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APRIL 26, 2018
PSA WEBINAR
STRATEGIES FOR BUILDING AND STRENGTHENING
THE CHW EFFORT IN YOUR AREA

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>> OPERATOR: Audio recording for this meeting has begun.

>> CAMILA SANTOS: Hello, everyone. Before we get started I would like to provide a few notes. This webinar is scheduled to last one hour. The last portion of the hour will be a question and answer session. You can pose your questions throughout the webinar in the Q&A pod located in the right bottom corner of your screen. If you are experiencing trouble with your audio you can use the Q&A pod to request a call in number. You can adjust the speaker volume by using the speaker icon at the top of your screen. Above the Q&A pod is a chat box. You can use it to say hi and let us know where you're from.

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At the end of the webinar we will also provide a brief assessment that we encourage you to complete to help us improve our webinar and suggest potential topics.

I would now like to turn the webinar over to our moderator Kristen that Spilenell.

>> MODERATOR: I'm from the Utah Department of Health, office of health disparities. I would like to welcome everyone first of all to national minority health month. And in honor of this important month, we have a webinar that we are going to be talking about, strategies for building and strengthening the CHW effort in your area, a case study from Utah. It is also my pleasure and my privilege to introduce Anna Guymon, your presenter for today. Who is also with the Utah Department of Health. Anna currently works as the Community Health Worker specialist at the Utah Department of Health in healthy living through environmental policy and improved clinical care program. In her role, Mrs. Guymon oversees infrastructure development and maintenance of the CHW coalition, including support and coordination.

She supports strategy development for the CHW coalition through the identification of barriers and opportunities within the context for state action. And she assists CHW coalition work groups in development of action plans and timelines for implementation to pursue objectives related to financing, strategies, documentation, and evaluation standards for professional standards, certification, and public and professional recognition of CHWs.

In 2012 Ms. Guymon received the Utah public health her oweine of the year award from the Utah public health association for her work with under served populations.

It is my pleasure to introduce Anna and turn the time over to her.

>> ANNA GUYMON: Thank you so much, Christine. It is my honor to present the information related to the work done in Utah to support chorks and help others to see the incredible value of this workforce and to advance this workforce in Utah.

With that being said, I do want to state that it is a little bitter sweet for me to present this information today because I have recently accepted a new position in the disabilities and health program here at the Utah Department of Health. So I will no longer be spearheading this effort in the future. But I'm very excited to tell you about the number of partners that are involved and the Utah Department of Health will continue to be the backbone organization of this important effort. I'll be sure to provide that updated contact information. Christine is a great resource in Utah as well for this effort RFA with that said I'll go ahead and get started so that you have an idea what has been done and ways that you can take some of these strategies and this information and implement it in your state, if interested.

What I'll talk about is just a brief history of the Community Health Worker efforts in Utah. I'll discuss the efforts to build that infrastructure as to support the workforce in Utah and how to start and engage different stakeholder audiences in your Community Health Worker efforts.

So the main learning objectives that I want to cover today and hope that I will provide enough information to support these is really to discuss and help you to identify the main goals an progress of the Utah broad based CHW coalition also known as the CHWC. Describe the barriers and facilitators in coalition building which I'm sure many of you have experienced. And be able to assess current partners of your organization and identify those mutual shared goals in this effort.

So a brief history of the Community Health Worker efforts in Utah. This is very brief. So what this slide describes is essentially back in 2010 to 2013 a group of stakeholders came together. This predates my time at the Department of Health, but those stakeholders came together representing nonprofit organizations, the state health department and the University of Utah to conduct a literature review and to look at some sustainable finance strategies to help support this workforce.

So the University of Utah was commissioned to conduct a literature review to point to gaps in the policy areas that would support the Community Health Worker workforce in Utah. Then this group of stakeholders did work with the state legislature to run some legislation to support some temporary funding, some grant funds to expand and pilot some efforts for the CHW workforce.

The bill was run two years consecutively by Senator Luce Eskema and it failed to pass out of the Senate. From that effort, some lessons learned were gathered as well as the information from the literature review report that was published. And the group decided that there needed to be a symposium involving partners from different sectors to come together and hear from national expert Carl Rush. So Carl Rush came out in 2015. He really talked about stakeholders about these key policy areas that needed to be addressed to move the CHW work forward in Utah.

