**Evaluation of the Wisconsin Community Health Worker (CHW) Apprenticeship Pilot Program**

**2016 Progress Report**

**DRAFT**

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**Introduction**

Federal data for the United States for the fiscal year 2015 show 1,903 active apprentices in the health care and social assistance industry. In 2010, the federal Department of Labor designated Community Health Workers an Apprenticeable Trade. The State of Wisconsin has one of the nation’s strongest Apprenticeship programs overall (Table 1), giving way to the opportunity to develop a nationally-significant model CHW Apprenticeship Program.

**TABLE 1. Fiscal Year 2014 Wisconsin Apprenticeship All Fields and Programs Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| State Name | Active Apprentice | New Apprentices | Completers | Active Programs | New Programs |
| Wisconsin | 9,280 | 3,554 | 842 | 1,017 | 96 |

Following this trend, a group of Wisconsin Health Care Employers, Community Health Worker Coalitions and advocates, are seeking to pilot test a formal apprenticeship program for community health in partnership with the state health department, State Department of Workforce Development (DWD), community-based organizations, educational institutions, and other stakeholders.

Having as reference the currently Endorsed Core CHW Roles and Skills of the CHW Core Consensus (C3) Project, significant groundwork has been carried out to launch this effort to create an apprenticeship Program. Exploratory discussions have been held with an initial group of five Wisconsin health care employers. Background data have been gathered on CHW apprenticeships in other states, and brief interviews were conducted with two of these.

Despite evident employer interest, two primary concerns remain: (1) the norm in apprenticeships is that one journey worker will supervise one apprentice, and employers would like to have the flexibility for the same journey worker to oversee two or more; (2) investing in apprentices requires assurance of reasonably long term employment for these workers, and the funding structures that would provide such assurance are not yet common in the health care industry, especially under Medicaid.

Unfortunately, despite sustained efforts, the CHW Apprenticeship Pilot did not launch as planned during the initial period ending June 30, 2016. The final design of the apprenticeship itself was not completed until February 2016. Learning during this initial period suggests that pilot activity may only involve one or a few employers, so agreement was reached to approach the initial evaluation as a case study.

**Proposed Evaluation Study Design**

A case study of the Wisconsin CHW apprenticeship initiative is proposed in order to understand those factors that both help and hinder efforts to develop and begin a CHW apprenticeship Model. Sponsors of this Apprenticeship Program for Community Health Workers were willing to make a significant investment to design, implement, evaluate this apprenticeship program, oversee training development, provide hands-on learning and practical instruction for apprentices and eventually, provide jobs to apprentices. Wisconsin sponsors of this Apprenticeship Program, have developed structured standards, educational guidelines and evaluation plans that included requirements for classroom instruction and paid on-the-job learning, with appropriate supervision.

In particular, given the potential high value of the implementation of the Wisconsin Apprenticeship Program in clinical settings, a comprehensive process and outcome evaluation has been recommended both, for the long term implementation of the Apprenticeship model and even in the case the Model is not implemented.

This evaluation approach of the Wisconsin Community Health Workers apprenticeship will use a case study design. It will involve both, a qualitative and a quantitative analysis in its’ process, collection, organization, and analysis of a comprehensive, systematically data and in-depth information, gathered from the experience of CHWs, employers, stakeholders and agencies supporting this project during the study period. Particularly, this evaluation will focus on the following areas:

Employers and Organizational Levels:

Assessment of Employer Readiness including baseline examination interest in the CHW workforce

Mentor and Apprentices (Staff levels):

 Assessment of Apprentice

Assessment of CHW Mentor baseline characteristics including knowledge and problem-solving skills related to those they will serve

Alignment with the CHW Field:

Assessment of the extent of alignment of the Wisconsin CHW Apprenticeship Curricula with National Guidelines including the C3 Roles, Skills and Qualities

**Data Collection, Methods, Sources of Information and Data Analysis**

Both, existent and new data will inform the Case Study. Whenever possible, available data will be collected on individual-base experiences at different levels, including Community Health Workers exposure to a particular apprenticeship model generated for clinical scenarios in Wisconsin. Program documents, statistical profiles, program reports, program proposals, interviews with program participants and staff, program observations and program histories will also be included.

In depth-conversations with clinical employers of CHWs, in four proposed hospitals, will allow the extraction of key information supported by key documentation from interview-data, observations and documentary data analysis of apprenticeship curricula, records and files of participating CHWs, mentors and employers.

