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  - CNE/CEU's are available for this live webinar. You must take the pre and post tests. 80% is required on the post test to receive CNE/CEU's.
- Certificates will be emailed out to you within two weeks

# Community Health Worker Roles in Diabetes Self-Management

Carl H. Rush, MRP  
Project on CHW Policy & Practice  
University of Texas – Houston,  
Institute for Health Policy

# Speaker bio

Carl H. Rush, MRP, has worked full time for and with CHWs for almost 20 years, specializing in state workforce policies on CHWs and preparing health care organizations to integrate CHWs, including supervisory skills training.

He was a lead author on the CHW National Workforce Study for HRSA (2007), and has run a college-based CHW education program in Texas. He has advised CHW policy initiatives in more than 20 individual states, and serves as an advisor or subject matter expert on a number of national projects.

# Topics: CHWs in national context

- Getting on the same page: definitions and standards
- Examples of population and individual approaches
- CHW roles in CDSM
- Opportunities in the revised Medicaid rule on preventive services



Definitions and standards

# GETTING ON THE SAME PAGE

# What's your definition of CHW?



# Community Health Worker Definition American Public Health Association (1)

- The CHW is a frontline public health worker who is a **trusted member** of and/or has an unusually close understanding **of the community served**.
- This trusting relationship enables the CHW to **serve as a liaison/link/intermediary** between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

## Community Health Worker Definition - APHA (2)

- The CHW also **builds individual and community capacity** by increasing health knowledge and self-sufficiency through a **range of activities** such as
- outreach, community education, informal counseling, social support and advocacy.

APHA Policy Statement 2009-1, November 2009

# CHW Roles And Functions (1)



National Community Health Advisor Study (1998):

- ❑ Cultural mediation between communities and health and human services system
- ❑ Providing culturally appropriate health education and information
- ❑ Assuring people get the services they need
- ❑ Informal counseling and social support

## CHW Roles And Functions (2)

- ❑ Advocating for individual and community needs
- ❑ Providing direct services, mainly in remote areas, and meeting basic needs
- ❑ Building individual and community capacity

<http://crh.arizona.edu/sites/crh.arizona.edu/files/pdf/publications/CAHsummaryALL.pdf>

# What Is Distinctive About CHWs? (1)

- ❑ Do not provide clinical care
- ❑ Generally do not hold another professional license
- ❑ Expertise is based on *shared culture and life experience* with people served

# What Is Distinctive About CHWs? (2)

- ❑ Rely on *relationships and trust* more than on clinical expertise
- ❑ Relate to community members *as peers rather than purely as clients*
- ❑ Can achieve certain results that other professionals can't



A stylized, monochromatic illustration of a plant with several large, pointed leaves and a cluster of small, round buds or flowers on the left side. The illustration is rendered in a dark brown color against a lighter brown background.

CHWs at Work in Diabetes:

# PROGRAM EXAMPLES



[www.spectrumhealth.org/healthiercommunities](http://www.spectrumhealth.org/healthiercommunities)

# Overview of Core Health

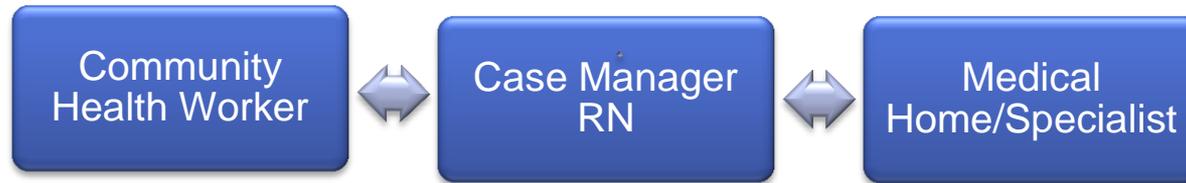
## Overview:

Core Health is a continuum-based free 12 month program for adult clients with **Heart Failure** and/or **Diabetes** that:

