

**COFFEE BREAKS 2019:  
INVESTING IN STATEWIDE CHW  
WORKFORCE DEVELOPMENT**

CENTERS FOR DISEASE CONTROL AND PREVENTION



Colleen Barbero, PhD | Applied Research and Translation Team  
November 12, 2019

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION



DIVISION FOR HEART DISEASE AND STROKE PREVENTION

MODERATOR:

Welcome to today's Coffee Break presented by the Applied Research and Evaluation (ARE) Branch in the Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention.

We are fortunate to have **Dr. Colleen Barbero** as today's presenter. She works as a Health Scientist with the **Applied Research and Translation Team (ART)** within CDC's Division for Heart Disease and Stroke Prevention.

My name is **Lauren Taylor** and I am today's moderator. I am also on the ART team within the **ARE Branch**.

## BEFORE WE BEGIN...

- All phones have been placed in SILENT mode.
- Any issues or questions?
  - Use Q & A box on your screen
  - Email [AREBheartinfo@cdc.gov](mailto:AREBheartinfo@cdc.gov)



MODERATOR:

Before we begin we have a few housekeeping items.

All participants have been muted. However, to improve audio quality please mute your phones and microphones.

If you are having issues with audio or seeing the presentation, please message us using the chat box or send us an email at [AREBheartinfo@cdc.gov](mailto:AREBheartinfo@cdc.gov)

If you have questions during the presentation, please enter it on the chat box on your screen. We will address your questions at the end of the session.

Since this is a training series on applied research and evaluation, we hope you will complete the poll at the end of the presentation and provide us with your feedback.

## DISCLAIMER

The information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention.

MODERATOR:

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So, without further delay. Let's get started. **Colleen**, the floor is yours.

## AGENDA

1. Provide a **REMINDER** about who is a **Community Health Worker (CHW)**?
2. Share **EVIDENCE** to help make the case for investing in CHW workforce development
3. Describe a general **PROCESS** for implementing CHW workforce development investments
4. Assess **PROGRESS** made by states as October 31, 2019
5. Discuss **CONSIDERATIONS** and share **RESOURCES**

Hi everyone, welcome to this presentation on community health worker (or CHW) workforce development. Today I will first provide a **reminder about who is a CHW. Then I will share evidence that could help you** make the case for investing in the CHW workforce. Next I'll describe a general process for implementing CHW workforce development investments and assess the progress made to date. Lastly we'll discuss **considerations** and share **resources**.

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WHO IS A COMMUNITY HEALTH WORKER?

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## WHO IS A COMMUNITY HEALTH WORKER?

American Public Health Association Definition:

- is a **trusted member** of and/or has an unusually close understanding of the community served
- serves as a **liaison/link/intermediary** between health/social services and the community
- facilitates **access to services**
- improves the quality and **cultural competence** of service delivery
- builds **individual and community capacity** by increasing health knowledge



This slide provides the American Public Health Association's definition of a CHW. The CHW is a trusted member of and has a close understanding of the community served, which **is** among the most noted and distinctive attributes of CHWs. **The trusting relationship with community members enables the CHW to serve as a link between health and/or social services and the community, facilitating access to services and improving the quality and cultural competence of service delivery, and building individual and community capacity.** This is the widely accepted definition for CHWs.

## WHO IS A COMMUNITY HEALTH WORKER?



There is much diversity among CHWs because CHWs serve diverse populations as well as different geographic communities. Next we are going to discuss evidence that supports investments in the CHW workforce.

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THE CASE FOR INVESTING IN CHW  
WORKFORCE DEVELOPMENT



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## CHRONIC DISEASES: EFFECTIVENESS AND COST-EFFECTIVENESS

The Guide to Community Preventive Services recommends engagement of CHWs for:

- Cardiovascular disease prevention
- Type 2 diabetes prevention and management
- Breast, cervical, and colorectal cancer screening



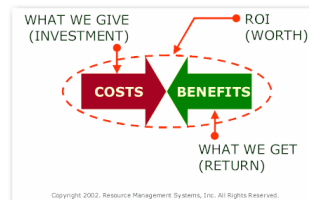
The screenshot shows the 'Community Health Workers' page on The Community Guide website. The page features a search bar at the top, navigation links for 'Topics', 'CPTF', 'Publications & Resources', 'About', and 'GuideCorpus'. Below the search bar, the title 'Community Health Workers' is displayed. A photograph shows a community health worker in a light blue shirt talking to an older woman. Text on the page explains that community health workers help meet national health goals by conducting community-level activities and interventions that promote health and prevent disease and disability. It also notes that community health workers serve as a bridge between underserved communities and healthcare systems. A small box on the right side of the page identifies the topic as 'National Strategic Community Health Workers to Prevent and Manage Disease' and credits the development to 'The Community Guide' in September 2017.

<https://www.thecommunityguide.org/content/community-health-workers>

There is strong and credible evidence for the effectiveness and cost-effectiveness of interventions engaging CHWs. The Guide to Community Preventive Services now recommends engagement of CHWs for **cardiovascular disease** prevention, **type 2 diabetes** prevention and management, and **breast, cervical and colorectal cancer** screening.

## COSTS SAVINGS & RETURN ON INVESTMENT (ROI)

- Reduced Emergency Department visits, primary care visits, direct medical costs<sup>1,2</sup>
- Healthcare cost reductions:
  - -\$82 per patient per year for cardiovascular disease prevention<sup>3</sup>
  - -\$72 per patient per year for type 2 diabetes management<sup>3</sup>
- Savings of \$138 per beneficiary per quarter<sup>4</sup>
- \$2 ROI for chronic diseases<sup>5</sup>

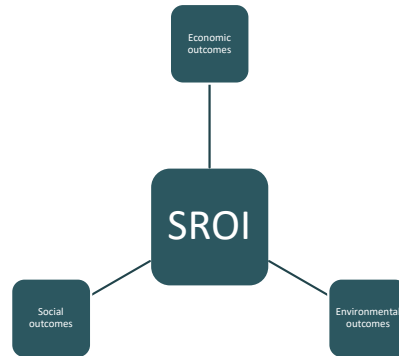


1. London K, Tikkanen R. Sustainable Financing Models for Community Health Worker Services in Connecticut: Translating Science into Practice. 2017.
2. Umass Medical School. Sustainable Financing Models for Community Health Worker Services in Maine. 2016.
3. Jacob V, et al. Economics of community health workers for chronic disease: findings from Community Guide systematic reviews. 2019; Am J Prev Med, 56(3):95-106.
4. Research Triangle Institute. Healthcare Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative Year 3. 2018; Baltimore, MD.
5. Kangovi S, et al. Community health worker support for disadvantaged patients with multiple chronic diseases: a randomized clinical trial. Am J Public Health. 2017;107(10):1660-1667.

