Research Report

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Medicaid Reimbursement and Other Funding Strategies for Community Health Workers: Perspectives of Employer Organizations in Indiana

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ABSTRACT

Objective: To investigate challenges and opportunities related to Medicaid reimbursement and other funding strategies for community health workers (CHW) among employers in Indiana.

Design: Qualitative study using in-depth interviews with organizational and program leaders in 2024. Analysis used a framework approach.

Setting: Indiana.

Participants: Leaders from 8 Indiana-based CHW employer organizations, including health systems, federally qualified health centers (FQHCs), local health department, and community-based organization, supplemented by leaders of 3 non-Indiana-based organizations engaged in CHW policy, research, or advocacy elsewhere in the United States.

Main Outcome Measure: Organizational perspectives on CHW workforce funding, specifically Medicaid reimbursement, and alternative funding approaches.

Results: We found that CHW employers relied on short-term grant funding but that there was diversity in funding approaches. Only 1 of 8 Indiana-based CHW employers billed Medicaid for CHW services, with barriers to Medicaid reimbursement related to low reimbursement rates, complex billing procedures, limited billable activities, and structural exclusion to Medicaid reimbursement for some providers like FQHCs. Alternative funding approaches identified by employers included reforms to the current Medicaid policy, moving towards value-based payment models, pursuing braided funding approaches, and advocating with organizational leadership based on return-on-investment from CHW activities. Non-Indiana–based stakeholders highlighted additional strategies that could be pursued in Indiana to enhance sustainability, including managed care incentives or requirements for employing CHWs and dedicated workforce development partner organizations that can support CHW employers in building and sustaining their CHW workforces.

Conclusions: Insights from this study revealed current structural and policy challenges that CHW employers face in Indiana and can inform reforms to build a more sustainable CHW workforce to serve diverse health and community settings.

KEY WORDS: community health workers, sustainability, Medicaid reimbursement, Indiana

Introduction

Community health workers (CHWs) are a critical cadre of the health workforce who effectively bridge gaps in healthcare access, address social determinants of health, and reduce healthcare costs.[1,2] In the United States, CHWs are predominately funded

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This study was approved as exempt by the Indiana University Institutional Review Board (IRB no. 21790). All participants provided verbal consent to be recorded, transcribed, and for their interview data to be analyzed and published. Before consent, participants were informed that all names, interview data, and institutional affiliations would remain anonymous.

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through short-term grants that threaten long-term sustainability of the workforce and services.[2] In the past decade, policy reforms created opportunities to expand the CHW workforce in the United States. One of these reforms allows states to direct Medicaid funds to CHWs through State Plan Amendments (SPA) and Section 1115 Demonstration waivers. By 2024, over half of states provided Medicaid coverage of some CHW services either through SPAs, waivers, or both, but Medicaid billing for CHW services in most states is low because of insufficient reimbursement rates, complex billing requirements, and limitations on billable services.[3] States can also incentivize or require Managed Care Organizations (MCOs) to employ CHWs; for example, Michigan requires MCOs to employ a minimum of 1 CHW to every 5000 members.[4] Alternative payment models that shift funding from fee-for-service to value-based outcomes, including capitated, bundled, and performance-based payments, may be particularly relevant to sustainably financing CHW workforces in healthcare settings, but there is limited evidence on their implementation related to CHWs.[5,6]

Despite new and innovative financing approaches, sustainable funding remains a barrier to expanding and bolstering a robust CHW workforce. Employers of CHWs can offer valuable insights into the contextual and nuanced challenges of implementing sustainable CHW financing and programs based on different organizational missions, strategic priorities, and patient-facing impact.[7–12] Given Indiana's focus on using SPA-directed Medicaid reimbursement as a strategy to expand the CHW workforce, in this study we conducted interviews with organizations employing CHWs in Indiana to investigate challenges and opportunities related to Medicaid reimbursement alongside other funding strategies for CHWs.

Methods

Setting

In May 2023, the Bureau of Labor Statistics estimated that there were 980 CHWs employed in Indiana.[13] In 2018, Indiana was only the second state to be approved under a SPA to allow reimbursement of CHW services through its Medicaid program, but utilization remains challenged by the factors identified above. The Indiana Community Health Workers Association serves as the state's professional body and advocates for CHWs through education, research, and policy. The authors are members of the Indiana CHW Sustainability Taskforce established in 2024 by researchers, program leaders, and representatives from the Indiana Community Health Workers Association to advance the workforce in Indiana.