- Live in Kent County
- Have economic, demographic, or cultural barriers to healthcare
- Are able to participate in a self-management program

**Address barriers to achieve Self Management!**

# Case Manager RN/CHW Model



Core Health Program Team

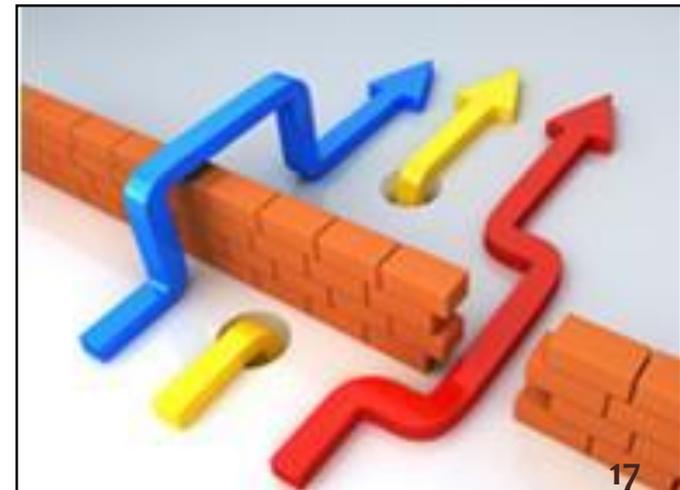
# Case Manager RN/CHW Model

## Patient Experience - CHW

Weekly to Monthly visits

- Data collection – VS, foot check, self report
- Goals using Motivational Interviewing
- Education
- Referrals – community connections
- Self-Efficacy

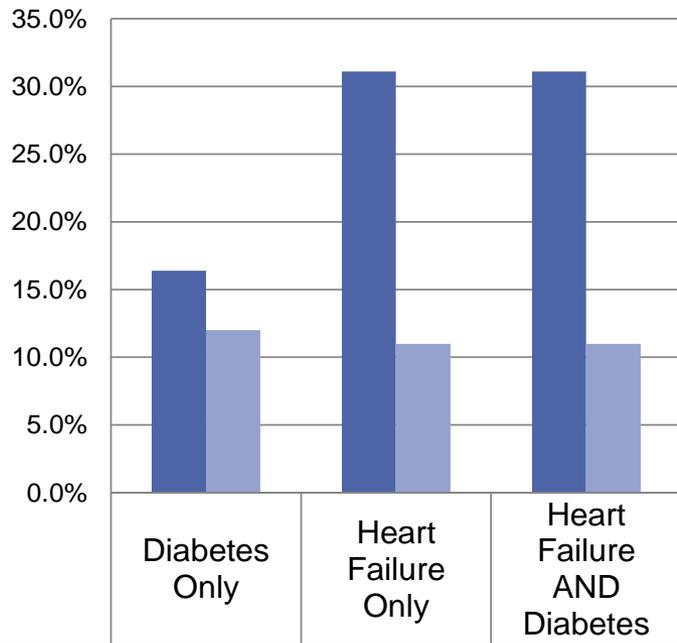
**Patient Centered - Address barriers of equity and access**