In order to conform the CHW Case Study, the following activities and sources of information will be used for the study evaluation, according to the following timeline (based on a start dated to be determined)

TIMELINE

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Activity | Month 1 | Month 2 | Month 3 | Month 4 | Month 5  | Month 6 | Month 7 | Month 8  | Month 9 | Month 10 | Month 11 | Month 12 |  |
| Observation | — | — | — | — | — | — | — | — | — | — | — | — |  |
| Interviews | — | — |  |  |  |  |  |  | — | — |  |  |  |
| Phone Calls | — | — | — | — | — | — | — | — | — | — | — | — |  |
| Reviews |  | — | — | — |  |  |  |  |  |  |  |  |  |
| Data Analysis |  |  |  |  | — | — | — | — | — | — |  |  |  |
| Cross Walk |  |  |  |  |  | — | — |  |  |  |  |  |  |
| Cross Case |  |  |  |  |  |  | — | — |  |  |  |  |  |
| Focus Groups |  |  |  |  |  | — | — |  |  |  |  |  |  |
| Report |  |  |  |  |  |  |  |  |  | — | — | — |  |

**Case Study Activities and Sources of Information**

Observations of each CHW at each clinical setting, twice during the apprenticeship period, to determine changes on the roles and skills of the apprentice.

Interviews with each CHW, two times during the period, at the time of each observation to aid in the assessment of apprentice changes.

Informal phone discussions along the period, with project staff to support evaluator perceptions of the apprenticeship process

Reviews of apprenticeship materials, reviews of CHWs projects, materials and other related documents to support evaluators perceptions of the apprenticeship process.

Finally, a systematic review of each CHW apprentice record will be carried out.

In addition, the CHW Apprenticeship Evaluation process will include employer interviews, once during the study period.

Accumulation of raw case-data will be used for the generation of organized, edited information into a case-records for each participating apprentice CHW.

Case records will be used to construct a case study of the organizational development of the Wisconsin CHW Apprenticeship Pilot, to be shared with program decision makers, policy makers, stakeholders and CHWs.

Cross-case comparisons from each individual experience in the participating clinical settings will be performed to provide a clear understanding of clinical setting-needs of the roles, skills and qualities of CHWs in Wisconsin hospitals.

Cross-Walk Analysis comparing the Apprenticeship Program with the reference C3 Project’s roles and skills will be carried out to examine the alignment of the Apprenticeship curricula with the C3 Program.

Early employer phone-based interviews and discussions about their interest and concerns on the upcoming CHW Apprenticeship Program. Interviews will be taped and analyzed to identify key preparedness patterns, interest and concerns on the program.

Focus Groups with Employers, Mentors and Apprentices will be conducted to assess knowledge, concerns and hopes on the Apprenticeship Program implementation, process and success. Meetings will be recorded and analyzed to identify key patterns, interest and concerns on the program. An early draft of an employer intake interview protocol is provided as Attachment A.

Two evaluators will review the aggregated materials to independently make judgments of each case record. An external evaluator will review the data and check for biases, facts, interpretations and unwarranted conclusions. Finally, the external evaluator will participate in the organization and edit of the final version of the case study report.

Informed consent will be addressed for all taped and recorded interviews and discussions.

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Rakich JS, Longest Jr, BB, Darr K, Cases in Health Services Management. Health Professions Press, Baltimore, US, 1990

Apprentice Performance Evaluation Form <http://www.tricountyjatc.org/filemanager/UserFiles/File/ApprenticeEvaluation.pdf>

Apprenticeship USA. United States Department of Labor. Data and Statistics. <https://www.doleta.gov/OA/data_statistics.cfm>

**Background data collection: employer interviews**

Initial interviews were conducted in November 2015 by Sherri Ohly and Carl Rush with five potential employers: Aurora Health Care, Children’s Hospital of Wisconsin (and Children’s Health Plan), the Wisconsin WellWoman/WiseWoman Program, Froedtert Hospital/Medical College of Wisconsin, and the 16th Street Clinic of Milwaukee. These conversations led generally to the summary concerns noted in the Introduction, but the dialog was a productive one. These meetings were recorded, and detailed notes were made from transcripts of the meetings with Children’s Hospital and 16th St. Clinic, but the transcription process, from multiparty conversations, proved to be very labor intensive. The notes from transcripts for Children’s and 16th St. appear as Attachment B, and the recordings will remain available for future reference. Sherri Ohly continued dialog with a number of employers, and a meeting was held on May 2, 2016 involving Children’s Hospital and Owen Smith of DWD (with Carl Rush participating by phone).

