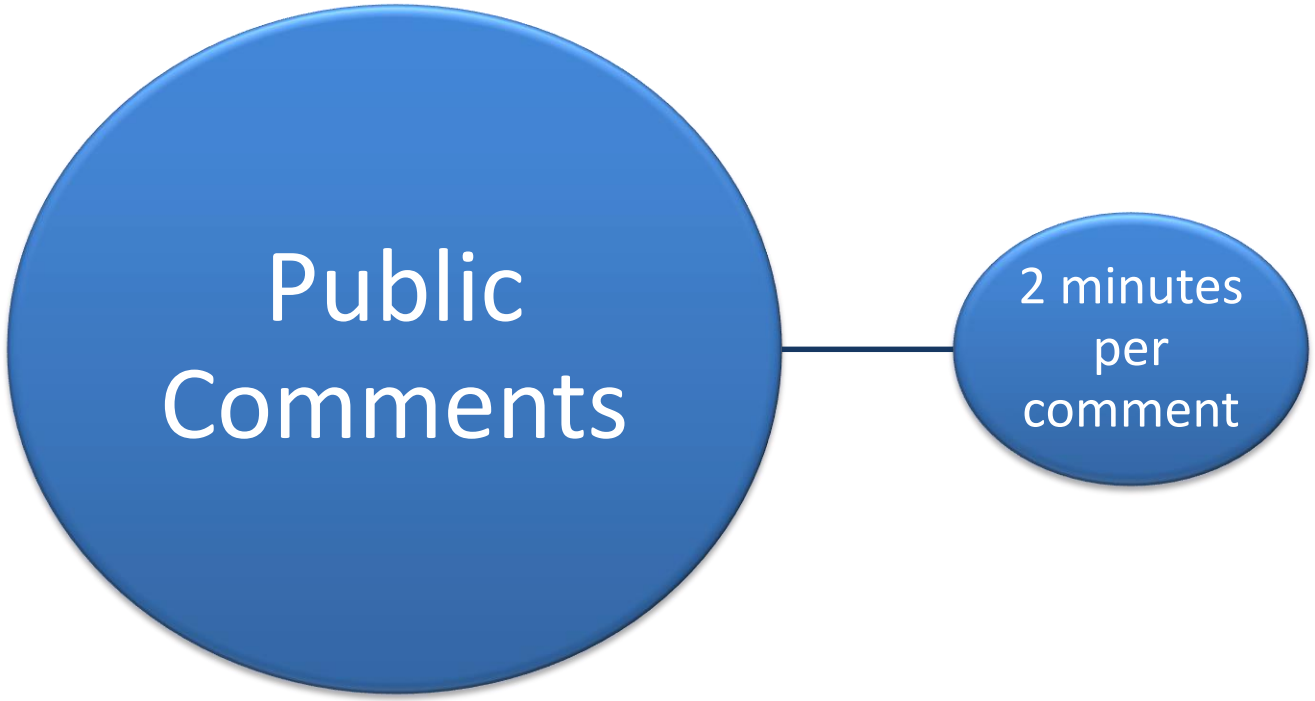
Community Health Worker Advisory Committee

June 14, 2016

Meeting Agenda

Item	Allotted Time
1. Call to order and Introductions	5 min
2. Public Comments	10 min
3. Approval of the Minutes	5 min
4. Community and Clinical Integration Program Introduction	20 min
5. CHW Symposium Recap	15 min
6. CHW Definition and Scope of Practice- Discussion	50 min
7. Wrap Up and Next Steps	15 min
8. Adjourn	

