

# Community Health Worker Forum: Summary Report

A Meeting Sponsored by the Centers for Disease Control  
and Prevention, Division of Diabetes Translation

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“ I think of ... how much passion and commitment there has been to get us where we are. And now we are ... really trying to make sure that CHWs are not an afterthought—that CHWs are a central part of the care team, and they’re a critical part of the care team. ”

**ANN ALBRIGHT**, Director, CDC/DDT

“ As I’ve watched the movement grow over time, really blossom, [I’ve seen] the gifts that community health workers bring to people and communities. ”

**URSULA BAUER**, Former Director, CDC’s National Center for Chronic Disease Prevention and Health Promotion

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# EXECUTIVE SUMMARY



## BACKGROUND AND METHODOLOGY

On May 10–11, 2018, the Centers for Disease Control and Prevention’s Division of Diabetes Translation (CDC/DDT) hosted a forum to better understand and think through ways to maximize the impact of community health workers (CHWs)<sup>1</sup> on diabetes outcomes.

Nineteen participants attended the forum, representing CHWs, CHW allies, and state health department representatives (including recipients of funding through 1305 and 1422 cooperative agreements). Participants work with a range of target audiences—including Hispanics/Latinos, African Americans, Asian Americans, and American Indians—in a mix of rural and urban U.S. communities and have experience in adult chronic disease outreach, including diabetes. Several CDC project officers and members of DDT leadership were also in attendance to provide introductory comments about CDC’s activities and to actively listen to the forum discussion.

Insights from the forum discussions will inform guidance and technical assistance (TA) to CDC grantees and others working in diabetes management and type 2 diabetes prevention on how to better engage and support CHWs.



## SUMMARY OF DISCUSSIONS

The meeting addressed four objectives:

- Identify existing barriers and gaps to developing a statewide infrastructure to promote long-term sustainability and reimbursement for CHWs as a means to establish or expand their engagement in:
  - CDC-recognized lifestyle change programs for type 2 diabetes prevention through the National Diabetes Prevention Program.
  - American Diabetes Association (ADA)-recognized/American Association of Diabetes Educators (AADE)-accredited diabetes self-management education and support (DSMES) services.
- Identify promising practices and lessons learned in CHW reimbursement and sustainability that may inform and guide the future efforts of states, CHWs, and others to develop a statewide infrastructure to promote long-term sustainability and reimbursement for CHWs.
- Identify promising practices and lessons learned about the roles CHWs can play in increasing enrollment and improving retention in CDC-recognized lifestyle change programs for type 2 diabetes prevention and/or ADA-recognized/AADE-accredited DSMES services for diabetes management.

<sup>1</sup> In Hispanic communities, CHWs are often referred to as *promotores de salud*, and some forum participants also used that term. In American Indian communities, the term *Community Health Representatives* is used. For simplicity, however, this report uses the more common term, CHWs.

- Gather “pearls of wisdom” from the perspective of CHWs that would be important to share with states, CHWs, and others engaged in this work.

Within the broad framework of those objectives, participant discussions centered on several themes and concepts. This report summarizes the insights and opinions of the participants around those themes.

**This report is not a consensus document**—that is, the forum discussion was not intended to achieve agreement among all participants—nor does it represent official recommendations endorsed by CDC. Rather, it offers the perspective of diverse CHWs, allies, supporters, and states on what they believe is needed to build an infrastructure for CHW sustainability and financing.

## A NOTE ABOUT TERMINOLOGY

Participants noted that the agenda topic of “reimbursement” would be better addressed more broadly. They recommended instead discussing financing, which encompasses not only reimbursement of CHW services, but also funding for professional development and efforts to develop CHW organizations and networks, including establishing and supporting the National Association of CHWs. Therefore, although the objectives for this forum mention reimbursement, we have used the term financing throughout the discussion summary to reflect the forum participants’ views.

## PARTICIPANT INSIGHTS

### Defining CHWs’ Roles and Developing the Workforce

- **CHWs follow the adage “Nothing about us without us.”** The same should apply to efforts to develop a statewide CHW infrastructure.
- **A consistent definition of what constitutes CHWs’ roles is needed, along with a greater understanding among decision makers of those roles and the value CHWs bring.** It is critical that the CHW definition capture the full array of their skills, roles, and responsibilities; the range of places in which they work; and the variety of job titles that encompass similar tasks—and to communicate their core competencies and value.
- **Workforce development is essential.** Better systems are needed to attract and prepare the next generation of CHWs and ensure retention and promotion of current CHWs. There is a general lack of funding and time for professional development and peer learning among CHWs. Additionally, managers and supervisors of CHWs, and top executives in their organizations, may not fully grasp the realities of the CHW job; advocacy and fostering professional development for CHWs could be included in training and TA for individuals who supervise CHWs.
- **There is disagreement about the need for and value of CHW certification.** Some people believe standardized training and certification are necessary, while others believe CHWs can perform their roles effectively with less formal training coupled with experience in the field. Some states have opted for voluntary certification of CHWs and others have not.

- **Support for networks should be a priority.** This includes launching and maintaining the National Association of CHWs—which is intended to elevate the CHW profession and provide a forum for communicating about and within the workforce—as well as statewide alliances and networks. Current funding to support such groups and CHWs’ participation in them is lacking.

### Increasing Integration of CHWs in Health Care Systems and Community-Based Organizations

- **CHWs have not become part of the fabric of health care.** Despite the evidence of CHWs’ contributions, buy-in from the health care and public health communities is not universal. CHWs should be integrated from the start in strategies and budgets. It is also essential that CHWs have access to electronic health records to facilitate their ability to serve clients effectively.
- **A single interaction between a CHW and client may address multiple clinical needs and help ameliorate the impact of social determinants of health.** Given the relational nature of their work, CHWs often perform activities beyond the “official” scope of their job to meet client needs.
- **CHWs desire, and should have, a voice at the table with decision makers at all levels (federal, state, health system, organization, etc.).** They can help educate policy makers and administrators about CHWs’ roles and inspire them to support and advocate for this workforce. In such conversations, CHWs must convey not only the compassionate side of their work but also the financial benefits.

- **Expanding integration of CHWs within both medical and public health systems and community-based organizations requires identification and dissemination of effective methods for doing so and addressing challenges in payment options for CHWs.** Such efforts should draw on existing examples and guidelines and seek to strengthen partnerships between health care and CBOs.
- **Enhancing financing strategies to build the CHW infrastructure and facilitate CHW engagement is essential and will require an openness to identify and consider novel approaches.** Current funding mechanisms—which often flow from federal sources to states for specific health purposes—can limit the types of health issues CHWs address. There may be ways to leverage the increasing focus on population health to advance the infrastructure for CHWs.
- **It is important to foster CHW connections across federal agencies,** including in the Department of Transportation, Federal Interagency Health Equity Team, Health Resources and Services Administration, Office of Minority Health, and all the Department of Health and Human Services.

