MEETING MINUTES
Community Health Worker (CHW) Workgroup
Thursday, January 18th, 2018 10:00-11:30am
Indiana Government Center South, Conference Room 22

Members Present:

Judy Hasselkus, *Chair, Program Director, Employer Engagement & Sector Specialist for Health Care, Ag., & Life Science*, Department of Workforce Development (DWD)
Laura Heinrich, *Co-Chair, Director of Cardiovascular Health and Diabetes*, Indiana State Department of Health
Kathy Cook, *Executive Director,* Affiliated Services Provider of Indiana (ASPIN)
Margarita Hart, *Executive Director,* Indiana Community Health Workers Association (INCHWA)
Derris Harrison, Office of Medicaid Policy & Planning
Debbie Herrmann, *Deputy Director, Medicaid Initiatives,* Division of Mental Health and Addiction
Don Kelso, *Executive Director,* Indiana Rural Health Association
Jennifer Long, *Administrator of Community Based Care,* Marion County Public Health Department
Andrew VanZee, *Vice President***,** Indiana Hospital Association

Members Absent:

Carol Weiss-Kennedy, *Director of Community Health,* IU Health Bloomington
Rebecca Adkins, *Systems Director-Population Health***,** Ascension
Rick Diaz, *CEO,* HealthNet
Mandy Rush, *Director of Community Services*, Mental Health America of Northeast Indiana
Mary Anne Sloan, *Vice President Health Care,* Ivy Tech
Lisa Staten, *Department Chair of Social and Behavioral Sciences***,** Richard M. Fairbanks School of Public Health

Welcome

Judy Hasselkus calls the meeting to order at 10:00am and welcomes all workgroup members. Judy Hasselkus leads the workgroup in reviewing objectives from the workgroup charter. This meeting will be a continued look at existing initiatives around CHWs in Indiana to ensure that workgroup members have a common understanding.

Review of Previous Meeting Minutes and Roll Call

Judy Hasselkus asks for a roll call and roll was taken. She then asks for a motion to approve the previous meeting's minutes, which were distributed to workgroup members in advance of the meeting. Kathy Cook makes a motion to approve the minutes. Debbie Hermann seconds this motion. All members approve. No opposition. Motion caries.

Continuation: Report Out of Existing Training Programs

Kellie Meyer, a representative of HealthVisions Midwest, explains their history and describes their mission as building healthy communities together. Their focus is advocating for the poor and powerless, nurturing and fostering leadership, developing and facilitating partnerships, addressing systemic community health needs, and advancing environmental health. She explains that HealthVisions Midwest is a CHW training provider certified by INCHWA. She provides an overview of the training

program HealthVisions Midwest offers. Their training includes forty classroom hours over a span of five days and allows for adaptability with specialty areas. HealthVisions Midwest has been working with the Department of Workforce Development to identify stakeholders and partners to create work experiences for professional development. HealthVisions Midwest has also been working with the Indiana State Department of Health working to develop training for Safety Pin recipients (infant mortality initiative) and to certify trainers in disease specialty areas as CHWs. They have been working with the Family and Social Services Administration to help train CHWs as navigators and to promote self-management. Kellie Meyer says that CHWs can be used to eliminate barriers to accessing quality health care and will allow for advanced care coordination. She states that once the protocols are established, there needs to be provider education in order for the providers to understand how to access and utilize CHWs. She says that the newly published billing codes will inspire and invite providers to utilize CHWs. Currently, their organization has not certified any previously trained CHWs, but when they do, it will consist of a two-day (14-16 hours) training.

Debbie Hermann asks how many people have been certified by HealthVisions Midwest and Kellie Meyer responds that they have certified approximately 120 individuals.

Debbie Hermann asks about eligibility requirements to become a CHW through HealthVisions Midwest and Kellie Meyer responds that currently their requirements are being 18 years of age, holding a GED or high school diploma, and being literate in the English language.

Kellie Meyer discusses the organization's thoughts on hiring a felon and states that it depends on what the provider network wants.

Hannah Maxey asks Kellie Meyer to clarify what HealthVisions Midwest's core competencies are and where they came from. Kellie Meyer refers to the training overview slide and describes some of the core competencies that are addressed in training (cultural humility, privacy, respect, etc.) She states that a CHW should have cultural humility, and understanding of privacy and boundaries, and be a reflection of the community they are working in.

Margarita Hart states that as an approved training vendor, when HealthVisions Midwest submitted their curriculum, they had to line up to the core competencies with the ones that are defined by INCHWA.

