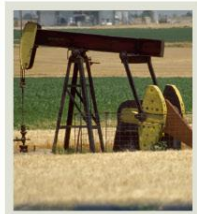
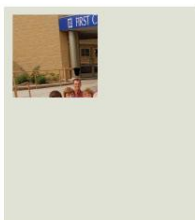




Center *for* Rural Health

Report on Community Health Worker Programs



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Community Health Worker

INTRODUCTION

North Dakota does not currently have a system in place to train and certify individuals to serve as Community Health Workers (CHS). The North Dakota (ND) Coordinated Chronic Disease Prevention Program (CCDPP) has designated funds to develop an infrastructure for training and certifying CHWs. Background information, examples of state CHW programs and related resources were gathered by the Center for Rural Health, in coordination with the Area Health Education Center (AEHC), at The University of Medicine and Health Sciences. This information will be utilized by the ND Department of Health to inform the potential development of a CHW infrastructure in the state.

Contact was made to key personnel by phone and or email. Core programmatic questions were developed by staff of the DentaQuest grant program, ND Department of Health, to gain insight when contacting CHW program representatives from other states. In addition, a significant amount of information and pertinent resources were gathered through internet sites pertaining to the subject.

Core Programmatic Questions:

1. Do you have a Community Health Worker program in your state?
2. What title is used (such as Community Health Representatives, Patient Navigator, etc.)?
3. What settings (hospitals, clinics, reservations, housing developments, community based, long-term facilities) do they work in?
4. How did you assess the current CHW or related programs in your state (i.e. survey, etc.)?
5. Do you have state policy that supports reimbursement for CHW program?

6. Do you have a particular interest group or organization(s) that lead the development of the CHW program? Have you held a summit/forum around the need for CHWs and their roles?
7. Do you have formal education, training, certification, and/or website?
8. Do you currently have curriculum developed?
9. Is the curriculum available for purchase?
10. If yes, what is the cost?

BACKGROUND

A key component for individuals with chronic disease is to maintain the maximum level of health, which revolves around their ability to manage chronic disease conditions. When individuals are unable to manage their care, additional healthcare costs occur. The Community Health Worker/Patient Navigator can serve as a bridge between the medical system, the individual, their home and community. The term Community Health Worker and Patient Navigator are often used interchangeably. For the purposes of this project, the term Community Health Worker (CHW) will be used. The American Public Health Association defines the CHW as the following: a trusted member of the community that has an unusually close understanding of that community served. This trust relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

The Centers of Disease Control and Prevention (CDC) chronic disease programs promote integration of CHWs into the public health workforce as evidenced by integration of CHWs in the following programs: heart disease and stroke prevention, diabetes and breast and cervical cancer screening programs.

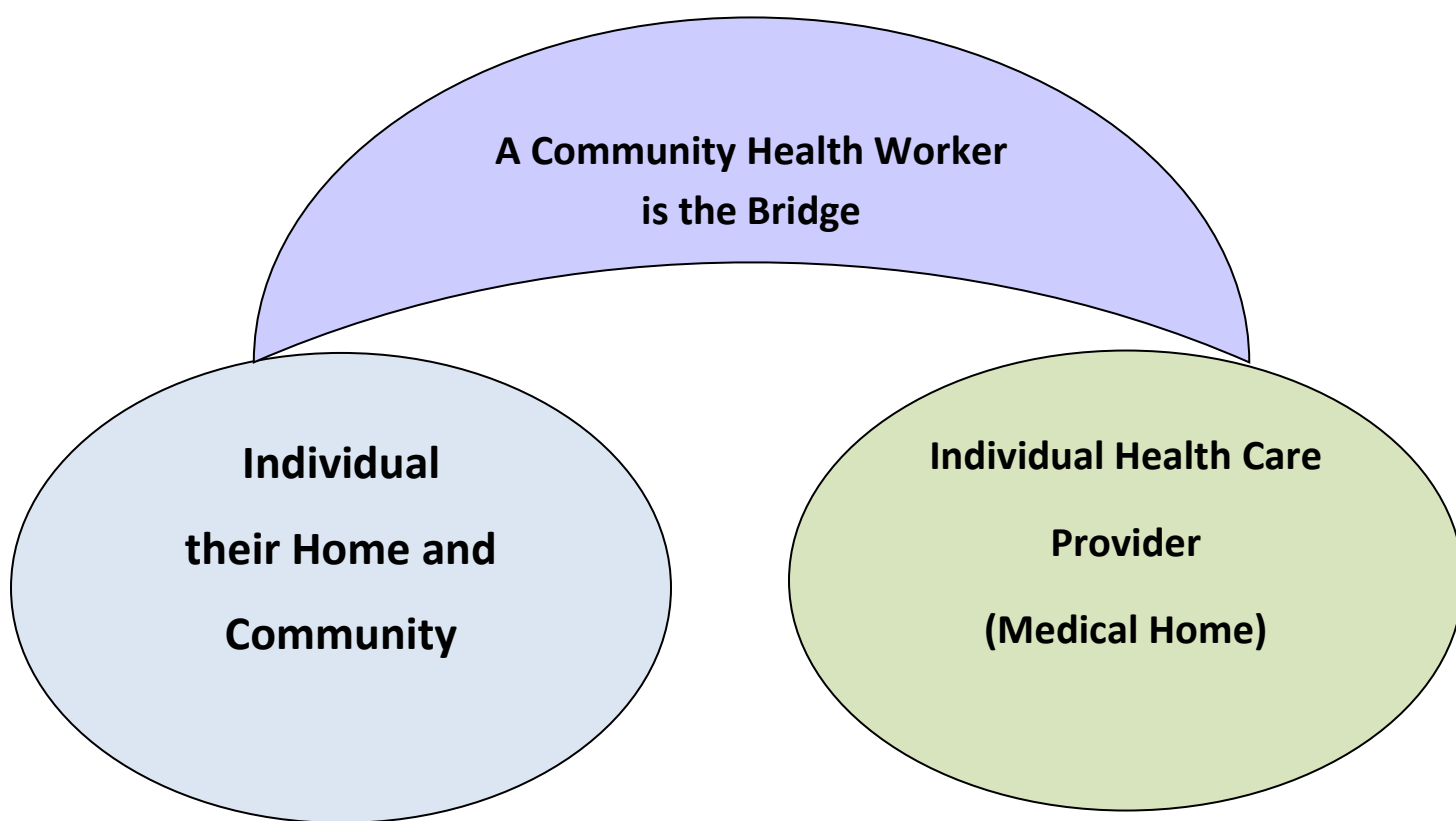
Community Health Workers (CHWs) assist individuals to improve or increase their capacity for self-management of chronic diseases including heart disease and stroke,

cancer, diabetes and arthritis. There are many benefits to having CHWs. They improve health outcomes of individuals and reduce the system cost for health care by linking them to community resources and avoiding unnecessary hospitalizations and other forms of more expensive care.

The National Community Health Advisory Study has created 5 “Core Roles” of the Community Health Worker.

1. Bridging cultural mediation between communities and health care systems:
 - a. CHW's are uniquely qualified as connectors to the community because they generally live in the communities where they work and understand the social context of community members' lives.
2. Providing culturally appropriate and accessible health education and information by:
 - a. using education methods that are known to be effective in that specific community, and
 - b. providing linguistic and cultural translation assistance.
3. Ensuring individuals get the services they need by:
 - a. supporting the individual's relationship with their health-care provider (medical home), and
 - b. helping individuals navigate health care systems by providing assistance with making appointments and referrals as well as facilitating transportation to and from appointments.
4. Advocating for individuals, by:

- a. empowering individuals with tools to communicate their health concerns and needs to their health-care provider, and
 - b. communicating health needs to the health-care provider on behalf of the individual.
5. Building individual capacity for self-management, by:
- a. educating individuals and their families on the importance of lifestyle changes and finding ways to increase risk reduction behaviors.
 - i. help individuals understand their current risk behaviors,
 - ii. assist and/or motivate individuals to engage in behaviors that reduce their risk,
 - iii. provide support and encouragement for maintaining their risk reduction efforts, and
 - iv. coordinate and oversee involvement in support groups and classes to encourage/educate lifestyle changes.
 - b. listening to the health concerns of individuals and their family members, helping them solve problems.
 - c. supporting individualized goal-setting.
 - i. assessing how well a self-management plan is helping individuals meet their goals, and
 - ii. reporting self-management plan status to the health-care provider, making adjustments as needed.
 - d. assisting individuals in obtaining home health devices to support self-management.



COMMUNITY HEALTH WORKER PROGRAMS – STATE EXAMPLES

Minnesota

Minnesota is currently the only Midwest state to have a Community Health Worker (CHW) program. This alliance was started in 2005 with a collaborative effort of over 45 agencies. The alliance represents a diverse set of public and private sector leaders including CHWs, state agencies, post-secondary education institutions, state associations, non-profit organizations, payers and the healthcare industry.

A community health worker (CHW), defined by the state of Minnesota, is a trained health educator who works with recipients of Minnesota health care programs (MHCP), Department of Human Services, who may have difficulty understanding providers due to cultural or language barriers. CHWs extend the reach of providers into underserved communities, reducing health disparities, enhancing provider communication, and improving health outcomes and overall quality measures. Working in conjunction with primary care providers, CHWs bridge gaps in communication and instill lasting health knowledge.

CHWs in Minnesota work in a variety of settings. In healthcare, CHWs provide services in hospitals, clinics, dental offices, Hospice and mental health departments. In public health, they can be found in schools, county services, Women, Infant and Children (WIC) programs, Head Start and at food pantries. They also work through contracted services, with non-profit and independent organizations.

Curriculum and Training

Minnesota currently has a mission, committee/alliance and education in place. An Education Committee works to advance the knowledge and skill set of Minnesota CHWs through a certificate program and ongoing trainings in partnership with higher education, CHW networks, employers, state and local public health, voluntary health agencies and others. The Committee serves as a forum for exchange and coordination on the implementation of the statewide CHW curriculum. The Committee also works to expand access to the MN certificate program in greater Minnesota and promotes careers as a

CHW to high school students, new refugee communities, foreign-trained health professionals and others.

The Education Committee includes representatives from the four schools that currently offer the MN CHW certificate program (Minneapolis Community and Technical College, Rochester Community and Technical College, St. Catherine University and Summit Academy Opportunities Industrialization Center [OIC]), those who plan to introduce the program and others who are interested in CHW education and ongoing training.

The services provided by the CHWs are diagnosis-related, medical intervention, and are not a social service. CHWs also provide patient education services to enrollees of managed care organizations (MCOs). CHWs must contact the MCOs for enrollment requirements and coverage policies. As of January of 2009, CHWs, work under the supervision of a dentist or a certified public health nurse (PHN). CHWs must have a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demonstrating they have completed the approved community health worker curriculum.

