

Community Health Workers:
Their Role in Preventing and Controlling Chronic Conditions Webinar
February 11, 2015

1. *Betsy Rodríguez*: Welcome, everyone, to today's webinar. I am Betsy Rodríguez, Deputy Director of the National Diabetes Education Program at CDC. First of all, thank you for the tremendous support and interest in today's webinar that surpassed 1,100 participants. This is very exciting.
2. Today, we have one of the best panels I have seen in years, all experts in the community health worker field. We will begin with Dr. Alberta Mirambeau, who is with the Division for Heart Disease and Stroke Prevention at CDC and co-leads the CDC Community Health Workers Workgroup. Then we will have Dr. Nell Brownstein, who just retired from the Division for Heart Disease and Stroke Prevention at the CDC, and Dr. Brownstein is considered one of the leaders in community health worker research. Following her we will have Dr. Bina Jayapaul-Philip, who works for the Division of Diabetes Translation at CDC and co-leads the CDC Community Health Workers Workgroup. She is also a key member of the HHS Community Health Workers Workgroup. Then we will conclude with our guest community health worker, Pamela Smart, from the Northeastern Vermont Regional Hospital, who is the coordinator of the community health worker team in St. Johnsbury, Vermont. Welcome to all.
3. Before I give the microphone to the first presenter, I would like to go over the purpose of today's webinar. Who are community health workers and what are their roles in preventing and controlling chronic conditions? We will also describe the CDC's strategies to engage community health workers in the prevention and control of conditions and policy development, among others. Our speakers will discuss the history and evolution of community health workers at the national level, highlighting the experience of some organizations implementing the community health worker model, and lessons learned on how to work effectively with them to address chronic conditions while achieving health equity. So, we have a very ambitious agenda in front of us.
4. Today's conversation is about addressing many of the questions that most of you have around roles and emerging issues related with the use of community health workers in chronic care and beyond. Here we can see an example of the questions that some of you shared with us during the registration process. For example, "Who are community health workers?" "Is there a national scope of practice for community health workers available or being developed?" "How are they trained to know the limits of the education they provide, like not giving medical advice?" This is just an example of the many questions we have received from you all.
5. Now we are going to do a poll. Please answer the following question in your computers. Our first question today is: How are you engaged with community health workers? You have here several options. For instance, "I am a community health worker." "I supervise community health workers." "I train community health workers." "I work with community health workers," and "Other." I see the responses coming up. We have 250 responses so far, so let's wait a little bit before we stop the poll. Wow, 335 responses. We are closing the poll.
6. As we can see here, the big chunk of people, 47.8, is in "Other." So we will have to figure out, panelists, what "Other" means. On the other hand, we have "I work with community health workers," 29 percent. "I train community health workers," 17 percent.

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“I supervise community health workers,” 12 percent, and “I am a community health worker,” 16.7 percent. So let’s move to our next slide.

7. But first, let me share with you some basic information.
8. Here you can see the official definition of community health workers, coming from APHA that has been used far and wide for many, many organizations. My dear colleague, Dr. Brownstein, will say there has been a lot of effort putting together this definition, so we would like to share this with you. There are many out there, and we decided to share with you the one that is coming from APHA. I’m not going to read the whole slide, but from this definition I’d like to showcase several key words, such as “frontline public health worker,” “trusted member,” and “trusting relationship.” And while building the capacity of individuals and communities through increased knowledge and self-sufficiency via many ways like outreach, community education, inform and counseling, social support, and advocacy activities.
9. So we have here another question. Read the question and send your answers through your computers, and this is the question that we have for you all right now: In what setting do you work with (or regarding) community health workers? Community-based organization, health system, faith-based setting, federal government, state or local government, and others. We are getting our responses here. 294 responses so far. Let’s give it a couple of minutes.
10. I guess we can close the poll, and what we have here? Community-based organizations, 22.8, versus state or local government, 29.9. We compare that to federal government, 6 percent, and faith-based organizations, 1.4 percent. In “others” we have 20.8. I guess that this is demonstrating how community-based organizations is one of the biggest areas where most of community health workers are working right now. Let’s move forward to our next slide.
11. Where and to whom do community health workers deliver their services? A community health worker is distinguished from other health professionals because he or she is hired primarily for his or her understanding of the populations or communities he or she serves. Therefore, they conduct outreach and outreach represents a significant portion of their time, and they’re experienced in providing services in the community settings. So they are performing a range of important activities to promote, support, and protect the health of individuals, families, and communities. Here in the slides are some of the examples of the settings and audiences, like hospitals, health agencies, community organizations, people at home, rural migrant and seasonal farm workers, vulnerable populations, and tribes.
12. From this slide you can tell that community health workers have many names and many job titles. The name of their job titles and their functions is as diverse as the cities in which they operate or the funders or payers where they work.
13. In this slide we’re showcasing the core role of community health workers. In 1998 the National Community Health Advisor Study was done, and Nell Brownstein was part of that group. And they identified the seven core roles of community health workers. These are core roles that are commonly used today in the community health worker field. You can see that community health workers have a variety of roles, and they include things like closing the gap between communities and health care to providing culturally