Additionally, CHWs are shown to be associated with cost savings and return on investment or ROI. CHWs are associated with reduced Emergency Department visits, primary care visits, and direct medical costs. Additionally, the Community Guide determined that the median change in healthcare cost was a reduction of \$82 per patient per year for CHW interventions to prevent CVD, based on seven studies. For CHW interventions to manage type 2 diabetes, the median change in healthcare cost was a reduction of \$72 per patient per year, based on four studies. Other positive cost savings and positive ROI have also been found.

## SOCIAL RETURN ON INVESTMENT (SROI)

- SROI has been defined as a framework for measuring and accounting for the much broader concept of **value** including **health/economic, social, and environmental outcomes**



Banke-Thomas AO, et al. (2015). Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review. *BMC Public Health*, 15, 582.

It's important to remember that CHWs impact a wide range of outcomes. Social return on investment or SROI has been defined as a framework for measuring and accounting for the much broader concept of **value including health, economic, social, and environmental outcomes**.

## MAKING THE CASE FOR SROI: OTHER BENEFITS OF CHWs

### Other economic benefits

- Quality of care<sup>7</sup>
- Work attendance<sup>1,2</sup>
- Lifetime taxes paid<sup>8</sup>

### Social/environmental benefits

- School attendance<sup>1,2</sup>
- Post-incarceration re-entry<sup>9</sup>
- Social capital<sup>10</sup>
- Social needs & SDoH,<sup>11</sup> e.g., housing,<sup>12</sup> environmental factors<sup>13</sup>

7. Kangovi S, et al.. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes. JAMA. 2014;174 (4): 535-543.
8. Wilder Research. Social return on investment: community health workers in cancer outreach. 2012; Saint Paul, MN.
9. Wilmont D, van Olphen J. Challenging the health impacts of incarceration: the role for CHWs. Ca J Health Prom. 2007;3(2), 38-48.
10. Ingram, et al. Community health workers and community advocacy: addressing health disparities. J Community Health. 2008;33(6):417-424.
11. Damio G, et al. Addressing Social Determinants of Health through Community Health Workers: A Call to Action, Hispanic Health Council Policy Brief. 2017; Hartford CT.
12. Freeman A, et al. A pilot community health worker program in subsidized housing: the Health + Housing Project. Cityscape. 2018;20(2): 19-38.
13. Cohen SJ, Meister JS, de Zapien JG. Special action groups for policy change and infrastructure support to foster healthier communities on the Arizona-Mexico border. Public Health Rep. 2004;119(1):40-47.

This slide provides a sampling of the literature to date on other economic benefits and social outcomes of engaging CHWs. For example, CHWs have been shown to help increase quality of discharge in patient centered care, as well as increase work attendance by improving symptoms. Engaging CHWs in cancer outreach has been estimated to increase lifetime additional taxes paid per person served by CHW.

For outcomes that are more social in nature, CHWs have helped to increase school attendance in children and post-incarceration reentry into the workforce. Additionally, CHW roles including advocacy and mobilization of communities have been shown to increase social capital and help address social needs and social determinants of health.

**(Poll question) Looking at this list, can you think of stakeholders in your state who may have an interest in these outcomes?** Please type your answer in the chat box below.

Now that we've provided an overview of the case for CHW workforce investments, let's look at a general process for implementation, and the progress made.

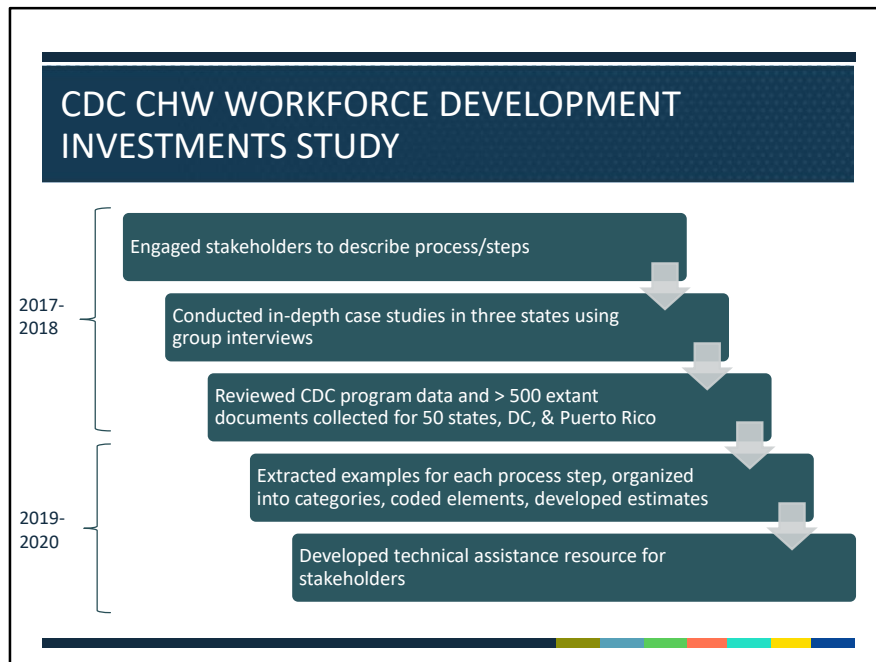
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GENERAL PROCESS FOR CHW WORKFORCE  
DEVELOPMENT