Before interviews, the study team conducted a statewide mapping of CHW employers and programs across organizations in Indiana using publicly available information. The study team then reached out to employers by email and asked if they would provide information about their CHW programs, funding models, and organizational type. The statewide mapping of CHW employers and programs was used to create a database of major CHW employers in the state and provided important context about the types of organizations that employed CHWs, their funding models, and program structures, thereby informing the selection of interview participants. The largest employers of CHWs were healthcare organizations followed by health departments, with only 1 employer identified that was actively billing Medicaid for CHW services.

Study design

A sample of organizations was purposively selected to participate in this study using the database of CHW employers. Selection was based on inclusion of employers that broadly reflected where most CHWs worked in the state and employers with more established CHW programs who could speak to long-term sustainability. To gather information about funding models and sustainability outside of Indiana and to allow for comparative analysis and complement statewide findings, we included 3 national-level stakeholders in interviews. After an in-depth literature review, a semi-structured interview guide was iteratively developed by the study team. The question domains included: (1) organizational information about their CHW workforce and program(s); (2) funding strategies, mechanisms, and challenges related to Medicaid reimbursement; and (3) recommendations for policy reforms to enhance sustainability. Interviews were conducted in-person or by Zoom between April to October 2024, with organizational representatives ranging from 1 to 3 per interview. Interviews were recorded with permission and transcribed for analysis. This study was approved as exempt by the Indiana University Institutional Review Board (IRB# 21790).

Study participants

We conducted 11 semi-structured interviews. Eight interviews were with Indiana-based organizations, including 3 interviews with federally qualified health centers (FQHC), 3 with health systems (1 county health system and 2 nonprofit health systems), 1 with a county health department, and 1 with a nonprofit organization. All of these organizations employed

CHWs, ranging from 7 to 30, except for 1 FQHC that was exploring starting a CHW program. Detailed organizational characteristics are included in Table 1. Interview participants were working in a leadership position and knowledgeable about their organization's CHW programs and financing.

We also conducted 3 interviews with non-Indiana–based key informants that were able to provide national context on Medicaid reimbursement and other funding strategies for CHWs. These individuals were from a national MCO that employed CHWs across several states, a research organization familiar with state-based CHW reimbursement policies, and a state-based advocacy organization that worked with employers on Medicaid billing and other funding strategies. Two of these key informants participated in a Sustainability Summit organized by the Indiana CHW Sustainability Taskforce in 2024 and were later invited to participate in interviews.

Analysis

A framework qualitative analysis method was used.[14] Deductive coding was conducted and informed by the research questions and interview guides, followed by inductive coding using latent content analysis to identify new codes and themes. The interdisciplinary analytic team included all authors. A matrix was created in Microsoft Excel with each interview ("case") in its own row and primary themes in columns. To ensure intercoding reliability, each team member charted data for a separate interview with weekly team meetings over the course of 2 months. An analytic memo was maintained throughout the process, and the coding framework and matrix were updated iteratively. The team collaboratively reviewed the final matrix with charted data to map and interpret patterns, relationships, and implications of findings within and across cases. Additional analytic details are provided in Supplemental Digital Content 1, http://links.lww.com/JPHMP/B707.

Results

CHW funding and sustainability strategies and challenges

Sustainable funding was a challenge for all Indiana organizations and most used a patchwork of funding streams. Federal, state, and foundation grants were the most common funding sources, with several organizations leveraging increased federal and state grant funding available during the first few years of the COVID-19 pandemic and now approaching grant cliffs. As described by 1 participant, "This limping along by grant after grant after grant, that is our lot in life … it's exhausting, and it's very lumpy" (*FQHC 2*).

Most organizations had explored billing for CHW services under Medicaid, but only 1 in this study—the local health department—was billing and being reimbursed for CHW services. Participants pointed to low reimbursement rates as a major barrier, especially given the administrative burden for new billing practices. According to 1 participant, "the reason that we haven't yet pursued [reimbursement] is that it seemed like the cost-benefit analysis was not in our favor" (*NGO 1*). Another concern was the limited scope of reimbursable services, with health navigation services, transportation support, and insurance enrollment support not reimbursable under the current policy.

