MEETING MINUTES
Community Health Worker (CHW) Workgroup
Tuesday July 10th, 2018 1:00 pm – 2:30 pm
Indiana Government Center South
302 W. Washington St. Indianapolis, IN 46204
Conference Rooms 4+5

Members Present
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
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
Rebecca Adkins, *Systems Director-Population Health,* Ascension

Reactor Panel Members
Wilma Griffin, CHW direct supervisor, WeCare Program

Welcome
Chairwoman Judy Hasselkus calls the meeting to order at 1:02pm.

Review (Approval) of Previous Meeting Minutes* and Roll Call
Chairwoman Hasselkus refers to the previous meeting minutes and asks for comments, corrections, amendments, or a motion to approve. Andrew VanZee makes a motion to approve the minutes. Terry Cook seconds this motion. All members approve. No opposition. Motion carries.

Judy Hasselkus provides an overview of the agenda and reviews meeting materials. The workgroup will continue discussing regulatory framework for CHWs. Judy states the August meeting will include voting to formalize the recommendations that will be presented to the Governor's Health Workforce Council.

As a part of the administrative support provided to the workgroup, a summary document of the workgroup's previous discussion was created. This summary document was sent to the workgroup in advance of the meeting for their review, feedback, and revision requests. The workgroup walked through this document throughout the meeting and addressed any remaining unknowns. Hannah Maxey served as facilitator of discussion.

Hannah Maxey summarizes the first point of discussion from the previous meeting, which was whether an advisory body should be established to advise on governance of the CHW workforce. At the previous meeting, the workgroup reached consensus that an advisory body should be established and should be outlined in statute. The workgroup's rationale for this was that "authorizing an advisory body to advise governance of the CHW workforce will enhance agility of the workforce to meet the dynamic needs of the population/community." Hannah Maxey asks the workgroup if the documented information reflects the perspective of the workgroup and if there are any additional comments. There were no disagreements or additional comments.

What function(s) shall the advisory body serve?

Margarita Hart responds that the functions depend on the perspectives reflected in membership. Hannah responds that Margarita's feedback touches on the next follow-up question, "How should membership be determined?" She suggests that the group begin to brainstorm what perspectives should be included in an advisory group. Hannah suggests that while consensus has been determined that the advisory body should be authorized in statute, the workgroup has not yet discussed whether the advisory body will be responsible for regulation or whether regulation would be the responsibility of the state entity or agency. Judy Hasselkus reminds the workgroup that the workgroup decided on establishing an advisory body in statute as an alternative to outlining scope of practice in statute.

Lisa Staten states that one role of the advisory body could be to perform a periodic review of certification criteria to ensure the state-determined criteria are relevant to ensure the CHW workforce meets the needs of the state and their community. Mary Anne Sloan poses to the workgroup whether the advisory body should set requirements for the flexible curriculum and a CHW registry or if the state would determine those requirements. Hannah Maxey reminds the workgroup that the workgroup previously discussed a standardized assessment. Mary Anne Sloan responds that a standardized assessment should be created and implemented. Margarita Hart asks for clarification on whether the workgroup had consensus on a state-standardized curriculum or just the curriculum parameters. Hannah Maxey responds that the general consensus from the group was a non-standardized curriculum that met standardized parameters. Hannah Maxey continues that in order to implement this, there would need to be a review mechanism in place to ensure curriculum is aligned with the state parameters. Hannah provided an example of a state, Oregon, that has adopted a flexible curriculum model and has the advisory board in place to review curriculum for alignment with state-defined parameters. Kathy Cook suggests that the advisory body should conduct workforce analyses on CHWs, including the number of individuals trained as CHWs, employment settings, salary, and scope of work. Lisa Staten adds that the advisory body should provide council on implementation of the regulatory schema for the CHW workforce. The workgroup expresses consensus. Mandy Rush adds that the advisory body could advise the state entity on re-certification and continuing education criteria as well.

The workgroup reached consensus that the state entity would be responsible for maintaining the registry and determining curriculum requirements, but the advisory body would provide counsel on how that is achieved.

How shall membership of the advisory body should be determined?

