Idaho Patient Centered Medical Home (PCMH)
Webinar – (August 17, 2017)
Transcription

Date: August 17, 2017 **Time:** 12:00pm MT

Speaker/Moderator: Jeanene Smith

Title: Community Health Workers in the Patient-Centered Medical Home Model

Jeanene Smith

Welcome to the first targeted discussion for our mentorship webinar series. Just wanted to review what our goals were with this and a series of these similar types of events happening between now and the end of the year and into January for the rest of the Cohort II year. We want to the share the implementation of experiences and lessons learned, you know, kind of down in the weeds experiences with those clinics that have started to try these new innovations and then clinics who are either in the midst of starting up, revising, or wanting to get started on these same types of activities. We want to make sure that you have plenty of time to ask questions because this is really less of a didactic session of overall topics but more of a chance for you all to talk to each other. We will have a couple of mentors to kick us off, and then the rest of the time will be spent on discussions. We really want to share the lessons learned and increase the knowledge, and for those of you who might not be as familiar with the mentorship framework, there is a link here to the discussion that was a subcommittee of your IHCs to kind of focus and the Statewide Healthcare Innovation Plan (SHIP) team developed this in partnership with many of you maybe even some of you that are maybe on the phone and that is available at that link.

Today's topic is Community Health Workers (CHW) and I pulled this from the CHW stakeholders group as sort of their sort of definition and many of you on this call are familiar with this and it is an adoption from the American Public Health Association definition. As a frontline public health worker who is a trusted member of the community and works as a close liaison with the teams inside the PCMH and the health systems and really builds some individual and community capacity to increase health knowledge and self-sufficiency through a range of activities. I know this from working in other states as well there are a lot of different ways CHW's are being used and very successfully, but outreach, community education, informal counseling, social support, and advocacy.

Today, we are pleased to have two of the folks from Genesis Community Health: Johnny Farrell and Josh Campbell in Region 4 and they are going to kick this off and then we will have this followed with Shari Kuther from Saint Mary's to talk about her experiences. Then we have a couple of folks identified, we are trying to get Don McKenzie on from St. Luke's and hoping that Cristina Froude can join us because of their experiences in the community health worker programs as well and see if they have additional insight and they have specific questions. The next slide are the questions that I wanted the mentors to try and cover in about 10 minutes each. We will start with Josh and Johnny at the Genesis clinic.

Johnny Farrell

The first one; describing your clinical setting, we are an outpatient, faith based, free clinic located in Garden City. Our mission is to express the love of Jesus Christ by partnering with people whose need to improve health and wellbeing. We see patients between the ages of 18 and 64 that do not have health insurance that are 200 percent or below the federal poverty line.

The next question: why did your clinic decide to move forward with this effort? We moved forward with this to better address our patients holistically, since we do see patients that are 200 percent or below the federal poverty line, the idea behind the program was to address the determines of health that effect our patients in their health outside of clinic needs. We are based off of the county health remodel, which now you can see that 40percent of the patients overall health is effect by these social needs.

Where is our project and program today? We have eight volunteer community health workers and a community health coordinator and myself, who oversees the volunteers. The volunteers meet with patients who need help addressing these issues, the social determinates of health. That might include things like food scarcity, access to health care, dental needs, mental health, or housing and utilities assistance. In all of that we screen for in the clinics, at the very beginning they fill out our community risk health screening form and then our community health workers take that, review it, and go in and meet with the patient; then after the doctor is done with them. They can access them to different community health resources and social services. Then after a week's time we follow up with the patient based off of what they were seen for and follow up with them to see if they were able to use those resources.

