Delta Center Learning Session:
Community Health Worker and Peer Support Specialist Workforce Policy: Insights from Sandra Wilkniss

Rachel Tobey (Delta Center) [00:00:00] And with no further ado. Sandra. Welcome back.

Sandra Wilkniss (NASHP) [00:00:03] Rachel, thank you so much. And hi, everyone. I'm delighted to be back. And I'm just so delighted, about the nature of the work that you all have undertaken here in the Delta Center writ large. And those of you around the screen, it's so, so important. And I hope to, inform you a little bit by taking us back up to the state policy level, which is where I function currently. And talk about two types of workforce. And I'll start with community health workers, because we've been very deep in this space. And I think that is probably applicable to a lot of the, you know, thinking that you all are doing around how to expand access and how to reach into community. And we'll talk a little bit, too, about peer support, policy trends that may be of interest to this group. And again, I'll be talking state level. But I'm hoping to bring to you some policy that may really be instrumental in the work that you're trying to drive, as association partners and on the ground, with, with the providers you represent. Next slide please. And thank you all. Delta center for driving slides.

Sandra Wilkniss (NASHP) [00:01:06] So Rachel already mentioned National Academy for State Health Policy. In short, all the work we do, we're nonpartisan, and nonprofit. And we all the work we do is to support state health policymakers and everything they need through deep technical assistance, through, through writing, through connections and convening and so on. So that's us. Next slide please. And this is how we advance our mission. I don't think I need to spend a lot of time here. If if it's of interest to you, here it is. We can always come back to it. But I know I'm a fast talker too, and I have a lot to share, so I'm trying to slow it down. So let's skip this slide and get to the meat of probably what you'd like to hear.

Sandra Wilkniss (NASHP) [00:01:46] Okay, I'm going to start with community health worker policy. And what's really interesting is I just came off a meeting yesterday at the New York Federal Reserve. Right. And it's really interesting that they were hosting me. One of their three pillars in their community investment is health. And they're really, really jazzed about investing in community health workers. As, as this workforce, that both helps create connection and link to community to drive equity and also to, understand that that workforce is part of, you know, building a new economic engine, in the community. So it was a super cool meeting, happy to share more and Q&A. But it really, you know, revitalized our thinking here in the work that we're doing.

Sandra Wilkniss (NASHP) [00:02:29] So why and how is NASHP in this work we've been doing? We've been and we do a lot of state tracking. So if you've ever seen our website, I'm happy to share that. I think the tracker is in the last slide. So you can look at some of those, but we track a whole bunch of stuff that's happening in terms of state health policy. And we've been tracking community health workers state policy for a while. And then we decided, okay, the state officials are really jazzed about this. Of course, coming off of Covid, this workforce was so instrumental and in all of the community engagement work, and there was really a renewed interest. So we pulled together a roundtable discussion.

And that led to what, what we call a state policy learning collaborative, which we thought, okay, it's going to be a dedicated set of folks who really care about this issue. It turns out that we have most almost all states represented, because there's such an eagerness to really be smart about state policy and partnership in this space. And we've been meeting them ever since, every couple of months, when we talk about all kinds of issues, it's anchored a lot in Medicaid policy. So we have a lot of Medicaid folks, really trying to understand how to leverage Medicaid in this space. And also do a lot of thinking about cross agency, whole of government approach to partnering with community health workers and building that muscle.

Sandra Wilkniss (NASHP) [00:03:44] And then what I think what might be really interesting to you all as well is we we decided, okay, we've heard a lot that they want to co-design policy in partnership with community health workers. That's you know, we're usually at 30,000ft. That's not a space we dive into a ton. But what we decided to do was develop these in state technical assistance projects where we and it was a competitive process for states to apply. And the idea was, let's help you set the table. We're state officials, community health workers and partners and, and, of interest to you all. And you probably already know this. A lot of primary care associations are really instrumental in helping to build, and develop community health worker associations in the states and those networks of community health workers. So oftentimes the PCAs were at the table as well. And we had these convenings we brought people together and learned so much about the opportunities and challenges for co-designing policy, with a workforce that, for a lot of reasons, has never been deep in the policy weeds, certainly not talking Medicaid, coming to the table to help do that. And I'm happy to share more insights there. But that's sort of our trajectory. And, and, I would say, you know, our credentials in terms of the work we've been doing in this space. Next slide please.