Minnesota developed a statewide standardized curriculum to educate CHWs, defined a “Scope of Practice” and professional standards that define their role in the health care delivery system. Five core areas of competency were identified related to protocols for reimbursing providers for CHW services are as follows:

- Bridge the gap between communities and the health and social service systems
- Navigate the health and human services system
- Advocate for individual and community needs
- Provide Direct Services
- Build Individual and Community Capacity

The curriculum is available for purchase (\$400) which covers the cost of the CHW teaching manual, tools and PowerPoint presentations on a DVD. In exchange for using the Community Health Worker curriculum, institutions and organizations are required to sign a copyright terms of agreement which covers the following principles:

1. In Minnesota documentation verifying accreditation of the college or university must be submitted and the curriculum will not be released to non-accredited training programs. Other states are not obligated to verify this information.
2. The copyright of this work is owned by the MN CHW Alliance and the Alliance welcomes use of the curriculum within the constraints of the Copyright Act.
3. An entity may use, copy, reproduce, distribute (within your institution) and/or create derivative works of the curriculum only for non-commercial and academic purposes, subject to the restrictions of the copyright license.
4. Maintain use of the MN Community Health Worker logo on all training materials.

Minnesota's CHWs Current Curriculum Outline:

- Role of the CHW – Core Competencies (9 credit hours)
 - Role, Advocacy and Outreach
 - Organization and Resources
 - Teaching and Capacity Building
 - Legal and Ethical Responsibilities
 - Coordination and Documentation
 - Communication and Cultural Competency
- Role of the CHW – Health Promotion Competencies (3 credit hours)
 - Healthier Lifestyles
 - Heart and Stroke
 - Maternal Child and Teens
 - Diabetes

- Cancer
- Oral Health
- Mental Health
- Role of CHW – Practice Competencies – Internship (2 credit hours)

Financing

The Minnesota program is funded by a grant from the Blue Cross and Blue Shield of Minnesota Foundation to the National Fund for Medical Education. Through state legislation, Minnesota has successfully negotiated with Minnesota Health Care Programs (MHCP) for reimbursement of CHW services. Community Healthcare Workers enrolled with Minnesota Health Care Programs - may bill for Patient Education and Care Coordination Services only. The CHW covered services must be supervised by professionals listed in legislation; have orders signed by an MHCP- enrolled professional in the chart of an MHCP- eligible client; have a documented care plan, provide CHW services face-to-face; and use an established curriculum.

CHWs must work under the supervision of enrolled physicians, advanced practice nurses, dentists, certified public health nurses operating under the direct authority of an enrolled unit of government or mental health professionals. CHWs can bill for patient education and care coordination services, but must be in 30 minute units, limited to 4 units per 24 hours per recipient, and can have no more than 8 units per calendar month per recipient.

MINNESOTA CORE PROGRAMMATIC QUESTIONS & ANSWERS	
1. Do you have a Community Health Worker program in your state?	Yes
2. What title is used (such as Community Health Representatives, Patient Navigator, etc.)?	Community Health Worker
3. What settings (hospitals, clinics, reservations, housing developments, community based, long-term facilities) do they work in?	Hospitals, clinics, schools, county services, WIC etc.

4. How did you assess the current CHW type programs in your state (i.e. survey, etc.)?	n/a
5. Do you have state policy that supports reimbursement for CHW/Patient Navigation program?	Yes
6. Do you have a particular interest group or organization(s) that lead the development of the CHW program?	Yes, Community Health Worker Alliance & Minnesota CHW Peer Network
7. Does your state have formal education, training, certification and website?	Yes, http://www.mnchwalliance.org/ http://www.wellshareinternational.org/chw-peernetwork
8. Do you currently have curriculum developed?	Yes
9. Is the curriculum available for purchase?	Yes
10. If yes, what is the cost?	\$400

Massachusetts

The Massachusetts Department of Public Health (MADPH) defines CHWs as public health workers who apply their unique understanding of the experience, language, and/or culture of the populations they serve in order to carry out many roles. They provide culturally appropriate health education, information, and outreach in community based settings, such as homes, schools, clinics, shelters, local businesses, and community centers. CHWs are the advocates for individuals and for their communities. They provide direct services, such as informal counseling, social support, care coordination and health screenings. They also assure people access to services they need. CHWs are distinguished from other health professionals because they are hired primarily for their understanding of the populations and communities they serve. They conduct outreach a majority of the time and have experience providing services in community settings.

“Community health worker” is an umbrella term for a number of job titles that perform functions listed above. Examples of the job titles that organizations and agencies use for CHW positions include: Outreach Worker, Community Health Educator, Family Advocate, Peer Leader, Promotor de Salud and Health Advocate.

CHWs are employed by a wide variety of agencies, including community health centers, hospitals, community-based organizations, housing authorities, immigrant and refugee associations, and faith-based organizations. CHWs also work with a wide variety of at-risk populations, including but not limited to people with substance abuse disorders, homeless persons, immigrants and refugees, persons at risk for or living with HIV/AIDS, and adolescents, among others. Most clients served by CHWs receive or are eligible for publicly funded health insurance.

Massachusetts has a statewide CHW professional association called Massachusetts Association of Community Health Workers (MACHW). They were founded in 2000 to enable CHWs to lead the movement to organize, define and strengthen the profession of community health work. Their mission is to strengthen the professional identity of community health workers, foster leadership among CHWs and promote the integration of CHWs into the health care, public health and human service workforce. MACHW achieve its mission through education, research, policy development and advocacy.

Curriculum/Training

A significant number of CHWs receive some training for the work they do, although the type and source of training varies. Some CHWs are trained in specially designed, formal training programs based on identified core competencies for CHWs. Some receive on-site training from their employers for their jobs, and others receive training in specialized health topics for their jobs in various settings. Often, CHWs are hired to work in programs that focus on specific health issues, such as asthma, HIV/AIDS, or diabetes, and are trained in those areas, but they do not receive training in the broader set of core competencies needed to conduct their work. A significant number of CHWs do not receive any training at all.

Currently, there is no statewide infrastructure to support standardized training for the CHW field. However, Massachusetts has formal CHW training opportunities in two existing well-established and highly successful programs in certain areas of the state. These training programs (Boston Public Health Commission's Community Health

Education Center and Central MA Area Healthy Education Center(AHEC) Outreach Worker Training Institute [OWTI]) use a similar curriculum based on sound principles of interactive adult education, address similar core competencies, are both 45-55 hours long, and have linkages to higher education. Other program strengths include the employment of strategies which are culturally sensitive and supportive of diversity, flexibility in their implementation, the use of CHW co-trainers, provision of individual support to participants to assist them in addressing systemic/organizational barriers, and support for individual professional development.

In order for community health workers (CHWs) to do their jobs effectively and to grow personally and professionally through their work, they should possess certain core skills. The following are the core skills and applied knowledge (or competencies) necessary for CHWs to work well in a variety of settings. They have been determined by the Community Health Worker Initiative of Boston, building upon the HRSA National Community Health Worker study and the ongoing work of the Boston Public Health Commission and the Massachusetts Department of Public Health. These competencies are NOT discrete, nor ranked in order of importance, but rather are the set of overlapping and mutually reinforcing skills and knowledge essential for effective community health work and advancement in the field.

- Outreach Methods and Strategies
- Client and Community Assessment
- Effective Communication
- Culturally Based Communication and Care
- Health Education for Behavior Change
- Support, Advocate and Coordinate Care for Clients
- Apply Public Health Concepts and Approaches
- Community Capacity Building
- Writing and Technical Communication Skills
- Special Topics in Community Health

Financing

Funding for the CHWs programs is typically uncertain and allocated through categorical, cyclical grants related to specific populations, diseases and conditions. Funding priorities and amounts change from year to year, leaving CHWs and the people they serve vulnerable. The unstable nature of funding for CHWs undermines their unique effectiveness in successfully engaging clients through building relationships based on trust. The MADPH CHW Advisory Council has made recommendation for a sustainable CHW program in Massachusetts in the following areas:

1. Conduct a Statewide Identity Campaign for the CHW Profession
2. Strengthen Workforce Development: Create a Statewide CHW Training, Education, and Certification Infrastructure
3. Expand Financing Mechanisms
4. Establish an Infrastructure to Support CHW Work

MASSACHUSETTS CORE PROGRAMMATIC QUESTIONS & ANSWERS	
1. Do you have a Community Health Worker program in your state?	Yes
2. What title is used (such as Community Health Representatives, Patient Navigator, etc.)?	Community Health Educator, Patient Navigator, Health Advocate, Outreach Worker
3. What settings (hospitals, clinics, reservations, housing developments, community based, long-term facilities) do they work in?	Community Health Centers, Hospitals, Community-based Organizations, Housing Authorities, Immigrant and Refugee Associations, and faith-based organizations
4. How did you assess the current CHW type programs in your state (i.e. survey, etc.)?	Surveys
5. Do you have state policy that supports reimbursement for CHW/Patient Navigation program?	Yes

6. Do you have a particular interest group or organization(s) that lead the development of the CHW program?	Yes, Massachusetts Association of Community Health Workers (MACHW)
7. Does your state have formal education, training, certification and website?	Yes, http://www.machw.org
8. Do you currently have curriculum developed?	Yes
9. Is the curriculum available for purchase?	n/a
10. If yes, what is the cost?	n/a

New Mexico

Community Health Workers (CHW)/Promotores de Salud have been part of the health care delivery system for decades, both in the U.S. and other countries. Since 1968 the Indian Health Service (IHS) has trained “Community Health Representatives” to serve the Native American population in New Mexico, Alaska, Montana and many other states. CHWs often work in rural areas where the medical model of health care is limited or non-existent. Over the years CHWs in New Mexico and other states have been effective health educators and service providers. They are often involved in community organizing and the development of health and social service projects and are an important link in the health delivery model. They serve as interpreters and a direct link in accessing health care. Many of them are on-site Medicaid application determiners and have been instrumental in signing people up for Medicaid. New Mexico has a number of community health worker programs operating independently from one another in both rural and urban areas.

The New Mexico Community Health Workers Association (NMCHWA) was informally developed under the University of New Mexico Prenatal Care Network in 1993 to provide a venue for community health workers to gather information regarding health and social service resources, share info on CHW programs best practices, education, legislative updates, peer support, political power for the CHW model and networking. Their mission is to bring community health workers together into a cohesive body that promotes outreach, education, and support for the CHW model, each other as well as their

respective communities. Additionally, the association provides networking opportunities, information exchange and training for community health workers.

Curriculum/Training

As community health worker programs were being formed here in New Mexico, it became evident that education, funding, and networking were areas of need for new programs. While training was available for social workers and nurses in maternal and child health issues, there was no training available for the lay health worker. In 1993, a training curriculum was developed through a collaborative effort between the University of New Mexico Area Health Education Center, The Prenatal Care Network and focus groups that were made up of CHW program staff. The New Mexico Department of Health and the New Mexico Chapter of the March of Dimes Birth Defects Foundation provided funding for the curriculum. The curriculum, *Reaching Out: A Training Manual for Community Health Workers* includes 40 hours of training in topics such as:

- Orientation into the CHW model
- Communication Skills (including confidentiality)
- Community Resources
- Prenatal Care I
- Prenatal Care II
- Labor and Delivery/Postpartum Care
- Breastfeeding and Nutrition
- Substance Use/Domestic Violence
- Sexuality, Family Planning, STD's
- Early Childhood Development

Although the curriculum appears to have a maternal and child health (MCH) focus, other topics are introduced as needed by the program or individuals. The New Mexico Community Health Workers Association members meet on a quarterly basis and request training on other skills and topics, such as: evaluation, meeting facilitation and

planning, public speaking, group dynamics, communication, mental health, grant writing and fundraising, board training and the use of computers.

