

GEORGIA HEALTH POLICY CENTER



Meeting Summary

Georgia Community Health Worker Forum

November 2016



SUMMARY
Community Health Worker Forum
November 17, 2017

Over the past decade, there has been increasing interest and effort of stakeholders across the state to understand and demonstrate how community health workers (CHWs) might play a role in promoting wellbeing and improving the health of disparate populations across Georgia. On November 17, 2016, the Georgia Department of Public Health, Kaiser Permanente of Georgia, Morehouse School of Medicine, Grady Health System, Atlanta Regional Commission and the United Way of Atlanta co-sponsored a CHW forum that was attended by over 100 stakeholders. The Georgia Health Policy Center (GHPC) provided facilitation services for the event.

The purposes of the forum were:

- A. To create a common understanding among stakeholders on the definition, roles and value of CHWs and
- B. To foster alignment of CHW efforts in supporting health improvement and healthcare access in Georgia.

Four primary objectives were outlined for the meeting.

Participants will:

1. Increase their awareness of current Georgia-based CHW programs, practices, opportunities and resources
2. Explore national promising practices and possibilities
3. Begin to draft the core elements and recommendations for a statewide CHW model in the state
4. Participate in peer to peer learning and exchange of ideas

Principles developed to guide the meeting and ongoing dialogue on forming an agreed upon Georgia model:

- *Inclusivity* – appreciating the work and voices of all who are engaged in activities that link and navigate clients to health and through the health care system
- *Excellent information* – using what is already known to be working and regarded as promising practice to help inform the conversation.
- *Big picture thinking* – encouraging the ability to see and engage in ways that move everyone beyond vested individual interest.
- *Congruence* – reaching agreement on how to address the issue together

This document provides a summary of the work and information from each Forum session

I. Session Summary - Georgia CHW Programs/Stakeholders

Participants generated the following list of CHW programs and stakeholder organizations in Georgia. This list is expected to grow as more becomes known about community health worker engagement and programs across the state.

COMMUNITY HEALTH WORKER STAKEHOLDERS IN GEORGIA

Organizations

1. Alliant Quality
2. American Cancer Society's Breast Cancer Prevention Program
3. AmeriGroup CMO
4. Atlanta Regional Collaborative for Health Improvement (ARCHI)
5. Area Agencies on Aging (ARC)
6. Arthur M. Blank Family Foundation
7. ASPIRE Home-based Care and Services
8. Athens Nurses Clinic
9. Atlanta Metro College – training through the schools
10. Avon Comprehensive Breast Cancer Program/Emory University
11. Cancer Patient Navigators of Georgia
12. Center for Black Women’s Wellness
13. Center for Pan Asian Community Services
14. Center for Working Families
15. Centers for Disease Control and Prevention - Betsy Rodriguez, CDC/NDEP Deputy Director
16. Children's Healthcare of Atlanta - population health and Hughes Spaulding health navigators
17. CHOICE Neighborhoods
18. Choose Health
19. Clayton Center (Marcus Thomas- Community Connector, Clayton Co.)
20. Clayton Community Service Board
21. Community Service Boards
22. Congregational Nursing - Gwinnett / Georgia Faith Communities
23. County Health Departments
24. DeKalb Board of Health Refugee Health Center
25. East Lake Healthy Connections
26. Emory Urban Health Initiative
27. Environmental Health Inspectors
28. Feminist Women’s Health Center
29. GA Charity Care Clinic Network
30. GA Department of Public Health
31. GA Hospital Assn
32. GA Primary Care/FQHC’s
33. GA Watch
34. Good Samaritan
35. Grady Hospital ER based Navigators and CHWs
36. Grady Paramedicine
37. H.E.A.R.T. Coalition
38. Heal Westside Healthy Connections

