The Promotor(a) Model and the Affordable Care Act: Promoting Health Education while Reducing Healthcare Costs
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The Promotor(a) Model & Accountable Care Structures
Our Mission
Migrant Health Promotion provides culturally-appropriate health education, outreach and sustainable community development to farmworker, migrant, border, and/or other underserved or isolated communities throughout the nation. Through increased knowledge and skill building, individuals and families are empowered to live healthy lives.

Strategic Plan: 2011-2015
- Engage in policy discussions to support our mission, including defining and evaluating MHP's role at the national, state, and local levels in the development of Accountable Care Organizations (ACOs) and Health Care Reform.
- Continue expanding and ensuring holistic services to populations served by our mission nationwide.
- Broaden and diversify the funding streams for programs that fulfill our mission.
- Establish integrated, comprehensive national trainings to support Promotora Models as Programs in appropriate settings.
Staggering Statistics in Healthcare

We are spending more and getting fewer results than other countries.
A group of health care providers who give coordinated care, chronic disease management and thereby improve the quality of care patients receive. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

What is an ACO?
They provide leadership, peer education, support, and resources to support community empowerment.

As members of minority and underserved populations they are in a unique position to build on strengths and to address unmet health needs and disparities in their communities.

They integrate information about health and the health care system into the community's culture, language and values system, thus reducing many of the barriers to health services.

**Promotores(as) produce results because they are:**

- **Culturally competent** - successfully addressing cultural differences that inhibit access to health care and information.
- **Accessible** - living and working with the people they serve.
- **Expert** - knowing intimately the strengths and challenges of their community and which strategies will work best.
- **Sustainable** - serving as a resource to their communities over a long period of time.
Section 5101: Promotores(as)/CHWs defined as “primary care professionals.”

Section 5313: Authorizes CDC grants to promote the community health workforce, “...to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.”
Patient-Centered Care
- Appointments when needed
- Support when needed (e.g. transitions between health care settings)
- Coordination between patients and providers
- Health Information Technology
Health Care Delivery System

**Current System**
- Fragmentation
- Focus on “doing”
- One-to-one care
- Misaligned financial incentives
- Focus on volume/intensity

**ACO System**
- Integration
- Cooperation
- Focus on managing a population
- Team-based care
- Aligned incentives
- Focus on quality and efficiency
In the traditional payment system, providers are paid more if patients have more procedures and tests.

In an ACO, if patients’ health care costs go down but health care quality stays the same, the ACO gets to keep a part of those savings.
- Creates a financial incentive to keep patients healthy.
- Creates a decrease in hospital and urgent care admission/readmission.
ACO Quality Measures

- **Improve Care For Individuals**
  - Patient Experience
  - Care Coordination

- **Improve Care For Populations**
  - Preventive Health
  - Chronic Population Management
Example: Medical Home

A Patient Centered Experience
High Blood Pressure Intervention


Brest Cancer Screening Intervention

Denver Health System

- N= 590
- Outreach by Promotores(as)
- They Decreased:
  - Total charges by $300,000.
  - Uncompensated charges by $206,485.
  - $95,941 in Savings Annually
  - ROI = 2.28:1

ACOs & The Promotor(a) Model

- Greater need and opportunity for involvement of Promotores(as)/CHWs in health care settings.
- Continuity of care.
- Ensures trust between patients and providers/facilities.
- Help patients navigate a new health care system.
- Provides culturally competent health care delivery.
- Decreases language barriers.
- Provides appropriate health literacy to patients.
- Motivates patient/doctor communication.
- Increases patient compliance for a healthier lifestyle
- Reduces healthcare costs and creates cost savings at multiple levels.
Objectives

- Diabetes Impact
- Definition and Role of CHWs
- Patient-Centered Medical Home
- Diabetes Self-Management Education vs Diabetes Self-Management Support
- My Health Comes First/Mi Salud es Primero Diabetes Program at Alivio Medical Center
- Lessons Learned
In the mid-1980s, Carmen Velásquez, Alivio’s founder and only Exec. Dir. Troubled by the medical needs of local residents living in Pilsen, Little Village and Back of the Yards.