The training manual is provided free of charge to all new local CHW programs in New Mexico. The training is conducted in modules and takes 40-hours to complete. It includes role-playing home visits, viewing films, class discussions, lecture and visits to health care providers. The written material is at a level that is easy to understand by the lay health worker. Upon completion, participants are presented with a Certificate of Completion from the University of New Mexico Health Sciences Center at the annual statewide training conference.

Financing

They are funded in part by state, federal and private foundation dollars. Some programs have developed a way to bill for services under Medicaid dollars and Children's Health Insurance Program funding. Many programs began their efforts targeting maternal and child health outcomes, some have selected other health risk factors as their target, among them are access to care/Medicaid enrollment, Substance Use or Smoking Cession, Diabetes, Breast and Cervical Cancer, HIV/AIDS and traditional medicine; community health workers also serve as interpreters and doulas. There are 32 counties in New Mexico, 26 of these have established a Maternal and Child Health Councils to formally address health and social service needs for childbearing women and their families. Most of the outreach, prevention, health education needs is being met by community health worker services in these counties.

NEW MEXICO CORE PROGRAMMATIC QUESTIONS & ANSWERS	
1. Do you have a Community Health Worker program in your state?	Yes
2. What title is used (such as Community Health Representatives, Patient Navigator, etc.)?	Community Health Representatives (CHWs)
3. What settings (hospitals, clinics, reservations, housing developments, community based, long-term facilities) do they work in?	Community Based Organizations

4. How did you assess the current CHW type programs in your state (i.e. survey, etc.)?	n/a
5. Do you have state policy that supports reimbursement for CHW/Patient Navigation program?	Yes
6. Do you have a particular interest group or organization(s) that lead the development of the CHW program?	New Mexico Community Health Workers Association
7. Does your state have formal education, training, certification and website?	www.nmchwa.com
8. Do you currently have curriculum developed?	Yes
9. Is the curriculum available for purchase?	Yes, \$25

New York

Community Health Workers (CHWs) are frontline public health professionals who are trusted members, or have an unusually close understanding, of the communities they serve through shared ethnicity, culture, language, and life experiences. This trusting relationship enables them to bridge social/cultural barriers between communities and health or social service systems. They help individuals navigate complicated and unfamiliar health care systems and help gather information for other health providers that might not be otherwise accessible. CHWs help build individual and community capacity through a range of activities such as outreach, health education, home visiting, community organizing, informal counseling, social support, translation/interpretation, and advocacy. CHWs have many general job titles. A few examples are: Care Coordinator, Community Health Advocate, Health Advisor, Health Educator, Patient Navigator or Promotor(a).

The New York State Community Health Worker Initiative (NYS CHW Initiative) is a statewide partnership between the CHW Network of NYC, The New York State Health Foundation, The Mailman School of Public Health at Columbia University, CHWs statewide, and other stakeholders. The purpose of this partnership is to advance the CHW practice by establishing stable financing models. One of the ways in which they are

seeking to accomplish this goal is through the guidance and support of the project's Leadership Advisory Group, which is made up of prominent New York leaders from the various CHW stakeholder sectors, including CHWs, heads of statewide professional associations, employers, funders, payers, regulators and elected officials. CHWs and CHW advocates from networks in Rochester, Buffalo, and NYC represented their constituencies on the Leadership Advisory Group, making up 25% of their membership.

The CHW workforce in New York (an estimated 11,000 according to Health Resources and Services Administration (HRSA), CHW National Workforce Study) does not yet have a standard scope of practice or training and credentialing standards that encompasses and supports the varied, critical work performed by these workers. There is also a lack of sustainable funding streams that leads to an inefficient use of resources and instability in the CHW field.

The NYS CHW Initiative has a vision and mission set in place. Their vision is to have a stable CHW workforce fully integrated within health and social service systems with sustainable financing throughout the State of New York. Their mission is to establish these objectives:

- establish a New York standard scope of practice for CHWs,
- develop statewide training standards and a credentialing process for CHWs, and
- identify stable financing streams and reimbursement mechanisms for CHWs.

The network advocates for the integration of CHWs into the health and social service systems, credentialed training in core competencies and health-related specialties and direct payment for CHW services for improved career ladder, market, and wages.

Curriculum/Training

This community health worker (CHW) training program is unique in that it was created by CHWs in direct response to the documented needs of CHWs and the CHW business community in New York City. The CHW leadership of this effort has resulted in the creation of a training program that is unique in both content and pedagogy and is

responsive to the distinctive character of CHWs and their scope of practice. Although some CHWs work in programs that take a holistic approach to health, many more CHWs are often hired to work in programs that focus on specific health issues, such as asthma, diabetes, HIV/AIDS, MCH, etc. The training is designed in two sections: Core Competencies and Health-specialty areas.

Research has shown that Community Health Workers (CHWs) must be trained appropriately and respected by the health care system for their unique role and identity. CHWs can be effective health workers provided they are taught skills that have come to describe their practice and are supportively and educationally supervised. Very importantly, this same research reveals that CHWs trained in irrelevant hospital settings, trained by nurses with no connection to the community or removed from community for training suffer loss of credibility in their communities and lose the very quality for which they were originally sought out. When forced to look like and sound like traditional members of the healthcare delivery system, they lose their access and the trust they enjoy in their communities.

Appropriate training of CHWs is therefore vital to their effectiveness. This is a significant challenge for healthcare systems interested in integrating CHWs in that the dominant culture of healthcare providers focuses on the acquisition of knowledge and technical expertise. CHW training also suffers from the current categorical funding and disease focus of public health interventions. Because most employers only employ a few CHWs at any given time, there is seldom enough CHW staff to institute training programs and therefore the CHWs are only trained with the resources at hand - resources which usually only include clinical expertise to the exclusion of training in core competencies. CHWs, on the other hand, focus on the holistic health and empowerment of individuals, families and communities. Successful training of CHWs must therefore include training in core competencies and enthusiastically embrace adult and popular education philosophies and methodologies.

In this program, community health workers (CHWs) are trained using a 105-hour curriculum, including 70 hours of training in core competencies and 35 hours of health-

specific training in working with individuals and families. The training of CHWs includes the development of the following core competencies.

1. Communication Skills - verbal & non-verbal, non-violence, observation, documentation, negotiation, conflict resolution
2. Interpersonal Skills - relationship-building, trust, empathy, compassion, personal & professional boundaries
3. Informal Counseling - behavior change, goal setting, maintenance & relapse prevention, disease management
4. Service Coordination Skills – home visiting, system navigation, linking to services, case management
5. Capacity-Building Skills - strength-based approach, community organizing, individual empowerment, capacitation
6. Advocacy Skills - inform health & social service systems
7. Technical Skills - adult teaching, facilitation, group presentations
8. Organizational Skills - identify strengths, planning, outreach, time management, prioritizing, safety

Upon completion of the training in core competencies, CHWs in this program will then receive up to 35 hours of training in working with individuals and families within a health concentration of their choice. Health specialty modules are available in the following.

1. Asthma education, treatment, management and control
2. Diabetes management, prevention and treatment
3. Hypertension treatment and prevention
4. Nutrition

This course of study (Appendix B) is designed to help community health workers (CHWs) develop the core skills that have come to describe the field. The curriculum also contains optional specialty tracks designed to help CHWs develop expertise in working with families and individuals on chronic disease management. The courses are designed to be participatory and are governed by adult learning and popular education principles.

Because CHWs rarely lecture the individuals and families they serve, this training limits the amount of didactic experiences in favor of more experiential learning methods that model the work CHWs do.

NEW YORK CORE PROGRAMMATIC QUESTIONS & ANSWERS	
1. Do you have a Community Health Worker program in your state?	Yes
2. What title is used (such as Community Health Representatives, Patient Navigator, etc.)?	Patient Navigator, Promotor(a), Patient Navigator
3. What settings (hospitals, clinics, reservations, housing developments, community based, long-term facilities) do they work in?	Community Based Organizations
4. How did you assess the current CHW type programs in your state (i.e. survey, etc.)?	n/a
5. Do you have state policy that supports reimbursement for CHW/Patient Navigation program?	No
6. Do you have a particular interest group or organization(s) that lead the development of the CHW program?	Yes, New York State Community Health Worker Initiative (NYS CHW Initiative) http://chwnetwork.org
7. Does your state have formal education, training, certification and website?	Yes
8. Do you currently have curriculum developed?	Yes
9. Is the curriculum available for purchase?	n/a
10. If yes, what is the cost?	n/a

Colorado

Colorado has CHWs in the state, but no state recognized roles. They are called CHWs, Promators, Lay health advisors/workers or Community Health Advisors. They work in publicly funded health systems, community based organizations, reservations and are predominantly grant funded. Denver conducted surveys to assess what CHW programs existed in their state. They decided to create an education program for CHWs at the community college, they invited stakeholders to meet and provide input. No state policy

exists to support reimbursement for CHWs. The CHW program are predominantly grant funded and the only supported CHWs are those who assist in enrolling people in publicly funded health coverage programs.

Denver does not have a formal organization/alliance for CHWs. However, there is a group currently meeting to discuss group visions, mission, goals, etc.

Curriculum/Training

Denver Health (Medical Center) provides monthly in-service trainings for their CHWs on a variety of topics, including Spanish, improving communication and presentation skills, and providing tobacco cessation counseling. In partnership with the Community College of Denver, Denver Health has also developed a certificate program for CHWs, and celebrated their first graduates. Standardizing training and certification has become an important step towards integrating the CHW profession into the health career ladder in Denver.

Denver Health and Community Voices teamed up with the Community College of Denver and the Denver Mayor's Office to pilot a CHW training and certification program. This will further develop the role of CHWs and strengthen the CHW vocation, in light of the educational and employment challenges CHWs face. A certificate can be very important, especially in agencies where credentialing is a major consideration in the hiring process. For individuals, the CHW certificate program is an entry way to a health career and is a valuable opportunity for those interested in health and who are transitioning from welfare to work.

With input from the Annie E. Casey Foundation, San Francisco-based and Denver-based CHWs, and community organizations, Denver Health designed an Essential Skills certificate for CHWs who successfully complete a 17-credit, one-semester program. To enter the program, potential CHWs must have earned a high school diploma or GED. These courses are specifically designed for CHWs are listed and briefly described below. The program is not available for purchase.

Current Curriculum Outline

Intro to Community Health Work (2 hours)

- Introduces students to the basic concepts of community health work, to the roles of community health workers and to basic practical skills necessary to the occupation.

Community Health Issues (3 hours)

- Introduces students to the multiple health issues for community health workers. Develops core competencies to function as a community health worker.

Community Health Resources (3 hours)

- Introduces students to the skills and resources necessary for the community health work with clients in the community.

Community Health Worker Field Experience (2 hours)

- Provides students with an opportunity to apply community health worker knowledge and practice community health worker skills in community settings.

