

MEETING MINUTES

Community Health Worker (CHW) Workgroup
Tuesday, February 13th, 2018 10:00-11:30am
Indiana Government Center South, Conference Room C

Members Present:

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

Kathy Cook, *Executive Director*, Affiliated Services Provider of Indiana (ASPIN)

Margarita Hart, *Executive Director*, Indiana Community Health Workers Association (INCHWA)

Derris Harrison, *Long Term Care Reimbursement Manager*, Office of Medicaid Policy and Planning

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

Debbie Herrmann, *Deputy Director, Medicaid Initiatives*, Division of Mental Health and Addiction

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

Don Kelso, *Executive Director*, Indiana Rural Health Association

Jennifer Long, *Administrator of Community Based Care*, Marion County Public Health Department

Mandy Rush, *Director of Community Services*, Mental Health America of Northeast Indiana

Carol Weiss-Kennedy, *Director of Community Health*, IU Health Bloomington

Welcome

Judy Hasselkus calls the meeting to order at 10:00am and welcomes all workgroup members. She acknowledges the upcoming retirement of workgroup member, Debbie Herrmann, and thanks Herrmann for her contributions to the workgroup. Debbie Herrmann introduces Terry Cook, Assistant Director of the Division of Mental Health and Addictions, who will represent DMHA on the workgroup going forward.

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 meeting minutes from the January 18, 2018 meeting that were distributed to workgroup members in advance of the meeting. Margarita Hart makes a motion to approve the minutes. Kathy Cook seconds this motion. All members approve. No opposition. Motion carries.

Brief Update on FSSA CHW Initiatives

Derris Harrison thanks the task force for allowing time to go over an updated draft policy distributed to the workgroup at the start of the meeting. FSSA and OMPP changed the definition of a CHW. He states they have adopted the definition of CHWs from the American Public Health Association. Another item they looked into was their definition of covered services. Currently, covered services consist of 1) diagnosis-related patient education towards self-managing physical, mental, or oral health in conjunction with a health care team *and* 2) facilitation of cultural brokering between an individual and a member of a health care team. Services that are not covered consist of enrollment assistance, case management, and advocacy efforts. They would like input from the workgroup for additions, subtractions, or revisions of covered services. FSSA and OMPP are still on target for an August 1, 2018 effective date and they have been working with their fiscal agent to create a fiscal impact, but utilization associated with existing code for the Certified Recovery Specialist has been low. This makes it difficult to create a fiscal impact. Derris Harrison reiterates that this draft policy is a living document and that their core group meets once a week to discuss the issues surrounding CHW reimbursement and future directions. He welcomes any comments, questions, or concerns about the draft policy and asks those replies be sent to him at least a week prior to the next CHW Workgroup meeting (March 20th).

Introduction of Proposed Course of Action for Workgroup

Judy Hasselkus and Laura Heinrich present a draft document titled “Proposed Direction/Vision for the Future of the Community Health Worker (CHW) Occupation in Indiana”. This document describes a vision for the CHW occupation in Indiana. The draft provides an overarching vision as well as implications for stakeholders including CHWs, employers, and state agencies. The draft vision statement is provided below:

Proposed Direction/Vision for the Future of the Community Health Worker (CHW) Occupation in Indiana

Indiana has a CHW workforce:

- employed in a variety of settings where they support patient and community health and positively affect health outcomes
- with access to high-quality, low cost, short-term training which results in a recognized credential (Certified Community Health Worker or CCHW)
- with minimal regulation to reduce barriers to entry in the occupation, but with sufficient oversight to ensure quality, safety, employer confidence, and alignment with reimbursement opportunities

Community health workers:

- may serve their communities without certification but will have access to a State-recognized credential* to increase recognition of their profession and to improve their employment opportunities
- serve in an entry level health sector occupation that offers opportunities for advancement through career pathways and additional education and training

Health care providers, community organizations, and others who employ CHWs:

- have access to a talent pipeline for the CHW workforce with a baseline skillset that has been validated
- may build upon existing skill sets of certified individuals to meet the needs of their patients and communities

Implications for State Policies and Agencies:

State CHW certification policies provide a supportive framework that positively affects the CHW workforce and patient outcomes.

- Certified Community Health Workers (CCHW's) are deployed in communities across Indiana in various roles, including supporting patient and community health by serving as a liaison and/or uniquely qualified connector to healthcare and community resources (ISDH)
- The State of Indiana provides reimbursement for selected supportive healthcare services provided by CCHWs (FSSA)
- CCHW is part of a health sciences career pathway and is a stackable credential. Opportunities exist for CCHWs seeking career advancement (DWD/DOE/CHE)

*Note: Explore legacy provision to allow CHWs who have earned certification prior to implementation of State-recognized credential to earn a CCHW without requirement of additional training.