- 1989: 1st clinic opens
- 2000: 2nd clinic opens
- 2007: dental clinic and 1st school-based health center
• 98% pts fall at or below 200% fed’l poverty level
• 97% are Latino, predominately Mexican
• 70% prefer to be served in a language other than English
• 71% pts have not completed high school
• 2012: 26,297 pts; over 121,061 pt visits
Diabetes Impact

- 23.6 million people in the United States
- 7th leading cause of death
- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 - 4x
- Leading cause of kidney failure, lower limb amputations, and adult-onset blindness
- In addition to these human costs, the estimated total financial cost of DM in the US in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.
- In the U.S., Latinos, American Indians and AA are disproportionately impacted
Diabetes Impact

- **There is growing concern about:**
  - Substantial increases in diabetes-related complications
  - Increase in the number of persons with DM and the complexity of their care might overwhelm existing health care systems
  - The need to take advantage of recent discoveries on the individual and societal benefits of improved diabetes management and prevention by bringing life-saving discoveries into wider practice
  - The clear need to complement improved diabetes management strategies with efforts in primary prevention among those at risk for developing DM
Healthy People 2020 Goal

Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.
All the world’s cultures have a lay health care system made up of people who are natural helpers—community members whom neighbors turned to for social support and advice.
Successful program to close the diabetes disparities are built on strengthening the links between health care providers and the community members they serve.

Diabetes prevention and self-care are less dependent on “high tech” and more on “high talk” efforts that provide social support, outreach, consistent follow-up, preventative care, community and family ed, and community mobilization.
CHWs-Capacities and Contributions

- CHWs unique ability to serve as “bridges” between community members and health care services
- Connectors: b/c live in the communities, understand what is meaningful for that community, communicate, and recognize and incorporate cultural (cultural identity, spiritual coping, traditional health practices)
- Provide social support that complements health care services
- Educate providers about community’s needs and cultural relevancy of interventions (cultural competency)
ACA created the Center for Medicare and Medicaid Innovation (CMI), a $10 billion budget over 10 years, for the purpose of testing “innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.

- PCMH
- Care Coordination models
- Accountable Care Organizations (ACOs)
The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

A continuous relationship with a personal physician coordinating care for both wellness and illness

Mindful clinician-patient communication:
trust, respect, shared decision-making

- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care
Patient-Centered Medical Home

- Access to Care and Coordination
- Practice Services
- Care Management:
  - population mgmt., care coordination
- Continuity of Care Services
- Practice-Based Care Team
- Quality and Safety
- Health Information Technology
- Practice Management
DSME is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life.
Diabetes education has changed a great deal in recent years. DSME are more patient-centered with greater emphasis on ongoing support to sustain self-management gains made by pts. as a result of education.
From DSME to DSMS

• Effectively manage diabetes over a lifetime: must support the continued enhancement of self-mgmt. skills, behavioral strategies, social support, and metabolic improvements following DSME.

• Diabetes Self-Management Support.: flexible, not pre-determined, understanding “real world”, collaborative approach
By developing self-mgmt. skills in the context of the challenges that they encounter daily, patients derive direct benefits from these learning experiences and thereby increase their motivation for sustained self-care behaviors.
• **Diabetes Self-Management through Peer Support and Community Outreach with the Patient Centered Medical Home**

• Funded by Bristol Myers Squibb for 3 years
  - **Planning Phase:** December through June 2012
  - **Implementation Phase:** June 2012 – June 2014:
  - **Evaluation Phase:** June 2014 – October 2014:
Together on Diabetes® of the Bristol-Myers Squibb Foundation

↓

Peers For Progress

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Alivio←←NCLR
Partners

• Alivio Medical Center: implementation site

• American Academy of Family Physicians Foundation: program administration

• Peers for Progress: overall program leadership, program monitoring and evaluation

• National Council of La Raza: guidance cultural and linguistic tailoring, resource development

• TransforMED LLC: PCMH enhancement and practice change

• University of North Carolina: Peers for Progress Development Center, program administration
Goals: document and promote the contributions of peer support linked with PCMH in improving health outcomes and quality of life of Latinos with Type 2 diabetes

Population
- 4000 patients:
  - measure clinical indicators
- 400:
  - intensive, longitudinal study (research cohort)
  - High need patients

Demonstration project aims to improve health outcomes of the target population:
- Engagement in regular clinical care and self-mgmt.
- Improvement in self-management behaviors (e.g., prescription adherence, physical activity, healthy diet, etc.)
- Improved clinical indicators (e.g., HbA1c, BP, BMI, etc.)
- Improved quality of life
• **Inclusion criteria:**
  - Visit in the last year
  - Rx
  - Elevated A1C ≥ 8
  - Barriers to DSM:
    - ↓SES
    - Personal/Social:
      - lack of family support
      - low comprehension
    - Frequent visits to ER

