Systems Change to Support a Community Health Workforce

APRIL 2026

EPIC
Evans Policy Innovation Collaborative
UNIVERSITY of WASHINGTON

ABOUT THIS REPORT

This project began with a central question: *What promising approaches or tools can meaningfully improve persistent health disparities in Washington State?* In late 2024, we partnered with University of Washington's Population Health Initiative to find out. A literature review, field interviews, and a design workshop with public health leaders from across the state pointed towards a clear opportunity: strengthening the systems that support and scale a community-based workforce. What followed was 18 months of learning alongside the field. Significant changes caused by federal executive actions and corresponding alterations in state administrative and service strategies happened throughout this period, which altered our initial plans for research and program design. This report documents that journey.

The Evans Policy Innovation Collaborative (EPIC) is a policy lab at UW's Evans School of Public Policy & Governance that partners with communities, organizations, and government to design, test, and scale policy innovations for the public good. Our process blends statewide policy analysis with deep, community-engaged inquiry.

In this effort, we collaborated with regional Accountable Communities of Health (ACHs), public health leaders, and community-based workers (CBWs) themselves, combining rigorous research with deep, sustained engagement to understand what's working, what's missing, and where systems change is most possible. This meant listening to frontline workers, examining county-level data, and mapping policy changes to understand what it looks like when community-based health prevention work is done well and what gets in the way.

Human-centered design (HCD) drives every step of the EPIC process, emphasizing iterative learning, trust-building, and honoring frontline expertise. By nature, HCD is iterative and organic, requiring collaborators to learn and build along the way rather than prescribe predetermined solutions. Each conversation opened new doors and raised new opportunities, building a richer picture of the complex and dynamic field over time. This meant shifting away from extractive research models toward a partnership model that shares knowledge back with communities in real time. An overview of our process and timeline is included in Appendix A. The result is this report that aims both to describe Washington's CBW ecosystem during this period and illuminate pathways for strengthening it.

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This work was generously supported by an internal grant from the University of Washington's Population Health Initiative.

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OVERVIEW

Washington State's community-based workforce (CBW) plays a critical role in helping people navigate fragmented health and social systems. Through lived experience, cultural knowledge, and trusted relationships, CBWs can reach people that traditional systems often miss, including those facing homelessness, language barriers, or chronic illness. Yet our inquiry reveals a bifurcated approach to closing public health disparities: while CBWs continue responding to urgent and growing needs in the directly impacted communities on the frontline of our biggest health challenges, broader efforts to strengthen and transform this system have largely stalled amid federal funding cuts and shifting policy approaches. As a result, the policies, programs, and practices that support community-based health work remain unstable, underfunded, and misaligned with the complex realities of frontline practice, limiting the potential for CBWs to advance health equity across the state.

Over an 18-month period, the Evans Policy Innovation Collaborative (EPIC) partnered with statewide health leaders to better understand the gap between what CBWs make possible and what current systems allow. We found a workforce under increasing strain but deeply committed to continuing their work, even as conditions deteriorate. CBWs describe being asked to do more with fewer resources, often without a meaningful voice in decisions that shape their daily work conditions.

Without intentional, coordinated investment to connect system change efforts with frontline realities, Washington risks losing a workforce essential to health equity at the moment when communities need it most.

Across Washington, counties consistently identify mental and behavioral health, access to care, and housing instability as top preventative health priorities, closely aligning with the work CBWs are already doing in communities. Yet CBWs are rarely involved in defining health priorities or shaping local responses, missing a critical opportunity to ground public health strategies in frontline knowledge of community life.

CBWs describe their effectiveness as rooted in trust, relationships, and long-term engagement. They say success can look many ways, like a client securing housing, finally seeking care, or feeling understood for the first time. These outcomes matter deeply to communities but remain largely invisible within current funding, contracting, and evaluation systems. At the same time, policy shifts and the expiration of temporary funding streams have led to layoffs, shrinking teams, and widespread burnout, even as community needs continue to rise.

This report identifies three priorities for strengthening Washington's CBW ecosystem: (1) centering CBW voices in policy and implementation design, (2) building an evidence base that reflects frontline context, and (3) shifting policy incentives to support sustainable, community-rooted practice.

INTRODUCTION

Shorter lifespans. More preventable disease. Widening health gaps. According to data from the University of Washington's Institute of Health Metrics and Evaluation (IHME), these are the troubling trends facing future generations of Washingtonians if we fail to intervene.[1] Communities most affected — including low-income households, rural communities, New Americans[2], communities of color, military veterans, and LGBTQ+ individuals — are encountering growing gaps in both social and clinical support. At the same time, federal and state policy changes have destabilized the systems intended to promote broader access and wellbeing for all Americans.

State public health leaders have identified a promising solution: CBWs. These frontline workers include community health workers, promotores de salud, doulas, peer specialists, recovery coaches, and community-based social workers who connect residents to essential resources and reduce barriers created by fragmented systems. CBWs bring cultural, linguistic, and lived experience that enables them to reach people who are consistently underserved by the clinical system, operating at the intersection of communities and systems to bridge individuals and fragmented health and social services. However, even as demand for CBWs grows, the emerging workforce is experiencing shrinking funding, unclear and competing policy expectations, and limited structural support.

This report documents an unraveling field and a potential path toward strengthening it. Over 18 months, the University of Washington's Evans Policy Innovation Collaborative (EPIC) has partnered with state health leaders to explore the gap between the potential impact of community-based health work and its current reality. Throughout our research process, many participants faced job uncertainty, layoffs, reassignments, and shrinking teams as public health funding shifted. However, we witnessed a resounding commitment to this work and unwavering determination to expand services for communities in need. Drawing on statewide policy analysis, community convenings, interviews, reviews of county-level Community Health Needs Assessments (CHNAs) and literature, we highlight both the urgency and the opportunity to build sustainable, community-rooted systems so that every Washingtonian has access to the resources they need to improve their health and wellness.