Those were the same policy areas that were described in the literature review that had been conducted. Through Carl's expertise and experience and technical support when I started, we were really able to identify some action steps, some really concrete action steps to move forward and develop this infrastructure which is today the CHW coalition in Utah.

So the approach that we take as a group of stakeholders is a collective impact approach. That coalition that I keep mentioning, the CHW C was formed officially in 2015. So I think

many of you are familiar with the collective impact approach. I do just want to point out, the backbone organization of this effort is the Utah Department of Health. So with that role, we really guide vision and strategy, support the aligned activities defined by all partners in the group; establish the shared measurement, help to advance policy and really look at ways to mobilize funding.

So the quote that I have here at the bottom is really an important one as it relates to the work that has been done and the progress that we have achieved as a group of stakeholders.

That is, individual commitments to a group effort, that is what makes a team work, a company work, a society work, and a civilization work, by Vince Lombardi.

As you see, our mission and vision, I would tell you that that is really the guiding compass of all of this work. That commitment is shared. It is strong here in Utah with these stakeholders, to really move this work forward and to support this incredible workforce.

So in than understanding some of the policy gaps, which I'll talk about and talk a little bit more about the infrastructure in just a moment -- it was important for us to understand the challenges facing Community Health Workers as well as the challenges for the workforce development overall.

So again I think this is probably not new information for many of you. But the reality of work for many Community Health Workers includes poor pay and benefits, insecure jobs, ill defined roles, unlimited expectations, uneven supervision, sometimes a lack of respect, and in some cases toxic personal stress.

So it was important for all of our stakeholders at the table to really have an awareness of some of these challenges facing Community Health Workers so that as we moved forward in recommendations for policies that we're really taking this into consideration.

Some of the workforce development challenges that were laid out by national expert Carl Rush as well as outlined in that literature review that the University of Utah conducted years ago included a unified professional identity, provider readiness, integration of strategies, supervision, training and career ladders within some of the team-based career situations, sustainable financing, training infrastructure, documentation, credentialing and documentation, research and data standards.

These challenges combined with those challenges on the previous slide were what guided our action plans that we developed to really put forward some good public policy in the future to support this workforce.

So those key policy areas that were identified for consideration in advancing the Community Health Worker workforce included the occupational definition. So agreement on scope of practice and skill requirements, looking at different sustainable financing models. So really looking at how can we diversify funding strategies to support this workforce long-term. Documentation, research, and data standards, records, evidence of effectiveness or presenting that Rio to show the effectiveness of this incredible workforce. And workforce development training, understanding the capacity needed, the resources that we had to implement standardization for that workforce development training.

So in looking at the infrastructure needed, you can see here on this slide just an organizational chart, if you will. So the Utah Community Health Worker is a state level partner who are looking to support, promote and improve the experience of Community Health Workers in Utah. Facilitate the sharing of ideas.

As I mentioned before, the backbone agency of the coalition is the Utah Department of Health. And to date, over 40 organizations representing different sectors as well as CHWs themselves are on the coalition.

The members and sectors represented include the Utah public health association, community health workers section, which is the professional association for CHWs in our state.

Individual Community Health Workers as I mentioned community-based organizations, government organizations including public health, state and local health departments, substance abuse, Department of workforce services, we have health systems represented on the coalition as well as health payers.

Educational institutions, faith-based organizations, social service agencies, medical providers, and medical provider organizations.

The Community Health Worker coalition has an advisory board which you can see under the list of stakeholders on the left-hand side. The advisory board acts as governance over the coalition activities and proposals.

We have three work groups. The advocacy work group, evaluation and sustainable finance work group and the workforce development work group. The CHW role is defined on the advisory board in the charter. So there is a minimum number of Community Health Workers in leadership positions that are established on the advisory board. We have an advisory board of around 18 members. At this point in time. And minimally five Community Health Workers must be in those advisory board positions. So we

want to make sure that those experienced Community Health Workers have that voice at the table to guide these decisions.

Our efforts do consider other ways to help involve Community Health Workers with different levels of familiarity with meeting structure to ensure they can actively participate.

We have Community Health Workers on all of the work groups, as well as the advisory board as I mentioned. We are constantly looking for new ways to involve Community Health Workers with different levels of experience in that formal kind of meeting structure.