39. Healing Bridge
40. Healing Our Communities
41. Hispanic Health Foundation
42. Historic Westside Gardens ATL, Inc.
43. Houston Medical Center - Faith Community Nurses
44. I Care - Grady
45. Live Healthy in Faith in Columbus- partnership of the Center for Health Disparities at Columbus State University and Live Healthy Columbus
46. Mercy Care Services
47. Mercy Clinic in Athens
48. Morehouse School of Medicine REACH programs
49. Neighborhood Associations
50. Northwest Georgia Healthcare Partnership Promotoras Program
51. Oakhurst Medical Center
52. Peach State CMO
53. Piedmont Fayette
54. Piedmont Hospital's SAMS program (operating in Newnan, Fayette and Henry Counties)
55. Primary Health Clinic at Clayton State University
56. REACH Program – Community Health Preventive Medicine
57. Regional Cancer Coalitions of Georgia
58. Ryan White Part A Peer Navigators
59. Salvation Army (Ray Joan Kroc Center)
60. Sickle Cell Foundation
61. Sisters Action Team
62. Southside Medical Center
63. Statewide AHECs
64. Tri-cities HS students CHWs
65. UGA School of Law / Bowling & Associates
66. United Way's Healthy Beginnings Nurse Navigator Program
67. WellCare CMO
68. Wellstar- Congregational Health Network
69. West Central Georgia Cancer Coalition
70. West Central Health Department
71. West End Family Medicine/Medical Center (FQHC)
72. Zap Asthma

Rural Hospitals:

1. Union Medical / Appling / Crisp Regional - Paramedicine
2. Habersham Medical Center / Upson Regional / Miller County (nurse based care coordination)

All Public Health Departments

II. Session Summary – Keynote Address

Jill Feldstein, Director of the Penn Center for Community Health Workers (Center), based in Philadelphia, provided the audience with a well-received overview of the Center's work and the evaluation of the CHW initiative.

The mission of the Center is to improve health in high-risk populations through effective use of CHWs. Their approach focuses on the IMPaCT Model of Care in which people most affected by health challenges must participate in finding solutions. Key elements in the IMPaCT program include:

- Target patients
- Set goals
- Support
- Connect
- Measure outcomes
- Supervision of CHWs – meet every week
- Infrastructure

Through the evaluation process of the Center's CHW initiative, community members indicated that community health workers were most valued for their ability to navigate the healthcare system; connect people to resources (public programs, subsidies etc.); and various types of support (physical, psychosocial etc.). Key traits of effective CHWs included being non-judgmental and being an actively engaged listener. Qualitative interviewing skills were also highly regarded.

Finally, Jill referred to some of the challenges to their program. These included:

- staff turnover;
- variability of effectiveness in working with patients;
- lack of infrastructure to provide CHWs the needed support to do their jobs;
- disease-specific needs and variance;
- difficulty in integrating the effort into healthcare system – no electronic medical record (EMR) access, no permission to talk to healthcare providers (HCPs); and
- low-quality evidence – mentioned by funders who often need good data to understand their return on investment (ROI) and impact.

III. Session Summary - Panel Discussion

Local CHWs and trainers participated in a panel discussion to share their own experiences of operating in the Georgia environment. Panelists were: Erin Hernandez (Co-Chair, Cancer Patient Navigators of Georgia), Anthony McLaren (Community Health Worker, Grady Health System) and Pam Daniels (Lead, Academic and Community Partnership Morehouse). Key responses to questions asked of the panel are highlighted below:

Community Health Works – Local Models

1) What are the two most primary roles that you are delivering/preparing workers for?

- a. Sharing the right resources – where to point people, how to access the system.
- b. Learning to listen – really able to listen beyond that which is said and determine the need.
- c. Making linkages between patients, families and the health care system
- d. Speaking the language of the people we serve and share that back
 - i. Time that it takes to develop the bond/trust
- e. Education and awareness through training of CHWs
 - i. Access to master CHW/trainers
 - ii. Professional development opportunities
- f. Going back into the community and being “true” community health workers
 - i. Data collection/management
 - ii. Put social capital back into the community
 - iii. Providing sustainable resources

2) What are the essential skills of an effective CHW?