Intro to PC Applications (3 hours)

Reading 100-level course or higher (3 hours)

Communication for the Workplace (3 hours)

Or Psychology of Adjustment (2 hours)

COLORADO CORE PROGRAMMATIC QUESTIONS & ANSWERS	
1. Do you have a Community Health Worker program in your state?	Yes
2. What title is used (such as Community Health Representatives, Patient Navigator, etc.)?	CHWs, Promoters, Lay health advisors/workers, Community Health Advisors
3. What settings (hospitals, clinics, reservations, housing developments, community based, long-term facilities) do they work in?	Publicly funded health systems, community based organizations and reservations
4. How did you assess the current CHW type programs in your state (i.e. survey, etc.)?	Surveyed in the past. When it was decided to create an education program for CHWs at the community college, stakeholders were invited to meet and give input
5. Do you have state policy that supports reimbursement for CHW/Patient Navigation program?	No, role is grant funded. Only sustainable CHW role is those who assist in enrolling clients in publicly funded health coverage
7. Do you have a particular interest group or organization(s) that lead the development of the CHW program?	No, there is a group meeting now to discuss these findings
7. Does your state have formal education, training, certification and website?	Yes, formal training at community college. 17 credit hours and a certificate of completion.
8. Do you currently have curriculum developed?	Yes
9. Is the curriculum available for purchase?	No
10. What is your website?	http://www.denverhealth.org , http://www.communityvoices.org

Washington

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served, like migrant farm workers. This trusting relationship enables a CHW to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency

through a range of activities such as outreach, community education, informal counseling, social support and advocacy. They are usually bilingual and bi-cultural.

Washington has Community Health Workers at Family Health Centers (FHC). They are a federally qualified, community and migrant, health center with multiple sites in very rural Okanogan County in north central Washington. They have a large agricultural component here, mainly fruit orchards. FHC received a significant grant from HRSA for Rural Health Care Services Outreach. As a result of this grant, Family Health Centers teamed up with two main organizations to assist with creating an alliance for CHWs, Washington Association of Community & Migrant Health Centers (WACMHC) and Northwest Regional Primary Care Association (NWRPCA).

The Washington Association of Community & Migrant Health Centers (WACMHC) is committed to assist communities in outreaching underinsured and underserved communities by co-sponsoring the Washington Community Health Workers Network (WCHWN). WACMHC's main goal is to ensure that all Washingtonians have access to primary health care, regardless of geographic locations, nationality or income level. In addition, WACMHC provides training, mentorship, and direct communication to produce a confident broadly trained workforce of Customer Services Representatives and Community Health Workers/Promotores.

Curriculum/Training

Washington Association of Community and Migrant Health Centers (WACMHC) and Northwest Regional Primary Care Association (NWRPCA) provide resources such as training, conferences and other events and materials for development of CHWs. WACMHC's training conference is an intensive 2.5 days event, which includes various workshops/presentations and activities. These workshops and activities are conducted in Spanish using "Popular Education" techniques.

Popular Education is a philosophy and methodology used for teaching, which seeks to create a comfortable environment where participants can discover and extend their knowledge to generate positive changes in their own lives and in their communities. When compared to traditional education, "Popular Education" can help participants

develop a deeper sense of their potential, while furthering their understanding of the many skills they already possess. Currently in the United States, it is gaining importance and is being used as a strategy to empower communities to help them achieve equality while seeking and/or receiving health care.

During this intensive training, facilitators use interactive techniques such as dynamics, socio dramas, and digital stories, exchange of ideas, and techniques of cooperative learning. The program allows participants to explore how they can use what they already know and what they have learned.

Trainings teach how to integrate Promotores and Outreach Workers into the Health Center Setting. Promotores de Salud and Outreach Workers are integral to the high quality, culturally competent services that are provided by Migrant and Community Health Centers across the country. As trusted members of their communities, they perform the invaluable function of taking information and services directly to the most vulnerable members of those communities. However, their work is frequently disconnected from the day-to-day work of health care administration. They are often unaware of specific health center or program grant requirements, and may not have a clear understanding of how their work fits into the organization's overall health care plan or strategic plan. Moreover, they may unknowingly violate health information privacy (HIPAA) laws.

Participants learn about key requirements that all federally funded health centers must meet and to read a health care plan and understand the importance of aligning their own activities with the goals and objectives contained in the health care plan. They learn the key privacy rules that ensure patient confidentiality. By the end of the session, participants are able to describe at least 3 basic program requirements for Federal Qualified Health Centers, develop personal goals and objectives to support the organization's health care plan and Implement at least two strategies for integrating their work into the broader health center setting understand and follow regulations protecting patient privacy. Attendees also get training in Safety & Health. During this special "train the trainer" event, they learn about different regulations, procedures and methods to better promote safety and health among the Hispanic monolingual workers in the

Agriculture and Construction industry. This training helps people understand the various types of personal protective equipment available and how to get people motivated about preventing injuries and illnesses.

There are four different areas of focus that are covered during these sessions. They are Sharing Best Practices: Promotores Program Presentations, Washington State Health Care Options, Prevention and Diabetes Management Training and Mental Health; Healthy Migrant Families.

The session on Sharing Best Practices: Promotores Program Presentations, registered participants prepare a 15 minute presentation on the services, programs, organizations or community groups they represent. During these presentations participants learned about teaching techniques being used successfully in the community, and had the opportunity to practice their public presentation skills.

After attending the Washington State Health Care Options presentation, participants learn about all the health care programs for kids and adults available in Washington State. They also obtained information about the program eligibility requirements.

After completing the Prevention and Diabetes Management Training all participants learn different aspects of diabetes prevention and management. They learn not only the complications of diabetes, but also the reasons that these complications occur, as well as how to control and prevent these complications. During this presentation, the curriculum of “Tomando Control de su Salud”, designed by Stanford University is used as a guide. This presentation teaches participants an easy and fun way to exercise, how to create healthy meals, and how to read nutrition labels. Finally, a popular education activity using guided images shows the power of the mind and how to control stress.

The Mental Health; Healthy Migrant Families session discusses the lives of men, woman and children who experience a painful family separation due to current immigration laws. Participants explore the reality of a mock family and create a sculpture of before and after the separation. Participants learn about some of the symptoms that are common in partners, and children who have been separated. They also learn how they can help

families experiencing this situation by providing moral support techniques and mental health care resources available.

Financing

Washington does not, at this point, have state policy in place for reimbursement. This is a core function of the Family Health Center and they will continue to provide outreach and education for patients, in particular migrant and seasonal farmworkers.

WASHINGTON CORE PROGRAMMATIC QUESTIONS & ANSWERS	
1. Do you have a Community Health Worker program in your state?	Yes
2. What title is used (such as Community Health Representatives, Patient Navigator, etc.)?	Community Health Workers and Promotores
3. What settings (hospitals, clinics, reservations, housing developments, community based, long-term facilities) do they work in?	Clinics
4. How did you assess the current CHW type programs in your state (i.e. survey, etc.)?	n/a
5. Do you have state policy that supports reimbursement for CHW/Patient Navigation program?	No
8. Do you have a particular interest group or organization(s) that lead the development of the CHW program?	Yes, Washington Association of Community and Migrant Health Centers (WACMHC) and Northwest Regional Primary Care Association (NWRPCA)
7. Does your state have formal education, training, certification and website?	Yes
8. Do you currently have curriculum developed?	No
9. Is the curriculum available for purchase?	n/a
10. Do you have a website?	http://wacmhc.org/displaycommon.cfm?an=1&subarticlenbr=77 http://www.nwrpca.org/community-health-worker-networks.html http://www.ncfh.org/

Wisconsin

Wisconsin has CHWs in the state, but no state recognized roles, does not have a statewide CHW alliance; but are currently working on establishing one. In the city of Milwaukee a CHWs Coalition exists which is called the Milwaukee Latino Coalition. Their mission is to increase the health and well-being of Latino communities by organizing power for social change.

The Milwaukee Latino Health Coalition is a group of people who are passionate about Latino health. They are health care professionals, social service professionals, community advocates, health promoters, community members and much more. The purpose of the Milwaukee Latino Health Coalition is to work within a social justice framework to organize the Latino community to address the social determinants of health affecting all of us. They define social justice as the equitable distribution of resources to ensure that everyone has opportunities in all aspects of health for complete physical, mental and social well-being.

In February 2007, The Milwaukee Latino Health Coalition (MLHC) was founded to increase collaboration between organizations and community members and, using a holistic approach, improve Latino health. The MLHC founding organizations are CORE/El Centro (a grassroots, non-profit organization that offers individuals of all income levels access to natural healing therapies) and Aurora Walker's Point Community Clinic. Walker's Point leadership recognized a need for true collaboration among the Latino-serving agencies, government and hospitals. They wanted agencies to move from networking into sharing resources and creating collective vision.

People from all levels of the community (healthcare, community organizations, legislators, schools, churches, and individuals) attended an initial meeting. It was decided to focus on: information sharing, knowledge and education, resources and opportunities to network and collaborate. MLHC identified 3 areas of interest affecting Latino health in Milwaukee: access to health care, preventive education and supporting the health promoters.

The MLHC continues to expand its leadership, involve Latinos in taking action to address their needs for health and well-being, and utilize the hard work and dedication of its members to carry out the mission and create change.

WISCONSIN CORE PROGRAMMATIC QUESTIONS & ANSWERS	
1. Do you have CHWs roles in your state?	Yes
2. What are they called?	Lay Health Educators and Promotor (a) de Salud
3. What setting do CHWs work in?	n/a
4. How did you start finding out what the state had for CHWs?	Surveys
5. Does the state have a policy for reimbursement?	No
6. Do you have a formal organization/alliance for CHWs?	Yes, Milwaukee Latino Health Coalition
7. Does state have formal education, training, certification and website?	No
8. Do you have current curriculum?	No
9. Is it able to be purchased?	n/a
10. Do you have a website?	http://www.mlhc.org/

Community Paramedics(CP) as an Option

Community Paramedicine is an emerging field in health care where Emergency Medical Technicians (EMT)s and Paramedics operate in expanded roles in an effort to connect underutilized resources to underserved populations. EMTs and Paramedics have operated in expanded roles in several foreign countries, such as Canada, England, and New Zealand, for many years. The concept first came to the attention of the EMS community, particularly the rural EMS community, with the publication of the “*Rural and Frontier EMS Agenda for the Future in 2004.*” This report defined paramedicine as “an organized system of services, based on local need, which are provided by EMTs and Paramedics integrated into the local or regional health care system and overseen by emergency and primary care physicians. This not only addresses gaps in primary care

services, but enables the presence of EMS personnel for emergency response in low call-volume areas by providing routine use of their clinical skills and additional financial support from these non-EMS activities.”

There has been significant movement toward the implementation of such programs across rural America in order to more efficiently allocate scarce health care resources and improve access to care underserved areas. Many programs, both rural and urban, take health care into the patient’s home. Community paramedicine programs tend to focus on specific medical needs such as diabetic monitoring or on broader health care issues such as mental health. Most importantly, each of the successful programs now in place across the country are uniquely and specifically designed to meet one or more health care needs essential to that community. Additionally, successful programs capitalize on collaboration and integration with other health care resources in the community.

In 2009 The Joint Committee on Rural Emergency Care(JCREC) was established as a collaborative effort of the National Association of State EMS Officials (NASEMSO) and the National Organization of State Offices of Rural Health (NOSORH). This Committee is dedicated to advancing policy and practice to ensure access to timely, affordable and high quality emergency care services in rural America. One focus area of the committee has been the expansion of the paramedicine concept after exposure to the program at the first International Roundtable of EMS in Nova Scotia, 2004. The JCREC developed a discussion paper in 2010 “State Perspectives on Development of Community Paramedic Programs.” The Discussion Paper addresses the opportunities and challenges in funding and reimbursement; regulation, education, medical direction, support from nurses and other health professionals and other areas to consider when exploring the potential development of a community paramedicine program. The paper is included (Appendix C) in its entirety as a valuable resource to inform discussion and decision making.