And I do want to point out on the right-hand side you can see that on this organizational chart the Utah public health association is the umbrella organization for the CHW section, which again is the professional association for CHWs in Utah. They are a partner organization on the coalition.

So as far as the processes that guide the coalition in how we operate, we do have a charter document which I mentioned on the previous slide that defines the number of positions for Community Health Workers as well as some of the other sectors listed under the stakeholder groups on the previous slide. This is to ensure that we really do have that broad based perspective in the decision making that is going on to support this workforce in Utah. All of our meetings are open meetings. So they are listed on the Utah Department of Health website. There is a conference call in number for those who cannot attend in person. We do post meeting agendas as well as meeting notes on the website.

We do have a strategic planning process with goal-setting and action plans. Those action plans, I will send to -- I will actually have those sent through Christine so that you can view those if they are helpful to you, as well as the charter document. You'll see within those action plans we really outline the policy goals that we are trying to accomplish with different smart objectives, timelines and tasks assigned to different members of each work group.

It very much is a working coalition. It is pretty inspirational to see the number of stakeholders who have really come together, who value and understand the incredible impact of Community Health Workers and that Community Health Workers are truly a part of, a big part of the answer to achieving health equity. Our stakeholders believe in that. And you can see that with the time that they put into moving this work forward.

We have an established consensus based decision making process. So that is outlined in our charter document as well. And criteria is established by each work group. That criteria is then used to develop proposals. So for our standardized training, for example, an evaluation rubric tool was developed.

That evaluation rubric contained the criteria by which we assessed different curricula that existed and compared it with the criteria that we had endorsed for the core skills. That work group came to the conclusion of an endorsement for our standardized state curriculum, which I'll talk about in just a minute.

The consensus-based decision making is inclusive, participatory, collaborative, agreement seeking. So everyone has a voice and gets to exercise that voice. It is presented with transparency.

Couples channels is something we are always looking to improve upon. So we've identified various communication channels for stakeholders to include. In some cases social media, but our website and email are really the primary communication channels that we use in addition to meeting schedules that are established with frequency.

We do have progress reporting on action plans and those goals. So those progress reports are presented by the different work group chairs at the advisory board meetings every other month so that a level of accountability is there and everyone can see the progress moving forward. That has worked well.

So our vision is true collaborative health for all communities in Utah. And our mission is to support, promote, and advance the work of Community Health Workers in Utah. And as I mentioned, this is something that our stakeholders feel very strongly about. Just the level of work that some of our partners have done purely volunteer status, it's just been an incredible and very inspirational thing to see.

What can be accomplished when so many people work together in support of a mission. It has been awesome to be a part of it.

So the way that our strategies and our goals were determined, we drew upon several different sources, including the national experts, which I mentioned previously in the literature review that was conducted. But we also used the policy evidence assessment report from the CDC. And from that we really targeted some of these best practices that they support in that policy report.

So defining a scope of practice and really looking at, okay, the evidence is very strong for the potential public health impact. You know, stipulating the settings, defining the professional roles, function, activities and supervision requirements. That is something that our stakeholders and the coalition really got behind and wanted to establish quickly or endorse quickly. I'll talk more about that in just a moment.

The state certification laws. So that is also considered as having strong evidence and a best practice in that CDC best practice policy guide.

Really looking at establishing a certification process has been a primary goal of our coalition efforts. So describing the education, training, core competencies, and involvement of Community Health Workers in certification and certifications linked to reimbursement.

We have not completely defined that certification process yet. But I do anticipate that the coalition will have a final recommendation on that process by September. So I'm very excited to see based on all of the criteria that they've evaluated and established what that will end up looking like.

We also drew upon the expertise of the Community Health Worker core consensus project which I'm sure many of you are very familiar with. And having met Carl Rush early on in my job or in my role as the Community Health Worker program specialist, it was exciting to see this convening of national experts, including many experienced CHWs contributing to this document and this guidance.

And the guidance that we received as a coalition from this document actually shaped our core competencies and our scope of practice. And so it was really helpful to have this information as we were looking at endorsing those. So here are the strategies for the coalition. So you can see that really in consideration of the policy gaps that I mentioned previously in the workforce development challenges, the sustainable financing challenges, this is how we divided up our priority areas.