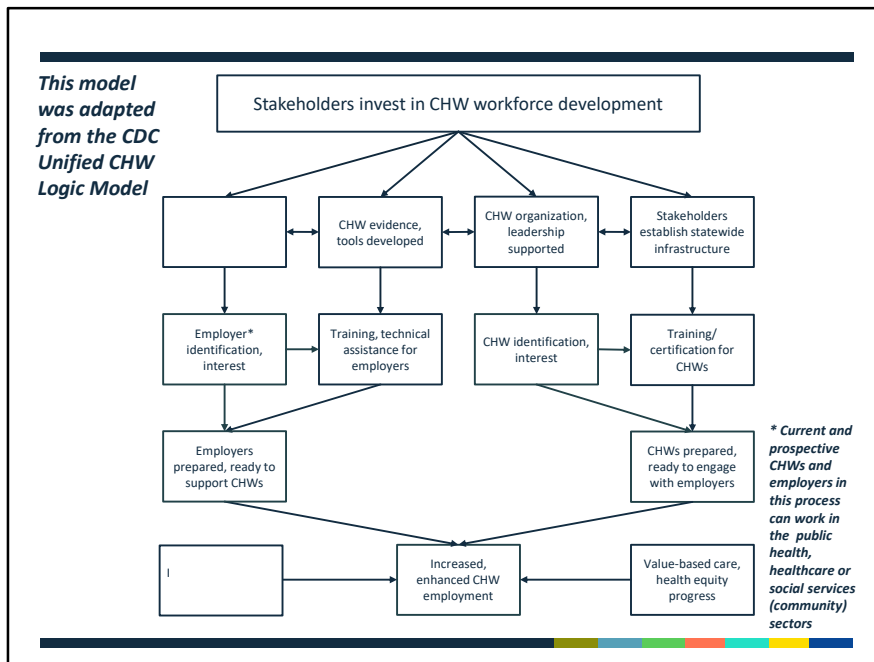
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The CDC CHW Workforce Development Investments Study began in October 2017. First, stakeholders were engaged to describe the process for implementing CHW workforce development investments. Using the process as a framework, our research team conducted in-depth case studies in three states. Next we reviewed: websites of national organizations tracking state CHW models, including the National Academy for State Health Policy and the Association of State and Territorial Health Officials; CDC program activity and budget data; and over 500 extant documents collected from internet searches and those working in the field. Experienced qualitative researchers directed the team in extracting examples from these data sources and coded examples to each step in the process. Examples within a step were organized into categories, and jurisdictions were coded for specific elements of workforce infrastructure.

Today you will see an overview of the results. We are in the process of developing a technical assistance resource with the full set of state examples and cost estimates. One limitation is that we did not survey jurisdictions; however, using a variety of primary and secondary data sources allowed for triangulation of findings and more confidence in the accuracy of results.



This is the general process we adapted from the CDC Unified CHW Logic Model, and refined based on stakeholder input regarding how implementing CHW workforce development investments leads to increased and enhanced CHW employment. This process may or may not be implemented in a linear fashion, and stakeholders may choose different pathways. Next we'll walk through some of the progress made by states in implementing each of these steps.

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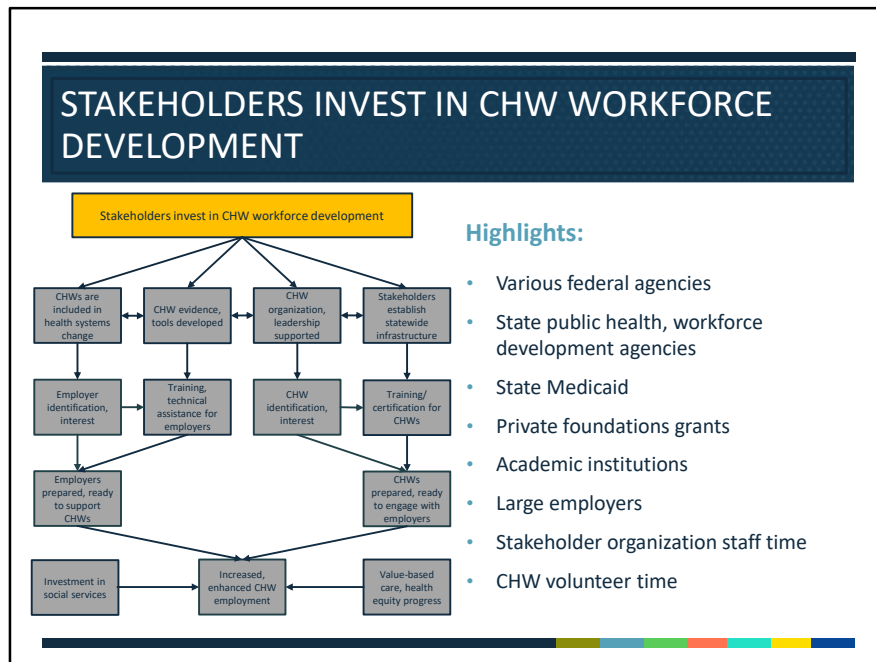
PROGRESS IN IMPLEMENTING CHW  
WORKFORCE DEVELOPMENT INVESTMENTS