Several programs were exploring and piloting documentation related to health-related social needs using "Z codes" to support future reimbursement, especially in fixed payment models such as managed care and capitated payment arrangements that several participants highlighted as key reimbursement shifts that needed to occur for healthcare organizations to more widely employ CHWs. Articulating a mission-oriented value case for CHWs was also important for directing internal or organizational funds outside of grants. The "value" of CHWs, including improving health outcomes, return-on-investment financially, return-on-mission, and service to the community, allowed CHW programs to "pretty much [pay] for ourselves" (Health System 3) if organizations fully understood and appreciated the benefits of CHWs. Several participants expressed that leadership often had limited grasp of the broader value CHWs brought to their organizations, which contributed to limited funding options.

A case of Medicaid reimbursement for CHW services

A local health department program was the only employer in this study being reimbursed for CHW services under Medicaid. For several years, the program relied on a blended funding strategy of Medicaid reimbursement and state and county health department grants as a single stream of financial support for 14 home-visiting CHWs for pregnant and parenting women. Their early experiences revealed the complexity and uncertainty of Indiana's Medicaid reimbursement policy for CHW services, even though the county had an experienced team and infrastructure. The program leaders described a trial-and-error process to figure out which diagnosis codes would be approved by Medicaid, which resulted in only 1 code being reliably reimbursed (related to "Other specified counseling"). As they described, "We [learned] to use a broad code, but we did try

TABLE 1
Employer Organizations, CHW Programs, and Funding and Sustainability

ID	Organization Type and Description	Interview Participant(s) Title/ Role	CHW Program/ Focus Area	Number of CHWs in Organization and Position Titles	Current Funding Model(s)	Key Challenges for Funding and Sustainability
Health system 1	Non-profit county health system in Central Indiana	Executive director of behavioral health services (n = 1)	Behavioral health; justice-involved services	Seven CHWs: including health-oriented (n = 2) and justice-oriented (n = 2) navigators, a certified peer recovery coach (n = 1), outreach coordinator (n = 1), and mobile response team	Community benefit grants; foundation grants; county funds	Due to low Medicaid reimbursement rates, they have not initiated Medicaid billing practices; limited grant opportunities/ grant cliffs
Health system 2	Non-profit academic health system operating throughout the state	Directors (n = 3) and program managers (n = 2) in community & maternal health and SDOH	Maternal and child health; hypertension	Twenty two CHWs: perinatal home visitation CHWs (n = 12) and supervisor (n = 1), CHWs following pregnant/ postpartum women with hypertension (n = 9)	State and federal grants	Due to low Medicaid reimbursement rates, they have not initiated Medicaid billing practices; limited grant opportunities/ grant cliffs
Health system 3	Non-profit health system operating throughout the state	Director of health access program (n = 1)	Health outreach and access for maternal and child health; pharmacy assistance; transportation coordination	Thirty CHWs: health navigators (n = 10) and health advocates (n = 20)	Return on investment; health foundation	Due to low Medicaid reimbursement rates, they have not initiated Medicaid billing practices; uses their well-established internally developed return-on-investment model
FQHC 1	FQHC operating in northern Indiana	CEO (n = 1)	N/A	N/A	N/A (not hiring CHWs pending sustainable reimbursement option)	Prospective payment system rate does not cover CHW services and Medicaid billing not allowed

(*continues*)

TABLE 1
Employer Organizations, CHW Programs, and Funding and Sustainability (*continued*)

