STATE OF CONNETICUT
State Innovation Model
Community Health Worker Advisory Committee
Meeting Summary
Tuesday, August 30, 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: Yolanda Bowes, Juan Carmona, Michael Corjulo, Grace Damio, Loretta Ebron, Linda Guzzo, Terry Nowakowski (Chair), Lauren Rosato, Milagrosa Seguinot

Members on the Phone: Migdalia Belliveau, Thomas Buckley, Tiffany Donelson, Chioma Ogazi, Mayce Torres, Robert Zavoski

Members Absent: Ashika Brinkley, Darcey Cobbs-Lomax, Peter Ellis, Liza Estevez, Jacqueline Ortiz Miller, Nicholas Peralta

Other Participants: Luisa Casey, Supriyo Chatterjee, Meredith Ferraro, Bruce Gould, Kelly Korwek, Maggie Litwin, Katharine London, Jenna Lupi, William Tootle, Garrick Wong (phone), Stanley Zazula

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 7/21/16 –Terry Nowakowski
Vote: all in favor.

4. CHW Roles and Skills—Approval
Katharine London reviewed the changes that the committee made to the C3 Project roles and skills on 7/21/16.

Motion: to approve changes made to C3 roles and skills–Terry Nowakowski; seconded by Yolanda Bowes
Vote: all in favor.

5. CHW Symposium—Certification Review
Meredith Ferraro recapped the results of the certification breakout session from the CHW symposium that was held on 5/24/16. Participants in that session generally agreed that certification is necessary, grandparenting is vital, assessments should be performance based, and a tiered system should address various kinds of skills (e.g., basic, leadership, clinical, community).

Ms. Ferraro also clarified the distinctions between certificates, certification, licensure, and registration:

A certificate demonstrates that one was present at and completed some kind of course. It does not necessarily indicate that the person absorbed and mastered all of the content that the course covered. In an academic setting, a certificate has a somewhat different meaning. There it demonstrates that one has a specific level of knowledge about a subject and has completed a specified number of college credits. The 28-credit Health Career Pathways Certificate at community colleges in Connecticut is an example of an academic certificate.

Certification affirms that one has a certain amount of education and knowledge in a specific field. One demonstrates that knowledge through some form of assessment (a written exam, a performance-based exam, a professional exam, etc.).

Registration means that because one has met all of the educational and testing requirements for a particular profession, one's name appears on a list of all those eligible to practice that profession in a state.

Licensure relates to scopes of practice (for nurses, physical therapists, etc.) that legislation defines and restricts the performance of to those who have met certain requirements. Professional licenses are generally issued by states, and states sometimes recognize the licenses of other states.

To help illustrate these distinctions, Michael Corjulo explained that to practice as a registered nurse (RN), one has to take a national exam and apply for a state license, which means that one could be an RN (i.e., registered) and not have a license, but not have a license without being registered.

Linda Guzzo suggested that the committee might benefit from thinking about CHW certification in terms of a CNA (certified nurse aide) model versus a PCA (personal care assistant/attendant) one. In Connecticut, both CNAs and PCAs can receive a certificate of completion from colleges. But for CNAs to become certified and get on the CNA registry, they have to pass a competency exam and meet state requirements. By contrast, there are no state requirements for PCAs, and they do not have to complete a training program.

To Jenna Lupi's question about whether PCA services are covered by insurance, Terry Nowakowski responded that Social Security Disability Insurance covers a portion of the cost of PCA services, depending on the level of one's needs.

Mr. Corjulo asked whether medical assistants (MAs) could serve as a model for thinking about CHW certification. Katharine London responded that there is a significant difference between CHWs and MAs—namely, that MAs are co-located with clinicians whereas CHWs often see patients/clients on their own at locations where no one else from their organization is present.

Dr. Guzzo said that Capital Community College offers both a clinical MA program that can lead to certification and an administrative one that does not.

