MEETING MINUTES
Community Health Worker (CHW) Workgroup
Tuesday June 5th, 2018 10:00 am – 11:30 am
Indiana State Department of Health, 5th Floor Training Room

Members Present
Rebecca Adkins, *Systems Director-Population Health*, Ascension
Kathy Cook, *Executive Director*, Affiliated Services Provider of Indiana (ASPIN)
Terry Cook, *Assistant Director*, Division of Mental Health and Addiction
Derris Harrison, *Long Term Care Reimbursement Manager,* Office of Medicaid Policy and Planning
Margarita Hart, *Executive Director*, Indiana Community Health Workers Association (INCHWA)
Judy Hasselkus, *Chair, Program Director, Employer Engagement and Sector Specialist for Health Care, Ag., and Life Science*, Department of Workforce Development (DWD)
Laura Heinrich, *Co-Chair, Director of Cardiovascular Health and Diabetes*, Indiana State Department of Health
Rick McComb for Mandy Rush, *Director of Community Services*, Mental Health America of Northeast Indiana
Don Kelso, *Executive Director*, Indiana Rural Health Association
Jennifer Long, *Administrator of Community Based Care*, Marion County Public Health Department
Mary Anne Sloan, *Vice President Health Care*, Ivy Tech Community College
Lisa Staten, *Department Chair of Social and Behavioral Sciences,* Richard M. Fairbanks School of Public Health
Andrew VanZee, *Vice President*, Indiana Hospital Association

Members Absent
Rick Diaz, *Chief Executive Officer*, HealthNet
Carol Weiss-Kennedy, *Director of Community Health,* IU Health Bloomington

Reactor Panel Members
Karina Buenavides, CHW, HealthLinc Community Health Center
Wilma Griffin, CHW direct supervisor, WeCare Program

Welcome
Chairwoman Judy Hasselkus calls the meeting to order at 10:05am and welcomes all workgroup members. Judy Hasselkus introduces the reactor panel (Karina and Wilma), who represent the Community Health Worker voice. Wilma Griffin shares that she currently supervises 12 CHWs that focus on lowering infant mortality rates. Karina Buenavides shares that she is a CHW working at HealthLinc where her main focus is diabetes.

Review of Previous Meeting Minutes* and Roll Call

Judy Hasselkus asks for a roll and roll was taken. Judy refers to the meeting minutes from the previous meeting and asks for any comments, corrections, or amendments. Hearing none, she asks for a motion to approve the meeting minutes from the April 19th, 2018 meeting. Rebecca Adkins makes a motion to approve the minutes. Derris Harrison seconds this motion. All members approve. No opposition. Motion carries.

Judy Hasselkus briefly reviews the previous meeting discussion when the workgroup began discussing occupational regulation following presentations by national guests on occupational regulation and the CHW landscape in other states. She states that this meeting served as a starting point for today's deeper dive in these discussions. Judy directs workgroup members to the documents that were previously adopted by the workgroup: the vision statement and the competencies/skills to be recommended to the Council. These documents were provided in the workgroup members' folders for their reference during discussions.

Judy Hasselkus reviews occupational regulation terminology discussed in previous meetings. She references previous discussions on "certificate" from the perspective of an academic/technical program and certification from the perspective of regulation which is a declaration by some issuing authority that an individual has certain qualifications. Judy emphasizes that certification does not necessarily regulate practice unless a responsible authority chooses to make it so. It is also not automatically a state function. A certification-issuing authority can be a governmental agency, employer entity, educational institute, or an independent association. Generally, certification would protect the use of a title as a "certified" CHW, but it would not necessarily regulate the authority of an individual to act as a Community Health Worker, if the setting in which they are working or the services they are providing do not require that certification or title. Judy Hasselkus reminds the workgroup that consensus was already reached by the group to work toward a process for state certification for CHWs.

