STATE OF CONNETICUT
State Innovation Model
Community Health Worker Advisory Committee
Meeting Summary
Thursday, June 14, 2016
2:30 pm – 4:30 pm

Location: Hartford Room, CT Behavioral Health Partnership, Suite 3D, 500 Enterprise Drive, Rocky Hill, CT 06067

Members Present: Migdalia Belliveau, Thomas Buckley, Darcey Cobbs-Lomax, Grace Damio, Loretta Ebron, Liza Estevez, Terry Nowakowski (Chair), Milagrosa Seguinot, Mayce Torres, Robert Zavoski

Members on the Phone: Ashika Brinkley, Juan Carmona, Peter Ellis, Linda Guzzo, Chioma Ogazi

Members Absent: Yolanda Bowes, Michael Corjulo, Tiffany Donelson, Jacqueline Ortiz Miller, Nicholas Peralta, Lauren Rosato

Other Participants: Bruce Gould, Meredith Ferraro, Stanley Zazula, William Tootle, Jenna Lupi, Mark Schaefer, Katharine London, Carl H. Rush (phone), Supriyo Chatterjee, Maria Rodriguez

1. Call to Order and Introductions
Terry Nowakowski served as Chair and called the meeting to order at 2:38 pm.

2. Public Comments
No public comments were submitted for discussion.

3. Approval of Minutes
Motion: to approve minutes from 5/19/16 – Thomas Buckley; seconded by Milagrosa Seguinot.
Vote: all in favor.

4. Recap of Ground Rules
Jenna Lupi reviewed the meeting ground rules that were discussed and agreed on at the previous meeting.

5. Community and Clinical Integration Program Introduction
Mark Schaefer presented an overview of the SIM Community and Clinical Integration Program (CCIP), using the example of a Cambodian refugee's experience with the healthcare system in Connecticut to illustrate how CHWs can improve the delivery of care. CCIP will provide technical assistance, peer learning, and transformation awards to provider networks to enable them to better address the care needs of complex patients, improve health equity, and integrate behavioral health into their delivery of care. The CHW Advisory Committee—through its work on developing a CHW definition, scope of work, etc.—will be instrumental in helping CCIP achieve its goals through the full integration of CHWs into care teams.

6. Recap of CHW Symposium
Meredith Ferraro reported very positive feedback from attendees of the CHW symposium on 5/24/16. 95% of the 43 attendees who completed evaluations "agreed" or "strongly agreed" that the symposium will better enable them to contribute to decision making about Connecticut's CHW service-delivery system.

7. CHW Definition and Scope of Practice
Ms. Ferraro provided a brief history of and background to the Community Health Worker Core Consensus (C3) Project, which released its report and recommendations regarding CHW roles and competencies in May 2016.

Katharine London explained that the committee's assignment for the meeting was to develop a definition of CHWs and a description of their scope of practice. Since many people across the country have been working on these issues for years, she and the SIM CHW Initiative staff thought it would be best to start by examining what others have done and getting the committee's thoughts on it.

Definition

Ms. London read the 2009 APHA definition of a CHW and the emendation made to it by the CHW Association of Connecticut (CHWACT) in 2014 and then opened the floor up to comments.

Milagrosa Seguinot relayed that CHWACT convened a working group in Hartford at the end of 2013 to develop a definition of CHWs in CT. They compared the APHA definition with those of other states (including MA and NY) and the US Department of Labor and decided that the modified APHA definition that Ms. London read describes perfectly CHWs in CT. The board of CHWACT approved the definition on 3/19/14. The definition can help employers identify who to hire for CHW positions. "It's very clear, it's to the point," she said. "It's what we adopted in 2014, and it's what we feel comfortable with."

As one who had been part of the work group that came up with the definition for CT, Darcey Cobbs-Lomax echoed what Ms. Sequinot said and asked several questions: Is adopting the 2014 definition an option? Do we need to revise it? If so, why?

Ms. London replied that that is the question. If everybody agrees with the definition as it is, then the work has been done for the committee; but the SIM staff wanted members to have time to look at it to make sure it is accurate for CT and doesn't leave anything out.

Peter Ellis pointed out that CHWACT's insertion ("and ability to communicate with") into the APHA definition seems to be more of a skill than a definition, although he conceded that communication is very important.

Robert Zavoski explained that if Medicaid is going to pay for CHWs, then the definition or relevant regulations will have to be "crystal clear," specifying precisely what is being done, who is doing it, and who and what are and are not included.

Ashika Brinkley agreed with Dr. Zavoski, saying that while nice the definition was too broad and could apply to most people doing interventions. It does not distinguish CHWs from other public-health workers engaged at the community level.