**Background data collection: information from other states**

Online documents were reviewed to get a sense of the experience with other states in implementing health care apprenticeships generally. Based on a selective scan of state apprenticeships programs, most focus on construction and the trades. Few states have health care apprenticeship programs. While the information below is a selective scan, there were several states researched but not reported. Those scanned not reported have no health care related apprenticeable occupations. Texas was not included in the scan due to the information already available, but it has been noted that although Texas was the first state to develop CHW apprenticeships, thjey have graduated only a few students, mainly due to the complicating issues noted in the Introduction..

All of the states scanned rely on grants and private funding for their programs. Some of the states offer state-based grants but all of them rely on federal funding. Ratios in most states are 1:1 and some included language such as the following taken from the Massachusetts regulations:

“A numeric ratio of apprentices to journey workers consistent with proper supervision, training, safety, and continuity of employment, and applicable provisions in collective bargaining agreements, except where such ratios are expressly prohibited by the collective bargaining agreements.”

States included in the selective scan yielded the following.

**Massachusetts**: Very few healthcare related apprenticeships to date. CHWs are being added to the approved list of occupations. Additional information will be gathered and included on a future report. Currently funding is available through grants to develop a program.

**Maine:** Has a robust apprenticeship program and includes several health related occupations. Among those dental assistant, mental health aide and medical assistant. Ratio for apprentices and journey workers is 1:1. Most funding comes from grants provided by Maine DOL.

**New York**: No direct health care apprenticeships, however, closely related fields include substance abuse counselor aide, HIV counselor aide, direct support worker. All have apprentice journey worker ratios of 1:1. Funding is available through grants.

**Florida**: No health care occupations are listed but online documents provide information for those newly approved. The ratio is 1:1 for all newly approved occupations.

**Kentucky:** Community health worker is included under approved occupations. Apprenticeships are both publically and privately funded. Ratios of apprentice to journey worker are 1:1 for the first journey worker and then 1:3 employed on each project by an employer.

**California:** Available health services fields are completely unrelated to CHWs.

**Washington State**: Vast listing of occupations but few health related (medical assistant and school health technician). Private funding, some grant funding available ratio is always 1:1 with specific numbers for construction & housing trades.

A review of the federal DOL **Apprenticeship America** grants shows 11 states including Wisconsin have provision for CHWs in their funded program. The other states are Alaska, Arkansas, Connecticut, Florida, Massachusetts, Minnesota, Pennsylvania, Rhode Island, Texas and Vermont.

Carl Rush conducted brief interviews with Alaska (state DOL) and Pennsylvania (SEIU Local 1199c). Alaska wants to align with current Medicaid redesign efforts, which led them to their interest in CHWs in the first place. They have been able to align state and federal training dollars, so they can reimburse employers for apprenticeship mentorship wages (and supports that model), but can’t pay direct apprentice wages; they embrace the view that the ideal mentor is an experienced CHW. The Alaska DOL sees CHWs mainly as being responsible for care coordination. As might be expected, they face challenges of scale due to distance between frontier communities. The Alaska Community Health Aide/Practitioner (CHA/P) Program is quite separate and viewed as mainly providing clinical care; the rest of the state is fairly new to the idea of CHWs. A major concern for the Alaska DOL is sustainable financing for the classroom instruction portion of the program.

The Pennsylvania interview with 1199c was held on April 12, 2016. They clarified for the first time that a 1:1 mentor-apprentice ration does not mean “24/7” – in many cases the journey worker may only spend 1-2 hours a week with the apprentice. The Apprenticeship America grants prioritized occupations that are presently being filled by H1B visa workers, but this includes treating CHWs (for example) as nurse extenders, reducing the pressure to hire foreign workers. The 1199c apprenticeship grant is subsidizing supervision costs; as in other states their main agendas are sustainability and employer engagement. 1199c is partnering with Temple University, which offers a robust classroom training program in CHW core skills.

The fact that multiple states are experiencing the same challenges in impoementing CHW apprenticeships suggests that a formal learning collaborative among this group pf states would be beneficial.

**Attachment A**

**Employer interview questions (draft)**

For many of these questions there will also be a probe such as “What questions do you have about…?”

1. Do you currently employ other CHWs? Have you employed them in the past?

 a. In what roles?

 b. Please describe the training they received – who provided it?

c. If not, how well do you understand the potential roles and benefits of CHWs in your organization?