## Improving CHW Compensation and Documentation of CHWs' Contributions

- **Compensation for CHWs should be commensurate with the professional services they provide.** Institutionalizing CHWs as a public health career path would be an important first step to ensure compensation similar to other public health professionals. Compensation is often complicated by short-term funding (e.g., grants) and Medicaid policy limitations and budgetary pressures.
- **Inadequate documentation of CHWs' contributions results in an incomplete understanding of CHWs' program impact and can have financing ramifications.** Efforts to show impact should build on existing evidence and provide compelling local data; the National Association of CHWs could help gather and disseminate this information.

## Promising Practices and Lessons Learned about CHWs' Roles in CDC-recognized lifestyle change programs for type 2 diabetes prevention and/or ADA-recognized/AADE-accredited DSMES services for diabetes management

- **Because CHWs understand the cultures that make up their community, they can help policy makers and programs better understand, reach, and serve target populations.** CHWs should be engaged in tailoring and adapting diabetes management and type 2 diabetes prevention curricula and activities to ensure they are user-friendly and culturally and linguistically appropriate.
- **Standardized training related to the National Diabetes Prevention Program and DSMES could help CHWs more effectively support those programs and services.**

- **Because many of CHWs' clients live complex, marginalized lives, getting commitment to attend DSMES services or lifestyle change programs can be difficult.** Emphasizing how CHWs' involvement in type 2 diabetes prevention and diabetes management programs can help individual clients as well as contribute to the overall well-being of the community may encourage CHWs to connect individuals to these programs and services.
- **Best practices for engaging CHWs in diabetes management and type 2 diabetes prevention activities at the grassroots level already exist.** Systematically documenting and sharing such practices is necessary.
- **CHWs work to address all of an individual's health issues.** Thus, it is important to explore ways for CHWs to address diabetes management and type 2 diabetes prevention alongside other health conditions and social determinants of health.

## NEXT STEPS

This CHW forum provided many helpful insights that will inform future work. CDC will consider how to incorporate this information in a training and technical assistance guide for working with CHWs in this arena, which is currently under development, and explore development of other materials such as job aids to distill key information and foster communication with and support for state health departments.



# SUMMARY REPORT

## BACKGROUND

On May 10–11, 2018, the Centers for Disease Control and Prevention’s Division of Diabetes Translation (CDC/DDT) hosted a forum to better understand and think through ways to maximize the impact of community health workers (CHWs)<sup>2</sup> on diabetes outcomes.

### Objectives were to:

- Identify existing barriers and gaps to developing a statewide infrastructure to promote long-term sustainability and reimbursement for CHWs as a means to establish or expand their engagement in:
  - CDC-recognized lifestyle change programs for type 2 diabetes prevention through the National Diabetes Prevention Program.
  - American Diabetes Association (ADA)-recognized/American Association of Diabetes Educators (AADE)-accredited diabetes self-management education and support (DSMES) services.
- Identify promising practices and lessons learned in CHW reimbursement and sustainability that may inform and guide the future efforts of states, CHWs, and others to develop a statewide infrastructure to promote long-term sustainability and reimbursement for CHWs.
- Identify promising practices and lessons learned about the roles CHWs can play in increasing enrollment and improving retention in CDC-recognized lifestyle change programs for type 2 diabetes prevention and/or ADA-recognized/AADE-accredited DSMES services for diabetes management.
- Gather “pearls of wisdom” from the perspective of CHWs that would be important to share with states, CHWs, and others engaged in this work.

Insights from the forum discussions will inform guidance and technical assistance (TA) to CDC grantees and others working in diabetes management and type 2 diabetes prevention on how to better engage and support CHWs.

## METHODOLOGY

Nineteen participants attended the forum at the invitation of CDC/DDT staff. Participants represented three general audiences: 1) CHWs, 2) CHW allies, and 3) state health departments (including recipients of funding through 1305 and 1422 cooperative agreements; see next page). They work with a range of priority populations—including Hispanics/Latinos, African Americans, Asian Americans, and American Indians—in a mix of rural and urban U.S. communities and have experience in adult chronic disease outreach, including diabetes.

<sup>2</sup> In Hispanic communities, CHWs are often referred to as *promotores de salud*, and some forum participants also used that term. In American Indian communities, the term *Community Health Representatives* is used. For simplicity, however, this report uses the more common term, CHWs.

Several CDC project officers and members of DDT leadership were also in attendance to provide introductory comments about CDC's activities and to actively listen to the forum discussion. A list of participants is provided in Appendix A.

To help define and prioritize the discussion topics and develop the agenda and facilitation guide for the forum, CDC contractor FHI 360 held 30-minute pre-forum conversations by phone with confirmed participants to gather relevant input on the potential discussion topics related to CHW reimbursement and sustainability and CHWs' roles in type 2 diabetes prevention and diabetes self-management.

During the two-day forum, to set the stage for discussion, CDC/DDT presenters acknowledged CHWs' contributions to type 2 diabetes prevention and diabetes management and outlined the Division's investment in and commitment to CHW engagement. They also shared an overview of relevant work under previous CDC cooperative agreements (i.e., 1305, 1422), lessons learned by grantees already engaging CHWs in increasing enrollment in CDC-recognized lifestyle change programs for type 2 diabetes prevention and DSMES services, and known challenges or barriers to expanding CHWs' roles.

A trained facilitator led forum participants in guided discussions, adapting the flow of conversation and agenda topics to meet the priorities of the group. She also encouraged participants to write "pearls of wisdom" on sticky notes to help CDC capture further input about resources, tools, and actions needed to support CHWs to meet their full potential to serve families and communities. In addition to discussing topics in the large group, participants took part in small-group activities and reported their insights to the full group. At the end of the second day, participants met in four small groups—national, state, grassroots, and medical, based on the sectors or areas they represented—to discuss opportunities for states and CHWs to

## CDC SUPPORT OF CHW EFFORTS: COOPERATIVE AGREEMENTS

- [1305](#): Increase engagement of CHWs in the provision of self-management and ongoing support for adults with diabetes
- [1422](#): Increase engagement of CHWs to promote linkages between health systems and community resources for adults with prediabetes or at high risk for type 2 diabetes

work together to build statewide infrastructure to promote CHW sustainability. Thoughts from those group conversations have been incorporated into the overall forum summary, as many insights and comments echoed and expanded on concepts discussed throughout the forum. (See [Appendix B](#) for the full event agenda.)

Forum discussions were recorded and transcribed, and a note taker captured insights and considerations, which are summarized in this report.

To ensure forum participants' views and considerations were accurately presented, participants received an opportunity to review a draft before the summary report was finalized.

## REPORT CONSIDERATIONS

**This report is not a consensus document**—that is, the forum discussion was not intended to achieve agreement among all participants—nor does it represent official recommendations endorsed by CDC. Rather, it offers the perspective of diverse CHWs, allies, supporters, and states on what they believe is needed to build an infrastructure for CHW sustainability and financing.

Although the discussion may have included suggested action steps, funding and other restraints may limit what is possible for funders, grantees, and the CHW community to do in the near term. Thus, this document is in no way prescriptive.