For a glossary of specialized words, acronyms, and technical jargon used in this report, see Appendix B*.*

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[1] (IHME 2024; GBD 2021 US Burden of Disease Collaborators 2024)

[2] The term "New Americans" encompasses immigrants, refugees, temporary or long-term visitors, non-native English speakers, U.S.-born children of immigrants, and people who consider themselves new arrivals, regardless of documentation status or country of origin (see Flinner et al., 2019).

BACKGROUND

After losing her husband to suicide, she found a driving purpose: ensuring that no other military veteran would fall through the cracks. Today, she is the only community health worker at a veteran-serving nonprofit in Washington, where she spends her days connecting veterans in crisis to meals, housing, and the services that help them live fuller, healthier lives.

> *"I like to think that every day I have a success even if it is the tiniest thing," she said. "And sometimes it's even just listening... just hearing them and allowing them to feel validated in their story, in who they are. And showing up for them. I feel that, for me, is a success."*

She is one of thousands of CBWs across Washington doing work the formal health system often cannot — or will not — do. Research shows that Washington's community-based health workforce plays a critical role in advancing health equity by bridging the gap between individuals and fragmented health and social services. They see the communities they serve as neighbors rather than patients, allowing them to draw not just on technical knowledge but on shared experience and cultural connection to those underserved by traditional health systems. Evidence from the U.S. and globally shows this model works: CBW programs improve access to care, support chronic disease management, strengthen mental health outcomes, and reduce disparities for underserved populations.[3] Yet CBWs remain underutilized and under-resourced, and largely unseen by policymakers, creating conditions for their work to go unrecognized and unmeasured.[4]

This is not a new problem and Washington is not alone. Globally, CBWs have anchored primary health care for more than half a century. However, historians trace similar community-based preventative health practices as far back as ancient Egypt.[5] From China's "barefoot doctors" to large-scale national programs in Brazil, India, and Ethiopia,[6] sustained investment in community-based care has expanded access and improved population health at scale. The U.S. has taken a more fragmented approach, with uneven integration across clinical, public health, and community settings.[7] Research identifies persistent

[3] (Berini et al., 2022; Bush et al., 2023; Mistry et al., 2021; Portillo et al., 2020)
[4] (Hartzler et al., 2018; Bureau of Labor Statistics, 2025)
[5] (ILCHWA, 2025)
[6] (Perry, 2013)
[7] (George et al., 2020; Lohr et al., 2018; Love et al., 1997; Pinto et al., 2020)

implementation challenges: unstable funding, unclear roles, limited career pathways, and gaps preventing workforce growth and stability.[8]

Since 2015, Washington State has recognized CBWs as key to addressing widening health disparities,[9] launching task forces, training initiatives, and pilot programs aimed at deeper clinical integration. But these efforts have surfaced further tensions. Policies and funding prioritize standardized training and measurable outputs, while frontline practice emphasizes trust, relationship-building, cultural knowledge, and responsiveness to community-defined needs. These frontline practices are critical qualifications that are not easy to quantify and credential, and this has created conditions for high turnover, fragile infrastructure, and sparse understanding of what it takes for these workers to create meaningful impact.

The misalignment is most felt in the relationship between state policy and frontline practice. While state-level organizations like the Washington State Department of Health innovate to explore training pathways and app-based tools to support CBW efforts, they do so with no clear funding mechanism to develop and sustain these opportunities. At the same time, CBWs express frustration — the focus on innovation does not seem aligned to the "survival mode."

Meanwhile, certification debates continue to fracture the field, with growing concern that medicalized models privilege clinic-based practice and erode the community-rooted work that makes CBWs effective in the first place. The risk is a workforce shaped more by billing requirements than by community need. At the organizational level, Accountable Communities of Health (ACHs) — independent regional health care networks — emerged as central implementation hubs for piloting CBW workforce development, but performance mandates, administrative burden, and weak alignment with CBW needs limit their effectiveness in these settings. Even as ACH leaders express a genuine desire to better represent and support the workforce they coordinate.

The federal policy environment has made an already fragile situation worse. Recent federal actions have created major funding uncertainty for Medicaid-supported care, threatening roles that rely heavily on state and federal coverage pathways. More specifically, the "One Big Beautiful Bill Act" is projected to strip Medicaid coverage from 250,000 Washingtonians and ACA coverage from another 150,000, resulting in an estimated $3–5 billion in annual state funding losses.[10] The impact is uneven: clinic-based CBWs may have a bit more stability as the system resets under new conditions, while community-based CBWs integrated into social systems are at significant risk. Across Washington, ACHs, community-

[8] (Brown et al., 2020; Lapidos et al., 2019; Schmit et al., 2022; Westgate et al., 2021)
[9] (Community Health Worker Task Force, 2016)
[10] (Goldstein-Street, 2025; Ives-Rublee & Musheno, 2025; Santos, 2025)

based organizations, and state agencies are navigating workforce cuts, shifting priorities, and deepening uncertainty.

Meanwhile, demand for CBW services is rising as communities encounter growing barriers to care, especially in rural areas and among populations experiencing housing instability, economic insecurity, and unmet behavioral health needs. CBWs are increasingly relied upon to fill system gaps and provide continuity of care, yet the structures supporting their work are unstable.

Our collaborators have already felt the consequences of these trends in their communities. CBWs who spent years building trust in immigrant communities have been laid off, severing relationships that took years to establish and cannot be quickly rebuilt. The populations CBWs serve are absorbing the impact. As these workers disappear, so does the connective tissue holding fragile health and social systems together. Emergency departments see more preventable crises. Chronic conditions go unmanaged. Health disparities that CBWs were hired to narrow are widening again.

As statewide partners navigate funding cuts, workforce reductions, and shifting policy priorities, the need for a coordinated, community-aligned approach has never been clearer. We've found that CBWs remain a critical yet precariously supported pillar of Washington's health equity infrastructure.

STUDY DESIGN

This report draws on an iterative and organic mixed methods process designed to understand both the statewide CBW landscape and the lived experiences of the workers within it. Rather than treating these as separate inquiries, we explored them in tandem, with each informing and deepening the other. Our approach aimed to build a layered understanding of the CBW landscape across Washington State.