Sandra Wilkniss (NASHP) [00:05:02] Okay, I already discussed all this. These are just links to the tracker I mentioned. Link to, some issue briefs, and you can see a few others that we've developed there that's really around, Medicaid policies. What what do state Medicaid plans look like? And we're just about to issue an update because it's such a fast moving place, space that we're going to issue a frequently asked questions and an update to what this the state, Medicaid environment looks like. And I already told you about this stuff. And I'm happy to share more about the six states a little bit later. Next slide please.

Sandra Wilkniss (NASHP) [00:05:38] Okay, so here are some of the national trends. Tons of interest in Medicaid. And I'll show you a map in just a moment and try to break down for you a little bit about what the Medicaid space looks like. And this is really coming off the heels of right, the end of the big Arpa and Covid dollars, and in CDC investment and HRSA investment in this workforce, it's, you know, there's a big cliff coming. We're heading towards that. You know, there's some extensions to some of this on the state side, but it's coming fast. And so there's a ton of interest in financial sustainability of the workforce. So that's a big push. So what can Medicaid do? As you all may know. Also you know there's now Medicare is in the game. And I'll give you those details in a moment. But also what is this whole of of government braided funding approach. So you'll see aging agencies are investing in community health workers, departments of labor. Like how do you knit all that together to have a really smart, investment approach?

Sandra Wilkniss (NASHP) [00:06:33] The other key issues that come up and we have a lot of detail here, but I'll just hit the highlights, is that half of the states recognize or administer some sort of certification program. It's almost it's almost invariably voluntary. So that's an important factor to lay out there. But that that's a growing area as well. And,

there's a strong need to define the workforce specifically, the lived experience component. This is a space where some, some mandatory dollars are coming in, and there are all kinds of folks, you know, clamoring to get in this space to say we are also community health workers because of X, Y, z reasons. So there's a strong desire to define that workforce. Next slide please.

Sandra Wilkniss (NASHP) [00:07:19] So this is just our map cheat sheet. And again you can go to the tracker and actually drill down into what each individual state is doing on definition certification, Medicaid strategy and so on. But hopefully this gives you a bit of a snapshot. There are 24 states that currently reimburse community health worker services through Medicaid. Eight of those are on a fee for service basis. Six through managed care. About nine. There are different managed care strategies, and I won't go into the weeds on some of these. Five states use both fee for service and managed care approaches. And then I think would be what's probably of great interest to you is that this is an emerging area: four states pay for community health worker services in FQHCs outside of the PPS. California does that through a sub capitated arrangement. Louisiana has a carve out, Rhode Island as well. And Nevada is also fostering some of this. And this is an emerging space, right. Is how do you how do states partner better with their FQHC partners to really help, you know, be in this network of supporting in a sustainable way CHW partners.

Sandra Wilkniss (NASHP) [00:08:26] So by far the most popular thing right now are state plan amendments. So that's what you see here and and in fee for service. And in part that's because it's it is unknown to the Medicaid program how to think about this benefit. You know, Medicaid directors are always worried about opening the floodgates. I'm here to tell you that has not happened in the community health worker space that we can talk about. You know, what, some of the challenges are there. But, so they're dipping their toe in trying to understand this workforce, the benefit and how to shape it going forward. So it's really this, you know, this first foray into that space. Having said that, some of those states with the big 1115 demonstration waivers that health related social needs waivers, I hope I'm not using acronym soup too much, but I think everybody on this screen knows what I'm talking about. Are also building in some of these services and supports in a in a more creative way. Next slide please.