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competent information, advocating for access to service, provisional services, and building capacity for communities.

14. Now I would like to leave you with Dr. Alberta Mirambeau, who will present an overview of the Community Health Worker Workgroup housed in the National Center for Chronic Disease Prevention and Health Promotion. Alberta?

Dr. Alberta Mirambeau: Thank you, Betsy, thank you for that very thorough introduction about community health workers. I will just take a few minutes before my colleagues, Dr. Jayapaul-Philip and Dr. Brownstein, speak a little bit more about community health workers, and what I would like to talk to you about is what we at CDC identified as an opportunity to create synergy and streamline our approaches related to community health worker guidance.

15. So, to begin I want to start by sharing what the mission of the workgroup is. It is primarily to facilitate, support, and advance community health worker initiatives that help accomplish public health goals. Just to give you a little bit of background on the workgroup, it's comprised of about nine divisions that make up the center. So, for example, our center is made up of a Division of Diabetes Translation, a Division for Heart Disease and Stroke Prevention; you also have a Division of Cancer Prevention and Control, Physical Activity and Nutrition. And within all of these divisions we started to see that there was a natural overlap in terms of the work that was being done around community health workers and that we were all promoting very similar strategies. So this presented an opportunity for us to streamline the approach in which we used to provide technical assistance in support to our funded partners.
16. On the next slide, here we present to you what we found were the three key areas of the work that the divisions were doing within the center. One of the ways in which we help promote the field of community health workers is providing support to our partners, and we do that mainly in three ways; either through funding, training, and/or technical assistance. We're also very involved in looking at and conducting evaluations that specifically address financial sustainability, interventions around health promotion and disease prevention, and also looking at how community health workers have been integrated into the health care systems. Pamela Smart, who will conclude this presentation, will speak a little bit more about a program that we evaluated where community health workers are integrated into their system. We are also very involved in developing products such as training tools, health education materials, and also peer-reviewed publications.
17. And just to share with you, here are a few of the key activities that our workgroup is engaged in as we come together and identify ways to enhance opportunities for collaboration. In the summer of last year we came together and identified that there are two key areas that we can focus on, and that was primarily to look at how the interaction between CDC programs, and state and local grantees can be improved. And we also wanted to look at how we could enhance and create a community health worker infrastructure through collaboration. The workgroup has also created an environment so that the disparate members of the divisions can come together and look at how we can better coordinate our efforts and share information around our different projects. One example of this is last spring—almost a year ago—we conducted a project officer

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training. So, for our colleagues here within CDC, we provided them information related to community health workers so that all project officers are receiving similar guidance—the same and/or similar guidance—to share with their funded program partners. We also created a document that took an inventory of all the community health worker–related activities taking place within our center, and we hope to provide this document and make it available publicly so that you have a chance to also see the scope and spectrum of work taking place.

18. And then I also want to share what are some of the pending and ongoing activities of the workgroup. We meet regularly to serve as a central and coordinating entity for the center. We're also helping to field TA requests and provide guidance and expertise to our different program partners. And currently what we have planned is to develop a community health worker resources webpage. Right now, if you go to CDC, you will find a plethora of resources related to community health workers, but they are spread throughout different websites of CDC. So we're now working to compile and have all of these resources on one webpage for our funded program partners as well as the public. We also plan to have a round two of our project officer forum and are looking and beginning discussions around developing standardized evaluation measures for community health workers.

19. At this time I would like to go ahead and turn it over to my colleague, Dr. Nell Brownstein.

Dr. Nell Brownstein: Thank you. I'm going to try and answer some of the many questions that were raised as I go through my presentation.