Our first priority area is state and institutional policy. So this involves establishing those professional standards or scope of practice, looking at the credentialing and certification, getting support from providers and clinicians, pursuing diversification of funding streams for sustainability for the workforce, looking at potential contract incentives for supporting the workforce, pursuing Medicaid coverage of Community Health Worker services. Then, of course, the data and business case.

In just a moment I'll talk about our progress related to some of these strategies and there are some exciting things that have happened related to some of those state and institutional policy areas.

Our second priority area is public education and engagement activities. Really ensuring that we've targeted multiple audiences with key messages to create awareness and value for the work that Community Health Workers do across our state in every community. Looking at -- well, we have held public meetings and presentations to engage and educate. Engaging

media. So opinion leaders, testimonials and human impact stories. One of the most impactful things that we did, and I hope will continue to be done, is before we planned the first Community Health Worker pre-conference to help support the association here in Utah, we worked with one of our newspapers and a reporter there. This is a newspaper that we targeted because many of our state legislators and decision makers get their news from this specific source. So we were able to connect the reporter with some community health workers as well as the people's lives who had been impacted positively through these Community Health Worker interventions related to diabetes and obesity. It ran on the front page of the newspaper just before the conference. Because of that article we got a meeting with the President of the Utah hospitals association wanting to know more information about Community Health Workers.

We had several state Senators come to the conference that was just a few days later. Again I'll talk about that in a minute. Earned media can be a very powerful tool for that engagement which I'm sure many of you are aware of and probably have done amazing things.

We are looking at connecting organization position statements. So from local boards of health endorsing the scope of practice that we support. From the Utah medical association endorsing the scope of practice that we support. These are strategies that we've looked at to help make our case for some of these policy initiatives in the future.

We've also looked at through those public education and engagement activities the need to articulate employer needs and priorities and how Community Health Workers, their scope of practice and their work aligns with addressing those needs and those priorities, especially around the social determinants of health.

Relating those capabilities, CHW capabilities to needs is a big part of the education and engagement. Highlighting those employer success stories which I'll talk about again in just a minute, so that other employers in the same sector can see: Wow, that was the impact of a Community Health Worker working for that agency that really led to those successes.

Then our third priority area are those practice and implementation models. So I'm sure as many of you do, here in Utah we have some larger health systems which include many clinics and hospitals. And then we have health systems or, excuse me, smaller independent clinics that may be located in rural communities who aren't part of those larger health systems. So we are trying to present examples of practice models in both the interest rural clinics and also within these larger health systems, to help those clinics and systems

understand how CHWs could be integrated into their practice and workflow.

The business case and evidence is also part of the practice and implementation models. And then providing education and assessments or technical assistance on successful pim.

So our progress on some of these strategies and goals. Over the last couple of years has been really incredible. So in November of 2015 which coincided with the very first advisory board meeting for the coalition, the Community Health Worker definition was endorsed and approved by our advisory board. That definition is the exact same definition as the American public health definition of Community Health Worker. In April of 2016 in an effort to build professional identity of Community Health Workers in Utah, the Community Health Worker broad based coalition planned and supported the first public health CHW pre-conference. We had over 160 Community Health Workers attend that conference, with five primary languages identified and every county in our state was represented with the CHWs who were in attendance. It was an awesome thing. The coalition provided scholarship to cover membership dues for those interested in joining the Community Health Worker section or the professional association for ccs. We had Carl Rush as one of the keynote speakers, we had Fernando Pineda, a Community Health Worker leader from Colorado in attendance. We had there Anna Maria Lopez, vice-president for health equity and oncologist from the University of Utah talk about the importance of Community Health Workers and how they have been integrated into her practice in Arizona. It was a very successful event. We were so excited about the overwhelming response from Community Health Workers across the State.

In July of 2016 the coalition endorsed the core skills or core competencies which mirror the C3 recommendations as well as the scope of practice that is the roles of Community Health Workers. That was endorsed the same as the core consensus process or the C3 project recommendations.

We also endorsed in July of 2016 the Community Health Worker code of ethics that was developed during the annual national unit service held in Albuquerque New Mexico in 2008. That was such a well done code of ethics that our entire coalition really got behind it and endorsed that as what we wanted the code of ethics to be for CHWs in Utah.