Appendix A

New York State - Comprehensive Training in Core Competencies for CHWs

Module I: Essentials of Community Health Workers (7 hours)

- Lesson 1a: Orientation and Introductions
- Lesson 1b: Participants' Expectations
- Lesson 1c: Course Expectations, Learning Methods, Course Schedule, Journals
- Lesson 1d: Guidelines for a Positive Experience
- Lesson 2: Community Health Worker History
- Lesson 3: CHW Identity, Core values and Code of Ethics
- Lesson 4: CHW Skills, Roles and Qualities

Module II: Community Health Worker Approach (14 hours)

- Lesson 1a: Adult Cognitive Development
- Lesson 1b: Adult Learning Methods
- Lesson 1c: Adult Dimensional Development
- Lesson 1d: Kolb Learning Style Inventory
- Lesson 1e: Adult Learning Styles
- Lesson 1f: Multiple Intelligences
- Lesson 2: Family Assessment Paradigm Shift
- Lesson 3a: Popular Education Philosophy and Methods
- Lesson 3b: Traditional "Banking" Approach vs. Liberation Education
- Lesson 4a: Empowerment Approach
- Lesson 4b: Service Model vs. Development Model
- Lesson 5: CHWs as Mentors
- Lesson 6: Conversations to Empower

Module III: Health Care Systems (10 hours)

- Lesson 1: Determinants of Health – Public Health
- Lesson 2: Treatment and Prevention

- Lesson 3: Prevention, Acute Care & Chronic Care
- Lesson 4: Health Care Facilities and Services (Formal & Informal)
- Lesson 5: How Health Insurance Works
- Lesson 6: Public Benefits & Social Services, Entitlements
- Lesson 7: Community and National Resources
- Lesson 8: Community Health Worker Roles

Module IV: Community Health Worker Skills I – Communication (14 hours)

- Lesson 1: Establishing Partners
- Lesson 2a: Introduction to Communication
- Lesson 2b: Introduction to Non-Violent Communication
- Lesson 2c: Communication Skills Outline
- Lesson 3a: Compassionate Communication
- Lesson 3b: Cognitive Approach to Compassionate Communication
- Lesson 4a: Making Observations
- Lesson 4b: Conversation Blockers – Zingers
- Lesson 4c: Making Observations Exercises
- Lesson 5a: Identifying Feelings
- Lesson 5b: Expressing Feelings
- Lesson 6a: Expressing Needs Clearly – Positive Action Wants
- Lesson 6b: Making Suggestions – Not Demands
- Lesson 7: Magic Formula – “I” Statements
- Lesson 8: Typical Responses to “I” Statements
- Lesson 9: Communication Do’s and Don’ts – Health Literacy & Pictures
- Lesson 10: Giving Thanks

Module V: Health Promotion & Behavior Change (14 hours)

- Lesson 1: Health Promotion
- Lesson 2: Healthy lifestyle choices – not just a few pills
- Lesson 3a: Behavior Change - Transtheoretical Model

- Lesson 3b: Process of Change
- Lesson 3c: Adults in Transition
- Lesson 3d: Transition and Cognitive Development
- Lesson 4a: Supportive Communication vs. Didactic Teaching
- Lesson 4b: Facilitation vs. Lecturing
- Lesson 4c: Communication for Family Empowerment - Facilitation
- Lesson 4d: Communication for Group Empowerment - Facilitation
- Lesson 5: Strategic Thinking for Problem Identification & Resolution
- Lesson 6a: Tailoring Communication to Individual Stage of Change
- Lesson 6b: Communicating for Empowerment: Getting past the fears

Module VI: Community Health Worker Skills II (14 hours)

- Lesson 1a: Informal Counseling – Role of CHW
- Lesson 1b: Power & Privilege
- Lesson 1c: Ethical Power
- Lesson 2a: Informal Counseling - Building Trusting Relationships
- Lesson 2b: Informal Counseling - Personal & Professional Boundaries
- Lesson 3a: Informal Counseling - Active Listening
- Lesson 3b: Informal Counseling – Non-verbal Communication
- Lesson 4a: Prejudice, Bias and Labels I
- Lesson 4b: Prejudice, Bias and Labels II
- Lesson 5: Goal Setting & Negotiation

Module VII: Outreach Methods and Strategies (14 hours)

- Lesson 1a: Making and Confirming Appointments
- Lesson 1b: Making the Phone Work for You
- Lesson 2a: Home Visiting
- Lesson 2b: Home Visiting Safety (self & client)
- Lesson 2b: Introducing Yourself and Your Program
- Lesson 2c: Handshake and a Smile

- Lesson 3a: Interviewing Skills
- Lesson 3b: Minimizing Paperwork – Keeping People First
- Lesson 4: Facilitating Meetings
- Lesson 5: Organizing Events and Workshops

Module VIII: Advocacy and Responsibility (10 hours)

- Lesson 1: Medical Terminology & Adaptive Communication
- Lesson 2: Professional Conduct - Ethical and Legal Responsibility
- Lesson 3: Mandatory Reporting
- Lesson 4: Crisis Intervention
- Lesson 5: Confidentiality, Respect and Dignity
- Lesson 6: HIPAA and talking about medical/registry records
- Lesson 7a: Advocacy 101 - What is advocacy?
- Lesson 7b: What is Policy
- Lesson 7c: Legislative Bodies & Processes – Federal, State and Local

Module IX: Working for Long-term Goals (7 hours) – required for chronic disease modules

- Lesson 1a: Orientation and Introductions
- Lesson 1b: Participants' Expectations
- Lesson 1c: Course Expectations, Learning Methods, Course Schedule
- Lesson 1d: Guidelines for a Positive Experience
- Lesson 2a: Review Communication Essentials
- Lesson 2b: Review of Behavior Change Models
- Lesson 2c: Review of Goal Setting and Negotiation
- Lesson 3a: Strategies for progressive change: Promotion of Childhood Immunizations
- Lesson 3b: Incorporating immunization reminders into routine work

Module IX: Working for Long-term Goals (7 hours) – required for chronic disease modules

- Lesson 1a: Orientation and Introductions
- Lesson 1b: Participants' Expectations
- Lesson 1c: Course Expectations, Learning Methods, Course Schedule
- Lesson 1d: Guidelines for a Positive Experience
- Lesson 2a: Review Communication Essentials
- Lesson 2b: Review of Behavior Change Models
- Lesson 2c: Review of Goal Setting and Negotiation
- Lesson 3a: Strategies for progressive change: Promotion of Childhood Immunizations
- Lesson 3b: Incorporating immunization reminders into routine work

Module X: Chronic Disease Management – Asthma (Optional) (14 hours)

- Lesson 1: What Do We Know About Asthma? A Definition.
- Lesson 2: Asthma Facts and Myths
- Lesson 3: Asthma Physiology – How We Breathe
- Lesson 4: The Asthma Experience – How Asthma Feels
- Lesson 5: Asthma Triggers
- Lesson 6: Asthma Trigger Control
- Lesson 7: Home Environmental Assessment
- Lesson 8: Integrated Pest Management
- Lesson 9: Asthma Medications
- Lesson 10: Asthma Equipment
- Lesson 11: Asthma Classifications
- Lesson 12: Asthma Treatment Adherence
- Lesson 13: Asthma Self-management and Working With Parents
- Lesson 14: Asthma Action Plan

Module XI: Chronic Disease Management – Diabetes (Optional) (14 hours)

- Lesson 1: What Do We Know About Diabetes? A Definition.
- Lesson 2: Diabetes Facts & Myths
- Lesson 3a: Biology of Diabetes
- Lesson 3b: Diabetes Signs and Symptoms
- Lesson 3c: Complication of Diabetes
- Lesson 4: Diabetes Risk Factors
- Lesson 5: Diabetes Management and Control
- Lesson 6: Diabetes Prevention
- Lesson 7: Nutrition and Activity

Module XII: Chronic Disease Management – Hypertension (Optional) (7 hours)

- Lesson 1: What Do We Know About Hypertension? A Definition.
- Lesson 2: Hypertension Facts & Myths
- Lesson 3a: Biology of Hypertension
- Lesson 3b: Hypertension Signs and Symptoms
- Lesson 3c: Complication of Hypertension
- Lesson 4a: Hypertension Risk Factors
- Lesson 4b: Early Detection - Screening
- Lesson 5: Hypertension Management and Control
- Lesson 6: Prevention of Hypertension
- Lesson 7: Nutrition and Activity

Module XIII: Nutrition (Optional) (14 hours)

- Lesson 1: Nourishment and Nutrition
- Lesson 2: Dietary Guidelines and Food Pyramid
- Lesson 3a: Portion Control and Portion Distortion
- Lesson 3b: Conscious Eating
- Lesson 4: Big-ticket Items – How Much Sugar, Salt and Fat?
- Lesson 5: Food Labels
- Lesson 6: Review of Goal Setting

APPENDIX B

STATE PERSPECTIVES DISCUSSION PAPER ON DEVELOPMENT OF COMMUNITY PARAMEDIC PROGRAMS



Joint Committee on Rural Emergency Care (JCREC)
National Association of State Emergency Medical Services Officials
National Organization of State Offices of Rural Health
State Perspectives Discussion Paper on Development of Community Paramedic Programs

State Emergency Medical Services (EMS) Offices and State Offices of Rural Health are both committed to the principle that rural EMS systems should be able to respond in a timely, appropriate manner whenever serious injury or illness strikes someone in need. In 2009 the National Association of State EMS Officials (NASEMSO) and National Organization of State Offices of Rural Health (NOSORH) created a Joint Committee on Rural Emergency Care (JCREC). This Committee is dedicated to advancing policy and practice to ensure access to timely, affordable, and high quality emergency care services in rural America. In 2010, the JCREC developed "Improving Access to EMS and Health Care in Rural Communities: A Strategic Plan"¹ which was approved by both Associations. This discussion paper is intended to further the community paramedicine elements of that Strategic Plan.

Statement of Purpose:

The concept of community paramedicine represents one of the most progressive and historically-based evolutions available to community-based healthcare and to the Emergency Medical Services arena. By utilizing Emergency Medical Service providers in an expanded role, community paramedicine increases patient access to primary and preventative care, provides wellness interventions within the medical home model, decreases emergency department utilization, saves healthcare dollars and improves patient outcomes. As the Community Paramedicine model continues to be adopted across the country, states and local communities need assistance in identifying common opportunities and overcoming challenges. This discussion paper offers insight into the historical perspective and future considerations for Community Paramedicine programs. As well, it advocates for the development of an implementation guide for states.

Community Paramedicine in Action

At 2:35 am on a cold November morning the Emergency Medical Dispatcher in the 9-1-1 center received a call from a man, frantic with concern about his wife. "Please send help! My wife is having a hard time breathing and I don't know what to do!" After surmising that the patient was conscious with labored breathing, the dispatcher alerted the appropriate response units to assist before walking the caller through further assessment questions and ways he can help his wife be more comfortable.

