STATE OF CONNETICUT
State Innovation Model
Community Health Worker Advisory Committee
Meeting Summary
Thursday, November 17, 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, Yolanda Bowes, Michael Corjulo, Terry Nowakowski (Chair), Milagrosa Seguinot

Members on the Phone: Ashika Brinkley, Thomas Buckley, Juan Carmona, Darcey Cobbs-Lomax, Tiffany Donelson, Liza Estevez, Chioma Ogazi, Mayce Torres

Members Absent: Grace Damio, Loretta Ebron, Peter Ellis, Linda Guzzo, Nicholas Peralta, Lauren Rosato, Robert Zavoski

Other Participants: Tekisha Everette, Faina Dookh, Meredith Ferraro, Meredith Gaffney, Bruce Gould, Maggie Litwin, Katharine London, Jenna Lupi, Geralynn McGee, William Tootle, Stanley Zazula

1. Call to Order and Introductions
Terry Nowakowski served as Chair and called the meeting to order at 2:37 pm.

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

3. Approval of Minutes
Motion: to approve minutes from 10/20/16 –Yolanda Bowes; seconded by Milagrosa Seguinot
Vote: all in favor.

4. CHW Certification—Review and Design Group Plan
Katharine London reviewed highlights from the 10/20 discussion of certification:

- Many categories of certification can be considered, each with pros and cons and various levels of cost.
- Statutory recognition was identified as an option to identify CHWs without an associated administrative cost or complicated certification pathway.
- There was general consensus that the purpose of CHW certification should be to provide CHWs with a professional feeling and respect.
- There were concerns that disciplinary action for CHWs at the state level would not be ideal and could be damaging to CHWs and that some forms of certification could be a barrier for some CHWs (e.g., because of cost).
- CHWs need to look like other healthcare professionals in order to be integrated into the healthcare system. For example, a CPR-like certification may not be enough.

- CHWs are an asset to the healthcare team, but the committee noted the importance of preserving the role of CHWs outside of the healthcare setting in any type of certification.
- While many states are pursuing certification, some feel that CHW skills do not require regulation.

5. Community and Clinical Integration Program—Review

Jenna Lupi provided an overview of the Community and Clinical Integration Program (CCIP), which aims to enhance advanced networks' (large groups of providers) and FQHCs' capabilities in comprehensive-care management, health-equity improvement, and behavioral-health integration. CCIP requires that CHWs be integrated into care teams to achieve these enhanced capabilities. Successful integration of CHWs can demonstrate the effectiveness of CHWs in Connecticut at improving care, achieving outcomes, and strengthening care teams. The roles of CHWs in CCIP include:

- Bridging of social, cultural, and health-literacy gaps
- Health coaching/education
- Patient navigation
- Advocacy
- Behavioral health perspective
- Linkage to community resources and supports
- Care coordination
- Support to care teams in the execution and monitoring of care plans

The advanced networks and FQHCs that are eligible to participate in CCIP are those that have been accepted to participate in PCMH+, which is a SIM payment-reform initiative run by the CT Department of Social Services that uses a shared-savings benefit to incentivize reduced costs and improved outcomes. Although CCIP participating entities (PEs) must use CHWs to achieve the CCIP standards, it is entirely up to them to decide whether or not to use the CCIP transformation awards to pay for CHWs. For example, as Faina Dookh pointed out, if some PEs already have CHWs on their care teams, they may choose to invest the CCIP funds elsewhere to help them achieve the CCIP standards (comprehensive-care management, health-equity improvement, and behavioral-health integration).

Ms. Lupi explained that PEs may not have experience with using CHWs on their care teams, which is the reason for the discussion of CCIP: to gather input from committee members on their experience with CHWs that can inform the CCIP vendor's technical assistance to those PEs requiring help with integrating CHWs into their care teams.

Meredith Gaffney asked for some clarification on how shared-savings programs work. She asked if the idea is that in the long run shared savings will cover the cost of CHWs but that for now there are CCIP grants that practices can apply for. Ms. Lupi said that was somewhat correct. The idea behind shared savings is that, compared to something (e.g., previous spending), a practice that demonstrates cost savings gets to keep a portion of it. That is one idea for how to pay for CHWs, but there are many non-fee-for-service alternative-payment models being experimented with across the country that could generate savings to fund CHWs. Michael Corjulo noted that the shared-savings program in PCMH+ uses several quality and outcome measures and that the amount of savings that providers get to keep is tied to how well they perform against those measures. Bruce Gould elaborated, describing how shared-savings programs require a recorded baseline of spending for a specific number of patients in order to calculate savings. He also stressed the importance of linking shared savings to quality and outcomes. The portion of savings that goes to the government is used to reinvest in the system and reduce the total

cost of care. Mr. Corjulo added that shared-savings programs are kind of risky because organizations don't know for sure that they will save money. The theory, however, is that better preventive care, better primary care, and better community care—all of which CHWs contribute to—will save money.

