STATE OF CONNETICUT
State Innovation Model
Community Health Worker Advisory Committee
Meeting Summary
Thursday, October 20, 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: Juan Carmona, Michael Corjulo, Grace Damio, Tiffany Donelson, Loretta Ebron, Liza Estevez, Terry Nowakowski (Chair), Lauren Rosato, Milagrosa Seguinot, Migdalia Belliveau, Mayce Torres

Members on the Phone: Yolanda Bowes, Ashika Brinkley, Thomas Buckley, Darcey Cobbs-Lomax, Peter Ellis, Linda Guzzo,

Members Absent: Chioma Ogazi, Nicholas Peralta, Robert Zavoski

Other Participants: Chris Andresen, Luisa Casey, Meredith Ferraro, Bruce Gould, Kelly Korwek, Maggie Litwin, Katharine London, Jenna Lupi, William Tootle, Stanley Zazula

1. Call to Order and Introductions
Terry Nowakowski served as Chair and called the meeting to order at 2:33 pm.

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

3. Approval of Minutes
Motion: to approve minutes from 8/30/16 –Terry Nowakowski; seconded by Michael Corjulo
Vote: all in favor.

4. CHW Definition—Approval
Mayce Torres reported back on the results of the definition design group (9/29/16), and members commented on the design group's proposed CHW definition, which Ms. Torres said she thought was all encompassing and open to the future. The red text reflects input from Carl Rush after the design group had met. It reads:

> A Community Health Worker (CHW) is a front line public health worker who is a trusted member of, and/or has a unique understanding of the experience, language, culture, and socioeconomic needs of the community served. A CHW serves as a liaison/intermediary between individuals, communities and health and social services to facilitate access to care, improve the quality and cultural responsiveness of service delivery, and address social determinants of health.
>
> CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of culturally appropriate services such as: outreach and

engagement; education, coaching, and informal counseling; social support; advocacy; care coordination; basic screenings and assessments; and research and evaluation.

Jenna Lupi asked if the definition captures what the group has been discussing the last several months. Milagrosa Seguinot suggested making "front line" one word. Michael Corjulo affirmed that it does capture previous discussions and that it is very encompassing and flexible enough to accommodate future expansion of CHW roles. Lauren Rosato agreed, adding that it is clear and reads well, unlike some other CHW definitions that she has found confusing. Ms. Torres noted that she is really proud of the definition and relayed how she has already used it to help someone better understand what CHWs do. Mr. Corjulo added that his gut impression when he read the definition was that this is an important job that is filling a big gap, that there is not another job like it that fills this need.

Motion: to accept the CHW definition proposed by the definition design group –Terry Nowakowski
Vote: all in favor.

5. CHW Certification—Review from August
Katharine London noted that at the last meeting (8/30/16), the majority of the group had agreed that:

- Connecticut should pursue certification for CHWs
- certification should be voluntary and include a "grandparenting" process
- there should be one certifying entity
- a multi-stakeholder board should decide skills, training, and experience

She also reviewed some of Carl Rush's slides on certification from the May symposium.

6. CHW Certification—Lessons from Other States & Other Providers
Stanley Zazula and Maggie Litwin presented details about the certifying entities in New Mexico, Massachusetts, Florida, Rhode Island, Oregon, and Minnesota.

New Mexico: Chris Andreson responded to some confusion by explaining that boards (often composed of attorneys) have legal authority, whereas advisory councils do not.

Massachusetts: Ms. London stressed the importance of incorporating a timeline and deadlines into the certification strategy. Massachusetts's lack of deadlines has slowed down the implementation of its certification process.

Florida: Ms. Seguinot asked whether Connecticut has anything like the independent nonprofit organization in Florida that administers certification for CHWs and many other professions. Mr. Andresen responded by explaining that the for-profit company Prometric tests and certifies nurse aides in Connecticut, which makes people eligible to appear on the Nurse Aide Registry. The state does not pay Prometric, which makes money by doing the testing and certification. The state maintains the registry so that employers can check to see who is certified, who has violations, etc. Prometric, not DPH, determines and manages the certification process, but DPH is the one who investigates complaints about nurse aide violations and provides evidence for hearings for those charged with a violation. Jenna Lupi informed the committee that she had invited Mr. Andreson to attend the meeting so that he could answer questions about DPH's role in certifying various professions. He said Florida's independent certifying board, like Prometric, is probably funded by fees.