6. Certification Discussion

Benefits

Katharine London reviewed committee members' responses to the certification-worksheet questions. With quite a lot of agreement, members identified the following potential benefits of CHW certification:

- Adds clarity, standardizes requirements, fosters respect
- Creates sustainable and stable employment
- Increases chance for payer reimbursement
- Improves personal and professional value
- Legitimizing the profession improves salaries and could create more job opportunities
- Clarifies scope for employers
- Simplifies recruitment for employers and minimizes risk for hiring

Problems

With less agreement, members noted the following potential problems with certification:

- Potentially creates a class system of CHWs
- Barriers to education due to cost, access
- May be difficult for seasoned CHWs to attain necessary credentials
- For employers, increasing salaries could be challenging
- Could create a shortage of qualified workers

Ms. London paused from reviewing the worksheet responses to propose that the committee focus on recommending a process for certification rather than deciding on all of the details of certification, which would take more time than the committee has. She suggested that the committee determine, for example, all the elements that members are absolutely sure should be part of the certification process (e.g., required training) and identify issues that another group would later need to consider and think hard about (e.g., the content of training and who should provide it). The committee agreed, and Ms. London set up two flipcharts on which to record the basic elements that should be part of the certification process (“requirements”) and the details that should be looked further into and decided on in the future (“considerations”).

Voluntary vs. mandatory & grandfathering

The vast majority (82%) of the 17 worksheet respondents indicated that certification should be voluntary. Members expressed the following views on the issue of voluntary-vs-mandatory certification:

- Voluntary certification allows individuals to try out the career before committing to certification
- There are many different types of roles-certification may not be necessary for some, for example those in health education or community engagement
- Certification could negatively impact the connection CHWs have with the community
- Voluntary certification will give employers more choice of who to hire (or who to keep employed), especially if CT does not adopt a reimbursement model
- Voluntary certification will help alleviate marginalization of volunteers and lower barriers to entry

Loretta Ebron explained that certification could disrupt CHWs’ connection to the community by making all certified CHWs appear as interchangeable in the eyes of their employers and thus deployable anywhere instead of to the particular communities about which they have deep knowledge and to which they are closely connected.

Related to the potential misplacement of CHWs and lost community connection that Ms. Ebron described, Grace Damio expressed concern about CHWs being clinically bound (certification or not) and stuck in limited roles that do not fully embrace what is required of them to address community needs. She encouraged the committee to continue to keep in mind the importance of community connection and actually doing work in the community so that CHWs do not get tossed into contexts that do not facilitate what by definition they should be doing for the community. Her hope is that the certification process and overall CHW design will reflect this community aspect of CHWs and ensure that the CHW system has the capacity to provide sufficient CHW presence in the community. She conceded that CHWs can play limited roles in clinical settings, but still stressed the importance of remaining alert to the full spectrum of what they can and should do for the community. Losing sight of this full spectrum is a risk whether or not a certification system is in place.

Bruce Gould noted that a well-designed certification process could potentially facilitate not forgetting the breadth of CHW functions. He went on to say that the committee may also be able to further address this issue when it takes up questions about technical assistance to employers and others in its second phase.

Michael Corjulo asked whether one is a CHW if he or she does not work in the community, observing that some organizations employ what they describe as CHWs, but yet may limit their actual time in the community. Yolanda Bowes said that it all depends on how an organization defines "community." Is it their community of patients or the actual community in which their patients live?

Migdalia Belliveau explained that her community health center in Willimantic has CHWs and MAs that can function as CHWs and that, as Mr. Corjulo suggested, the organization decides whether CHWs are to be out in the field or in the clinic. It depends on the community needs. Sometimes they may be needed to reach out to migrant farmworkers on the farms near Willimantic. Other times, they may be needed in the schools or the clinic. It varies by organizational capacity and the culture of the community in which the CHWs are located.

Ms. Bowes stated that her sense is that getting financial recognition for CHW services is the underlying goal of the committee. There may not be reimbursement for individual CHW encounters, but getting them included, as extensions of providers, in the overall reimbursement for the services of the whole care team is what she views as the goal of the committee. Keeping that in mind might help the committee move along.

Dr. Gould pointed out that the changes in Medicare reimbursement (known as [MACRA]) that are coming mean that soon no one will likely be paid by the encounter. The new system will pay for population health. The hope is that because providers will have to accept responsibility for the care and outcomes of populations of patients, health systems and communities will want to pay individuals to go out and make sure they reach everyone they are responsible for. He hopes the committee's work will help get CHWs vertically integrated throughout the whole system.