Laura Heinrich reviews the vision document with workgroup members. Judy Hasselkus notes that from a DWD perspective it is important that the CHW occupation can be an entry point to the healthcare workforce that is not a “dead end”—that it can be part of a career pathway. She noted that it is also important not to create barriers to entry into the occupation or to invalidate experience that CHWs have obtained through previous training or work experience. The co-chairs welcome any questions, comments, or concerns pertaining to the document. Lisa Staten recommends that the use of patient and community health should be consistent throughout the document. The co-chairs also encourage workgroup members to email them directly following the meeting with any additional recommendations.

Best Practices in Education and Credentialing

Mary Anne Sloan introduces her presentation on roles, skills, and competencies. She explains that Ivy Tech Community College has a focus on the workforce and educating individuals to prepare them for entry into the workforce.

Mary Anne explains that roles are jobs or positions that have a specific set of expectations. Competencies are observable and measurable knowledge, skills, and abilities that demonstrate success of a job/role. Skills are specific learned tasks or activities.

She explains the differences between certificates, certification, and licenses. Training providers award certificates after completion of required coursework, exams, and other performance evaluations. They are not a professional designation. Certifying bodies award academic certifications, which evaluate the knowledge and skills of an individual to ensure a desired level of competence. Governmental agencies award licenses, which permit an individual to practice in a specific field.

Hannah Maxey suggested that, in general, if a government body regulates entry into an occupation, it is considered a licensed occupation. Mary Anne Sloan says that she has confirmed with the Indiana State Department of Health that CNAs are not licensed, but are instead certified and on a registry. They must re-register every two years.

Andrew VanZee asks what qualifies an individual to be placed on the registry by the Indiana State Department of Health and Mary Anne Sloan states that they have to take a one-time CNA exam, but there is no requirement for continuing education.

Mary Anne Sloan states that CHWs would likely not be regulated by the Centers for Medicaid and Medicare Services but there is also not a national certification. Currently, from the educational perspective, CHW training would not be at the same level as a medical assistant (17 credits). The CHW currently falls more into the training hours of a CNA (5 credits). If there were a certifying body that required CEUs and a time limitation, it would become a certification. If it were a registry, one would take a course and receive a certificate. Hannah Maxey suggests that the regulatory discussion might be tabled until future meetings when legal counsel is available to inform the discussion.

Margarita Hart states that there is developing legislation at a national level that APHA is trying to put through for CHWs surrounding definitions and certifications. Mary Anne Sloan asks if it is going to the federal government for legislation and Margarita Hart replies affirmatively. Mary Anne Sloan asks if this is being legislated for CMS purposes and Margarita Hart explains that she is unsure because they are still in the beginnings of the conversation. Mary Anne Sloan asks if there is a process being developed for certification and Margarita Hart says that she does not know at this time, but she will keep the group updated.

Mary Anne Sloan states that there are gray areas with certification. If there is not a national body to determine the competencies, CHWs might be considered a certificate-level occupation. Hannah Maxey replies that in the absence of a national model, if an individual wants training or certification from the state, the state would have to develop a formal process for validation purposes. She states there are levels of occupational regulation, with the baseline being a registry. Generally, governmental entities do not maintain registries. A registry does not exist nationally, so if the state issues anything or determines entrance into the profession and continuation into that occupation, it may technically be considered a professional license.

Margarita Hart states that licensing could limit who can become a CHW and Hannah Maxey replies affirmatively.

Mary Anne Sloan defines stackable credentials using the definition created by the U.S. Department of Labor. Stackable credentials are part of a sequence of credentials accumulated over time to build up an individual's qualifications and help them move along a career pathway or up a career ladder to different and potentially higher paying jobs. She uses a Long-Term Care Specialist as an example to show stackable credentials: Certified Nursing Aide (5 credits), Dementia Care (3 credits), QMA (5 credits), and choosing between Restorative Aide and Meal Planner (3 credits). She explains that Ivy Tech has adopted these definitions of roles, skills, competencies, certificates, certifications, and licenses. She states that the goal is to create stackable credentials in other health care professions.