Research Methods

- Literature review
- Convenings
- Interviews
- Analysis of Community Health Needs Assessments

Methodologically, we used a Human-Centered Design (HCD) framework for this investigation; the work evolved iteratively given significant disruptions because of federal policy changes. During autumn 2024, we began with stakeholder interviews and hosted a design charette in November 2024 that brought together 40 cross-sectoral leaders. In total, we conducted 32 stakeholder interviews, including conversations focused on how CBWs define and evaluate their impact. We also hosted convenings with CBWs through Better Health Together's (BHT's) Community Based Worker Network in Eastern Washington to center the perspectives of those carrying out this community-based preventative health work. Finally, we analyzed Community Health Needs Assessments (CHNAs) from across Washington, primarily the 2021–2023 cycle, to

identify where CBW involvement is most needed, using the Social Determinants of Health (SDOH) Framework to connect county-level health priorities to evidence of CBW effectiveness. Full methodological detail appears in Appendix C.

Figure 1: Social Determinants of Health Framework

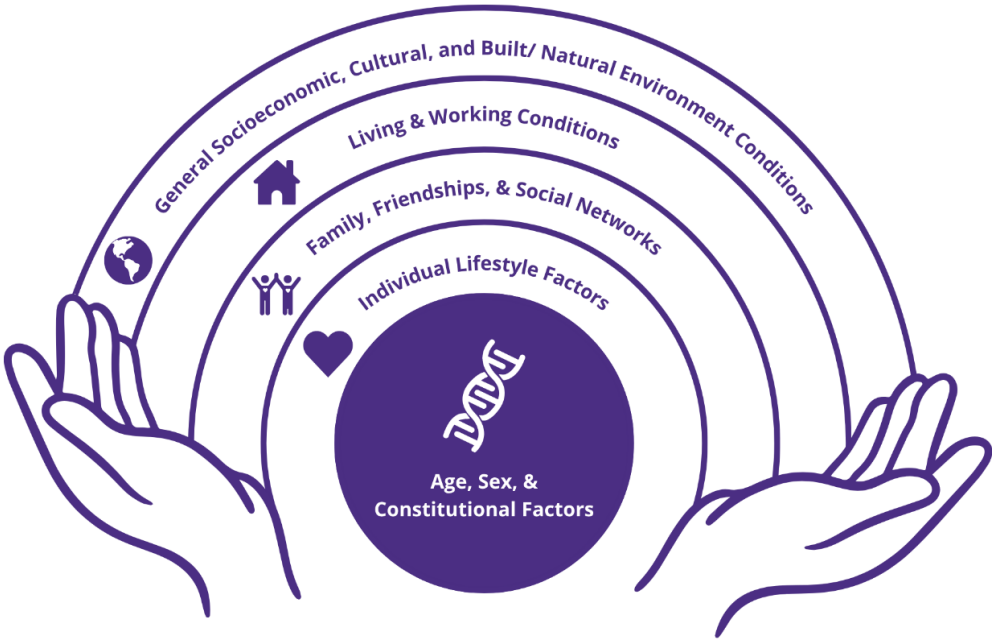


Figure 1: The SDOH Framework describes the conditions shaping health outcomes across five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Framework and SDOH Rainbow illustration adapted from Marmot (2005).

FINDINGS

Washington's counties have clearly identified where community health needs are most acute and where CBWs have the most to contribute. This section presents what we found: First, we paint a statewide picture of community-identified health priorities drawn from CHNAs. Then, we weave together the stories and perspectives of CBWs themselves, illuminating how they are working to meet those needs, what gets in the way, and what would help them go further.

We draw on two primary sources: an analysis of CHNAs from across Washington State, and engagement with more than 70 people across the public health landscape — frontline community-based workers, supervisors, organizational leaders, state agency staff, and policymakers — through convenings, interviews, and ongoing dialogue.

What Counties Say They Need

Our analysis of CHNAs reveals both the scale of unmet health needs across Washington and the clear potential for community-based workers to help communities meet their health and wellness goals. Federal law requires all nonprofit hospitals conduct a CHNA every three years by centering input from underserved populations in shaping local health priorities, providing a window into an area's top health challenges.

Mental and behavioral health emerged as the top priority statewide, with 34 of 36 counties[11] highlighting it as a priority area. Access to health care followed closely, with 23 counties naming it a central focus of their community health implementation strategies. Housing and homelessness ranked as key concerns in more than 20 counties, with many CHNAs identifying both the cost and availability of housing as essential to improving health outcomes. Other top priorities across the state include health equity, chronic disease management, access to primary care, and improving economic security — all areas where research consistently shows community-based workers are making a meaningful difference.[12]

Figure 2: Top Community-Identified Health Needs for Washington State

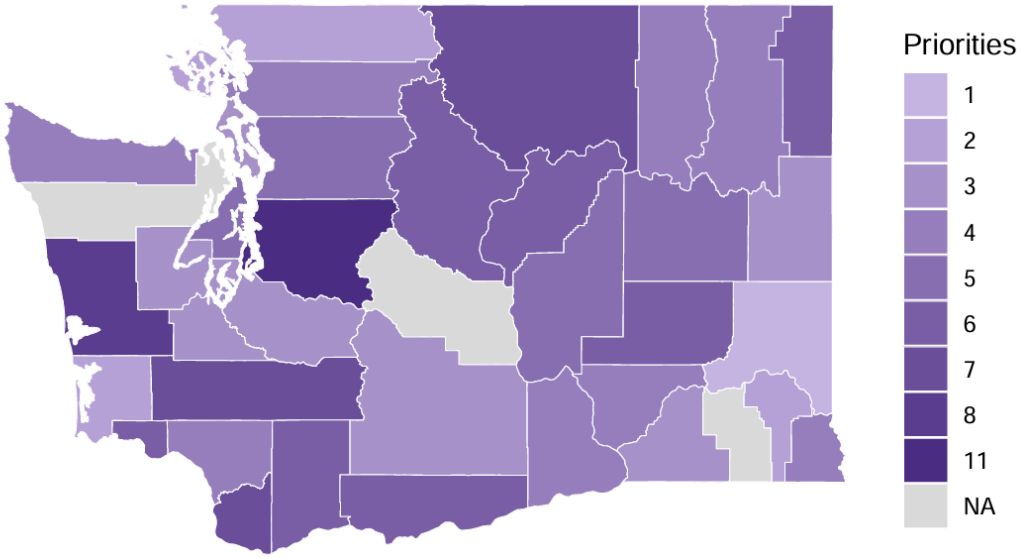
Every county we analyzed identified at least one priority area where community-based workers have effectively moved the needle — and most identified several. Counties identified between three and ten major priorities each. A full list of priorities identified by counties appears in Appendix C.

