Maryland Department of Health and Human Hygiene
Workgroup for Workforce Development of Community Health Workers
Meeting Minutes
Meeting Date: Friday, November 14, 2014
10:00 AM to 1:15 PM

Call to Order: The fourth meeting of the Workgroup on Workforce Development of Community Health Workers (CHW) was held on the 2nd Floor Conference Room L-3 at DHMH, 201 West Preston Street, Baltimore, Maryland, on Friday, November 14, 3014.

Members in Attendance: Deborah Agus, Kim Burton, Pamela Bohrer-Brown, Perry Chan, Elizabeth Chung, Jennifer Dahl, Ashyrra Dotson, Wendy Friar, Terri Hughes, Debra Hickman, Ann Horton, Michelle LaRue, Ruth Lucas, Susan Markley, Pat McLaine, Dwyan Monroe, Sonia Mora, Bettye Muwwakkil, Marcos Pesquera, Rosalie Pack, Tricia Roddy, Maura Rossman, Yvette Snowden, Laura Spada, Lesley Wallace, Lisa Widmaier, Richard Tharp

Objectives for the fourth Workgroup Session were:

1) Approval of minutes
2) Review and Finalize CHW Definitions
3) Review and finalize CHW Roles
4) Identification of CHW Core Competencies
5) Public Comments

Small group compilation: The members were:

Team 1: Elizabeth Chung, Jennifer Dahl, Dr. Cheryl Holt (absent), Terri Hughes, Sonia Mora, Ruth Ann Norton (absent), Michael Rogers, Novella Tascoe (absent)

Team 2: Pamela Bohrer Brown, Mar-Lynn Mickens, Dwyan Monroe, Rosalie Pack, Tricia Roddy, Laura Spada, Lisa Widmaier

Team 3: Deborah Agus, Perry Chan, Rev. Debra Hickman, Ruth Lucas, Kate Scott (absent), Dr. Yvette Snowden, Richard Tharp, Lori Werrell (absent).

Team 4: Dr. Kimberly Coleman (absent), Shirley Devaris, Ashyrra Dotson, Wendy Friar, Dr. Michelle La Rue, Maura Rossman, Maxine Reed-Vance (absent), Lesley Wallace

Team 5: Dr. Chris Gibbons (absent), Ann Horton, Beth Little-Terry (absent), Susan Markley, Dr. Pat McLaine, Bettye Muwwakkil, Marcos Pesquera

Approval of Minutes: Minutes for September 22, October 6th and October 20th were electronically distributed to members for review prior to the meeting on Friday, November 14, 2014. A brief discussion regarding the minutes—a member reminded the group that more CHWs are needed on the Workgroup. The attendee list should be updated and noted in the minutes. Members had not reviewed the minutes, therefore; approval of the minutes was postponed to meeting on December 1, 2014.

Summary of Workgroups Discussion:

This Workgroup session was opened with the large group divided into five (5) teams as assigned and a brief discussion on norms to help guide the small and large group discussions. Also, it was highlighted that the charge of this Workgroup is to focus on the non-clinical role of the Community Health Workers. There was a brief discussion on clinical vs non-clinical CHW. The Workgroup members and Delegate Tarrant agreed that this Workgroup focus would be non-clinical and clinical would have to be another meeting/workgroup. The Workgroup members moved into a discussion finalizing the CHW definition and roles. The Survey Monkey results were shared with the members before getting a consensus on the definition and roles. Due to the underrepresentation of members responding to the Survey Monkey, the Workgroup members were given about 10 minutes for a brief small group discussion on the definition and roles. Providing everyone an opportunity to have a voice, each group by a vote indicated they had a consensus on the definition and roles. Each team then reported out to the large group. The Workgroup arrived at a consensus of the definition and roles with minor changes.

CHW Definition: The Workgroup's consensus on the definition. Each team had an opportunity to present proposed changes to the definition and roles.

All the teams approved the definition has presented. Team #4 questioned whether "should the definition includes reference to integration with health care/primary care team". The Workgroup did not confirm this language as inclusion in the definition. Team #5 suggested adding "Community Health Worker (CHW) is defined as a … The consensus definition for recommendation to the state is …

"A Community Health Worker (CHW) is defined *as 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 CHW 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.