Discussion of Occupational Regulation

The workgroup began to engage in semi-structured small group discussion regarding various occupational regulation considerations. Workgroup members are given question prompts and engage in small group discussion regarding occupational regulation considerations, followed by a report out to the full group. The questions are presented below, with commentary from group members also provided:

"Should education/training be standardized for CHWs through a state-approved standardized curriculum (that could be implemented by training vendors)?" or *"Should education/training be standardized for CHWs through a flexible curriculum that meets competencies (training vendors developing a curriculum that would need to meet state competencies and be approved)?"*

Hannah Maxey provides clarification that these two questions are related but are not comprehensive for options related to curriculum development, but the prompts serve as a starting point for discussion.

One group reported they preferred a flexible curriculum that could be created by trainers to meet the state competencies. They feel a flexible curriculum allows for variations in training to meet

the community needs and fulfill job roles. However, they recommend ensuring state competencies are met by implementing a standardized examination for trainees after completion of training. They recommend authorizing an approval mechanism for a standardized examination that is validated to test the competencies.

The second group believes there should be a standardized state curriculum with options for a flexible curriculum with add-ons. They state that this would allow for the base (core) training to be standardized, but flexibility is permitted among additional supplemental trainings.

The third group commented on both curriculum delivery options. They stated that standardized curriculum would ensure consistency in the information being taught to all CHWs. However, they comment that it would likely be a long process to develop such a curriculum. Additionally, a standard curriculum may be prescriptive and may not adhere nor meet the needs to all individuals wanting to pursue a CHW role. In regards to the flexible, competency-based curriculum, they stated that many details would need to be worked out for the implementation of the curriculum approval process (i.e. who is going to be reviewing the curriculum? How often? How many vendors are going to be involved with the curriculum? What amount of time is needed for the review process?). This group states they were on the fence between the two curriculum delivery types.

The final small group comprised of workgroup members reports that they were also undecided in regards to curriculum delivery. They were in agreement around implementation of a standardized examination for quality assurance. However, they stated that standardizing curriculum may stifle innovation or flexibility of training.

The reactor panel also provides their input, stating that they tend to agree with a standard examination to evaluate competencies, but after delivery of a flexible curriculum. This group added that variables such as cost and location of training would also need to be heavily considered. They state that they have had experience in trying to train a large group of CHWs; the training cost and travel required to receive the training were prohibitive. Additionally, the reactor panel believes that state oversight is still vital in some place whether it is approving the curriculum or assuring quality through the standard examination.

Hannah Maxey summarizes the general theme of the workgroup's response to this category, stating that most groups preferred flexibility in curriculum development/delivery, with some level of state intervention to ensure quality (with the most widely suggest state intervention being a post-training assessment).

"How should CHW education/training be delivered (classroom/didactic, clinical/hands-on, etc.)?"

The first group responds that they believe there should be didactic coursework and that shared the group had a strong view on the value added by in-person instruction, but they considered a hybrid approach of both online and in-person teachings. They added that in-person training would be preferred given the emphasis on social interactions and communication in the CHW roles. In regards to clinical/hands-on training, the group recommends avoiding the term

"clinical," as they believe the term is most often applied to experience with patients in a care facility or an outpatient clinic. However, the group shares yes, it is important to have hands-on training if it is a practicum or mentor. They believe the exposure to clients and real life situations is important.

The second group reports that they believe education/training could be delivered in a combination of both classroom and online instruction. However, they add that classroom is the ideal method for education delivery, but they note the limitations in on-site instruction for individuals from rural communities and that younger generations may prefer the accessibility and flexibility in an online course. In regards to the clinical training, the group agreed with the previous group, stating they preferred the term "practical skills" over "clinical." They state that this type of training is also important, but noted there may be opportunities for non-traditional practicums over online platforms such as Skype.

The third group reports that their collective group response was flexibility in education delivery is needed but they agreed on having a face-to-face approach. This group did discuss whether online or web-based training would make sense, but they sense that younger learners still prefer face-to-face instruction and that demographic of learners would not be lost if online delivery was not made available. They also agree that some type of hands-on learning is important. This group also avoided the term "clinical," but responds that online shadowing or a role-playing approach might be used. The group reports that they did consider the implications of these discussions, including: how to implement the hands-on approach, whether an approval process should be established for training delivery, are sufficient clinical/practicum supervisors available, is there an ideal practice setting or employer partners to facilitate the hands-on training, etc. Also, they considered that if there were individuals serving as supervisors for the hands-on portion, would another certification be required to serve as supervisor?