Derris Harrison asks about the cost of the training and Kellie Meyer responds that the training costs $1,500. Derris Harrison asks if the individuals in the training are sent from their employers or attending for personal interest and she replies that she has classes filled with a mixture of both people wanting to be trained for personal interest and people that are sent by their employers.

Andrew VanZee asks how much of the training is grant supported and how much is paid out of pocket and Kellie Meyer responds that most of the individuals pay out of pocket for training.

Judy Hasselkus asks of the ~120 certified individuals, how many were sent to training by their employers versus the ones that attended training for personal interest. Kellie Meyer states that about 95% of the trained individuals are sent from employers while about 5% are individuals seeking training out of personal interest.

Judy Hasselkus asks what constitutes being certified as a CHW and if there is an exam at the end of training. Kellie Meyer states that during the five-day training, the individuals must be present for the full forty hours of the five-day training in order to become certified. Kellie Meyer states that there is a three-hour timed test that the trainees have ten days to complete. Judy Hasselkus asks who developed the test and Kellie Meyer responds that the curriculum and program directors at HealthVisions Midwest developed this test with the approval of INCHWA.

Andrew VanZee asks if the test is proctored and Kellie Meyer responds that the test is not proctored and that it is a take-home test.

Judy Hasselkus asks what kind of records are kept on the trainees that go through this training certification process. Kellie Meyer responds that records on the trainees are kept in their offices at HealthVisions Midwest, with duplicates of those records being sent to INCHWA.

Hannah Maxey asks to what extent are CHWs prepared to deliver health education services. Kellie Meyer states that individuals are expected to have a baseline training of health education, as well as being open to new trainings to learn different specialties. Health education is incorporated in training, but it is mostly found in group discussion.

Derris Harrison asks what data points are included in the records that HealthVisions Midwest tracks and sends to INCHWA. Kellie Meyer responds that she personally does not track that data, but that her colleagues would have that information.

Margarita Hart states that INCHWA tracks how many students are certified through the training program and tracks the renewal of certifications, but that the burden of more robust tracking/monitoring is on the training vendors. Kellie Meyer states that she believes HealthVisions Midwest has data on gender, ethnicity, and employment status.

Margarita Hart states to Hannah Maxey that when INCHWA certifies a training vendor, they have core competencies and a scope of practice that is to be followed. CHWs are not intended to be clinical and any health education that a CHW provides would be through more training of specialized health education. When INCHWA approves the curriculum, they are making sure that the individuals will be able to develop a basic understanding of the social determinants of health and the ecological model of health.

Judy Hasselkus thanks Kellie Meyer for her presentation and introduces Derris Harrison's presentation.

Update on FSSA (Family and Social Services Administration) CHW Initiatives
Derris Harrison is with the Office of Medicaid Policy and Planning in the Reimbursement section and he states that their task from Dr. Jennifer Walthall is to create a reimbursement vehicle for CHWs. Currently, FFSA/OMPP has defined a CHW as a trained educator who works with IHCP (Indiana Health Coverage Programs) members to provide culturally-appropriate care in the form of diagnosis-related education and supportive services. CHW is currently used as an umbrella term and it looks to capture just about everything that can possibly be imagined that could fall under CHW. CHWs extend the reach of providers in underserved communities, with the goal of reducing health disparities, enhancing provider communication, and improving health outcomes and overall quality measures.

Derris Harrison says that FSSA envisions this reimbursement will cover diagnosis-related patient education services and will require supervision by an IHCP physician or HSPP (health services provider in psychology). The provider must order the member education services. These services will involve teaching a member how to self-manage their health effectively in conjunction with a health care team. This service can be provided to a member (individually) or it can also be provided in a group. The service can be provided in an out-patient setting, in a home, in a clinic, or another community setting. Derris Harrison states that this is currently where they are at for covered services and while looking at the reimbursement structure, eligible billing providers will be physicians, HSPPs, dentists, podiatrists, nurse practitioners—basically anybody that is enrolled as an IHCP provider and has the capacity to bill. He states that they have looked at different state's approaches to CHW programs and have been able to come up with some specific codes that would cover a CHW and based on their findings, they were able to come up with three codes that they are looking to implement. Based on those codes, they are looking at billing one unit per fifteen minutes with a maximum of about eight units per 24 hours. That works out to about $77/hr individually.