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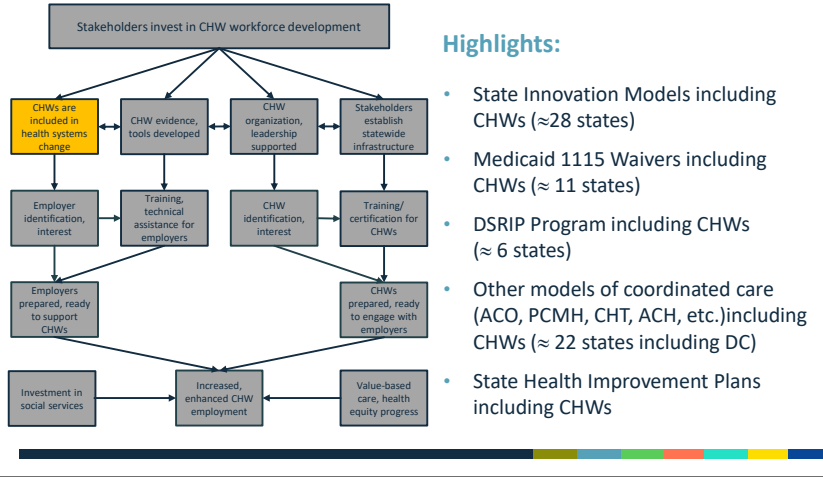


For the first step, stakeholders have reported various funding sources allowing them to make investments in CHW workforce development. This included federal agencies such as the Centers for Disease Control and Prevention, Health Resources and Services Administration, Department of Health and Human Services, Office of Maternal and Child Health, Office of Rural Health Policy, Centers for Medicare and Medicaid Services (CMS); Department Of Housing and Urban Development, and Department of Education. For example, the CMS State Innovation Model fund in Connecticut has allocated nearly \$1 million to CHW workforce development.

Other funding sources included state public health as well as economic and workforce development agencies, state Medicaid, large employers, and private foundations, for example, the Robert Wood Johnson Foundation and Penn Medicine.

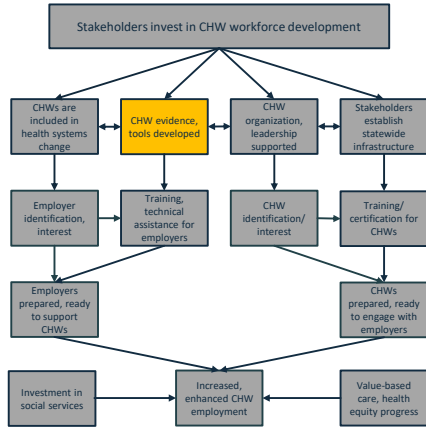
Massachusetts also provides an example of Medicaid investment, where collaboration between the Office of CHWs in the state department of health and MassHealth led to significant investment in CHW training, supervisor training and a learning community. In many states, volunteer and in-kind investments from various stakeholders have also been key to advancing initiatives.

## CHWs INCLUDED IN HEALTH SYSTEMS CHANGE



More specifically, workforce development for CHWs has been catalyzed in many states through their inclusion in state health systems transformations including the State Innovation Model (in about 28 states); Medicaid 1115 Waiver projects (in about 11 states); Delivery System Reform Incentive Payment programs (in about 6 states); and new models of team-based or coordinated care (in about 22 states including DC). Including CHWs in state-level health and workforce planning also is a strategy. For example, *The Oklahoma Health Improvement Plan* now includes an initiative on Health Workforce, which includes CHWs.

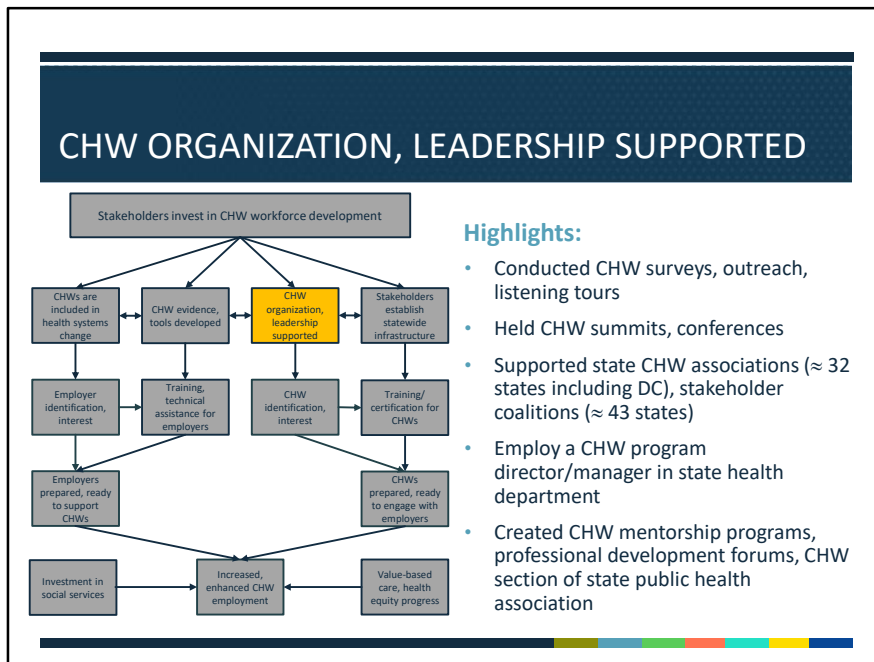
## CHW EVIDENCE, TOOLS DEVELOPED



### Highlights:

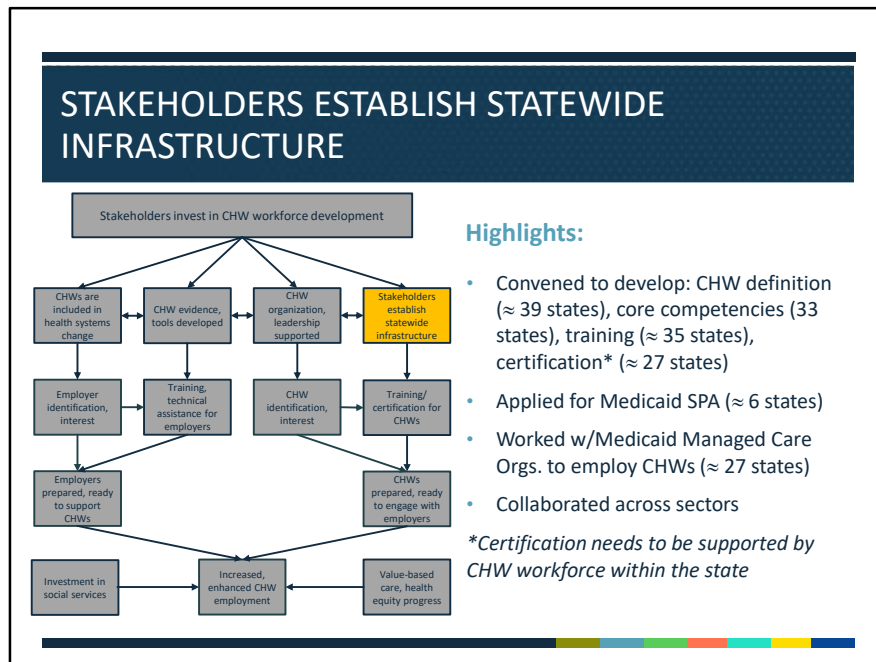
- Developed integration toolkits
- Shared CHW success stories
- Piloted CHW integration, training programs & developed white papers, manuscripts
- Built integrated, aggregated data collection systems
- Completed ROI studies