2. Who will supervise the new CHW(s)? Do they have background as/with CHWs?

3. Who will serve as the journey-worker for the new CHW(s)? What is their background?

4. What are the principal duties you expect to assign to the new CHW(s)?

a. Will they be working as part of a team with individual patients?

b. Will they have duties in population-based services such as health education?

5. Will the new CHW(s) have access to patient records?

 a. Will they be recording actions and observations in these records?

6. What other kinds of employees will interact with the new CHW(s)?

a. How much experience do they have working with CHWs?

b. Have they received any orientation on working with the new CHW(s)?

**Attachment B**

**Employer interview transcripts**

**Children’s Hospital – November 5, 2015**

[note post interview insight: since the hospital’s initials are also “CHW” they will likely never adopt the position title of CHW for their workers]

Laura Kerecman (Children’s Health Plan): Lessons learned: 3 home visits are not enough (will not move the dial, change behavior). Data slow from claims. Completers less likely to use ER for non-emergency. Using NY algorithm shows likelihood visit was in one of 4 categories: treatable in lesser setting, primary care, avoidable, true emergency.

9 Navigators, 2 Case Management Outreach Coordinators.

Goal of interview: How you feel about apprenticeship – how it fits with needs, goals. Organizational support can be “a mile wide & an inch deep.”

Community health navigators, school nurses Project Ujima (violence intervention). Volunteer respite

Gabe: supervisor of all community engagement. Strategy around “touch points” to engage Pts in healthier lifestyle. 3 Navigators in each neighborhood (10-12K pop.) community-based, door-to-door, past 3+ years, 2.5 years in the field (CMMI $). Main focus on jobs and housing. Safety education, PCMH, energy assistance. 60% of their time in the field. Also work with school nurses, who are often first “touch point.” School based services now also serve parents/caregivers. Community health educators also. Using REACH model, emphasizes civic engagement, community capacity building. Neighborhood advisory boards as accountability mechanism. Transient population, one is being redeveloped.

His background is in psychology, getting Master’s/license. Moving from targeted pop to whole community social psychological model (Bronfenbrenner). Familiar with roles that have not been called CHWs. Violence prevention “liaisons” training is a little different, but still CHW work. Boys & Girls Club have similar workers.

Bridget: ED Community Health and Education - roles in integrating CHWs into system, medical teams? “Prevention/intervention space” statewide – “community engagement is a tactic under population health” (priority across the system) – not just clinical health. CHW projects exist in pockets across the system, opportunity for synergy, best practice sharing, still independent, isolated. Navigator role is broad, not disease focused. Most kids are well. CHWs are extension of community as well as care team. Clinical health navigator program in one clinic as well: these are medical students. Want integrated role definition across system in the long run. Recently Navs have gained access to EHR (Laura’s workers do not – they use a parallel records system in Health Plan) – different access points and legal requirements.

Integration: Gabe said it is only taking place on a pilot basis now, but providers understand Pts need added supports at home, things like mitigation of asthma triggers, Navigators are better equipped to handle that.

Training needs: pros, cons of Apprenticeship: Gabe finds it most appealing in terms of moving field forward, supporting transition from “feel-good” to high-demand role, tie to State certification, reimbursable. Likes being in forefront. [?] CHW field needs validation – “anyone could do that job” – changing mindset of community and Partners. Hiring from the community is not just for publishing in our year-end report, more about community as a whole rather than a specific good deed. Important personal validation. Also each neighborhood is different, needs, skill requirements are different.

To reduce health care costs, lot of discussion about nurses practice at top of license. CHWs don’t have a SoP to practice at the top of, so they are dismissed from that conversation. Lack of certification is a barrier in accessing EHR, no license to be taken away for violations. Also market nationally does not value CHWs as highly as we do – some workers have to hold 2 jobs, when they bring much greater value than pay scale would indicate. “Field is held hostage to the lack of credentials.” Using data from “employee commitment survey” across the system. One employee said they work full time for Children’s and qualify for the same benefits as the people I’m serving – what does that say?

[Carl redirects conversation to specific advantages of Apprenticeship] Gabe: community now expects new hires to hit the ground running. Appr. would allow them to be immersed in work environment as well as education, have the support of an experienced worker. Challenge may be that a worker trained in one neighborhood can then be assigned to a different one requiring different knowledge and skills, as well as needing to gain the trust of that community. Important decision as to where the apprenticeship will take place. [Carl: CHWs often know what they need to do to gain credibility in a new place. Also small communities may not have a pool of local candidates.]