Call to Order


Public Comments
2 minutes per comment

Approval of the Minutes

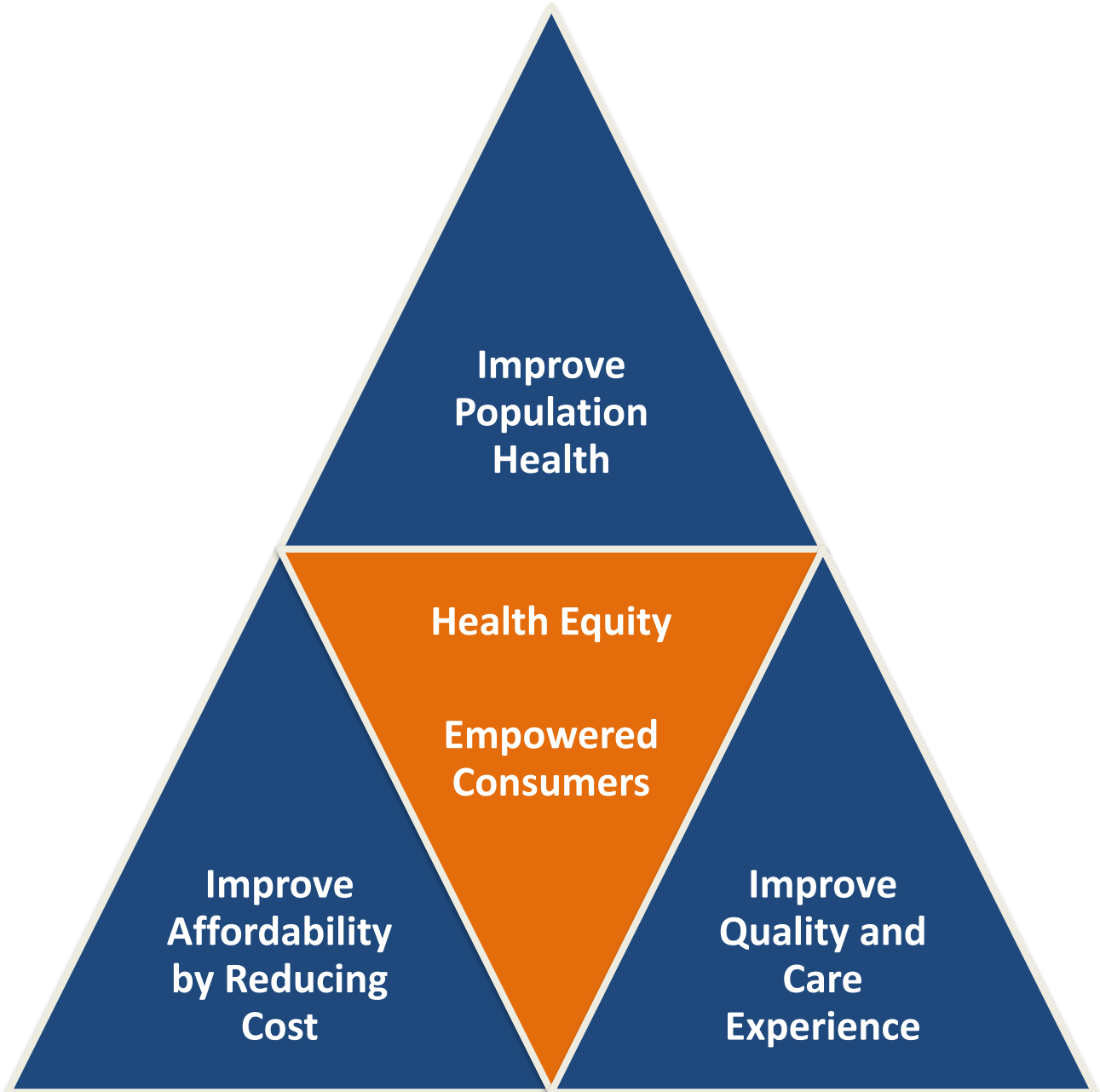
Recap Ground Rules

Ground Rules

- Start and end on time
- Cell phones Off
- Keep phones on mute when not speaking
- Success depends on participation – share ideas, ask questions, draw others out
- All ideas are valid
- Allow every voice to be heard
- One speaker at a time
- Raise your hand
- Share your unique perspective
- Speak honestly
- Stay open to new ways of doing things
- Disagree without being disagreeable
- Have fun!

The Role of CHWs in CCIP

Review: Connecticut SIM Vision



CT SIM: Primary Drivers to achieve Our Aims

$5.8M

Population Health

$8.8M

Payment Reform

$13.5M

Transform Care Delivery

$650K

Empower Consumers

Health Information Technology $10M

Evaluation $3.5M

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Kahn’s Story

Kahn and her Provider

Arrived in the office of Khmer Advocates in a “dazed” state, stiff, trouble moving, unkempt

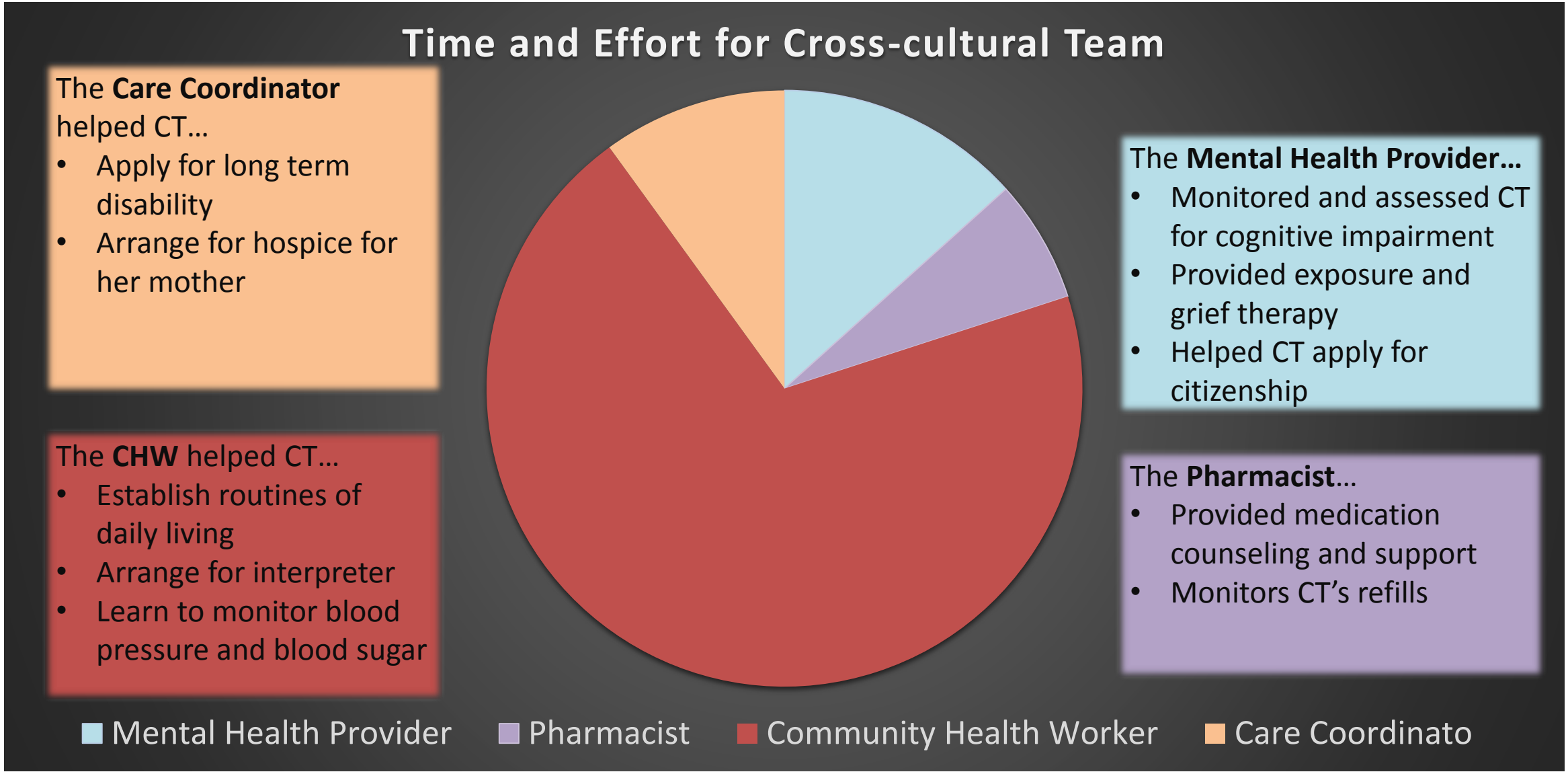
What we learned…

- Language and health literacy barriers
- Traumatic experiences including torture, slave labor, starvation, loss of family members
- Behavioral health conditions including PTSD and depression
- Untreated diabetes and hypertension
- Lack of awareness and support for accessing unemployment, transportation and social services
- No plan of action

How would Kahn's story have been different if…

- Kahn's home life and background had been assessed
- An interpreter was available for her preferred language
- A follow-up plan had been developed after her accident
- She had been connected to a **Community Health Worker** who would help her…
  - Primary care doctor understand her cultural ways of expressing symptoms
  - Understand her primary care doctor and what s/he wanted her to do
  - Make a plan for managing issues related to her food, unemployment, housing, transportation, and most important her need to care for her family