Kennedy was just finishing a patient care report to give to the emergency department when a call came over the radio, "Medic 1, Alleghany EMS, Hillsborough Fire; Respiratory Difficulty. 38-year-old female, 3415 Washo Drive. Patient conscious and alert. Code 3 ALS response,

all others Code 2.” Snapping the clipboard shut and grabbing the radio, Kennedy bundled up against the cold and hopped in Medic 1, her paramedic response car. While Kennedy navigated the long, dark country roads to get from the Critical Access Hospital in town out to Washo drive, she thought about the scenarios that could be unfolding. Knowing that even though the fire department and ambulance were not using lights and sirens, they would most likely get there before she did. They will have applied oxygen and gotten the patient comfortable and may be able to give a quick update on the radio if they had time.

The husband, Carl, watched nervously as the first responders worked with his wife. Several years ago, his wife had suffered from an infection of the lining of her heart that resulted in potential lifelong dependence on medications to keep her lungs from filling with fluid as a result of her weakened heart. Just yesterday they had decided with her primary care provider to reduce her “fluid pill” medication in an effort to try and wean her off slowly. It looked now that it hadn’t worked. A knock at the door spun him around and as he pushed the door open he saw the warm, comforting smile and an outstretched hand, “I’m Kennedy, a community paramedic, let’s go check on your wife.”

The brief update from the first responders confirmed Jen, the patient, was having difficulty breathing with just room air. On a mask that delivered a high concentration of oxygen, Jen still had labored breathing but was oxygenating well. Breath sounds confirmed fluid in the lungs and after the basic assessment, Jen was given nitroglycerin, put on a 12-lead ECG and an IV was established. Because the likely culprit of the current emergency was the reduction in the congestive heart failure medication, Kennedy determined that 80 mg of Lasix IV was the best next step. While she was waiting for the medication to take effect, an ECG and quick phone call to the medical control physician in the ED was made so they could consult on next steps.

Carl was just short of amazed. Within 20 minutes after the community paramedic had arrived, Jen was comfortable, off oxygen, breathing normally and saying she didn’t want to go to the hospital. What a relief! She was OK, back to normal and instead of facing an hour ride to an emergency department and what has been a guaranteed two days in the hospital, this was now a minor blip in their day and a follow-up visit with their primary care doc tomorrow.

Before leaving the home, Kennedy assured and confirmed that if Jen started to have any problems to call 9-1-1 and they would be right back. Jen and Carl were so grateful to get the help and to avoid the hassle and overwhelming bills of the ED. It was hard to explain what Kennedy felt other than to say she was content feeling that she had made a meaningful difference. She knew that her intervention had met Jen’s needs, exceeded the Carl’s expectations and provided for the highest quality, most cost-effective intervention that could be provided. Kennedy was actually looking forward to future interactions with Jen, her primary care doc and her partners in community health that all work together to ensure that folks like Jen received coordinated, wellness-focused care.

Executive Summary

While "community paramedicine (CP)" is a relatively new term, first described in this country in 2001² as a means of improving rural EMS and community healthcare, it is not a new concept in practice, either here or in other parts of the world.

Note: In much of the world, paramedic is a general term used to identify all levels of Emergency Medical Technician (EMT). For the purposes of this discussion paper, 'community paramedicine' or 'CP' will be used to describe generically programs that specifically utilize any level of EMT (basics to paramedics) to provide community paramedicine and community health services.

The *EMS Agenda for the Future*³, released in 1996, presented the vision that EMS will be community-based and fully integrated with the overall health care system. The agenda additionally described that EMS of the future would have the ability to not only provide acute illness and injury care, but also identify health risks and provide follow-up care, treatment of chronic conditions and community health monitoring. The *Rural and Frontier EMS Agenda of the Future*⁴, released in 2004, further reinforced a community health role for EMS with a vision that recognized EMS providing not only a rapid response, but also filling roles as a community resource for prevention, evaluation, triage, referral and advice⁵. Both documents make numerous references to community health roles where EMS is integrated with other elements of the health care delivery system. As such, the concept of community paramedicine embraces EMS providers who are utilized in an expanded role as part of a community-based team of health services and providers.

This discussion paper summarizes the current status of community health and communityparamedicine programs and present a synopsis of some of the opportunities and challenges state EMS offices will face as these programs are contemplated in local communities. This Discussion Paper advocates for the development of a guide for states to refer to as community paramedicine and community health programs emerge, either locally or statewide. Much information about community paramedicine can be found at <http://communityparamedic.org>. However, the "information tab for policy makers" is virtually blank and this Discussion Paper is meant to provide context for discussions in this area and assist states with implementation of community paramedicine programs.

Background:

The original intent of EMS systems was to provide patient care for acute or emergency events. However, studies show that 10-40% (or more) of ambulance service responses are for non-emergent events. Many times, patients who lack access to primary care utilize EMS to access emergency departments for routine health care services. While these patients could be more appropriately cared for in primary care offices or alternate locations, the current healthcare and reimbursement infrastructure systems do not support other appropriate, cost-effective EMS transport alternatives.

After some 30 years of development of the current model of providing prehospital care, the future of EMS may be much different. The erosion of the volunteer model in many rural areas, generational changes in the overall workforce, continued budget challenges and national changes in healthcare are challenging rural EMS infrastructure--- and demanding innovational strategies.

Emergency medical services of the future, whether it includes community paramedicine or not, will not likely involve an initial patient contact with two EMT responders in a \$150,000 ambulance and an automatic ride to the emergency room for many calls.

Future calls may begin with a priority dispatch system which can triage and send a variety of resources, including community paramedics, who then provide a more comprehensive triage followed by treat and release to primary care or other appropriate treatment options.

Historically, there are numerous examples of programs in which EMS and community health providers have been utilized to provide emergency care as well as assure access to primary care. While the Red River project in New Mexico is often noted as one of the most well known demonstration of this concept, other models include the following:

- **Seattle/King County SPHERE (Supporting Public Health with Emergency Responders)** – In this King County program, EMS is utilized to help prevent future 9-1-1 calls by identifying potentially life-threatening conditions whenever a patient is seen by responders. Instead of a quick assessment and release of a patient who called 9-1-1 for a transient event, a blood pressure, blood sugar or other assessment is conducted. Patients are provided a card with the results of the assessment and they are encouraged to follow up with their primary care physician. The patient receives a follow-up call a month later to help assure that the physician contact was initiated.
- **Winnipeg, Canada** – Instead of an automatic trip to the ED, paramedics respond to thousands of non-life threatening 9-1-1 calls to triage and evaluate the patient's medical needs. Based upon the assessment, patients are provided appropriate treatment on scene and protocols are then implemented to transport patients to not only ERs, but also to urgent care clinics, primary care physicians and other alternate sites when appropriate. The paramedic can make decisions to arrange transport by ambulance, in the paramedic response vehicle and even by taxi or stretcher vehicle. The paramedic union president is quoted as saying "The idea is to have medics out in the community engaging people with problems and find the best place in health care for them instead of a system of 'you call, we haul'."
- **Alaska Community Health Aide Program** – Staffed by selected Alaska natives in remote communities, not necessarily paramedics, this program was began as a strategy to use village workers to distribute antibiotics to combat a tuberculosis epidemic back in the 1950's. It became a federally funded program in 1968 and today over 550 Community Health Aides/Community Health Practitioners are employed by 27 tribal health organizations in 178 rural/frontier communities. CHA/Ps are the patients' first contact within the network of health professionals in the Alaska Tribal Health System.
- **Nova Scotia, CN** – The Islands of Long and Brier are only accessible by ferries. Transport to the closest hospital is a 50-minute trip with the regional hospital another hour away. The island residents recognized the need for primary and emergency care and launched a multi-phase initiative. The first phase provided 24/7 emergency paramedic coverage based from an abandoned physician's clinic. Next, the paramedic role was expanded to provide flu shots, blood pressure and diabetic clinics and other primary care. Lastly, the paramedics were integrated

Your fire department measured your non-fasting blood sugar during your medical emergency. **Your blood sugar level was very high.**

Date: _____
 EMT: _____

Without proper treatment, high blood sugar can lead to heart disease, kidney disease, and nerve damage. There are effective ways to manage high blood sugar. You need to discuss this with a doctor.

We recommend that you contact a doctor to have your blood sugar level checked again as soon as possible.

Your blood sugar: _____

Non-Fasting Blood Sugar Guidelines

Category	Range	Action
Possible diabetes	175	
Diabetic	200	Better control needed

Non-diabetic Diabetic

You may be called in a week or two in order to find out how you are doing.

with a nurse practitioner to provide more comprehensive and complex care. The traditional paramedic role was expanded to include home visits for injury and fall prevention as well as primary care patient assessments and evaluation.

- MedStar, TX Alternative Destination/Alternative Transport Program – A collaborative effort of MedStar, the emergency physicians board and public health, the overall goal of this program is to help assure the right patient, receives the right care, at the right time and the right setting. Patients in this program receive better healthcare at reduced cost to the patient and the community. Patients with chronic or non-acute conditions are treated by Advanced Practice Paramedics who bring preventative services to patients most at risk for medical emergencies. The program reduces health care expenditures by reducing the probability of providing acute emergency medical care for at risk and medical underserved patients.
- Wake County EMS, Raleigh, NC – In addition to providing increased community resources for acute care, paramedics in this program also provide preventative care to some high-risk patient populations, and seek further care for those patients who may be better served at locations other than local hospital emergency departments. These paramedics are part of a health care team that improves emergency response, mitigates the need for some responses and provides care to some patients that have limited access to any other care.
- Minnesota Community Paramedic Program – The pilot of this program was funded by the Minnesota Department of Public Health and Office of Rural Health. The first course consisted of hand-picked, experienced paramedics interested in providing an expanded role in their communities. As part of their education, each community paramedic conducted a community analysis to determine gaps in health care. These paramedics then molded their practice to needs ranging from provision of mobile clinics for Native American populations, free clinics for communities, 'chase car' enhancement of local EMS response, critical access hospital staffing and regional/national disaster response.
- Western Eagle County Ambulance District, Eagle, CO –Championed by the local EMS service manager and the local public health department, the goal of this program is to take the current EMS resource and link it with existing health care services to provide EMS and public health services. In addition to physician-directed treatment delivered directly to patients in their homes, paramedics utilize expanded training in assessments, blood draws, wound care, diagnostic monitoring and other procedures. Assessment and treatment findings are linked with other appropriate health services in order to increase health care at a savings.



In their varied states and provinces, these are examples of community paramedicine programs in which EMS providers are used to not only provide emergency care but also expand their roll to address primary care needs and direct patients to the most appropriate level of definitive care. There are many more examples of community paramedicine being conducted in the U.S. and communities will continue to look at CP to help bridge the gap between the health care needs and the resources available to meet those needs. Currently, most U.S. programs are pilots or local programs born out of necessity. It is important for

states to assess the opportunities and challenges to development of these programs and this paper is a brief discussion of several areas to be considered and developed into a *state community paramedicine guide*.

Funding and Reimbursement

There are increasing concerns about shrinking healthcare reimbursements and budget shortfalls. The primary goal of community paramedic programs is to save healthcare dollars by reducing illness and injury and prevent unnecessary ambulance transports, emergency department visits and readmissions through more efficient use of existing resources.

Opportunities:

Community paramedicine is not without data showing cost savings. After five years, the Nova Scotia program demonstrated a 40% reduction in emergency room visits and a 28% reduction in clinic visits. A U.S. program that focused on preventing readmissions of frequent flyers quotes a 64% reduction in 9-1-1 visits and \$1 million savings in health care costs. These examples need to be validated and collected into a comprehensive package that can be presented to policy makers and tax payers.