ID	Organization Type and Description	Interview Participant(s) Title/ Role	CHW Program/ Focus Area	Number of CHWs in Organization and Position Titles	Current Funding Model(s)	Key Challenges for Funding and Sustainability
FQHC 2	FQHC operating in central Indiana	CEO (n = 1) and director of community & clinical health (n = 1)	SDOH; diabetes	Twenty two CHWs: community weavers (n = 6), SDOH-focused CHWs (n = 11), and diabetes-focused CHWs (n = 5)	Organizational and federal grants; health foundation	Prospective payment system rate does not cover CHW services and Medicaid billing not allowed
FQHC 3	FQHC operating in central Indiana	Social workers (n = 2), financial analyst and CFO (n = 2), and chief communications officer (n = 1)	HIV care; diabetes; maternal and child health; geriatric care	Ten CHWs: mobile health CHWs (n = 2), HIV-focused CHWs (n = 2), and coaches (n = 5) in addition to a diabetes-focused coach (n = 1)	State grants	Limited grant opportunities/ grant cliffs; prospective payment system rate does not cover CHW services and Medicaid billing not allowed
Local health department	Local (county) health department in southwestern Indiana	Program Manager/ CHW (n = 1), social worker (n = 1), and program and financial supervisors (n = 2)	Maternal and child health	Fourteen CHWs	State and federal grants; Medicaid reimbursement: local ordinance non-reverting fund	Medicaid billing covers minimal CHW duties; sustainability challenged by billing insurance code does not map with specific services provided; low Medicaid reimbursement rates
Non-profit organization	Non-profit organization providing home- and community-based support services in central Indiana	Vice presidents of in-home services and business development (n = 2), directors of Meals and research (n = 2), and CHW coordinator (n = 1)	Aging and disability; behavioral health; nutrition	Thirteen CHWs: behavioral CHWs (n = 5) and supervisor (n = 1), disability-focused CHWs (n = 5), and outreach (n = 1) and care coordinator (n = 1)	State grants; Medicaid waiver	Limited billing autonomy under Medicaid and Medicare contracts; limited grant opportunities/ grant cliff; loss of Medicaid waiver funding

Abbreviations: CEO, Chief Executive Officer; CFO, Chief Financial Officer; CHW, community health workers; FQHC, federally qualified health centers; SDOH, social determinants of health.

initially to be more specific [with our diagnosis codes] …. We know we're using a safe code that encompasses what we're doing." Participants expressed a major advantage of Medicaid reimbursement as unrestricted funds that could be used for training, equipment, rent, and liability insurance, which grants

often do not cover. A major challenge was that non-education and counseling activities provided by the program's CHWs were not reimbursable. Participants shared that "we [have] to get creative in terms of sustainability." The program estimated that reimbursement from Medicaid was currently covering less than 10% of the program costs. Despite these challenges, program leadership was optimistic that Medicaid reimbursement could become a more sustainable funding strategy if rates increased.

The diverse funding strategies of health systems

Health systems in this study had the broadest range and flexibility to support their CHW programs. For example, Health System 1, as both a nonprofit and county hospital, leveraged funding from their community benefits, hospital foundation, external grants, and county funds to support CHWs in the outpatient behavioral health services department. When asked about Medicaid billing for CHW services, the program had prepared the codes and documentation but reimbursement was ultimately not pursued because of low rates. In addition, the participant shared the concern that if they started to bill for CHW services, clients on private insurance would likely be charged, stating that, "unless you're on Medicaid, that's typically coming out of your pocket." Similar challenges were faced by another nonprofit health system that supported their maternal-child health CHWs through community benefit dollars (a requirement of nonprofit hospitals to maintain tax-exempt status) and short-term state and federal grants. Facing grant cliffs, Health System 2 shared they were open to Medicaid billing but shared concerns regarding "how documentation…[has] been limiting for us in terms of whether we do [reimbursement] or not" because the rate was perceived to be insufficient to cover any overhead costs.

Health System 3 used an innovative braided strategy that combined community benefit dollars and internal hospital funds to pay for different components of their 30 CHWs serving community members, regardless of whether they were patients in the health system. Since 2015, their department worked with the organization's finance team to provide a list of individuals served by CHWs, which the finance team used to determine the program's return-on-investment, calculated as the revenue generated to the health system from reimbursable services in comparison to program costs. The program director shared that "since 2015, [our program] always had a positive return on investment," despite the estimate that more than half of their clients go on to receive care at a different health system. Utilizing internal funding has strengthened the program's sustainability and resulted in low CHW turnover.

On the frontlines of primary care: perspectives from FQHCs

All FQHC participants in this study recognized CHWs as critical members of the primary care workforce, sharing that FQHCs were uniquely positioned to use CHWs targeting underserved populations. Two FQHCs had existing CHW programs, with the third FQHC anticipating employing CHWs in the future. Of the 2 existing CHW programs, 1 FQHC employed 22 CHWs who were funded through a CDC grant, a local philanthropic grantor, and internal foundation dollars. *FQHC 3* employed 10 CHWs who provided wrap-around social determinants of health services and funded by a patchwork of grant funding from federal and state agencies and private foundations.