From November of 2016 to June of 2017, the standardized training core skills curriculum, 90 hours, was commissioned, developed and approved by our advisory board. As I mentioned previously, we had some criteria established and wanted to ensure that each of those core skill areas and those core role

areas defined by the C3 project were included and that we could point to where they were included in that curriculum.

So we did develop a crosswalk document that really evaluated each session in the curriculum and where that particular core skill or core role was supported by the content.

And the content was actually, we commissioned a professor at the University of Utah was the primary developer of the curriculum, but we had five Community Health Workers representing different communities here in Utah as authors of that as well.

From November of 2017 to March of 2018, we conducted a feasibility assessment for the best delivery mechanism of the training. And the advisory board approved a hybrid delivery mechanism, two in-person days with the remaining content online. The standardized training curriculum was converted to an online learning management system platform to assure statewide access for no cost for Community Health Workers.

In March of 2018 we implemented the very first core skills training here in Utah. I think I have a picture of the cohort in the slide dec here, I hope.

Yeah, there they are! So an awesome group of Community Health Workers representing different communities in our state, different population groups. It is just so exciting to see these incredible Community Health Workers embracing the content, learning new skills and just really being incredible participants in this pilot. So with that being said, in moving forward here are some of the key areas that the coalition is really looking at over the next six months. So of course an evaluation of the pilot when that concludes, and ways to improve that training. Then beginning the next cohort, most likely in September of 2018. We have been working with some delegates from the Utah CAD my of pediatrics as well as family medicine docs to provide recommendations for supervision structure in clinical settings. These are medical providers who have experience working with community health workers in their clinics.

One of the doctors, she actually was so excited in some of these initial meetings that she suggested that she would author a case study and have it published in a peer-reviewed journal so her peers could understand the incredible benefit of including Community Health Workers in team-based care.

We are also looking at that establishment of the credentialing and certification process for Community Health Workers, highlighting the employer engagement and champions.

So our coalition worked with Levitt papers and commissioned a white paper from them. For those who aren't aware of Levitt partners, they carry a lot of weight in our state with

policymakers and health systems, they are a healthcare intelligence firm. They authored and eight to ten page white paper, almost ready to be released. In that paper they interviewed some of our community-based organizations as well as one of our health systems and our primary care association to understand the roles of Community Health Workers in those specific settings.

And the paper will really outline based on the roles that we define in the scope of practice where Community Health Workers interventions could have the greatest impact geographically in our state based on the different needs of the different areas of the State. They looked at different chronic disease measures, looked at behavioral health, depression, suicide, rates and other things to really understand and be able to point to where those Community Health Worker roles could have significant impact.

That paper will be shared with health systems, health payers. We are looking also at requesting reimbursement as building block funding from Medicaid based on the roles we have defined in our scope of practice, and really showing the cross-cutting impact of the work that Community Health Workers do and how it could benefit and be a very cost neutralizing measure for Medicaid.

So I know we are running out of time. What I want to describe on the next couple of slides are specific ways that you can start to engage partners in your areas.

So the way that partners were recruited in Utah is really looking at the context and the history first. The core group of stakeholders, and meeting with those stakeholders to identify other potential coalition members and doing gap analysis to understand who wasn't at the table and who needs to be there and getting meetings with some of those organizations.

Scheduling individual discovery meetings with potential members to discuss and focus on the purpose and mission of the coalition, get to know their priorities as an organization or individual, and then highlight where those priorities align with what the coalition is trying to accomplish to support this workforce.

We invited stakeholders to the initial advisory board meeting in November of 2015. And at that time we conducted an assessment of all stakeholders so that they could self identify their strengths, skills and the time that they were willing to commit to the coalition efforts. as well as whether they had a desire to participate in leadership.

So I will be sure to share that assessment template with the other documents that I mentioned so that if it is helpful to any of you, that you can adapt it to your needs.

At that initial meeting we agreed on the infrastructure that was needed, the mutual goals and the direction that we were going. And again to date we have over 40 organizations that are represented on the coalition and of course Community Health Workers themselves.

Recruitment efforts are ongoing and include efforts to assure representation from different communities from across the state, with some of our rural counties, one of the best ways that we have been able to facilitate participation is through offering a conference line for them to call in. But we are always looking at ways that we can get better at ensuring that inclusion.