- Lisa Staten responds that the hands-on portion that the group describes could simply be an experience requirement to obtain the certification. This would remove the training vendor from facilitating that interaction between learners/employers/CHW supervisors.
- Laura Heinrich responds that separating the experience from the didactic training could present a barrier to learners, if they have difficulty finding an employer/supervisor willing to host them for the on-the-job training experience.
- Andrew VanZee responds that there are other occupations that have a similar training/experience structure. Certified phlebotomists, for example, have to complete didactic training and have a certain amount of experience before receiving certification.
- The group then discusses experience requirements, while it may be perceived as a barrier to certification for some, may result in a higher quality preparation of the workforce.
- Hannah Maxey responds that the experience requirements may depend on the "specialty" or setting where the CHW would be employed. If they were working within a clinical care team, an employer or supervisor might consider an additional component to the training, whereas if someone was interested in becoming a lactation consultant there might be different considerations.

The final small group reports that they agreed on some portion of training being delivered as didactic. The group stated that they agreed the training should not be a 100% online approach and that a face-to-face portion would be necessary. The general breakdown they discussed would

be 40/60 as far didactic online (40%) versus face-to face (60%). They thought the online portion could be delivered before the face-to-face portion. They believe there should be some type of internship, however their group formed similar comments as the earlier groups in regards to timing of the internships/experience and certification.

Mary Anne Sloan comments on the concept of job shadowing and/or internships, stating this type of experience is in line with other state educational initiatives. She continues that there may be an opportunity to provide more information about the CHW role online, so that potential students can research the role and understand the contribution of CHWs before enrolling for the program.

Hannah Maxey summarizes the CHW workgroup's discussion, stating that an overall theme is that some type of face-to-face didactic training is important, as well as some type of hands-on experience. The group is in consensus to exclude the term "clinical" and lean toward use of the terms "internship," "practicum," or "job shadowing." The consensus is that CHW students should gain hands-on experience through practicums, internship, and/or job shadowing, or have employers host all of their experiential training as a part of their on-boarding.

Andrew VanZee asks other workgroup members if approximately two weeks of training for CHWs would be considered reasonable (40 hours classroom, 40 hours internship)? Kathy Cook comments that this seems high. Margarita Hart responds it might depend on the student; some individuals are seeking the CHW training on their own, others are sent by their employer. For those sent by their employer, it seems that 80 hours would be too high for them to leave their job for training. Hannah Maxey responds that these hours could be accounted for in their return to their job as on-the-job training. Margarita Hart responds that would be easier. Andrew VanZee states that there could be flexibility on implementation of the 40 hour internship piece, based on employer or setting.

Terry Cook poses to the group what they believe the likelihood of hosting students as interns might be for certain employers such as community mental health centers. Mandy Rush responds that she anticipates they would be willing to host students for the internship, as the current CHW initiatives in Indiana around reimbursement and increasing standards by professionalizing the workforce help to raise the interest of employers. Kathy Cook responds that they have found a high turnover rate among CHWs, at around 30-40 percent turnover. She foresees an issue in employers hosting 40-hour internships or doing on-the-job training and then having the students or employees leave after completing those hours.

Laura Heinrich raises a concern with employers having to cover the costs associated with hosting students or precepting. She states that many employers do not pay for continuing education for any of their employees and those costs generally have to be paid for by the individual. Terry Cook responds that the employer may have to calculate the tradeoff of training costs and reimbursement rate for this workforce. He states that covering costs for training/precepting may not be a problem for larger employers but may be prohibitive to smaller employers.

The reactor panel also provides their input on this question. They believe that face-to-face training is essential for various reasons such as: exposed to human touch with patients, creating a

bond with patients, ensuring the CHW is capable of communicating and earning trust with their clients. The reactor panel also shares that many times the CHWs have to work independently, as they are out in the community and at times there may only be a single CHW in that county. They state that all of the CHWs they work with are charting in electronic medical records and their direct supervisors and clinical staff rely on the CHWs to establish a trusting relationship with patients who might end up trusting the CHW enough to share more information with them that they might have hidden from the doctor.