Josh Campbell

First steps and key strategies, Johnny mentioned this, but one of the biggest models that we are looking at that lots of folks are using now and you guys are probably really familiar with, county health rankings model which is basically looking at what are the factors that impact how long a person lives and how well. Social determinates has a 40 percent impact whereas clinical care has a 20 percent impact. So us seeing that and saying we obviously do clinical care among some of the needs in our community and we feel like we do that fairly well but how do we impact these social determinate-type issues. That is kind of what burns our community health program to begin with, not that you would call that a strategy but really the model that was the foundation for everything that we have done here. Our first steps we are really looking at what others have done. I wrote my masters thesis on community health workers in Idaho. When we started there was not much or anything in Idaho that we could find of what we wanted to do. So we really had to look outside of the state, but there were plenty of places like; Minnesota, Massachusetts, Oregon even that had community health workers that have implemented them in medical settings. So we had looked at what they had done, what had been successful, and then what kind of fit our own capacity and feasibility. We have 10 staff at Genesis and 200-plus volunteers. We knew that our program had to be pretty much volunteer-driven, that is going to look different then probably a lot of you guys on the phone but that was the reality for us. That was a key thing that we had to look at. We started off with the pilot program after we had some ideas, we know that we wanted to screen for social determinates for every patient that came through and then connect folks to those social determinates via relationships that we had built with community health partners. That was a key strategy that we are not trying to just give people a piece of paper saying this is where you go get food but we actually have a relationship with that food bank. Johnny can call Sam at the Vineyard Church Food Bank and we have this person coming if we need to do that. That is a key piece for the success of this program are those relationships, but we started a pilot and we are tweaking the different resources that we are referring people to base on feedback from our patient population and what their needs were. Simultaneously, there is a program in Boston that started a few years before us, called Health Leads and some of you might be familiar with that. We were doing I think was a three month training through Health Leads on social determinate screening, tools that you can use on patients that you might want to use, this for all of those kind of things. Those were things going on at the same time. We are

tweaking our program and like I said from the beginning we are using volunteers. We have a staff person overseeing the program, which is our community health coordinator, Johnny; and then we have had a different community health coordinator when that started and then we had volunteers for seeing the patients as well as that community health coordinator.

Who and how did you take this undertaking effort? I feel that I have addressed that in the previous question. And then Johnny was going to address how we financed the effort.

Johnny Farrell

For the financing effort, much like the rest of our clinic, it is primarily volunteer-driven so we do have 200 plus volunteers that help our clinic keep going. We are not paying anyone as a community health workers, right now we have roughly eight volunteers and I am the only one that is currently funded and that is through various grants and different people have been business, churches, and communities. Josh can talk about challenges; the top two challenges we had.

Josh Campbell

One thing that I forgot to mention for folks to consider that was a key strategy: ideally community health workers come from the community that you are working. Again that is the ideal because they understand the community and they are that bridge. We tried that at first, and what we ran into was the people that we are trying to volunteer to help us were the same ones that were in crisis so it was hard for them to commit to our regular volunteering schedule or things like that with our set-up. We ended up, all of our volunteers, I think our currently are a student in some capacity, so it looks very similar to health lead. If anyone is thinking about using volunteer doing a similar set-up like this, students are trying to get hours for medical school, nursing or whatever it is have been a great resource for us as community health workers. They learn quickly and our patients have seemed to respond to them pretty well for the most part. That has been a key strategy as well. In terms of challenges or barriers, the top challenges that we identified were number one identifying the community-specific needs that there were. We started off with a baseline again looking at the county health ranking model that impacted health and wellbeing, but again it took us awhile of surveying our patients and what are the ends of this that you are actually experiencing, what are things that were missing. We are tweaking our social screening form for a good couple of months before we landed on this is what we are going to use for the next year, and every year we revisit it and tweak some of those needs that we are screening for. Then the other thing is tracking our successes and referral numbers. In general, that was a challenge and then how do you define success. The way that we overcame that in terms of tracking is we figured out ways to integrate it without our EMR we use Athena and it is not designed to do this but we kind of figured out ways to make it do it but it took a lot of work on Johnny's part, literally probably six to eight months and he is probably still going to do some refining. That has helped us be able to track our success a lot better and our success come through knowing we do follow ups and people say yes I went to the food bank or got that housing application and filled it out (whatever it is) and then he can track that as a success in Athena and we can run reports on it. Then I know this is a challenge, an ongoing challenge I know is how do we empower folks so that balance of doing things for people and empowering them to do it themselves, and that is something we are still trying to figure out to be honest.

Major lessons learned from this effort, number one I think that anything you read about community health workers is you are going to read this: success is based on relationships that is what makes these programs successful. Got to have relationships with the patients over time the community health workers build relationships. It is different than a relationship with a doctor

or a nurse it is more of a peer-type of relationship. We just see folks make changes in different ways because of that, ourselves as well. Recognizing small successes has been a big one and I will let Johnny speak to that.