We do have a health equity lens where we are looking at connection to people, place, process, and power. So the work of the coalition really intend to support and advance the work of Community Health Workers in Utah. Including Community Health Workers and Community Health Worker employers across the state is critical to shaping policy decisions for the workforce.

We have great representation from the urban area of the state with the rural and frontier areas we had to adapt and understand how to better meet their needs. We worked with the local health department partners from across the state to conduct an environmental scan of Community Health Worker employers in their areas. And I don't have enough time to really get in depth on this, but the approach that we took when we created a template for them to populate with potential organizations working with Community Health Workers was really looking at the different social determinants of health and having them identify, okay, who is addressing early childhood education in your area? Who is addressing food security? Those types of things really helped each of those local health department partners generate a list of potential organizations within their areas and then we created a survey tool to understand if these organizations had community health workers working for them. If so, how they financed them, what the roles of the Community Health Workers were within their organizations, whether they were interested in training opportunities for their community Health Workers, most specifically related to diabetes and hypertension but other areas as well.

We also wanted to know about the organizations' interest in participating on the coalition itself and over 30 percent of them indicated an interest. We had about 160 responses. Every county in the state represented in the sample. And about 160, as I said, respondents with about 30 percent indicating an interest in participating on the coalition.

We also have ongoing efforts with our partner and coalition member, the UPHCW section to increase representation to ensure

Community Health Workers are actively contributing to the conversations decisions and planning.

We regularly collaborate with the office of health disparities, Utah Indian health advisory board and peer support specialist network, the Community Health Workers addressing mental health, substance abuse in our state. They have some of the services covered under Medicaid here in our state.

So some of the primary barriers and challenges related to the coalition work in developing the infrastructure. First I don't think this is lost on anyone, but turf and competition is a challenge. So the territoriality and competition among coalition members can be a real barrier. It is important to understand that personal and organizational self-interest is part of the reality and what motivates people. Taking that into account, and bringing it back to that mission and that vision. So focusing on the larger and common good, especially that of community and neighborhood. And emphasizing the value and the need of all stakeholders being around the table.

So just wanted -- I won't get into any stories because I know I'm out of time. You know, it really can get a little heated in those early meetings because some people feel like maybe the health system shouldn't be there or maybe the health payer shouldn't be there, but helping the entire group to understand that everyone has a role to play in supporting the mission and division is important.

Looking at that history and misperception. Whether it is mistrust or misperception of other participants at the table or previous unsuccessful attempts at policy, really learning the history and context of the previous attempts and lessons learned is a good way to consider shaping policy in the future.

Creating a fair and open process that allows everyone to participate. So that consensus process that I mentioned earlier gives everyone a voice at the table. And we continue to strive to identify and use various communication channels, which I alluded to earlier. Ensuring that we have transparency in how we operate and that we are all working together.

Another barrier is long-term planning meetings and assessments that drag on for months or years can lead toll member disengagement when no action or results are achieved.

Those action plans, that was really something that was done to address that barrier and then producing some action and results in the first few months of the coalition' history to show people that we were serious about getting work done and that we were moving forward.

And so again I'll share those action plans with you.

The last one I think -- I think this is the last barrier is just the logistical support for coalition work. The backbone

organization shoulders the responsibilities of the logistics. And I am no longer in the pox, but the position that I was in spearheading this work, it was really just one full-time employee. So having a successful effort is really driven by the commitment and the participation and the work of volunteers and partners.

So just mapping that out with the infrastructure development is important to understand capacity and resources.

Okay. Let's see.

Okay. So elements that were critical forgetting the work off the ground. Commitments. As I mentioned before in the quote by Vince Lombard di, commitment is Keystone to anything happening long-term. Having an infrastructure so the backbone organization and groups, having buy in from key stakeholders and partners, having the action plans, will the roadmaps to how we are going to get where we want to go ahead and lessons learned and guidance from other states. Many of you on the call probably had a conversation with me at some point. I want to say thank you for all of your work and for helping to guide these efforts in Utah as well as the national experts.

So with that said I'll leave you with a quote. Alone we can do so little. Together we can do so much.

Thank you so much for your time. I appreciate the opportunity. Best of luck to each of you in your coalition building efforts.