## SUMMARY OF DISCUSSIONS

For each objective, discussions centered on several themes and concepts. The insights and opinions of participants that follow are organized by those themes within the broader objectives. Where possible, we have included quotes from forum participants that illustrate or reiterate key points from the discussion.

The forum agenda originally called for participants to discuss the topics of sustainability and reimbursement separately, with the goal of teasing out specific insights for each of these interrelated topics. However, participants felt these two issues are too closely intertwined, with an infrastructure for CHW reimbursement being but one significant aspect of sustainability of CHW engagement, and the conversation would be more representative if the issues were addressed in concert. Thus, these topics are addressed together in the summary.

## A Note about Terminology

Participants noted that the topic of “reimbursement” would be better addressed more broadly. They recommended instead discussing financing, which encompasses not only reimbursement of CHW services, but also funding for professional development and efforts to develop CHW organizations and networks, including establishing and supporting the National Association of CHWs. Additionally, the term “reimbursement” can connote the original fee-for-service (FFS) model of Medicaid payment for clinical services. In the specific context of financing of CHW services, FFS reimbursement is only one option (and perhaps the least promising strategy) for such financing. Proposals to make CHWs a reimbursable provider category face resistance as potential “new spending” because such spending is not tied to anticipated results. Therefore, although the objectives for this forum mention reimbursement, we have used the term financing throughout the discussion summary to reflect the forum participants’ views.



## OBJECTIVE 1

Identify existing barriers and gaps to developing a statewide infrastructure to promote long-term sustainability and reimbursement for CHWs as a means to establish or expand their engagement in CDC-recognized lifestyle change programs for type 2 diabetes prevention through the National Diabetes Prevention Program and ADA-recognized/AADE-accredited diabetes self-management education and support services.

### Need for Better Understanding and Consensus about CHWs' Roles and Value

- Greater understanding is needed among policy makers, medical and health care agencies, payers, and public health professionals that “community health worker” is a separate and distinct occupation, not simply anyone who works in or with the community or addresses community health issues. Variations in the understanding of CHWs’ roles can also be found within the CHW workforce itself.
- A CHW’s relationship with members of the community is based on shared power—the CHW and client work together to find solutions that work. This differs significantly from the traditional relationships between patients and health care systems or public health agencies. And given the relational nature of their work, CHWs often perform activities beyond the “official” scope of their job to meet client needs.
- The CHWs’ role is often perceived narrowly as working within clinical settings. Although CHWs play a vital role in those settings—such as assisting with patient follow-through of doctor’s instructions—their influence is much broader.
  - CHWs frequently address multiple clinical needs as well as those related to social determinants of health, support behavior change related to prevention, and may foster community advocacy and capacity building.
- Just as their titles are different, there are distinctions between CHWs, *promotores de salud*, and Community Health Representatives in the approach to their work, partly on cultural grounds. However, these professionals may all be allied or fall under the “umbrella” of CHWs.
  - The titles of these professionals may have ramifications, if funding is tied to services performed by individuals with a specific position or job title.
- Managers and supervisors of CHWs, and top executives in their organizations, may not fully grasp the realities of the CHW job—which can involve traveling long distances within their service areas, focusing on development of relationships, and spending time tailoring and adapting materials to the cultural context of their clients—and therefore may not provide adequate support.

### CHW SNAPSHOT: Going Beyond the Job Description

One forum participant shared a glimpse into her work. Participants are recruited into the program she works with—but when it ends, they want CHWs to continue to support them. She wants participants to refer others to the program, so she doesn’t want to turn them away. The community trusts her; she can’t tell them, “I don’t need you anymore because the program ended.”

She spends time outside of work hours and beyond her job description to support her community and meet her clients’ needs. She also trains other CHWs on ways to help the community.

This “extra” effort adds to her program’s success, but it may not be captured/ reported because it is not in her official job description or program role.

## Challenges Related to CHW Certification and Workforce Development

- Career pathways for individual CHWs are not always clear. In addition, better systems are needed for workforce development to help advance the next generation of CHWs and ensure retention and promotion of current CHWs.
- Not all states have opted for certification of CHWs; in those that have, certification is voluntary. That is, certification is not required to practice as a CHW, but there are regulations about the title of “Certified CHW.”
  - Some people believe standardized training and certification are necessary, while others believe CHWs can perform their roles effectively with less formal training coupled with experience in the field.
  - Within the CHW community, there may be concern that certification threatens the organic nature of the profession (to engage people from the community), while others believe certification will help advance the profession by further legitimizing CHWs’ work, particularly in the health care system where advanced degrees are necessary and highly valued.
  - Decisions around CHW certification take place largely at a state level. Even if CHWs in a state choose not to have formal certification, there can be benefits of having a robust dialogue about the nature and scope of CHWs’ work, leading to common understanding among CHWs, employers, and payers.

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“ CHWs [come] out of college with credentials, and they’re trained, and they’re going off into the sunset and get a job and that’s great. However, for those CHWs who have been doing it for years, they have the practical experience. These programs have come up; they didn’t go through [them]. They are 10,000 times more experienced than a fresh community health worker coming out, except that the fresh one has the credentials. ”

### FORUM PARTICIPANT

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- Recent development of certification programs may put seasoned CHWs at a disadvantage. Many community colleges have CHW training programs that provide recent graduates with certificates or other credentials. CHWs who have been doing this work for years, but have not completed such programs, lack formal certification, yet they have far greater experience and knowledge than new CHWs.
- Professional development for CHWs—whether attending conferences or engaging in more informal peer learning—can be difficult given existing time commitments of the job, a lack of funding for such activities, or lack of permission from program leadership to participate.
  - It is also important to provide opportunities for advancement for CHWs who desire roles in supervision, training, or program management.
  - Programs that offer opportunities for CHWs to move into other professions should avoid the implication that a CHW position is only (or primarily) a stepping stone to something else.

## Need to Educate and Inspire Policy Makers and Administrators about CHWs

- It is important that policy makers, agency leaders, health care administrators, and others in leadership not only understand the role and value of CHWs but also show commitment to facilitating development and sustainability of an infrastructure to support CHWs' work.
- As elected officials and other leaders move on, their knowledge of and support for CHWs often goes with them. Education for new officials would be helpful in fostering their engagement and support. It is also vital to get the information to leaders and administrators at the right levels, where decisions are made about the systems and infrastructures within which CHWs work.

## Opportunities to Expand Integration of CHWs within Medical and Public Health Systems

- Despite the available evidence of CHWs' contributions, buy-in from the health care and public health community is not universal. CHWs have not become part of the fabric of health care.
- Some CHWs feel as though their involvement is often treated as an afterthought, rather than being incorporated from the start in strategies and budgets. They often feel they do not have a voice within health care and public health when decisions are being made.
- Administrators who do not understand CHWs' roles may consider their services a duplication of services provided by other members of the health care team with related responsibilities, such as nurse navigators.