As far as a timeline is concerned, OMPP/FSSA is looking to present their findings to the state budget agency in April 2018 to determine a potential fiscal impact. One issue that they have run into is that there are currently no designated or reimbursement opportunities for CHWs. They looked at similar professions/codes that they felt would match their definition of CHWs and that is how they derived the three codes surrounding CHWs for Indiana. They are looking to implement this reimbursement vehicle starting July 1st, 2018. Before these codes can be passed, the collected information has to be submitted to the state budget agency to look at the potential fiscal impact, a state plan amendment has to be established in order to receive the federal match from the federal government, and a rule would have to be submitted in order to have the authority to implement this reimbursement vehicle for CHWs. As far as the state plan amendment goes, if this reimbursement vehicle is going to be implemented by July 1st 2018, they need to have it submitted by September 30th, 2018. The rule and propagation process can

take longer, but as long as there is a state plan in place, they would be able to move forward with reimbursement.

Discussion

Andrew VanZee asks for clarification on the date of implementation: July 1st, 2018 or 2019. Derris Harrison responds that they are aiming for the date of implementation to be July 1st, 2018. Andrew VanZee asks for clarification on the timeline for the state amendment and the rule approval. Derris Harrison replies that the rule does not have to be in place prior to implementation of any programs. As long the state plan has been approved by July 1st, 2018 and it is submitted to CMS (Centers for Medicaid and Medicare Services) by September 30th, 2018, they should be able to implement the program.

Andrew VanZee asks if FSSA is able to start the service before they get the state plan approved and Derris Harrison replies affirmatively. Andrew VanZee asks if there will be reimbursement for the service if the state plan is not approved and Derris Harrison replies that there is retroactive reimbursement if the state plan is approved but not if it is rejected. Andrew VanZee asks for clarification as to whether the reimbursement is tied to the provider (CHW) or the service provided. Derris Harrison replies that it is tied to the service.

Kellie Meyer asks if the provider would still be paid and if state dollars would be used if the state plan was not approved and Derris Harrison replies that potentially it could be state line dollars that would have to be used, but that is not something that he has seen happen in the past.

Kathy Cook asks if telehealth is reimbursable and Derris Harrison replies that telehealth is not reimbursable at this time. Kellie Meyer states that CHWs can spend a lot of time on the telephone and asks if there is any way that telephonic service delivery could be included. Derris Harrison replies that they are not going to reimburse anything surrounding social services, enrollment assistance, or advocacy. Derris Harrison explains that reimbursing telephone work done by CHWs is something he can take back and discuss with his team.

Margarita Hart replies that INCHWA uses the term navigator to describe helping a patient navigate their way through the health care system. She said that the one term can be associated with two different roles and that it would be important to distinguish how someone with the navigator title is being utilized. She also says that in the southern part of Indiana and in rural areas, there is a lot of telemedicine work completed by CHWs.

Hannah Maxey asks Derris Harrison how a dentist could employ a CHW and bill for their services if only a physician or HSPP can supervise CHWs. Derris Harrison states that anyone that is an enrolled IHCP provider would be able to bill for the service. Hannah Maxey replies that a dentist could bill for a CHW, but would not be able to supervise a CHW due to the occupational hierarchy roles. She states that in the occupational

hierarchy, there is a designated supervisory role and if a provider is not in that role they cannot supervisor, and theoretically, will not be able to bill for CHW services.

Hannah Maxey states that all billable providers should have the ability to supervise or they will not be able to have CHWs work under them and that the language surrounding billing and supervising needs to be clearly defined and stated. Derris Harrison responds that all providers that can bill are also able to supervise. Debbie Hermann recommends that what is intended by supervision should be defined.

Judy Hasselkus asks Derris Harrison how diagnosis specific or diagnosis related services, such as telephone appointments or follow-ups that are ordered related to the diagnosis will be considered. Derris Harrison responds that this is not something his team has currently addressed but he will take it back as an action item for them to discuss.

Margarita Hart asks Derris Harrison if helping someone with transportation, making sure they have their medication, and making sure they have adequate housing are things they would classify as social services because these are services that CHWs provide. Andrew VanZee asks Derris Harrison if the codes he is talking about reimbursing are more around education and training and Derris Harrison responds affirmatively. Andrew VanZee clarifies that under this reimbursement structure, a CHW could not be reimbursed for social work, but they can be reimbursed for education that could include social service discussion and Derris Harrison replies affirmatively.

Laura Heinrich asks if reimbursement is based on the education that can be given surrounding the individual's medical diagnosis and Derris Harrison responds affirmatively.

