

Webinar Questions and Answers

Questions for Both CDC and Rhode Island

1. **Why are community health workers called out in 6|18 and not others such as health education specialists, etc.?**

CDC Response: For asthma interventions, CDC consulted the use of reviews such as CDC's Community Guide which promotes the use of home-based, multicomponent interventions by a wide range of trained personnel including community health workers (most common), nurses, respiratory therapists, social workers, and physician. Similarly, for cardiovascular interventions, the Community Preventive Services Task Force found strong evidence of effectiveness for interventions that engage community health workers in a team-based care model to improve blood pressure and cholesterol in patients at increased risk for CVD. There is also sufficient evidence of effectiveness for interventions that engage community health workers for health education, and as outreach, enrollment, and information agents to increase self-reported health behaviors (physical activity, healthful eating habits, and smoking cessation) in patients at increased risk for CVD. If there is specific health and cost impact data on any of the 18 interventions specifically involving health education specialists, please share at healthpolicynews@cdc.gov.

Rhode Island Response: Additionally, as indicated in the webinar, Rhode Island is looking at the Community Health Worker profession in a very broad sense to include home visitors, and tobacco cessation and education components. As a state they are establishing bare minimum qualifications for CHWs so there is some standardization, but people can specialize above and beyond that if they choose.

Questions for CDC

2. **Can you please explain the differences and similarities between the 6|18 initiative and CDC's winnable battles?**

There is overlap between the conditions covered by the Winnable Battles and conditions covered in the 6|18 initiative. Evidence-based prevention interventions promoted by Winnable Battle programs include traditional clinical, innovative clinical, and community-based interventions for broad implementation by multiple partners and sectors. The 6|18 initiative promotes mostly traditional clinical and innovative clinical interventions based on health and cost impact and are specifically framed for health care purchasers, payers, and providers. CDC programs that are involved in both efforts often share lessons learned across the spectrum of interventions and partners they work with.

- 3. Have you considered adding mental/behavioral health to your six high burden health conditions? This is an area that we have difficulty finding adequate coverage and reimbursements.**

This is an important area for future consideration and as promising interventions arise in mental/behavioral health with strong health and cost impact data, CDC programs will develop a plan to promote these interventions to purchasers, payers, and providers.

- 4. Does CDC have initiatives in workforce development for 6|18, particularly interprofessional education (as is being developed in CSELS/DSEPD/Population Health Branch)?**

CDC units have started discussions on how to incorporate 6|18 content into curricula and workforce development programs. A timeline has not yet been established but there are plans to begin work in this area soon.

- 5. Are there current grant opportunities for other states to implement 6|18 initiatives?**

The 6|18 initiative does not currently have a designated grant program for state implementation. However, some of the CDC programs involved in the 6|18 initiative are working with their state grantees on how to engage state and local insurers, including state Medicaid programs, on implementing 6|18 interventions. States will also benefit from the tools and resources on the www.cdc.gov/sixeighteen website. Additional tools and lessons learned will be added as they are developed.

- 6. Does CMS know about this CDC initiative? Have they shared this info with the state Medicaid programs so they are aware of it and ready to partner with Public Health?**

CDC has been engaged with CMS from the inception of 6|18. CMS has provided guidance and consultation throughout the development and will continue to do so through the implementation of this initiative. CDC is working closely with 7-8 state Medicaid programs and departments of public health who have demonstrated success in implementing 6|18 interventions and have state leadership that are interested and supportive of building on that success. Lessons learned from their implementation will be shared with CMS for future coordination and rollout to a larger group of states.

- 7. Which states were funded for the 6|18 initiative? When was the FOA released?**

There is no direct funding to states nor related FOA. CDC is working with 7-8 states to provide technical assistance on implementation needs.

- 8. How will CDC monitor the degree of adoption of the evidence-based interventions and the impact of their adoption on the six priority health conditions?**

The 6|18 evaluation plan covers a spectrum of evaluation activities including quantitative measures, qualitative measures, and health and cost outcomes. For example, CDC and its partners are working closely with state public health and Medicaid programs to set specific measurable goals for their partnership with the 6|18 Initiative and will track state-led implementation of these efforts and support modeling to project the impact on health and cost.

Additionally, CDC is working initially with a number of large commercial health insurance companies, and will monitor uptake of the evidence-based interventions and their impact on the priority health conditions as pilot projects are developed, implemented, and evaluated. We intend to share the lessons learned through various trade and member associations and hope that these interventions are then scaled within other commercial health insurance companies.