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“ We play a role in every [social] determinant, if you will. In every sector, from preconception to death. We should be included in all of that. Funding for us should be included in [all of that]. I think we, as a community, should be talking that way, too. ”

### FORUM PARTICIPANT

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## Limited Engagement in Community-Based Organizations

- An issue closely related to integrating CHWs in health care and public health systems is further engaging them in community-based organizations (CBOs) that serve their communities and linking those CBOs with an individual's or family's overall care team.
- New health care payment models are being developed that provide for CHWs embedded in clinical services (often as members of care teams), but payment options are currently much more challenging for community-based CHWs. There is promise, however, in more holistic models such as “accountable health communities,” which embrace broader concepts of community development as contributing to health.
- Although many health systems see the wisdom of investing in or partnering with CBOs, effective methods for doing so are lacking. CBOs may also be unaware of how to access funding that is available to them.

## Inconsistencies and Inadequacies in Compensation for CHWs

- Grant-based and other short-term funding makes it challenging to offer stable, sustainable employment for CHWs. CHWs can provide long-term, sustained support for their communities—but current funding systems do not always provide a mechanism for sustained CHW involvement.
- CHWs are professionals, but their pay does not always reflect that. There are misconceptions that CHW services are free, which may stem from the fact that many CHWs started as volunteers or in programs that paid them in gift cards and a few dollars an hour.

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“ I don’t believe in free labor. Not this critical labor.... It shouldn’t be free. Nobody should work for free. ”

### FORUM PARTICIPANT

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- As stated previously, CHWs often put in more than established business hours to meet the needs of their clients and communities, and their pay may not reflect this “extra” time.
- CHWs often do not know how to “sell” their services or to set a value for their services. It is difficult to establish equitable compensation if CHWs have not been engaged in ongoing payment structures before.
- Barriers at the state government level, including Medicaid policy limitations and budgetary pressures, contribute to challenges with compensation.

## Need for and Challenges in Establishing CHW Networks, Associations, and Alliances

- Having CHW networks and alliances can bring bargaining power for the CHW workforce and provide a “by us, for us” platform for resolving issues that can happen within the workforce.
- The National Association of CHWs, currently in development, is intended to give a voice to CHWs at the highest levels and lend credibility to the CHW profession. It could also interact with other national organizations, such as the Association of State and Territorial Health Officials and the National Association of Community Health Centers, and bring together diverse voices to support and advocate for CHWs.
- Funding is a key barrier to creating and sustaining CHW networks at all levels. It is typically difficult to use federal resources to support statewide alliances, but a number of states have been investing in network development through CDC [1305](#) and [1422](#) grants.
- CHW networks and alliances may find themselves needing to rebuild, in part because of changes in leadership, given the voluntary aspect of these roles and the lack of funding to allow more stability. This can make it difficult for these entities to gain traction.
- There is inconsistency in how existing networks and alliances function. Guiding principles for these entities could be useful.

## Incomplete Documentation of CHWs’ Contributions

- Some decision makers may be skeptical about grassroots approaches like the work CHWs do, especially when results are often anecdotal. It is important that evidence of CHWs’ contributions be documented to give them greater credibility.

- Recognition for success is often ascribed to the program or program leaders, rather than to CHWs who are on the frontline doing the work. This can result in an incomplete picture of what contributed to success and can have ramifications related to financing (as funding typically follows what works).
- Showing impact of CHWs' work is essential, but not everyone defines impact in the same way. Performance indicators are critical, and it is necessary to show CHWs' impact according to those metrics.
- Documentation in health care systems increasingly relies on electronic health records (EHRs), and many EHR systems do not allow for entry of CHW activities or observations; some organizations do not allow CHWs to access EHRs directly.

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“ CHWs' work doesn't stop.... You don't turn off your neighbor like you do a computer. Yet that support time, which can truly change outcomes, isn't accounted for in the data. ”

#### FORUM PARTICIPANT

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### Limitations in Funding Mechanisms

- Funding awarded to state health departments by CDC is directed by congressional appropriation, which determines how that money can be spent. It is generally not intended to pay for direct services that CHWs may provide.
- There is incongruity between how initiatives are funded and how CHWs work. Funding typically comes from one agency to address specific health issues, risk factors, or conditions. However, CHWs' work across health conditions and social determinants of health, rather than focusing on an individual disease, like diabetes.

## OBJECTIVE 2

Determine promising practices and lessons learned in CHW reimbursement and sustainability that may inform and guide the future efforts of states, CHWs, and others to develop a statewide infrastructure to promote long-term sustainability and reimbursement for CHWs.

### Solidifying the Definition of CHWs and Raising Awareness of Their Roles

- It is important to establish a definition for the CHW profession that captures the full array of CHWs' skills, roles, and responsibilities; the range of places in which they work; and the variety of job titles that encompass similar tasks.
  - [The Community Health Worker Core Consensus \(C3\) Project](#) in 2016 provided a good start for this process, outlining core roles and skills for CHWs based on standards and guidelines from states and other select sources throughout the United States.
  - The American Public Health Association (APHA) has a definition of CHWs, developed by APHA's [CHW Section](#).
  - CHW marketing and advocacy efforts should convey the financial value of their services and community relationships, as well as the compassionate side of their work. Busy decision makers need to hear a quick explanation (i.e., “elevator speech”) of the value of CHWs, in terms of return on investment.
- Communicating core competencies of CHWs is vital to help people better understand what they are getting for their money.
  - It may be helpful to articulate that CHWs play a role in all three aspects of public health infrastructure: 1) a capable and qualified workforce; 2) up-to-date data and information systems; and 3) agencies capable of assessing and responding to needs.

- CHWs can advocate in their own communities so community members are aware of CHWs and can ask for their services. Advocacy efforts might include:
  - Engaging mothers whose families have benefited from CHWs to share their experiences.
  - Going to parent-teacher association (PTA) meetings to be a part of that community.
  - Holding community forums to discuss integration of CHWs in various settings (e.g., [“Serving from the Heart Across the Workforce”](#) symposium in 2017 in Los Angeles).

### Developing the Workforce

- Just as it is necessary to establish agreement on definitions of CHWs, it is vital to build an evidence base of best practices for training new CHWs, continuing education, and other capacity building. This should include training for supervisors of CHWs to ensure they understand the CHWs’ roles and challenges and the value of trust within their communities.
- To develop a pipeline for new CHWs, it is important to foster an interest in community advocacy at an earlier age, rather than waiting until young adults get to college.
  - For example, [Photovoice](#) projects give youth a voice about problems in their community and how to address them, which can foster community organizers for advocacy and activism and inspire career paths like CHWs.
- CHWs need a way to more easily share and access information, including training available to CHWs, success stories, and lessons learned.
  - Several states have websites with CHW resources or have CHW alliances and networks that can provide information and training. Noted during the forum were the Minnesota Department of Health [CHW website](#) and [CHW alliance](#); Boston

Public Health Commission’s [Community Health Education Center](#), which has a network of CHWs; [CHW Network of New York City](#); and Illinois Community Health Worker Association.