Rhode Island: No comments by committee.

Oregon: Ms. Lupi relayed that although none of the states being presented on have commercial payers that are paying for CHWs, Oregon has tried, but so far without success. Medicaid does pay for certain CHW services in Oregon.

Minnesota: Meredith Ferraro stressed that only Medicaid is paying for CHWs, and that only for health education and not care coordination. CHWs have been underutilized because providers are not billing for CHW services because only health education is billable. Tiffany Donelson added that another reason they are being underutilized is because many providers are using other health professionals besides CHWs to provide navigation/coordination services.

Mr. Andresen advised the committee to keep in mind the potential conflicts that can occur between professions over who can be certified to perform certain tasks (e.g., health education or assessment). Migdalia Belliveau encouraged the committee to keep in mind the difference between the kind of health education and associated activities that Certified Health Educators perform and the kind of health education that CHWs provide. Stanley Zazula said that that is partly what the term "coaching" in the definition is meant to do, adding that the US Department of Labor's CHW definition excludes health educators. Grace Damio noted that since much of the health education that CHWs do essentially reinforces what clinicians do, it is not certified health education. She also stated that such reinforcement differs somewhat from coaching.

Michael Corjulo asked Ms. Ferraro if part of the reason for underutilization of CHWs in Minnesota has to do with the amount providers are reimbursed for CHW health-education services. She replied that she was not sure, but that that could be a reason, as could be the administrative burden involved in billing for a small amount of money.

7. CHW Certification—Recommendations for a Certifying Entity

Katharine London explained that the committee had lots of decisions to make about certification during the meeting, but probably would not be able to make all of them during the remaining hour. The certification design group will take up whatever certification-related work remains. She recommended, then, that the priority for the remainder of the meeting be determining what questions the committee wants the design group to answer. The committee could try to answer some of those questions to the degree that time allowed.

Ms. London presented the following list of what she thought a certifying entity should do. Who should do these things is a separate and later question.

- Develop training and experience standards and requirements for voluntary certification
- Develop process and timeline for applying for certification and for renewal
- Develop process for assessing whether an applicant meets the requirements
- Establish an application fee (if necessary)
- Establish grounds for complaints related to CHW services and process for the review and resolution of such complaints
- Establish a disciplinary process in response to such complaints, including a process for CHWs to appeal any disciplinary action

To Ms. Damio's question about whether disciplinary processes are standard across the professions certified by DPH, Mr. Andresen said that it depends. DPH's authority to discipline comes from statutes, which may not deem as warranting discipline some actions that a professional organization might. For example, he related how the national organization for marital and family therapists recently disciplined a licensed one in Connecticut for something like incorrectly writing a word in a chart, which does not warrant discipline as far as DPH is concerned. DPH does not regulate job performance (e.g., bedside manner), which is up to employers.

Migdalia Belliveau asked if codes of ethics play a part in DPH's assessment of alleged violations. Mr. Andresen said that codes of ethics are sort of separate from enforcement actions. He sees them as part of how professions regulate themselves. Ms. Belliveau responded that there needs to be some kind of standard or guideline to make sure disciplining is not subjective. After learning from Ms. Seguinot that there is a CHW code of ethics, Ms. London asked members if they thought a code of ethics should be part of the certification process. There seemed to be agreement that one should.

To Mr. Corjulo's question about whether DPH enforces roles/jobs like CNAs, MDs, etc. because there are laws that define them, Mr. Andresen said yes. Mr. Corjulo then suggested that one of the recommendations of the committee might be whether or not it thinks legislation defining CHWs is required because without it DPH has no authority to regulate their certification and practice. Mr. Andresen urged the committee to keep in mind the potential unintended consequences of CHW legislation (e.g., the barring of uncertified CHWs from continuing to provide CHW services).

