AHEC MONTANA AREA HEALTH EDUCATION CENTER | MONTANA STATE UNIVERSITY | Office of Rural Health Area Health Education Center

Montana Community Health Worker Dialogue
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Why we are meeting

- Community Health Worker interest in Montana
- National Perspectives on CHWs (Carl Rush)

Definitions and Standards

- Definition adopted by American Public Health Association: "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."
    - Montana's State Health Dept. and State Labor Dept. need to accept/adopt definition and work together
- "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."
- CHWs are unlike any health related professions
    - Challenge is to understand that CHW view is very broad
        - Do not provide clinical care – assist with non-medical needs
        - Generally do not hold another professional license
        - Expertise is based on *shared* life experience and usually culture within the population served
        - Rely on relationships and trust more than on clinical expertise
        - Relate to community members as peers rather than purely as client
        - Can achieve certain results more effectively than other professionals
        - Uniquely able to "work both sides of the street – skilled at community-level and patient-level strategies

Why CHWs now?

- The "Triple Aim"
    - Improving patient experience of care (quality and satisfaction)
    - Improving the health of populations
    - Reducing the per capita cost of health care
- What's missing or broken within our system?
    - **Relationships and communication**
- CHWs Address Social Determinants

Curriculum and Training

- Must Consider Key Dynamics to be Successful Training Program
    - Unique nature of CHW workforce
    - Dynamics of CHW labor market
    - Emerging consensus of definitions and standards
    - Other necessary aspects of policy infrastructure

Supervisors/instructors need to be trained on program in order to implement successfully and role model the relationship they expect CHWs to have with community members (patients)

- Training
    - Has to fit policy and infrastructure
    - Central importance of practicum/internship – apprenticeship models
    - Use performance-based assessment
        - Interpersonal skills
    - Most students require financial aid or employer subsidy
    - Ongoing dialogue about knowledge base requirements and pre-hire vs. in-service learning

Employment Opportunities

- CHW Labor Market has unusual dynamics
    - History of marginalization and isolation
    - Dominant pattern of "siloed" financing thru short term grants and contracts
    - Unique presence of volunteers
    - Diversity of roles
        - …but specific jobs often narrowly defined
    - Central importance of "community membership" or shared life experience as a qualification
        - …not everyone can be a CHW
        - …and employers will hire the "right person" first and then train them – no conventional pipeline
    - Healthcare payers are interested in CHWs
        - "Hot-spotters" – better care for "super-utilizers"
        - Chronic disease management
        - Improving birth outcomes
        - Cancer screening and navigation
        - Care transitions
    - Based on shared experience – not for those coming out of high school or college
        - Interest with older individuals who have life experiences

CHW Policy and Financing

- 4 interrelated policy areas affect CHWs
    - Occupational definition (agreement on scope of practice and skill requirements)
    - Sustainable financing models
    - Workforce development (training capacity/resources)
    - Documentation, research and data standards (records, evidence of effectiveness and "ROI") – often neglected
- Certification
    - Declaration by issuing authority that an individual has necessary skills
    - NOT the same as an educational "certificate of completion"
    - Issuing authority: government, educational, association or employer-based; does NOT have to be the State government

- A *responsive* CHW certification system has:
    - Multiple paths to entry, including based on experience ("grandfathering")
    - User friendly application process without unnecessary barriers of education, language, citizenship status
    - Required education available in familiar, accessible settings
    - Skills taught using appropriate methods (adult/popular education)
    - Easy access to CEUs, distance learning
    - Respect for volunteer CHWs – "first, do no harm!"
    - Financing, models, etc.
        - NASHP webinar - https://www.statereforum.org/integrating-chws
- Key principles in policy change
    - Minimize barriers of language, education level, citizenship status, and life experience
    - Encourage contracting with community-based organizations for CHWs' services
    - Remember not all CHWs work in healthcare!
    - Again, respect volunteers
- Stakeholders
    - Every state needs to have awareness campaign for stakeholders – 90% of employers probably does not know what a CHW is or does
- Federal agencies are increasing support for CHW strategies
    - CDC, HRSA support for state policy change
    - CMMI grantee learning collaboratives
    - HHS CHW Inter Interagency Work Group
    - CMS-CDC discussions
- Medicaid Preventative Service rules have changed
    - 78 FR 135 p. 42306: 7/15/13 – (effective Jan. 2014)
      § 440.130 Diagnostic, screening, preventative, and rehabilitative service
    - "*Preventive services* means services recommended by a physician or other licensed practitioner…" (previously read "provided by")
    - Brings rules into conformance with ACA
    - Commentary clearly reflects interest in funding services by CHWs and other "non-licensed" providers
    - Payment for CHW services will no longer need to be treated as admin costs
- Taking Advantage of Medicaid Rule Change
    - Medicaid State Plan Amendment – must specify:
        - What non-licensed occupations are covered, and qualifications (skill requirements)
            - not necessarily certification
        - What services will be paid for (CPT codes), and what categories of Medicaid recipients may receive them
        - Rates and mechanisms of payment (FFS, MCO, bundled payment, etc.)

Standards, Metrics, Documentation and Evaluation

- Documentation of CHW activity has not been a high priority
    - Historically separate from medical records
    - Lack of common metrics has hampered pooling and comparison of data
    - No coherent research strategy exists
    - Example: CMMI Innovation Grants
    - Increasing recognition of beneficial CHW roles in research (CBPR)
    - Value of CHW observations for clinicians is being recognized

    - Adapting to the CHW workforce:
        - Equipping CHWs to document and report appropriately
        - User-friendly documentation tools for field work
- Other initiatives on CHW research
    - Institute for Clinical Economic Research 2013 report
    - PCORI planning national conference to fill evidence gaps

Next Steps – Strategic Planning

- **Keep engaged – AHEC's CHW Listserv, etc.**
- **Maintain infrastructure at state level – PCORI grant, payers need to be involved**
- **Montana Healthcare Foundation**
    - **collaborative funding source**
- **Currently in process of creating Environmental Scan of Montana's Community Health Workers – collecting data from survey**
- **Review training and curriculum development materials used in other states instead of creating new – create sustainable model**