20. There is considerable research evidence at this point that community health workers do enhance individual and community health literacy through their teaching and educating and coaching. We have heard feedback from providers that work with diverse populations and have community health workers as part of their team. They state that their own cultural competency has really improved. We also know that community health workers can significantly improve health outcomes of patients and care teams.
21. There aren't too many cost-effectiveness studies, but I wanted to bring your attention to six recent return on investment studies, which show a 3 to 1 net return or better. As you can see, we've got a Medicaid HMO, a couple of community-based programs, Langdale Industries is here in Georgia, and we have a number of hospitals in Texas that have demonstrated return on investment by employing community health workers. Hospitals, in particular, are engaging community health workers in patient discharge teams to ensure patients follow instructions and stay out of the hospital, and that's because hospitals are now penalized if a patient comes back in within 30 days of being released.
22. Some exciting new and important work that is coming out from CDC in 2015 are two community guide reports. The first will be on hypertension and the second one on diabetes. I think they will have a big impact and make it easier to promote community health workers and their services, specifically for cardiovascular and for diabetes work. Several years ago, several members of our Chronic Disease Center conducted two community health worker systematic lit reviews, and they were published in 2006. That was on diabetes.

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23. We found an increase in knowledge about diabetes and improved health behaviors, but not very many specific improvements in A1C. In 2007 we came out with a hypertension review that revealed significant improvements in blood pressure in 13 out of 14 studies. The way we found that community health workers were effective is they kept people in care and having their blood pressures measured over time and they kept people on medications. We even found one large study that showed decreased mortality from cardiovascular disease. While the community guide staff have thoroughly reviewed all the current literature, there are 31 Cardiovascular Disease (CVD) papers that will show significant improvements in patients with blood pressure and high cholesterol, and I believe there are about 51 papers that are going to be part of their diabetes paper, again, showing significant improvements in A1C and intervention involving community health workers.
24. I know we have others that are going to talk about our national program. I just wanted to mention that a lot of you had questions about integration of community health workers into health care teams. This is really a work in progress. There have been publications out, and CDC hopes to learn much, much more about this whole process and how community health workers really work to link community members and patients to community resources. Bina is going to talk in a little while about our new TA guide for the states on integrating community health workers into health care teams. I think if you consult that, a lot of your questions will be answered.
25. In 2009 I moderated an APHA session, and Gail Hurst from Massachusetts and Ann Willard presented about the progress in their states, and I said, “You know, we ought to write this up,” and we did. In 2011 we had two publications that came out as well as CDC’s community health worker policy and systems change brief. Well, Massachusetts has really been an early innovator. The health department has worked with community health workers since the seventies. They built and promoted and sustained a community health worker association, and then in 2010 they came out with a report that basically says that states can’t be one-trick ponies.
26. They’ve got to work on comprehensive systems and policy approaches in order to move the community health worker field forward and to sustain the workforce. There are a number of different approaches to this comprehensive method. Infrastructure development is really important, and state health departments can help facilitate this along with their partners. I’m talking about infrastructure, for example, with regard to helping build and support community health worker associations in the state because those associations are prime stakeholders. They do training for their members and they’re very important advocates for themselves. The other infrastructure piece is community health worker stakeholder networks, coalitions, or alliances—different states call them different names. This is a group of stakeholders, along with the state health department, community health workers, community health worker employers, insurers, federally qualified health care centers, Area Health Education Centers (AHECs), offices of rural health, colleges, and many, many more. One of you asked about, what do you do in a rural health area? Really, contact your office of rural health. The National Rural Health Office has been very supportive, for many years, of community health workers. So that’s a good place to start in rural areas.