- a. Listening-understanding what others are communicating verbally and non-verbally (i.e. body language).
- b. Motivational interviewing; learn how to interview without interviewing – communications
- c. Discernment
- d. Effective communication and sharing what is appropriate – you never know what information will be needed
- e. Being flexible and knowing how to coordinate (working with others and other organizations)
- f. Ability to identify communication resources
- g. Effective use of resources
- h. Participating in community activities
- i. Understanding their roles and responsibilities (understanding the scope of practice)

- 3) How do you modify and make sure the training for CHWs is responsive to the residents you serve?**
- a. Request resume of the participants prior to trainings (gather pre and post information from attendees)
 - b. Address cultural competency based on zip code/neighborhoods
 - c. Use evaluations to modify content
 - i. Might provide case studies of the kinds of populations they might see (e.g., sorority members, hair dressers)
- 4) How do you assure cultural competency and how is it integrated into the work that you do?**
- a. Stressed cultural competency through 4 day training sessions – allowed participants to role play
 - b. They have to learn to be appreciative of the communities
 - c. Conducting training in sexual orientation sensitivity
 - d. CHWs complete 35 hours of training including how to speak to different communities
 - e. Annual trainings (e.g. as a Grady employee)
- 5) What do you think are the successes and challenges of integrating CHW into the health care delivery system?**
- a. Grady:
 - i. CHWs are an integral part of staff. CHWs connect with patients before they get home and help assess patient's state at home.
 - ii. Educating the doctors/case managers/nurses – getting buy in and participating in home visits
 - iii. Doctors, case managers, and nurses still must be educated about the role of CHWs and how their services can be used.
 - b. Federally Qualified Health Centers (FQHCs):
 - i. CHWs have been successfully placed in FQHCs over the past 3 years
 - ii. CHWs have benefited patients with diabetes
 - iii. Funding and sustainability has been a challenge
 - c. Linking the population with screening opportunities and providers
 - i. Smoking cessation programs and a training for health care organizations (who need help in identifying people at risk)
- 6) What do you measure to determine success in your (CHW) programs?**
- a. There is a need to standardize what is measured to evaluate CHW programs across the state.
 - b. Morehouse School of Medicine:
 - i. We use our evaluation and referral forms that reference the IDAP program
 1. The number of referrals to FQHC/PCP
 2. The number of trainings of CHWs

- 3. Number of CHWs who conduct their own trainings
- c. Grady:
 - i. Number of readmissions
 - ii. Number of non-emergency emergency care center (ECC aka ER) visits
 - 1. *Cost of \$450 million over the year*
 - 2. *Reduced the number of ECC visits by 84% and readmission by 70%*
- d. Cancer Society:
 - i. Number of individuals trained to be a CHWs
 - ii. Number of screenings/early detection and diagnosis

7) What is the one thing we need to keep in mind given your success as a CHW?

- a. The CHW is at the center of the certification program
- b. As we expand this, don't make the error of not including the people who have made this successful and "got this thing going".
 - i. Currently hiring Master's degree applicants for CHW (it started as an *each one teach one* program); previous CHW workers that have made the program successful can't even apply. It is a grassroots effort.
- c. CHWs need to look like the community
 - i. We should not block people from helping their community (e.g. individuals who might have a criminal background)
- d. The best initiatives will be led by the communities, and the community members need to be at the table.
- e. Remain flexible - we need to be flexible because funding is always changing
- f. Nurture relationships
- g. CHWs need to be paid a living wage

Session Quote

"There is a lot already going on. Let's continue to think about where we are and decide where we want to be. We are in this together and there is a lot of people already on the ground, so we need to think about how we value the work that is already being done."

IV. Session Summary - Developing Georgia Model

During this time in the meeting participants had the opportunity to use the Georgia context to:

- reflect on two commonly held definitions of community health workers;
- describe the key roles of a community health worker; and
- identify the supporting skill, traits and qualifications

REACTION TO THE DEFINITIONS

American Public Health Association (APHA) Definition

A Community Health Worker (CHW) is 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.

Bureau of Labor Statistics (BLS) Definition

Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resource, provide social support and informal counseling, advocate for individuals and community health needs, and provide such services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health educators".