A major challenge for FQHCs was the inability to bill Medicaid under the current reimbursement policy. FQHCs are reimbursed under a Prospective Payment System (PPS) rate, which in Indiana requires a medically necessary, face-to-face encounter with a credentialed provider (which CHWs are not) to receive a bundled per-visit payment. CHW services provided incidental to that visit are covered under the existing PPS rate and cannot be billed for separately. As explained by 1 participant, "The key to the whole thing [is FQHCs] find that we are on our own little island when it comes to coding and billing…it is very disheartening" (FQHC 2). Even the enhanced PPS Medicaid rate and additional federal grant funding were insufficient for FQHCs to sustainably build and expand their CHW programs, with 1 participant sharing, "that [flat] rate hasn't kept up with…the complexity of [CHW] jobs" (FQHC 3). There was consensus across FQHCs that "changing the reimbursement model of Indiana [from fee-for-service] with Medicaid into more of a value-based reimbursement" (FQHC 1) would be required for sustainable payment strategies for CHWs. One participant shared, "[Payment reform] is where we are putting most of our eggs and still limping by with grants and help from the foundation until it happens" (*FQHC 2*).

The fact that FQHC providers were the most limited in accessing Medicaid reimbursement was found to be "backwards" because they had the most to gain from using CHWs to connect with high-risk clients, with the participant sharing, "What FQHCs do best is team-based care and collaboration with the community. And those are the reasons that value-based care … getting paid differently can work." (FQHC 2). Another FQHC leaders added, "From the state level, that additional [CHW reimbursement] documentation

isn't getting us any additional funding" (FQHC 3) and that "there's a lot of uncertainty right now in regards to reimbursement," but "we're going to have to crawl first" (FQHC 1). The state's primary health care association was in the process of establishing a clinically integrated network of Indiana FQHCs that could negotiate capitated reimbursement rates with MCOs where FQHCs would receive fixed per-patient per-month payments. From the perspective of FQHC participants, this was the key to allowing FQHCs the upfront investment and autonomy to invest in their CHW workforces.

A nonprofit organization focused on elder and disability services

A nonprofit Indiana organization focused on community- and home-based services to older and disabled people employed 13 CHWs funded by federal and state grants, contracts with MCOs, and internal financing. At the time of the interview, the organization was not billing Medicaid or Medicare but had started early discussions of reimbursement with leadership. Participants revealed how they were navigating complex national- and state-level policy changes; in 2024, the Indiana PathWays for Aging Program was introduced as the state's managed care long-term services plan for Indiana residents aged >60 years on Medicaid and dual eligible. Participants shared that this meant the organization was developing strategies for contracting with MCOs with "real concerns about continuity of care." The organization was cautiously optimistic about the potential for new Medicare reimbursement for Health-Related Social Needs that included CHWs but was still unclear of how billing would be operationalized.

Perspectives from other key informants

The perspectives from other state and national organization participants provided important insights into shared challenges across state contexts. For example, several states have required or incentivized MCOs to employ CHWs for members, where Indiana does not. As shared by 1 MCO working in states with this approach, "Our states vary as to whether they expect us [to provide CHW services] and what the ratio is. [In Michigan], you have to have one community health navigator for every 5000 members." They added: "We're not necessarily billing these services to the state or to ourselves. This is part of our care model." Another national participant was a CHW collaborative initially established in 2020 and supported under their state's health department to focus on CHW workforce development. As the director of the organization elaborated, "Just because we have reimbursement doesn't mean that a workforce magically appears" (NGO 2). Now its own nonprofit organization, the director credited the organization's role in advising Medicaid leadership and supporting reimbursement implementation as critical to strengthening Medicaid billing and CHW sustainability statewide. As the director described, "It's a lot of getting connected with the right people in the Medicaid office to really emphasize the benefits that they're going to see from implementing CHW reimbursement" (NGO 2). The other national participant, a nonprofit collaborating with stakeholders to provide CHW program-related resources and services, shared that "reimbursement does remain a challenge" (NGO 3), despite the organization's expertise and experience working with a variety of organizations nationwide, because of a lack of "best practice data" and "granularity" (NGO 3) across current state policies.