Terry Nowakowski asked how non-medical organizations like hers that work with the chronically homeless will eventually be able to participate in programs like CCIP and PCMH+. Ms. Lupi responded that, through the Population Health Council, SIM will be trying to expand to non-clinical areas what comes out of CCIP—which is really about building up the care teams of advanced networks—and other initiatives. Faina Dookh explained that prevention service centers (PSCs) is how the Population Health Council will be concretely linking community-based organizations, like those that serve the homeless, to the healthcare sector. Unlike CCIP, however, the PSCs are still only in the planning phase because it is very complicated.

Dr. Gould explained that the idea behind the concept of population health is that clinicians' responsibility no longer stops at the front door of the clinic. Just telling patients what to do and giving them a prescription no longer suffices. Now, within a population-health model, clinicians will be held accountable for whether their patients fill their prescriptions or have the money to fill them, for their living conditions, for the air and water quality in their communities, etc.—that is, for all the things that affect health outcomes. Not being accountable will financially hurt practices. The status quo is where folks come into a clinic and are on their own after they leave. The first phase of moving from the status quo toward a population-health model of healthcare involves practices' looking at just their population of patients and tracking whether they are coming in for visits, filling their prescriptions, etc. Phase two, a full-blown population-based model, will involve looking at the social determinants of health in the larger communities in which a provider's patients live. Within a population-health model, it is in the financial best interests of administrators and clinicians to actually work with community agencies, public health, and people living in neighborhoods to address some of the root causes of poor health. Migdalia Belliveau suggested that it is time for epidemiologists, MPHs, physicians, and CHWs to marry.

Ms. Lupi concluded the CCIP overview by explaining that it is SIM's expectation that the committee's work on developing a policy framework (scope of work, training, etc.) combined with CCIP's attempt to demonstrate the effectiveness of CHWs in Connecticut will lead to the identification of a sustainable funding source for CHWs and development of a vibrant and sustainable CHW workforce. To Mr. Corjulo's question about how many CHWs will be involved in CCIP, Ms. Lupi responded that while the CCIP proposals include numbers of CHWs, a big part of CCIP will be testing out how many CHWs are actually required to achieve CCIP's aims. This is something the committee could potentially weigh in on. SIM hopes that the first wave of CCIP PEs will provide a lot of information about CHW numbers for the second wave of PEs.

Ms. Belliveau asked if Qualidigm is the one who will be providing technical assistance (TA) to the CCIP PEs and, if so, whether they have a CHW on their team. Ms. Lupi answered yes to both questions, adding that AHEC will be advising Qualidigm on CHW issues and that input from the committee can enhance Qualidigm's TA.

Ms. Lupi set up the subsequent discussion by pointing out that it should focus on pre-implementation planning elements of CCIP and questions about identifying the right CHWs, interviewing CHWs, and bringing them onboard. There will be a lot more to consider later—how to actually work with CHWs on care teams, how to evaluate CHW interventions, etc.—but the next couple of months will be fast-paced

and focused on working with the PEs and Qualidigm to figure out how to do this right and get the right people in.

6. Community and Clinical Integration Program—Discussion
Katharine London asked members what they thought about the CCIP model of integrating CHWs into care teams and whether anyone had worked on a care team with CHWs integrated into it. She asked the several who said that they had to describe what has been successful and challenging and to identify issues that the CCIP planners should be thinking about.

Ms. Belliveau said that in her experience ***home assessments*** by CHWs and regular, routinized ***direct communication between CHWs and other members of the care team*** have been important. Home assessments allow providers to develop realistic care plans, and regular face-to-face communication ensures that everyone knows what the others are doing, preventing critical tasks from falling through the cracks.

Mayce Torres observed that there needs to be harmonization between CHWs and the rest of the clinical team and that this can be achieved by ***educating employers and the care team about how to use CHWs***. She also pointed out the ***importance of collecting good data*** on what CHWs are doing, what does and does not work, and the overall positive impact that they make.