Difference between apprenticeship and internship? Curriculum needs to include boundaries and ethics, self-care if living and working in the same environment. They need to be able to “unplug.” Sometimes the same is true of teachers, police, has not often been done well. Work is skill-based, can’t be learned from a book, so apprenticeship adds rigor that health systems demand. Internships are short term, not usually related to actual employment setting. Apprenticeship is also part of the job, interns finish then look for a job. Apprenticeable skills are portable, generalizable.

A challenge in working with HR – this is a very different hiring/training process from what other employees go thru. Meeting scheduled in Dec. Changing systems for a small group of employees may be too big an ask. What does literature on other health care apprenticeships say?

Question: longer term financing not solidified - when apprentice graduates, what are payment sources, currently would be unfunded. Current navigators are grant funded. We don’t have an ROI calculation to justify them. Journey worker would be taking time off current tasks, grant funders have expectations. Is their time seen as an investment in the community? [Carl; payers seeing payoff in quality, cost control; Sherri: talking with Medicaid about possible focus on high utilizers]

Laura re CMMI grant: state formed work group on high-utilizers. Turns out they are small numbers, mainly duals or SSI, most are FFS not enrolled in managed care – we don’t participate in SSI. The kids are mainly SSI. Conversely, most kids are not high utilizers. Agree with all the pros from health plan side. State withholds 3.25% of cap rate, paid out based on performance metrics - $ millions/year. Have to decide which members to work with to help hit metrics – apprentice might focus on diabetes. State may require shift in emphasis, would require realigning CHW duties. We will need help with general performance monitoring – don’t have a year to see if they are going to “make it.” Also have 1/3 who are part time. [Carl: classroom work is fairly generic, OJT is about technique/application, built around or can be adjusted to actual job duties.]

[Sherri: hiring with degrees/not. Degree does not mean they can’t be effective in community.] But “just because you have a degree doesn’t mean you’re right.” Asking apprentice to do classroom, work, and learn our system (including complex org. culture). That takes time and effort; it is also changing rapidly. [Carl: part of mentoring is acclimation to the org.] [Sherri: in RI apprenticeship can be FT for a year or half time for 2 years]

Gabe: where did the number of OJT hours (2,000) come from? [Sherri: employer group wanted 1-2 years, nobody less than 1] License in counseling requires 1,000 direct service hours, 3,000 indirect. May seem overwhelming to employer. “Certification doesn’t have a lot of validity” with regard to reimbursement.

Any history of employers that have gone thru apprenticeship? Texas has trained 4, that’s about it. Not sure where it’s going from there. MA is in similar status to WI, but they have certification standards, established education resources; also grant-funded.

**16th Street Clinic – November 6, 2015**

created curriculum that trains to those needs

in order to integrate there needs to be work around their supervisors

JOHN: let me ask you this - so the community health worker kinda in my mind is antithetical to a health system, right, because health systems by nature are where you go; there aren’t a lot of health system that say, “let's get out into the community.” I’m just thinking of the health systems we have now - they come to us and say can you do this for us.

We’re a community health system, not a health system. And the health departments come to us and say can you do this for us.

CARL: in the longer term, sounds like you have some experiences for a specific reason to you need to do is there are some arguments for the relationship being longer-term one that you the folks who do it best are the ones closest to the community.

JOHN: I did a sabbatical in San Antonio at [San Antonio] MetroHealth 12-13 years ago and the [local] health director was taking a sabbatical - he said well can you come over and take over for me while I'm gone

SHERRI: Carolina [wife of former San Antonio health director] was an early advisor to United Voices.

HOLLY: That’s the grassroots part where I became involved.

[CARL talks about AMA resolution]

JOHN: but what about reimbursement? CARL: well yeah they do make the point that providers, payers need to get their act together on sustainable funding - one of the sort of immediate [opportunities is that] most of the health plans have a lot more latitude to finance or employ CHWs. some of them are hiding behind the fact that community health workers are defined as providers and so especially with the new rules which when they’re finalized but the proposed rules on Medicaid health plans make it clear in a couple places that (I haven't got the actual citation) but any activities that are aimed at improving the quality of care do not count as administrative, and so I don’t know the situation in Wisconsin, where Medicaid health plans are on requiring the medical loss ratio In a lot of states they’re not – only commercial plans [are required to do it].

(16:30) JOHN: there are - in their contract there are quality indicators that they have to meet– but the thing that we do so well, for as long as I’ve been here, is that outreach workers improve your quality. There’s no question - now to document how that is actually done to a legislator is a different issue but it's kinda like the fluoride varnish - we do that here. We had a governor who said we’re going to pay for that under Medicaid (Doyle) now that would never happen today - that's an indication, that's a quality thing where if you put fluoride varnishes pediatricians can bill for we can you’re preventing cavities, which in the long run is a good thing – you could do the same thing with outreach workers.