- Having a one-stop resource would be ideal; the National Association of CHWs could house and disseminate such information.
- Monthly or quarterly meetings of CHWs, webinars, and free statewide CHW conferences are potential ways to foster communication and peer learning among this workforce. Making participation in such activities part of CHW position descriptions could facilitate information sharing.
- Specific training and TA for CHW leadership and others who “carry the torch” for CHWs would help them do that more effectively.
  - For example, models like the Department of Health and Human Services (HHS) Office of Women’s Health [National Health Leadership Institute](#) for CHWs could be replicated.
  - Advocacy and fostering professional development for CHWs could be included in training and TA for individuals who supervise CHWs.
- Discussions about certifications and other requirements for new CHWs should be sensitive to potential ramifications related to financing.
  - Referring to “trained CHWs” could be misinterpreted to mean a requirement that CHWs have a degree; what constitutes training must be carefully defined.
  - Creating opportunities for long-time CHWs to attain a certificate based on their experience should put them on level ground with, or even ahead of, inexperienced CHWs who may have completed formal education programs.

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“ Sustainability has the component of ‘How do you get CHWs into the communities and into the practice?’— That’s education, training, and reaching out to new generations of future CHWs. It’s [also] keeping them there, so that has to do with stability around financing, integrating them as core components of care teams, and also offering opportunities for growth and advancement, to keep people where they’re adding value. ”

**FORUM PARTICIPANT**

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**Providing Opportunities for CHW Input**

- CHWs desire, and should have, a voice at the table with decision makers at all levels (federal, state, health system, etc.).
  - Recognition by federal agencies and other leaders of CHWs as public health contributors can be powerful and can aid in opening opportunities for discussion.
  - CHWs’ organizing to engage in education and advocacy could also lead to invitations to participate at the table with decision makers.
- Education for new policy makers across sectors and agencies can foster understanding of what CHWs do and ensure support for CHWs does not end when someone leaves their office or position.

- At the national level, due to turnover in elected positions, congressional staff may be one audience to educate.
- At the state level, partnering with organizations such as the National Governors’ Association can help reach leaders.
- Building political will within local communities is also essential.
- One potential policy that could facilitate providing a voice for CHWs is APHA’s [Position Statement 2014-24, “Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing.”](#) which states that 51 percent of any task force or other body charged with decision making about the CHW infrastructure should consist of active or retired CHWs.
- It is also necessary to educate and equip CHW leadership to advocate among decision makers for recognition and sustainable financing.
  - Capacity building could also include training about the purpose and processes of legislative bodies, including finance committees.

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“ It’s important ... that we have people who understand, who know, and are committed to sustaining [CHWs] ... Those people in the decision-making mode need to be informed and committed to the workforce in order to maintain or sustain it. ”

**FORUM PARTICIPANT**

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## Improving CHW Integration into Health Systems and CBOs

- Existing examples and guidelines can inform efforts to better integrate CHWs in the health care system.
  - Models to draw from are the [East Central Ministries' clinic](#) and [Pathways Model](#).
  - Other ideas include pairing a CHW with a medical student or paramedical professional to help answer patients' questions and enhance service delivery, and having CHWs accompany medical providers when they do home visits for clients with complicated health situations.
- Educating health care providers—both current practitioners and those in training—and administrators about the role of CHWs in prevention (primary, secondary, and tertiary prevention), post-diagnosis, and continued care can help build champions for CHWs.
  - This education should include information on how CHWs can help address social determinants of health, recognizing that CHWs address patient needs when patients do not access any other services in the medical system.
  - CHWs can engage in this education themselves—for instance, by attending meetings with local health care providers, going into hospitals to teach practitioners about the cultural issues patients face, and submitting abstracts and research to the annual conference of the National Association of Community Health Centers (the conference has a workgroup on enabling services, which can include CHWs).
- There may be ways to leverage the increasing focus on population health to advance the infrastructure for CHWs. Health systems desire help in this arena, so the time might be ripe for conversation about CHW services.

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“ Everyone who is supporting [a] patient and [a] community in gaining optimal health is working together. They need to know about each other. They need to know each other's strengths, [and] where one or the other is not proficient. And the patient and community need to know the same thing. We have to continue to educate the patient ... And make sure the money follows the work of everyone on that team. ”

### FORUM PARTICIPANT

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- Reactivating the CHW workgroup within the Department of Health and Human Services (HHS) could provide more authority and influence to address CHW engagement.
- Partnerships between health care and CBOs could be strengthened, as illustrated by the following examples:
  - Using a Delivery System Reform Incentive Payment allocation, Texas Medicaid funded 1,200 local projects, about one-third of which involved CHWs. Through the San Antonio local health department's neighborhood engagement project, 10 CHWs—employed as community organizers—worked with selected neighborhoods to determine top health issues and come up with strategies to address those issues.
  - The Monroe Plan for Medical Care contracted with a CBO to engage CHWs in birth outcomes outreach. From the hospital's perspective, the project resulted in reductions in neonatal intensive care unit (NICU) costs; from the community's and CHWs' perspective, the real payoff was healthy babies and families.

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“ CHWs are unique in that they can be in clinics, they can be in CBOs, they can be in public health, [and] they can be on their own. They could probably be in education and many other areas.... I think we need to find those opportunities and show [their] the value. ”

#### FORUM PARTICIPANT

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### Achieving Compensation Commensurate with Professional Services Provided

- Institutionalizing CHWs as a public health career path would be an important first step to ensure compensation similar to other public health professionals.
- Another key step is engaging payers in conversations about CHW value and compensation. Payers are interested in stretching the money they pay on claims to address social determinants of health, and CHWs are uniquely positioned to help in that arena. This may give CHWs bargaining power.
  - In addition, as more studies are done on return on investment and cost savings related to CHWs, it will be important to explore how to invest these savings into hiring and maintaining CHWs as full-time employees.
- Establishing salaries that are better aligned with the value of CHWs' work requires that buyers understand clearly what they get for their money.
  - It may be helpful to define the services CHWs offer and set a price for each, recognizing that the cost of services (and thus, the salaries of professionals providing those services) varies geographically.
- The Department of Labor has a [Standard Occupational Classification for CHWs](#).

### Building CHW Networks and Fostering Peer-to-Peer Connections

- Establishing and supporting the National Association of CHWs is important, for the reason cited earlier, as is exploring additional ways to fund statewide networks and alliances.
  - Some states used 1305 cooperative agreement funds to help support such networks.
  - Funding could not only establish and maintain these organizations, but also cover CHW participation in them.
- Leadership of CHW networks, associations, and advisory boards should hold true to the principles of self-determination that are fundamental to CHWs. This might be achieved by requiring that at least 51 percent of participants in state CHW advisory groups be active CHWs.
- Even in the absence of official networks or an association, there is value in organizing locally. Some CHW colleagues network informally, sometimes meeting after the workday. Meetings may include training and idea sharing to help address challenges. Project coordinators and other CHW leadership can facilitate or encourage such peer-to-peer connection and learning. Larger, more established networks could support smaller ones with training and communication.

