



**IDAHO COMMUNITY HEALTH WORKER (CHW)
TRAINING COMMITTEE MEETING**

Thursday, October 15, 2015

MEETING NOTES REPORT

Meeting Goal: “To identify an Idaho Community Health Worker training curriculum and delivery method for the Idaho Department of Health and Welfare to recommend to the Idaho Healthcare Coalition.”

Participants

Name	Organization
Susan Ault	IPCA
Miro Barac	Bureau of Rural Health and Primary Care - IDHW
Josh Campbell	Genesis World Mission
Chris Christopher	Pioneer Health Resources
Dieuwke Dizney-Spencer	Division of Public Health - IDHW
Marilyn Edmonson	Saint Luke’s Health System
Ariel Foster	Bureau of Rural Health and Primary Care - IDHW
Megan Gomeza	Lifeways, Inc.
Rachel Harris	Southwest District Health
Katrina Hoff	Idaho Area Health Education Center
Bill Holstein	Shoshone County EMP Corp
Ellen Jones	Idaho State University
Taylor Kaserman	SHIP - IDHW
Samantha Kenney	DDID Community Outreach
Shari Kuther	St. Mary’s Hospital
Luis Lagos	FMRI
Martha Madero	FMRI
Mike Mikitish	Idaho State University
Gina Pannell	Central District Health Department
Janet Reis	Boise State University
Patty Romey	Bureau of Rural Health and Primary Care - IDHW
Linda Rowe	Qualis Health
Nicole Runner	Division of Public Health - IDHW
Jon Schott	St. Luke’s Health System
Mary Sheridan	Bureau of Rural Health and Primary Care - IDHW
Mark Siemon	Boise State University School of Nursing
Cory Surber	Saint Alphonsus
Maria Vargas	Valley Family Health Care
Ana Vidales	Southwest District Health
David Welsh	Division of Medicaid, IDHW
Gina Westcott	Division of Behavioral Health - IDHW
Jennifer Yturriondobeitia	St. Luke’s Health System

Facilitator: Monica Revoczi

Welcome

Mary Sheridan
Chief, Bureau of Rural Health and Primary Care
Division of Public Health
Idaho Department of Health and Welfare

Mary welcomed the group and provided an overview of the CHW Project. She reviewed how this effort aligns with the State Healthcare Innovation Plan (SHIP) model test grant.

Key Considerations for Achieving the Meeting Goal

Monica Revoczi reviewed the key considerations to keep in mind while assessing the various curriculum and training delivery methods to be discussed at the meeting:

1. CHW competencies – these were presented and prioritized at the last CHW Training Committee Meeting (July 30, 2015) as follow:
 - Culturally Based Communication and Care (20 votes)
 - Effective Communication (17 votes)
 - Outreach Methods and Strategies (16 votes)
 - Health Education for Behavior Change (14 votes)
 - Support, Advocate, and Coordinate Care for Clients (14 votes)
 - Client and Community Assessment (10 votes)
 - Apply Public Health Concepts and Approaches (6 votes)
 - Writing and Technical Communication Skills (4 votes)
 - Community Capacity Building (3 votes)
2. CMMI restrictions – discussed by Mary
3. Delivery methods – four primary (and can be combined/adapted, as necessary):
 - 100% onsite, in person
 - Online – live, interactive webinar format
 - Online – recorded, not live (can access any time)
 - Hybrid - in person and online (live or not)
4. Direct adaptability (e.g., to the rural attributes/realities of Idaho)

Overview, Discussion, and Prioritization of Existing CHW Training Programs

Miro Barac

Project Manager

Bureau of Rural Health & Primary Care, SHIP Regional Collaborative

Division of Public Health

Idaho Department of Health and Welfare

Ariel Foster

Health Program Specialist

Bureau of Rural Health and Primary Care

Division of Public Health

Idaho Department of Health and Welfare

Monica Revoczi

Ariel provided an overview of CHW training programs offered in Washington State, Oregon, Massachusetts, and New Jersey. After each was presented, the group identified corresponding pros, cons, and conclusions in relation to Idaho suitability. Next, group members were invited to contribute other curricula or training components/models to consider. Finally, the group reviewed the conclusions drawn from the above, and came to consensus on the CHW training curriculum recommendations for Idaho.