Sandra Wilkniss (NASHP) [00:09:25] Okay. The only other thing I'd like to emphasize is what are some of the codes? There's a certain family of codes that's used relatively frequently. Again, you can look at our tracker, but there's a growing use of preventive, preventive services, in trying to broaden out the codes that are available for use for services. And, and the Medicare, the new Medicare rule will help do that as well. I think I have that on the next slide. Or maybe I don't. I probably have the 11/15. Okay, I'm getting to Medicare. So these are the 1115 waiver. That's okay. Go ahead and go ahead and go to the next slide. These are the states with 1115s that also include community health worker services. And you go to the next slide. Okay. And here are just a couple of examples of how that works. And I we'll read to you. I'm sorry. I know that that's kind of annoying, but in New Jersey, they have a pilot program that earmarks 25 million over the five year period. In order to support these services and evaluate. I mean, this is a really important piece of it. There's limited there's some strong. Research around return on investment and in specific models of community health worker services. But there's states need their own measures of how is this workforce actually contributing. And then Georgia as their resource mothers program as well. Next slide please.

Sandra Wilkniss (NASHP) [00:10:55] And these are the states with managed care approaches. And you'll, you'll get these slides so you can go back and take a look and dig

through the tracker to get into some details that the whole idea of this is just to tell you, this is a fast moving train, and states and plans and other partners are getting on board. Next slide please. Thank you Jen. Okay. Medicare. This is the you know, this is a big, of course, whenever Medicare does something, everybody's watching to see how it actually affects the whole health system, health delivery and payment system in their 2024, final rule, physician fee schedule rule. They added through something called the community health in agree. And I, I apologize if you guys already know this. I'll just be brief. The community health integration, program initiative and the principal illness navigator. I always get that wrong. The PIN initiative. They added that a certain types of workforce, including peer support specialists and community health workers, can actually provide services if a physician directs them to do so. And of course, that really, changes the landscape in, in the health delivery system when Medicare puts their foot down. They've been very, I think, accommodating around standards for this. And they have decided if a state has certification put in place for certain training requirements, we're going to go with that. And otherwise we'll, we'll rely on, what's called the C3 principles that are sort of long standing ideas around, sort of, core competencies for community health workers. What's, you know, how are we trying to understand this? Of course, since we work often with the Medicaid program. And how might this affect people who are duly eligible for Medicaid and Medicare and also just generally continued, you know, the continuum of services and support? Happy to share more about that, but that's a big change. Next slide please.

Sandra Wilkniss (NASHP) [00:12:53] Okay. Just a few key issues. And again, we can dig into any aspect of this that you want. You know, these are really hot topics is whether to certify how and and who's doing it. What's really important is some of these key topics that come up. One is the work experience pathway rather than, testing and training. If people have demonstrated that they've been doing community health worker work for the last 20 years, that counts towards certification. And some states have taken that approach. Also understanding that there are volunteers in this work and really trying to drill down into, diverse educational and training providers, a lot of these are community college and, you know, sort of the usual suspect partners around workforce development. And then some are initiated or lead training opportunities. Big issue, is a real reality background check requirements for community health workers. This is coming up, even more, frequently lately because of the new reentry opportunities in Medicaid. There are a number of states have been given these approved waivers for Medicaid coverage or people prerelease from correctional settings or justice involves populations there and community health workers is seen as a really important workforce in that work as well. And then it's really just about the money. Who's going to pay for it and who's going to run it? Next slide please.

Sandra Wilkniss (NASHP) [00:14:24] Couple of highlights here. For those of you who are tracking this. And that is there are some states that are actually where the certification process is created, led and administered by the Community Health Workers Association. So South Carolina is a really good example of that. In Rhode Island they have a third party doing it. So it's not state owned. It's not a top down opportunity, but it's an opportunity to really put your money where your mouth is in terms of these partnerships. And then, others are doing it through the state like Texas. Next slide please.

