Community Health Workers in Connecticut
Meeting Minutes
September 13, 2012
Legislative Office Building, Room 2B
Hartford, Connecticut
1:05 – 2:57 pm

Welcome & Introductions

Welcome by Renee Coleman-Mitchell (DPH CHAPS Section Chief)

Self-introduction of attendees: Joanne Calista; Meredith Ferraro; Beth Lamarre; Darianne Berman; Amanda Versilone; Salina Hargrove; Ava Nepaul; Patrice Sulik; Katie Shuttleworth; Elizabeth Reynolds; Mary Windar; Cindy Kozak; Mary Scully; Valerie Fisher; Sularey K.; Linda Ferraro; Joseph Erlichiano; Melanie Smith; Cathy Henley; Kathleen Sullivan; UConn School of Nursing students; Mike Corjulo; Jacqueline Ortiz-Miller; Kathy Traugh; Kathy Lewis; Lisa Davis; Roberth Zivosky; Bruce Gould; Patty Lugo; Rebecca; Linda Paris; Millie Seguinat; Maria Vickens; John; Mattiene Fraiser; Mehul Dalal; Lisa McCooey; and Eileen Boulay

E.Boulay welcomed attendees and pointed out a table of resources that state the case for CHWs.

Purpose of the Meeting

M. Ferraro: Discuss the role of Community Health Workers (CHWs) and what is going on in other states in light of health care reform.

Panel Presentations

Joanne Calista, Director of Central Massachusetts Area Health Education Center (CM AHEC)

The Massachusetts Outreach Worker Training Institute offers core competency and supervisory training for CHWs. There is a long history of CHWs in MA with strong support of the Massachusetts Department of Public Health (see http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health-workers.html). There are many efforts to integrate CHWs into work about asthma, HIV/AIDS, and other chronic diseases.

A professional organization is important – it drives policy and education initiatives. The Massachusetts Association of Community Health Workers (MACHW) is the professional organization of CHWs in MA (see http://www.machw.org/). MACHW was founded in 2000.

Training is an essential element for CHWs. Massachusetts has learned from the experience of other states like Texas. The National Education Collaborative is a resource for training best practices (see http://www.chw-nec.org/). Core competencies are the foundation of any training. Training is dependent on funding. Currently, 48 hours of core competency training are offered. Methodology of training is also important. Value, credibility, and authenticity to programs are brought by involving CHWs as trainers. Training can be located in a variety of places like community colleges; but also, community-based settings are important for people who cannot access college locations.

Health Care Reform and payment reform are opportunities to incorporate CHWs. The Massachusetts Department of Public Health conducted a study of CHWs in MA in 2005 and a statewide panel reviewed findings. Payers were very clear about what they wanted to see in terms of certification. The study recommendations were: stabilize funding for training of CHWs; statewide accessibility & affordability; and establish a certification board for CHWs.

Certification and certificate are not interchangeable terms. Certification is just one part of a credentialing process.

Concerns about certification:

- Would it change the nature of the work?
- Would we lose CHWs who have been practicing for years?
- Would it be driven by other health professionals?

The hope is that certification supports:

- Better recognition;
- Respect;
- More livable wages;
- Stabilization of funding for CHW positions;
- Reimbursement for work; and
- Professional growth.

MACHW did outreach with CHWs throughout Massachusetts and people stated overwhelmingly that they were interested in certification (see policy brief). People wanted something that was not mandatory, access to training opportunities, and wanted certification to be CHW-driven. Resulting legislation was passed to establish a Board of Certification at the Massachusetts Department of Public Health that is appointed by the Commissioner. The Board, which sits in the DPH Division of Licensure, requires four CHWs on the panel. Board meetings are public and the minutes are published online.

<u>Beth Lamarre, Manager, Community Health Worker Association of Rhode Island (CHWARI)</u>

The Community Health Worker Association Rhode Island (CHWARI) is working to help Rhode Island residents achieve optimal health and health equity and to professionalize CHWs. The Association began formation in 2008. The formation process began with a conference for CHWs and a post-conference survey about the experience and what other professional education was desired. A Special Interest Group was formed and snowballed into CHWARI. CHWARI Listserv has over 350 participants, including supervisors.

Context – 3,300 CHWs were counted in Rhode Island according to a Rhode Island Department of Labor report. Healthcare and social services are the largest employers in Rhode Island. Surveys demonstrate CHW interest in professional development activities.

In 2010, a curriculum outline was developed, similar to the one in MA, but dictated by fiscal climate in Rhode Island. Curriculum is currently being piloted and a section on how CHWs can use Medline Plus is being added. Curriculum development for supervisory skills is being planned.

Networking opportunities are as important as training. CHWARI partnered with large public health care provider and held a CHW networking session last year.

