MEETING MINUTES
Community Health Worker (CHW) Workgroup
Tuesday, October 17th, 2017 9:30am-11:00am
Indiana State Department of Health, Yoho Board Room

Members Present:
Rebecca Adkins, *Systems Director-Population Health,* Ascension
Kathy Cook, *Executive Director,* Affiliated Services Provider of Indiana
Margarita Hart, *Executive Director,* Indiana Community Health Workers Association (INCHWA)
Judy Hasselkus, *Program Director, Employer Engagement & Sector Specialist for Health Care, Ag., & Life Science,* Department of Workforce Development
Laura Heinrich, *Director of Cardiovascular Health and Diabetes,* Indiana State Department of Health
Debbie Hermann, *Deputy Director, Medicaid Initiatives,* Division of Mental Health and Addiction
Jennifer Long, *Administrator of Community Based Care,* Marion County Public Health Department
Cody Metzger, *Program Director,* Medicaid Policy
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
Andrew VanZee, *Chair of Council on Workforce Development,* Indiana Hospital Association
Carol Weiss-Kennedy, *Director of Community Health,* IU Health Bloomington

Members Not Present:
Rick Diaz, *CEO,* HealthNet
Don Kelso, *Executive Director,* Indiana Rural Health Association

Welcome
Chairwoman Hasselkus calls the meeting to order at 9:30am. She welcomes workgroup members to the meeting and introduces Dr. Hannah Maxey to provide background on the Council and share how the workgroup was prioritized.

Hannah Maxey shares the background of the Governor's Health Workforce Council. She shares the history of the initiative, which began with Indiana's participation with the National Governor's Association Health Workforce Policy Academy. From participation in this academy, it was determined that there was a need for health workforce data coordination and policy coordination. She shares the three priorities identified by the Council for task force formation in 2017: 1) State Loan Repayment Program, 2) Health Workforce Modernization and Innovation, and 3) Community Health Worker.

Review of Charge & Workgroup Charter
Chairwoman Hasselkus reviews the taskforce protocol adopted by the Council. Workgroup members received this document in advance of the meeting. She also reviews the project charter that was created by workgroup leadership before the meeting.

Member Introductions
Each workgroup member introduced themselves and explained their understanding of the definition and role of a CHW from their organization's perspective.

Mandy Rush says that she trains people to be Certified Recovery Specialists (CRS) and in that training there are some CHW components. She is interested in learning more about what a CHW is and what their roles are.

Jennifer Long states that she works with CHWs and that they play many roles in her organization. She states that her organization's CHWs do clerical work, provide front desk staff in clinics, immunization outreach programs, administering of tuberculosis medication, and work in schools as vision/hearing screeners.

Cody Metzger reports that he does clinical research in data analysis to help inform and propose policy.

Lisa Staten worked with CHW programs in Arizona and is now working with the Indiana State Department of Health's (ISDH) on initiatives to assess CHWs to define their roles. She believes that a CHW tends to be a person that represents the community and can serve as a bridge to link people to health systems, social, services, and provide human touch social support.

Rebecca Adkins helped develop a program called "Rule and Urban Access to Health" that has 25 state-wide health advocates (CHWs) that work off of an evidence-based path model to help the community with insurance enrollment, pregnancy, social services, medical referrals, etc. She defines CHWs as the "glue" for external and internal health care and as a body of people that help expand health care in the community and within medical teams.

Debbie Hermann reported that community health workers and certified recovery specialists have similar roles and goals. It is their goals to link the community to health care and she believes it is important for these individuals to have lived experience in the community. She brought the two curriculums of CHW training and CRS training together to educate both parties on the same material in order for them to go back into the community and provide support, empowerment, and education.

Carol Weiss-Kennedy states that her organization makes use of CHWs through Women, Infants, and Children (WIC) programs such as peer counselling, continuing breast feeding, baby and me tobacco free, safe sleep practices, etc. She believes CHWs are people with like-lived experience who come from the community to provide evidence based information to help create a link to health care. She also states that it is a great way to build the health care workforce and get the community involved in a health care career path.

Kathy Cook helped merge the two curriculums with Debbie Hermann and they offer the training over a course of three days. So far, they have cross trained 20 CHWs in helping patients navigate health insurance, understand health care literacy, stay in contact with PCP, and help utilize preventative care. She also explains how her team targets college students with General Studies degrees to pipeline them into entry-level CHW positions.