Challenges:

The case for this has not yet been made such that insurance providers universally are implementing reimbursement for CP services.

Hospitals and physicians are not necessarily proponents for community paramedicine as they depend upon patient contacts and volume to fund their operations. However, the proposed changes to a reimbursement scheme which limits reimbursement for a patient's disease through Accountable Care Organizations, Value Based Purchasing and Bundled Payment mechanisms may represent an opportunity for a role such as community paramedics to be extremely valuable.

Regulation of Community Paramedicine Programs & Community Paramedics

Are states prepared to sufficiently provide for or allow the regulatory oversight and support necessary for the expanded role that community paramedicine may practice?

Opportunities:

EMS provides a triad of health care, public safety and public health services. As noted in the above examples, community paramedicine does not necessarily change the scope of EMS practice. Community health services are already provided by EMTs in the current scope of practice. While CP seems to emphasize the role of EMS providing primary care in the patient's home, it is already an environment and role in which EMTs already practice. Much of the infrastructure and regulation is likely already in place in states to allow community paramedicine.

Challenges:

Currently, state regulations may only allow CP providers to practice in a prehospital environment with a skill set designed for acute responses to medical diseases or traumatic

injuries. In most deliberations about community paramedicine, participants are careful to characterize that CP providers provide an expanded role, not an expanded scope. This expanded role is often depicted as the ability for CP providers to perform an expanded assessment and medical history and to develop care plans; use of non-traditional medications such as vaccines; and expanded treatments for chronic diseases such as diabetes.

Additionally, community paramedicine services are related more to primary care and public health roles than the traditional 9-1-1 response. For example, a CP provider may perform home visits to follow up on the health of patient with diabetes, mental health challenges and other issues. The CP role may also include injury prevention activities such as conducting home safety assessments for falls and other hazards.

All of these regulatory issues need to be considered by states early-on if a community paramedic program is to be successfully implemented.

Expanded Role of Community Paramedics

Every day, EMTs encounter patients who require assistance with non-emergent conditions. As well, many patients have chronic and secondary conditions that have precipitated the emergency call such as loneliness, mental health, lack of home care and other special needs.

Opportunities:

The community paramedic is generally described as an expanded role and, with few exceptions, does not incorporate new skills or an expanded scope of practice (suturing being one exception in a model CP curriculum). The idea of expanded role or non-traditional settings is not a new concept. EMS has long been active in emergency rooms and clinics, as wildland fire medics, in industrial sites and with other roles with specialized practices.

Community paramedicine is not a new practice, but rather a specialty much like emergency medicine is a specialty. As other health care professionals choose a specialty for a variety of reasons, EMTs may choose CP. For example, an 'aging' paramedic may choose to extend their EMS career by choosing a community paramedicine practice may be less physically demanding on their health and family life.

Challenges:

Several pilot CP programs are preemptively responding to patients with these conditions in order to prevent more serious illness and to negate emergent calls requiring advanced care and transport. The CP provider may gather a more detailed medical history and perform expanded examinations as needed. A CP may utilize current skills to administer vaccines. In a CP program, the paramedic may provide prenatal, preventative and chronic care, x-rays, wound dressing with local anesthetics and mental health assessments.

An emergency nurse is not necessarily a public health nurse and an emergency physician is not necessarily a primary care physician. A 9-1-1 paramedic may not necessarily want to be a community paramedic and it would be problematic for states, EMS services and communities to not consider this. Current pilot programs are hand-picking EMTs who have an interest in this area. Some programs are rotating EMTs between roles; for example working

one month on 9-1-1 and one month in a CP role. Others are integrating CP duties into typical shift downtimes. The challenges of these models will need to be considered in a statewide rollout of community paramedicine.

Lastly, if you've seen one community paramedic program, you've seen one community paramedic program. By design, CP programs are encouraged to first conduct a community assessment gaps in health care needs and then to build local programs that fill those gaps. As such, states will be challenged with the regulation and oversight of local programs that may provide very diverse services.

Community Paramedic Education

A community paramedic's education should prepare EMTs to meet identified community health needs and should address gaps revealed by a community assessment. As such, CP education should be standardized, but capable of being tailored for each community.

Opportunities:

Several partners, including Creighton University in Nebraska, Dalhousie University in Nova Scotia, Mayo Clinic in Minnesota, the North Central EMS Institute and state offices of rural health in Minnesota and Nebraska, came together and studied community health education programs such as from Alaska and Australia. This consortium created a curriculum for community health in the States.

This Community Healthcare and Emergency Cooperative group provides the curriculum to accredited colleges and universities. These institutions can then customize this standardized curriculum for individualized certification programs. This curriculum provides direction on educating about primary care, expanded emergency care, public health, disease management, prevention and wellness and mental health.

This curriculum is conducted in two phases:

- Phase 1 – Approximately 100 hours of foundational skills in advocacy, community outreach and community health assessments, public health and development of prevention and primary care strategies.
- Phase 2 – Clinical skills (ranging from 15 hours to 146 hours depending on the students previous knowledge and background) that is supervised training by the program medical director and other health care providers.

Challenges:

The community paramedicine model has been in existence around the world for some time, this US version of the curriculum is still new. It will need to be evaluated and updated as necessary to accommodate expanded roles identified as more CP programs are implemented. Otherwise, the 'standardized but customizable' format of CP could propagate a wide variety of education programs across states and even among institutions within states. The educational program described may need to be further credentialed in order to be accepted into any college or university curriculum offering.

Community paramedicine is designed to meet the particular needs of communities and it can meet an important role particularly in rural communities where primary care access is a critical issue. This is seen in the Alaska Community Health Aid program that targets

community members to meet those needs. Emphasis on educating EMTs in rural areas through a college curriculum presents an 'educational paradox' where the people who most need the education may not be able to access necessary resources.

Medical Direction and Control of Community Paramedic Programs

As with traditional delivery of prehospital care, community paramedic programs must also be physician- driven.

Opportunities:

In well developed, mature CP programs, the community paramedic can be the eyes and ears of primary and emergency care physicians and an extension to their practices. Community paramedicine presents opportunities to decrease unnecessary ER visits and decrease the acuity of patients needing emergency or primary care. EMS is a delegated practice and nothing in a community paramedic's expanded role is designed to change that.

Challenges:

Expanding medical oversight of paramedics to public and community health roles may present challenges. In more urban systems, offline medical direction has traditionally been provided by physicians with an emergency background. Online medical direction has been provided by emergency room physicians. Community health is designed to link the patient with their primary care physician. Therefore, a community paramedic may evaluate a patient and decide that the patient's care may be best met by transport to an urgent care clinic or to their primary care physician's office (maybe even by taxi or some other means). Given this expanded role, will traditional online medical control be comfortable directing patients to alternate sites without ever seeing the patient themselves?

Community paramedicine is intended to fill gaps in rural communities where medical control and primary care may be provided by the same physician and the above scenario less likely. However, there may be a 'medical direction paradigm' in rural areas where CP is needed most but also where physicians are neither educated nor have the support to provide oversight for these expanded services.

To ensure community paramedics are effective, they must be an integral part of the medical home concept where patients are cared for by a physician who leads the medical team and all aspects of preventive, acute and chronic needs of patients. EMS has proven it can be an effective member of this medical team. Everything in the continuum of care from how the CP provider participates in the development and implementation of a patient's care plan, where to get the orders and, how to provide documentation in the patient medical record, will present new challenges for community paramedics and medical directors.

Challenge – Support from Nursing and other Health Professions

Key recommendations of agenda documents and Institute of Medicine reports is that EMS needs to be more integrated with the other elements of the health care system. Community paramedicine represents an opportunity to effect such integration.

Opportunities:

Approached correctly, the introduction of community paramedicine should be viewed as an opportunity not a challenge or a threat to other providers. Particularly in rural communities where health resources are limited, extending the role of the paramedic into different settings and partnering with public health should be viewed as a benefit to the patient. As long as communities continue to understand that community paramedics have a unique education and background and that nursing also has a unique education and background – and that each can compliment rather than compete with each other – potential conflicts should be negligible.

Currently, CP programs have found ways to foster such partnerships and have not created disagreements and conflict. For example, the Colorado pilot program is a partnership under the leadership of the EMS manager and the public health nurse designed to meet both EMS and public health goals.

Challenges:

Implementation of community paramedicine may meet resistance or face opposition from nursing, public health and other health professionals in engaged in providing community or public health. The role of community paramedics lies within much of what EMS is already doing in an environment they are already functioning within. By design, a CP program should begin with an assessment of a community's health needs and implementation of CP should be to fill gaps in a community's needs. As such, potential conflicts over concerns that the CP role overlaps or infiltrates into other areas of practice can instead result in constructive partnerships like the one in Eagle Colorado.

States may need to begin open early discussions, provide education, and develop partnerships with professional groups and advocates to best ensure a community paramedicine program.

Data, Performance Improvement and Outcomes Evaluation

States will need to enhance current information systems to not only plan for the development of community paramedicine programs but also to justify the continued implementation and viability of such programs.

Opportunities:

CP should not continue without a vision about what data is needed to evaluate programs and any benefits and outcomes associated with them. The National EMS Information System (NEMSIS) has been accepted as the standard electronic medical record (EMR) data set for EMS by all 50 states. Adoption of community paramedic programs may necessitate new or

modified NEMSIS fields and other documentation. The Health Resources and Services Administration (HRSA) Office of Rural Health Policy contract in late 2010 for development of an evaluation framework and tool for community paramedic programs represents an excellent strategy towards this end.

Challenges:

How and what services a CP program provides is dependent upon an assessment of a community's health care needs and gaps. There currently is no state model for such an assessment. Development of a community assessment tool will help states and the communities develop the need for CP programs and help more consistent implementation of programs. Over time, refinement of an evaluation tool can also maintain a focused development of CP programs nationally and around the world to prevent any potential creep in scope of practice. If there is not a need in a community that cannot be met by utilizing EMS providers in the expanded role of CP, then other solutions must be sought.

Currently, CP programs in the US are typically funded through grants and CP as pilot or demonstrations projects and services are not reimbursed by insurance providers. If CP is to become financially viable, CP programs will need to institutionalize documentation of services provided and their effectiveness – whether the result is better patient outcomes, decreased costs to healthcare or other measures.

Linking the patient information community paramedics collect at the home to the patients' permanent health record at their primary care physician's office or medical home will be a new challenge. The typical patient care record used now to document the care provided to a patient in a response for emergency help will not likely be appropriate to documenting community health services. Community paramedicine providers will need to be part of the development and delivery of a patient's care plan and services provided will need to be integrated into a patient's entire health record. Linking CP providers to electronic health records and the use of technologies such as telemedicine will be key strategies to be considered.

Summary:

As it has done since its formal inception in the U.S. in 1973⁶, Emergency Medical Services will continue to evolve and develop to meet the needs of our society. All healthcare will continue to be challenged by health care reform, workforce issues, cost containment and reimbursement models, rapidly expanding technology, educating the next generation of providers and many other issues. Because EMS is the healthcare link between public safety and public health, it remains the safety net for patients and will face these challenges at an accelerated rate due to its proximity and value to community-based efforts.