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27. In terms of workforce development, we're looking at developing core skills and competencies and providing training and continuing education for community health workers that have to find answers to give their clients. Also, training for supervisors is really important for people who have never supervised community health workers.
28. To answer your question, no, there is no national core training curriculum, nor a clearinghouse at the state or national level, although a number of state health departments have a lot of good materials on their websites. Texas State Health Department and Massachusetts State Health Department particularly have a lot of resources about community health workers. In terms of what a core curriculum looks like, there certainly is a lot of focus on communication skills, and they certainly address confidentiality and the Health Insurance Portability and Accountability Act (HIPAA) requirements, and they also focus on the core skills for community health workers. Just to give you an example, Massachusetts, two AHECs—and that's an Area Health Education Center—do all the training for the community health workers in that state. And Texas five AHECs all use the same curriculum, and they train all of the community health workers in Texas. In Minnesota, colleges and community and technical colleges do the training for its state-wide curriculum. Minnesota also sells its state-wide training curriculum, and every community health worker that wants to be reimbursed by Medicaid must take that state-wide training curriculum. Also, community-based organizations do a lot of training as well. Just to give you one brief update, there are two groups that are currently working on updating the roles and skills of community health workers, and the results will be out in the fall, some recommendations. In terms of occupational regulation, if you're not knowing exactly where to start, occupational regulation is not the place to go.
29. There is a lot of other work to do first. There are some cons to credentialing community health workers that people may not be aware of. For example, how do you fairly deal with volunteer community health workers and those who have many years of experience but no standard training? How do you deal with all of this fairly? I know three states—New York, Massachusetts, and Minnesota—have been working on this whole credentialing issue very thoughtfully for at least a couple of years, and hopefully they will come out with some recommendations in the near future. No, there is no national scope of practice for community health workers. Most states don't have a scope of practice, either. A scope of practice is what specifically community health workers are allowed to do. Moving on to evaluation. As Alberta said, it is very, very important to do. We need more information about the effectiveness and the cost effectiveness of community health workers.
30. Then, in terms of financing mechanisms, a lot of you had questions about reimbursement. Let me just cover a few things. There are a lot of ways that state health departments and their partners can play a critical role in supporting and advocating for reimbursement of community health worker services. There are public payers, such as Medicaid and the Children's Health Insurance Program. There are private payers who pay for fee-for-service. I know that Blue Cross/Blue Shield of Minnesota is very supportive, and so is Molina Healthcare. Then there are ACOs, accountable care organizations. The advantage of becoming an accountable care organization is that you can bundle all of your services together. So you can bundle the community health worker services in along with all of

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your other services. I know that a number of federally qualified health care centers have become or are in the process of becoming accountable care organizations for that very reason. There are a couple of new models in practice that I want to bring your attention to. One is a linked community-based organization clinical practice in which community health workers are trained and supervised by a community-based organization. The reason this is done is so that community health workers are seen as still part of the community and not just a cog in the health care system. Also, the community health workers are contracted through the community-based organization by the health care settings, and they get supervision on the job as well as more training, and there is communication between that CBO and the clinical entity. There also is something else that you may not be aware of. A couple of years ago Health Resources and Services Administration (HRSA) and the Department of Labor got together, and they gave funding to the Texas AHEC to do a community health worker apprenticeship program where community health workers got training in the classroom and then they also got on-the-job training. This was seen as a mode of getting community health workers—of really building up the workforce more quickly. And there is a call for funding announcement from the Department of Labor, which has an April 1 deadline, and it calls for public/private development and implementation of apprenticeship programs, and that can include community health workers. So for those of you that are up for that that is an opportunity. I think those are models that are going to continue to grow in the future, this linked model between CBOs and clinics and apprenticeship programs. I want to remind you, one of the resources CDC has is an e-learning community health worker reimbursement course. It is being updated and should be out at the end of the month. It is very helpful. It will be on CDC-TRAIN (CDC TRAIN is a gateway into TRAIN National, the most comprehensive catalog of public health learning products.), and you will get Certified Health Education Specialist (CHES) and Continuing Education (CE) units if you desire.

31. I want to talk a little bit about all the work that CDC has been doing—our center has been doing—on community health worker policy. We've been tracking and have done state analyses.
32. We have a summary of laws. Last summer we released a database that has all of the legislation throughout the United States. If you're interested, this is the place to go and look. One important caveat is that it is absolutely essential that everyone involves community health workers in all aspects of this work.
33. There have been some hard-learned lessons that you cannot impose on another workforce occupation; whatever you like, you really need to get them involved at all levels.
34. We have a survey question next. Do you know about the new Centers for Medicare & Medicaid Services (CMS) ruling of 2014? [PAUSE]
Betsy Rodríguez: 327 responders so far.
35. *Dr. Nell Brownstein:* 62 (percent) of you do know of the new ruling. I'll spend a little more time talking about that.
36. A number of you had questions about reimbursement, and specifically Medicaid reimbursement. There are a number of ways that states can get reimbursed for community health worker services. For example, I've heard that states are renegotiating contracts

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with their state Medicaid offices. There's a reference at the bottom of the paper that will give you a lot more detail on all of these different techniques. There are demonstration projects that are funded. For example, there are projects in which they are working with community health workers in patient-centered medical homes. That is just one example. States can apply for 1115 Waivers. For example, Minnesota has had an 1115 Waiver for over eight years. It is the first state that negotiated directly with Medicaid for reimbursement for community health worker services.