Ms. Damio clarified for the group that there appears to be three levels at which CHWs could be monitored and disciplined for stepping outside the bounds of what is considered good practice: employer, professional organization, state agency. In other words, the disciplinary process can be brought to a new level if it is embedded in a state entity. Ms. Lupi asked the committee if they felt that discipline at the state level would be necessary to protect CHWs or the public.

Ms. Seguinot wanted to know more about how other states are handling the issue and emphasized that the purpose of credentialing CHWs is not to make their lives onerous but rather to provide them with professional feeling and respect. Ms. London stressed that the certification would be voluntary and gave the example of lifeguard and first-aid certificates, which employers are free to require or not. Ms. Belliveau asked the committee to bear in mind that discipline at the state level beyond the employer could severely impact a CHW's career.

The upshot of an exchange between Mr. Corjulo, Ms. London, and Mr. Andresen was that a certificate of, say, training completion could be a requirement for certification, but would not itself be certification—at least, not as it is being considered by the committee. Certification is a larger and more comprehensive process. Ms. Seguinot enumerated many things besides a training certificate that will need to be required for certification: letters of reference, volunteer experience, etc. Mayce Torres expressed concern about having a certification process that is so onerous and expensive that it excludes the very people who are best qualified to be CHWs and who desire opportunities for upward mobility.

Ms. London proposed several questions about certification design that need to be answered:

Certifying Entity

- Who should develop the certification process? (1st, 2nd, 3rd choice)
    - DPH alone

    - CHW Board within DPH
    - Independent Board
    - Academic Institution
    - Other
- What process should it use to get public input?
    - Establish formal Advisory Committee
    - Hold public hearings

Training Curriculum

- Should the certifying entity:
    - Develop 1 curriculum to be used statewide?
    - Review and approve curricula submitted by outside entities?
    - Develop a set of required core competencies and approve any curriculum that teaches those core competencies?

CHW Roles

- Should the certifying entity adopt a set of approved roles for CHWs, using the roles document approved by this CHW Advisory Group as a model?
- That is, should CHWs be certified to perform a certain set of services?

Timeline

- By WHEN should the certifying entity finalize these processes?
    - e.g. within one year of its first meeting?
    - Different deadlines for different tasks?
- How often should the certifying entity review and update its decisions and processes?
    - Every five years?
    - Whenever it feels the need?

Mr. Andresen reviewed several ways through which professions can be recognized in Connecticut:

1. DPH Licensure, Certification, or Registry (RNs, CNAs, social workers)
2. Certificate Program (former CT DPH HIV educator certificate)
3. Certification outside of DPH (CPR)
4. Statutory Recognition/Title Protection (music therapists, behavior analysts)
5. Insurance Mandate (behavior analysts, which are paid through Medicaid even though they are not certified or licensed)

Tiffany Donelson stated that CHWs need to look like other healthcare professionals if they are going to be integrated into the healthcare system. She admitted that it will require a delicate balance to avoid over professionalizing CHWs, but they need much more than something like CPR certification. Bruce Gould added that payers have told him that they don't want to even talk about paying for CHW services until they are certified like the rest of the healthcare workforce.

Ashika Brinkley expressed concern about the potential for certification to negatively impact the CHW-client relationship. Peter Ellis recommended doing no harm. And to Ms. Brinkley's point about the importance of community connection, he said he supposed CHWs could provide a letter or some other kind of document attesting that they know their community well. He also asked if the committee could

be given a menu of options for certification, starting with the minimum or most basic and ending with the maximum, accompanied by pros and cons. He felt that mapping out the options like that would facilitate the committee's deliberation. Yolanda Bowes asked if the assumption about certification is that it will apply to people with no post-secondary education. She wanted to know where it fits in the education continuum. Ms. London suggested that one question that needs to be answered is whether the committee thinks there should be tiered levels of certification (basic, specialized, etc.).

Ms. Belliveau asked Mr. Andresen how much input DPH would have if it were the certifying entity. For example, could it increase the fee for certification or remove a core CHW value? He said that DPH could not alter anything that was already in law; its role is to enforce. It could, however, comment on proposed CHW-certification legislation before it became law by, for example, pointing out that it is written too vaguely to regulate. The law would need to describe the basic requirements for certification, but could delegate determination of things like continuing-education requirements to another entity. He added that a formal process already exists for professions wanting to become licensed. It's called a Scope of Practice Determination and enables all stakeholders to provide input to the process.