The Work of the Khmer Advocates Team…



Kahn's Result

Recovery in health…

- Kahn now has her diabetes and blood pressure under control
- She regularly sees a behavioral health specialist
- She learned self-care and manages her physical and mental health
- She knows how to access needed services
- She has her feet checked every year, an eye exam, and a flu shot with a reminder from a community health worker

And in life…

- Kahn cared for her mother and ex-husband through the end of their lives
- She teaches community members about exercise and healthy diet and advocates for policy changes

Community & Clinical Integration Program

What is it?
A SIM initiative to improve care delivery

What will it do?
Provide technical assistance, peer learning, and transformation awards* to provider networks

Who can participate?
Provider networks in the Medicaid Quality Improvement and Shared Savings Program (MQISSP)

What will it focus on?
Three key standards:
-Complex Care Management
-Health Equity Improvement
-Behavioral Health Integration

*MQISSP Track 2 Participants Only

What will the networks work to improve?

Comprehensive Care Management

Comprehensive care team, Community Health Worker , Community linkages

Health Equity Improvement

Analyze gaps & implement custom intervention ✚ CHW & culturally tuned materials

Behavioral Health Integration

Network wide screening tools, assessment, linkage, follow-up

Community Health Collaboratives

Oral health Integration

E-Consult

Comprehensive Medication Management

CCIP Standards: Why Comprehensive Care Management?

Socioeconomic factors at the patient and community levels are shown to be related to the probability of readmission

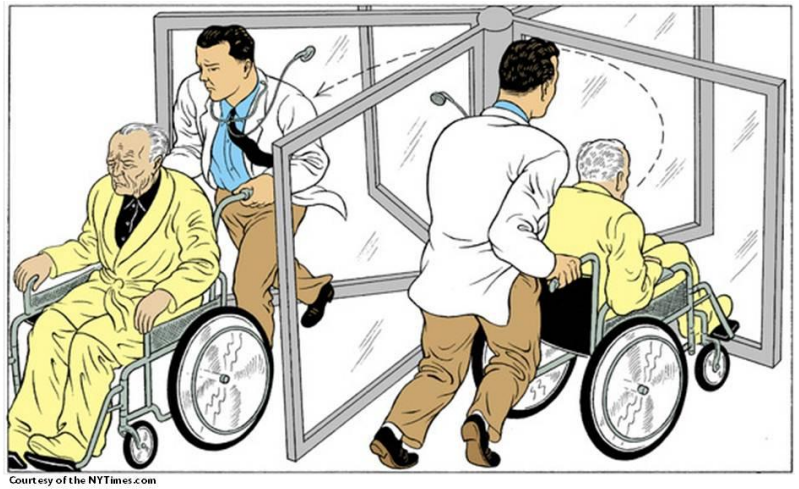
Poverty, illiteracy, housing, food insecurity, social isolation, transportation

For example,

People living in high poverty were **24%** more likely to be re-admitted

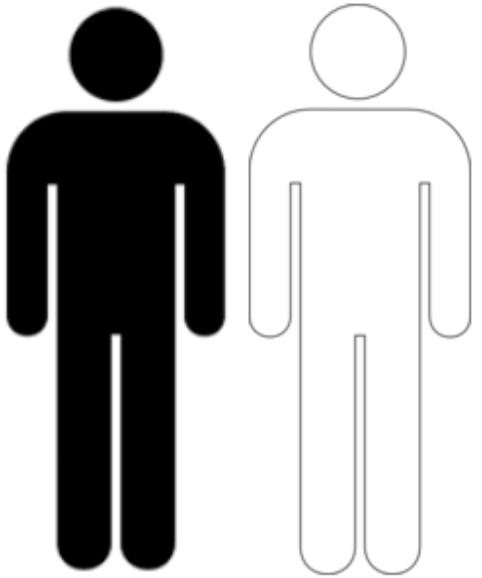
http://content.healthaffairs.org/content/33/5/778.full.pdf+html

CCIP Standards: Why Comprehensive Care Management?



Another study found that...

1 out of every 2 hospitalizations in the homeless population resulted in a 30-day hospital inpatient readmission



54% of readmissions occurred **within 1 week**

And **75% within 2 weeks**

http://www.ncbi.nlm.nih.gov/pubmed/23929401

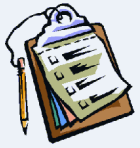
Key Elements of Comprehensive Care Management

Identify and Assess

Identify Individual with complex health care needs

Conduct Person-Centered **Assessment**

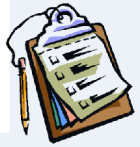
Plan and Execute



Develop Individualized **Care Plan**

CHWs

Establish Comprehensive **Care Team**



Execute and monitor individualized care plan

Monitor and Evaluate

Identify patient readiness to **transition** to self-directed care maintenance and primary care team support

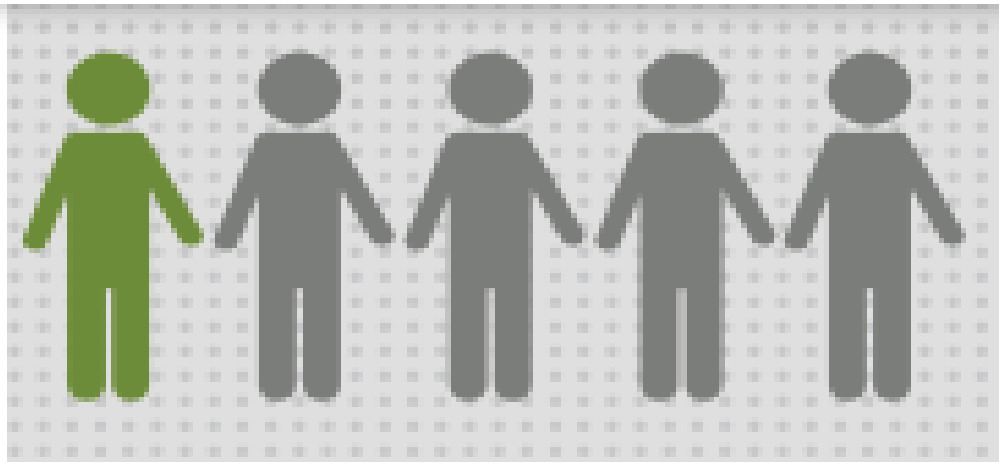
Monitor individuals to reconnect to comprehensive care team when needed