"Should the certification system include a path based on experience rather than education, or some "grandfathering" provision for individuals who have an educational certificate of completion for prior CHW training?"

The first group responds that yes, this provision is important. They state they recognize that some individuals have been working as CHWs for many years and are competent, but need some mechanism to demonstrate the competencies or achievements throughout their career. They state that prior learning assessments might be utilized by CHW supervisors to assess whether or not an individual meets these competencies.

The second group also responds that yes, some type of experience pathway to certification should be made available. They recommend limiting this to a specific time frame, recognizing a basic form of training, requiring an examination.

The third group agrees that yes, grandfathering should be provided, but the logistics of a grandfathering provision would need to be determined. That should include a limited time to offer grandfathering and limited "experience" should qualify. They believe that work experience should qualify for grandfathering, but an individual with just "lived" experience should not qualify just on that basis. They state that their guiding value as a part of their discussion was to ensure unnecessary barriers to workforce entry/certification are not created for those with many years of work experience as a CHW.

The fourth group responds that they also agree that grandfathering should be allowed. They recommend requiring those who will be grandfathered in be required to take a one-day didactic or refresher course before certification. They also recommend that the qualifying criteria for grandfathering would need to be developed.

Finally, the reactor panel also responds yes, grandfathering provisions should be included.

Hannah Maxey summarizes the discussion, stating that there is consensus for grandfathering provisions.

Due to time limitations, the workgroup discussed the remaining questions prompts on occupational regulation as a large group instead of breaking into smaller groups.

"Should statute outline a scope of practice associated with certified CHW competencies and skills?"

Andrew VanZee responds no, stating that once statute is created, any changes would be difficult. He states that authorizing an advisory body in statute to make those determinations may be a reasonable alternative. Terry Cook responds in agreement, stating that changes in code can take upwards of a year, but authorizing a group/entity/board to make those determinations would allow the CHW workforce to respond more quickly. Derris Harrison responds affirmatively, stating that they expect the rulemaking process for the Medicaid reimbursement policy affecting CHWs to take 12-18 months.

- Mary Anne Sloan asks whether authorizing an advisory body would require legislation. Andrew VanZee responds that yes, the initial definition and scope of that body could be in statute. However, not each of the outlined criteria such as competencies or scope of practice would be in statute, but could reside in administrative code or organizational documents.
- Margarita Hart asks what implications there are with having scope of practice outlined in statute? Hannah Maxey responds that a benefit of outlining scope of practice for any profession is that it clearly defines what someone may or may not do under that license or certification. She further describes the role of licensing in state intervention as a mechanism for ensuring safety and public protection, stating that that state intervention ensures someone providing a scope of services is deemed competent by the state to do so.

"Shall Indiana maintain a list of its certified CHWs?"

Mary Anne Sloan responds yes because a list would be utilized to reference and enforce regulation. This list will then serve as a benefit for employers to ensure their staff or potential staff have met these requirements. Terry Cook makes a comparison with the Professional Licensing Agency's public license verification feature, stating it is useful to their team as they are seeking to verify someone's credentials.

"Shall an individual be required to present evidence of training completion and/or evidence required for grandfathering to be placed on this list?"

Hannah Maxey clarifies the question by asking does the group feel as though in order to be on some list in the state of Indiana that you should have fulfilled requirements and demonstrate evidence of doing so. Andrew VanZee responds that the group has discussed with general consensus that a certification or standardized exam would be required for an individual to be on the list.

Lisa Staten asks where the responsibility lies for providing the required information for the registry. Hannah Maxey responds that it depends on the how requirements to be on the list are determined. It could be the responsibility to of the individual to demonstrate proof of training requirements, or the registry-entry could be providing evidence of successful completion of the examination, which might be done automatically if the examination is provided by the state.

"Shall an individual be required to present evidence of continuing education (CEUs) to maintain active status on this list?"