Small Group Discussion and Report Out

Hannah Maxey refers to the "CHW Roles, Competencies, and Skills" document distributed to the workgroup at the start of the meeting. She states that the information included in this document is from the C3 project and aligns with the work that has been done by INCHWA. She states that the focus of this meeting was for the workgroup to come together and review the competencies and skills for CHWs. She states that once there are established competencies and skills for Indiana CHWs, a discussion of regulations can be had. The workgroup split into groups to discuss competencies and skills and to identify anything missing or in need of clarification. The competencies and skills which were presented for reflection can be found below, followed by workgroup member comments:

	Competencies	Skills
1	<i>Communication Skills</i>	<ul style="list-style-type: none"> a) Ability to use language confidently b) Ability to use language in ways that engage and motivate c) Ability to communicate using plain and clear language d) Ability to communicate with empathy e) Ability to listen actively f) Ability to prepare written communication including electronic communication (e.g., email, telecommunication device for the deaf) g) Ability to document work h. Ability to communicate with the community served (may not be fluent in language of all communities served)
2	<i>Interpersonal and Relationship-Building Skills</i>	<ul style="list-style-type: none"> a) Ability to provide coaching and social support b) Ability to conduct self-management coaching c) Ability to use interviewing techniques (e.g. motivational interviewing) d) Ability to work as a team member e) Ability to manage conflict f) Ability to practice cultural humility
3	<i>Service Coordination and Navigation Skills</i>	<ul style="list-style-type: none"> a) Ability to coordinate care (including identifying and accessing resources and overcoming barriers) b) Ability to make appropriate referrals c) Ability to facilitate development of an individual and/or group action plan and goal attainment d) Ability to coordinate CHW activities with clinical and other community services e) Ability to follow-up and track care and referral outcomes
4	<i>Capacity Building Skills</i>	<ul style="list-style-type: none"> a) Ability to help others identify goals and develop to their fullest potential b) Ability to work in ways that increase individual and community empowerment c) Ability to network, build community connections, and build coalitions d) Ability to teach self-advocacy skills e) Ability to conduct community organizing
5	<i>Advocacy Skills</i>	<ul style="list-style-type: none"> a) Ability to contribute to policy development b) Ability to advocate for policy change c) Ability to speak up for individuals and communities
6	<i>Education and Facilitation Skills</i>	<ul style="list-style-type: none"> a) Ability to use empowering and learner-centered teaching strategies b) Ability to use a range of appropriate and effective educational techniques c) Ability to facilitate group discussions and decision-making d) Ability to plan and conduct classes and presentations for a variety of groups e) Ability to seek out appropriate information and respond to questions about pertinent topics f) Ability to find and share requested information g) Ability to collaborate with other educators h) Ability to collect and use information from and with community members
7	<i>Individual and Community Assessment Skills</i>	<ul style="list-style-type: none"> a) Ability to participate in individual assessment through observation and active inquiry b) Ability to participate in community assessment through observation and active inquiry

8	<i>Outreach Skills</i>	<ul style="list-style-type: none"> a) Ability to conduct case-finding, recruitment and follow-up b) Ability to prepare and disseminate materials c) Ability to build and maintain a current resources inventory
9	<i>Professional Skills and Conduct</i>	<ul style="list-style-type: none"> a) Ability to set goals and to develop and follow a work plan b) Ability to balance priorities and to manage time c) Ability to apply critical thinking techniques and problem solving d) Ability to use pertinent technology e) Ability to pursue continuing education and life-long learning opportunities f) Ability to maximize personal safety while working in community and/or clinical settings g) Ability to observe ethical and legal standards (e.g. CHW Code of Ethics, Americans with Disabilities Act [ADA], Health Insurance Portability and Accountability Act [HIPAA]) h) Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements i) Ability to participate in professional development of peer CHWs and in networking among CHW groups j) Ability to set boundaries and practice self-care
10	<i>Evaluation and Research Skills</i>	<ul style="list-style-type: none"> a) Ability to identify important concerns and conduct evaluation and research to better understand root causes b) Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) c) Ability to participate in evaluation and research processes including: i) Identifying priority issues and evaluation/research questions ii) Developing evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings
11	<i>Knowledge Base</i>	<ul style="list-style-type: none"> a) Knowledge about social determinants of health and related disparities b) Knowledge about pertinent health issues c) Knowledge about healthy lifestyles and self-care d) Knowledge about mental/behavioral health issues and their connection to physical health e) Knowledge about health behavior theories f) Knowledge of basic public health principles g) Knowledge about the community served h) Knowledge about United States health and social service systems

“Communication and Skills”

- Approval of sub-bullets a through e
- On sub-bullet f (“Ability to prepare written communication including electronic communication”), suggested change was to define “written communication.”
- On sub-bullet g (“Ability to document work”) the suggested change was to add “the ability to communicate with care team (or employer) if applicable.”