Johnny Farrell

Especially with the patients that we work with and what Josh was talking about: empowering verses enabling. Looking to see and not dwelling on patients not getting better, not going to fill out this application or this patient is still looking for housing. Being able to focus on and seeing the small successes and look at how far that patient has come. One of the last major lessons was it is important to focus on the patients priorities; so when addressing these social determinates of health, asking deeper questions into what else is important to you. If you filled out the screening form and you said that you needed help with health, with food. Asking more about what does that look like for you, in what ways are you struggling with this, and then asking them out of all of the things they were triggered for on the form what is the top priority to you so we make sure that we are being intentional on resources that were given and not just handing them a piece of paper that we talked about at first. When it is all said and done, we love our community health program and would highly recommend folks implementing one; this really makes a huge difference in people's health.

Shari Kuther

I am the practice manager at Saint Mary's Clinic in Cottonwood, Idaho. We actually are sister hospitals with Clearwater Valley Hospital in Orofino, and by sister hospitals we share upper administration; we are both owned by Ascension Health from Duluth, Minnesota but we each have hospitals, we have clinics, and we each have medical staff. They only admit at their own hospitals, we do not cross back and forth. But, our community health workers are one of many of our joint projects. So, we actually have eight family practice clinics across the area. Pierce is a community health center (CHC), but all of the rest of them are Critical Access Hospitals (CAH), fee-for-service (FFS) clinics. Why did we decide to move forward with this effort? Well, about five years ago we started working with the Bureau of Rural Health and Primary Care on some population health projects and really looking at hypertension and diabetes in our area because those are two chronic diseases that we have a lot of patients need help with in that area. So, one of the things that we did we really wanted to look at not so much the folks that were coming into our clinic but how did we reach those folks that were not coming into our clinic. We started out and we had some Certified Nursing Assistants (CNAs) and Emergency Medical Technicians (EMTs) and they went and set-up at the grocery store or the bank or pharmacy or wherever kind of the community was and they would do some blood pressure screenings and glucose screenings. Then if they were abnormal they would make the referral and say hey, you really need to go visit with your provider about this. Then we started looking at how we could expand that model with population health and the direction it was going. We actually reached out, and we applied, and were awarded a Health Resources & Services Administration (HRSA) grant, so that is kind of the how did we fund this. The other piece that kind of went along with that was when reaching out to our providers it was, what was the biggest barrier that you see to healthcare? A lot of our providers said well, we have a lot of self-paid people, we do have Medicare population, Medicaid population, and we have a lot of private insurance. We are also a very predominate farming community here on the prairie and then there is a lot of logging and other industry in the valley.

The doctors really felt like they needed help getting people screened because they cannot afford and they felt that is why they were not coming in, because they could not afford their

[screening] testing. With this grant, we were actually able to hire six community health workers and they covered then our services areas. For the last two years, or 18 months, where we started was each of the community health workers were doing a lot of outreach events. Because, just like what Josh said, that relationship is that important piece and you have to build the relationship in the community with your community members [to address] that distrust of medicine, that kind of thing. So really, those six community health workers spend a huge, huge amount of time having events; and whether they were in the grocery store, they went to an employer, they set-up booths at the county fairs, there were just all kinds of places that they went and did these events-basketball games are couple of the different schools-as folks came to those events. That is kind of where we started now where we are at after that first year we looked at transitioning. I forgot to mention that part of our grant; we have a ton of community partners, so we are partners with the food bank, Office of Rural Health, the Department of Health and Welfare-their public health agencies; community actions folks, the human needs councils, and behavioral health. We have this huge group of partners and so where we have gone now and one of our big partners is a free clinic and it is the only free clinic in Lewiston and is the only free clinic in our area. Our patients actually travel some even 70 or 80 miles to go to the free clinic and get free care. One of their things to continue to get free care and medications through them, they have to have a visit every month with that clinic. In our partnership, we talked with how we could use community health networkers to help bridge that need and gap. The clinic has been making referrals of patients to our community health workers with certain things they want them to do and focus on. The community health workers have now been going and doing those one on one visits with those folks and then reporting back that information to the clinic and that is allowing them to continue to help patients with their medications so the patients does not actually have to make the trip in, unless there is something abnormal in the community health worker screening or if they have some other type of medical event during that period and then, of course, they would be going back in there.