1) Washington

Pros

- Regional trainers
- Generic core competency training and optional modules
- Fast training of workforce
- Not all requires in-person attendance
- There is an in-person component
- Self-paced
- State-funded (mixed?)
- Pre-assessment and knowledge assessment
- Certificate
- Off-the-shelf solution
- No cost to individual or agency
- Have access to the curriculum
- Software allows for consistency across states
- Technical assistance available
- Quick response to course questions

Cons

- Always free - lacks financial vesting
- Clinical credibility (not in a clinic)
 - Two full days in person may not be sufficient
- 8 weeks short to gain competencies
- Lacks hands on to practice and “prove it”
- Lacks “popular education”
- Data collection content is missing - important
- Limited networking time to build connections
- More in person
- Technology requirements/ capabilities (rural ID)
- Lack of agency readiness assessment
- Individual versus agency focus
- Retention planning/resilience
 - Self-care
 - Roles and boundaries
- Lacks crisis training
- No refresher

Conclusions

- Good, but needs tweaking
- Needs heavier emphasis on in-person
- Knowledge-based versus competency-based
- Technical knowledge/requirements are a potential deterrent

2. Oregon

Pros

- Extensive data collection component (based on categories of intervention, user-friendly)
- Momentum to use this model (e.g., St. Al’s)
- Intensity - “overtraining” is beneficial
- Impact of certification on CHWs (importance)
- Cohort model enables significant networking
- Intensity of in-person
- Credits transfer to college (look at closely)
- Continuing education required
- In-person discussion of various cultural considerations/norms
- Regionally adaptable
- More public-health focused (e.g., wellness, health promotion)
- Strong clinical linkage - focus on those with highest needed
- Focus on substance abuse, trauma, behavioral health (these drive cost)
- Clinical and disease model
- Social determinants of health
- Local content experts integrated
- Networking emphasis encourages becoming part of, or forming, coalitions
- Free for some in Multnomah County and CDC grant for some others (Eastern Oregon)
- Good value for money

Cons

- Expensive
- Intensity may prohibit access
- N. Idaho: difficult to travel (time, money)
- Fewer CHWs could be trained
- Licensed – must be purchased, lack of flexibility and adaptability (but may “Idaho-ize”)
- More labor-intensive to implement
- Focused on individual versus directly involving care team (although there is a supervisor’s training and letter of support required from agency)

Conclusions

- Expensive to attend
- Content is “restrictive”
- More competency-based (versus just knowledge-based)
- Strong curriculum
- CHWs are much better prepared
- Solid history and experience (Pathways)
- Peer support network
- Proven model

3. Massachusetts

Pros

- HUB model – fits RCs
- Flexibility of module selection
- Core competencies split from health topics
- Leadership skills
- Community organizing
- Insurance benefits
- CPR
- Motivational interviewing
- Mix of training delivery methods to support access
- Central board
 - Vetting
 - Flexibility
- Second part – have choice to adapt to needs
- Reasonable number of training hours
- Potentially available for free (Federal funds)

Cons

- Not available until spring 2016
- Lack of clinical interfacing
- Data collection unknown
- Interface/partnering with community and employers?
- Crisis training?
- Personal safety?
- In person delivery limits accessibility in remote areas
- Does not specify team-based care
- Mental health/substance abuse is optional

Conclusions

- Different context – Massachusetts has Medicaid expansion
- Curriculum is quite comprehensive
- Based on best practices/experience of others
- Very good core competencies
- Good balance between standardization and flexibility
- Feasible time frame

4. New Jersey

Pros

- Very comprehensive curriculum
- Face-to-face
- Mentoring
- Clusters (like RCs)
- Regionally adaptable
- Develop personal resource directory
- Practicum
- Presentation skills
- Community assessment module
- Employer connection
 - As a group
 - With CHWs
- Legal and ethical issues included
- Curriculum is available (quick implementation)
- Free? (State determines)
- Flexible delivery options
- Modules 15, 16, 17 (financing, facilitation, advocacy)
- Continuous updating of content
- Making connections with agencies in the community

Cons

- Practicum
 - Infrastructure (supervision, complexity)
 - Barrier for remote areas
- Length and intensity - look to most successful examples and delivery
- Personnel heavy (trainers/supervisors) and sustainability?
- May be too technical and academic for some established community leaders
- Keep it simple - entry level focused
- Data collection component unknown
- New, not yet tested
- “Adaptability” across regions - may be difficult to maintain/reinforce/standardize timelines
- Emphasis on in-person (lacks flexibility)