“Interpersonal and Relationship Building Skills”

- On sub-bullet a (“Ability to provide coaching and social support”), suggested change was to include “problem solving skills” as a service provided to the client.
- On sub-bullet b (“Ability to conduct self-management coaching”), suggested change was to define “self-management.”
- On sub-bullet c (“Ability to use interviewing techniques [e.g. motivational interviewing]”), the workgroup asked if there was potential for motivational interviewing to be a stackable skill/credential.
- On sub-bullet f (“Ability to practice cultural humility”), suggested change was to define “cultural humility”

“Service Coordination and Navigation Skills”

- On sub-bullet a (“Ability to coordinate care [including identifying and accessing resources and overcoming barriers]”), the workgroup noted that it was also important for the CHW to understand the broad health system (including social services and medical system)
- On sub-bullet c (“Ability to facilitate development of an individual and/or group action plan and goal attainment”), the workgroup questioned if this skill should be included.

“Capacity Building Skills”

- A general comment from one group was that some of the broader, larger community activities may be too broad.
- On sub-bullet c (“Ability to network, build community connections, and build coalitions”), the workgroup noted that “building coalitions” might not be feasible at this occupational level.
- On sub-bullet e (“Ability to conduct community organizing”), the workgroup stated that this skill might be eliminated.

“Advocacy skills”

- On sub-bullets a and b, (“Ability to contribute to policy development” and “Ability to advocate for policy change”) these two skills were rejected by some workgroup members, but others wanted them to remain with a focus on community health. One workgroup member noted that one example of this might include patients identifying that scheduled clinic hours were a barrier. In that case, the CHW could advocate for “policy” change on behalf of a patient, family, or community.

- On sub-bullet c (“Ability to speak up for individuals and communities”), the workgroup stated that this should remain when culturally appropriate and on behalf of the client.

“Education and Facilitation Skills”

- On sub-bullets a-c and e-h, the workgroup generally suggested that these skills should be in the context of culturally appropriate strategies.
- On sub-bullet d (“Ability to plan and conduct classes and presentations for a variety of groups”), the workgroup suggested that this could be an opportunity for professional career development for CHWs.

“Individual and Community Assessment Skills” – No comments.

“Outreach Skills”

- On sub-bullet a (“Ability to conduct case-finding, recruitment, and follow-up”), the workgroup suggested replacing “conduct case-finding” with “identify need.”
- On sub-bullet b (“Ability to prepare and disseminate materials”), some members suggested that focus should be on the *dissemination* rather than the *creation* of materials. Also, some members suggested clarification is necessary for “prepare” and “disseminate.”

“Professional Skills and Conduct”

- Too many things lumped together in this section and it could be broken down into different categories
- On sub-bullet a (“Ability to set goals and to develop and follow a work plan”), some workgroup members suggested that it may be more appropriate for a CHW to “observe” a work plan, rather than “follow.”
- On sub-bullet c (“Ability to apply critical thinking techniques and problem solving”), some workgroup members suggested adding “the ability to flag cases for follow up with a larger team.”
- On sub-bullet e (“Ability to pursue continuing education and life-long learning opportunities”), some members suggested there needs to be a clear definition of “ability.”
- On sub-bullet g (“Ability to observe ethical and legal standards”), some members suggested adding “follow.”

“Evaluation and Research Skills”

- On sub-bullets a and b, workgroup members suggested eliminating these skills as they do not feel it is necessary for CHWs to have research and evaluation skills.
- On sub-bullet c, workgroup members suggested changing the complex terminology to accommodate for individuals of lower education levels.

“Knowledge Base”

- One general comment from some workgroup members was that this section of skills seems too broad. Another general comment suggests that “situational

awareness, cultural competence, appropriate language, and professional skills” should be added.

- On sub-bullet a (“Knowledge about social determinants of health and related disparities”), workgroup members suggested using simpler terminology.
- On sub-bullet d (“Knowledge about mental/behavioral health issues and their connection to physical health”), some members suggested adding “the ability to recognize baseline issues or problems”
- On sub-bullets e and h (“Knowledge about health behavior theories” and “Knowledge about United States health and social service systems”), a workgroup member suggested this skill was too in-depth and needs clarification.

Next Steps

Hannah Maxey states that the Bowen Center will synthesize this information and put it into a format that will be sent to the workgroup for review in advance of the next workgroup meeting.

Closing and Adjourn

Judy Hasselkus thanks the workgroup for their contributions. She calls the meeting to adjournment at 11:30am and reminds workgroup members of the next meeting on March 20th.