We started with that, and now our nurse case managers are making some referrals to the community health workers. As well as we have another hospital in Grangeville and they too, as one of our partners, then they can make a referral to our community health workers. That is what we are kind of doing now, as a next steps we are looking to expand that one on one visit and how we can get more folks services and connected into the health care system, wherever they may live.

How did we finance? Like I said originally, we had a HRSA grant that paid for everything. However now like everything else we need to look at sustainability and so where we are looking at with that is hopefully by increasing the interaction between the community health workers and our case managers that they will be able to take some of those lesser risk folks and folks that need community referrals or they need somebody checking in on them, like getting to the pharmacy, whatever they might need, and then the numbers for our case managers would actually increase. In a roundabout way that would help finance the community health worker piece and then with less readmissions to the hospitals and then the more screenings that we do and the more amoralities that we find then we can help get those folks referred in and seen to the clinic. Then, by the community health workers having those visits with the folks that actually increases access to the clinic because those folks are not taking a spot that is needed by someone with more acute or more medical needs then what they are needing in that social visit to come into the doctor and talk about how to some food or get whatever it might be. Those are the ways that we are thinking that we can help sustain the community health worker piece.

Our first steps if you do not have anything in your system right now, you have to create that job description and decide what you really want them to do. Just like the folks at Genesis said, there are a lot of different models out there and a lot of different ways you can approach this and do this. For your group or your clinic to decide what fits for you. This is what fit for us so this is the direction that we went. I had gone to the original SHIP community health worker meetings as they kind of started looking into this whole idea. Then we looked at what was happening in other states as well, like Josh had mentioned Massachusetts and some of the other states. Then some of the other conferences that we had been to they had talked about using the community health workers, gleaning that information from the, bringing it back, and adapting that into what we thought would work as well. Another place too that we got a lot of good information even was our clinics being part of the SHIP project and our coach for the PCMH piece had a lot of good ideas and avenues for us to look at as well. Karen Hill was the one that we used at that point in time and she just had a lot of really great ideas as well.

What were are top two challenges or barriers? The one that probably surprised us the very most was finding applicants. We thought that oh, that would be so easy, that's a cool idea, this is a cool job, we will have all kinds of people. No. Not so much. The other thing with that is you do have to be kind of picky, because it does take the right person. You have to have somebody that is willing to forge that new stream, it is not something that we had in our service area before. You have to have someone who is willing to step even out of their comfort zone, start approaching people, and talking to people. If you have someone who is shy and quite, this may not be a good role for them. Again, that was one of our biggest challenges and still today continues to be some of our biggest challenges. We had originally planned to hire nine, we currently have seven. We just had one resign because she got a full time position from somewhere else in our institution, but that is ok we will just go back to the drawing board again.

Another challenge or barrier that we had was because this was a new idea, a new concept, there was a lot of concern and hesitancy from the providers and the nurses. Well, what are these guys going to be doing? Are they qualified to do these things? What kind of medical advice are they going to be giving? Us reassuring them that they were not going to be giving medical advice. We have our policies and our procedures very much lined out before we started so that we can share that with them and say this is what we are really trying to do, this is where our target is, this is what they are going to be doing, and this is how they are part of the whole big piece of healthcare that we are going to provide as part of Saint Mary's and Clearwater Valley Hospital. Those were probably about two and then I would agree again with the Genesis folks, tracking has been a nightmare. We created what Vicky and I thought was really a cool spreadsheet and with these great, grandiose ideas and in theory it all sounded great and the IT folks said yes it should not be a problem, let us test it out and get it working. Then you go to the realities of Central Idaho and Internet service. Things do not work as well as you think they should. Tracking has been a little bit of a challenge for us in being able to produce results. Part of that too, has to do with us because we are stretched across so many different health systems, so not everything goes through our Electronic Health Records (EHR) because not all of the folks that the community health workers are interacting with, are patients of ours. Having to send notes to various providers and interacting with those other EMRs has also been part of that tracking piece. Major lessons learned from this effort: definitely it takes time; you have got to work and do your due diligence in the beginning, get those job descriptions, policies, and procedures. Try and think of any possible issue that might come up and have plans and answers for that so that you are prepared as you take off. Again it does take that time, but it also takes patience and perseverance. The first time that your community