The workgroup agreed that the state entity would appoint membership. Margarita Hart states that the group should discuss the different sectors that should be represented on the advisory body; she states that much of the group's previous discussion has been on medical care, but she believes there needs to be representation from social services as well. Mary Anne Sloan responds by referencing other state advisory bodies; she states that the Indiana State Board of Nursing has only approximately eight members and

would advise the membership of a CHW advisory body to be as representative as possible but remain small in size. The workgroup began discussing membership recommendations for the advisory body. The workgroup generally discussed the balance between having a representative discussion with key perspectives, but keeping the membership small. The workgroup discussed there would be value added from the perspectives of the Indiana Family Social Services Administration (Office of Medicaid Policy and Planning), a consumer member, the Indiana Rural Health Association, and the Indiana State Department of Health, Indiana Community Health Workers Association, education, certified CHW employer, and the perspective of a certified CHW member.

Hannah Maxey reviews the next point of discussion, that the workgroup previously decided that the state should maintain a list of certified CHWs because the workgroup felt "it is important for employers to quickly verify the education/training/competency of staff and/or potential employees."

Who shall be responsible for maintaining this list [registry]? (ex: state department/agency, advisory body, training vendors, etc.)

The workgroup discussed the possibility of various state agencies to house the registry: the Professional Licensing Agency (PLA), the Department of Workforce Development (DWD), and the State Department of Health (ISDH), and Family and Social Services Administration (FSSA). The workgroup discussed that currently FSSA does not maintain any such list, so other agencies may be better suited for this purpose as it could be most easily achieved administratively. Mary Anne Sloan adds that currently ISDH maintains the registry for certified nurse aides (CNAs). Hannah Maxey adds that while regulatory functions for CNAs are through ISDH, the administrative processes are routed through the PLA. Margarita Hart stated that DWD might make sense because the workgroup has discussed CHW structured as a stackable credential, but the workgroup discussed that DWD does not currently have an administrative structure in place for maintaining the list. Derris Harrison suggests to the workgroup that in order for any agency to assume this responsibility, there would need to be some level of funding in place to support these activities. Andrew VanZee responds that a small registration fee could be created to cover administrative costs. Mary Anne Sloan responds that in the case of CNAs and Qualified Medication Aides, a fee is collected for standardized testing, but might not be fully cover all costs associated with testing and registry maintenance. Hannah Maxey adds that many times in the case of CNAs, employers actually pay most of those costs, which might be a potential solution for CHWs as well to minimize any cost burden on individuals. Derris Harrison adds that funding is provided to ISDH through Medicaid to run the CNA registry and other related activities, approximately $6 million every biennium. Judy Hasselkus opens the floor for final discussion, concerns, and feedback. Hearing none, the workgroup reached consensus that ISDH would be best suited to provide regulatory oversight for the CHW workforce and house the registry.

What information should be maintained on certified CHWs (examples given include: name, DOB, SSN, address, qualifying education/training provider information [name, address, date of completion, director's signature], examination information, etc.)?

Margarita Hart asks about tracking of social security numbers (SSN). Andrew VanZee adds by asking what information is tracked on CNAs currently. Hannah Maxey replies stating that social security numbers are tracked which allowed for the study that linked CNAs to other occupations to be completed. She adds that SSN is tracked for professions licensed through the PLA. A workgroup member expressed concern that requiring this information may exclude a large number of CHWs. Mary Anne Sloan responds that with respect to higher education, all the databases for public universities include social security numbers, used for employment purposes. This information is used to match placement rate of graduates and monitor employment or unemployment status. She notes that data security measures are in place to protect this sensitive information, but the data is still utilized for evaluation and tracking. Margarita Hart

states that there are a number of CHWs that work in community settings such as community centers or churches that are undocumented or are unable to get a social security card. Mary Anne Sloan responds that social security number is required for CHW application in Ohio. Hannah Maxey responds that the Bowen Center will look into whether requiring social security number for CNAs is a federal or state requirement and will report back to the workgroup. Hannah Maxey asks the group for their feedback on the other information variables. Kathy Cook responds that the group should leave it open for more data collection that includes information on employment. She suggests the advisory body may have additional recommendations for data collection once established. Hannah Maxey responds that information on employment or practice could be collected at time of certification renewal, similar to other renewing health occupations. Kathy Cook adds that it might need to be collected at time of initial certification as well for those that will be recognized in the grandfathering provision. The workgroup reached consensus that information on the CHW workforce could be collected at time of certification provision or renewal. With the exception of SSN which will be discussed at the next meeting, the workgroup was in consensus with collecting the aforementioned information.

Shall an individual be required to present evidence of continuing education (CEUs) to maintain active status on the list [registry]?