37. Then this year, in 2014, the State Plan Amendment Rule came out. This really opens the door for supporting expanded roles for non-clinicians, such as community health workers. CMS has told us in our conversations that they know of seven states that are currently working on a state plan amendment. I have to add that these are all states that have infrastructure. They have training in place. They have community health worker associations and they have state coalitions. We see other states are really scrambling to find partners to work on specifics on training. It will probably take them a good couple of years before they're ready to put in a state plan amendment. States can define what non-clinical people they want to put on the plan and what their qualifications are and what kind of services they will provide. CMS is willing to review draft state plan amendments regarding community health workers and others. So if you send it to them, they will send it back with a critique. So that should be helpful to folks. Further information about—again, states will need to work with their state Medicaid offices on these state plan amendments that will be going to CMS. And again, the states have to do the standard Medicaid policies. They would have to provide community health workers statewide and have a freedom of choice of providers. A very important caveat that a number of you asked about: Credentialing is not required by CMS, not at this point. They do want to know if you are credentialing, but they don't require it. But, very specifically, there is no template to provide—that CMS has provided—since this is the first round of this new ruling, but they do require that states provide what the qualifications are of the people that they're promoting, what required education they have, their training and experience.
38. Just a couple more points about state plan amendments: community health workers will not automatically be put on them. It is going to require partnership and advocacy to get them on state plan amendments. There are other parties that are really pushing—around the country—for medical assistants to get on the state plan amendments. So people will have to work together to accomplish this. There are some questions about the difference between a community health worker and a patient navigator. The short answer is that navigation is a role that all community health workers play in the community and in clinical settings. Some programs even have titles called community navigator. We consider community health workers navigators under the umbrella term of community health workers, but realize that patient navigators can also include other professions, like nurses and social workers, and they do their work strictly in the clinic, they're not out in the community.
39. A big takeaway is: please remember the importance of networking and partnering and getting involved with your state health department, and if your state health department is not well-experienced with community health workers, ask them to play a role in

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facilitating the critical policy and systems changes. I want to wind up by just mentioning some of our resources.

40. A number of you asked questions about what kind of training is available, is there any lifestyle risk factor training, etc. I want to bring your attention to the first resource. I spent part of the last two years at CDC working on a CDC evidence-based training resource for preventing heart disease and stroke. It is a national specialty training that is very useful to use with integrating community health workers with a health care team. There are 15 chapters; they include all of the lifestyle risk factors. They include a chapter on cholesterol, a blood pressure chapter that even includes a pictorial instruction on how to take blood pressure measurements. There is a very large diabetes chapter, which integrates all of the CDC diabetes info and more information that Betsy will tell you about. We have chapters on heart attack, stroke, atrial fibrillation (AFib), heart failure, how to talk to your doctor, how to take meds, and a chapter on teens and kids, and it will soon be available in Spanish. It is now on CDC-TRAIN, and you can get credit for taking the course. Again, our e-learning course, and then Community Health Worker Brief is coming out, updated, later this month. It will give you a highlight of CDC programs with community health workers. It also will have a completely updated list of state community health worker networks and state community health worker associations.
41. Now I would like to turn the program over to Dr. Bina Jayapaul-Philip.
Dr. Bina Jayapaul-Philip: Thank you, Nell, for a very thorough overview on the state of the CHW field.
42. The next set of slides are based on community health worker interventions in the CDC cooperative agreement State Public Health Actions To Prevent And Control Diabetes, Heart Disease, Obesity, And Associated Risk Factors And Promote School Health, referred to as 1305 for short. Patient interventions are in two domains of the cooperative agreement: Domain 3, which focuses on health systems, and Domain 4, which focuses on community-clinic linkages. Under health systems, the intervention focuses on engaging CHWs in multidisciplinary care teams within health care systems. In Domain 4 there are two interventions. One focuses on engagement of CHWs in delivering and supporting diabetes self-management education, or DSME programs. The other intervention focuses on engaging CHWs to link patients to community resources for the control of blood pressure. There are performance measures related to each of these interventions that state health department grantees will report on annually. Two of the performance measures are focused on the proportion of health systems that engage CHWs. The Code 1 will focus on proportion of DSME programs that engage CHWs.
43. For a picture of the states implementing CHW interventions, fully 36 states are implementing at least one intervention in this cooperative agreement. Nineteen of the states are doing two interventions, and there are three states that are doing all the three CHW interventions. Regarding the type of interventions, 24 states are implementing the intervention related to linking patients to community resources, 20 are engaging CHWs in multidisciplinary health care teams, and 17 state grantees are engaging CHWs to deliver and/or support DSME programs.
44. Here is a picture of the country in terms of CHW interventions being implemented in this cooperative agreement. The darkest blue is the three states that are implementing all three

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of the interventions, and the next shade of blue is the 19 states that are implementing two interventions, and the lightest blue is the 14 that are implementing one intervention, the white being those states that don't have a CHW intervention under this cooperative agreement at this time.