>> MODERATOR: Thank you so much, Anna. It looks like we have questions. I'll go to the first one. It says: How do you make sure CHWs are not overpowered by other professionals in reality?

>> ANNA GUYMON: Maria, thank you so much for your question. I think that it is concerning. And it is something to always have awareness of because many of the CHWs who participate in the UPHCHW section, for example, may have limited experience in participating in formal meetings. So one of the things that we wanted to do with the infrastructure for sure was ensure that we had those positions described within the charter document that were for Community Health Workers. And those spaces have mainly been filled by experienced Community Health Workers who can kind of shepherd some of the Community Health Workers with less experience in those situations to help make them feel more comfortable.

One of the things that we talked about this year in Utah and sadly I may not be a part of it, but with the UPHCHW leadership, we talked about the networking retreat and act at this times so that some of the Community Health Workers from the section could get to know some of the different members of the coalition and maybe feel less intimidated by creating some of those personal

relationships outside of the business of the coalition. So I think it is a great question. I think it is one that always needs to be kept in mind.

Hopefully that answers your question with our approach.

>> MODERATOR: Thank you. We'll go to the next one. It says do the competencies and curriculum include linguistic competence?

>> ANNA GUYMON: Yes, one of the core skills is communication. And culturally appropriate communication and strategies are part of that. So Catalina, hopefully the question will be answered when you take a look at the core skills and roles that we have in the coalition. I'm happy to send you a information for our standardized training.

>> MODERATOR: Okay, I think we have that one. Can you share where the CHW work in what settings, what are the pay levels? Are the policies now established to provide reimbursement? Reimbursed by whom besides Medicaid. Can you share the URL or the online training modules?

>> ANNA GUYMON: Okay, Isabell, the community health workers, the settings that they work in, that report is nearly ready to be released by our agency. And so I'm happy to channel that to Christine, who is here with me. She is in our leadership for the mountains states region. I am make sure she has a copy of that report to distribute. There were a lot of can different settings identified and different pay scales. You can hopefully see all of that related to questions 1 and 2 in that report as you read through it.

The policies now established to provide reimbursement. So as I mentioned before, we have kind of a diversified approach to reimbursement for community health workers here in Utah. And because we don't have that certification officially recognized yet, it has been a challenge to get that reimbursement where it needs to be without that credentialing in place.

Although I did mention before, the peer support specialists who are the specialized Community Health Workers working in behavioral health, they do actually receive reimbursement or coverage through Medicaid. That is because the state plan was amended for Medicaid several years ago to include them in the state plan.

So part of our approach with Medicaid at least is to approach either another amendment to the state plan or an 1115 waiver to really kind of show that effectiveness of community health workers and the many roles that they have.

As far as other areas for sustainable finance, one of the things that we are looking at are city and county contracts especially as it relates to priorities that city and county governments may have related to the social determinants of

health where they could link up with community-based organizations who work with CHWs. There are a couple of approaches that the coalition is looking at. Hopefully that answers your question.

Related to question number 4, the URL to the online training modules, so at this point in time there is an application process because each cohort or each classroom can only hold so many Community Health Workers. So if you have interest in an upcoming, when you look at the table of contents for the core skills training if you have more interest in that, I think that as I mentioned at the beginning of the call I will provide the contact person's name for the EPIC program, her name is Michel Drury. You can ask her more information as that new cohort becomes available.

>> MODERATOR: I a.

>> CAMILA SANTOS: I apologize for interrupting. While addressing the questions I would like to encourage you all to complete a brief assessment of the webinar. In order to do so, please click on the link right on the presentation. And we appreciate your feedback so that we can find out what information is helpful and what we can do to improve our future webinars.

With that being said I turn back to the moderator to read the next question.

>> MODERATOR: Thanks, Camila. The next question is a follow-up. Sorry, have the training tools been developed in Spanish?

>> ANNA GUYMON: The quick answer to the question is not yet. An interesting approach was taken with this pilot cohort because many of the CHWs who are enrolled in the pilot, Spanish is their first language and English is their second language. So if they write or make posts in the discussion forums and something that is a reflection of what they've learned that we call an aha journal, they have been encouraged to write in their native language.

So one of the assistant instructors for the class, Spanish is her first language. She's a very experienced Community Health Worker and she has been assisting with some translation related to those forum discussion posts and other things to ensure that learners have the best experience possible.