health workers goes out to the community and says hey, I am here; do you want me to do your blood pressure, an A1c, I have fit test to offer, or how about a depression screening. People are like, no thanks - not today. So, the first events that they had did not have a lot of attendance but it did not take long and all of a sudden they had a lot of people that were there. We had some really early-on, significant wins. We found some pretty sick individuals that really were not linked in anywhere to any health system, so the community health worker was able to work with them and help them get plugged into the system. That even help the sustainability piece of the project because when you have wins like that it is a lot harder for administration to say this is not a valuable program, let us just nix it. Those things were good, but it does take time and patience and perseverance, certainly open communication and honestly being able to talk about how it is working, what is working and what is not working, and how are things going between the community health workers and nurses or providers. I would agree, we absolute love our community health worker program; we are going to try everything that we can do to continue to make sure that is sustainable and viable. Like I said, they have done a great job for us. Certainly I am willing to answer any questions, at any time.

Jeanene Smith: We have Don McKenzie from St. Luke's If you could give a quick thumbnail or some observations about setting up CHW programs.

Don Makenzie

We represent a small region in Idaho is about a 100 miles from any other major hospital. We are a provider-based clinic attached to the McCall Hospital. We have family medicine, primary care clinics. We have about 9,700 patients empaneled to us. Family medicine, from cradle to grave. In McCall, a lot of my family medicine docs work in the hospital as well and cover all of those service lines as well as in the clinic. Why did we decide to move forward with this effort? I had done some PCMH work in a clinic before I moved here. I was with Indian Health Services (HIS), and they were doing a lot of work around that and being in a rural setting, so they were doing a lot of work around that. When I got here it was one of the asks from the Saint Luke's Health System and being in a rural setting, there were a lot of unmet needs in the community. Just met with a couple of folks over lunch one day and we have a conversation about this would be the right thing to do. Jennifer Yturriondobeitia who is on the line, she is our program manager and she is really specialized in the integration in behavioral health and clinics. Then our Foundation, we all had this discussion, sat down and wrote the grant, got approved for a HRSA grant to move forward to be able to become a PCMH.

We are in the third year of our grant. Our CHW was embedded pretty much fully two years ago, so working under the Register Nurse (RN) care coordinator and working under a licensed social worker, looking at gaps in our medical neighborhoods and identifying resources and building those things that we do not have in our community. Plus, the work that she does with patients that are under care, under care management, and/ or behavioral health. She does a lot of work that is delegated to her from the supervisors, so keeping that work within a specific scope. So a lot of people have questioned what they do, how they do it, what is their capability. Working under supervision of someone is probably one of the most critical elements to stay within the scope of work that they are trained to do. That was probably one of our biggest challenges. Again, when you develop something like this everybody wants them to do something for them and so the referral process is really a key component, is that everyone has to understand the scope that, that person works through. The CHW here does not actually go and do the work unless it has been vetted by one of the supervisors. So a referral goes into care management, a referral goes into care coordination, a referral goes into licensed clinical social worker from any source on our campus that wants to refer patients to them for whatever purpose, whatever

reason and then they delegate that work after they meet with the patients and go through everything that you guys talked about; social determinates and their history and whatever it is they are trying to achieve. I think from a health system perspective, the hardest thing for us to do was also creating a job description; there was not one in the Saint Luke's Health System. If you work with large HR departments those can be barriers; and then setting up this scope. I think keeping a CHW working in scope otherwise they get stretched way too thin. I think that the scope is determined on their capability under supervision and what the rest of medical staffing community and our partners really feel like what we really need to work on in McCall.

Jeanene Smith

I wanted to start off with one question for Don is how are you financing your community health worker program? What was the one angle that would be available for others?

Don Makenzie

We are in the third year grant, so this position was funded by the grant. How do we sustain it at the end of the year, looking on return of investments? We have a lot of data that we are pulling forward that there are a lot of great stories but it does not always relate to finance in terms of measurable. So there are a lot of indirect things that we do: lowering readmission rates to hospitals, patients that have frequent visits to the emergency rooms or operating room once we get them under care coordination and work with the CHW. Those are some indirect cost savings, but with the whole care coordination team, we will actually be going through NCQA to get our certification with the state moving us up to the tier four, that revenue itself – that revenue can help us with offsetting the cost.