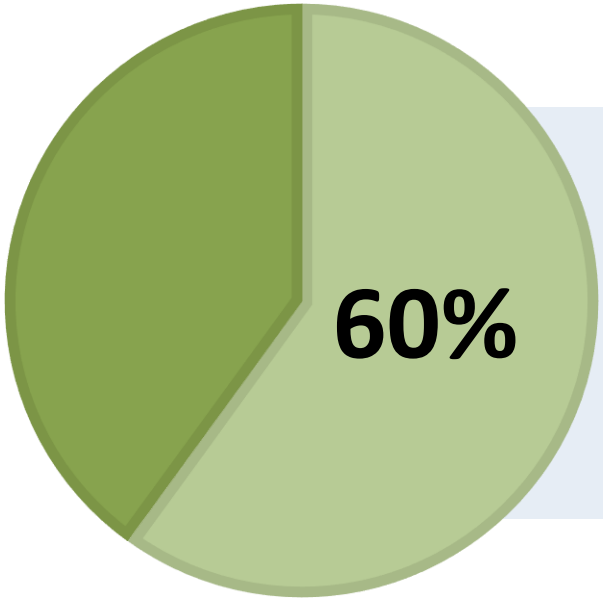
Evaluate and improve intervention

CCIP Standards: Why Behavioral Health Integration?

SIM connecticut state innovation model

1 in 5 adults in America experience mental illness in the previous year



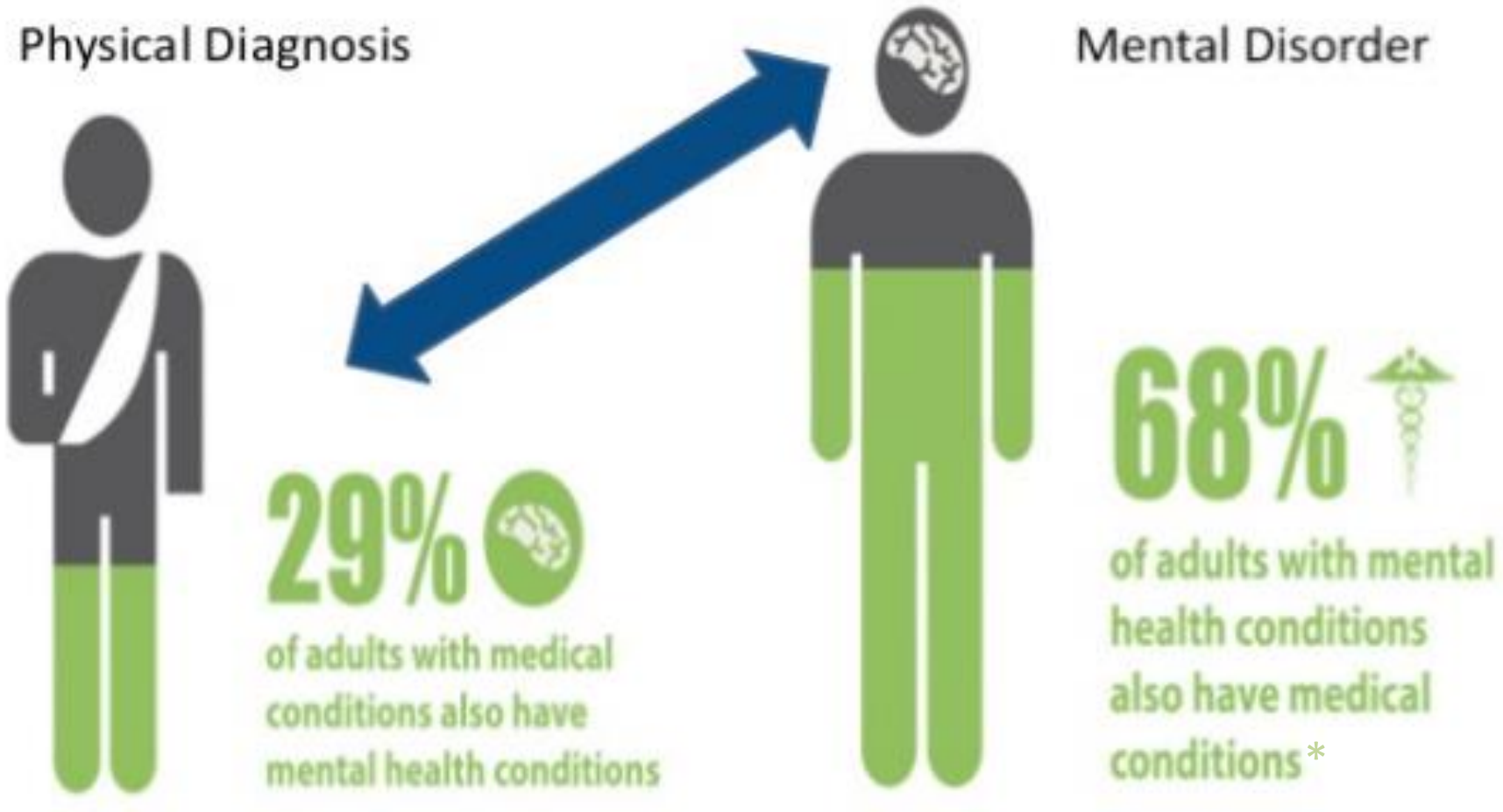


60% of adults with a mental illness didn't receive mental health services in the previous year

57% of adults will experience mental illness at some point in their lifetime

Source: https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf

CCIP Standards: Why Behavioral Health Integration?



Combined Physical & Behavioral Health Needs

Under-diagnosis

Across the top 9 chronic conditions, including Arthritis, Asthma, and Diabetes, depression goes undiagnosed **85%** of the time**

Source: *Druss, B.G., and Walker, E.R. (February 2011). Mental Disorders and Medical Comorbidity. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation
**http://www.ncbi.nlm.nih.gov/

Key Elements of Behavioral Health Integration

SIM connecticut state innovation model

Identify

Identify individuals with behavioral health needs

Serve

Integrated (on-site) brief assessment and treatment

or

Behavioral health referral and treatment

Behavioral health coordination with primary care source of referral

Evaluate

Track behavioral health outcomes/improvement for identified individuals

CCIP Standards: Why Health Equity Improvement?