Discussion and Conclusion

This study found that Indiana employers of CHWs approach funding models differently, partly because of constraints associated with organizational types, which reflect both organizational characteristics and policy contexts. Our analysis highlights clear distinctions: FQHCs are largely excluded from the current Medicaid policy of fee-for-service billing for CHW services, whereas health systems and nonprofit organizations often strategically avoid Medicaid billing because of insufficient reimbursement rates. The 1 organization billing Medicaid, a local health department, demonstrated limited uptake with only partial cost recovery necessitating continued reliance on grants. Sustainable funding for CHW services among these diverse organizations reveals that there is currently no "one-size-fits-all" approach or policy, with diversified funding streams remaining critical to CHW employers. Our study reveals several promising approaches for blended and braided funding as well as the challenges faced by specific types of organizations.

Increasing the reimbursement rate under Medicaid was a major policy reform advocated by employers in this study. From 2018 to 2023, the reimbursement rate for one-to-one CHW services was $9.70 for a 30-minute encounter in Indiana, which was tied with the lowest reimbursement rate in the United States.[15] In 2024, the rate increased to $26.56, but still falls far below what one study estimated as the minimum sustainable rate of $47.35,[16] and the reimbursement for CHWs under Medicare's Community Health Integration which was $50.26 in the same year.[17] Although upward revisions of reimbursement rates are important, this reform alone will not address other

Implications for Policy & Practice

- To support employers, Indiana should adopt policy reforms that build on national best practices for supporting sustainable CHW employment. These include:
- First, state agencies should strengthen Medicaid reimbursement for CHW services by increasing reimbursement rates and expanding and clarifying billable services, following examples from states such as Minnesota and Massachusetts that provide reimbursement for a more robust range of services and activities by CHWs.
- Second, the state should support efforts to move toward value-based payment reform and managed care requirements for CHW services in value-based contracts as has been done in states such as Michigan. These reforms would anchor CHW roles more firmly within Indiana's healthcare and public health infrastructure.
- Third, the state should promote statewide and regional CHW networks and employer collaboratives to support shared training, evaluation, and funding strategies, similar to what has been done in South Dakota with the CHW Collaborative.
- Together, these reforms would support the growth of a more stable CHW workforce with significant implications for improving population health across Indiana.

challenges with the current Indiana policy, including the limited scope of covered services and inability of FQHCs to bill for these services.

FQHCs can include CHW costs in their PPS rate through a change-in-scope request, although the process is administratively complex. Several states including Louisiana, Michigan, Minnesota, New Mexico, Rhode Island, and South Dakota created specific carve outs for Medicaid billing or alternative payment models for CHWs services at FQHCs outside of the PPS.[4,18] In our study, participants advocated for more fundamental reforms like a clinically integrated network. This shift would enable more value-based contracts that support care coordination and provide flexibility to fund nontraditional team members like CHWs. Although not always labeled "clinically integrated networks," multiple states including Minnesota, New Mexico, Oregon, and Washington use Medicaid and value-based payment models to enable provider networks to fund CHWs as part of care coordination strategies.[4,18] Research on the rollout of this network in Indiana will be important to understand the potential pathways and challenges to sustainability through more value-based payment mechanisms for FQHCs.

To strengthen the sustainability of CHW programs in Indiana, diversifying funding streams is essential. Although grants and philanthropic support provide crucial start-up resources, integrating CHWs into core operations and budgets can ensure longer-term viability. Employers can also leverage Medicaid reimbursement and work collaboratively to expand billing infrastructure and documentation practices; however, structural changes are needed to advance towards value-based care models. In addition, demonstrating the value of CHWs through rigorous data collection on health outcomes, cost savings, and patient engagement can help make the business case to leadership and external funders. Recent policy and research work have largely centered on Medicaid reimbursement, which proves to remain limited for many employers. Greater attention to value-based payment models, including bundled payments and performance-based contracting, is necessary to achieve sustainable pathways for CHWs across diverse care settings.

Limitations

There are several limitations. First, although we developed a database of CHW employers in the state and purposively sampled for diversity of participants, generalizability is limited. Because of familiarity between the research team and interviewees, selection bias should be considered in the context of these results. Additional interviews with departments of health, social service, and community-based organizations may have further strengthened the findings. Second, there are limitations with the framework qualitative analytic method itself, such as the potential for data reduction. To address this, we relied on an interdisciplinary analytic team and the robust framework analytic approach. Finally, the interviews with employers represented a snapshot of their funding strategies amidst a rapidly changing policy landscape for public health funding. Despite the quickly evolving policy landscape, these qualitative results remain important and novel for supporting CHW sustainability in Indiana and nationwide.

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