A CHWARI Steering Committee was established. There is a two-year role for Steering Committee members. Present steering committee members include a variety of stakeholders. Initial partners included Lifespan and Neighborhood Health Plan.

In 2012, CHWARI established a paid membership structure and initiated a "members only" section of the Association website.

The Rhode Island Department of Health is funding CHWARI operations, salary, and meeting & conference space. Fiscal agent is RI Parent Information Network. Currently B. Lamarre is the only staff person and work is supported by student workers. CHWARI activities: curriculum; professional development; networking; partnership project; newsletter, website; representation of CHWs in RI.

Working on: needs assessment with Brown University Community Outreach; Chronic Conditions workforce (looking into reimbursement for CHWs); apprenticeship with RI Department of Labor & Training; higher education and technical school opportunities; and New England Regional Workgroup.

<u>Meredith Ferraro, Director, Southwestern Area Health Education Center (SW AHEC)</u>

AHECs became federally funded in 1997; 4 AHECs across the state with the mission to improve access to primary, preventive healthcare.

Had a curriculum, but did not know what the need for CHWS was. 1999 needs assessment for outreach workers showed that generally: CHWs were female and that there were regional differences in education level of CHWs. Barriers identified included: lack of stable funding; multiple definitions of CHW; training needs; and difficulties of supervising CHWs with different work experiences.

Curriculum development has to be a grassroots approach. The model is to have the CHWs teach the curriculum. AHEC worked with a community college to offer the curriculum and educational programs for CHWs. The technical assistance partner was the CHW National Educational Collaborative. 50 competencies (see packet). There are specialized content areas for chronic diseases as well. Mentoring, job-shadowing, and bilingually-delivered courses were done. To date, 100+ CHWs have been trained in the core competencies. Problem - people were trained, but there were limited number of jobs.

Support of CHWs in health reform is evident in the National Health Workforce Commission, which includes CHWs and primary care professionals. Supposedly, grants will be coming to promote the CHW

workforce. AHEC is mentioned in health care reform for training CHWs. CHWs are mentioned in healthcare reform legislation dealing with: preventable hospitalizations; patient-centered medical homes (PCMH); Patient Navigator Program; CMS Innovation Grants; outreach for health insurance exchanges; new models for global payment to include; and standard preventative care benefits. See slides from Karl Rush (Texas).

An issue is that CHWs are called different names. Who are CHWs? Because they are called so many different names, it's tough to say. Currently in the midst of a survey to find out how many there are with the CT-RI Public Health Training Center (PHTC). In identifying CHWs, we would like to know what their needs are, what training is needed, and what barriers exist. PHTC did CHW focus group and more are planned.

An Employer Needs Assessment (modeled after 1999 survey) has begun, but of the 2,000 e-mail surveys that were sent out. There have been only 85 responses in the past two months.

Resources- Free CDC policy education webinars. CDC e-learning modules, six-part series developed through Heart Disease & Stroke Prevention. Office of Women's Health CHW leadership training.

On the horizon- Department of Labor recognition of CHW as an apprenticeable trade with a 6-month pilot project ongoing in Texas. Federal Office of Minority Health has a new Promotora/CHW Initiative.

Mehul Dalal - what's going on at the federal level?

- strong message that improvement of clinical-community linkages -reference integrated chronic disease bucket #4
- ACA health reform is another area where the role of CHWs can be better defined

Question & Answer/Audience-Panel Dialogue

Question from Mehul Dalal, Chronic Disease Director, CT DPH

Q: What is going on in Massachusetts with regard to chronic disease and CHWs?

J. Claista: There was National Heart, Lung, & Blood Institute funding to train CHWs in MA. The MA DOH sponsored funding four years ago to move CHWs into chronic disease self-management with CHWs funded in Community Health Centers. There is still a lot of work to do. There is a Robert Wood Johnson grant to support people with diabetes. Would like to have other state agencies get involved with using CHWs (e.g., behavioral health). There is a 2010 report online that documents MA's efforts in this area.

Question from Mike Corjulo, Health Services Coordinator, ACES

Q: What % estimate of the reimbursement is grant funded and how do you foresee who is going to pay for CHW services?

J. Calista: One of the challenges is documenting and quantifying the impact of CHWs. The literature is moving ahead – recent studies on return on investment (ROI). There are examples in New Mexico and Ohio. ROI is a powerful mover for payers. In MA, most CHWs are grant-funded; however, there are 11 CHWs in the operating budget at Edward M. Kennedy Health Center. It's a double-edged sword - reimbursement may change the profession. I think the payers are starting to come on board. Because of the instability of funding and turnover, it has been tough on the workforce.

B. Lamarre: Evidence-based self-management programs are being used as a model and starting to engage employers who've used CHWs to get information on services provided by CHWs. In RI, 50% of CHWs are part of the operating budget.

J. Calista: In the past, RI has done innovative work to develop contracts for care teams in behavioral health and could bill for particular services.