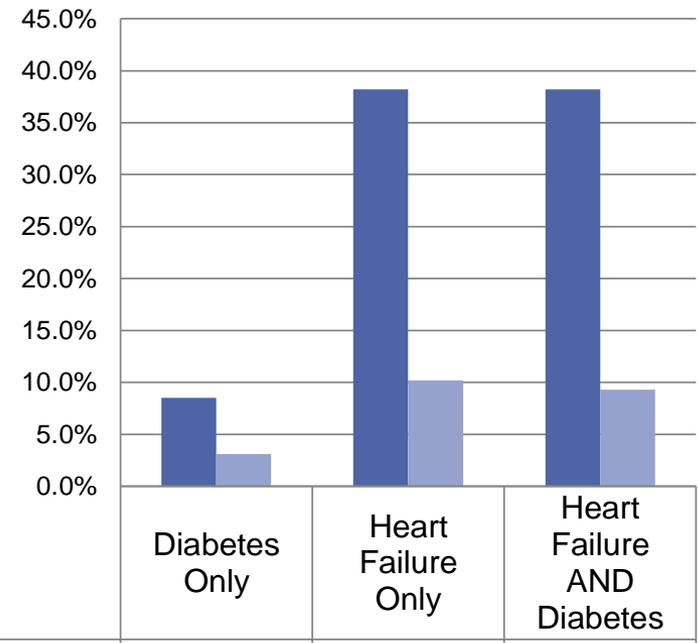
# Cost Efficiencies – Right Place Care

## Emergency Department Visits



■ Usage Rate BEFORE Core Health	16.4%	31.1%	31.1%
■ Usage Rate for Core Health Experience	12.0%	11.0%	11.0%

## Hospital Admissions



■ Usage Rate BEFORE Core Health	8.5%	38.2%	38.2%
■ Usage Rate for Core Health Experience	3.1%	10.2%	9.3%



*a program of*



# Community Health Worker Led Diabetes Coaching within the Medical Home

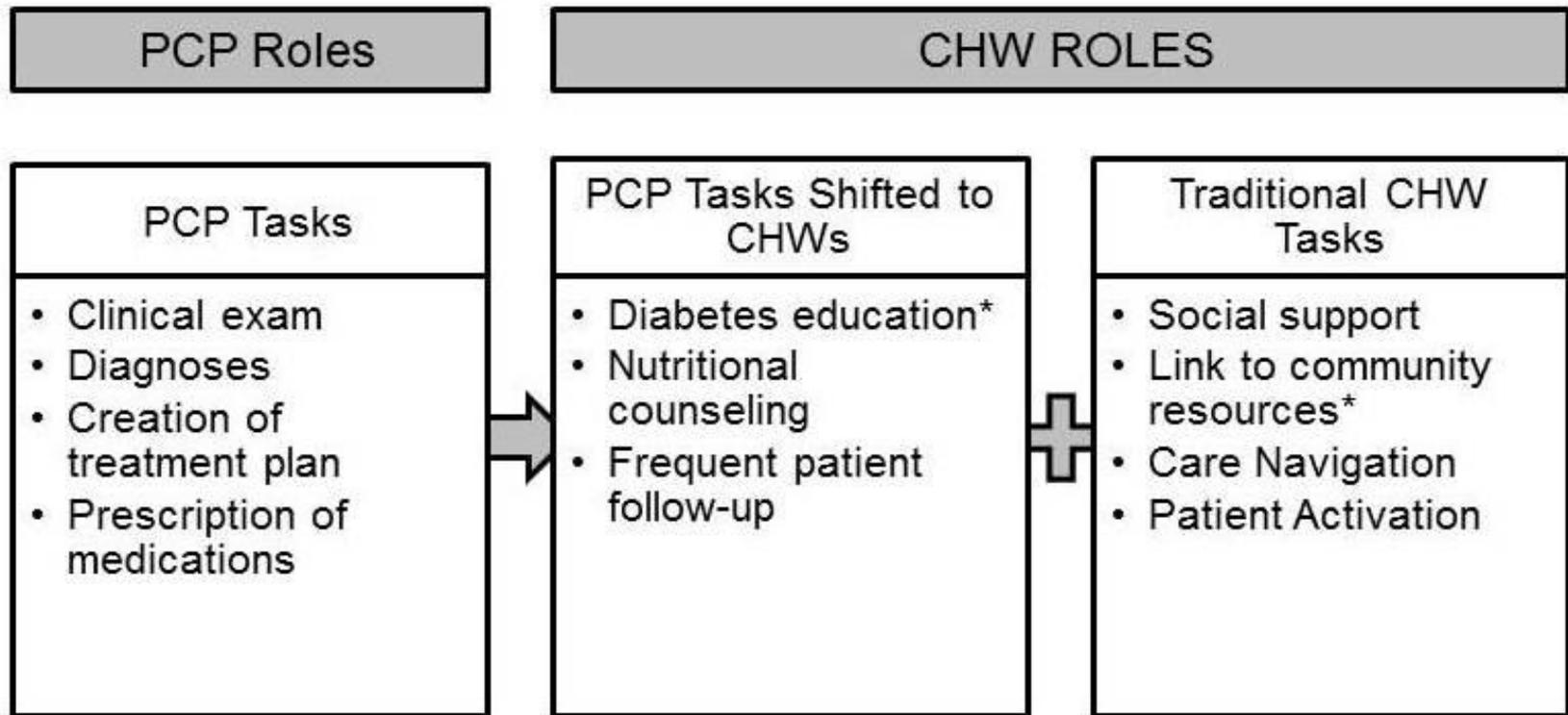
Christine Snead, RN  
Erin Kane, MD  
Baylor Scott & White Health