Experienced trauma related to regimes of Khmer Rouge and Pol Pot in the 1970s and 1980s

There are 4,000 Cambodians in Connecticut

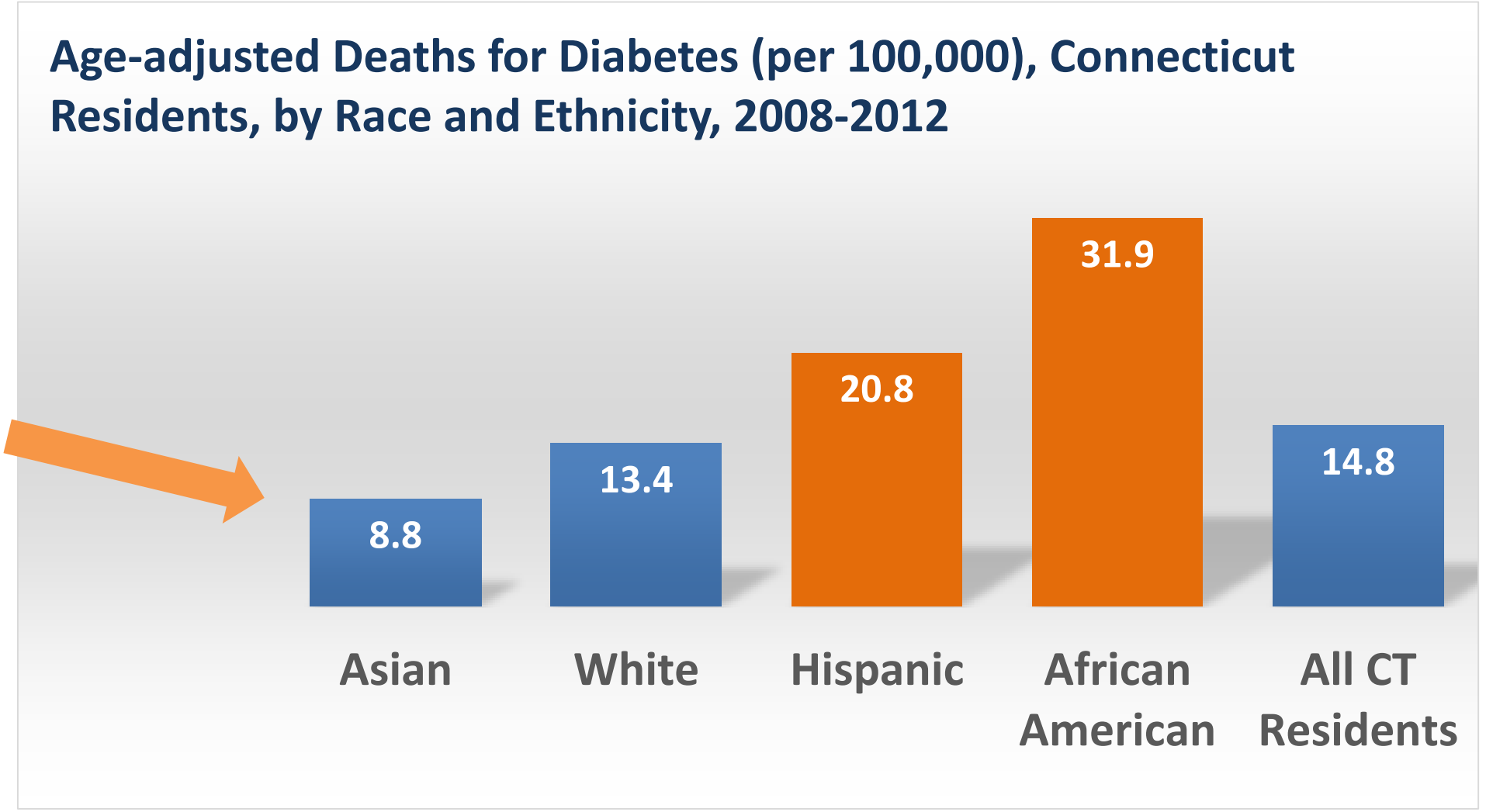
45% of Cambodians self-reported suffering from **Post Traumatic Stress Disorder (PTSD),** and 50% have a chronic condition

Much higher risk of **diabetes, hypertension, cardio-vascular disease, cervical cancer,** and more

Barriers to care – cultural appropriateness, low cultural acceptance of preventive health, language, other social factors

CCIP Standards: Why Health Equity Improvement?

Needs go unrecognized, difficult to target for quality improvement



Data Source: CT DPH, Vital Records Mortality Files, 2008-2012 data.

Health Equity Improvement: P1 – Continuous Quality Improvement

SIM connecticut state innovation model

Analyze

Expand collection reporting and analysis of standardized data stratified by sub-population

Identify and prioritize opportunities to reduce a healthcare disparity

Implement

Implement interventions to address identified disparities

Evaluate

Evaluate whether the intervention was effective

Health Equity Improvement: P2 – Conduct a pilot

SIM connecticut state innovation model

Assess and Plan

Create a more culturally and linguistically sensitive environment

Establish a CHW capability

Identify individuals who will benefit from **CHW** support

Implement

Conduct a person-centered **needs assessment**

Create a person-centered self-care **management plan**

Execute and monitor the person-centered self-care management plan

Monitor

Identify a process to determine when an individual is ready to transition to self-directed care maintenance

CCIP Goal: Whole Person-Centered Care

Attitudes, values, beliefs
Challenging life events
Behavioral health and physical health needs
Personal goals for care

Understanding the whole person

Patient as part of the medical home team

Connecting with the care team

Health Coach
Patient Navigator
Behavioral Health Counselor
Nutritionist
and more…