But I know that a lot of discussion has been held related to converting the training to Spanish.

>> MODERATOR: We are going to keep moving along with these questions, as many as we can.

The next one is, it seems like we really need Community Health Workers in the community setting rather than a hospital or clinic. What could we do to promote compensation for a CHW

in the community setting with the ability to go door and door and educate those people who are not going to a provider?

>> ANNA GUYMON: Yeah, I think that's a really great question, Jamie. It's one that we have had a lot of discussions about. What are the answers to really supporting community-based organizations who know their communities and have the CHWs that come from the communities that they serve going out into the community? How can we get away from short-term grant funding for these organizations and get to a space where we have more sustainability?

The city and county government contracts is one thing that we've really discussed related to that. I think that there is a role with community clinical linkages, especially for health system partners to contract. I know your question was more related to the CHWs who are just working in the community, but I think they could still just work in the community through that community-based organization and really help provide follow-up or resources or information to people after they are released from care or help them with prevention efforts.

I think there is a lot of exploration. It would be good to have kind of a compiled document of successes related to sustainable finance efforts from those who really succeeded in establishing contracts and some other things in that way.

>> MODERATOR: We'll go on to the next question. Has the coalition engaged any representatives of the populations being served by community health organizations? Example of disability advocacy organizations or area agencies on aging?

>> ANNA GUYMON: Great question! One of our advisory board members serves on the Utah council and is a strong advocate for persons with disabilities, make.

(Unit developmental disability council and strong advocate for making sure that that is covered.

We have reached out on aging and had initial meetings. They don't actively participate on the coalition yet.

(Chuckles.)

>> ANNA GUYMON: I say. Hopefully they will at some point in time, but the V.A., we do have representation from the V.A. on the coalition as well.

>> MODERATOR: The next one is, can you talk more about the process of getting CHW work reimbursed by Medicaid? Were there certain areas that seemed to make sense to start with and gained traction for another area? Are you working through MCO contracts or other areas?

>> ANNA GUYMON: They are ACOs and all of the ACOs participate on the Community Health Worker coalition. From my experience this has been a tough nut to crack. In our state, consider how many people does Medicaid actually serve? There

are still a lot of people in that gap that can't qualify for Medicaid. We've looked at a couple of different approaches with the 1115 waiver and some other things.

Home visits is one area where I see a lot of promise for inclusion of community health workers in that role. As a matter of fact, some of our ACOs already have CHWs. They just kind of funnel through administrative payments and other things. That's how they pay the salary.

For our refugee population, one of our ACOs if a person who has refugee status and is on Medicaid is hospitalized and released from the hospital, the CHW role kicks in and the CHW does the home base the visit with the nurse. And the CHW really talks about medication adherens, makes sure that the education and resources are culturally appropriate and meet the needs of that individual.

So I think home based visits is really promising. I know we are just about out of time but we do also have what is called, it is federally mandated. I think they exist in every state. I would hope that they do. They are called medical community Advisory Committees. We shortened them to call them the MAC here in Utah.

That group is a group of volunteers who represent medical providers as well as persons with disabilities, community advocates, persons who have Medicaid themselves. And they really shaped the building block priority funding requests that are presented to the governor. And so we have presented to them last year the coalition did in June to make community health worker reimbursement a priority for the governor's budget. Think had to rank 20 priorities, out of those Community Health Workers were ranked number 11. So there were some emergent kind of needs ranked higher than the Community Health Worker reimbursement. But based on the lessons that we learn from that request, the request this year to the MAC is going to be honed a little bit better to really kind of address some of those lessons that we learned.

So hopefully that answers your question.

>> MODERATOR: It looks like we are out of time, according to what we have.

Camila?

>> CAMILA SANTOS: Yes. So that concludes our question and answer session. I would like to remind you to please complete the webinar assessment. It will remain open for another ten minutes. This webinar has been recorded and will be posted on the mountain states region at health equity council website at the address shown on the screen and you will also find future webinar announcements that we encourage you to attend.

We thank you, Dr. Guymon, for the work that you do and for the great presentation. Thank you for your audience, for your participation.

(Chorus of thank you.)

(The webinar concluded at 2:00 o'clock p.m. CDT.)

(CART captioner signing off.)

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