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|  | **SIM X Subcommittee**  **Date:2/26/14**  **Time:3-5pm**  **Location:4 Seasons Family Practice**  **Fairfield** |

**Chair and Staff: Barbara Ginley, Ben Hummel, Rebecca Miller, Ann Clark, Kara Hay, Deb Halm, Vicki Foster, Theresa Mudgett, Dede Swan, Sally Healey, Isabella Borrero, Linda Coleman**, **Julie Carroll, Karen O’Rourke, Rebecca Matusovich, Shonna Poulin Guitierrez, Patty Hamilton**

**Ad Hoc Attendance:** N/A

**Interested Parties:** N/A

**Members Absent:** N/A

*Subcommittee documents available at***: (**insert web address)

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| **Agenda Item/Related SIM Objective (if applicable)** | **Obj. SST ID** | **Risk/concern discussed** | **Escalation to Steering (y/n)** |
| 1-Announcements | N/A | N/A |  |
| 2-Review January Meeting Notes |  | Dd Swan’s name spelled incorrectly in January notes |  |
| 3-Shared Learning- Paramedicine Project in Maine (Julie Carroll) |  | See Slides Attached. |  |
| 4-Common Language Roles & Responsibilities |  | Need within the ICER documents for more user friendly language  Need for a broader definition of CHW clients to include community members in addition to patients  Need for broader CHW roles, those in the ICER documents are specific to clinical settings  Some of the CHW roles listed would require a lot of specialized training, education, higher-level support  Some of the CHW roles overlap too much with those of provider  The scope of CHW roles depends upon the setting they are working in and the team they work with  Needs to be more clarity about the roles that CHW assist in versus those they are responsible for |  |
| 5 Formal Education Qualifications for CHWs |  | CHW position might serve as a point of entry into clinical work and secondary education, if the educational bar is set too high for CHWs many people will be cut off from these opportunities  We do not want to create an arbitrary educational bar that might rule out candidates that would be otherwise well matched to a specific job, especially when interpersonal skills and community connections are often most important for CHWs  Creating a standardized curriculum and certificate for CHWs risks pushing out experienced CHWs from the workforce that do not have the money, study skills, English skills, transportation to complete courses. |  |
| **Agenda Item** |  | **Discussion Points and Decisions** | |
| Review January Meeting Notes |  | Two different versions of notes from January meeting, new SIM template will be used in the future | |
| Shared Learning- Paramedicine Project in Maine (Julie Carroll) |  | **Introduction**  **Barbara Ginley** Thinking about similar positions to CHWs across the state  Julie Carroll invited to present on the Community Paramedicine Project  CHW definition has link to that of an EMS worker- who is also front line public health worker, member of/ close relationship to the community being served  **See slides for notes on presentation**  **Question and Answer**  **Barbara Ginley** Are there other places where referrals could come from for the community EMS program besides medical providers in a hospital or primary care setting? Can patients refer themselves?  **Julie Carroll** A care coordinator or a primary care provider in a health home must start the referral process.  **Dd Swan** Does the project use existing staff or are additional staff hired? Are they paid or volunteer?  **Julie Carroll** The project must use existing staff and they are paid. In other pilot sites outside of Lincoln County the staff is volunteer. The EMS workers are paid for their regular shift work then use their downtime for the project. EMS workers do not receive reimbursement for outreach unless they transport patients.  What is the training for EMS workers? Number of years?  **Julie Carroll** Different levels of EMS are involved in the project. JC will follow-up with the number of years that different EMS train. Doing this type of community service has been show to help with provider fatigue.  How do EMS intersect with providers from a medical home?  **Julie Carroll** This depends on the service area. But all service providers in the project communicate and work together. The coordinated care should be the goal. For example, fire departments and EMS teaming up with hospitals to do education and follow up for elderly patients suffering from repeated falls.    What will be the metrics used to evaluate the pilot sites?  **Julie Carroll** The 12 pilot sites are beginning to meet so they can look at common metrics together. Everyone has an eye on ED utilization rates and they are collaborating with Jay Bradshaw at Muskie to help develop evaluation tools. Collecting data on patient satisfaction might also be possible.  **Julie Carroll** Patient centered medical homes and community care teams have developed sophisticated systems for collecting data that have shown triple aim improvements resulting from linkages. Hopes to see future models where PCMH, CCT, and EMS all working together.  What were the requirements for the 12 pilots sites?  **Julie Carroll** Applications went before a committee. Started in ED circles and then was spread to peers. Certain characteristics for qualifying, sites must be more integrated than primary care.  **Deb Halm** How long will the project be?  **Julie Carroll** Each pilot three years from start date. | |