Hannah Maxey adds that the workgroup did not reach consensus on this point in the previous meeting. She adds the summary of the previous meeting's discussion "The CHW workforce is more agile than most health-related occupations, as they work broadly in a variety of settings and with varying occupations, but also respond to the unique health/social/cultural needs of a particular community. As such, CEUs would be beneficial to ensure the workforce receives the latest information/skills to employ in their practice. However, the Workgroup noted that some health occupations with higher qualifying education requirements (such as physicians and nurses) do not have continuing education requirements associated with their license renewal. The Workgroup has not yet discussed alternatives to formal CEUs, such as in-service training that is more employer/setting specific."

Judy Hasselkus states that one of the purposes of certification renewal is to ensure the list of individuals certified includes only those individuals actively practicing under that certification. Andrew VanZee suggests that the topic of continuing education requirements might be added as a responsibility of the advisory body. Jennifer Long asks for clarification on what would be required with CEUs, whether the individual would be required to submit what they have attended or what CEUs they have completed throughout the time between renewal. Hannah Maxey responds that CEU requirements could be implemented in a number of ways. For example, licensing boards generally assess CE compliance through auditing. Individuals who are randomly selected are required to provide proof of their continuing education. In general this method is utilized frequently as it is less of an administrative burden but still promotes compliance.

Margarita Hart states that there is enough change in the landscape of health that CE requirements would ensure an individual stays up-to-date on this knowledge. Andrew VanZee states that per his knowledge the group did find consensus that CE is important but it was not decided as to whether it would be mandated to maintain active status in certification. Margarita Hart responds that she does not suggest it should be mandated. Mary Anne Sloan agrees, stating that nurses do not have CE requirements along with many other licensed health professionals. Mary Anne adds that does not preclude employers from offering CEU opportunities and requiring individuals to complete them to maintain employment. Kathy Cook adds that in the case of the Indiana Navigator certification, two CEUs are required annually through the Indiana Department of Insurance to maintain active certification. Laura Heinrich states that CE could be a financial burden depending on what opportunities are available. Judy Hasselkus adds that a priority of the workgroup is to remove any unnecessary barriers to entry for the CHW occupation. Mandy Rush states that currently for the CHW certification offered through Mental Health America of Indiana on

behalf of the Division of Mental Health and Addiction, CHWs are required to have 14 minimum CEUs per year to renew certification. She states that employers have had positive feedback to this. She notes they offer more than 14 hours of CEUs online at no cost, covering various topics via webinars. Kathy Cook adds that CEUs could be counted through various mechanisms: webinar, conference calls, in-person sessions created by an employer, etc. Hannah Maxey echoes Judy's point about removing unnecessary barriers to licensure. She describes the state's participation in the Occupational Licensing Policy Learning Consortium, where states receive expert technical assistance to identify best practices in licensing policy to ensure states employ the least occupational regulation required to ensure the welfare and safety of the public. Mary Anne Sloan asks if the workgroup feels it would be appropriate for the advisory body to make recommendations on CE. The workgroup expresses consensus on this, that the advisory body can make recommendations for CE but it will not be included at this time.

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

Hannah Maxey summarizes that consensus was not reached on this question and then reads the summary of previous discussion, "the 'scope of practice' for a profession defines what services may or may not be provided, in alignment with an occupation's skill and training. 'A state's scope of practice can be defined in general or specific terms, and legislatures struggle to balance the need for outlining rights broadly, so as to allow for innovation, with the precision needed to ensure that a professional meets the governing standard of care.' In some states/occupations, the scope of practice is omitted from statute altogether."

Hannah Maxey states that in preparation for this discussion, information was pulled for the workgroup on examples of how scope of practice is addressed in other occupations in Indiana. She states that in the case of the CNA and the QMA, ISDH makes the decisions on the scope of practice. With diabetes educators, who are regulated by the Medical Licensing Board, the Medical Licensing Board sets the standards for the professional responsibility for diabetes educators in alignment with the American Association for Diabetes Educators. She also describes the scope of practice for addiction counseling, which defines the services or practice of addiction counseling. After reviewing these occupational examples, Hannah re-states the question, whether the workgroup believes statute outline a scope of practice associated with certified CHW competencies and skills.