Mary Anne Sloan believes that CHWs are community-based and reflective of their community. She states that they are very aligned to public health and that they serve in multiple roles to promote wellness, improve quality outcomes, educate the community, and offer and help with the transition of care.

Margarita Hart serves as both executive director of INCHWA and executive director of Esperanza Ministries. She states that they have 39 volunteer CHWs that serve their community. She defines a CHW as someone who is extremely trusted by the community, acts as a liaison or advocate where social services, health care issues, or anything pertaining to wellness of a human being is involved. She developed a certification process to train vendors that can then train people in becoming a CHW based on the geographic and health needs in the community. Health Visions Midwest is the one vendor certified in training CHW by INCHWA thus far. She also sent out a survey to Indiana employers, asking them what barriers they faced in hiring CHWs.

Andrew VanZee describes CHWs as individuals that do not fit into another category of licensed health care providers. He believes CHWs serve as an extension of care team internally and externally.

Community Health Worker Workforce – DWD Data and Perspective
Chairwoman Hasselkus describes the CHW workforce from the perspective of workforce development. She describes that each occupation has an associate Standard Occupational Code (SOC). She states that this occupational classification is important because it helps to make projections, describe the workforce, and classify individuals based on their job characteristics. She states that previously the Standard Occupational Code (SOC) definition for CHWs included health educators, but health educators was considered a separate role in 2010. She states that CHWs are expected to grow at 15%, faster than the average for all occupations. She states that this growth is likely driven by efforts to improve health outcomes and reduce healthcare costs. She states that in Indiana, there is projected growth for CHWs in all economic growth regions.

Community Health Worker Workforce – ISDH Perspective
Co-Chair Laura Heinrich provides the public health perspective on the CHW role. She states that from the perspective of ISDH, CHWs are utilized to link the community to health care, to reduce cost, form trusted connections, and help providers expand into the community. She shares the American Public Health Association's definition of the CHW. She also shares some primary titles of CHWs in the state, provided by employers.

Small Group Discussions and Report Out

Chairwoman Hasselkus directs workgroup members to form small groups and discuss key aspects of the CHW workforce (training, skills, roles, and reimbursement). After small group discussions have concluded, Chairwoman Hasselkus welcomes the group members to discuss their thoughts on the question prompts.

CHWs: How should they be trained?
One group states that as far as training, they came up with idea because CHW is so broad. Some sort of core CHW training would be good, as well as added specialty education for other areas that a CHW may be tasked with in their specific job.

A group member asks for clarification on what a core education would require; would it be in terms of a certificate or in required continuing education? The group responded that they had discussed both options, but did not commit to either direction.

Another workgroup member shares that they think the training should be thorough in nature and minimal in clinical because the people may be less educated. There should be national core competencies that should be taken into consideration.

The next group shares that relationship building, critical thinking, problem solving, and motivational interviewing should be foundational to CHW training. They state that traditional nursing curriculum prepares nurses to graduate with a standard set of skills that they build upon (experientially) when they work in specialty areas (such as OB/GYN, etc.). They believe that CHW training/core competencies should be set up in a similar manner.

The next group confirms that they agree with the requirements the other groups have mentioned. They think the training should be "on the job, competency-based." They further state that there should be a didactic piece (some classroom) but mostly on-the-job training. They also discussed the option of training occurring in the classroom or offering it online, but did not decide on which style would work best. They

also discussed the hours required in training and concluded that 18 to 24 hours seemed reasonable. The group member mentions that INCHWA's training course is currently 40-60 hours in addition to a 20-40 hour internship. Mary Anne Sloan shares that in general, a 40-60 hour training would qualify as a certificate which allows for financial aid participation. This may allow for pathway accessibility from CHW to additional education programs.