Research Cohort Group of 400
Exclusion Criteria:

- Diabetes in pregnancy
- Severe medical conditions that might preclude frequent visits to the clinic
- Poor short term prognosis (expected death in <2 years)
- Serum creatinine level > 3.5 mg/dl
- Dialysis
- Chronic kidney disease: Stage 3, 4
- Active alcohol or drug abuse
- Lack of permanent residency in Chicagoland
Patient Engagement/Support Contacts

• **400/High Need Group:**
  - Biweekly contacts for 12 weeks, then monthly for 6 months until no longer meet criteria for High Need or until progress has stabilized.

• **36 Group:**
  - Regular Care (balance of approx. 3,600 patients w/ diabetes)
  - Quarterly contacts, encourage clinical care and use of resources (e.g., group classes) and self management, transition to High Need prn.
Flexible, nondirective strategies to engage patients in peer support include:

- Low demand – initial call to describe and offer services, not push to accept
- Repeat calls in 2-4 weeks (according to judgment of Compañero/a) to “check in with” not “check up on” patient
- Two-year availability to patient
- After patient is engaged, begin working on individually chosen goal from set of key (AADE 7) behaviors, health eating, etc.
Organizational Interactions

Clinical Resources — Primary Care — Compañeros en Salud — Community

- Linking to clinic & community resources
- Delivering consistent, integrated DSME
- Providing ongoing Peer Support for DSM
- Enhancing clinical care

Patient

Primary Care Delivery of consistent, integrated DSME

- Linking to clinic & community resources
- Delivering consistent, integrated DSME
- Providing ongoing Peer Support for DSM
- Enhancing clinical care

Community
What does DSMS look like for this project?

• Assist with enrollment in medical home
  o Help pt navigate systems (health, community)

• Part of health team and help with care coordination

• Provide pre and post medical visit prep and debriefing
  o Help pts. understand medical advice
What does support look like for this project?

• **Liaison between PCP and pt**
  - Access to PCP, CDE, RN for F/U and concerns re: pts

• **Ongoing support (practical, social, emotional)**
  - Assess needs, ID and address barriers to diabetes mgmt.
  - Available by phone and in clinic
<table>
<thead>
<tr>
<th>Diabetes Self-Management (DSM) Services at Alivio</th>
<th>Regular Care</th>
<th>High Needs (~400)</th>
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</thead>
<tbody>
<tr>
<td>Overall DSM program/services at Alivio - Everybody receiving same services and messages about diabetes</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Compañeros en Salud (CES) Community Events – to increase diabetes awareness, promote appropriate screening, diagnosis, and referral for/access to reg. clinical care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Primary care PCMH clinical health services (quarterly visits, care plan)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CES as a resource – CES programs &amp; encourage use of community resources such as affordable healthy food, physical activity, etc.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Open events/drop-in activities at Alivio to reach and engage patients into clinic services and diabetes support (health fairs, weekly info table is lobbies)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diabetes self-management education (group or individual)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Support groups (bi-weekly, monthly)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Individual, intensive support for DSM</td>
<td></td>
<td>X</td>
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</table>
## Patient Encounters

<table>
<thead>
<tr>
<th>Patient Encounters</th>
<th>GROUPS</th>
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<tbody>
<tr>
<td><strong>1:1</strong></td>
<td></td>
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<tr>
<td>Phone calls: CES contact pts</td>
<td>Diabetes Self-Management Education groups: series of 4 two-hour workshops</td>
</tr>
<tr>
<td>following protocol schedule</td>
<td></td>
</tr>
<tr>
<td>Clinic: previously scheduled</td>
<td>Diabetes Self-Management Support groups: weekly, ongoing 1 1/2-2 hour, semi-structured sessions. No limit on # of sessions. To begin in June 2013</td>
</tr>
<tr>
<td>encounter w/CES</td>
<td></td>
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<tr>
<td>Clinic: not previously scheduled</td>
<td>WIC: 4 times/month CES present to WIC clients, 30-45 minutes, on diabetes and the program</td>
</tr>
<tr>
<td>scheduled encounter w/CES</td>
<td></td>
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<tr>
<td>ID pt when pt comes in for PCP</td>
<td></td>
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<tr>
<td>appt</td>
<td></td>
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<tr>
<td>Info table: in lobby of clinics.</td>
<td></td>
</tr>
<tr>
<td>Pts approach table and CES</td>
<td></td>
</tr>
<tr>
<td>approach pts in waiting area</td>
<td></td>
</tr>
</tbody>
</table>
10 Primary Care Providers
Certified Diabetes Educator
Diabetes Trainer
4 RNs
Medical Assistants
Mi Salud es Primero Manager and Coordinator
9 Compañeros en Salud (CHWs)
Patients
Results to Date