So here's what we do - we negotiate with the health plan and say here's what we want you to pay for, say community health workers, this is what you're gonna pay me based on what we’re going to provide to you, and it's going to be on top of our cost based reimburse because if you roll it into that then you gain nothing. SHERRI: so this is a piece that I’m trying to understand lately when we’re talking about value-based payment and bundled payment – how does that actually work?

JOHN: it's not part of the reimbursement, it’s on top they get paid differently anyway, community health centers. CARL: we’ve been after HRSA for a while saying they should allow them to include CHWs in the cost basis. JOHN: we’re negotiating with the HMOs to do that, currently we don't so we eat the cost because it's good quality.

CARL: this is a different world (FQHCs) from most providers, and they have these arrangements with Medicaid and with HRSA. JOHN: the way the reimbursement works is most health centers in the state are on cost base, we’re on PPS [prospective payment] - the state long ago said we’ll pay you the higher of the two so we just happen to have a higher PPS rate than a cost rate, because we used to have a dental clinic, so now the state is saying everyone's got a goal off of cost to PPS – well, some of these health centers are gonna lose a ton of money if they do that. We’re negotiating with the state right now, because what I've said is, no you can set up whatever methodology - and I was involved with the first methodology on PPS, and I said whatever you do that methodology is not cutting our rate back. We’ll either stay or go out - we'll see if that works. So we bill the HMOs costs or PPS rate – we’ll separate Medicaid because commercial doesn’t matter, but we make more money on Medicaid. SHERRI: most other clinics don’t.

JOHN: we get our PPS rate vs. the commercial rate, which is probably half. So we like Medicaid patients: and that's who we take care of! That’s our mission, so we we bill the HMOs and every month we send the cost report - I'll call it cost, it's an encounter rate, so depending on how many encounters we have times whatever our rate is, minus what the HMOs paid us, then the state every month makes up the difference. And then supposedly (we don't have a lot of state auditors anymore), every year we would have a year-end audit, and they would make up the difference between what we bill the state and what we were owed. And my position has always been bill 13%, 15% less then we think we should get. I don’t want to be paying the State back, so we always get money back, but the thing is that there are no auditors anymore so everyone’s behind.

CARL: problem is that a contact by a CHW is not counted as an “encounter” or “visit”. JOHN: right, because they aren’t considered a provider under the FQHC encounter, and not only that I've been working to do mental health telemedicine for years, and the state has never considered telemedicine a face-to-face encounter. The thing is that every state is different, and every medical board is different, every Medicaid agency is different and in Wisconsin historically they never considered a computer face-to-face as being face-to-face - and that's the requirement to get reimbursed. we just started with the psychiatry program at MCW. Now they have this big grant so we’re not billing anything, but what they're doing is - our pediatricians are - they only have this for child psychiatry –“peds” can call them, get a face-to-face with the client and then they will tell them what drugs they should prescribe based on that computer interaction. but it's the more pediatrician – a consult. I just heard from Schuler? last week, their CMO, [said] the medical board has softened their position on telemedicine, so we'll see where that goes.

SHERRI [get back to how you get paid] JOHN: so what I call it is enhanced payment - so I'm doing something more than we would normally do so that we can save you money, So if we save you money then we should share in that pot. So if it takes community health workers to do that, and we save you a ton of money, then we should get that money back to pay for those workers - now that doesn't legitimize them, unfortunately, right? …

CARL: that’s a separate strategy, maybe interim or short-term strategy: we’re seeing that happen some with supplemental care coordination fees working with high utilizers and that coordination could be based in FQHCs, but in many ways this is a shift in mindset that it’s better don't at the community level, because a lot of the care coordination is not about medical services at all.

JOHN: the other thing is that most patients have no clue who their HMO, they don’t know about HMOs: they know us, so the other thing that I'm doing is talking to the HMOs and saying, pay me so that I can, rather than you doing the care coordination - because nobody knows they only know us, pay us to do it for you.

SHERRI: which health plans seem to be biting on this? JOHN: well, Molina is, United is, only because - I think they set up via FQHC advisory committee - they would send 20 of us to Minneapolis quarterly to advise them on what they should be doing with community health, and one of the issues was this – nationally. So the result of that I think was more willingness to invest to do this payment on top of what we get. Then Managed Health Services is, kind of sort of ,only because of my relationship with them, so I think we’re going to get there.