The workgroup formed consensus that they would like to hear more information about technical certificate requirements. The group also discussed wanting to hear additional information on National Core Competencies for CHW training. The Bowen Center for Health Workforce Research and Policy (Bowen Center) is poised to provide research support in this area and will bring the information to the next meeting. In addition to national core competencies, the group discussed that it would be beneficial to hear additional information on the competencies covered in the current Indiana-based training programs. The individuals/groups that currently represent training programs (INCHWA, ASPIN, Mental Health America) will provide information on the competencies and additional program information (hours, duration, how many individuals are trained annually, etc.) to the workgroup. In addition to state-specific programs, the workgroup expressed interest in understanding national models of training for CHWs. The Bowen Center will provide information on these models at the next workgroup meeting.

Andrew VanZee suggests it may be important to understand other states' licensure process for CHWs. Hannah Maxey responds that the Bowen Center can research that data.

Another group member suggests there may be a well-recognized definition for community health worker from Oregon. Hannah Maxey states that the Bowen Center will identify that information and create a summary for the workgroup.

Another member asks if it would be helpful for the group to understand the current certification process for Certified Recovery Specialists (CRS) in Indiana. Debbie Herrmann will provide that information for the workgroup. Kathy Cook states that she can assist with gathering this information.

CHWs: What competencies/skills should they have?

One group shares that some competencies they had believed to be important were: problem solving, awareness of the community they serve, teaching/education, motivational interviewing, following HIPPA guidelines, and ethics. Additionally, skills in patient education of chronic diseases would be helpful. This group specifies that the education would be non-clinical in nature.

Another group member suggests generational cultural training would be beneficial. Training in information technology and relationship building were also identified to be important.

Margarita Hart shares that situational awareness is a current identified competency by INCHWA. She defines this as problem solving: the ability to look at the larger landscape and understand/navigate the smaller problem of the client. She states it is also important to possess cultural competency of the medical culture and the patient's culture.

Another group added that confidentiality is also important.

CHWs: What is their role?

One group believes that their role is to extend the reach of health care, including any health care provider. They state that CHWs can act as a liaison for bi-directional communication between the patient and the health system. Another group emphasizes the CHW role as an advocate or linkage to the health care team to facilitate care coordination. Additional roles that were identified were case management, teaching/education, and cultural brokering (the ability for CHWs to interpret/translate material into a

mechanism that would be well-understood by the patient). Significant emphasis was placed on the role of CHW as a bridge between the medical world and the patient.

CHWs: Should they be reimbursed? If so, how?

One group responded that reimbursement may be more important for some organizations/employers and not for others. Therefore, if some organizations rely reimbursement for services provided by CHWs, then the workgroup determined that ensuring reimbursement is a priority of the workgroup.

Hannah Maxey asks if the workgroup believes reimbursement should be associated with training/certification. Andrew VanZee responds that reimbursement should be tied to the service provided and by proxy, by certification/training that is required to provide that service.

Cody Metzger states that moving forward, a sustainable method to financially support CHWs is critical. He states that most of the current programs are funded by grants, which are short-term funds. He states that finding federal and state dollars to establish a sustainable mechanism would serve the CHW workforce well.

One group member states that having a return-on-investment analysis completed would be beneficial to justify financial commitments. Cody Metzger state that an ROI will be completed by the end of the year through the Office of Medicaid Policy & Planning. He offers to share that information with the workgroup once it is completed.

Hannah Maxey asks if IU Health Bloomington has done any examination on cost-benefit or cost-effectiveness of CHWs. Carol Weiss-Kennedy responds that they have not yet completed one.

One group member shares that Minnesota has published a potential model for reimbursement that may be adopted by the workgroup. The Bowen Center will explore this model and share information with the group at the next meeting. Ascension may also have some information that could be brought to the next meeting.

One group member clarifies discussion; he states there are two mechanisms for reimbursement: fee-for-service and population/value-based. With the value-based system, organizations are enabled to use different levels of caregivers to deliver the same value-based care.

Debbie Herrmann shares that there is currently a process for fee-for-service reimbursement of CHWs in the behavioral health and primary care realm. She shares that provider members have suggested the reimbursement rate is low. However, she states that she is willing to share additional information about this service at the next workgroup meeting.

One group member asks that given the significant discussion and priority given to reimbursement, should a private payer be represented as a workgroup member. The workgroup has consensus that the perspective of a private payer would be beneficial to discussion/the work of the workgroup. The workgroup chairs will work to identify a private payer member for future meetings.

After discussion concluded, Chairwoman Hasselkus adjourned the meeting at 11:01am.