- 1085 pts have been reached by a CES
- 403/472 (84%) of HIGH NEEDS (research cohort) have been reached
- 202 (19%) of all pts reached have set a self-mgmt goal
- 5,036 successful 1:1 peer support pt contacts
Patient Case Studies

- **Male, 37 y/o, dx 9 yrs ago**
  - 1st support contact 9 mos ago (10/2/12)
  - 12 support contacts with CES to date
  - A1C:
    - 8 mos ago 11.2
    - 5 mos later (4/6/13) 7.7

- **Female, 49 y/o, dx 7 yrs ago**
  - 1st support contact 10 mos ago (8/7/12)
  - 15 support contacts with CES to date
  - A1C
    - 9.7 on 5/11/12
    - 8.3 on 12/10/12 (4 mos after 1st contact)
    - 7.4 on 4/8/13 (8 mos after 1st contact)
Lessons Learned

• **Non-compliant vs unreached vs “hard-to-reach” patients**
  o Patient contacts should be flexible, nondirective but also focused on at least 1 of the 7 key DSM behaviors

• **Resistance/hesitation on part of PCPs**
  o PCPs/clinical staff actively involved in shaping of project including staff training
  o Constant updates and communication to other staff
    • All staff meetings, employee newsletters

• **Silos**
  o Support from organizational leadership

• **Support/supervision/training of CHWs/CES/peer supporters must ongoing and consistent**
  o Allow for CHWs/CES/peer supporters to learn from and support each other
¡Mi Salud es Primero!
PROGRAMA DE DIABETES
Sustaining Promotor(a) Programs through Opportunities in the Affordable Care Act (ACA)

Presented at:
2013 NCLR Annual Conference
July 22, 2013
New Orleans, LA

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Our mission is to
Accelerate best practices in peer support around the world

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✓ Improving Affordability of Health Insurance
✓ Expanding the Public Health Workforce
✓ Improving Healthcare Quality
✓ Lowering Healthcare Expenditures
✓ Reducing Health Disparities
✓ Emphasizing Wellness and Prevention
Community Health Worker

An individual who promotes health or nutrition within the community in which the individual resides:

- By serving as a liaison between communities and health care agencies,
- By providing guidance and social assistance to community residents,
- By enhancing community residents’ ability to effectively communicate with health care providers,
- By providing culturally and linguistically appropriate health and nutrition education,
- By advocating for individual and community health,
- By providing referral and follow-up services or otherwise coordinating care,
- By proactively identifying and enrolling eligible individuals in federal, state, and local private or nonprofit health and human services programs.

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Health Homes and Medical Homes

Chronic Health Homes

Awards benefits for states to establish health homes to coordinate care for people with Medicaid who have chronic conditions. States receive a 90% enhanced Federal Medical Assistance Percentage for the first 8 quarters the program is effective. States are eligible for up to $500,000 in planning funds to explore health home option.

31 states have demonstrated interest in health homes and 12 have received federal approval.

Community Health Teams to Support the Patient Centered Medical Home

States may apply for grants to establish health teams and provide health homes to support primary care practices. States may designate CHWs as qualified members of the health teams.

Not currently funded
Medicaid Expansion

The ACA has changed the eligibility thresholds for Medicaid, which is set to begin in 2014. The expansion will particularly benefit childless adults and low income parents. States have to option to comply, but most are predicted to participate. About 11 million Americans will gain coverage by 2022 through this provision.

Funding options

Medicaid administrative funds
Medicaid Managed Care Organizations
Section 1115 waivers
Patient Navigator Programs

Reauthorizes programs to provide patient navigator services to assist patients overcome barriers to health services. Employing CHWs as patient navigators is heavily favored.

State health insurance exchanges are required to establish patient navigator programs.
ACA PROGRAMS

Hospital Readmission Reduction Program

The Centers for Medicare & Medicaid Services will reduce payments to Inpatient Prospective Payment System hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.