# Diabetes Equity Project



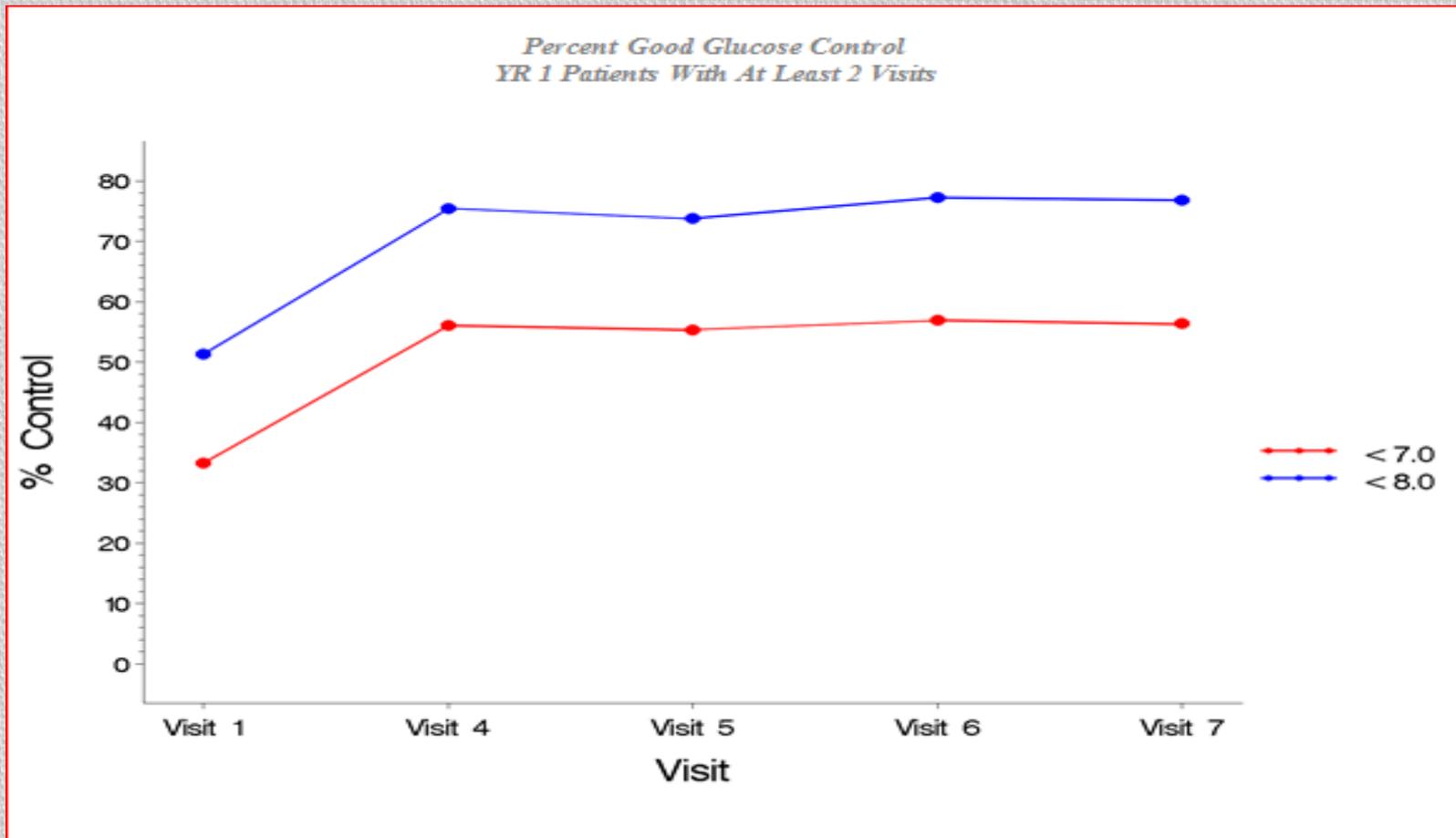
- Goal: To optimize primary care for “at-risk” patients with diabetes
- Tactics:
  - Embed community health workers within PCMH
  - Train and manage CHWs
  - Leverage software for data capture and communication
  - Scale to five sites