Community paramedicine is a dynamic part of the future of EMS and this Discussion Paper lays out the numerous opportunities and challenges that states will grapple with as community paramedicine programs are contemplated by their communities. The development of a State Guide for Community Paramedicine to more comprehensively address issues, challenges and potential solutions will be an effective resource. The JCREC's mission is to educate and lead on issues such as community paramedicine. As such, the JCREC will continue to engage our organizations and partners to develop the guide and examine strategies that can help the states that choose to initiate community paramedicine.

References:

1. McGinnis KK, DeTienne J, Tilden C; *Improving Access to EMS and Health Care In Rural Communities: A Strategic Plan*; Joint Committee for Rural Emergency Care (National Association of State EMS Officials, and National Organization of State Offices of Rural Health); July, 2010.
2. Rowley T.; *Solving the Paramedic Paradox*; Rural Health News; Volume 8, Number 3, Fall 2001.
3. Delbridge T; *Emergency Medical Services Agenda for the Future*; National Highway Traffic Safety Administration, US Department of Transportation, Washington, DC; 1996.
4. McGinnis, KK; *Rural and Frontier Emergency Medical Services Agenda for the Future*; National Rural Health Association Press; Kansas City, MO; 2004
5. Ibid; page 1
6. Emergency Medical Services Systems Development Act of 1973. Hearings. 93rd Congress, 1st Session, on §504. and §654. Washington DC: United States Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Health; 1973

APPENDIX C

RESOURCES

Centers for Disease Control (CDC) and Prevention E-Learning Training Series

Promoting Policy and System Change to Expand Employment of Community Health Workers (CHWs) Training Course

http://www.cdc.gov/DHDSP/pubs/chw_elearning/index.html

Course Description

This course is designed to provide state programs and other stakeholders with basic knowledge about Community Health Workers (CHWs), such as official definitions of CHWs, workforce development, and other topic areas. In addition, the course covers how states can become engaged in policy and systems change efforts to establish sustainability for the work of CHWs, including examples of states that have proven success in this arena.

The six-session course covers:

- CHWs' roles and functions
- Current status of the CHW occupation
- Areas of public policy affecting CHWs
- Credentialing CHWs
- Sustainable funding for CHW positions
- Examples of states successful in moving policy and systems change forward

The course sessions are self-paced. Completion time for each session is between 30–45 minutes. The user does not have to take each session in succession.

Technical Requirements

- Microsoft® Internet Explorer® 7 browser (or higher)
- JavaScript enabled
- Popup blocker disabled

- Broadband Internet connection (recommended for optimal loading times and course viewing)
- Adobe Reader for PDF's

Course Developers

This course was a collaborative effort between the Division for Heart Disease and Stroke Prevention (DHDSP) and the REACH Program of the Centers for Disease Control and Prevention (CDC). The primary author of this course is Carl Rush, MRP of Community Resources, LLC. The developers of the course are GEARS, Inc. and C2 Technologies. The course is provided free of charge from the DHDSP web site.

Disclosure Statement

CDC, our planners, and our content experts disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. This course does not include any discussion of the unlabeled use of a product or a product under investigational use.

Additional CDC Resources:

The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke (DHHS, Centers of Disease Control and Prevention)

http://www.cdc.gov/dhdsp/programs/nhdsp_program/chw_sourcebook/pdfs/sourcebook.pdf

Spanish Version – The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke (DHHS, Centers of Disease Control and Prevention)

http://www.chronicdisease.org/resource/resmgr/cvh/chw_sourcebook-spanish_web.pdf

Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach (National Center for Chronic Disease Prevention and Health Promotion)

http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

Promoting Policy and Systems Change to Expand Employment of Community Health Workers (Division for Heart Disease and Stroke Prevention)

http://www.cdc.gov/dhdsdp/pubs/chw_elearning.htm

Community Health Workers Toolkit

<http://www.raconline.org/communityhealth/chw/>

Designed to help evaluate opportunities for developing a CHW program and provide resources and best practices developed by successful CHW programs.

The toolkit is made up of several modules. Each concentrates on different aspects of CHW programs. Modules also include resources for you to use in developing a program for your area.

- [Module 1: Introduction to Community Health Workers](#)
An overview of community health workers and their roles.
- [Module 2: Program Models](#)
Elements of differing models for CHW programs.
- [Module 3: Training Approaches](#)
Available training materials and procedures for CHWs.
- [Module 4: Program Implementation](#)
Building a program from the bottom up.
- [Module 5: Planning for Sustainability](#)
How to ensure your CHW program functions properly.
- [Module 6: Measuring Program Impacts](#)
Methods that allow you to measure the effectiveness of your program.
- [Module 7: Disseminating Best Practices](#)
Letting other people know what you have done with your program.
- [Module 8: Program Clearinghouse](#)
Examples of and contacts for successful CHW programs.

Implementing Community Health Worker Programs: Lessons from Rural Communities

Includes a Q&A with Dr. Alana Knudson, Co-Director of the NORC Walsh Center for Rural Health Analysis regarding community health worker programs in rural communities and a toolkit intended to support them. <http://www.hwic.org/news/jan12/knudson.php>

Community Paramedicine Resources:

Community Paramedic Program

Website: <http://communityparamedic.org/>

Community Paramedicine – Evaluation Tool (March 2012)

Website: <http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf>

State Perspectives Discussion Paper on Development of Community Paramedic Programs (December 2010)

http://www.ruralcenter.org/sites/default/files/community_paramedic_programs.pdf

Rural and Frontier Emergency Medical Services Agenda for the Future

McGinnis, KK; National Rural Health Association Press; Kansas City, MO; 2004

State CHW Program Resources and Contact Information:

Minnesota

Minnesota Community Health Worker Alliance - <http://www.mnchwalliance.org/>

Minnesota CHW Peer Network - <http://www.wellshareinternational.org/chwpeernetwork>

Community Health Workers in Minnesota: Bridging Barriers, Expanding Access, Improving Health - <http://www.bsbsmnfoundation.org/>

Washington

Family Health Center Promotora Program, Okanagan, Washington

Contact person: Heather Findlay

Email: hfindlay@myfamilyhealth.org

Website: <http://www.myfamilyhealth.org/fhchome.htm>

Washington Association of Community and Migrant Health Centers (WACMHC)

Contact Person: Lilia Gomez, BA

Email: lgomez@wacmhc.org / Phone: (360) 786-9722 ext. 230

website: <http://www.wacmhc.org/>

Northwest Regional Primary Care Association (NWRPCA)

Contact person: Seth Doyle, MA Migrant Health Coordinator

Email: sdoyle@nwrpca.org / Phone: (206)783-3004 ext. 16

website: <http://nwrpca.org/community-health-worker-networks.html>

New Mexico

New Mexico Community Health Workers Association

www.nmchwa.com

Reaching Out: A Training Manual for Community Health Worker Curriculum

Email: bjciesielski@gmail.com / Phone: (505) 255-1227

Colorado

Colorado Trust

Contact person: Chris Armijo, Program Officer

Email: chris@coloradotrust.org / Phone: (303) 837-1200

University of Colorado Cancer Center

Andrea Dwyer, Ph.D., Coordinator-Clinic Inreach/Outreach

Email: Andrea.dwyer@ucdenver.edu / Phone: (303) 724-1018

Denver Health

Contact person: Liz Whitley, Director of Community Health Grants

Email: Liz.whitley@dhha.org / Email: (303) 436-4071

Website: <http://www.denverhealth.org>

Colorado Community Health Network

Contact person: Maureen Maxwell

Email: Maureen@cchn.org / Phone: (303) 861-5165 ext. 259

New York

Community Health Worker Network of New York City

Website: <http://chwnetwork.org>

Wisconsin

Wisconsin CHW Contacts

Dr. Brenda Gray, Milwaukee AHEC Exec. Director

Email: bgray@milahec.org

Denise Patton, AHEC Consultant

Email: bpuckettpa@aol.com

Ana Paula Sores, Promotura expert affiliated with CORE/El Centro

Email: anapaula26soares@gmail.com

Pang Vang, RN, Hmong lay health educator program

Email: pangvang@uwm.edu

Dr. Sandra Underwood, CHW breast cancer outreach manager with UW-Milwaukee:

Email: underwoo@uwm.edu

Maria Barker, Planned Parenthood

Email: Maria.Barker@ppwi.org

Wisconsin Area Health Education Center System

<http://www.ahec.wisc.edu/>

American Cancer Society, Midwest Division

Contact person: Jennifer Nkonga, Manager, Community Programs & Training

Email: Jennifer.Nkonga@cancer.org / Phone: (262)312.4005

Website: cancer.org

National Community Health Worker and Related Organizations:

American Public Health Association, CHW Association and Network Corner

Website: <http://www.apha.org/membersgroups/sections/aphasections/chw/Resources/>

Community Health Worker National Education Collaborative Website: <http://www.chw-nec.org/>

Health Outreach Partners Website: <http://out-reach-partners.org/>

Migrant Health Promotion Website: <http://migranthealth.org/>

National Association of Community Health Representatives Website:

<http://www.nachr.net/>

National Center for Farmworker Health: <http://www.ncfh.org/>

Related Articles:

Advancing Community Health Worker Practice and Utilization: The Focus on Financing (National Fund for Medical Education) http://futurehealth.ucsf.edu/Content/29/200612_Advancing_Community_Health_Worker_Practice_and_Utilization_The_Focus_on_Financing.pdf

Community Health Worker National Workforce Study

<http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf>

Community Health Worker Programs Materials (National Breast and Cervical Cancer Early Detection Program – NBCCEDP)

<http://www.cdc.gov/cancer/nbccedp/training/community.htm>

Community Health Workers: Promoting a Vital Workforce (Massachusetts Health and Human Services) <http://www.mass.gov/dph/communityhealthworkers>

Community Health Workers: Valuable Assets to the Healthcare Workforce (The Planning Council for Health and Human Services)

<http://planningcouncil.wordpress.com/2011/04/28/community-health-workers-valuable-assets-to-the-healthcare-workforce/>

Core Competencies for Community Health Workers (The Community Health Worker Initiative of

Boston) <http://www.machw.org/documents/CHWInitiative10CHWCoreCompetencies10.17.07.pdf>

Do it for them! But for you too. – Bilingual version (National Diabetes Education Program)

<http://ndep.nih.gov/media/DoltForThem.pdf>

Financing Community Health Workers: Why and How (National Community Voices Initiative)

http://www.pscinc.com/LinkClick.aspx?fileticket=Vu_X9O_UHHg%3D&tabid=65

Foundations for Community Health Workers (paperback)

<http://www.josseybass.com/WileyCDA/WileyTitle/productCd-047017997X.html>

Promoting Policy and Systems Change to Expand Employment of Community Health Workers

(Division for Heart Disease and Stroke Prevention)

http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm

Toolkits and Other Resources (Center for Sustainable Health Outreach, Univ. of Southern Mississippi) http://www.usm.edu/csho/non-managed_care_toolkit.html

Views from the Field: Building the Community Health Worker Field through Partnership and Innovation (Blue Cross Blue Shield of Minnesota Foundation)

http://www.gih.org/usr_doc/Community_Health_Workers_BCBSMSFdn_August_2010.pdf

What is a Tool Kit?

<http://apps.publichealth.arizona.edu/chwtoolkit/about.htm>