Conclusions

- Several steps ahead of where Idaho is
- Flexibility of modules
 - Customize
 - Prioritize
 - Baseline and future
- Complete package
- Number of hours may not be feasible

Other Curriculum Options or Training Models/Content to Consider

- Project Echo in New Mexico
 - Case study model - agency partnership
 - Online – synchronized
 - Approx. 30 hours site-based
- If more than 120 hours, will lose people
- Many CHWs wear multiple hats
 - Make it scalable
 - Match community needs
- Natural evolution of clinical appreciation for CHWs
 - Facilitate via RC communication
- HUB/Pathways - good model for data collection
- Esperanza Community House (CA)
- WOHSTEP (UCLA) - train the trainer model
- IDEPSCA day laborer curriculum for health promoters, CHWs
- Focus on/relevance for individual communities
 - Key to effectiveness
 - Possible to develop in-house?
 - Build on basic training
 - Expectation that organizations facilitate specialized training
- It is key to educate PCPs on how CHWs help improve care
- RCs could manage tailoring of customizable aspects
 - Perhaps taught in-house
 - Be intentional about measurement
- Look at Idaho Time Sensitive Emergencies model
- Put some burden on employers – customizable part
- Training for telehealth/telemedicine? (LT)
- Meet PCMH needs
- Mountain States Group – Promotores curriculum (Hispanic Health Project website)
- Common measures are essential to successful integration – core and optional (latter based on agency type); need baseline now
- PCMH assessment – to include CHW readiness component
- Address sensitivity to language barriers

Training Curriculum Recommendations for Idaho

The group came to consensus on recommending adapting the Massachusetts training model for Idaho, as described below.

Part 1: Core – adjust to 13 required courses, to include/add:

- Mental health
- Substance abuse
- Chronic disease (diabetes and heart disease/hypertension)

Part 2: Electives – select three; options including but not limited to:

- Tobacco
- Cancer
- Methods for serving underserved populations
- Team-based care
- Personal safety
- Crisis management
- Advanced diabetes
- Children
- Weight management

Other Essential Elements

- Organization readiness assessment (and corresponding provider training based on results)
- Process evaluation
- Outcome data

Additional Considerations

- Logistics for CPR training
- Incentives for PCPs
- Align with SHIP needs
- Role of RCs – potentially select additional competencies especially important in respective regions
- Can select some “additional” modules (possibly require, increases flexibility)

Overview, Discussion, and Prioritization of Training Delivery Methods

The group discussed the various CHW training delivery methods for Idaho and identified the following preferences and accompanying considerations:

In Person

- Easiest
- Podcast/other material to review in preparation

Use "Base Camp"/Google Drive

- Discussion board
- Calendar

Trainers

- CHWs - train them how to teach
- Trainer mentoring program
- Train trainers in all areas of Idaho
- Electives – online, recorded
- Use Community Colleges (expert training health professionals) as instructors and to help get information out
- Train first at the hubs - need incentives to participate
- Meet the needs of rural Idaho
 - See train-the-trainer notes
 - Regions may adapt to local needs
- Cohort Concept - NJ Cluster Concept
 - CHWs
 - Employers
- May need phases of delivery methods to ensure timeliness/feasibility in early stages
- Need to determine who manages the training
- Look at YHI model for ideas
- Determine how to accommodate ESL – look to Jannus for ideas
- Must be affordable

Wrap Up

Next Steps

- 1) Committee members will receive the meeting notes report and accompanying recommendations to the Idaho Healthcare Coalition (IHC) by 11/16/15.
- 2) The Committee's recommendations will be presented at the 11/18/15 IHC Meeting.
- 3) Outcomes of the 11/18/15 meeting will be emailed to Committee members.
- 4) Approved recommendations will be implemented in early 2016.
- 5) The SHIP website will be utilized for future CHW updates.
- 6) The CHW Stakeholder Group is expected to reconvene in early 2016.

Parking Lot (Bike Rack)

- Workforce - agency readiness assessment
- Public health or clinical focus?
- Data collection
- Self-care
- Tiered approach?
- Compare Idaho's definition of CHW to other states
- Forward thinking - long term sustainability
- First do no harm