# Shifting Tasks to the CHW



- Licensed personnel (RNs, CDEs, SWs) handle more complex cases.
- CHW oversight by licensed program manager (RN or SW) and program Medical Director. Patient specific direction taken from PCP.

# A Population View: Glycemic Control Improves



DEP patients with at least two measures within specified period were included in the analysis. Visits listed are quarterly. The most recent measure was used. Data source is the registry used for the DEP. Data extracted January 6, 2014.

# Patient Feedback: Qualitative Interviews



- Relaxed, safe environment
- Frequent contact
- Relatable and accessible when there are issues

“With the (CHW), you can be part of the conversation in deciding your health.”

“She tells me the truth. I believe she’s honest about things. I feel I can get open with her because she’s the kind of person who will listen to what you’re going to say.”

\* Twelve qualitative interviews conducted by BHCS Director of Health Sciences Research Funding, 2012.

- **CHWs improve efficiency and quality of care**
  - Build rapport with patients quickly → identify barriers → providers refine medical management
  - Spends more time with patients than providers are able
    - Navigate needed services
    - Hold patients accountable as the driver of improved outcomes
    - Follow up with CHW occurs between provider visits
  - Providers recognized CHW knowledge base which increased professional trust

\* Twelve qualitative interviews conducted by BHCS Director of Health Sciences Research Funding, 2012.



Health IT Framework  
 Evaluation Framework

- A foundation of medical homes and community health teams that supports coordinated care and linkages with a broad range of services
- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams
- A health information infrastructure that includes electronic health records (EHRs), hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact



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## Traditional Healthcare Workers Join CCO Movement

*This work force is intended to help people lead healthier lives, as well as save money*

By Amanda Waldroupe

July 1, 2013—Traditional health workers and their impact on Oregon's healthcare system, particularly the Oregon Health Plan, were the subject of an all-day conference sponsored by Aclumetra Health last week.



The legislation creating coordinated care organizations (CCOs) requires them to use three types of traditional healthcare workers: community health workers, peer wellness specialists and patient navigators. Doulas, and other types of workers, can also be used.