A CHW 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."

Team discussions resulted in a consensus on the CHW roles with minor changes. Each team shared proposed changes to the 9 roles from the Survey Monkey.

Team 1. 1. Ok; 2. 'Keep it broader" – Health; 3. Ok; 4. Eliminate "nutrition"; 5. Add … "health equity"; 6. Split into two (suggested 10/20)

6. a. **Providing care, support, follow up, and education in community settings such as homes and neighborhoods.**
6. b. Monitor health and social needs to support adherence to care and wellness.

No changes to 7 thru 9.

Team 2 only had a change to role #8 "social services" to "human services". Team 3 recommended language to clarify roles listed are not exhaustive "role such as …". Team 4 Changing "coordinated care orgs" to "health care"; 2. Provide evidence based guidance and social …; 3 and 4 no changes; 5 Add the

word “equity” to the end of sentence; 6 thru 9 use Survey Monkey language; Add 10 – Monitoring health and social needs … role from Survey Monkey. Team #5: 1 thru 3 OK; 4 Comment: Providing services problematic; 5-7 OK; 6 “Providing” care …; 8 Align social/human to definition; 9 Revision: Proactively identifying and referring individuals to federal, state, local private or non-profits health and human services programs”; 10. Eligibility.

Finalized and approved on Friday, November 14, 2014. Changes are **bold**.

The identified roles listed are not exhaustive, but includes role such as …

1. *Serving as a liaison between communities, individuals and coordinated **health** care organizations.*
2. *Provide **evidence based health** guidance and social assistance to community residents.*
3. *Enhancing community residents’ ability to effectively communicate with health care providers**.***
4. *Providing culturally and linguistically appropriate health education.*
5. *Advocating for individual and community health **equity.***
6. ***Providing care, support, follow up, and education in community settings such as homes and neighborhoods.***
7. ***I**dentifying and resolving issues that creates barriers to care for specific individuals.*
8. *Providing referral and follow-up services or otherwise coordinating health and **human** services options.*
9. *Proactively identifying and **referring** individuals to federal, state, private or nonprofit health and human services programs.*
10. ***Monitoring health and social needs to support adherence to care and wellness.***

Following this discussion, the Teams moved into the discussion on Core Competencies. Due to limited time, the Teams identified core competencies for the first five CHW roles and the remaining five will be completed at the December 1st meeting. Highlighted below are the Core Competencies. Each group had an opportunity to report out to the large group. Synthesizing the Core Competencies will be finalized at the meeting on December 1, 2014.

Core Competencies for Non-Clinical CHWs

Serving as a liaison between communities, individuals and coordinated health care organizations.	
Provide evidence based health guidance and social assistance to community residents.	
Core Competency	**“Must Have”**
Culturally based communication skills	
Interpersonal skills	
Knowledge base for systems and services	
Advocacy skills	
Service coordination skills	
Organizational skills	
Teaching skills	
Capacity building skills	

Enhancing community residents’ ability to effectively communicate with health care providers.

Core Competency	"Must Have"
Effective written/oral communication skills with client (literacy/language issues)	
Interpersonal skills that are culturally competent	
Knowledge base on health issues; identify health priorities by jurisdiction/client	
Capacity building skills- empowerment of the client	

Advocating for individual and community health equity.	
Core Competency	**"Must Have"**
Knowledge of community and culture served	
Excellent written and verbal communication skills	
Outreach methods and strategies	
Ability to bridge needs and identify resources	
Service coordination	

Providing culturally and linguistically appropriate health education.	
Core Competency	**"Must Have"**
Communication	
Interpersonal skills	
Service coordination skills	
Advocacy skills	
Teaching skills	
Organizational skills	
Knowledge on specific health issues	
Cultural competence	

Serving as a liaison between communities, individuals and coordinated health care organizations.	
Core Competency	**"Must Have"**
Outreach Methods and Strategies	
Effective Communication	
Cultural Responsiveness and Mediation	
Education to Promote Healthy Behavior Change	
Care Coordination and System Navigation	
Advocacy and Community Capacity Building	

Provide evidence based health guidance and social assistance to community residents.	
Core Competency	**"Must Have"**
Outreach Methods and Strategies	
Effective Communication	
Cultural Responsiveness and Mediation	
Care Coordination and System Navigation	
Use of Public Health Concepts and Approaches	
Advocacy and Community Capacity Building	

In this session, the Workgroup only had the opportunity to report out from their Team .