45. To get to a picture of sample grantee activities to promote CHW roles within this cooperative agreement, it is appropriate to think of them as falling under three categories: One is working with state-level entities, two is working with health systems and providers, the third is working with CHWs and CHW organizations. Under working with state-level entities, the activities focus on participating with community health worker collaboratives to create sustainable state-wide models for reimbursement, working with CHW training programs to establish pathways for certification, and adapting CHW curricula for use in the state. Working with health systems and providers, the focus is on developing and implementing communication plans to inform providers, payers, policy makers on the role of patient navigators and CHWs. Increasing availability and awareness of existing curricula and trainings on inclusion of CHWs in care teams, and providing tools to assist in the adoption of policies, protocols, and processes to support the implementation of team-based care models like Patient Centered Medical Home (PCMH). As far as working with CHWs and CHW organizations, collaborating with CHW organizations to develop and implement culturally appropriate strategies to connect patients to clinics. Training CHWs to provide or support delivery of DSME programs, and develop marketing materials and training tools and resources for CHWs to promote community resources for patients.
46. To take a look at the reach of CHW interventions or give an idea of the extent of the effort, based on currently available data, Texas has 27 DSME programs that are currently engaging CHWs in the delivery and support of programs. Rhode Island plans to increase from the current eight programs to 40 programs over the five years of the FOA. Massachusetts and Michigan are currently engaging CHWs in 10 health care systems to link patients to community resources and have a five-year goal of at least doubling that number.
47. Our newest cooperative agreement is 1422 that incorporates CHW interventions. Under the community clinic linkages component, the intervention is to engage CHWs to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or who are at a high risk for type 2 diabetes. Here too, we have two associated performance measures. One focuses on the number of health systems that engage CHWs to link patients to community resources for high blood pressure control. The other one focuses on number of health systems that refer persons to the National Diabetes Prevention Program.
48. Some of the technical assistance resources that we have available for the implementation of these interventions are: a draft Driver Diagram For Community Health Worker engagement in DSME programs; a Technical Assistance Guide that we recently put out, and that Nell mentioned, that is broadly aligned to the interventions in this cooperative agreement and should provide answers to a lot of the questions that were asked by webinar registrants; and we're also planning to bring out shortly some Emerging Practices Documents on CHW interventions based on grantee experiences.

49. I want to also provide a brief overview on the draft driver diagram for CHW engagement in DSME programs. Over on the left side we have the performance measure proportion of DSME programs engaging CHWs in the delivery or support of DSME programs. We think there are three main drivers for this performance outcome: DSME program readiness to engage CHWs, awareness and implementation of CHW roles in target DSME programs, and CHW sustainability in DSME programs. Those drivers are further detailed by the intervention components that comprise these drivers. DSME program readiness to engage CHWs would focus on enabling the recruitment of CHWs in these DSME programs, enabling the training of CHWs for program delivery and access to information and resources. As far as awareness and implementation of the CHW roles within the DSME programs, these would focus on some of the core CHW roles, including program delivery, conducting outreach to participants to bring them into the DSME program, being a liaison for referral from the health systems to the programs, and providing support for program participants. The last driver of CHW sustainability in DSME programs: engaging with state and local stakeholders for items like the training curricula and delivery processes to identify certification and credentialing processes, and then to identify sustainable financing mechanisms.

50. Now I'll turn it over to Pam Smart.

Pamela Smart: Good afternoon. Thanks for giving me the opportunity to talk about our team-based approach using the community health worker here in rural Vermont. We have created this team-based approach and it has been up and running for about seven years now. You can see, I will show you on our first slide here, this is a diagram of our community health team.

