCT's evidence-based model to 14 programs across the state and established a partnership with the Tennessee Community Health Worker Association (TNCHWA) to develop and oversee CHW/P program accreditation standards for quality and long-term sustainability. The state plans to leverage RHTP funds to expand accredited programs to rural communities.¹²⁸

Payer Initiatives

Payer investment in CHW/P programs is a growing trend. While information on the scope of payer-supported CHW/P initiatives is limited, examples of major payers employing CHW/P programs to improve outcomes and control costs include Kaiser Permanente, Cigna and Aetna.

Kaiser Permanente, in partnership with IMPaCT, launched an evidence-based CHW/P initiative in the Pacific Northwest targeting members in low-income zip codes. After a three-month CHW/P intervention, members had fewer hospital days, increased engagement in primary care and more

screenings for social needs.¹²⁹ As of 2025, Kaiser Permanente is scaling CHW/P programs to additional geographic areas.¹³⁰ Cigna operates a CHW/P pilot in high-risk communities in Memphis and Houston, focusing on members with diabetes. Members are paired with CHW/Ps who help them set personalized goals and connect with resources to meet social determinants of health needs like food and transportation. Participants have shown improvements in A1C, blood pressure and weight.¹³¹ Aetna integrates CHW/Ps into an initiative focused on closing Healthcare Effectiveness Data and Information Set (HEDIS) care gaps and reducing readmissions for Medicare Advantage beneficiaries.¹³²

Value-based Payment Initiatives

States, payers and providers can integrate CHW/Ps into value-based models to improve outcomes and reduce costs. For example, the Center for Medicare and Medicaid Innovation's Transforming Maternal Health Model (which aims to improve access, outcomes and cost control for mothers and newborns) encourages state Medicaid programs to integrate CHW/Ps to enhance access and whole-person care.¹³³

Financing Takeaways - Promising Practices and Barriers

- New financing approaches for CHW/P services are emerging, but insufficient reimbursement rates and difficulties in adopting Medicaid or Medicare billing codes show that reimbursement alone cannot sustain the workforce or programs.
- Short-term state and federal funding supports time-limited investments in the CHW/P workforce (e.g., hiring, training, program start-up). However, there must be longer-term strategies that include funding for infrastructure (e.g., systems for billing, data collection, evaluation, professional development and program quality) to ensure sustainability.
- Payer investment in CHW/P programs is growing and presents an opportunity to scale the workforce and ensure long-term program sustainability.
- Value-based models offer opportunity for CHW/P integration into team-based care given CHW/Ps can improve outcomes, quality and reduce costs.

C. National CHW/P Workforce Development and Support

As CHW/P initiatives expand, stakeholders (including states, payers, health systems, CBOs and others) are implementing strategies to support the workforce and ensure CHW/P program quality. This requires engaging CHW/Ps in program and policy development, cultivating a community-aligned workforce (e.g., CHW/Ps who come from the communities they serve), and establishing program guardrails to sustain quality and the workforce (e.g., training, supervision, clear career pathways).

CHW/P Leadership in Policy and Program Development

CHW/P associations and leaders must be engaged in policy and program design to ensure that initiatives are developed with the workforce in mind and are able to achieve intended outcomes.

One example of successful CHW/P association partnership with state policymakers is Michigan, where the Michigan Community Health Worker Alliance (MiCHWA) oversees the Michigan Medicaid CHW Registry, a database of CHW/Ps that meet the state's Medicaid qualification standards.¹³⁴ MiCHWA leaders also serve as advisors to the state via the state's CHW Subcommittee and Advisory Council. In this capacity, MiCHW helps develop recommendations for the Michigan Department of Health and Human Services on CHW/P workforce support.¹³⁵ Similarly, the Oregon Community Health Workers Association participates in the state's THW Commission, advising the Oregon Health Authority on THW-related policies.¹³⁶

CHW/P Certification

As of March 2024, approximately half of states had established or were developing CHW/P certification programs.¹³⁷ Many states use a multi-pronged approach to certification, allowing CHW/Ps to achieve certification through training completion or documented work experience.¹³⁸ While certification is voluntary in some states, Medicaid reimbursement for CHW/P services is often contingent upon it. State approaches to oversight vary: some states (e.g., Massachusetts, Texas and Oregon) delegate oversight to a state health department or agency, while others (e.g., Indiana, North Carolina and Arizona) assign this role to the CHW/P association or a certification board, placing oversight outside of government.¹³⁹

Evaluations of the impact of certification are mixed. One study showed that CHW/P employers in states with certification programs are significantly more likely to adopt nationally recognized occupational standards, skills and roles into their hiring practices.¹⁴⁰ However, another study concluded that certification requirements do not significantly improve program quality.¹⁴¹ Other

research suggests that certification may reinforce pay inequalities between male CHW/Ps and CHW/Ps of color or women.¹⁴²

It is critical to ensure these standards do not create a barrier to entry for authentic CHW/Ps and that they support adoption of nationally recognized, consensus-based CHW/P core competencies.

CHW/P Program Accreditation

An emerging approach to ensuring program quality is adoption of consensus-based, CHW/P program accreditation standards.¹⁴³ Accreditation assesses whether CHW/P programs adopt best practices for supporting the workforce. These practices include: hiring CHW/Ps based on lived experience, clearly defining their role, offering comprehensive training and professional development, and providing regular supervision from a manager who deeply understands the CHW/P's role.¹⁴⁴

In 2023, Tennessee became the first state to implement CHW/P program accreditation standards. TNCHWA partnered with the National Committee for Quality Assurance (NCQA) and the state's Medicaid program to develop standards for CHW/P employers. TNCHWA serves as the accrediting body, ensuring that CHW/P employers meet standards across seven elements.¹⁴⁵ As of February 2026, nine programs across seven organizations had achieved accreditation.