### Documenting and Disseminating CHWs' Contributions

- Much evidence of CHWs' effectiveness already exists, and efforts to show impact should build on those results. For instance:
  - [The Community Guide](#) has examined research which supports the work of CHWs.
  - The Center for Medicare & Medicaid Innovation's [third annual meta-analysis evaluation report](#) of the Health Care

Innovation Awards (140–150 grants), released in February 2018, shows that the CHW model produced cost savings, which was an emphasis of these grants.

- Success stories are necessary because most organizations do not want to be pioneers. CHWs need a system for gathering and disseminating this information.
  - The National Association of CHWs could help with publishing, documentaries, and advocacy.
  - Another option could be a state or local system for capturing best-practice learning (e.g., a Pathways databank).
  - Individual CHWs can also keep a journal to document their stories and consider publishing results of their work, even if it is not official research.
  - An associated issue is having a mechanism to pay for CHWs' time to contribute to this knowledge base.

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“ It gets exhausting to have to explain what I do over and over and over again. ”

#### FORUM PARTICIPANT

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- In addition to research that focuses on translating theory into practice, it could be helpful to look at existing practices and develop research to determine which are most effective.
- Data must be analyzed and shared with key stakeholders, including medical and clinical providers and state health departments. In addition, states want to see state-specific data. TA for states could include guidance on synthesizing and presenting data effectively.

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“ We're overflowing; we're awash in evidence now. One thing we've learned is, evidence from other places doesn't count. We need to see evidence from our state. ”

#### FORUM PARTICIPANT

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### Exploring Funding Mechanisms that Facilitate CHW Engagement and Sustainability

- The [Community Health Worker Core Consensus \(C3\) Project](#) serves as a blueprint document that can provide background information for all efforts related to CHWs.
- CHWs and their allies should be encouraged to join boards and committees of relevant agencies to bring the voices of CHWs—and the communities they serve—to decision-making bodies and processes.
- It may be wise for CHWs to go where the money is and focus on opportunities to show their benefit and return on investment.
  - For example, in one community, emergency departments (ED) were being used midday for non-emergencies. Federally Qualified Health Centers hired CHWs in neighborhoods where these ED visits were most frequent, and the ED visits decreased. The CHWs were so beneficial that the health centers kept the CHWs even after grant funding ended.
- Given that CHWs often work across health and social determinants of health issues, it makes sense for agencies that want to engage CHWs to work together to identify innovative ways to blend financing into one source that could fund CHW programs to work across silos.

- Strategies for this exploration may include engaging a champion, involving CHWs in meetings with the state Medicaid director to discuss how to address social determinants of health, and bringing together state or national associations to develop a project that uses the [Social Innovation Fund](#) to demonstrate CHWs' value.
- In Minnesota, for instance, there is a history of public health working with transportation and housing; in fact, departments are required to work together. This could be replicated in other states.
- Programs like Pathways tap into funding from schools, behavioral health, housing, and other sectors and braid or blend that funding.

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“ Go where more money is, which might not be where you normally would think of going ... and then show your value. ”

#### FORUM PARTICIPANT

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- Nonprofit hospitals must conduct community health needs assessments—required by the Internal Revenue Service to maintain tax-exempt status—and implement programs to address the needs identified to benefit the community. These hospitals may be open to directing some of the funds for such programs to cover CHW services.
- It may be advantageous for CHWs and their networks to form relationships with a full range of local entities to sustain the CHW workforce and support professional development.
  - For instance, in one county, 1 percent of mill levy dollars are used to fund local agencies to hire and sustain CHWs.

- In Massachusetts, accountable care organizations are required to address eight proposed social determinants of health indicators, an arena in which CHWs generally work.
- It is important that language related to financing not only be broad and representative of the range of payment structures and systems used (e.g., sustainable financing), but also incorporate new terms the field may be transitioning to.

### OBJECTIVE 3

Identify promising practices and lessons learned about the roles CHWs can play in increasing enrollment and improving retention in CDC-recognized lifestyle change programs for type 2 diabetes prevention and/or ADA-recognized/AADE-accredited DSMES services for diabetes management.

#### Engage CHWs in Tailoring and Adapting Curricula and Activities for the Community

- Different subpopulations may need different adaptations of the PreventT2 curriculum to ensure it is user-friendly and culturally and linguistically appropriate. CHWs can help programs understand the communities they serve and the realities and challenges they face.
  - Issues to address in the curricula may include cultural perceptions, myths, and fears associated with diabetes. For example, how does a wife negotiate portion size with her husband? How does one address the concept of fatalism and the reality that everyone in the client's family who had diabetes had a bad outcome?
  - Adaptations may be necessary to address limitations in literacy or health literacy. CHWs can develop or consult on communication tools such as flipcharts and drawings to help clients understand concepts or instructions.

- CHWs can also help in adapting lifestyle change program activities to participants' needs and preferences—within the parameter of program requirements—to ensure they are relevant, engaging, and feasible for participants who may be dealing with complex health, mental health, or social issues. For instance, lifestyle change programs have added Zumba, grocery shopping trips, and church picnics, contributing to greater participant success and higher retention rates.

### **Provide Training for CHWs to Support These Programs and Services**

- Training for CHWs related to the National Diabetes Prevention Program and DSMES would help them better support those programs and services. Topics might include:
  - Elements that make up the National Diabetes Prevention Program or ADA-recognized/AADE-accredited DSMES services
  - Basic information about prediabetes and type 2 diabetes
  - Social determinants of health related to type 2 diabetes prevention or diabetes management
  - The importance of referrals to these programs/services by trusted practitioners
  - Techniques such as motivational interviewing and other support approaches
- Funding for organizations to provide such training to CHWs could help facilitate their increased participation. Providing organizations with standardized materials for training CHWs about these programs/services would ensure they receive consistent information and, in turn, would enable them to share consistent messages with clients.
- Meetings among CHWs who are involved in these programs may boost peer learning and support and increase engagement and retention of these professionals.

### **Recognize Challenges CHWs May Face**

- Many of the clients CHWs work with live complex, marginalized lives. Getting commitment to attend a month-long class or year-long program may be difficult. However, CHWs can contribute to connecting clients to DSMES services or lifestyle change programs and offer support during (and after) participation to foster their success.
- CHWs may need to be encouraged to connect individuals to lifestyle change programs and DSMES services and be equipped with messaging to explain how these programs and services can fit with clients' other priorities (e.g., family needs, other health issues, financial considerations).

### **Adequately Capture CHW Involvement in These Programs and Services**

- There are already best practices for engaging CHWs in diabetes management and type 2 diabetes prevention activities at the grassroots level, but as with much of CHWs' work, these practices are not being captured and reported systematically.
- CHWs can help ameliorate the impact of social determinants of health, and they often do more than teach the curriculum of a lifestyle change program or DSMES service to meet the spectrum of a participant's health needs. Much of the work is done outside the "system." Capturing those "extra" efforts is vital to have a complete sense of what contributes to outcomes.
- Success may look different to CHWs than the funder's or organizer's metrics for these programs. While CHWs contribute to the stated outcome criteria, they also help participants celebrate small, incremental improvements.