Expanding the care team

Linking to community supports

Using data to guide improvement

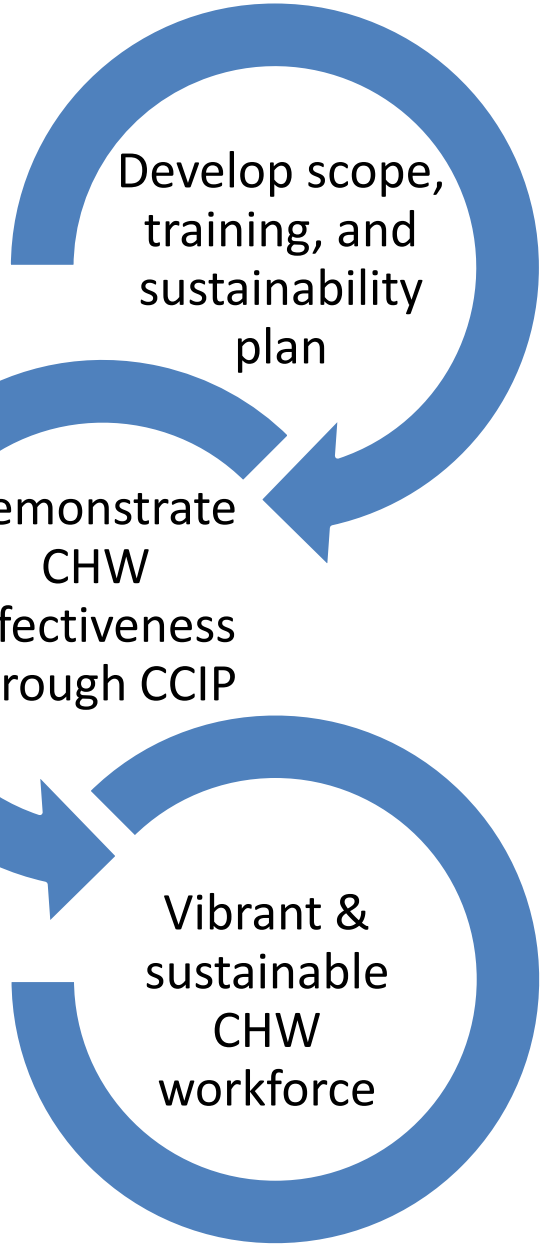
The Role of CHWs in CCIP

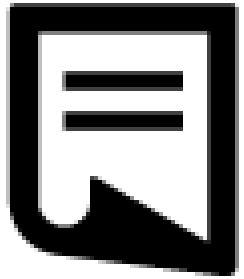
Comprehensive Care Management

Health Equity Intervention Pilot

- Bridge social, cultural, and health literacy gaps
- Health coaching/education
- Patient navigation
- Advocacy => Empowerment
- Behavioral Health perspective
- Linkage to community resources and supports
- Care Coordination
- Support care team in executing and monitoring care plan

CCIP Goal: Fully Integrate CHWs as part of the Care Team





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Your Role…

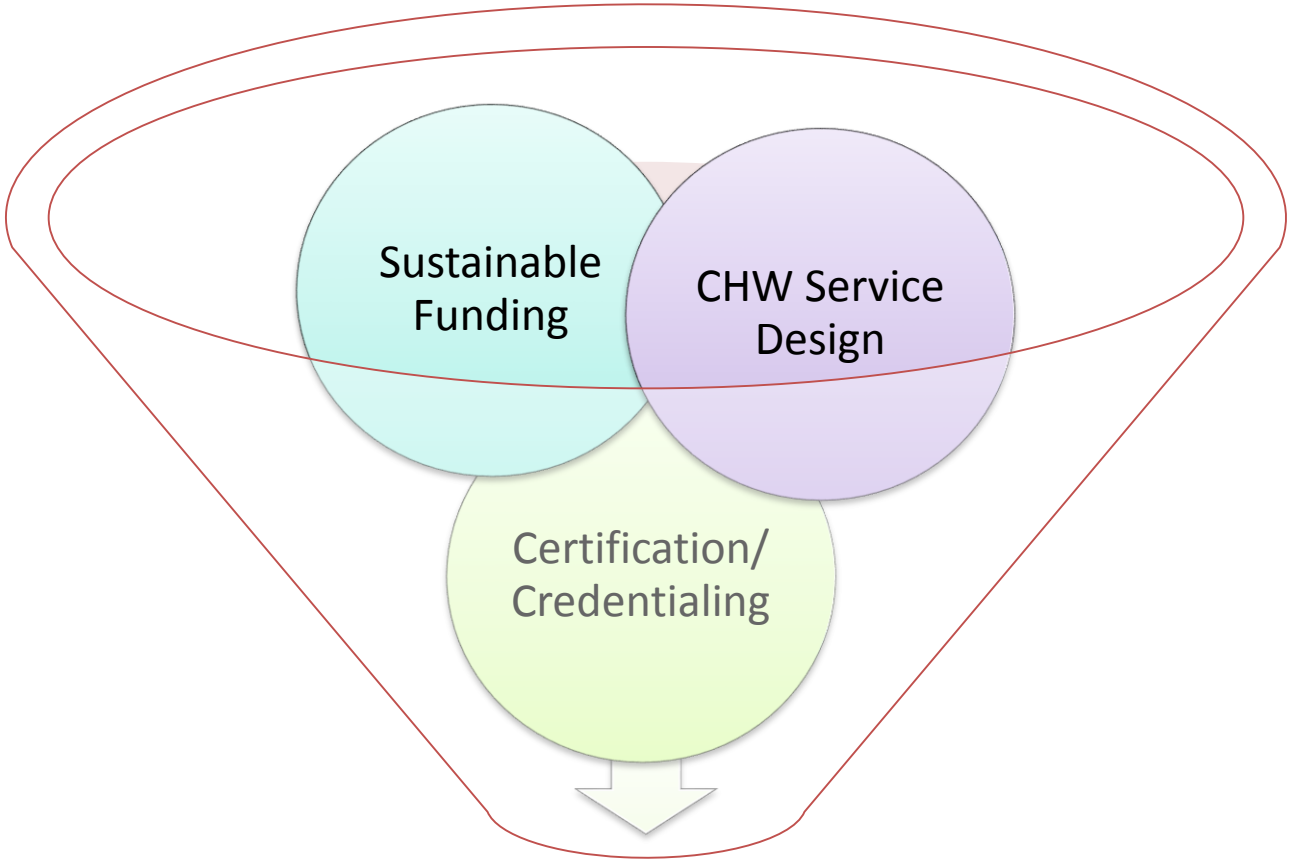
We need your help…

We can’t establish payment models without reaching consensus on CHWs:

- Who they are
- What they do
- What skills they need
- What training they require