To help generate interest in CHWs, stakeholders have also developed evidence and tools including: integration toolkits; success stories; white papers or manuscripts; integrated or aggregated data collection systems; and ROI studies. For example, in Virginia, the state department of health developed a tracking system to report CHW successes, to be completed by local health districts. As another example, Wisconsin is one of several states implementing the Pathways Model, where the Community HUB is a regional point of registry, and outcomes tracking brings together social service agencies and health care providers and payers.



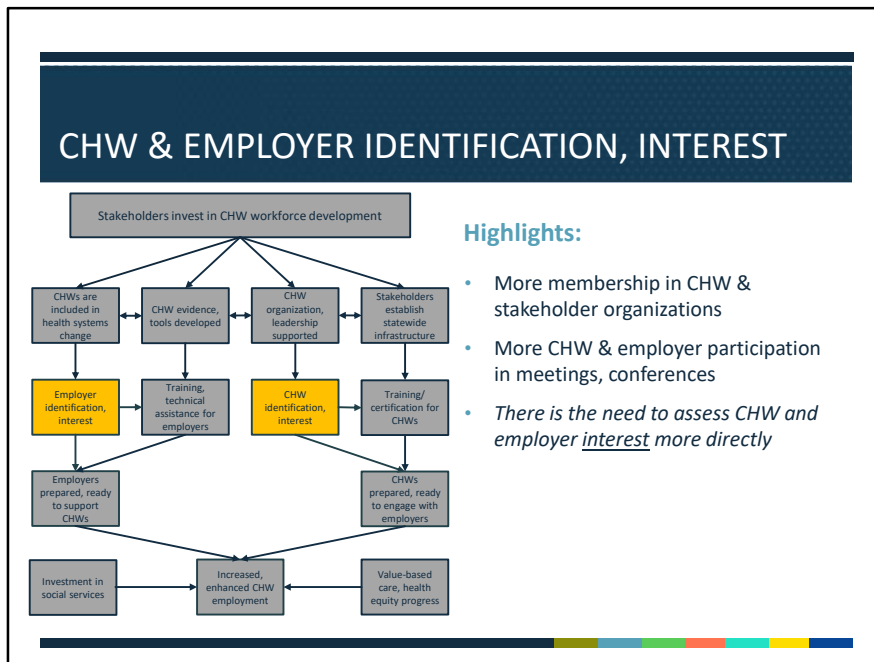
To support the organizing of the CHW workforce and the development of CHW leadership, stakeholders have: conducted surveys, outreach, and listening tours; held summits and conferences; supported state and regional CHW associations and coalitions; added a CHW program manager or director in state health department; and created mentorship programs, professional development forums, and a CHW section of the state public health association.

Right now about 32 states including DC appear to have a statewide CHW association comprised primarily of CHWs, and even more (about 43) states appear to have a multi-stakeholder CHW coalition. 28 states appear to have both. For example, in Arizona, there is the Arizona CHW Association and the Arizona CHW Workforce Development Coalition, which is led by a CHW Manager employed by the state department of health.



Stakeholders are also convening on a regular basis to develop a statewide: CHW definition (in about 39 states now); core competencies (in about 33 states); training programs (in about 35 states), and/or certification (in about 27 states). About 6 states appear to have applied for a Medicaid State Plan Amendment for CHWs and about 26 states appear to have at least one Medicaid Managed Care Organization that employs CHWs. Collaborating with other sectors is also a strategy. For example, the Washington state department of health collaborated with Washington Emergency Medical Services to include CHWs as a resource in the state 211 program. The Washington 2-1-1 program provides the most current and comprehensive database of community resources in the State of Washington with over 27,000 listings.

One important note here is that certification needs to be supported by CHW workforce within the state.

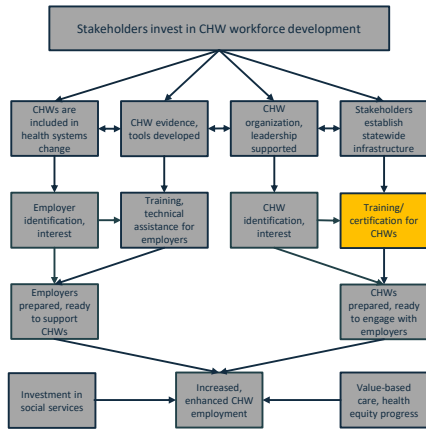


What outputs or outcomes have resulted from these activities?

Investments, particularly in CHW organizing and evidence, have identified more CHWs as seen by increasing CHW and employer membership in organizations and participation in events. For example, in Massachusetts, 380 CHWs were on the Massachusetts Community Health Workers Association mailing list in 2017.

However, across states, more evidence on CHW and employer interest in new opportunities is needed.