Katrina Buenavides responds yes. Judy Hasselkus asks if continuing education is a requirement for certified occupations with similar training, such as certified nurse aides, qualified medication aides, and home health aides. Andrew VanZee continues by asking if those occupations have to renew. Hannah Maxey responds yes, they renew every two years and have requirements for education/training hours received between renewal.

Andrew VanZee states that before continuing education is discussed, the group should discuss whether or not CHWs should be recertified at a certain period to maintain on the list. Andrew VanZee notes that the landscape in healthcare changes quickly and CHWs need to be positioned to be a flexible workforce to respond to need. Many workgroup members stated that renewal is beneficial as is a systematic process for clearing the list of former CHWs that have moved out of state, passed away, or no longer maintain active practicing status.

Mary Anne Sloan responds that it is challenging to decide whether or not CHWs should have continuing education requirements when there are a number of professions trained at higher levels that do not have continuing education requirements. Margarita Hart states that for public safety, CEUs would be beneficial since some individuals have been in the field for many years and new material has come up that continually needs to be learned and implemented into practice. Kathy Cook states that she agrees with Margarita Hart in regards to the value of CEUs for this workforce.

Jennifer Long asks what might be involved in recertification requirements, would another exam be taken? Hannah Maxey responds that has not yet been discussed.

Hannah Maxey summarizes the group discussion, that the group has reached consensus that some type of renewal mechanism would be beneficial, as is in the case with similar levels of occupations in Indiana (CNAs, QMAs, home health aides). However, the group has not yet reached consensus on requirements for renewal (continuing education, re-examination, etc.). Hannah Maxey states that renewal requirements will be added to the "Parking Lot" as an item to be discussed at a later time.

"Shall an advisory body be established to advise on governance of the CHW workforce?"

The workgroup discussed the possibility of statute to authorize an advisory body for the CHW workforce, as opposed to outlining scope of practice in statute. The general consensus of the workgroup is that yes, an advisory group should be established. Andrew VanZee comments that the nature of the advisory group and its authority would depend on what regulatory structure is in place. He continues by referencing Ohio's model, where there the Board of Nursing regulates the CHW workforce, but an advisory body comprised of CHWs and stakeholders informs the Board of Nursing.

Update on FSSA CHW Initiatives
Derris Harrison provides an update on FSSA's related initiatives. He distributed to workgroup members a copy of the current reimbursement flyer and a "Frequently Asked Questions" document. He states that the CHW reimbursement rates will be available for public viewing online starting July 1, 2018. A bulletin for news release was published on May 31, 2018. He shares with workgroup members that the most significant change from previous versions of the policy is under covered services; "direct preventive services or services aimed at slowing the progress of chronic diseases" was added as a covered service. Additionally, an item that was added under "Non-Covered Services" was direct patient care outside the level of training and certification an individual has attained. In terms of eligible certification, Derris Harrison shares the main change that was added under the direction of Secretary Dr. Jennifer Walthall to include individuals who have an academic degree (at least an associate's degree) in a health care related field or have employer-based training around health promotion and community health integration, related to the identified CHW competencies. Derris shares that the reimbursement will be start on July 1, 2018. The state plan will be submitted in approximately two weeks, around June 18th. He states the moving forward, the next step will be to submit the rules which are still currently be worked on.

Derris Harrison shares with workgroup members that he is available through email for any questions or comments. Judy Hasselkus thanks Derris Harrison and other OMPP team members for their work and for encouraging feedback/input from the workgroup throughout the process.

Next Steps
Hannah Maxey shares with workgroup members that the National Academy for State Health Policy (NASHP) has reached out to Indiana and is interested in the cross-agency collaboration that is occurring in the Governor's Health Workforce Council and associated workgroups. NASHP staff will be attending the next CHW workgroup meeting to observe the workgroup's discussion and function.

Closing and Adjournment
Chairwoman Judy Hasselkus thanks all participants for their contributions and input. She calls the meeting to adjournment at 11:34 am and announces to workgroup members the next meeting will be held on Tuesday, July 10th from 1:00 pm – 2:30 pm at the Indiana Government Center South in Conference Rooms 4 and 5.