URAC, an independent organization that accredits healthcare organizations to ensure quality, safety and compliance, also released national accreditation standards for CHW/P programs in 2024.¹⁴⁶ As of the program's second year, only Jefferson Health (a Philadelphia-based nonprofit health system) had achieved URACs accreditation. In 2025, NCQA proposed integrating evidence-based CHW/P programs into its Health Outcomes Accreditation and Community-Focused Care Accreditation programs for health care organizations.¹⁴⁷ As of the end of 2025, both the C3 Council and the National Association of Community Health Workers (NACHW) were discussing or planning the development of accreditation processes.¹⁴⁸

Workforce Development and Support Takeaways - Promising Practices and Barriers

- There must be a clear role for CHW/P associations and/or CHW/P leaders in state policy making and program development. This will ensure integration of the CHW/P perspective.
- CHW/P credentialing and certification requirements should not create barriers to entry or inequities within the workforce. State and CHW/P leaders should watch for unintended consequences of these policies and develop strategies to sustain CHW/P positions and programs beyond initial training.
- Accreditation is gaining traction as a mechanism for CHW/P employers to implement best practices, which supports workforce sustainability and the delivery of high-quality CHW/P programs (e.g., hiring, supervision and professional development).

6. A Draft Strategic Framework for Sustaining and Scaling CHW/Ps Across Texas

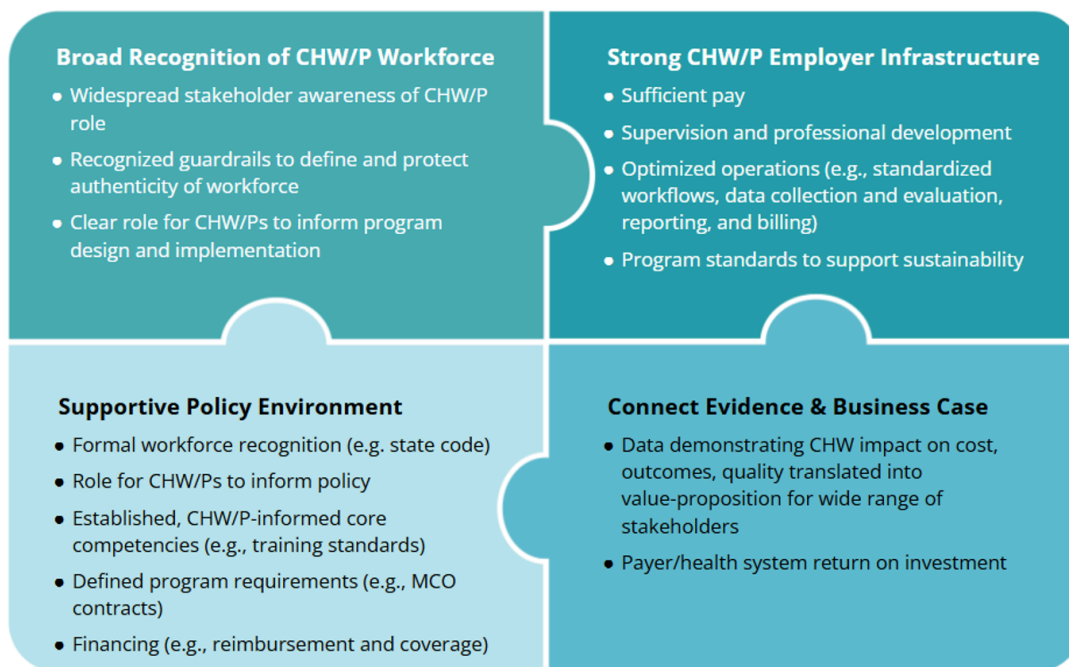
Texas' CHW/P workforce has grown significantly over the last six decades. A review of the Texas landscape identified barriers that should be addressed and promising practices that could be scaled as part of a strategy to support, strengthen and sustain the CHW/P workforce.

Draft Systems-Level Framework to Support, Strengthen and Sustain the CHW/P Workforce

Together, learnings from the Texas and National landscape reviews identify system level factors for long-term CHW/P sector success. These factors span four focus areas: a supportive policy environment, broad recognition of the CHW/P workforce, strong CHW/P employer infrastructure, and connecting evidence to the business case.

Figure 1 presents this framework as a roadmap to guide EHF and stakeholders in aligning on priorities and developing a strategic plan to strengthen the CHW/P sector's long-term reach and impact across Texas.

Figure 1. Draft Systems-Level Framework to Support, Strengthen and Sustain the CHW/P Workforce



7. Moving Forward

The CHW/P workforce is essential to improving the health of Texans, but systemic barriers limit its reach and impact. More is needed to support, strengthen and sustain Texas' CHW/P sector at scale. The systems-level framework presented in this report, based on Texas's current strengths and identified gaps, offers a draft roadmap for achieving lasting success.

To translate these findings into a unified strategy, key stakeholders—including CHW/P leaders, employers, payers, government officials and funders—can refine this framework to develop aligned priorities and a shared vision. The landscape findings, and draft strategic framework lay the foundation for this work.

Acknowledgments: The review of the Texas landscape was informed by interviews with 13 CHW/P leaders, allies and policy and technical experts. We thank them for their time and willingness to share their expertise and perspective.

Endnotes

1. This workforce includes community health workers, promotores, community health representatives, peer navigators and more.
2. A CHW/P is defined by AHPA as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.” Community Health Workers
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