51. You can see that it is interconnecting circles because we are interconnected, there is no one point of entry for anybody. We are all able to enter through any door. The big team, which we call our administrative core team, is comprised of our doctors, practitioners, our behavioral health specialists, care coordinators, Support and Services At Home, which is a program coordinated with our rural housing providers where there are SASH coordinators—Support and Services At Home—but they also function as community health workers. They do provide care at home to people. I know one of the questions mentioned people with dementia; these folks provide care to anyone with Medicare, so yes, there are some services there. We also connect with our community-based partners, which are all of our agencies, and anyone providing service to an individual as well as community members attend this team meeting. We meet once a month and all of us come together in a room for an hour. In the middle of the team is the important community health worker. The community health worker is really the one that navigates and connects people to all of the resources, but follows through to be sure they get them. We work in a holistic manner. We field things like housing. All of the things that need to be addressed to have a healthy lifestyle are addressed: food, health, housing, anything that contributes to keeping someone healthy. This team was formed—we did it as part of a pilot. We then proved our results of improving quality of life and decreasing costs for hospital care, and now every hospital area in the state—there are 14 hospitals in Vermont—have implemented a community health team approach.

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52. The components of our team are that large team I told you about. The functional team are the people that are doing the direct service, the people really involved, the care coordinators, the community health workers, the behavioral health therapists, and we also meet monthly as well as whenever necessary to pull a team around a patient. If a patient desires to have a small team, the patient identifies who they would like on their team. We meet as a team with the patient to see how we can provide and improve services. That community connection team is your community health worker group, and also our primary care physicians and our SASH people are part of our direct service.
53. So within our program there are several things that affect the implementation: the relationship, communication, and collaboration, and that is going very well. We have formed communication and collaboration with our partners as well as with our patients. We have behavioral health therapists located in the practices, as well as chronic care coordinators. The behavioral health has been a huge part of the primary care practice team also. We all have a commitment to patients and to clients, and the providers have bought in. The providers actually love the model. They feel like they never used to ask the question such as, “Where are you going to sleep tonight?” Or, “Do you want to stop smoking?” They felt that it took so much time, then, to access the services that were needed for that. Now they call a community health worker and things are put in place instantly. We have a community health worker who specializes in chronic disease, and particularly we look at diabetes, hypertension, and asthma. She works closely with the diabetes educator and with the physicians and the care managers to help the person get what they want to have happen. It’s all about self-management. She works to help provide the education. She may shop with the individual; she will work to be sure that person has access to the treatments they need. Some people don’t have insurance; we work to get them insured. We work to get them the meds that they need, and then whatever they want to have happen. It may be an exercise program or a nutrition program; she would connect them and follow them. She meets with them regularly to be sure they’re getting what they need and also keeps in constant communication with the provider and the diabetes educator.
54. So the factors affecting the implementation of our program? Navigating the health care record, the computer record, has been a bit of a challenge for communication. We find that many partners are on different systems and so that has been an ongoing issue. The time and workload of the community health worker is always an issue. We try to balance that out using interns. We currently have two interns working with us. And, of course, the individual’s readiness to change, the stages that they’re at, what do they want. If they’re not ready, we still work with them and follow them and support them in whatever way they may want. If they decide at some point they’re ready to take that next step, we’re there with them. Funding silos in community resources—that has really come a long way. In the beginning, people that were part of the team were afraid to share their funding, were afraid that we were going to receive funding that they might have had in the past. So it took a lot of reassurance that we are not competing for funding or duplication of service. And lack of clarity in the chronic care coordinator and the behavioral health roles were also an issue. Those have pretty much become a non-issue at this point. Thank you for giving me this opportunity.

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55. *Betsy Rodríguez:* Thank you, Pam. We have been getting a lot of questions. We will try to do our best with the time that we have, but rest assured, we have a commitment already made here that our internal group will go over the questions, and we will be working on a Q&A document that we will share with all of you. We will try to do our best to answer some of the questions that we have here in the chat box. I will start with Pam. Pam, there is a question here that I think that you can answer. The question says, “What community organizations have health systems that have been found to further the role of community health workers?”

Pamela Smart: We particularly partner with the Agency of Human Services and with our mental health system here in Northeast Kingdom Human Services and with our housing partners. Our housing partners, I think, have found the most success. They used to function on just bricks and mortar, and now they focus on the rest of the support services needed—not just housing someone, but housing them successfully.

Betsy Rodríguez: Thank you, Pam. I have another interesting question coming from Marion. I would like to give this question to Dr. Alberta Mirambeau. The question is, “Many states want to explore expanding reimbursement from January 24 CMS rules about prevention services. If the workgroup could provide some TA about how to effect those policy changes in the states, that would be a huge help. The Florida Community Health Worker Commission is working on the issue, but we want to make much progress.” By the way, TA stands for technical assistance.