### Featured Ev

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# Making the Connection: The Role of Community Health Workers in Health Homes

SEPTEMBER 2012

Prepared by:

HEALTH MANAGEMENT ASSOCIATES





## **AADE POSITION STATEMENT**

### **Community Health Workers in Diabetes Management and Prevention**

Ann Albright, PhD, RD; Racheal Araujo; Carol Brownson, MSPH, PHLC; Dawn Heffernan, RN, MS; Darrel Iron Shield, Melinda Maryniuk, MEd, RD, CDE; Laurie Ruggiero PhD; Phyllis Secraw, RNC, CDE

Acknowledgement: Kris Ernst, RN, CDE

#### **Introduction**

A complex set of social, political, historical, environmental, and behavioral factors influence both the onset of type 2 diabetes and the sustainability of diabetes self-care practices. No single set of interventions is capable of addressing all of these influences. Rather, multiple approaches that include education, social support, policies, and community programs are needed. These approaches should also be directed at multiple levels, including individuals, families, communities, healthcare providers, and policy makers. To strengthen the links between healthcare providers and community members, many health promotion and diabetes programs are engaging community health workers (CHW).<sup>15</sup>

<sup>10/20/15</sup> CHWs are uniquely positioned to collaborate with diabetes educators and other health care providers to improve the quality of diabetes education, care, and prevention in communities. CHWs who are dedicated



Versatile and adaptable  
**CHW roles in CDSM**



# CHWs play multiple roles in CDSM (1)

- ❑ Basic education on conditions, prevention and management techniques: community and individual
- ❑ Starting/leading classes: exercise, shopping, cooking
- ❑ Use of equipment: BP, blood glucose
- ❑ Longer-term support and coaching
  - ❑ Motivational interviewing
  - ❑ Enlisting social support networks

# CHWs play multiple roles in CDSM (2)

- ❑ Connecting to community resources
- ❑ Patient-provider communication
  - ❑ Health literacy
  - ❑ Appointment keeping
  - ❑ Routine follow-up



# CHW have had success in various diabetes management models

- ❑ Project Dulce
- ❑ DEEP
- ❑ National Diabetes Education Program
- ❑ Stanford CDSMP model
  - ❑ CHW roles can include Master Trainers

# The Road to Health Toolkit

## ACTIVITIES GUIDE

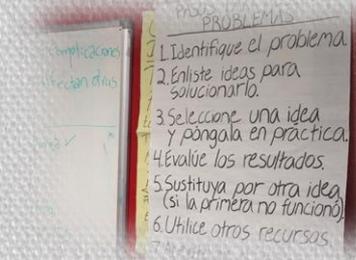
How to Prevent or Delay  
Type 2 Diabetes in Your Community  
An Activities Guide for Community Health Workers



October 2008



NDEP-104



## State and Federal POLICY DEVELOPMENTS



States and other healthcare payers are interested in CHWs in view of increasing evidence of effectiveness in:

- ❑ Chronic disease management
- ❑ “Hot-spotters” – better care for high utilizers
- ❑ Improving birth outcomes
- ❑ Cancer screening and navigation
- ❑ Care transitions

# States are pursuing various strategies in CHW policy innovation

- ❑ **Legislative:** Texas, Ohio, Massachusetts, New Mexico, Illinois, Maryland
- ❑ **Medicaid rules:** Minnesota, Wisconsin, DC
- ❑ **Policy driven by specific health reform initiatives:** New York, Oregon, South Carolina + SIM states
- ❑ **Broad-based coalition process:** Arizona, Florida. Michigan

# National initiatives in CHW policy

- USDHHS CHW Work Group
- CMMI HCIA/SIM CHW project group
- ASTHO, NASHP tracking efforts
- NASHP state-federal “discourse”
- PCORI Annual Meeting
- CHW Core Consensus (C3) Project

# Addressing Chronic Disease through Community Health Workers: A POLICY AND SYSTEMS-LEVEL APPROACH

## A POLICY BRIEF ON COMMUNITY HEALTH WORKERS

**T**his document provides guidance and resources for implementing recommendations to integrate community health workers (CHWs) into community-based efforts to prevent chronic disease. After providing general information on CHWs in the United States, it sets forth evidence demonstrating the value and impact of CHWs in preventing and managing a variety of chronic diseases, including heart disease and stroke, diabetes, and cancer. In addition, descriptions are offered of chronic disease programs that are engaging CHWs, examples of state legislative action are provided, recommendations are made for comprehensive policies to build capacity for an integrated and sustainable CHW workforce in the public health arena, and resources are described that can assist state health departments and others in making progress with CHWs.