## OBJECTIVE 4

Gather “pearls of wisdom” from the perspective of CHWs that would be important to share with states, CHWs, and others engaged in this work.

### Understand Who CHWs Are and What They Do

- CHWs are not *used* in or by programs. They are *integrated* into programs and services. Language matters when engaging CHWs.
- CHWs’ primary purpose is to help their community and support the individuals they serve. It is helpful to emphasize how CHWs’ involvement in type 2 diabetes prevention and diabetes management programs can help individual clients as well as contribute to the overall well-being of the community.
- Part of the value of CHWs is that they speak the language of their community (literally and figuratively), and they understand the cultures that make up that community. They can help policy makers and programs better understand, reach, and serve target populations.
- CHWs generally look at the whole person and the broad context of their life. In a single interaction with a client, a CHW may address multiple clinical needs and social determinants of health needs—such as making sure a patient has food to eat before making sure they are taking their high blood pressure medicine or teaching them how to use a glucometer.
- Simply communicating the impact of diabetes may not be compelling enough to engage people in diabetes management or type 2 diabetes prevention programs. It also takes compassion and caring; CHWs provide that.

### Give CHWs a Voice at the Table

- CHWs are passionate about what they do and welcome the opportunity to educate and inspire decision makers.
  - An important step in communicating about CHWs’ roles and contributions is developing an “elevator speech” that tells stakeholders what they gain by engaging CHWs—in a way that addresses both the heart and the pocketbook.
  - A marketing toolkit could help CHWs channel that passion into effective communication strategies.
- In their work with at-risk communities, CHWs follow the adage “Nothing about us without us.” This adage should also apply to efforts to develop a statewide infrastructure to promote long-term sustainability and financing for CHWs. They want to be part of those conversations at all levels.
- States are held accountable to meet targets set in their cooperative agreements. It is helpful for CHWs who speak to state decision makers to understand those targets and explain how CHWs can help reach them, while respecting the needs of the community.

### Respect the Grassroots Nature of CHWs’ Work

- Trust CHWs to use their knowledge and expertise to reach and engage those they serve. CHWs use a grassroots approach and rely on flexibility to respond to the needs of their community. Changing the grassroots model—to make every CHW’s training and skill set the same—may make them less effective.
- Integrating CHWs into health systems may have benefits as far as financing their services; however, some feel “medicalizing” CHWs could complicate the interactions they can have with clients. For some CHWs, employment within a

health system could make it harder for them to do their work, as their work may no longer be perceived as grassroots, and it may be more difficult for their community to access them.

### Prioritize Support for Networking

- Launching and maintaining the National Association of CHWs could help elevate the CHW profession and provide a forum for communicating about and within the workforce.
- Peer learning contributes to capacity building. Opportunities for CHWs to learn from one another can include peer-to-peer conference calls, state CHW networks, and attendance at conferences.
  - Funding for this practice is often lacking. It would be helpful to explore sustainable mechanisms to facilitate CHW peer-to-peer interaction.
- State grantees who work on CHW integration could benefit from continued opportunities to learn from others engaged in the same work, such as through communities of practice and other forums for peer learning.

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“ I think as a [national] association, our possibilities are endless. [The National Association of CHWs is] in the infancy stage. Certainly, somebody can help fund it and move it along... ”

**FORUM PARTICIPANT**

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### Enhance Financing Strategies to Build CHW Infrastructure and Facilitate CHW Engagement

- It is important to be curious about how federal and state funding works—to see what is possible and explore opportunities with those agencies.
- Within the parameters of a cooperative agreement, states can shape activities to ensure their needs are met where CHWs are concerned. For instance, a state could first need to focus on building an infrastructure for engaging and sustaining the CHW workforce before working to integrate CHWs into specific programs.
- It may be helpful for states to develop template language addressing CHW engagement to add to CBO contracts. Some states have already been successful in financing CHWs and are willing to share tools, resources, and additional insights to inform the work of others.
- The National Academy for State Health Policy provides a helpful resource. Its [State Community Health Worker Models](#) webpage highlights state activities to integrate CHWs into evolving health care systems in key areas such as financing, education and training, and certification and provide definitions, roles, and scopes of practice. It includes enacted state CHW legislation and provides links to state CHW alliances and networks and other leading organizations working on CHW issues in the states.

## Explore Ways to Address Diabetes Management and Type 2 Diabetes Prevention Alongside Other Health Conditions and Social Determinants of Health

- The populations CHWs work with have cross-cutting, interconnected health needs. It is essential for CHWs to be able to address not only diabetes-related activities and concerns, but all of an individual's health issues.
- Equally important is establishing ways that CHWs can support the National Diabetes Prevention Program or DSMES services and address the social determinants of health that affect their clients' health and well-being—whether in combination with or within the context of these programs and services.
- CHWs can be an extension of these programs, providing services and support that increase the likelihood of participant success.
  - For instance, home visits by CHWs can be effective at helping people manage diabetes; this strategy could be combined with DSMES services.
  - Complementary support groups led by CHWs after programs or services end may help participants sustain new behaviors to manage diabetes or prevent type 2 diabetes.

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“ There is no way you can tackle one condition at a time. It just doesn't work that way... You have to be able to provide the support the patient needs, regardless ... [to be] very individualized. ”

### FORUM PARTICIPANT

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## Keep the Conversation Going

- The CDC forum was an important starting point. Similar CHW forums are desired with other agencies within the Department of Health and Human Services (HHS).
- Help is needed to foster CHW connections across federal agencies, including the Department of Transportation, Federal Interagency Health Equity Team, Health Resources and Services Administration, Office of Minority Health, and all of HHS.
- It may be helpful for the National Association of CHWs to create a 5-year strategic plan for engaging CHWs and then, in 5 years, assess progress and set another plan for continued growth and sustainability of the profession.



## NEXT STEPS

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This CHW forum provided many helpful insights that will inform future work. CDC will consider how to incorporate this information in a training and technical assistance guide for working with CHWs in this arena, which is currently under development, and explore development of other materials such as job aids to distill key information and foster communication with and support for state health departments.