Ms. Damio observed that there appears to be a duality in the way the committee describes CHWs. On the one hand, stress is placed on ensuring their integration into healthcare teams. On the other, stress is placed on making sure the "community" in community health worker is not lost because there is something unique, profound, and important about their placement in communities, namely, their ability to address the social determinants of health. Both are important, and good coordination and

communication between community and clinic are necessary for the CHW model to be effective. She voiced concern, however, about conceptualizing CHWs as extensions of medical providers. In her view, they are better seen as a specialty in themselves that forms a core part of clinical care teams and communities.

Mayce Torres referred back to the earlier discussion about certification vs. certificates, mandatory vs. voluntary, etc. and stated that for CHW professional identity to be strengthened, there must be certification and it should be voluntary. She also said that employers should be enabled to creatively push CHWs to go as far as they can go. When she began her current CHW position two years ago, she was mainly doing enrollment. Since then, her job has become much more community based and filled with encounters with people with all kinds of needs. Continuing education beyond certification is necessary for her to develop professionally and keep up with the changing demands of her job.

Ms. London returned to reviewing members' views on whether certification should be voluntary or mandatory and asked if anyone wanted to speak in favor of mandatory certification or having no certification at all.

Ms. Damio expressed concern about a voluntary system's letting the uncertified fall through the cracks around payment since payers might choose only to reimburse certified CHWs. To her question about how this has played out in other states, Ms. London replied that a number of them have adopted voluntary certification but restricted Medicaid payment to certified CHWs. Other insures or certain employers might reimburse or hire only certified CHWs as well. Existing CHWs working on grants can continue without any change, however. Both models exist, but where new entities are hiring CHWs for the first time or payers are just starting to pay for CHWs, they have tended to hire and pay for only certified CHWs.

Milagrosa Seguinot pointed out that making certification voluntary provides opportunities to both those with formal training and those with years of CHW experience. She also relayed that the CHW Association of Connecticut has been looking at the certification processes in other states and referred to Rhode Island's as an example of how easy and convenient the process can be.

Ms. London observed that there had been many arguments for voluntary and grandfathering so far, but no voices in support of mandatory, which she explained would mean that a CHW would have to be certified to be paid.

Ms. Torres suggested that mandating a fairly rigorous certification/test might increase respect for CHWs and make them feel that they have really accomplished something that sets them apart.

Migdalia Belliveau said that grandfathering is important and cautioned that mandating certification could create a barrier for some. If it is voluntary, employers could encourage their CHWs to become certified, leaving the workers with some flexibility and choice. Not all workers would be in a position to go through the certification process, however, if by contrast the employer had to tell them they had *x* amount of time to become certified.

Ms. Damio wanted to make sure that both new and grandfathered CHWs would be subject to similar kinds of assessment, prompting Ms. London to explain that most states have both a training/experience and an assessment component and that what grandfathering allows is for those with adequate experience to jump straight to assessment.

Ms. Bowes made the case for voluntary certification, arguing that it supports the quality-improvement aims of population-health-based payment reform (e.g., by enabling identification of those who are qualified to work in the community) while at the same time giving providers a degree of choice in how they go about achieving those aims. Ms. London added that certification makes providers and employers more comfortable with assuming responsibility for patient care because it demonstrates that a person can perform the particular service they have assumed responsibility for providing and paying for.

The committee agreed on the following basic requirements for certification and set of issues that need to be considered by another body in the near future.

Certification Requirements

- voluntary
- application process
- minimum number of hours of experience
- training in core competencies for those new to the field
- grandfathering for those with a defined amount of experience
- assessment/exam tied to roles and skills
- certification good for specified period
- continuing education hours for maintenance and renewal
- small fee
- three paths to becoming a CHW
    - no certification
    - if have requisite experience, can skip training and go straight to assessment
    - if new to the field, need training, job shadowing, and assessment

Certification Considerations

- community
    - connection to and work in community
    - what is a community?
    - is one who does not work in a community a community health worker?
- integration of CHWs into care teams
- sustainable financing of CHWs
- easy for everyone to participate
    - new people to get training
    - grandfathering for those with years of experience
- roles and skills vs. qualities
    - exam assesses roles and skills
    - hiring process identifies those with necessary personal qualities
- review what other states have done and build on best practices
- need approved training providers
- similar approaches as other professions

Training entity

70% of worksheet respondents said that a board with multiple stakeholders should decide what skills, training, and experience should be required for certification. In the worksheets, members expressed the following views surrounding potential training entities:

- Multi-stakeholder board including CHWs, providers, patients, hospital administration. If a small board is selected, there should still be representation from higher education, state agencies, employers, and academic institutions.
- Expertise of seasoned CHW/professionals would assist in meeting the demands of recruitment, trainings, and certifications—like the CHW Association.
- Should be a governing entity of CHWs; if not, then a state agency.
- Competencies should be standard, but certification training programs could be delivered by a variety of organizations such as community colleges, AHECs, health departments, etc. Supplemental training programs could be offered for specific roles, such as chronic-disease management using existing curricula or training programs.