## Partner Spotlight

### The Road to Health Toolkit Hits the Border City of El Paso, Texas

The National Diabetes Education Program's (NDEP) [Road to Health Toolkit](#) found its way this past summer to a workshop in El Paso, Texas, where diabetes is prevalent in this border city.

In June, a group in El Paso began their instruction to become "Promotoras de Salud," or certified community health workers who are members of a target population that share many social, cultural, and economic characteristics. According to HHS' Rural Assistance Center, "promotoras" provide culturally appropriate services and serve as patient advocates, educators, mentors, outreach workers and translators.



*The workshop welcomed more than 40 participants.*



*Role Playing: A family conversation with a community health worker after a diabetes diagnosis.*

Familias Triunfadoras is a women-led, community-based organization that certifies community health workers in El Paso and works to empower women and families along the United States-Mexico border who are victims and survivors of domestic and dating violence. Because diabetes is prevalent in this area, Familias Triunfadoras has worked with the NDEP to increase the capacity of Promotores de Salud in diabetes prevention to address this serious public health issue.

"Diabetes is a growing problem here in the border" said workshop trainer Rosalba Ruiz- Holguin, who explained that 7.3 percent of El Paso residents reported having diabetes, compared with the state prevalence statistic of 6.5 percent. Meanwhile, Ruiz-Holguin added that El Paso Hispanics have the highest prevalence at 8.1 percent, while non-Hispanics have a prevalence rate of 5.5 percent, and diabetes risk for families is significantly higher among Hispanic families.

May Covernali, executive director for Familias Triunfadoras, said diabetes is a major priority in the group's program.

"The Road to Health Toolkit is a way to teach promotoras an interactive, motivating series of steps with specific messages in order for the individual to start identifying diabetes risk factors, types of diabetes, and prevention measures against this deadly disease," Covernali said.

Welcome to NDEP's Partner Spotlight webpage! The page is being updated regularly to feature some of the great activities that our partners are doing to promote NDEP.

The Partner Spotlight features partners who have used creative methods to highlight and promote [NDEP's campaigns](#) and [resources](#).

#### We Want to Hear from You!

Have you been featured in a local or national media outlet? Do you have a promotion that you'd like to see featured on the Partner Spotlight webpage? First answer these questions:

- Does your promotion highlight [NDEP's campaigns](#) and [resources](#)?
- Is your promotion innovative?
- Has the promotion been recently implemented, and are you able to evaluate how it's doing?
- Are there lessons learned that can help other partners?

If you answered yes to all of these questions, your organization could be featured in the next Partner Spotlight! [Complete the submission form](#) to let us know about your activities. Send any photos, media results, and contact information to Stephanie Corkett at [scorkett@hagerssharp.com](mailto:scorkett@hagerssharp.com).

# Medicaid Breakthru: Preventive Services

- 78 FR 135 p. 42306: 7/15/13– (effective Jan. 2014)
  - § 440.130 Diagnostic, screening, preventive, and rehabilitative service
- “*Preventive services* means services recommended by a physician or other licensed practitioner...” (previously read “provided by”)
- Brings rules into conformance with ACA
- Commentary clearly reflects interest in funding services by CHWs and other “non-licensed” providers
- Payment for CHW services will no longer need to be treated as admin costs

# Taking Advantage of Medicaid Rule Change

- ❑ Requires State Plan Amendment (not a waiver):  
not required to be budget-neutral
- ❑ Must specify what non-licensed occupations are covered and their qualifications (skill requirements) – not necessarily certification
- ❑ Must specify what services will be paid for (CPT codes) and which Medicaid recipients are eligible
- ❑ Must specify rates of payment and payment mechanism (FFS, MCO, bundled payment etc.)

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Thank you!

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