B. Lamarre: There are reports about these types of programs that have been very effective; RI DOH PPEP report that gives business model and cost-effectiveness report.

Anne Morris, Executive Director, Connecticut Affiliate of Susan G. Komen for the Cure

Q: Who are the employers of CHWs? Is there any organization that brokers CHW funding from specific diseases so that a CHW could be split-funded?

B. Lamarre: Government agencies employee CHW, social services, CHCs, many aspects; there are a few agencies that do what you asked about- subcontractor employees are partially by multiple organizations.

J. Calista: This also becomes an issue with training. A soundly practicing CHW does it all; however, some work environments are very restrictive. Personally, I think the CHWs should be about the whole person, regardless of the disease because people have many co-occurring conditions and I'd like to see it include behavioral health; but funding typically is by body part.

A. Morris: Who are the primary employers of CHWs in MA?

J. Calista: Mostly CHCs. There are some hospitals as well. There are some CHWs for patient navigation in clinical settings. Some CHWs in faith-based and refugee orgs. Primarily public funding. Some BC/BS and DentaQuest funding.

M. Ferraro: In Connecticut, the employers are mostly CHCs, non-profits, and public health agencies.

Linda Ferraro, State Dental Director, CT DPH

Q: In MA and RI, were CHWs incorporating oral health into what they are doing?

J. Calista: Yes. We do try and incorporate more and more into core training for oral health. Unfortunately, it has not always been the goal of the funders. But with National Heart, Lung, & Blood Institute funding, we are able to weave oral health information into training. Could be an option in CT to look at community benefits money (from hospitals) that can be a fair chunk of funding that is not driven by specific health conditions.

M. Ferraro: Included OpenWide in training of CHWs.

Millie Seguinot, Project Coordinator, SW AHEC

Millie discussed how she does outreach with families - presenting resources available to help people access services for which they are eligible. Community Messenger (CM) is the term used for people doing this type of outreach. CMs exists only in Bridgeport - group of parents that were selected from different parts of the city that train on what resources are available in the community to connect parents to services so that they can learn how to advocate for themselves and help their families. A lot of energy and passion around CM. Things are happening and people are very excited about it.

Kathi Traguh, Assistant Director, CT-RI PHTC & President, CT Public Health Association

The CT-RI Public Health Training Center is funded by HRSA and located at the Yale School of Public Health. We have been working with RI and SW AHEC in CT. We want to help more, but it's hard when there is not a group to work with. CPHA is interested in helping with formation of an organization of the CHWs in CT. CHWs have to be able to come together somehow - we offer through PHTC and CPHA resources to get CHWs to come together.

Bruce Gould - AHEC Director and City of Hartford Medical Advisor

Accountability for patients has extended beyond the doors of the clinic. We are now going to be held accountable for outcomes in our patients. ACO (accountable care organization). There is a huge opportunity to look at models of case management and outreach. I would push people to vision ahead so we don't miss the boat when it leaves the dock. It's coming. Think also about the utility model (contracting with small practices to provide CHW services) is something worth examining.

B. Lamarre: Speaking at all of the RI PCMH conferences that have been going on to inform physicians. Creation of standard referral form.

M. Corjulo: Has there been any discussion with Department of Children and Families (DCF) use of CHWs? That could be a potential source of employment for CHWs.

B. Lamarre: There are a few DCYF and parent outreach agencies that employ CHWs.

J. Calista: There are some in MA, in maternal & child health. Need more integration in DCF.

Mary Scully, Programs Director, Khmer Health Advocates (KHA)

Q: How do we deal with the system? It is really difficult to figure out who is the advocate in the state for CHWs. Who is assuring that CHWs are part of the system for accountable care?

E. Boulay: I think that's why we're here. We don't know what is going on in the state. It needs to be figured out.

M. Scully: Are we going to talk about that today?

E. Boulay: That may be a follow-up meeting once we summarize this meeting.

J. Calista: What helped us in Massachusetts was having legislative advocates.

Wrap-up

E. Boulay: There is definite interest in moving forward and it should involve more CHWs. If you have other partners like DHMAS and DCF, please e-mail us so that we will know who to invite to future meetings.

M. Ferraro: Please write down on the evaluation form if you would like to be on a workgroup. There are people who want to be engaged. Please, consider being part of the solution.

J. Calista: Invite to Sept 27th MACHW meeting.

Universal Health Care Foundation: Conference on PCMH at the University of Hartford on October 23rd.

M. Ferraro: Next steps – Please complete the evaluations and give your business cards. Want to hear from you where we go next. We do need to come sort of structure in terms of how to move forward.

E. Boulay: We will meet internally- DPH and SW AHEC to work on next steps.

Meeting adjourned at 2:54pm

Minutes recorded by Ava Nepaul, DPH Asthma Program