During the meeting, members identified **who should be involved in deciding on training**:

- CHWs
- CT Area Health Education Centers (AHECs)
- CT Public Health Association
- Community Health Center Association of Connecticut
- CT DPH
- Employers, academics, state agencies

Certifying entity

There was less agreement among worksheet respondents about who should administer a certification program: 29% said a state agency, 29% an academic institution, 29% a multi-stakeholder board.

Bruce Gould relayed that DPH has expressed a strong interest in creating a certifying process for CHWs similar to those of other health professions. Terry Nowakowski expressed concern about the potential for state-agency bureaucracy to be a barrier to what the committee is trying to achieve.

Linda Guzzo stated that DPH's certification process for CNAs works. Students want the certificate and acknowledgement, not just from the college but also from the state. And employers look for it. Certification needs to be full and formal, not just a certificate that says someone attended all the meetings of a course.

Michael Corjulo asked if there are other health roles besides CNAs that DPH provides certification for, and Dr. Guzzo mentioned EMTs.

Mace Torres expressed support for having a board similar to this committee work in association with DPH to provide CHWs with validating certification.

To Ms. London's question about whether other allied professions that are certified by DPH have boards, Chioma Ogazi replied that DPH works with the board of nursing to look at exams, schools, etc. and that many other professionals, from taxidermists to MDs, are certified by DPH. Dr. Gould pointed out that there is an online A-Z list of all the professions that DPH certifies or licenses.

Ms. London asked for one person each to speak for certification being administered by a multi-stakeholder board, an academic institution, a state agency/DPH, and any other entity. Ms. Bowes spoke in favor of DPH. She said there needs to be one entity to make sure that all entities offering training are held to a certain standard and that all CHWs adhere to a standard set of requirements. DPH already does this for lots of other entities. The community colleges or AHECs or a variety of other agencies could offer the training, and the CHW would complete one of them.

Ms. London asked if there is any example of a professional registration, certification, or licensing process in Connecticut that is not run through DPH or some national entity. Ms. Nowakowski said that Certified Alcohol and Drug Counselors (CADCs) are certified by the Connecticut Certification Board. Dr. Gould noted that DPH's website indicates that they are involved, too, to some degree in the certification of CADCs. Ms. London asked, then: if every other professional workforce goes through DPH in some way, is going through DPH a necessary step for professionalizing the workforce? She indicated that the committee needs to do some research on the issue, adding that what she was hearing from members was that there needs to be a strong balance in the certifying entity, that lots of people need to be in the room, that many voices need to be heard, and that there needs to be a structure that ensures all of this occurs.

To help clarify some of the discussion, Dr. Guzzo explained that in the case of community colleges and CNAs, DPH does two things. First, it certifies the colleges as trainers of CNAs. Second, after students have completed the training and submitted their applications, DPH certifies that they have met all the requirements and puts their name on the CNA registry.

During the meeting, members made the following points about **who should be involved in certification**:

- board of certification
- CHWs must be represented
- concern about bureaucracy in state agency/shutting down

7. Introduction to Sustainable Financing

There was no time to cover sustainable financing.

8. Wrap Up and Next Steps

Jenna Lupi noted that the committee will likely need to continue discussing certification at the next meeting on 9/27/16, which was originally scheduled to cover sustainable financing. She will get clarification from DPH about some of the questions raised about having DPH administer a potential CHW certification process and will develop a diagram of the three CHW certification pathways that the committee discussed. She will also reach out to those who volunteered for the definition design group. She also acknowledged that a certification design group may be necessary.

Linda Guzzo requested that the SIM staff create a graphical summary of DPH's certification process for CNAs to give the committee a better understanding of how certification works at DPH.

9. Adjourn

The meeting adjourned at 4:37 pm.