Sandra Wilkniss (NASHP) [00:14:57] Okay. This is something that you probably have some awareness of that these community health workers associations that are not everywhere, there are some that are very robust in states, and there is a real interest in developing them further. And as I noted before, a lot of primary care associations are in the business of helping to develop this, these associations. And the idea here is that is to to make sure that they're sustainable in their own right, so they can actually really be

effective partners, in co-designing policy implementation strategies and just overall targeting and partnership strategies as you're trying to reach certain communities. How much you pay them makes all the difference. Really quick anecdote here is a lot of the payments are low. But, there are some states that are trying new things, like South Dakota is actually a leader in the community health worker space, and they have changed their payment rate from, I think, 30 something dollars to $64. And they're they're seeing a big uptake now. So there's there's some states are trying to get really creative about really paying people for the work that they're doing and also creating these career ladders. And I talked to you about some of these other issues. And we can come back to these. Next slide, please.

Sandra Wilkniss (NASHP) [00:16:15] Okay, here are our resources. I meant to put them at the end, so apologies for that. I do think I have another slide at the end. If I sent you the right deck. Okay. Next slide please. I wanted to shift over into, the peer support workforce. I think you all have had a lot of conversations about peer recovery coaches, peer support specialist. And I just wanted to hit a few highlights on on policy trends in the states. Next slide please.

Sandra Wilkniss (NASHP) [00:16:43] These are the reasons, right? These are. This is the context within which, states are really eager to build, unlicensed workforce with peer support, specialist recovery coaches and, like being being out in front. In terms of the behavioral health work. And none of these are new to you. So I don't have to go through them, but these are really the motivating factors that are driving this. Next slide please. Okay, so you all know this, a lot of investment in in here support. I would also say that, from the community health worker standpoint, those are deep in the weeds in that policy space. They look at peer support specialists and the advances that have been made in this space. And they say, okay, they're ten years ahead of us. We want to kind of follow in their footsteps with a few caveats. But these are kind of the investments approaches, in terms of expanding the peer support workforce, using block grants, investing in education, training, technical assistance, a special focus on rural and underserved areas, and then, a number of approaches that really look at, how to effectively engage the workforce in conversation through committees, through work groups that states are leading. But actually, I think, working hard to put their money where their mouth is in terms of genuine lived experience, being part of the discussion. And then all of these workforce extenders, how does this all align? And that's, you know, that's a ten hour conversation in and of itself. Really, how did the talent digital pieces align with all of this? Next slide, please.

Sandra Wilkniss (NASHP) [00:18:21] Okay. So where where are we seeing a lot of action, a lot of action in the crisis space? In large part coming out of the pandemic, these are examples of where peer support specialists play a role. There are many other example. I just wanted to throw a few out there that I'm sure you're well aware of, but wanted to just be a reminder of how the states are looking at it. Peer to peer warm lines. In New Mexico. Colorado is a leader in that space as well. Minnesota covers peer services as part of mobile crisis teams. That's a growing area crisis stabilization units and and that and helping with handoff and transitions across the continuum is really critical. Michigan's focused a lot on that. And then, Virginia and many other states are working hard, with managed care partners, to really create contracts that honor, and create access, additional access to the peer support specialists. Next slide please.

Sandra Wilkniss (NASHP) [00:19:22] This may be new to you. The next slide will be probably newer to you. We have a team at NASB that tracks and supports across states, those officials who were required to think about how to distribute the opioid settlement

dollars that states are responsible for. Here are just a few examples of how states are investing using those dollars to invest directly or to braid funds, which is more typically, how they intend to approach it in peer support and recovery support staff and specialists. Indiana spending plan is one of the robust ones here. I again, I don't have to read it to you, but lay out uses for 50 million of $50 million of it. Now, the other thing to remember about these settlement dollars is they're a very long period of time. But some of this is being frontloaded recognizing that this significant need for workforce in the behavioral health space. So in Indiana's plan is laid out for you there. Kansas funded it, put a large amount of money into recovery and focus on recovery services. Kansas is also really drilling down on their CCBHC approaches, right? And trying to connect the dots with these kinds of investments and building out their continuum of care. And the New Jersey you have there as an example of their opioid abatement, report work, that they have invested 17.5 million, in expanding operations at peer recovery centers. Other state examples are listed there as well. I'm going to and I think I did this in the last slide to link to that tracker or sorry, there's a report that just came out from us that details all of the spending that's coming out of the settlement states. Next slide, please.