Referring back to Dr. Ellis's request for a summary of pros and cons, Ms. London observed that there are definitely pros and cons to think about in terms of having DPH as the certifying entity. On the one hand, a law would have to be passed. On the other, certification through DPH might carry more weight than certification through a non-state entity, which would not require passage of a law. Mr. Andresen said that administrative costs should also be considered. Even though Prometric handles the testing and certification for CNAs, DPH has to employ a full-time staff member to manage the CNA registry. Unless there was no enforcement related to CHWs and no complaint process—a possibility that would require close scrutiny—a CHW certification process located within DPH would need some level of staffing and would therefore incur administrative costs.

Maggie Litwin asked if statutory recognition is what would allow someone to call him- or herself a "Certified Community Health Worker" as opposed to a "Community Health Worker." Mr. Andresen said that was right, adding that one of the beautiful things about a statute is that you can write into it exactly what you want it to do. So, for example: "No person may call themselves a Certified Community Health Worker unless they have done x, y, and z." He recommended perhaps clarifying that with a statement about that restriction's not prohibiting anyone from calling him- or herself a "Community Health Worker." He also stressed the importance of having the professionals to be certified actively inform the policies that will regulate their certification.

Meredith Ferraro said that what she was hearing from the committee was that the medical/healthcare field wants CHWs to be certified, but she expressed concern about overemphasizing the healthcare setting, which is only one of the many in which CHWs work. Many CHWs may not need clinical skills. She pointed out that New York does not want certification because they feel that the skills that CHWs have do not require regulation. Not every state feels that certification is necessary. Ms. Donelson replied that she thought that was one of the reasons for making certification voluntary, that part of the power of making it voluntary was that people who do not necessarily want to be part of the healthcare profession per se could still have maybe a certification piece but not necessarily have the full DPH licensure. She felt that the voluntary nature of certification would help balance two competing priorities of the SIM, that is, certification and the use of CHWs in community-collaborative and advanced-medical-home models.

Ms. Damio related that her understanding of the SIM discussion of CHWs is that CHWs have a broad array of skills, in both clinical and non-clinical settings, and that, as the SIM Practice Transformation Task Force pointed out, health is about 15% attributable to healthcare. That means CHWs are needed within healthcare, but also very much outside it within the safety net, which is very fragile right now. Having the safety net paid for by healthcare could help sustain it, but that would not mean that what CHWs are doing is restricted to healthcare. There is payment, there is setting and skills, and there is some way to define all of that. And part of the reason behind creating a formal definition with certain skills in it is to get CHW services paid for. The reason for going to healthcare payers is that they are one of the options for sustainable payment. She appreciated the idea that CHWs work outside of healthcare and possess non-clinical skills and conveyed that she thought the committee was trying to make it clearer to payers what the full array of CHW services is—even when they are based in the community—and without making certification onerous. Ms. London followed up by noting that it is important to recognize that payers will still decide what they will and will not pay for.

Ms. Lupi stated that what the committee is discussing is two issues: (1) certification and the defining of a professional group and (2) payment for CHWs. SIM's goals are mainly focused on (2) and integrating CHWs into advanced networks. As for certification, SIM is not convinced that it is either necessary or the model that it wants to pursue for the Community and Clinical Integration Program. Nor is SIM convinced that certification will persuade payers to pay for CHWs. She therefore suggested that the committee focus more on determining whether certification is important for the CHW field and what it should look like based on that importance rather than on payment, although the committee will be moving into a discussion of payment later.

Components of certification identified and recorded on the flip chart:

- code of ethics
- not creating a barrier for CHW upward mobility
- not punitive at the state level
- disqualifications? e.g., felony convictions?
- tiered certification?

8. Wrap Up and Next Steps
Ms. Lupi will arrange for a certification design group to meet before the next committee meeting (11/17/16). Because of the committee's great discussion, the CHW team will need to regroup to think about what the focus of the design group should be.

9. Adjourn
The meeting adjourned at 4:30 pm.