NC Community Health Worker Summit: Synthesis of Feedback

December 16, 2016

Below is a synthesis of roundtable meeting notes, flip chart questions, participant feedback forms, and debriefing session notes that were gathered during the NC Community Health Worker (CHW) Summit, held on November 10, 2016 in Greensboro, NC. The information below is divided into the following sections: general issues, credentialing requirements and processes, core competencies and curriculum, roles, and considerations for moving forward. The NC CHW Steering Committee (and related Teams) will review the NC CHW Initiative Stakeholder Recommendations that were released at the CHW Summit and find passages that speak to the issues below. If the Recommendations already speak to these issues, associated statements will be strengthened. If the Recommendations do not address the issues, the Committee will consider adding language that can address the feedback received.

*** General Issues ***

Turf

Many people expressed the need to be sure role boundaries are clearly defined. Many people mentioned that case managers, social service workers, peer support specialists, patient navigators, direct support professionals, health coaches, and health educators could feel like some of the proposed CHW roles fall within the purview of their jobs. Summit participants also thought turf issues may vary between clinical settings and non-clinical settings.

Liability & Safety

People expressed concerns of liability and safety issues with CHWs.

Language & Documentation

People were concerned that CHWs would be asked to be interpreters, and they may not be adequately trained to do so. They also questioned how the CHW certification would impact documentation status. Some people were concerned about how the certification process could impact people who are undocumented who are currently doing this work.

Important to Rural Areas

Many people mentioned how important CHWs were to rural areas. Some were concerned that rural areas would have a hard time getting programs to become accredited or individuals certified.

Valuing Volunteers and Program History

People were concerned that volunteers and pre-existing programs would not be valued under the new system or that their programs would have to change. Summit participants also saw the need to protect the variety that comes with CHWs.

Buy in and Sustainability

Summit participants would like more information on building support for the certification process across multiple sectors. Others want to know how the process will be funded and sustained long term.

Return on Investment (ROI), Value-Based Care, and Patient Centered Care
People thought there should be an emphasis on ROI. Participants also mentioned that CHWs are needed in value-based care. Others warned that it will be a challenge to introduce the CHW model while the current health systems are adapting to Patient Centered Care.

Engaging Behavioral Health
Many participants noted that the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) along with various LME/MCOs should be involved in this process due to the similar roles Peer Support Specialists play. The focus of the CHW efforts has been on chronic disease. However, DMHDDSAS staff who went through the process of getting Peer Support Specialist services recognized as reimbursable could provide valuable lessons learned from the process.

Meeting People Where They Are – Literally and Figuratively
Participants felt that we should highlight that CHWs "meet people where they are".

*** Credentialing Requirements and Processes ***

Grandparenting & Merit Badges
There were many remaining questions about the processes related to grandparenting and merit badges.

Universities and Community Colleges
Some Summit participants noted that community colleges can train people to be CHWs but that they may not have the connections to transition CHWs to jobs. People wondered how 4-year institutions would become involved. Folks also asked that the NC System General Administration be considered in addition to individual institutions (though individual institutions can serve as a liaison).

Funding and Cost for Training
People wanted to ensure that the cost of certification, continuing education, and renewal remains attainable.

CHW Certification and Accreditation Board & CHW Database
Summit participants wanted additional detail about who is going to administer tests and conduct the trainings. They wanted to know who will be managing these processes. People also wanted to make sure that CHWs were involved with the management of these processes and that they would be well represented on the Board. Some people thought that the governing body should be at least 51% CHWs. Folks recommended that the credentialing process include something other than a paper/pencil test. People also requested a CHW database.

Recertification & Continuing Education
People wanted further definition of the continuation education requirements. They wanted to know how many hours and what content would be included. Some folks thought that recertification should be required every two years, rather than three. Summit participants also wondered if observation would be part of the recertification process.

Education Requirements
There were mixed comments on the education requirement. Some thought there should more flexibility, others agreed with the method proposed and a third perspective was that it should include more stringent requirements. There were also concerns about the assessment of a 9t^h grade literacy level.

Accreditation of Programs/Organizations
Some participants appreciated the flexibility of having an accreditation for organizations/programs. However, people had questions about the processes involved.

*** Core Competencies & Curriculum ***

May Be Too Much to Ask vs. May Need to Ask for More
Some participants felt like the core competencies may be too much to expect and others thought that additional competencies/sub-competencies should be added.

Methods for Instruction and Measuring Competencies
Summit participants wanted CHWs to have opportunities for cross-training specific to cultural competency; they also wanted opportunities for shadowing. People wanted to know how competencies would be judged and if observations or mock experiences would be used.

Requests for Specific Edits
Some Summit participants suggested specific changes to the learning outcomes for Advocacy Skills and Service Coordination Skills. For Advocacy Skills, a participant wondered if we could you add "Demonstrates the ability to advocate for health care provider/system" to the learning outcomes. For Service Coordination Skills, a participant wanted us to add involvement in community groups and committees to the third learning outcome.

*** Roles ***

General Feedback
People thought that the roles should be defined as best as possible roles. As one person wrote, "We are not in competition but on the same team." Some Summit participants felt there was not enough emphasis on the role of patient health education, the importance of follow up/rapport building, and that sharing topic-specific information (e.g., specific information on diabetes).

Health and Wellness Promoter and Advocate Roles
Folks suggested that "patient education skill building, ensure understanding resource opportunities, mentorship to other CHWs, and clinical interaction with medical providers and clinicians" be added to the health and wellness promoter role. People wanted to understand the boundaries of the advocate role.

*** Considerations for Moving Forward into Phase II: Outreach ***

Phase II of the NC Community Health Worker Initiative will begin in early 2017. During this phase of the Initiative, efforts will focus on outreach through small meetings with targeted groups, listening sessions across the state, and a statewide survey of CHWs. The Recommendations will be revised based on the feedback gathered through these activities. During Phase II work to develop a CHW Association will begin and a certification board business model will be developed and piloted. Below are considerations for moving forward that were identified during a debrief directly following the Summit.

- Need more input from: health systems, insurers, academic institutions, patients/consumers.
- Is there a role for faith communities? For middle/high schools? For aging services?
- Organizations will need sample tools (such as job descriptions and evaluations) to make this more feasible on the ground.
- Need CHWs to tell their stories.

- Continuity is so important and must be maintained as we widen the circle. Each time we add new folks, we're aware that it will take time for people to get up to speed. We will ask get new supporters to air their preconceptions and beliefs b/c if those are not put on the table, they can cause issues later.
- The process will take time requires patients.