Sandra Wilkniss (NASHP) [00:21:12] Okay, I just throw this in here because I can't talk about peer support services without mentioning Georgia. I'm sure you all have heard about Georgia's work there. They're among the first, right? To really delve into the peer support space. They got approval from CMS for, you know, building this workforce. And the only reason I wanted to highlight it here is because they're very creative in creating, a wide, wide opportunity for peer support specialists to engage in all aspects of service delivery. And here you see in the blocks and this is from a slide deck from Wendy Tiegreen. And she, she allowed me to use it. You see in the blogs all the ways in which peer support specialists engage in services and around what topic areas, and I won't go through each of these. I will say they also have done a really lovely crosswalk of the services through Medicaid. And then the on the Y axis is all the kinds of service providers who can provide those services. And included in there are all the peer support and recovery support specialists and they walk across the services. They also have different levels that that I think point to a career ladder opportunity, but also recognize when, peer support specialists are have additional credentials, or licensure or the like and how they can deliver services across the state. They're doing the same thing for community health workers. We keep trying to tell other states, do this mapping. So you see where the need is and where these different provider types can function. Next slide please.

Sandra Wilkniss (NASHP) [00:22:45] Okay, well, I think I have two more slides. I just wanted to flag, I, as, Rachel noted, I am a clinical psychologist, and before I got into the policy work, community behavioral health was my my passion, both in terms of research and practice and administration. And I work for a place called Thresholds in Chicago. That was really I didn't realize this at the time, but really was at the leading edge of providing, the kinds of services people with serious mental illness and substance use disorder need to live like a home, a job, and a friend kind of services. And they, in there, I learned that how critical it is to support peer run organizations and doing this work. So I just wanted to put a shout out to them. And one worth flagging that's really making some waves is, is People USA. And I should ask people if you know this stuff because I feel like I hate repeating things you already know. But they they are doing a great job. This is an all peer-run organization, and they do a terrific job of helping people understand what value they're bringing to the system and working with state governments in order to support more of this work. And I'll let you look at the I just thought this was a really nice slide that they put together that identifies their value in terms of the people that they serve and, and the value to those people. But also, of course, you know, speaking to the folks who care about this,

the money that is saved. So that's so if you ever have a chance to look at People USA and other consumer run organizations and the value that they're bringing to the system. Next slide, please.

Sandra Wilkniss (NASHP) [00:24:23] I think this is the last thing I wanted to highlight. And you probably already know this, but a really and this slide just is actually an old map of our community health worker work. But what I wanted to emphasize is that a number of states are really trying to think about how to weave together community health workers and, and people with lived experience of mental illness and or substance use disorder. Right. So marrying peers and community health workers and what that looks like from a policy and implementation and building out the workforce standpoint, some states are doing things like cross trainings for people or for people who identify as all of the above. And how can they actually make a difference in really plugging the holes in the the shortages slash poor distribution of the behavioral health workforce to achieve what we need to get done? Okay, I talk too much. I'm going to stop there. I'm happy to I, you know, identify, you know, or talk through any questions you have.

Rachel Tobey (Delta Center) [00:25:22] Sandra, I have a question of in your collaboratives and looking across Medicaid waivers and SPAs and all that sort of thing, are there states where they're actually trying to get CHWs and peers to work together on care teams in order to meet client needs? And I'm just curious if you have any stories about that happening from both a practice standpoint, but also then how they're braiding together the dollars to allow that to happen.