SHERRI: are any other FQHCs doing this? They don’t seem to have CHWs.

JOHN: because you don't get paid for it as an expense. HOLLY: we’ve worked really hard for grant funding for all of the diabetes and asthma educators because we are willing to put up that quality data out there right away. It’s still hard to say, someone’s A1c for diabetes might come down it is not exclusively because the physician diagnosed or prescribed, it’s because that person, the educator helped them figure out what to do and they have that support ongoing, and it’s kinda hard to quantify - I think that's part of my learning collaboratives that I've been involved in. Not just chronic disease stuff but community – we can’t talk about their asthma until we figure out what’s happening with their housing etc.: we all know that, even internally on with our medical providers “that sounds good, but what does it look like?” operationally what does it look like, what does the handoff look like? We’re still struggling with that internally.

JOHN: well once you get into the global payments, then that's going to change everything, because if you're on the hook for this person’s complete cost you’re going to want to do whatever you can do to keep them

JOHN: my good friend David Rogers who runs a huge Health Center in Yuma: he is a huge advocate of community health workers. My doctorate’s in public health so ~~I have that~~ when you deal with physicians, they have a completely opposite bent, so they’re used to people coming to them, they do whatever they do; they don't think of the bigger picture - so trying to blend those is difficult

JOHN: we’re a level 3 medical home. HOLLY: I’ve got scars. From just that dynamic, where it might conceptually, oh this is wonderful – so this is how we do it and you’re going to have to help pay for it….

CARL: one of the things we’re beginning to do is to shift away from the conversation with the detailed tasks and activities the CHWs are expect to do partly because it's so broad, but the other is to position all this in terms of meeting the needs of organizations going through these changes – what are the unique capabilities that the CHW brings. And they lie in things like communication - making communication between provider and patient complete and candid so it’s all about relationship – we’ve evolved this vending machine relationship to healthcare, and so the future of this which you all are practicing is how do you built this into a meaningful relationship. The third big one is trust, and this is where we see the most pain in big institutions, is in low-income communities, in addition to the power dynamic in which you can’t necessarily get straight answers because of the power differential; and the other dimension is mistrust of big institutions. And the fourth capability is around dealing with social determinants: in the patient level and addressing at a community level through advocacy and organizing; and finally helping clinicians understand the patient’s life. So those four capabilities tend to be the ones that they begin to see that the those capabilities and the stresses on the personnel meaning that a different kind of person is needed to provide those capabilities.

JOHN: so I have an example of what you just talked about. 15-16 years ago we started door-to-door lead screening. we literally had community health workers knocking on doors and asking if we started in 53204 we've expanded and we would say “you have a child under six, we'd like to draw your child's blood – we’re from 16th St.” 98% of the people let us do that. who the hell would let some stranger draw your blood, right? but because we were 16th St. we had credibility – if a health system said that? no way… we took the lead poisoning in this community down from 45% down to 4% it's the credibility, the relationship. HOLLY: or going to people's homes asthma. when I first started here I said to my staff “get out of this building” – Even here, we have them sitting at round tables, like my public health nursing experience, working off our laps - not like in an exam room, like sitting at someone’s kitchen table and just talking about stuff. We’ll get to the diabetes, right now what’s going on? that takes time – then other say it shouldn't take time, but we have to do this first before we connect them to the other evidence-based guidelines for diabetes – we have to build that relationship that stuff is hard - and it has to be patient driven which is the hardest for medical providers – no, the patient chooses each and every day what they’re going to do. CARL: I talk to a lot of organizations where they say it has to be more efficient, they don’t get it - not only is it education across the system, but the CHWs direct supervisor ends up having to draw their swords frequently. If the CHW happens to be on the phone in the office, and somebody goes and complaints to the supervisor that it sounded like a personal phone call. They don't recognize a lot of their interactions with the patient are gonna sound more like a personal call. HOLLY: I had to go to battle with - you know, they’re not seeing patients, but they need to be on the phone. it's just really that - they're trying to learn more and you have to be out there in order to be okay with the work - that's what it is and you can't check back okay, and you're done – what the work is like, it’s different, and I think we have the challenge of how do you quantify. They may say, we like those workers, but how many do we need or how many do we have per population – let’s say we get 1,500 patients with hypertension, how many CHWs do we need? and we don't know right now, we have to work through it.