Yolanda Bowes stressed the importance of ***making sure that CHWs are valued members of the care team***, that they are recognized as extensions of the provider team.

Mr. Corjulo enumerated what enabled the success of his CMS-funded asthma-home-visit program utilizing a CHW-team approach: the CHW received ***basic CHW training and specialized training*** (asthma) before starting the job, she was ***bilingual*** (English and Spanish) and came ***from the community***, she had a ***car***, she ***worked closely with an RN*** who mentored her, and he convened ***regular meetings*** with them to discuss hard cases and issues.

Milagrosa Seguinot expressed concern that the CCIP PEs will not know how to work with CHWs. CHWs are not the only ones who need training. ***Providers need to be trained in how to work with CHWs***. She also observed that ***job descriptions must align with the outcomes organizations aim to achieve through employment of CHWs***.

Faina Dookh explained that since CCIP PEs will be hiring CHWs in December, SIM would like immediate feedback from the committee on some very specific and time-sensitive issues.

Ms. London reviewed CHW-integration recommendations put out by the Institute for Clinical and Economic Review (ICER). Ms. Dookh asked if the committee could give any concrete advice around, for example, the ICER recommendation that employers should recruit CHWs from the communities that they will serve. For instance, are there interview questions—or as Ms. Lupi added, interview techniques—that could gauge whether someone is from a particular community?

Ms. Belliveau noted that, in addition to the issues of ***reliable transportation*** and sufficient ***car insurance***, ***background checks*** must be considered since CHWs will be going into homes. To an earlier question about whether social workers could be CHWs, she said that they could not because they represent a totally different discipline and perspective.

Ms. Lupi related that some of the CCIP PE proposals describe CHWs as performing only one or two CHW roles and asked the committee if that is sufficient to make someone a CHW.

Thomas Buckley pointed out that what seems to be missing in the discussion of what has worked for those involved with CHW-integrated care teams is ***action plans***. At the torture-treatment clinic where he works, the care team develops an action plan after each patient visit that spells out to the patient and all members of the care team exactly what everyone's next steps are to be.

Meredith Ferraro reiterated Ms. Seguinot's point that ***providers need to be educated about what CHWs do*** because the notion of team-based care is very different from what they ordinarily do. There needs to be job descriptions not just for CHWs, but also for every other member of the care team. And ***CHWs need to be a part of the whole process*** and not just brought in once a care plan has been decided on. ***CHWs need to provide input into care plans***.

Ms. Dookh asked for more comments on the issue of background checks because her sense was that they were not recommended so as to be as inclusive as possible and not discriminate against those with criminal records. Ms. London emphasized the distinction between doing a criminal background check and creating a rule that disqualifies those with a criminal record. She recommended examining each case separately and consulting the Obama administration's recommendations to employers regarding criminal records. Ms. Ferraro said it should depend on what population a CHW will be working with (e.g., former prisoners).

Mr. Corjulo seconded Ms. Belliveau's position on ***social workers***: they ***should not be CHWs***. He added that he didn't think any professional should be working above or below their license or certification, which means neither should a nurse be a CHW.

Ms. Seguinot cautioned ***against there being a minimum education qualification*** (e.g., a high school diploma) for CCIP CHWs because so many other factors (e.g., work experience) contribute to a CHW's qualification. Ms. Belliveau recommended, and others agreed, that presenting CHW applicants with a case from the community to respond to would disclose a lot about their qualifications and knowledge of the community. Ms. Seguinot said it was still important to start by asking them if they have any experience doing particular activities in the community. If applicants do not have an example, interviewers can then present a case to them.

Ms. Dookh asked if a social worker could be a CHW supervisor. Ms. London suggested than ***many professionals can supervise CHWs***, and several members agreed that they should receive CHW-supervisor training. Members did not feel that there should be a restriction on who could be a supervisor.

7. Wrap Up and Next Steps

Ms. London asked members to send to Ms. Lupi any materials (job descriptions, interview guides, etc.) that might be helpful in preparing the CCIP PEs to hire and work with CHWs.

Ms. London relayed that she is seeking employers of CHWs to participate in non-SIM interviews about CHW salaries, benefits, supervision, etc. She asked anyone interested in participating to email her.

8. Adjourn

The meeting adjourned at 4:34 pm.