# APPENDIX A.

## Forum Participants

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Campeños Sin Fronteras



# APPENDIX B.

## Forum Agenda

### DAY 1: MAY 10, 8:30 AM–5:00 PM ET

#### OPENING

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8:30–9:00 AM	<b>Breakfast/Reception</b>
9:00–9:05 AM	<b>Forum Opening and Introductions</b> <b>Elaine Arkin (Facilitator)</b> <ul style="list-style-type: none"><li>• Participant introductions.</li></ul>
9:05–9:15 AM	<b>Welcome</b> <b>Ursula Bauer, PhD, MPH (invited)</b> <i>Director, CDC National Center for Chronic Disease Prevention and Health Promotion</i>
9:15–9:25 AM	<b>Introductory Remarks</b> <b>Ann Albright, PhD, RD</b> <i>Division Director, CDC/DDT</i>
9:25–9:35 AM	<b>Meeting Overview</b> <b>Elaine Arkin</b> <ul style="list-style-type: none"><li>• Review agenda.</li><li>• Review meeting logistics and guidelines for discussion.</li></ul>
9:35–9:40 AM	<b>Meeting Purpose and Objectives</b> <b>Betsy Rodríguez, RN, MSN, CDE</b> <i>Senior Public Health Advisor, Health Education and Promotion Team, CDC/DDT</i>
9:40–9:55 AM	<b>CDC Diabetes Efforts and CHWs</b> <b>Patricia (Pat) Schumacher, MS, RD</b> <i>Chief, Program Implementation Branch, CDC/DDT</i> <ul style="list-style-type: none"><li>• Speaker presentation.</li><li>• Address participant questions.</li></ul>

## DAY 1: MAY 10, 8:30 AM–5:00 PM ET

### MORNING DISCUSSION SESSION

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9:55–11:00 AM	<b>Discussion Topic #1: Meaning of CHW Sustainability and Reimbursement</b> <i>Elaine Arkin and Forum Participants</i>
11:00–11:15 AM	<b>Break</b>
11:15 AM–12:15 PM	<b>Discussion Topic #2: Existing Barriers and Gaps for CHW Sustainability and Reimbursement</b> <i>Elaine Arkin and Forum Participants</i>

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### AFTERNOON DISCUSSION SESSION

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12:15–12:45 PM	<b>Lunch</b>
12:45–1:10 PM	<b>Financing of Community Health Workers: Issues and Options</b> <b>Carl Rush, MRP</b> <i>University of Texas School of Public Health</i> <ul style="list-style-type: none"><li>• Speaker presentation.</li><li>• Address participant questions.</li></ul>
1:10–2:30 PM	<b>Discussion Topic #3: CHW Reimbursement—Opportunities, Best Practices, and Lessons Learned</b> <i>Elaine Arkin and Forum Participants</i>
2:30–3:00 PM	<b>Break and Activity</b>
3:00–4:30 PM	<b>Discussion Topic #4: CHW Sustainability—Opportunities, Best Practices, and Lessons Learned</b> <i>Elaine Arkin and Forum Participants</i>

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### REVIEW AND WRAP-UP

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4:55–5:00 PM	<b>Closing Remarks</b> <b>Judith McDivitt, PhD</b> <i>Team Leader, Health Education and Promotion Team, CDC/DDT</i>
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## DAY 2: MAY 11, 9:00 AM–3:00 PM ET

### OPENING

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9:00–9:05 AM	<b>Welcome</b> <b>Judith McDivitt, PhD</b> <i>Team Leader, Health Education and Promotion Team, CDC/DDT</i>
9:05–9:15 AM	<b>Logistics and Agenda</b> <b>Elaine Arkin (Facilitator)</b>
9:15–9:20 AM	<b>CDC Remarks</b> <b>Betsy Rodriguez, RN, MSN, CDE</b> <i>Senior Public Health Advisor, Health Education and Promotion Team, CDC/DDT</i>

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### MORNING DISCUSSION SESSION

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9:20–10:20 AM	<b>Discussion Topic #5: Expanding the Roles of CHWs in Increasing Enrollment and Retention in Type 2 Diabetes Prevention Programs and Diabetes Self-Management Programs</b> <b>Elaine Arkin and Forum Participants</b>
10:20–10:35 AM	<b>Break and Activity</b>
10:35 AM–12:15 PM	<b>Discussion Topic #6: Opportunities for States and CHWs to Work Together to Build Statewide Infrastructures to Promote CHW Sustainability</b> <b>Elaine Arkin and Forum Participants</b> <ul style="list-style-type: none"><li>• Breakout Groups (National, Grassroots, State, and Medical)</li><li>• Group Discussion</li></ul>

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### AFTERNOON DISCUSSION SESSION

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12:15–1:00 PM	<b>Lunch and Activity</b>
1:00–2:15 PM	<b>Discussion Topic #7: “Pearls of Wisdom” from the Perspective of CHWs That Would Be Important to Share with States, CHWs, and Others Engaged in Developing Statewide Infrastructure to Promote Long-Term Sustainability and Reimbursement for CHWs</b> <b>Elaine Arkin and Forum Participants</b>

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### REVIEW AND WRAP-UP

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2:15–2:45 PM	<b>Final Thoughts from Participants</b> <b>Elaine Arkin and Forum Participants</b>
2:45–2:55 PM	<b>Next Steps</b> <b>Judith McDivitt, PhD</b> <i>Team Leader, Health Education and Promotion Team, CDC/DDT</i>
2:55–3:00 PM	<b>Closing Remarks</b> <b>Bryce Smith, PhD, MSSW</b> <i>Branch Chief, Translation, Health Education, and Evaluation Branch, CDC/DDT</i>

# APPENDIX C.

## Definitions Related to the National Diabetes Prevention Program and DSMES Services



### National Diabetes Prevention Program Lifestyle Change Program

The National Diabetes Prevention Program lifestyle change program is founded on the science of the Diabetes Prevention Program research study and several translation studies that followed, which showed that making realistic behavior changes helped people with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58% (71% for people over 60 years old). This lifestyle change program:

- Is a year-long, structured program (in-person group, online, or combination) consisting of:
  - An initial 6-month phase offering a minimum of 16 sessions over 16–24 weeks and
  - A second 6-month phase offering a minimum of one session a month (at least six sessions).
- Is facilitated by a trained lifestyle coach.
- Uses a CDC-approved curriculum.
- Includes regular opportunities for direct interaction between the lifestyle coach and participants.
- Focuses on behavior modification through healthy eating, increasing physical activity, managing stress, and peer support.

### Diabetes Self-Management Education (DSME)

DSME is “the active, ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care.” (*Joint Statement from ADA, AADE, and Academy of Nutrition and Dietetics*)

### Diabetes Self-Management Support (DSMS)

DSMS “refers to the support that is required for implementing and sustaining coping skills and behaviors needed to self-manage on an ongoing basis.” (*Joint Statement from ADA, AADE, and Academy of Nutrition and Dietetics*)

## Diabetes Self-Management Education And Support (DSMES)

DSMES is “the ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care, as well as activities that assist a person in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training” (*2017 National Standards for Diabetes Self-Management Education and Support*). By combining DSME and DSMS, services can “address the patient’s health beliefs, cultural needs, current knowledge, physical limitations, emotional concerns, family support, financial status, medical history, health literacy, numeracy, and other factors that influence each person’s ability to meet the challenges of self-management.” (*Joint Statement from ADA, AADE, and Academy of Nutrition and Dietetics*)

## Diabetes Self-Management Training (DSMT)

The Centers for Medicare and Medicaid Services (CMS) uses the term training instead of education when defining the reimbursable benefit (DSMT). (*Joint Statement from ADA, AADE, and Academy of Nutrition and Dietetics*). (The term DSMT is used specifically in the context of billing).