Sandra Wilkniss (NASHP) [00:25:53] Yeah. Yes. Thank you. I, I there are probably more than I can reflect here today. The one that stands out to me most is New Jersey because they've shared with us their cross training program. And I don't think I don't think they're braiding together any funds to really create, intentionally create a network. It's more a recognition that people may have multiple forms of lived experience. And how do we actually harness all of that? Having said that, and I'm going to blank. I'm so bad at names, one of the SAMHSA regional directors, and it'll come to me in a moment or I will share it back with you. Has been facilitating I want to say it's cross, but so that the the New England region who knows the regions. I will share this information with you. She has been facilitating for a long time regionally, conversations among community health worker leaders and peer support specialists about just this thing as how do how do we build a network? What do we need? What does the federal government need to do, what a states need to do in order to foster more of this, so that you're actually building out a network of of folks who have different specialties that they're bringing to the equation. So I can, I can let you all know her name and what reason she's with. I'm just really bad at names. So I think that's probably one of the best examples.

Sandra Wilkniss (NASHP) [00:27:11] But a lot more of this needs to be done. And this is where the associations I think are really important in the mix is because you're already, you know, there's already a lot of support going on to help build and develop this workforce, and it may not be all linked. Right. So the question now is how do you marry those efforts and really support a network of community based support specialists, and people lived experience that really build out what you're trying to achieve and actually get us closer to prevention rather than just treatment. Right. I think the associations play a key role there. So that's my charge to you is to do it there and lift it up and say, states, this is what we need you to do. Funding, regulatory, you know, loosen regulatory requirements, administrative simplification, whatever, in order to foster more of this, because there's a real hunger and energy at the state level to do more and to do it in a smart way that

actually results in services on the ground. That's where the disconnect is. Big levers being pulled at the state. There's a disconnect with services on the ground.

Rachel Tobey (Delta Center) [00:28:14] I'll ask another one. Sandra.

Sandra Wilkniss (NASHP) [00:28:16] Okay.

Rachel Tobey (Delta Center) [00:28:17] So one of the things that we've heard can happen is a state celebrates, oh, we're now reimbursing for community health workers, but the amount that they actually are reimbursing is abominable and is not commensurate with a living wage. And I'm curious if you can just comment on, you know, a la the South Dakota story, any efforts where you've seen successful advocacy for actually raising the living wage and sort of commensurate with the value that everybody agrees is being provided by both peers and CHWs but that sometimes when it comes time to write the check, they're like, well, we did it. But then people are saying, oh, you know, the floodgates aren't open because you are only reimbursing, you know, $25 or something for an encounter.

Sandra Wilkniss (NASHP) [00:29:15] Yeah, it's a tough one, right? Like all things in Medicaid, nobody's getting paid enough. So that's number one. Let's just take the Medicaid side for a moment. But, but I would say areas of opportunity: Medicare is in the game. Medicare just has higher rates for everything. Right. So that's number one. Right. They're going to be out there and Medicare Advantage plans and others are going to be taking, you know, advantage of that. So Medicare is in the game. I think we have, there's a program called Impact, and, it's an accreditation. It's a program for which they're setting standard for employers, and that will require some accreditation. There are mixed feelings about accreditation in the community health worker world. So I want to be I want to level set on that. However, they have a lot of research, a lot of talking points, a lot of ROI, information that can be brought to those kinds of conversations. So I will flag that. So look them up. Impact there at UPenn.

Sandra Wilkniss (NASHP) [00:30:16] And. Otherwise. This is part of the reason the New York Fed was having this conversation. And it can't just be our mandatory programs because we know what the challenges are there. There's got to be a concerted effort to understanding the value. So the other thing they were raising is, what about the commercial insurers? Now, the tension has always been community health workers tend to work with people who are in the safety net. Right. That's kind of the goal. However, if you can make the case that it's now about building community resilience, right, or through, what I think Oregon Health Sciences University has done something with, their employee program. So in replacing the EAP with Community Health Worker Services and paying them a higher wage has been a success. And I can give you the details on that. I have to look it up. Has been an interesting angle here. So there are different players to bring into the mix. Right. And as we move along in parity. Right. That's another lever to keep in mind as we think about bringing the commercials in, whether it's peer support specialists or community health workers or some combination of that. But, the other thing I wanted to say is the Federal Reserve is asking, so now we're talking about money from banks and CDFIs is and right, these other sources that often invest in place based strategies. And I think that's another place to look. So I wouldn't put all of our eggs in the Medicaid and Medicare basket. And then again, like I said, and of course, the conversation on a whole of government approach to this thing.