Public Comment:
Comments were invited from the public attendees. Speakers were given two minutes to make their comments. The speakers and their comments were as follows:

Leslie Demus

- Discussion re: ratio of CHWs to total number of the CHW Work-Group and proportion of men on the CHW Work-Group
- Decisions are going to be made as it relates to the population of the workforce
- Definition is very important, certain wording needs to be categorized or enlightened especially as you are speaking about community as related to community health workers
- A CHW needs to be "out of" that community, needs to be familiar with that community
- As you speak about clinical and non-clinical, initially began as a non-clinical CHW – with additional training (housing, case management, phlebotomy) – additional training and counseling and specifics may be dependent on the agency that the CHW works for
- In structuring the core competencies, you especially want to pay attention to the fact that the CHW has an unusual and very close understanding of the community that they serve – and also that outreach, community education, social support advocacy and informal counseling is part of the work so you don't want to be to technical

Terrie O. Dashiell

- Works for LifeBridge Health
- Main concerns from inception to now, is that as we speak about titles and salaries, that we also talk about the different settings in which CHWs will be practicing
- Important not only to train the CHWs but also the people that they are going to be working with as to what the impact of what their role is going to have
- This is important for the clinicians i.e. this was learned from personal experience
- Role is to take all facets of what patient is going to have to go through i.e not just go out and do what the physician says but how to form a health and wellness regimen even if you are still in treatment for an illness
- Important for practitioners that are not used to working with CHW to be able to understand the CHW role so that they can give the CHW the respect that they deserve, a lot of the language indicates that the CHW will enhance the community residents ability to communicate with the provider, it needs to go the other way around also i.e. especially in the private setting - the practitioner shouldn't just pull the CHW in and say "Go in that room and talk with Mr. Jones to

make sure that they take their medication" – the practitioner still hasn't addressed the problem (that needs to be understood) as the healthcare provider
- There needs to be some training of the healthcare provider of their role and exactly what the impact will be

Marsha Green

- Proudly represents CHWs, has been carrying out this work for about 15 years
- Before CHW was "coined" – this is a new phrase for CHWs
- Started out as an outreach worker for HIV/AIDS community with HIV pregnant mothers
- Started on the ground with the community
- The community trusts the CHW
- The CHW has a real stake in defining "who we are"
- CHWs demand respect for who they are and the work that is done
- The work is not properly represented
- Represents many, many outreach workers, case managers and the various other titles that CHWs have
- Some of the language bothers her i.e. adherence bothers her because the definition is narrow – ultimately don't want to just help the patient adhere to long term engagement, we want to help our patient and community gain independence
- Want to give them the strength and the power to take of their own health, thus empowering patients
- Advocates for their own health

Robyn Elliott

- Maryland Nurses Association
- Materials sent out earlier will help us pick up speed
- Some persons represent themselves, other persons represent organizations
- Materials further in advance which will provide time to be able to discuss materials with the organizations that they represent so that representatives can bring back organized responses

Action Items:

- Members will review all minutes and come prepared to approve at Dec. 1st meeting
- The Grant Group will get evaluation forms to Tara by Monday, Nov. 17th.
- Tara and Leo will get the expected outcomes to The Grant Group by Wednesday, Nov. 19th.
- The Grant Group will get the chunk agenda and meeting minutes to Tara by Thursday, Nov. 20th

Next Meeting: The next meeting will be held on December 1, 2014 at 10:00 a.m. Department of Transportation, 7201 Corporate Center Drive, Hanover, MD 21076.

Adjournment: The meeting was adjourned at 1:20 PM.

Approved by workgroup on: 12/15/14