Jeanene Smith

What Shari was mentioning you can build for your care management sometimes through the collaborative care codes in Medicare and others, so by allowing those to see more patients by offloading are another good financing approach, another way to add into that return on investment (ROI).

Don Makenzie

That is a good point, obviously adding the social worker and care coordination team working at their highest licensure level and being able to create more bandwidth for them to see more patients with the CHW would obviously have that impact here.

Jennifer Yturriondobeitia

The only thing that I would add, is just it is really important in regards to the ROI is that you guys are collecting data because some of the things do not financially and to show ROI you do have to show cost offsets but also the various things a community health worker does that is not really seen through claims or through clinical documentation.

Jeanene Smith

Yes, indeed. That is a huge challenge with our current claims-based data system.

(Christina is on the call now)

Can you give a thumbnail of what's going on at Terry Reilly program and what you want to chime in about.

Christina Froud

My position is interesting and is a grant-based position and It is a community health coordinator. They have a mobile health clinic and have been seeing people for a year and a half. All of these charts and data have not been gathered or evaluated so that has been some of my undertaking to do is to organize all of these charts into a database and pull data to get these folks into a primary care, a patient centered medical home which is what Terry Reilly is so we refer them over here. They get integrated care and we are getting to see a lot of people every month from the community. We go to three different cities: Wilder, Nampa, and Caldwell over here in Idaho. We do get a lot of patients every month and I think our outreach efforts are really working and we are increasing our attendance at these events. And now they have me to follow up with them on their care and get them to have a primary care physician instead of just ending up in the ER which is what some of the folks are doing because they do not have health insurance or they cannot afford their deductibles and things like that.

Jeanene Smith: What is the financing for your way you are set up there, your system?

Christina Froud

My financing is grant-based through Saint Alphonsus. A lot of our services we get a lot of grants; we do receive some federal money, but we do see patients with insurance, although that is not the majority of the cases, we get some funds that way.

Jeanene Smith: What would you say your major lesson's learned would be in setting up what you have there?

Christina Froud

Well, this program is definitely new, and my position started three months ago. There was a community health worker there so it is just the two of us, for now. Definitely try to find different funding sources. There are so many community events where there we are always invited to participate but its finding those funding sources to grow our staff and get more community health workers. That is definitely a struggle, and then also reaching out to the community and getting more community partners to give back that bilingual volunteer based system because primarily the clients we are seeing are Spanish-speaking.

Jeanene Smith: Laurence, can we open up and ask some questions?

Moderator – Laurence Brown now announces the options for asking questions during the session

Jeanene Smith: I wanted to come back to Shari. As you were writing your policies and procedures, what were your resources? Did you just create from scratch or how did you get some help on that?

Shari

Those are good questions. On some things we started from scratch on and researched; other things we reached out to Jen. Another place we went was the public health department. They did quite a bit of training for our staff and they had some things already in place and then other things we got from the different pieces from the first SHIP meeting that was sent to me, resources and the different places to look, kind of a conglomeration of different ways.

Jeanene Smith: And your data collection, you were having troubles? Josh and Johnny, any thoughts on data collection?

Josh: For us it is going to depend on what the community health workers are doing. Each program is a little differently; for us, social determinants and referrals, those were social referrals and did the patient actually get the resources that were needed. Initially, it was an Excel spreadsheet and we were just tallying things up, but over time we integrated to our EMR and we are able to do it as a procedure code and a community referral, lack of knowledge of community needs or something like that. Johnny will talk to that.

Johnny: On Athena, it is under deficient knowledge of community services and referral and under Athena and you can put community referral. Anybody who goes in there can see and make notes and you can see – you can make a note saying the patient was able to access something or was able to use a local food bank, or go a meeting with an insurance provider or something like that. Then It is just a matter of tallying it up at the end of the month.

Jeanene Smith: So, it is more manual? A little bit challenging?

Josh: It is a hybrid; It is an overall. We can run a report of the mass number of referrals, the number of patients we say, but then It is manual. Yep. But there are resources out there being developed, program that are specific to this kind of work, but It is not something we wanted to add yet. There are some things out there.