Corina Pinto [00:31:49] In all of these examples you've provided, have you seen kind of like a really because there's also like you named tensions within the quote world in terms of clinically adjacent in the community. But like, have you seen some really good coalition building that has helped, that has brought in more than just like the CHW, you know, state program, but also associations and other types of organizations to come together and help move this along. And what would be kind of the best example of that?

Sandra Wilkniss (NASHP) [00:32:26] Best example? I don't know the answer, the best example, because it's also historical. And that's why, I guess I would point you to Massachusetts and Rhode Island for historical examples. Alaska has done a lot of this recently. I would say there is also an appetite for like the Primary Care Association to help launch it and then no longer be part of it. Right? They want to become freestanding, sustained, self-sustaining entities that can partner now in a in an equal way with some of these others, with the other associations. So that's a sort of an emerging space, too. Alaska has done a good job with that or starting to.

Sandra Wilkniss (NASHP) [00:33:12] And for a whole of government strategy with really, really vocal and long standing community health worker spaces in the state. California has done a very good job, actually, I think from a state perspective to recognize where policy may have gone in the wrong direction and take a step back and bring in the community. It's not always right, but in 1 case, when we work with them, that was the case, which is, I thought was really pretty powerful. So advocate for that to.

Corina Pinto [00:34:02] I see, Randy, you're putting some stuff, some.

Sandra Wilkniss (NASHP) [00:34:05] Patience.

Corina Pinto [00:34:06] In the chat. Thank you. Yeah.

Sandra Wilkniss (NASHP) [00:34:07] Look at our tracker. We've got the codes all throughout. Which code states are using. If that's useful to you. It's usually that same family, right? It's usually three codes in that family. No not in the G codes. Oh that's for the yeah. Yeah that's for the community health integration. But there are usually three different in Medicaid. They're usually three different codes and states for using.

Corina Pinto [00:34:35] Any final questions for Sandra? This has been so informative and incredibly helpful. Sandra, thank you so much. I want to just reference, do we have any other like additional slides to share with Information team, or we're going to put an evaluation link in the chat for you all to fill out. So please fill that out. We'll have space to share any more additional questions that you have. And do we have the link for the email? Okay, great. But thank you again, Sandra, for all your help, in bringing all these different pieces together. We're going to have a recording of this and we'll share it out to the rest of the states, although we had really good representation today. And we will pass out those links, the slide decks and any of the links that Sandra has shared in this chat. We'll make sure we collect all of those and share it back with you all. But thank you so much for being here. Does anyone have any closing thoughts for Rachel? No, just a note of gratitude, Sandra, for all your work at night. Ashby and the trackers are great. Really helpful resources. And I highly recommend to anyone who hasn't looked at them yet to take a peek because they can be. We've seen them be very helpful for states that say, oh, I'm the, you know, one of ten states that's not doing this already. Okay. Like talk to me. It it can create some momentum and some weight when states know that other states are doing it. So. Really grateful for your work.

Sandra Wilkniss (NASHP) [00:36:28] Well, thanks for inviting me, I appreciate it. And, terrific work through the Delta Center. And I wish that we can have celebrations when we end grants, too. I'm going to take that up and use it for myself to thank you all. And feel free to reach out if you have other questions or if I can give you more information.

Rachel Tobey (Delta Center) [00:36:48] Take care everybody. You all later. Bye bye. Thank you.

Corina Pinto (Delta Center) [00:36:51] Bye.