Also, through a collaboration with the National Association of Community Health Centers and the Health Resources and Services Administration, CDC will stay abreast of successes and challenges related to the delivery of the evidence-based interventions in community health centers including the role of community health workers.

Questions for Rhode Island:

9. Would you elaborate about how patient-centered home visits can help in tobacco cessation activities?

The Rhode Island program is not specifically designed for home visitors to provide tobacco cessation counseling, but they do have a program where tobacco cessation counselors are embedded in the community, specifically through community health centers that provide group face-to-face counseling. However, they don't have that model happening in the home. The patient centered medical home (PCMH) provides a structured model that looks at how to connect the person in the clinic to address the needs they have in the community, because we know those social determinants of health are what are actually determining their health.

10. Was the home-based asthma response program (HARP) under the umbrella of HRiA's HCIA award?

Yes. HARP existed prior to Health Resource in Action's HCIA award, and was one of the primary asthma home-visiting models aligned with other models to create the standardized template used for the New England Asthma Innovation Collaborative (NEAIC)

11. Do you have any information on how to get certified asthma training for our home visiting staff?

Home visiting staff can become AE-Cs (certified asthma educators) by taking the national certification exam from the National Asthma Educator Certification board (NAECB). We sponsor prep-course trainings for the exam using the American Lung Association's curriculum for the Asthma Educator Institute.

For additional asthma education resources to be used with CHWs in home visiting, check out [NHLBI's asthma manual and video: A Breath of Life/Respirar es vida.](#)

12. What costs were included in the return on investment (ROI) analysis for asthma home visits - include professional, material, and administrative costs, and transportation time?

All the programmatic implementation costs mentioned were included in the ROI analysis of HARP. The only costs excluded were the evaluation and initial start-up/training costs.

- 13. Rhode Island's high level decision (at the Governor's level) to shift Medicaid from volume based to value-based seems to be a critical background piece to achieving success in RI in relation to 6|18 to date. Are there lessons learned from RI on how this high level of impact might be generalizable to other states?**

We need to make sure that all elements of those high levels are communicating as actively and consistently as possible. There is such great work going on and the governor has set the bar high, so the staff have to catch themselves from going too far down a path in that great work (e.g. reinventing Medicaid, Workgroup for Healthcare Innovation, or RI's Health Equity Zone work). Need to keep consistency in messaging. For example, when they talk about the Population Health/Behavioral Health Plan, the work through Rhode Island's State Innovation Model (SIM) Grant is charged with, they made sure to make that the same plan that the working group for healthcare innovation used, as well as the same plan required by the legislature from a healthcare capacity standpoint. By actively making sure the same plan is used throughout that helps them develop better structures (e.g. PCMH, community health teams) and moving those structures forward with consistent communication, especially between Medicaid and public health agencies. Connecting the dots to make sure things are moving simultaneously is the most important lesson learned.

- 14. What was the change that RI made to program eligibility requirements with regard to the number of ED visits experienced?**

Initial eligibility was for any asthma-specific ED visit. The change Rhode Island is recommending is to restrict eligibility to 2+ asthma ED visits or an asthma in-patient hospitalization.

- 15. Is Medicaid helping pay for the community zone organization? If so, how? On what basis (e.g. without connection to individual beneficiaries)?**

No, funding for the Health Equity Zone initiative currently comes from four different federal grants.

- 16. Does Medicaid cover the cost of the asthma home visits?**

Not currently, although implementing Medicaid coverage of asthma home visits is a goal for Rhode Island's participation in the 6|18 initiative. Part of the previous grant funding for the HARP program (through the regional NEAIC) was from a CMS Innovation Award.

- 17. Impressive cost/benefit data for the asthma initiative. How is this avoidance of ED visits a quality of life improvement for the person with asthma?**

Our initial looks at conducting an ROI cost/benefit analysis did include factoring in quality of life improvements, based on a formula provided by CDC. Evaluation of program impacts also included measurements based on quality of life surveys. However, the cost/benefit evaluation presented on the call was solely based on costs of implementation and actual reductions in utilization costs, rather than attempting to assign a financial value to quality of life

18. How are you defining "intensive self-management education" within the Asthma Initiative?

We follow the CDC National Asthma Control Program's definition, which is based on the asthma guidelines.

19. How have you been able to sustain funding for the community health worker role in your work in Rhode Island?

Sustainable funding for community health workers has been a challenge, and is something that we are working on addressing through having standardized core competency CHW certification through the RI Certification Board, and collaborating with the Office of the Health Insurance Commissioner to align CHWs with the statewide SIM initiative and community health team efforts.