In response to a question by Mayce Torres about which of the two definitions (APHA and CHWACT) is more clear to him, Dr. Zavoski explained that from his point of view both are philosophies (which he agrees with). He stressed the need to spell out the tasks of CHWs to the degree that even people who have no idea about what CHWs do, how they do it, or why will understand these things. He encouraged the committee to put on their "lawyer hats" and make the definition very concrete so that everyone will understand exactly what it describes.

Terry Nowakowski commented that the care-coordination aspect of CHWs seems to be missing from the definition. The message of who CHWs should be is there, but they also need to possess the technical skills and abilities necessary to coordinate care.

Ms. London encouraged the committee to try to keep formulation of a definition somewhat separate from the process of identifying specific CHW roles, skills, and qualities (i.e., the scope of practice). It is important to keep in mind what needs to be in the definition versus what needs to be in the scope of practice, which will be discussed after the definition. The definition cannot cover everything.

Ms. Cobbs-Lomax returned to Dr. Ellis's comments about the insertion of "and ability to communicate with" into the APHA definition, remarking that she believes the working group was referring to the linguistic ability to communicate with clients in their own language and that perhaps there is a way to express that more clearly. She also alerted the committee to the very detailed description of CHW roles and skills contained in the C3 handout because it may address some of the concerns about the abstractness of the definition under review.

Mark Schaefer expressed concern that the definition's sole focus on linkage to community services and building of individual and community capacity doesn't necessarily speak to the other things that self-funded employers and commercial health plans have found valuable and that they might consider covering. If we want to engage payers who are more accustomed to dealing with populations with fewer "social determinant risks," he said, but who may still benefit from health coaching or patient navigation, we may need to broaden out the definition from these two points of focus. He referred to Iora Health as a primary-care model whose health coaches and navigators probably do less community work but still provide critical coaching and navigation services to the populations they serve. He encouraged the committee to think about where the dividing line might lie between practices that mostly build coaching, navigation, and chronic-illness self-management capacities and those that might be much more about linkage to community supports and services. It is important that the definition speak to the full range of payers who might be interested in the services of CHWs.

Thomas Buckley pointed out that the definition appears not to reflect the WHO's recommendation that "CHWs should be answerable to the communities for their activities" and posed the question of whether the committee will be answerable to communities for the activities that CHWs carry out in the state.

Migdalia Belliveau acknowledged the need to honor the definition that CHWs adopted, but raised the possibility that building on it (by, for example, adding core functions) might not be incompatible with doing so. She said she wanted to figure out how to achieve a "win-win."

Grace Damio asked Dr. Schaefer to clarify whether his concern is about restricting CHWs to either a linkage/capacity-building role or a health-coach/navigator one or whether it is about making sure they are able to play both kinds of roles. He replied that it is the latter.

Ms. Damio responded by encouraging the committee to think about community in two different ways as it relates to CHWs. One way is to think of CHWs as extending the reach of healthcare and linking it to the community. Another is to think of them as being located in the community in organizations that play the dual function of linking the community to healthcare and addressing social determinants of health. She agreed that there is a continuum between these two aspects of community, but stressed the importance of not losing sight of the community-based aspect through over emphasis on the community-linkage one. She also raised concerns about the definition's not explicitly mentioning the core CHW role of addressing social determinants of health.

Dr. Ellis agreed that not losing community is important and stated that having a mechanism for community-based providers to bill for CHW services would be ideal. He asked if there is anything the committee can learn from states that are ahead of CT, for example, whether any have had trouble paying an Iora-type provider using an APHA-like definition of CHWs similar to the one under discussion.

Ms. London explained that although a couple of states (MN and maybe PA) allow fee-for-service payments for CHW services, most of those that use Medicaid funding for CHWs do so as part of payments to organizations for larger sets of services.

Dr. Zavoski explained that Medicaid in CT can make two kinds of payments. One is to an administrative services organization (ASO) for services provided by the ASO directly or by its contractors. In this way, a CHW would be working for a contractor of the state. The other is fee-for-service payments to providers for defined medical services, which means that to receive Medicaid reimbursement a CHW would have to provide a defined medical service or extension of a medical service. He agreed that building linkages is valuable, but emphasized that it is not a medical service. Since much of the focus has been on Medicaid payment for CHW services, he suggested that the committee might want to keep these Medicaid policies in mind as it deliberates on the definition.

Ms. Damio asked Dr. Zavoski if he could describe a kind of activity that would both meet the medical-service or medical-extension requirement and reflect the unique function of CHWs. Dr. Zavoski referred to the example of diabetes educators. Most of them are nurses, but there are nurses who might not understand the uniqueness of a community or the uniqueness of groups of people who, for example, look upon diabetes care in a different way with a different internal model. How do you improve diabetes outcomes, he asked, in a measurable way by doing counseling around diabetes care for someone in the community and link that to the healthcare system so that it is a measurable outcome?