| Common Language Roles & Responsibilities |  | **Introduction**  **Barbara Ginley** Last month we talked about the common CHW definition drafted in December and January  Readily acknowledged in the process that the definition did not include roles and responsibilities (R & R)  So the remainder of the day will be spent on drafting R & R  Any comments about the working definition? None  Brief explanation of the documents Ben Hummel gathered for today’s discussion  CEPAC put out the ICER report on outcomes and cost savings associated with CHWs  Within the report there are three user guides: Employers, Funders, CHWs  We will be using:  1 Sample CHW Job Descriptionfrom the ICER employer guide (borrowed NY state)  2 Sample CHW Scope of Responsibilities in Health Home from the ICER employer guide (via NY state)  -Divided into activities directly performed by CHW and those activities that CHW supports  3 Core Competencies & Skills, document Ben Hummel compiled from multiple resources  -Not much time will likely be spent on core competencies today because we need to R & R  **Instructions**  **Barbara Ginley** We will break into three groups (two in the room and one on the phone)  Please look at the ICER documents and highlight the R & R that fit with our working definition, those that do not work with the definition, or those that are missing  **Group 1**  Picked out the broader words and phrases that could be used in many settings:  -Outreach and engagement activities  -Support program in needs assessments: barriers and assets of the community  -Social supports: understanding the language, literacy, and cultural preferences of the community  -Promoting patient treatment adherence: identifying barriers to change  -Behavioral change, counseling, goal setting, action planning  -Navigating medical and social service system  -Care Coordination: identifying community resources, making referrals, follow up  -Disease self-management: support outside of the primary care setting  -Info technology, data collection and reporting  Did not include the 4th, 5th, 9th, and last requirement in the job description  **Group 2 (Ben Hummel, Ann Clark)**  The scope of CHW R& R depends upon the setting they are working in or the team they are embedded  There is not a 1 size fits all, rather think about different levels of CHW work  Some of the CHW roles listed would require a lot of specialized training, education, higher-level support  Some of the roles listed of particular concern in requirements 3,5, 6, 7, and 9 of the ICER report are:  Needs assessment, behavior change, counseling, chronic disease management  Oregon state has a lot of experience integrating CHW in care teams, good resource  Other helpful resources: CHES core competencies, Maine general peer navigator, MACHW definition  **Group 3** (**Barbara Ginley, Dd Swan)**  When CHW work as part of a team, hard to know their scope unless you know what other members do  CHW’s roles and responsibilities should be determined by:  What are the skills and strengths that a CHW can offer a medical team  What are the cost savings associated with CHW doing certain work  What are the patient needs  The supported by CHW category in the Sample Scope document looks very clinical  For example a high level of experience or formal education would be required for a CHW to make treatment changes and address medical conditions  Needs to be distinction between clinical and non-clinical work | |
| 5 Formal Education Qualifications for CHWs |  | **Patti Hamilton, Sally Healy** Maine Families Home Visitor Program: Home visitor similar to the CHW model and the  minimum qualification is bachelor degree and ongoing education also required.  **Dd Swan** All the CHWs she works with have degrees from other countries but they are not bachelor degrees  **Barbara Ginley** Because of the scope of skills, non-clinical work equivalencies of formal education or life experience counts for a lot currently. For many immigrants or peer/patient advisors, CHW position might serve as stepping stone into clinical work and formal secondary education.  **Dd Swan** At Somali Culture & Development weekly staff meeting focus a lot of training needs. Despite the fact that semester long CHW training are intensive, new staff still need ongoing training to meet all their job requirements, and organizations must plan for this  **Deb Halm** Has found that associates degree is so intensive that it has been sufficient for her staff  **Vicki Foster** Stanford University: Chronic Disease Lay Leader Model  Researchers found outcomes were better when the program is led by lay people with connections to patients, interpersonal and communication skills more important than certification  **Becca Miller** Job functions should be matched to education requirements, candidates should not be ruled out by arbitrary educational bar  **Anne Clarke** Oregon Peer Support Model: People from and for the community possess level of trust and which is very valuable for a team engaged in behavior change  **Becca Miller** Then there is the question of English proficiency, some medical interpreter courses contain pre-requirements for English proficiency and certain programs require CHWs to obtain this  **Barbara Ginley** Minnesota Model: Community Colleges partnered to develop CHW curriculum and certificate, when many established CHWS struggled to complete the courses, colleges offered additional support around study skills and English proficiency to prevent shutting out these CHWs from their livelihoods.  **Karen O’Rourke** Early child-hood professional development lattice might serve as a model for CHWs, multiple levels | |

**New Actions**

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| **Agenda Item** | **Action Items** | **Status** | **Who** | **Due By** |
| Shared Learning- Paramedicine Project in Maine (Julie Carroll) | **BG** will email the group the application requirements for the community para-medicine pilot sites.  *The legislation passed in 2012 authorized the ME EMS Board to review and select the 12 pilot sites. There were no funds available to the pilots for participating.* | Reported | BG | 3/14 |
| Common Language Roles & Responsibilities | **Barbara Ginley** will need to combine comments and highlights on R & R before we move to core competencies  March Meeting will be spent revisiting CHW roles and responsibilities |  |  |  |

**Outstanding Actions**

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| **Reference** | | **Action Items** | **Status** | **Who** | **Due By** |
|  | **Vicki Foster** Look into booking room at the Maine General Alfond Center for next month’s meeting  **Barbara Ginley** we need adobe connect when we work on multiple documents  **Barbara Ginley** will schedule presentations on peer support and family visiting programs at a later date |  |  |  |