## TRAINING/CERTIFICATION FOR CHWs

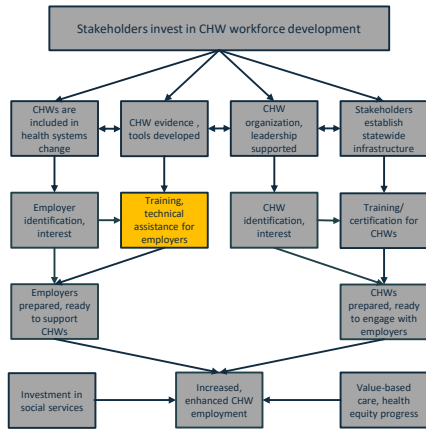


### Highlights:

- Offered in-person, online training for CHWs at low/no cost
- Provided technical assistance on applying for CHW certification
- Helped to offer/track continuing education

The next step has been to offer training or certification to interested CHWs at low or now cost, in a variety of formats and settings. Technical assistance has also been provided to CHWs interested in certification. Some states are even moving onto helping CHWs get continuing education hours. For example, the Michigan Community Health Workers Alliance has defined a continuing education process for maintaining CHW certification, which involves participating in the state registry and a web-based platform for submitting continuing education.

## TRAINING, TECHNICAL ASSISTANCE FOR EMPLOYERS

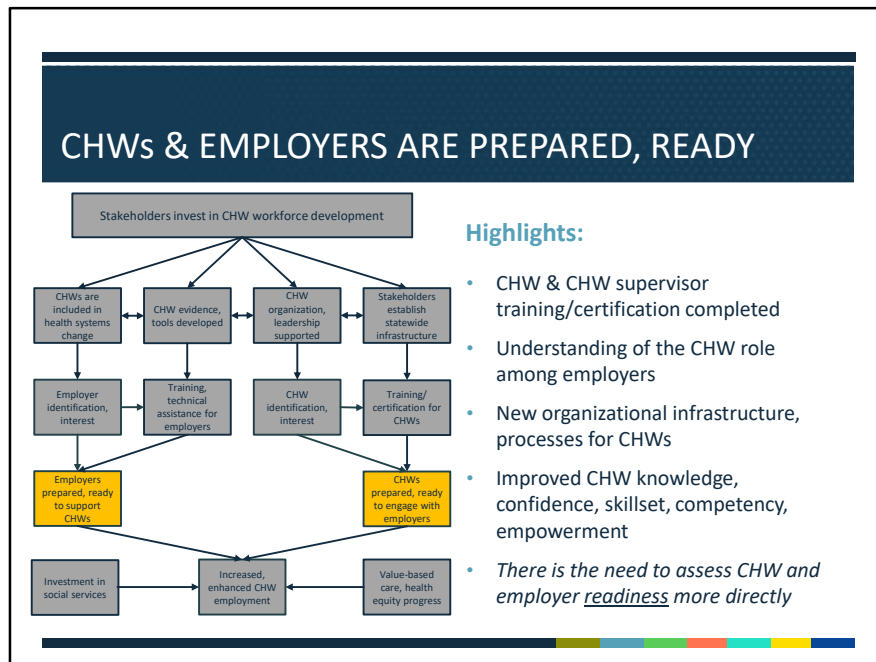


### Highlights:

- Provided training to staff who work w/CHWs (e.g., supervisors)
- Convened employer learning communities
- Provided technical assistance on CHW certification, financing/billing
- Provided integration, evaluation support at clinical sites

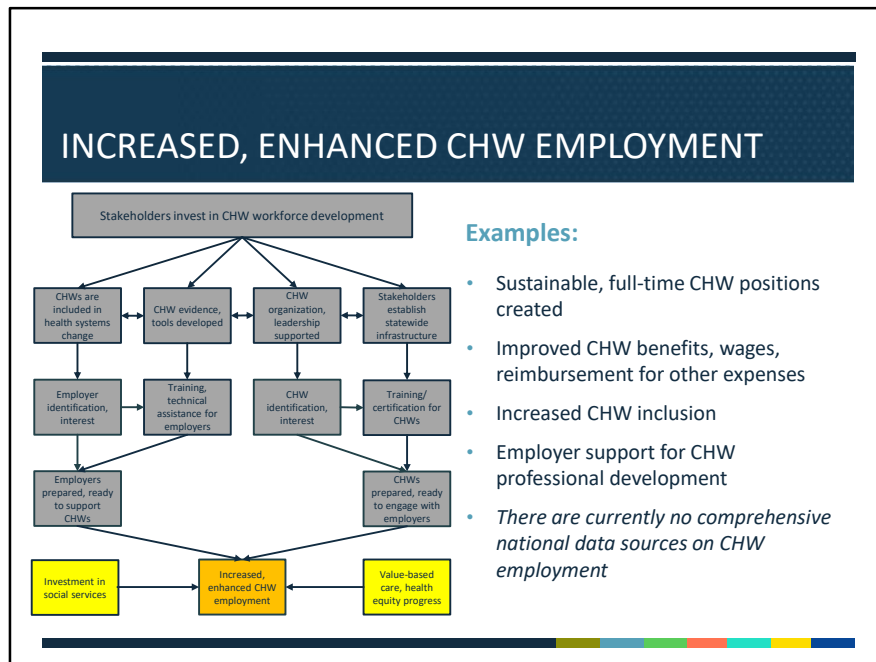
Similarly, stakeholders are helping employers to prepare for CHW employment by training staff and convening learning communities. Some state health departments are also providing direct technical assistance on certification, financing/billing issues, integration, and evaluation. For example, in Oregon, the state department of health is providing technical assistance to Coordinated Care Organizations to improve billing and coding practices for CHWs.





In some states, it appears that training and technical assistance has led to more prepared CHWs and employers. We saw evidence of completed training; increased understanding of the CHW role; new organizational infrastructure and processes; and improved CHW knowledge, confidence, skillset, competency, and empowerment. For example, when asked how the certification changed the outlook of their work, Rhode Island CHWs expressed that it strengthened and validated their work and left them feeling professional and empowered.

However, CHW and employer readiness needs further study.