Andrew VanZee responds that since the landscape of community health workers is still evolving nationally, it might make sense to omit it from statute at this time or include scope of practice as a function to be determined by the advisory body. Judy Hasselkus echoes the position to omit scope of practice from statute at this time; she refers to previous discussions when the workgroup expressed value of the flexibility and dynamic nature of the CHW workforce. Derris Harrison agrees with the plan to omit scope of practice from statute. Hannah Maxey states that in the case of some occupations, statutory language reads that the scope of services that a certified professional shall engage in "shall align with the competencies and skills of their training," which is broad enough to not define a particular service but specific enough to ensure the certified individual is practicing only within the scope of their training.

The workgroup reached consensus on adopting similar language to allow a certified CHW to engage in practice that aligns with the competencies and skills of their training. The workgroup also discussed adopting a code of ethics that aligns with national standards, which could be done through administrative code or in programmatic implementation.

Hannah Maxey reviews the workgroup's previous discussion on education and training. She reminds the group that they previously decided on a competency-based, flexible training for CHWs, with the option for specialty curriculum if desired by trainers, employers, or individuals. The workgroup reached consensus that a standardized assessment should be implemented.

Shall all curriculum should undergo a review process for competency alignment or shall the standardized assessment serve as the quality assurance mechanism for a training program's competency alignment?

Margarita Hart responds that an assessment could serve as the review mechanism to ensure competencies are met. Lisa Staten replies that the assessment might be too late of an assessment, if there are cohorts that are completing trainings that do not meet the competencies. Hannah Maxey responds that in that that case, the market might drive demand or utilization of a training program, accompanied by transparency in pass rates for the various training. She states that students would naturally avoid training vendors with lower pass rates.

Kathy Cook states that she believes there should be an online training option because she believes that is the preference for younger generations and other workforces receive online training. Andrew VanZee responds by asking for clarification on what the group previously meant by "face-to-face" training; whether that implied in-person, or if it could be considered face-to-face through video or web chat. Mary Anne Sloan responds that there has been success with a hybrid online component for CNA training, through a teleconference format. She further describes that in that setting, a student can interact with their instructor and ask questions but there still is that required clinical type experience of some sort.

The workgroup reached consensus that an examination would be created by the state agency that oversees the workforce, with input from the advisory board. The workgroup also reached consensus to recommend a review process for each training program's curriculum in addition to requiring students pass a standardized assessment after training completion and before certification.

Who shall be charged with creating/maintaining currency of the assessment tool?

The workgroup discussed that Ivy Tech currently administers the assessment for CNAs at a cost of approximately $85, via a paper assessment, at various testing centers or approved testing vendors throughout the state. The workgroup reached consensus that an electronic assessment would be recommended, and there may be an opportunity to administer this assessment at various testing sites throughout the state.

Who shall maintain assessment records (name, score, program, etc.) and shall aggregated (to program/year level) assessment scores be publically reported?

The workgroup reached consensus that the state entity should be responsible for maintaining a record of the assessments and aggregate information on assessment pass rates should be publicly reported (by program and year).

How shall training/education be delivered?

Hannah Maxey presents a summary of the workgroup's previous discussion on this matter, "the workgroup determined that a didactic portion of training is important. Face-to-face/classroom training is ideal. The workgroup deliberated on other training delivery mechanisms (i.e. hybrid vs. online-only options). The workgroup felt there should be some type of internship/job shadowing for students/CHWs, but they did not reach consensus on whether this experience should occur before or after certification."

The workgroup reached consensus that interactive training is important, but this could be delivered online through video conferencing or web-based chat. Don Kelso adds that for individuals seeking certification that are located in rural settings, an online option for training would be ideal, but that does not preclude other training options as face-to-face. The workgroup agreed, and further reached consensus that the advisory body could further advise ISDH on the number of required hours for training.

The workgroup discussed that the CRS, as well as other specialty services such as lactation consulting, doula, etc. would be assigned to the parking lot for discussion at a later time.

The workgroup ran out of time to discuss the final topic which was grandfathering. The workgroup was amenable to the Bowen Center preparing a drafted recommendation on this topic that represents previous discussions held by the workgroup. The drafted recommendations will be sent to the workgroup one week in advance of the next meeting. The workgroup discusses that the purpose of the August meeting will be to review the drafted recommendations and hold a final vote on whether these will be delivered to the Governor's Health Workforce Council.

Derris Harrison provides a brief update from FSSA, stating that CHW reimbursement went live as of July 1, 2018 and he will provide future updates as they are available.

The meeting was called to adjournment at 2:34pm.