Conditions tied to the social determinants of health, or the economic and social factors that shape whether people can live healthy lives, featured prominently across nearly every county. Beyond housing and health care access, economic security was identified by 11 counties and food and nutrition by nine. Other concerns included access to enough local

[11] CHNAs were not available for three of Washington's 39 counties.
[12] (Berini et al., 2022; Bush et al., 2023; Hartzler et al., 2018; Mistry et al., 2021; Portillo et al., 2020)

health care providers, social connection, and neighborhood conditions — all areas where community-based workers are already active.

Figure 3: County-Level Health Priorities Aligned with CBW Impact, Washington State, 2022



Source: EPIC analysis of Washington State Community Health Needs Assessments

Yet the gap between potential and practice is stark. Despite clear alignment between community-identified priorities and documented community-based worker impact, very few counties involve these workers in their health planning processes. Only two counties explicitly mention community-based workers in their assessments, and we identified just one instance where an ACH participated in conducting an assessment. This disconnect represents a significant missed opportunity and a concrete opening to build a more integrated, community-rooted approach to public health planning.

The methods counties use to engage community voice reflect this same gap. Community surveys were the most common approach, used by 28 of 36 counties though some relied on surveys alone, with no in-person engagement. Sixteen counties incorporated listening sessions or workshops, and some went further, designing engagement specifically for underrepresented populations. For example, Spokane County implemented a survey targeting the LGBTQIA2S+ community; and Island County hosted Spanish-language focus groups to ensure non-English speakers could participate. These examples point to what equity-centered engagement can look like — and how far most counties still have to go.

What We Heard from the Field

County health data tells us where needs are greatest, but it cannot describe what it takes to meet them. For that, we turned to CBWs themselves. Three themes emerged across our

inquiry: (1) the irreplaceable value of trust-based, relational work; (2) the growing strain of burnout and funding instability; and (3) a field-wide call for systemic change.

RELATIONSHIP IS THE WORK

CBWs are unambiguous about what makes them effective: relationships. More than any program, certification, and dashboard, these “trusted navigators” say that relationships grounded in shared experience and cultural connection allow them to reach people traditional health systems cannot. As one worker put it simply: "I am not here to change the system... I am here to help folks navigate the messed-up system."

This relational work is not a soft skill: it is the work itself. Workers described moving fluidly between direct client support, internal team coordination, and community outreach, carrying information in both directions — from organization into community and back again. They are systems navigators in the truest sense, finding ways through structures that were not designed for the people they serve.

When community-based workers described their impact, they reached for stories rather than statistics. Success in this work rarely looks like a clean outcome measure. Workers described impact as both practical and emotional. One considered herself successful when clients felt they had "somebody in their corner." Another described going well beyond her formal role to help a mother — someone who wasn’t even an official client — navigate a school transfer for a child who was experiencing bullying.

> *"I helped her get a therapist, and she's still doing that," she said. "Her kiddo just graduated from services, and she sent a really lovely little note."*

Trust is central to our findings. It is the foundation of CBW impact and the outcome that makes all others possible. CBWs say it’s hard to win as something slowly built over time across repeated interactions. Yet this relational work is entirely invisible in current funding and evaluation systems, and it is what the State risks losing as pressure mounts to formalize, certify, and professionalize the CBW role. One informant summarized the quandary in one simple sentence, “How do you credential trust?”

We find that the tension between state certification pathways — which enable Medicaid reimbursement but risk narrowing the role — and the relational, culturally-grounded work community-based workers actually do is one of the defining fault lines in the field right now.[13]

[13] (Personal communication, Sept. 2024)

AS FUNDING CLIFFS, NEED GROWS

As pandemic-era grants expire and Medicaid funding faces unprecedented cuts, CBWs in rural areas and community-based settings are facing job loss, paused training programs, and shrinking teams. Those who remain describe feeling undervalued, overburdened, and left behind in state-led reforms that were not designed with their needs in mind.

> *"Financial support is important, and this year we've had a decrease in funding," one CBW said. "And we're still trying to do the same scope of work. We see our director spending so much time writing grants and talking to donors... we would love to see him be more available to us."*

Burnout compounds the problem. CBWs say low compensation, long hours, and the emotional weight of serving people with complex needs take a cumulative toll. As one health leader observed: "This community health worker role holds so much, yet it's so underpaid. And they're helping people navigate so many challenges that they are often also navigating themselves. There's a secondary and tertiary level of trauma that they don't really have a space to ever process."

The irony is difficult to overstate: as the structures supporting this workforce collapse, demand for their services is rising. Communities facing health care facility closures, loss of insurance, and growing economic instability are turning to community-based workers in greater numbers at precisely the moment the workforce faces increased instability.

A FIELD READY TO LEAD

CBW supporters are calling for more than incremental tweaks to existing systems. They speak of the need for fundamental fieldwide reorientation toward lasting multi-level systems change. For example, some argue that funding should flow to the organizations that employ CBWs so that it builds accountability around employer practices and infrastructure development rather than placing the burden of certification and sustainability on individual workers. Flow of funding was a major focus area in our inquiry, with most of the CBWs we interviewed naming better pay and expanded funding streams as their top priorities. Some call for training around advocacy, articulating the need to lobby for support from policymakers and the public.

Above all, community-based workers want a seat at the table as state leaders consider the policy decisions that shape their work. They say they are not simply the subject of this conversation — they are its most important voice.