Finally there is some evidence of increased and enhanced CHW employment in states implementing workforce development investments. This include new positions, improvement of existing positions, and more inclusion and support of CHWs. For example, in Michigan, statewide CHW surveys show that CHWs are seeing improvements in employment rates, various funding sources, and job benefits. Michigan CHWs are being employed mostly as full-time employees through private insurance, primary care teams, self-management education programs, and grants. With these positions, they are seeing job benefits, such as sick and personal leave, health insurance, mileage reimbursement, and vacation accrual.

Here it is important to acknowledge that statewide employment outcomes will also be impacted by a state’s level of social service investment and progress in value-based care and health equity. Also, there are currently no comprehensive, national data sources on CHW employment that can be used to accurately assess this outcome across states.


Element	Total # (%) out of 52 juris.	List of jurisdictions with this element as of October 31, 2019
Has a state-level CHW organization comprised mostly of CHWs? (Can include CHW section of state public health association)	32 (62%)	AK, AZ, AR, CA, CT, DC, DE, HI, ID, IL, IN, KS, KY, LA, MD, MA, MI, MN, MS, MO, NE, NV, NM, OH, OR, RI, SC, TX, UT, VA, WA & WI
Has a state-level multi-stakeholder CHW coalition, task force, or other entity focused on advancing the CHW workforce?	43 (83%)	AL, AZ, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NV, NH, NM, NY, NC, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA & WI
Stakeholders have recommended/adopted a standard statewide CHW definition?	39 (75%)	AL, AK, AZ, <sup>a</sup> AR, <sup>a</sup> CO, CT, DE, FL, <sup>a</sup> ID, <sup>a</sup> IL, <sup>a</sup> IN, <sup>a</sup> IA, <sup>a</sup> KS, <sup>a</sup> KY, <sup>a</sup> LA, <sup>a</sup> ME, MD, <sup>a</sup> MA, MI, <sup>a</sup> MN, <sup>a</sup> MO, <sup>a</sup> MT, <sup>a</sup> NE, <sup>a</sup> NV, <sup>a</sup> NH, <sup>a</sup> NM, NY, <sup>a</sup> NC, <sup>a</sup> OH, OK, <sup>a</sup> OR, PA, <sup>a</sup> RI, SC, TX, UT, <sup>a</sup> VA, WA, <sup>a</sup> WV <sup>b</sup> & WI
Stakeholders have adopted or made the decision to adopt a statewide CHW certification process/program?	27 (52%)	AZ, CT, DE, FL, ID, IL, IN, KS, KY, ME, MD, MA, MI, MO, NC, NV, NM, OH, OK, OR, PA, RI, SC, TX, UT, VA & WV <sup>b</sup>
Stakeholders have adopted or made the decision to adopt CHW core competencies?	33 (64%)	AZ, <sup>c</sup> AR, <sup>c</sup> CT, DE, FL, <sup>c</sup> ID, <sup>c</sup> IL, <sup>c</sup> IN, IA, <sup>c</sup> KS, KY, <sup>c</sup> ME, MD, MA, MI, <sup>c</sup> MN, MO, <sup>c</sup> MT, <sup>c</sup> NE, NV, <sup>c</sup> NM, <sup>c</sup> NY, NC, OK, <sup>c</sup> OR, RI, SC, TX, UT, <sup>c</sup> VA, <sup>c</sup> WA, <sup>c</sup> WV <sup>b</sup> & WI
Has a statewide and/or state-approved CHW training program(s)?	35 (67%)	AK, AZ, AR, CO, CT, FL, ID, IN, KS, KY, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, OH, OR, PA, RI, SC, SD, TX, WA, WV & WI
Implemented a CHW strategy as part of the CDC 1305 or 1422 program(s)?	30 (58%)	AZ, AR, CA, CO, DE, FL, ID, IN, KS, KY, LA, ME, MD, MA, MI, MN, MO, NE, NY, NC, OH, OK, OR, RI, SC, TX, UT, VA, WA & WI

a. APHA CHW definition cited b. CHWs = "Community Health Resource Person" in WV c. National Core Competencies (C3) project cited d. SPA reimburses CHRs

The next two very detailed and busy slides provide data reported in this webinar. Please contact us after the webinar if you see any error in these data. I'll pause a moment so you can take screenshots now or we are happy to share the slides. While you see a lot of activity here it is important to remember that no jurisdiction has yet fully scaled CHW workforce development or employment to statewide.

Element	Total # (%) out of 52 juris.	List of jurisdictions with this element as of October 31, 2019
The State Innovation Model (SIM) includes, has included, or proposes to include CHWs?	28 (54%)	AR, CA, CO, CT, DE, HI, ID, IA, KY, ME, MD, MA, MI, MN, MO, MT, NV, NM, NY, OH, OK, OR, PA, RI, VT, VA, WA & WV
CHWs have been included in a Medicaid 1115 Waiver demonstration or pilot project?	11 (21%)	AK, CA, MA, MN, NH, NM, NY, OR, RI, TX & WA
CHWs have been included in a Delivery System Reform Incentive Payment (DSRIP) Program?	6 (12%)	CA, MA, NH, NY, TX & WA
CHWs are included in other new models of team-based or coordinated care (e.g., Accountable Care Organizations, Community Health Teams, etc.)	22 (42%)	CA, CO, DC, ID, ME, MA, MI, MN, MO, MT, NH, NM, NY, OR, PA, RI, UT, VT, VA, WA, WV & WI
Applied for a State Plan Amendment (SPA) to reimburse CHWs for preventive services under state Medicaid?	6 (12%)	IN, MN, MO, ND, <sup>d</sup> OR & SD
At least one Managed Care Organization/health plan in the state include CHWs?	27 (52%)	CA, CO, DC, DE, FL, IL, IN, IA, KS, KY LA, MD, MA, MI, MN, NE, NJ, NM, OH, PA, RI, SC, TX, UT, VA, WA & WI

a. APHA CHW definition cited b. CHWs = "Community Health Resource Person" in WV c. National Core Competencies (C3) project cited d. SPA reimburses CHRs



## CONSIDERATIONS AND NEXT STEPS

Considering everything presented today, what next steps or investments do you think will be important for advancing CHW workforce development?