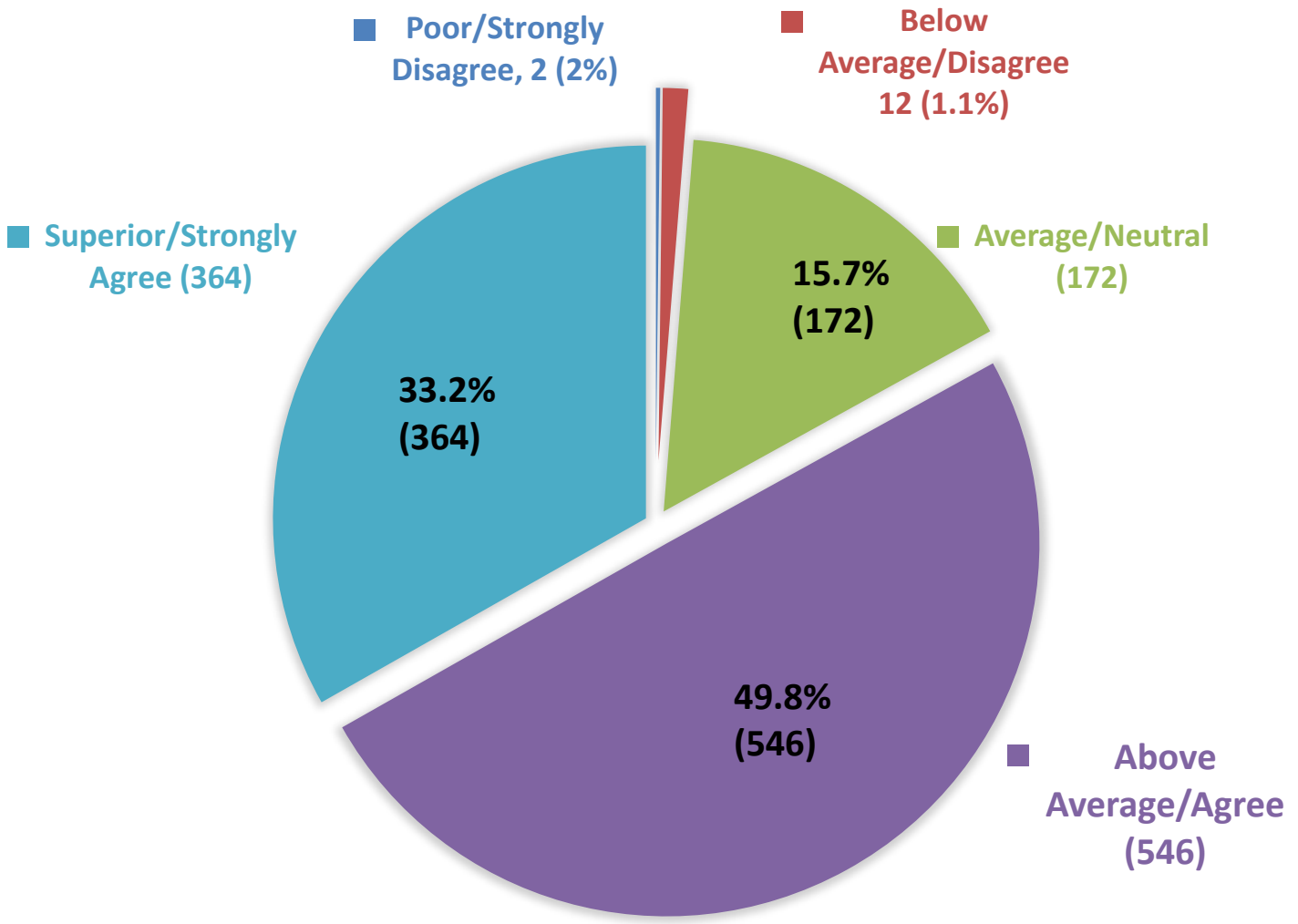
Recap: CHW Symposium

CHW Advisory Committee- Symposium Goal



Starting Point for CHW Model

Symposium Evaluation Results



83% of all ratings were “above average” or “superior.”

Evaluation Results (cont.)

- 95% “agreed” or “strongly agreed” that **the symposium will better enable them to contribute to decision making** about CT’s CHW service-delivery system.

- All **speakers** received predominately “above average” and “superior” ratings.

- All 14 of the attendees who correctly completed the evaluation of the **breakout sessions** “agreed” or “strongly agreed” that **the session they attended improved their understanding of the topic discussed**.

CHW Definition & Scope of Practice

SIM connecticut state innovation model

Moving Toward Consensus on CHW Roles/Scope of Practice and Competencies

Kansas CHW Symposium
May 11, 2016

Carl H. Rush, MRP

UTHealth | School of Public Health
The University of Texas
Health Science Center at Houston

Why C3 now?

- National Community Health Advisor Study (1998) - starting point for creation of CHW education programs, and state certification standards, BUT…
- Times have changed – more CHWs working “inside” health care
- More states developing official role definitions and skill requirements
- Pressure to create national standards, but agreement among states is not clear
- More organizations want to know “what’s a good training program?”

Project Core Value: CHW Self-Determination

- Reinforces APHA 2014 Policy Statement urging that standard-setting bodies for CHW practice consist of at least 50% CHWs

C3 Project Timeline

- Precursor activity in 2013: analysis of over 40 training program descriptions by Coastal AHEC (TX)
- Fall 2014 - Spring 2015: Roles and Competencies Crosswalk and Review by Advisory Committee including a majority CHWs
- Summer 2015: CHW Networks Review and consensus building
- Spring 2016: release of 2015 report

C3 Benchmark Documents

STATE	Roles /Scope of Practice (SoP)	Skills
California	California Health Workforce Alliance	City College of San Francisco CHW Curriculum
Massachusetts	State Board of Certification SoP Definition	State Board of Certification Core Competencies
New York	New York State CHW Initiative	New York State CHW Initiative
Oregon	Scope of Practice Committee, State Traditional Health Worker Commission	Scope of Practice Committee, State Traditional Health Worker Commission
Minnesota	MN Community Health Worker Alliance	Official State Curriculum
Indian Health Service CHR Program	National SoP Definition	*NA/Revisit –date TBD*
Texas	State Definition of CHWs	State Curriculum Standards (Coastal AHEC certified curriculum)

Definition

CHW Definition(s)

APHA CHW Section

- A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

- A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

CT Proposed Definition

- A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of, **and ability to communicate with** the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary among the community, health and social services to facilitate access to resources and improve the quality and cultural competence of service delivery.

- A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

CHW Association of CT adopted July 2014

Scope of Practice (Work) Recommendation

Adopt a CHW focused, comprehensive scope of work that includes the range of roles CHW provide and flexibility for clinical ***and*** community based interventions that address not only clinical needs, but address the fundamental social determinants of health.