Community-Based Care Transition Program

Tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. $500 million in total funding. Currently 47 community-based organizations partnering with acute-care hospitals.
In round two of the Health Care Innovation Awards, the Centers for Medicare & Medicaid Services will spend up to $1 billion for awards and evaluation of projects from across the country that test new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) enrollees.

CMS seeks models that improve the health of populations through activities focused on engaging beneficiaries, prevention, wellness, and comprehensive care that extend beyond the clinical service delivery setting.
Grants to Promote the Community Health Workforce

Authorizes a CDC grant program to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers to educate, guide, provide outreach, and connect patients to appropriate healthcare agencies and community-based programs to increase access to quality healthcare.

$10 million marked for new training for direct care workers
$5 million marked for demonstration projects to develop training and certification.
State Initiatives on Community Health Workers

State policy initiatives have been established in Massachusetts, Minnesota, Florida, and Indiana.

New state initiatives are underway in California, Illinois, Mississippi, New Mexico, New York, Ohio, Rhode Island, and Texas.

Healthcare reform bills that include CHWs have been passed in Pennsylvania, Oregon, and Rhode Island.
State Implementation of Chronic Health Homes

The ACA created an optional Medicaid State Plan benefit for states to establish health homes to coordinate care for people with Medicaid who have chronic conditions such as mental health, substance abuse, asthma, diabetes, heart disease, and obesity. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

State proposals for health homes have met federal approval in 12 states.
INTEGRATING PROMOTORES INTO STATE HEALTH PLANS

State Progress on the Development of a Medicaid Health Home Program

- Approved State Plan Amendment (SPA) (12)
- SPA Submitted (2)
- SPA Under Review (6)
- Approved Planning Request (9 plus D.C.)
- Approved Authorizing Legislation (2)
- No Activity (19)


Published by Amerigroup
CHALLENGES

Roles must be clearly defined so that promotores aren’t expected to do everything. The diversity of roles also makes it difficult to educate stakeholders about what promotores do exactly.

Promotores must keep their essence as members of the community and maintain peerness.

Patient-centered care requires a fundamental shift in the structure and delivery of healthcare. Large organizations can’t adopt innovations quickly. Some lack the capacity to support promotore programs.

Smaller, community-based organizations have to build coalitions to enhance strengths and address deficiencies.
RECOMMENDATIONS

Engage legislators and health departments. Joint development of CHW training protocols will increase the likelihood of receiving Medicaid reimbursement through the state.

Grant proposals should focus on scaling up evidence-based approaches. Strong evaluation measures are needed.

Program monitoring assists program refinement and enhances impact. Frequent reporting motivates program staff and secures continuing support from organizational leaders.

Promote promotore participation in research. This builds the evidence base for peer support, supports the professional development of promotores, and builds capacity.
A joint initiative with NCLR focused on developing and sharing evidence for peer support programs, best practices, effective evaluation methods, models of organizing peer support within health systems, and effective models of advocacy.

www.peersforprogress.org/npscln

The Peers for Progress website offers everything you need for program development and evaluation. In our weekly blog, we explore challenging issues and emerging trends in peer support.

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<td>Peers for Progress</td>
<td>Opportunities for Peer Support in the Affordable Care Act</td>
<td>2013</td>
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<td>Reducing Hospital Readmissions with Peer Support</td>
<td>2013</td>
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<tr>
<td>Harvard Law School</td>
<td>Health Care Reform: Opportunities for Peer Support</td>
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<td>Center for Health Law and Policy Innovation</td>
<td>Discretionary Spending in the Patient Protection and Affordable Care Act</td>
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<td>Congressional Research Service</td>
<td>Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach</td>
<td>2011</td>
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<td>Centers for Disease Control</td>
<td>Making the Connection: The Role of Community Health Workers in Health Homes</td>
<td>2012</td>
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<td>Paving a Path to Advance the Community Health Worker Workforce in New York State</td>
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<td>New York State Health Foundation</td>
<td>Community Health Workers: A Critical Link for Improving Health Outcomes and Promoting Cost-Effective Care in the Era of Health Reform</td>
<td>2010</td>
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<td>Project on CHW Policy and Practice</td>
<td>Community Health Workers: a National Perspective</td>
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<td>National Health Care for the Homeless Council</td>
<td>Community Health Workers: Financing &amp; Administration</td>
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<td>American Public Health Association</td>
<td>The Affordable Care Act’s Public Health Workforce Provisions: Opportunities and Challenges</td>
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<td>Kaiser Family Foundation</td>
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