Debbie Hermann asks for clarification on how the specialized and general CHW trainings are linked together. Derris Harrison replies that if there is a broad CHW training, FSSA is hoping that this individual will then go work for a provider that provides a specific service. They hope this CHW can take the skills learned from the general training (from state-approved training program) and the specialized training (ideally provided by employer), the CHW can utilize the two skill sets in order to provide the education services. These services would then be billable under the aforementioned codes.

Debbie Hermann asks if there would be a need for a secondary specialized certification to show that an individual is a certified CHW, but has also had X amount of education in a specialized area. Andrew VanZee comments that it depends if FSSA is going to define a minimum set of requirements for the education that is recognized to be required to qualify to provide the education service. He asks to Derris Harrison if anyone who has received approved training can provide the specialized service because CNAs, nurses, or even the physicians could go and offer services. He asks if providers are expected to use CHWs, or if it will not be dictated that a CHW has to be utilized. Derris Harrison responds that it will depend on what the core competencies and training programs will look like and it will go back to the provider because the responsibility is going to be on

that provider to ensure that the individual they have employed is a certified CHW. It will also depend on the provider's specialty and if that CHW is practicing within their scope.

Debbie Hermann replies that if the intent is to expand the workforce capacity by adding this credential in a more formal way and making some of the services conducted reimbursable, it may not be limited to only CHWs, but it would add a piece to the workforce who can deliver these services. Derris Harrison replies that this will likely be expansive to the workforce, but he does not think that doctors will go out and do patient education because the reimbursable rate is likely not comparable to what they make. Andrew VanZee replies that if the service can be provided in a group setting, then a physician could provide one hour of patient education to a large group of people and then bill for several units at once. Derris Harrison replies that that could potentially happen. Andrew VanZee clarifies that this reimbursement is not specifically around CHWs, but that a reimbursement mechanism will be in place for a service that could potentially be provided by a CHW. Derris Harrison responds affirmatively. He says that Dr. Walthall has considered changing the term CHW to something different that would encompass other roles that are centered on community health.

Next Steps

The workgroup reviews a diagram was conceptualized by Dr. Walthall to explain the vision for the reimbursement. Dr. Walthall sees that there is a great need for community health engagement services in a way of patient education for targeted issues. It is not a specific-disease or specific-condition centric interest; it is an interest in enhancing community health through a workforce of individuals that will go out in the community and extend education services, specifically related to this reimbursement. This does not preclude individuals from doing many other services within the scope of their training, but patient education is specifically what type of service will be able to be reimbursed. This will be employer-centric and provider-centric, which could be different than CHWs that may typically serve in communities or churches. In order to bill for this service, an education provider should be certified to have some level of foundational training as a CHW. The training, to some extent, has to have the same foundation, recognizing that needs are different among different provider groups that are going to use this workforce. These individuals could be traditional CHWs, health educators that complete CHW training, or para-medicine providers that complete the CHW training. As it stands now, anyone that is going to provide these services can work under a billable provider and deliver these services, will have to have completed some level of base training that is accepted by the State of Indiana through OMPP. The vision is that these services will be extended to improve community health.

Derris Harrison states that Medicaid is going to give a vehicle that allows for some services to be reimbursed. Hannah Maxey states that patient education is a tangible measure that would allow for reimbursement.

Margarita Hart asks if any of the reimbursements are subject to measures in health outcome. Derris Harrison states that eventually, once enough data and engagement from

the workforce is gathered, hopefully there will be significant progress in communities where CHWs have been utilized.

Don Kelso asks if these services would be covered under Healthy Indiana Plan and Derris Harrison states that that is something they are looking into. Don Kelso replies that CMS already has chronic care management that they reimburse for non-face-to-face care coordination and health education for twenty minutes a month that equals to around $40. It is important to consider how it coordinates if there is dual eligibility of HIP and Medicare because there could be overlap.

Closing and Adjourn

Judy Hasselkus refers to the document that is a summarization of the presentations and information that has been collected thus far. This workgroup has an opportunity to examine where there are some gaps and issues surrounding certification. It also has the opportunity to provide significant recommendations to help progress the work surrounding CHWs. The plan for the next meeting is to hear from Mary Anne Sloan in order to gain a higher education perspective, as well as clarity on the differences between skills, competencies, and roles. It is important to develop a baseline for the precise language that is going to be used moving forward. Judy Hasselkus encourages the group to write down on a post-it note any questions, concerns, or comments. Judy Hasselkus calls the meeting to adjournment at 11:30am.