Ms. London reminded the committee that discussion of the complex topic of payment systems is scheduled for later in the year and encouraged members to focus on first agreeing on what a CHW is and does (e.g., attends to the whole person).

Ms. Ferraro remarked that a definition describes the who and what and that roles describe the how. She pointed out that many of the issues being raised have more to do with roles and skills (scope of practice) than definition.

Scope of Practice

Ms. London presented Joanne Calista's recommendation to "adopt a CHW focused, comprehensive scope of work that includes the range of roles CHWs provide and flexibility for clinical ***and*** community based interventions that address not only clinical needs, but address the fundamental social

determinants of health" and steered the discussion toward roles and scope of practice, using the C3 roles as a guide.

Ms. Seguinot informed the committee that CHWACT participated in the evaluation of the C3 report and agrees with its recommendations.

Ms. London reiterated a member's suggestion that it might be useful to refer to the C3 roles in the definition as a way to address the many concerns raised about its abstractness. She also emphasized that not every CHW will necessarily perform every role in the C3 list.

Ms. Torres suggested that knowing what Medicaid will pay for might help the committee decide on a definition. In her opinion, the definition should encompass both the medical services that Medicaid will pay for as well as linkage services because as a CHW she provides both. The definition should reflect and honor both kinds of work.

The committee went through the C3 roles and sub-roles, reflecting on whether they are captured in the definition that was discussed earlier.

In response to Dr. Buckley's question about why CHWs are not called healthcare providers, Ms. Seguinot explained that CHWs are not healthcare providers because they do not possess the requisite knowledge. Instead, they are people from the community, like Community Messengers in Bridgeport, who help connect people to resources. Dr. Buckley said that he understands that CHWs are not formally trained as healthcare providers, but noted that internationally CHWs are considered healthcare providers even though they are also community advocates and agents of social change. Ms. London observed that in relation to some of the services that CHWs provide, they may appropriately be called healthcare providers given that in 2013 the Centers for Medicare and Medicaid Services made a rule change that allows non-licensed healthcare staff to provide prevention services recommended by licensed providers.

Loretta Ebron explained that CHWs are not providers, but rather the bridge that links providers, clients, and communities. Whatever a client needs outside the clinic, the CHW finds it in the community and makes sure the client knows how to access it. The CHW also conveys the provider's views and requirements to the client. And because clients often trust CHWs more than providers, she said, they are able to gain inside information about non-clinical factors (housing issues, a child's illness, job loss, etc.) that affect their health and ability to comply with recommendations and convey it to providers.

Ms. Torres stated that because the body and mind are connected, everything affects health. The CHW definition and scope of work should therefore reflect this fact by acknowledging that she as a CHW links directly not only to doctors and nurses, but also to non-clinical workers who can help people find employment or get food stamps. Capturing this in the wording of the definition and roles could help communicate to payers that linking people to non-clinical services affects their health.

Ms. London observed that the discussion suggests that there is not an exact alignment between the roles and definition and that perhaps more work needs to be done on the definition.

Ms. Ebron agreed, saying that the definition needs to be clearer so that CHWs can be integrated into payment. Ms. Cobbs-Lomax agreed as well that the discussion of the roles indicates that the committee needs to think more about the definition.

Ms. London noted that what members seem to think is missing in the definition is something about prevention, self-management, whole person, and assessment/evaluation. She asked for volunteers to form a subcommittee to explore the possibilities for integrating these missing pieces into the definition. Many members volunteered, and Ms. Lupi will help coordinate the subcommittee.

Bruce Gould remarked that the C3 list is quite comprehensive. The definition does not have to designate absolutely everything that is billable and everything that is not. It just needs to define the realm of a CHW and then perhaps cite C3 to indicate what their roles can include. Payers would then look at the list of roles and decide what they will and will not pay for, and providers would be responsible for billing accordingly.

Ms. London added that a brief definition/description of a CHW is necessary because many people do not automatically know, as they do with "doctor" and "nurse," what the relatively new profession of "community health worker" refers to.

8. Wrap Up and Next Steps
Since today's task was to settle on both a definition and scope of practice, Ms. Lupi proposed that in addition to the definition the subcommittee go through the C3 scope in more detail and bring back any issues to the committee at the July meeting. Everyone agreed. Committee members will email Ms. Lupi to convey any issues that they would like the subcommittee to consider.

Linda Guzzo asked that the committee be given examples of CHW job descriptions to inform members' thinking about the definition and scope.

9. Adjourn
The meeting adjourned at 4:32 pm.