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 “silied” 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:
  o Multiple paths to entry, including based on experience ("grandfathering")
  o User friendly application process without unnecessary barriers of education, language, citizenship status
  o Required education available in familiar, accessible settings
  o Skills taught using appropriate methods (adult/popular education)
  o Easy access to CEUs, distance learning
  o Respect for volunteer CHWs – "first, do no harm!"
  o Financing, models, etc.
    ▪ NASHP webinar - https://www.statereforum.org/integrating-chws

• Key principles in policy change
  o Minimize barriers of language, education level, citizenship status, and life experience
  o Encourage contracting with community-based organizations for CHWs’ services
  o Remember not all CHWs work in healthcare!
  o Again, respect volunteers

• Stakeholders
  o 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
  o CDC, HRSA support for state policy change
  o CMMI grantee learning collaboratives
  o HHS CHW Inter Interagency Work Group
  o CMS-CDC discussions

• Medicaid Preventative Service rules have changed
  o 78 FR 135 p. 42306: 7/15/13 – (effective Jan. 2014)
    § 440.130 Diagnostic, screening, preventative, and rehabilitative service
  o "Preventive services means services recommended by a physician or other licensed practitioner..." (previously read "provided by")
  o Brings rules into conformance with ACA
  o Commentary clearly reflects interest in funding services by CHWs and other "non-licensed" providers
  o Payment for CHW services will no longer need to be treated as admin costs

• Taking Advantage of Medicaid Rule Change
  o 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
  o Historically separate from medical records
  o Lack of common metrics has hampered pooling and comparison of data
  o No coherent research strategy exists
  o Example: CMMI Innovation Grants
  o Increasing recognition of beneficial CHW roles in research (CBPR)
  o 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