CBWs Meet Washington's Greatest Health Needs

The stories community-based workers shared map directly onto the top priorities identified in Washington's county health assessments — mental and behavioral health, access to care, housing stability, and the broader social and economic conditions that shape health. These connections make concrete what the data suggests: a well-supported community-based workforce can help bridge the gap between services and community need.

Mental and Behavioral Health

The majority of CBWs interviewed described work directly tied to improving mental health outcomes, including connecting clients to providers, accompanying them to appointments, and creating the conditions for clients to seek the help they need. One CBW described how they supported a network of individuals building out mental health supports for rural communities. Another shared the story of months of patient relationship-building that ultimately helped a client leave a harmful job situation.

> *"I accompanied him to a medical appointment and heard what kinds of advice he was being given…just sitting with him and asking his questions and helping him articulate what he wanted," she said. "I finally had to say, 'do you want me to help you resign from your job?' And he said 'yes.'"*

Access to Health Care

CBWs improve access to care not just by providing transportation to appointments, but by reducing the discomfort and stigma that prevent people from seeking care in the first place. All interviewed described helping clients navigate insurance systems, eliminate unnecessary costs, and stay connected to ongoing care, ultimately reducing emergency room visits and the downstream costs they generate. One participant described what it meant to advocate effectively for a client.

> *"I could tell that we had formed some sort of professional bond in the sense of being able to have open conversation," she said. "They felt heard, seen, and validated with me. And I was able to advocate for them, and within three weeks, they were able to have the surgery that they wanted, that they had been putting off for so long."*

Housing and Homelessness

Half of the CBWs we interviewed described housing stability as a core part of their work, sharing efforts to connect clients to affordable housing, navigate voucher transfers, and interview in eviction or safety crises. They were adamant that housing and health cannot be addressed in isolation, and their stories illustrated that CBWs are often the only health workers operating at that intersection. One participant said:

> *"We are working with folks who are dealing with homelessness or housing instability," she said. "I would say chronic homelessness is a healthcare issue. We do not frame it that way."*

Social Determinants and Beyond

CBWs described efforts to confront other key priorities like food insecurity, social isolation, economic security, and chronic disease management — areas embedded in the SDOH framework. They spoke about helping clients gain employment, access benefits, build language proficiency, and find community connection, bridging gaps between systems to prevent their clients from falling through the cracks.

BARRIERS TO IMPACT

Despite their vital contributions, community-based workers face significant and layered barriers. Inadequate funding tops the list — named by most people we interviewed as a key constraint. Resource gaps, insurance barriers, and long processing times for state programs compound to create overwhelming challenges for workers and clients alike.

The difficulty of capturing and communicating impact creates a damaging cycle: without evidence, investment is hard to secure; without investment, building evidence is nearly impossible. One worker described the impossibility of tracking even basic metrics on her own.

> *"I probably connect with around 15 people a day. It is kind of hard to put a number on it because I tried tracking that data. And there was no way I could track that data on my own. It was too much."*

At the individual level, low compensation, burnout, and the emotional weight of serving people with complex needs take a cumulative toll.

> *"I do enough work for three to four people," said one worker, "and I have had case managers tell me that they do not want to refer anybody to me because I am so busy. There is so much room for opportunity there to be able to help more people."*

WHAT WOULD HELP

CBWs are clear about what they need: sustainable funding, meaningful training, peer networks, and policy that treats them as experts rather than line items. Better pay and expanded funding is a top priority. They also know they have a story to tell and requested assistance in advocating with policymakers given their expertise. Others raised the need for training on boundaries and self-care, recognizing that sustaining this workforce requires investing in the people who comprise it.

> *“This community health worker role holds so much, yet it's so underpaid. And they're helping people navigate so many challenges that they are often also navigating. And there's this like secondary and tertiary level of trauma that they don't really have a space to ever process.”*

Beneath these specific requests is a larger ask: a policy environment that invests in CBW networks and the organizations that employ them, rather than placing the burden of sustainability on individual workers. As one participant shared, “knowledge is power, and the more education and knowledge we have, the better."

CBWs in this study represent a small window into the diverse community-based health workforce serving Washington State. Their stories make clear that with the right supports, CBWs have the potential to help counties meet their most pressing health goals and that the cost of not investing in them is already being borne by the communities they serve.

WHERE WE GO FROM HERE

Washington's community-based health workforce is at a crossroads. CBW The people playing these roles are poised to affect the health disparities in the state. Yet we’ve found that the systems meant to support them are rapidly disintegrating, leaving this critical health equity work underfunded, misaligned, and increasingly strained by a policy environment that threatens to dismantle what years of public health advocacy, trust-building, and organizing have made possible.

Across 18 months of research, convenings, and conversations, we found a workforce that is both indispensable and undervalued. CBWs are connecting people to care, holding

communities together through crisis, and quietly addressing the social conditions that shape how and whether economically vulnerable communities are able to live long, healthy lives. According to our investigation, they are often doing so with inadequate resources, unstable funding, and limited recognition, yet they persist with passion and determination to close gaps in access to care.

Recommendations

The path toward building an effective statewide workforce requires collective action, sustaining investment, coordinated development, and the willingness to let people closest to this work help lead it. As the policy landscape becomes increasingly contentious, an important window for systems change is opening. Although Medicaid cuts and long-standing tensions around professionalization and equity are reversing progress toward developing a statewide community-based workforce, these issues are working to surface timely conversations about the importance of this work. We see three interconnected areas where action is most needed:

1. Put Community-Based Workers at the Center of Policy Decisions

Community-based workers are not simply the subject of this conversation. They are its most important voice. Yet across Washington, they are rarely included in the planning processes that shape their work, from county health assessments to state workforce policy. This must change.

Meaningful inclusion means more than a seat at the table. It means building conditions under which workers' participation is genuine, their expertise is honored, and their time is respected. It means investing in their capacity as advocates and storytellers — people who can translate frontline experience into policy language and carry community voice into rooms where decisions are made. It also means designing convenings, planning processes, and policy forums that actively remove barriers to participation rather than assuming workers can show up on the system's terms.