JOHN: my docs, I say you have 15 minutes that's what you have - well I can’t do that in 15 minutes; well, you gotta do it, otherwise I’m gonna be broke. Part of this is - we have a program we call Triumph with the medical college, and we get medical students who experience the community. They are actually out in the community, and I always say when you say 16 Street Community Health Center, put the emphasis on community health, not Health Center. so we don’t want to be a revolving door for sick people, but it's a whole educational process because that's not where physicians are in med school. You’ve got to change the whole mentality, that it’s just not you come in to see me. and I tell you what to do. and then when you don't do what I tell you to do, what are you called? “noncompliant” - so it's going to take a while to - and I'm working with the college to try to do stuff. HOLLY: even with our AmeriCorps members in diabetes and asthma, we get a lot of the pre-med we get them hands on right away, one by one they go off to medical school and had two come back now a couple from the Triumph students that one is Americorps member he went to med school, came back as a Triumph student, and now he’s here as an internal medicine doc. So it’s sorta one person at a time. is what we get them into the community right away. Most of the Triumph students have had some exposure to the community. So they have this perspective going into medical school.

JOHN: I know at least one system, Aurora, is doing that (apprenticeship) but not for CHWs.

SHERRI: [explained pilot project]

HOLLY: we have a bunch, we employ at least 20 across all the programs, and there's that [?] they’re called something different. They’re in most of our programs. we also have our patient-centered volunteer community health centers that function more in the chronic disease types of things, we have a mix of the employed CHW and also the volunteer which you know it is the recipe for a lot of communities, and so for the volunteers our employed CHWs are sort of the point of contact into the system for documentation and those types of things.

SHERRI [related state recognized training and certification to reimbursement]

JOHN: It’s sort of equivalent to what we do here with MAs. it's really hard to get certified medical assistants, so what we do, we have a standardized curriculum. we bring people in and we train them, and we certify them. it's not like being from MATC and what we have found is that our training is actually better (for your needs? Right) but some kind of certification would be good because then the person can move. HOLLY: it also can provide the soft skills: the relationship and communication, the soft skills vs. task. That’s been a challenge we've had as far as the curriculum - how do we teach them, how do we hold them accountable for the soft skills. That is really a huge part of the value of their work. JOHN: but people don't want to hear about soft skills. HOLLY: that’s what we want people to pay for

SHERRI: Come January as we start the apprenticeship, is there space for that in your training needs?

JOHN: we should talk more about that – we should have the discussion, because there may be some possibility.

CARL each employers apprenticeship will be standardized to some extent but it will be built around the actual work that they're expected to be doing - the soft skills are woven through it, but the tasks that they’re learning are the ones they’ll be doing and there involves a graduated assumption of greater responsibility and autonomy. but also according to the rules of the program it involves graduated compensation – they start out as a trainee - so there are a lot of things that are very much customized to the individual employer

HOLLY: it’s a good pipeline - for CHWs which is an emerging profession - it becomes really nice pipeline of people [like] with AmeriCorps members [you can] test them while you're working with them, but also you built this rapport with that person that you can probably get a much stronger bond/relationship, an employee employer relationship. I’m also involved at the high school level with South Division a committee there when they are putting in, out of California the National Academy for Health Sciences. pipeline for HS students they come in better educated maybe for an a in a position those types of things and and decided to get credit via MATC credit, but also as we're looking to hire people coming into an agency like ours, we have people that are coming in with some experience in health

CARL: it sounds like with your experience you could be a great collaborator on another aspect of this which is career development.

JOHN: I’m thinking of [Elvira?] – she’s a prenatal case manager, we call her that. she is so dynamic, unbelievable, and she just wants to do what she does.

CARL: we’re learning some things about how to groom CHWs to be supervisors, to become trainers, become specialists in particular ways. That dialogue is really just beginning to happen if an organization has really thought that through or have had the financial wherewithal to keep people long enough for that to be to be relevant.

HOLLY: initially you may end up with more people like me where I'm at, I’m a public health nursed but I’m fully a CHW. we have found that even our certified diabetes educators are really CHWs. so I think that right now that might be some of the supervisory type level and then be able to grow that other pipeline.

SHERRI talks about national developments

HOLLY: we’ll be working on a WPHA CHW Section. SHERRI: United Voices will be in a leading role in that.

JOHN: so the boss knows absolutely nothing about what goes on

HOLLY: we've been really good here in our CHWs have been presenting at WPHA. At some point I’d like to have a conversation with our HR director internally one of my goals was to have all these job descriptions that are called something else become CHWs, then we can have many a much larger inventory than just the kind of people I’ve called CHWs.