CHW Roles
Scope of Practice—C3

	Role	Sub-Roles
1	**Cultural Mediation among Individuals, Communities, and Health and Social Service Systems**	a. Educating individuals and communities about how to use health and social service systems (in- cluding understanding how systems operate) b. Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication
2	**Providing Culturally Appropriate Health Education and Information**	a. Conducting health promotion and disease prevention education in a manner that matches lin- guistic and cultural needs of participants or community b. Providing necessary information to understand and prevent diseases and c. To help people manage health conditions (including chronic disease)
3	**Care Coordination, Case Management, and System Navigation**	a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping to address other barriers to services d. Documenting and tracking individual and population level data f. Informing people and systems about community assets and challenges
4	**Providing Coaching and Social Support**	a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (in- cluding chronic disease) d. Planning and/or leading support groups
5	**Advocating for Individuals and Communities**	a. Advocating for the needs and perspectives of communities b. Connecting to resources and advocating for basic needs (e.g. food and housing) c. Conducting policy advocacy

	Role	Sub-Roles
6	**Building Individual and Community Capacity**	a. Building individual capacity b. Building community capacity c. Training and building individual capacity with CHW peers and among groups of CHWs
7	**Providing Direct Service**	a. Providing basic screening tests (e.g. heights & weights, blood pressure) b. Providing basic services (e.g. first aid, diabetic foot checks) c. Meeting basic needs (e.g., direct provision of food and other resources)
8	**Implementing Individual and Community Assess- ments**	a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environmental assessment) a. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)
9	**Conducting Outreach**	a. Case-finding/recruitment of individuals, families, and community groups to services and systems a. Follow-up on health and social service encounters with individuals, families, and community groups a. Home visiting to provide education, assessment, and social support b. Presenting at local agencies and community events
10	**Participating in Evaluation and Re- search**	a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community con- sent processes a. Participating in evaluation and research: i) Identification of priority issues and evaluation/research questions ii) Development of evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings

CHW Skills – C3

	Skill	Sub-skill
1	**Communication Skills**	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 com- munities served)
2	**Interpersonal and Relationship-Building Skills**	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	**Service Coordination and Navigation Skills**	a. Ability to coordinate care (including identifying and accessing resources and overcoming barriers) a. Ability to make appropriate referrals b. Ability to facilitate development of an individual and/or group action plan and goal attainment a. Ability to coordinate CHW activities with clinical and other community services b. Ability to follow-up and track care and referral outcomes

	Skill	Sub-skill
4	**Capacity Building Skills**	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	**Advocacy Skills**	a. Ability to contribute to policy development b. Ability to advocate for policy change c. Ability to speak up for individuals and communities
6	**Education and Facilitation Skills**	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

	Skill	Sub-skill
7	**Individual and Community Assessment Skills**	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	**Outreach Skills**	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	**Professional Skills and Conduct**	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

	Skill	Sub-skill
10	**Evaluation and Research Skills**	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	**Knowledge Base**	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

CHW Qualities – C3

NCHAS	New York
Connected to the community (a community member or possess- ing shared experience with community members)	Connected to Community • Community member OR having a close understanding of the community they serve • Shared life experiences • Desire to help the community
Strong and courageous (healthy self-esteem and the ability to remain calm in the face of harassment)	Mature • Courageous • Prudent • Temperate • Wise
Friendly/outgoing/sociable	Friendly, Outgoing, Sociable • Gracious • Pleasant • Responsive • Welcoming
Patient	Patient [contained in list below]
Open-minded/non-judgmental	Open-minded/Non-judgmental--Relativistic, Non-dualistic • Unbiased • Flexible • Tolerant
• Motivated and capable of self-directed work • Caring • Empathetic • Committed/dedicated • Respectful	

NCHAS	New York
Honest	Honest, Respectful, [Patient] • Sincere • Candid • Polite • Courteous
Open/eager to grow/change/learn	
Dependable/responsible/reliable	Dependable, Responsible, Reliable • Trustworthy • Loyal • Motivated and capable of self-directed work • Committed/dedicated
Compassionate	Empathic, Caring, Compassionate • Kind • Gentle • Considerate • Sensitive
• Flexible/adaptable • Desires to help the community • Persistent • Creative/resourceful	Persistent, Creative, and Resourceful • Determined • Imaginative • Ingenious

The future of C3

- Mid-2016 – mid-2017:
  - Outreach and consensus building with other stakeholder groups
  - Analysis of roles and skills in community vs. clinical settings
  - Recommendations on methods to assess skill proficiency and Core Qualities

More Information on C3

- Email: **info@c3project.org**
- Join mailing list: **http://bit.ly/1UAyhRD**

C3 Other Resource Documents

- National Community Health Advisor Study
  http://crh.arizona.edu/publications/studies-reports/cha
- New York State CHW Initiative
  http://secureshopper.bisglobal.net/_templates/80/chw_initiative2011report.pdf
- Massachusetts Board of Certification
  www.mass.gov/dph/communityhealthworkers
- California Health Workforce Alliance
  http://www.phi.org/focus-areas/?program=california-health-workforce-alliance
- Forthcoming CDC policy study on certification

Resources

- American Public Health Association. (2014). Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing- Community Health Workers Policy Statement of Self Determination. Retrieved February 1, 2015, from:
- http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policydatabase/2015/01/28/14/15/support-for-community ww.apha.org/policies-and-advocacy/public-health-policy-statements/policydatabase/2015/01/28/14/15/support-for-community-health-worker-leadership.

- http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf MA study
- http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf hrsa workforce study
- C3
- MACHW Policy Statement
- Board of Certification of CHWs

Resources

- American Public Health Association. (2014). Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing- Community Health Workers Policy Statement of Self Determination. Retrieved May 23, 2016, from:
- https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/15/support-for-community-health-worker-leadership

- http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf MA study
- http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf HRSA workforce study
- C3
- MACHW Policy Statement
- Board of Certification of CHWs

Resources

Matos S, Findley S, Hicks A, Legendre Y, Do Canto L. Paving a Path to Advance the Community Health Workforce in New York State: A New Summary Report and Recommendations. New York, New York: The New York State Community Health Worker Initiatve;2011.

Resources

- http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf MA study
- http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf HRSA workforce study
- MACHW Policy Statement
- Board of Certification of CHWs

Next Steps

Next Steps

- Schedule a Design Group meeting, if necessary
- Share proposed language for definition and scope with the Committee-request additional feedback and edits

Meeting Schedule & Deliverables

Meeting Date	Topic for Discussion	Topic for Vote (if ready)
June 14	Definition of CHW, Scope of Practice	-
July 21	Skills, competencies, and training requirements	Definition of CHW, Scope of Practice
August 30	Certification process	Skills, competencies, and training requirements
September 27	Sustainable financing	Certification process
October 20	Follow-up	Sustainable financing
November 17	Follow-up	Final votes for Phase 1

Adjourn