Washington's county health assessments offer a concrete starting point. Only two counties currently mention community-based workers in their assessments — a striking gap given the alignment between county-identified priorities and documented worker impact. Involving community-based workers in shaping these assessments would not only improve the quality of the planning — it would begin to build the kind of sustained, trust-based partnership that makes implementation possible.

2. Build an Evidence Base

The field cannot advocate for what it cannot describe. One of the most consistent themes across this entire body of work is the gap between what community-based

workers do and what gets measured. This gap has significant consequences for funding, policy, and public understanding.

Current measurement systems were not designed for this work. Billing codes and client counts miss the sustained relationships that finally helped someone access stable housing, or the trusted presence that made a frightened client willing to seek care for the first time. As one worker told us: "It's not just a number of clients served... it's very much how their lives have improved."

Closing this gap requires new approaches to documenting impact — ones that center trust, relationship quality, and community-defined outcomes alongside traditional metrics. It also requires examining the workforce itself more carefully: who enters this work, from where, what supports them to stay, and what career pathways exist. Without this foundation, the case for sustained investment will remain difficult to make and the workers doing the most important work will remain the least visible.

3. Shift Policy to Support Sustainable, Community-Rooted Practice

Two areas demand particular attention.

a. **Funding must follow the work.** Right now, funding structures are misaligned with how community-based work actually happens. Short-term grants, billing-based reimbursement, and individual credentialing requirements place the burden of sustainability on the workers least positioned to absorb it. Community-based workers and their advocates are consistent on this point: funding should flow to the organizations that employ them, building accountability around employer practices and infrastructure development rather than individual certification. Stable, multi-year investment — not project-based grants — is what allows organizations to hire, train, and retain workers over time.

b. **Credentialing deserves honest reassessment.** State certification pathways matter, creating reimbursement opportunities and signal professional legitimacy. But they also carry real risks. Requirements that favor clinic-based practice and formal training can exclude workers who bring the lived experience and community connection that make this workforce effective. The field needs a clear-eyed examination of whether current credentialing models are strengthening the workforce or quietly narrowing it and whether the workers most affected have had genuine input into those standards.

The stakes of getting this wrong are high. As Medicaid cuts take effect and pandemic-era funding disappears, Washington faces the real possibility of losing a workforce it spent years building when communities need it most.

A CLOSING WORD

Across this work, we have witnessed something that data cannot fully capture: the deep, determined commitment of people who believe in this work and the communities it serves. That commitment is present in every conversation — the worker who helped a mother navigate a school transfer for a child who wasn't even her client, the veteran advocate who finds success in simply showing up and listening, the leaders who keep writing grants and showing up to meetings even as the ground shifts beneath them.

The communities CBWs serve are already absorbing the consequences of inaction. These are not abstract policy failures. They are happening now, in communities across Washington State.

This commitment is the foundation that everything else must be built on. The question is not whether CBWs can help build a healthier, more equitable Washington. The question is whether we will build systems worthy of the people already doing that work.

This report is not an ending. It is an invitation.

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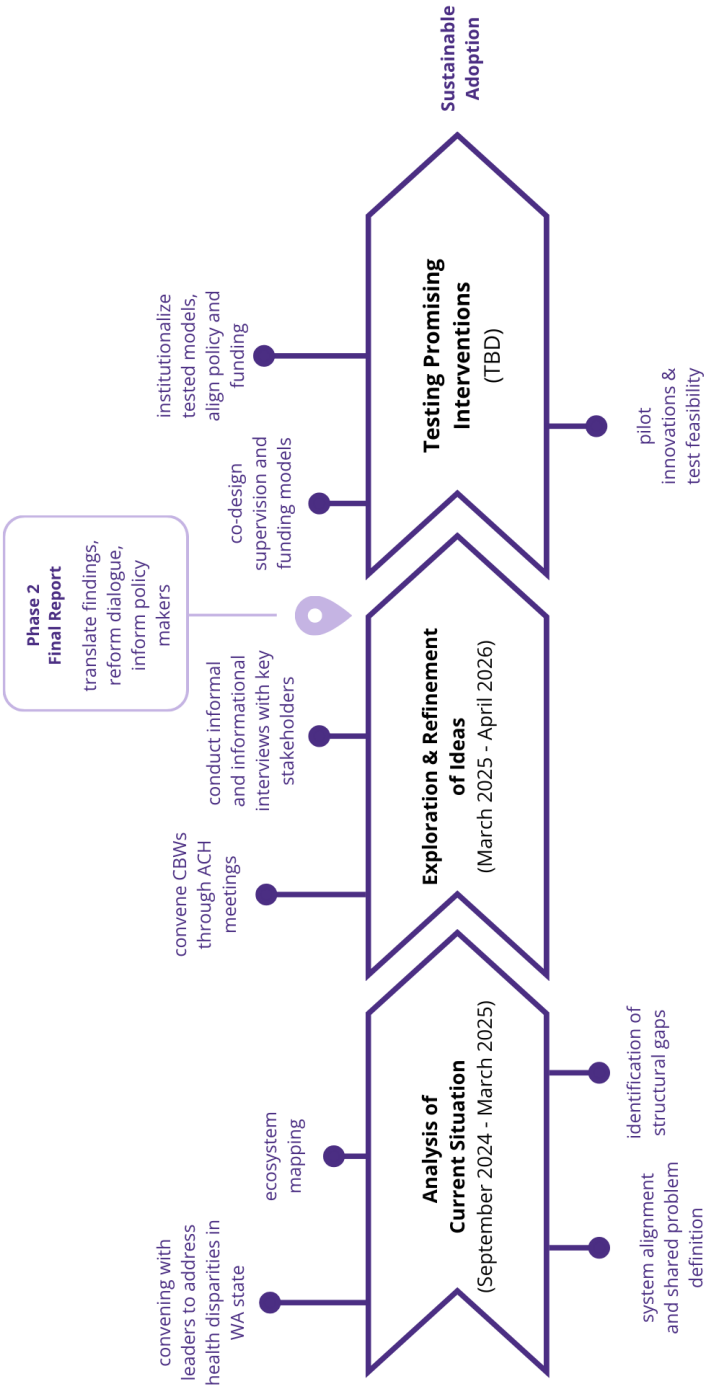
APPENDIX A: PROCESS OVERVIEW AND TIMELINES



A timeline of the three-phase Human-Centered Design process employed by EPIC is overlayed with the project timeline of Phase 1 (Analysis of Current Situation) and Phase 2 (Exploration & Refinement of Ideas). Phase 3 is to be determined by future funding. The primary activities of each phase are mapped out in light purple, along with where this report sits along the project timeline.

