**MEETING SUMMARY**

**DCHI Subcommittee on Community Health Workers**

**January 12, 2017**

**3 p.m. -4:30 p.m.**

**Meeting Co-Chairs:** Kathy Janvier & Lolita Lopez

**Facilitator:** Donna Cohen Ross

**Notes:** Liddy Garcia-Bunuel

**Attendees:** Kathy Janvier, Lolita Lopez, Cassandra Codes-Johnson, Nadinia Davis, Brian Rahmer, Megan Williams

**Absent:** Norma Everett, Tyrone Jones

**Others:** Julane Armbrister, Judith Chaconas, Noel Duckworth, Jeanene Smith, Sarah Arvey and Lori Weiselberg

**Welcome and Introductions:**

Kathy called the meeting to order and facilitated introductions of Subcommittee Members, support staff and the Health Management Associates team. She reviewed the charge of Subcommittee, which is to define role of Community Health Workers (CHWs) and recommend an infrastructure for training and credentialing. Lolita added that DE is adding a new element to the health care workforce. She encouraged work group to build on the work that has already been done, and not to reinvent the wheel.

**Health Management Associates’ Approach to the Work:**

Donna gave a brief overview of Health Management Associates, the team assigned to this initiative, the goals, approach, and timeline. Power point is attached.

**Perspectives and Priorities:**

Donna and Liddy facilitated a broad discussion among Subcommittee members about priority areas for the Subcommittee to address over the next six months. Major priorities identified and key elements of the conversation follow:

Affirm an Understanding of Delaware’s Approach to Population Health (described in SIM grant)

* What outcomes are envisioned?
* Value is placed on health equity.

Definition of Community Health Workers

* We need a definition that is flexible so that it can be applied regardless of the program area CHWs are working in, or the specific diseases on which they be focused.
* CHWs are the “connectors” or “liaisons” between the community and the health care system.
* Their scope of work will be key – CHWs are engaged in array of activities and we need to set boundaries (Do we include only people who are directly connected to the health care system? Do we include neighborhood block captains?)

Training Infrastructure

* We should identify core competencies, and should include cultural competence.
* We should use a curriculum already in existence, as the basis for Delaware’s
* Training should focus on basic skills that are transferrable (i.e. interviewing skills, documentation, translation, etc.)
* It can be broad with regard to subject matter, and then get into the specifics of specialty areas such as chronic disease management.
* Need to determine or decide who controls training and certification.
* A focus on “career ladders” can help explain how training should be organized.

System Needs

* There must be an understanding that CHWs are part of the health care team.
* Providers must recognize the value of CHWs and interact with them accordingly.
* How does work in the community get communicated to clinical team?
	+ Discussion included description of how EHRs are used by navigators/coordinators at Beebe. Challenges related to different EHRs, certain data fields not being included in the DHIN, rules around information-sharing.

Payment Issues/Sustainability

* The health care system needs to value CHWs. Paying them demonstrates they are valued.
* The ROI studies exist. We need to push for investment in CHWs.
* CHWs are undervalued – they are doing 3-4 times the work that is being evaluated.
* Hospitals want to target the highest utilizers. In the future if circumstances change, will there still be a perceived need?
* Payors are concerned about their own members.
* For sustainability, in some cases there needs to be a “neutral bridge” between CHWs and health care system– does DCHI serve as that part of the system? Could DHCI be a clearing house – employers can hire from DHCI.

State Policy Issues

* Consider the overall, statewide goals for population health, health equity
* What training is needed to achieve the stated goals?
* We need to focus on people with the greatest needs and describe how CHWs can help improve their health.
* We need to be honest about social determinants of health. For example, early childhood readiness teams serve a function. But in the future, can it be sustained? If we want sustainability, the healthcare system (including payor) have to value and pay for it.

**Other Issues**

* **Who is missing from the table?**
	+ CHWs
	+ Payors

**Next Steps**

* The Subcommittee is eager to move forward and not spend time on issues that have been discussed earlier. Articulating the design of infrastructure, payment and sustainability is most important.
* Given the compressed timeframe for the Subcommittee’s work, we need to come prepared to make decisions at each meeting. For February meeting:
	+ Affirm understanding of “population health” as presented in SIM grant.
	+ Adopt a definition of CHW, based on definitions discussed at 2014 forum.
	+ Adopt CHW core competencies, based on discussions at 2014 forum
	+ Review elements of training and programs and credentialing in selected states (Oregon, Massachusetts, Minnesota, New Mexico suggested.)
	+ Invite two CHWs to March meeting. Ask them to respond to specific questions (to be determined.)
	+ Invite a member of the Payment Committee to attend future meeting on Payment and Sustainability.
* Meeting announcement, agenda and supporting materials will be prepared and sent to the Subcommittee member in advance of the next meeting.
* Next meeting is March 9, 2017. Location to be determined.

**Meeting Adjourned**