Jeanene Smith: Others want to chime in, in terms of data collection?

Shari Kuther
(From St. Mary's)

So, what we did is we created this big Excel spreadsheet and then because it was a grant-based so we had grant deliverables we wanted to make sure that we were tracking. We put each one of those grant deliverables on there. One of the things that we were able to offer was a fit test for people that needed lung cancer screenings, there was a place for this in the spreadsheet for them to put if they had offered the fit test and then they were able to go back and look to see that it had been returned and so all of those fit test results are in our system whether they are our patients or not, because we are the ones who performed the test. Those kinds of things that we kept in the spreadsheet. So the pieces that work, work really well and you do not have to do as much hand calculations as if you were trying to track each one of those demographic sheets individually. Then, as part of the complexity of it, we wanted to be able to if their BMI was out of range, if their blood pressure was out of range we wanted to be able to show how many people we had screened that actually had abnormal results verses normal results. That is where part of where some of that complexity came in; we are actually looking at different software system now to use to be able to track that. Like the guys there at Genesis, some of it is just hand calculations and my community health worker at the end of the event or at the end of the month.

Jeanene Smith: I wanted to turn for a minute because I know we have Madeline Russell on the line. Everyone, all of you guys would have started from scratch and had different sources of where you have gone to get training. We have a couple of slides about what is coming up here in Idaho for SHIP sponsored training programs. This was a big issue in Oregon, I know, as we were starting our community health workers in terms of having some standards or approved training program so people who were going to hire CHWs kind of knew they were getting someone who had a pretty solid background in training and instead of having to train them, themselves entirely. Madeleine can we open up your line and let you talk briefly about these?

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Arial Serrano
(Works with Madeleine Russell; and with Mary Sheridan, Bureau Chief for the Bureau of Rural and Primary Care)

We did want to mention there have been some changes; this slide has a few changes that we do want to mention. We are implementing a CHW training program in collaboration with Idaho State University. This will be our third cohort that will be trained, so far we have trained 32 community health workers across Idaho and we are hoping to increase that significantly. There is no cost for this training; it is 13 weeks, online. Unfortunately, we were unable to get enough registered for the in- person event at Saint Mary's Hospital, so we are forced to cancel that for now, but we will be looking into doing more in person hopefully in the future with funding. With that, these classes take place live, online on Wednesday evenings. It is very interactive and very discussion based. Actually, Josh Campbell who is on the line as well, is one of our trainers so he can talk more about that portion if you have questions about what happens in the training. Our office does the approvals for the applications for this training, you do have to apply through the SHIP Website and then the application is two parts. There is a student application and an employer application. This is a part of the application process, we do have different categories for the needs for our community health workers, and however the categories are only to keep us in mind so we know where our community health workers are coming from. Category 1 who are CHWs who are currently employed in a PCMH in the SHIP Cohort clinic and then Category 2 are CHWs employed by an Idaho primary care clinics who are not currently part of the SHIP Cohort clinic. Then the third category [Category 3] is currently employed or volunteering at CHW and any other kind of community organizations. The only important part to remember about that is this application is two parts, so we do have an employer or community sponsoring. The application that needs to be completed before the student application to be completed. We do have to ask for some data collection. We ask for the CHWs to collect data - at least for one year. We are hoping for more than one year but it will be quarterly. This data collection is done on SurveryMonkey that our office sends out on quarterly bases then we collect and submit to SHIP. That's why we need our employers on board to help the CHWs get this data collected

Jeanene Smith

Great. The Website has more information available for folks that might be starting out.

Did you want to make a plug for Cohort III?

I will just say this: Our mentors have been kind enough, at least those that I have been able to talk to ahead of time, to get permission to put this on the slide, their contact information is here if you guys have specific questions for Johnny, Josh, or Shari and I am sure Christina and Don could also be tracked down to ask for questions and we could maybe add that to the final slide show when it goes on the portal.

The Virtual PCMH application deadline is tomorrow, Friday, August 18.

There is a lot of interest in behavioral health integration. If you want to share or have ideas for the mentorship series and reach out to myself, Nancy, PCMH coach, SHIP QI mentor we are a team working together.

Additional information on the mentorship series is available on the slides.

There were no additional questions.