APPENDIX B: GLOSSARY

Community-Based Worker (CBW)

A community-based workforce[i] includes trained community-based professionals (CBPs) such as community health workers (CHWs); promotores de salud; doulas; peer specialists; recovery coaches; community-based social workers; and community-based, nongovernmental nonprofit staff and human services providers. CBPs are trusted, frontline public health workers, often employed by community-based organizations (CBOs). They help connect people to the services and support they need, especially in communities facing structural barriers to health. Their work is key to addressing the social and cultural factors that shape the health of Washingtonians.

Social Determinants of Health (SDOH)

The Social Determinants of Health framework describes the conditions that shape health outcomes, including economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

Accountable Communities of Health (ACHs)

Washington is home to nine regional ACHs — independent, regional organizations that work with their communities on specific health care needs and services to improve health equity as part of Washington's Medicaid Transformation Project. Over the past seven years, ACHs have worked in many ways to improve the health of their communities as a whole, investing millions in regional care systems.[14]

Community Health Needs Assessment (CHNA)

An Internal Revenue Service requirement for every hospital recognized as a 501(c)(3) nonprofit entity to conduct an assessment every three years in which "a hospital facility must complete the following steps: (1) Define the community it serves. (2) Assess the health needs of that community. (3) In assessing the community's health needs, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health. (4) Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility. (5) Make the CHNA report widely available to the public."[15] Additionally, the hospital must develop an implementation strategy describing how they address or not the health needs.

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[14] (Coalition of ACHs, n.d.)
[15] (IRS, n.d.)

APPENDIX C: RESEARCH METHODS

OVERVIEW

Human-Centered Design (HCD) provides the operational framework for implementing systems change through a three-phase process: (1) analysis of the current situation, (2) exploration and refinement of ideas, and (3) testing promising interventions.[16] In practice, the boundaries between phases are fluid. In this study, what we learned in one conversation shaped what we asked in the next, and the work evolved accordingly — beginning with a broad analysis of the field before moving into convenings, interviews, and quantitative data analysis to understand CBWs and their potential for impact.

Some of the most important insights in this work came from data gathered from dialogues. We conducted a sustained series of conversations with people across Washington's public health landscape — from state agencies and ACHs to frontline CBWs and the organizations that employ them — striving to build trust over time and surface the kind of knowledge that formal reports rarely capture: the lived reality of people working inside a complex, under-resourced system (Sandfort and Quick, 2015; Sandfort et al., 2012).

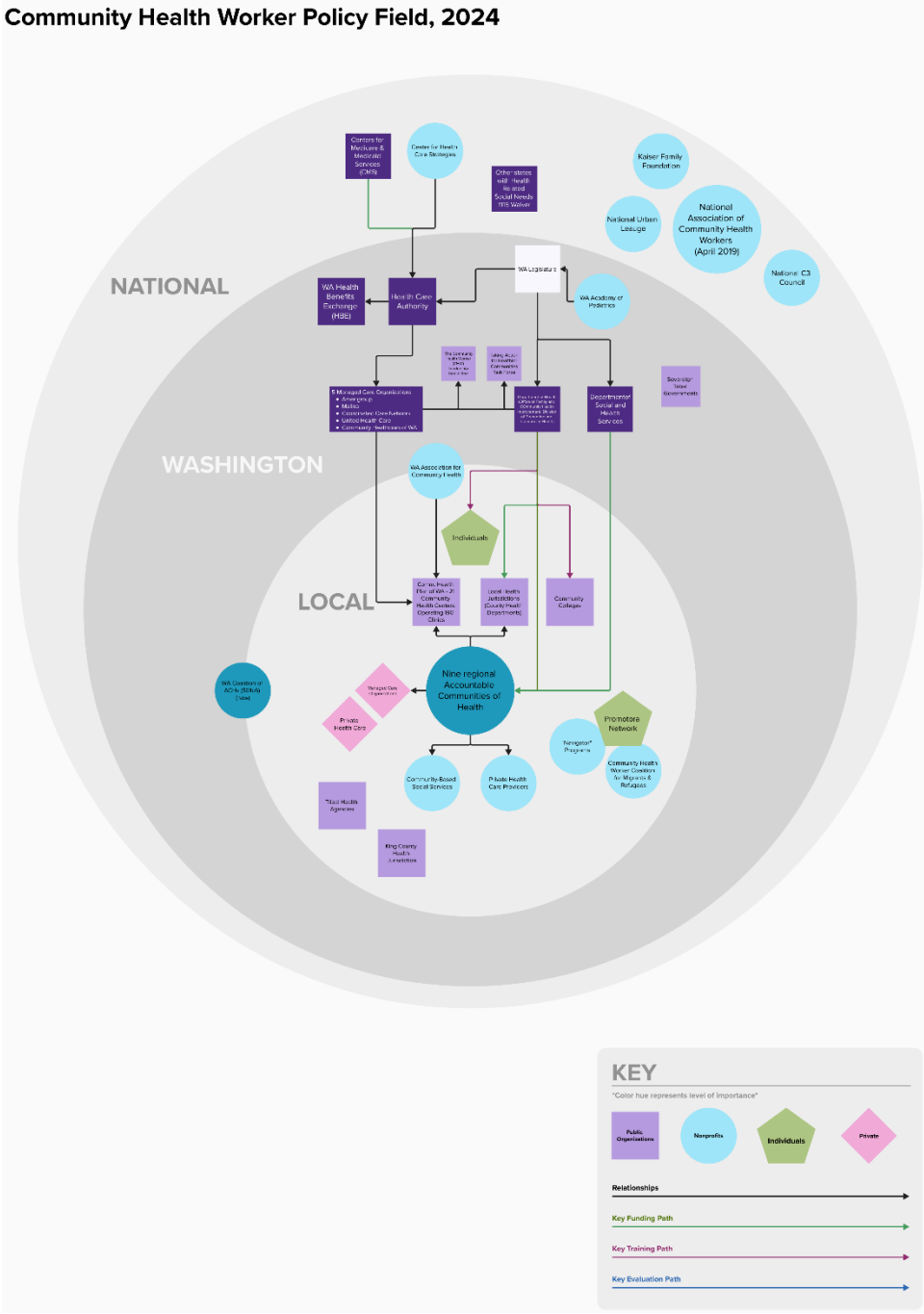
Our work began with informal interviews (n=10) to map the policy field and design a co-design session in November of 2024, cohosted by the UW Strategic Initiatives Office and the EPIC team, bringing together 40 cross-sectoral leaders, including researchers, philanthropic organizations, private sector representatives, and government leaders. Together, the group explored how policy and collaboration might better support frontline CBWs. Building on that foundation, we partnered with Better Health Together in Eastern Washington to convene CBWs through their emerging Community Based Worker Network, seeking to understand these potential opportunities from the lens of those most directly impacted, meeting with their network of about 30-50 CBWs three times in fall 2025. Findings from these convenings are woven throughout the case study section below.