Dr. Alberta Mirambeau: Thanks, Betsy, and thank you, Marion. I think that is a timely question. The workgroup has identified this as an area of need for our state-funded program partners. We are currently in discussions now with CMS to talk about identifying what are the common questions that are coming up from states as they prepare for their state plan amendments. We have invited them, and plan and hope to provide a lunch and learn or similar webinar format where CMS will be able to share updates in terms of different approaches or specific suggestions for how states can prepare a successful state plan amendment. So all that to say that we are fully aware of this need, and we’re in discussions for planning on how we can better meet this need for our program partners.

Betsy Rodríguez: Thank you, Alberta. Nell, I have a question for you. “How do I get the studies showing benefit of CHWs work on CV (cardiovascular) diseases?”

Dr. Nell Brownstein: We have our literature reviews from 2006 and 2007 that are available. I can provide the information on the return on investment studies and then again, in 2005 and fairly soon, the Hypertension Community Guide Report will be out with all of the studies and recommendations. And then just a little bit later this year the Community Guide on Diabetes will be out. So look for those. But we can supply some of the older data.

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Betsy Rodríguez: I think you have another question, Nell.

Dr. Nell Brownstein: Somebody asked, “can community health workers be clinical, such as a health care coordinator RN?” I think it is essential that there are career ladders for community health workers. For example, community health workers that have been promoted to supervising other community health workers, and I think there will be a lot more potential for them to become leads in case management. Some community health workers have gone on and become nurses as well. There are a lot of opportunities in the future as they become integrated into health care to be able to have—to go up the ladder.

Betsy Rodríguez: There is another question here, and I think, Nell, that you are better positioned to answer this question. “Are there any examples of language to include in a state Medicaid that covers community health workers?”

Dr. Nell Brownstein: In terms of language for state plan amendment? I don’t know what the language specifically would be. Alberta, do you want to address that?

Dr. Alberta Mirambeau: And Bina, please chime in. Based on the preliminary discussions that we’ve had on this topic, it is very early and CMS is really just getting into the throes of identifying and working with states on their state plan amendment. So they are also identifying what are the best practices for moving this forward. Bina, is there anything you want to add to that?

Dr. Bina Jayapaul-Philip: I don’t think we have any specific language to provide to those who are implementing CHW strategies, but I think that we are planning on technical assistance documents on an ongoing basis, and some of these will include experiences of states that have made some advances in that direction and so that might provide some guidance.

Betsy Rodríguez: I think you have another question, Bina. Can you address that question? It’s a question about the map that you were showing.

Dr. Bina Jayapaul-Philip: I think it’s a question about the three states that are implementing all three CHW interventions under the 1305 cooperative agreement. Those are Maryland, Michigan, and Delaware. I think there was one other question about specific TA for state health departments employing CHWs. I just want to point to a couple of the resources that I mentioned in one of the slides. The Technical Assistance Guide that we put out a few months back that is broadly aligned to the cooperative agreement intervention should provide more guidance.

Betsy Rodríguez: We don’t have time to answer any more questions, but I want you to rest assured that after this webinar you will be getting an e-mail with the slides. So

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everybody will get a set of the slides and as I said we will answer all of these questions. That will take some time because there are way too many, but rest assured that we will work very diligently to have those answers available for you.

56. We showcased some of the resources that we have in the National Diabetes Education Program.
57. I just want to highlight the *Hazlo por ellos! Pero por ti tambien*. Do It for Them, But for You Too. That has become a very popular resource around diabetes prevention.
58. We also have some CDs/DVDs, *Movimiento Por Su vida* and Step by Step. Those are good strategies to increase physical activity. The Step by Step is for African Americans; *Movimiento* is for Latinos but at the end is music, but I bet it will work for everybody.
59. Then we have The Road to Health Toolkit, one of the most popular resources in the National Diabetes Education Program; this is to start a community-based organization program on diabetes prevention. It has been developed by community health workers for community health workers.
60. In the slides you have my contact information; if you have any questions, that's my e-mail.
61. You also have the e-mails of all the presenters. Feel free to send e-mails with some of the questions that you may have. And this concludes our webinar for today. I'd like to thank everyone that joined us today. You have seen our contact information during the Q&A session so please feel free to contact us.
62. I also invite you to check out the updated NDEP/CDC website by visiting www.cdc.gov/diabetes/ndep. Thank you Alberta, thank you Nell, thank you Bina and Pam for sharing your expertise and words of wisdom.