This Photo by Unknown Author is licensed under CC BY-NC

**(Poll) Considering everything presented today, what next steps or investments do you think will be important for advancing CHW workforce development?** Please type your answers in the chat box and I'll read a few now.

## CONSIDERATIONS AND NEXT STEPS

1. Consider addressing the core competency of **CHWs advocating for individuals and communities**.
2. Invite **social service/community-based CHWs and employers!**
3. Need to develop **common indicators** and improve **statewide CHW employment data collection systems**.



The Community Guide. Ten Core Roles of a Community Health Worker. <https://sph.uth.edu/dotAsset/55d79410-46d3-4988-a0c2-94876da1e08d.pdf>. Accessed October 29, 2019.

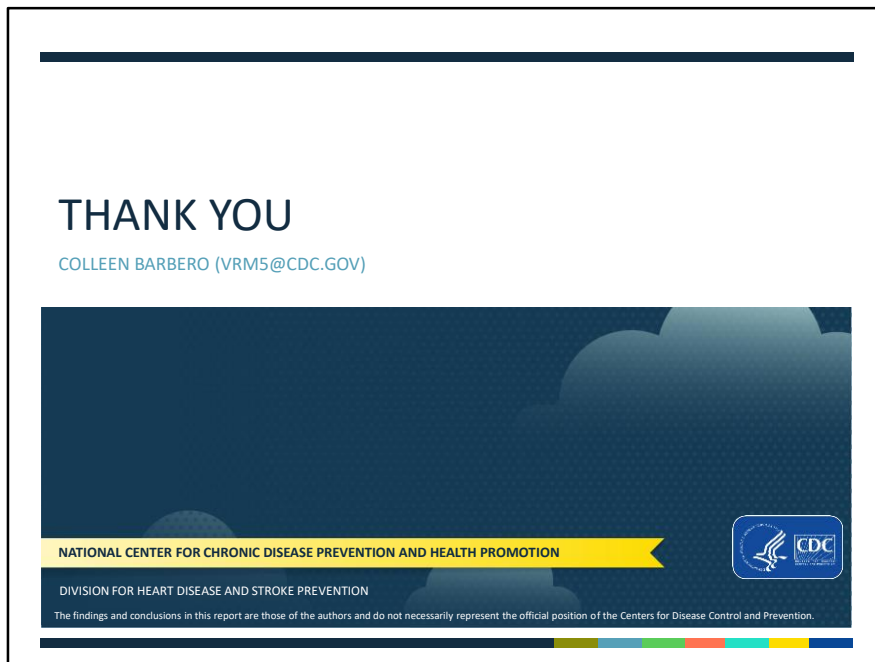
Here are some of our conclusion. One consideration is to include advocacy in CHW preparation, which has been done in several states, since if you review evidence on positive social outcomes, you'll see this competency in action. It also appears critical to include the social service and community-based CHWs in workforce organizing for the same reason. Lastly, a major takeaway is the need to develop **common indicators** and to improve **statewide CHW employment data collection systems**.

## LATEST AND UPCOMING CHW RESOURCES

- [CDC CHW Resources webpage including Certification Resource](#)
- [CDC CHW Forum Report & Job Aid](#)
- CDC Unified CHW Logic Model (manuscript under review)
- [NACHW CHW Resources Database](#) (in development)
- [CHW Common Indicators profiles](#) (in development)

*Questions? Contact the CHW Workgroup at CDC at [CHWORK@cdc.gov](mailto:CHWORK@cdc.gov)*

Finally, here are some of the latest and upcoming CHW resources including the CDC CHW resources webpage, the CHW forum, and the CHW logic model. CDC is also currently supporting NACHW in creating an online database of CHW resources and the CHW Common Indicators Project in developing indicators to evaluate CHW contributions. Please feel free to contact the CHW Workgroup at CDC with any and all of your CHW questions!



MODERATOR:

At this time, we'll take questions, but first we'll check to see if any questions have come in through the Q&A box.

**\*If we have questions ask the questions posed by the attendees to the presenter\***

*When is the technical assistance from this study going to be shared?*

We are still developing the webpages but it should be emailed to the same list of those invited to the Coffee Break around March or April 2020.

*How could CHW employment tracking be improved?*

Generally the information will need to come from state outreach and engagement of the CHW workforce as a whole, for example through statewide surveys and conferences. These data could then be shared with the Department of Labor to help improve their CHW category reporting. States may also need to share their statewide CHW definition with the Department of Labor so comparisons can be made among states.





MODERATOR:

Next, please stay with us for two short poll questions.

Please allow a few seconds for the poll to pop up on your screen. We will pause for a few moments after the question is presented to give you time to answer. One moment everyone.

**\*Moderator present poll question. Make sure to read the following after presenting each.\***

The **[first, second]** question should be showing, it read **[read question and potential answers]**

Please respond with the appropriate answer at this time.

**The level of information was**

Too basic

About right

Beyond my needs

**The information presented was helpful to me.**

Yes

Somewhat

No not at all

## REMINDERS!

- All sessions are archived and the slides and script can be accessed at <https://www.cdc.gov/dhdsp/pubs/webcasts.htm>
- If you have any questions, comments, or topic ideas send an email to [AREBheartinfo@cdc.gov](mailto:AREBheartinfo@cdc.gov)

Thank you for your participation!

As a reminder, all sessions are archived and the slides and script can be accessed at our Division website at the link shown. Today's slides will be available in about 3 weeks.

If you have any ideas for future topics or questions, please feel free to contact us at the listed email address on this slide.

## LAST 2019 COFFEE BREAK

Coffee breaks will resume in 2020.

Thank you for joining us this year!



### MODERATOR:

Finally, this is our last coffee break for 2019. We will be sending out a summary of all the topics we have covered this year in the coming weeks and we will restart again in 2020. As such, please keep a watch on your emails for the next round of coffee breaks.

Thank you for joining us. Have a terrific day everyone. This conclude today's call.