INTERVIEWS

While convenings gave us a broad overview of the CBW landscape, interviews brought us closer to the daily realities shaping its impact in community. We conducted two types of interviews throughout the process: 32 interviews with key stakeholders across the policy landscape throughout our process and six semi-structured interviews with CBWs themselves between January and March of 2026. Stakeholder interviews informed the policy field map, below, and shaped future phases of the work.

[16] (Hargraves, 2018; Norman, 1988; Sandfort, 2026)

Community Health Worker Policy Field, 2024



The CBW interviews centered on a question that emerged directly from our statewide conversations — one that public health leaders identified as both urgent and largely unanswered amid the uncertainty of recent federal policy shifts: how do CBWs define, create, and evaluate their impact? More specifically, we asked what CBWs do, how do they know they have made a difference, and what challenges and needs might be addressed to amplify their work? Participants were recruited through email outreach, Better Health Together convenings, and snowball sampling. All conversations took place virtually under

UW IRB approval, and each participant received a gift card in recognition of their time and expertise. Two team members transcribed, coded, and analyzed interview recordings, reaching consensus on the themes presented in this report.

COMMUNITY HEALTH NEEDS ASSESSMENTS

To identify where CBWs can have the greatest impact, we examined Community Health Needs Assessments (CHNAs) from counties across Washington State. Federal law requires all nonprofit hospitals conduct a CHNA every three years by centering input from underserved populations in shaping local health priorities (Liu, 2024). Although federal health privacy laws limit our ability to access the stories of those directly served by CBWs, CHNAs provide a useful, if imperfect, window into where need is most acute. We focused on the most recent available cycle from 2021–2023, reflecting priorities that shaped public health planning for 2023–2025. Where CHNAs were unavailable, we drew on Community Health Assessments (CHAs), noting that some reflect data from the mid-to-late 2010s — a limitation worth keeping in mind when interpreting findings.

Table 1: County-Level Health Priorities, Washington State, 2022

CHNA Priorities	Number of Counties
Mental & Behavioral Health	34
Access to Care	23
Housing & Homelessness	23
Economic Security	11
Health Equity	10
Chronic Disease Management	10
Food & Nutrition	9
Access to Primary Care	9
Supply of Health Care Providers	7
Social Isolation & Community Context	6
Neighborhood & Built Environment	5
Healthy Behaviors	5
Structural Discrimination	4
Culturally Appropriate Care	3
Social Determinants of Health (General)	3
Education	2

From each assessment, we focused primarily on identified health priorities as a signal of where CBWs might be best positioned to make an impact. To connect those priorities to evidence of CBW effectiveness, we drew on the literature around CBW outcomes — including chronic disease management, mental health support, housing, employment, and

social connection[17] — many of which align with the Social Determinants of Health (SDOH) framework, which describes the conditions shaping health outcomes across five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[18] Descriptive analyses by county, along with indicators of current CBW involvement in the CHNA process, appear in the findings below.

CASE STUDY: PARTNERING WITH BETTER HEALTH TOGETHER

We partnered with Better Health Together (BHT), an ACH serving Northeastern Washington's Ferry, Stevens, Pend Oreille, Spokane, Lincoln, and Adams counties as well as the Kalispel Tribe of Indians, the Spokane Tribe of Indians, and the Colville Confederated Tribes. Over a series of hybrid network meetings with 15 to 30 CBWs across this geographically expansive region, we built a foundation of shared understanding and mutual commitment before diving into data collection.

At our first meeting, we introduced the project and facilitated a brief co-creation activity, asking the group to describe what has felt extractive in past research partnerships, and what would feel genuinely supportive. Their responses shaped a collaborative commitments document that was shared with the network at a later session, discussed openly, and will remain a living document that continues to be shaped by feedback to guide our partnerships as we move forward in this work.

At a third and final session, we leveraged dialogue methods to build collective capacity for effective storytelling, asking CBWs to listen to a series of "stories of impact" for facts and data, emotions and senses, and story arcs. This session culminated with two questions at the heart of our CBW engagement:

1. What do you do in your role that is most valuable to the communities you serve? How do you know?
2. What is one thing you wish legislators, policymakers, or supervisors understood about the impact of your work?

The data that emerged from this engagement was clear and consistent. CBWs described their value as trusted resources, community builders, and navigators of complex systems. They describe measuring success not in metrics but in moments: a client's expressed gratitude, a relationship sustained over years. Above all, they wished the people making decisions about their work understood the real, lived needs of the communities they serve. A community-facing newsletter documenting this session is included in this report.

[17] (Barnett et al., 2023; Berini et al., 2022; Bush et al., 2023; Noel et al., 2022; Knowles et al., 2023)
[18] (Marmot, 2005)

Project Website

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