Perceived strengths of APHA definition

- Comprehensive; more broadly defined and makes sense
- Encompasses all that CHWs do and understands the work and the role of CHWs on the frontline, operating in the space between health and the social services
- Portrays values and root of CHWs
- Includes cultural competence, and is empowering
- Is more fluid and dynamic, less clinical; focused on trust
- Improving quality and cultural competence
- Underscores the value of CHWs for community health management
- Language is inclusive; wording is clearer

Perceived strengths of BLS definition

- Specific skills or activities that differentiate a CHW are articulated
- Seemingly allow more clinical light services... (e.g. first aid)
- Separate and clear understanding of MD's and CHW's roles; they collaborate to empower
- Language is simpler and the definition is more direct - "promote, maintain and improve community health."
- Describes how the CHW provides the outreach for medical staff
- Importance of data is recognized
- Definition is intentionally flexible re: qualifications

Perceived weaknesses of APHA definition

- May be too broad - funding/billing/payers
- Perceived more as an explanation and not definition
- Clunky language in parts
- Sounds like CHW does it all – no boundaries
- Too long and wordy – should be more concise and less complicated; average lay person may not understand – can be a barrier
- Public health" worker might create a misperception that public health will be a funder

Public health" worker might create a misperception that public health will be a funder

Perceived weaknesses of BLS definition

- Too much of a focus on what a CHW does; perhaps too much specificity
- Lack of clarity
- Excludes health educators
- Confusing with inclusions and exclusions
- Wording is redundant
- Too many run-on sentence – break it down
- Crossed the line into clinical
- Use of the terms "may" or "assist" are disempowering
- Maybe not robust enough, lost the meaning in the interpretation
- Doesn't understand the community. CHWs are a profession with a unique role that is clear; this is not how the definition reads; emphasis on the community liaison role is important – BLS definition suggests it can be learned
- Is data collection an essential activity or role of a CHW?
 - Inflexible; businesslike/not holistic/friendly. Seems more like a job description
 - Calls into question the educational background or training

Overarching Feedback

- More preferred the APHA definition but they saw strengths and weaknesses in both. Some made edits and recommendations for how to make them better.
- A true definition is perhaps a merger of both; textbook definition should probably include characteristics of CHW.
- Both definitions missed some of services CHWs provide.
- There is general consensus on the need for a uniform and national definition that differentiates positions and is taken seriously by funders.
- The APHA definition is perceived as being more population/public health focused while BLS definition is believed to be more aligned with the healthcare system.
- Definition should reflect where the work is happening and the level of adaptation that is required in the role.

THE GEORGIA CONTEXT

The discussion about the relevance of the definition to the Georgia context was lively and yielded a few themes.

Participants were concerned about general and geopolitical changes that were occurring and how those changes might have an impact on the way in which the Georgia model would be designed and implemented. Additionally, as one of the southeastern states, Georgia is more burdened by socioeconomic challenges and worse health outcomes than many other states. Some participants also lamented that though some promising early work was occurring, more needed to be done to integrate the CHW role as part of the health system.

Key elements of the discussion are captured below with emboldened text indicating a shared or reinforced viewpoint throughout the discussions.

Overarching Change

- We don't know who or what organization will be in charge of the country
- Will there be formal recognition in our state?
 - Culture of change needed; slow increasing acknowledgement of the position of CHW
- Bias against populations served
- Wedded to traditional model – resistance to change
- Industry and built environmental and landscape changes are occurring rapidly - Mercedes Benz stadium, NCR, Google, movie industry,

Geo-political Factors

- **Lack of Medicaid expansion – large population who are uninsured**
- **General resources limited in some communities, especially rural ones, and programs don't always reach those areas.**
- **Policy implications; funding, reimbursement**
- Many silos
- Lack of access to care in some geographical area
- The barriers and needs may be different based on rural vs. urban communities
- Rural hospital closures
- Location impacts which definition would work
- GA politics – Who are the “real” decision makers? – Are all voices at the table?
- Role clarity of providers
- Georgia is a “Red” state
- GA doesn't “support” people who aren't licensed
- Lack of infrastructure, funding and systems to support CHWs
- So many programs with various policies; there needs to be streamlining
- Political environment, i.e., enrollment, state priorities, primary care
- Relevance → must show how it matters to government, business etc. (loss productivity, healthy workforce)
- Some limits on what CHWs can talk about (e.g. sex education)
- Education status vs. member of community (can be resented by people)

Socio-economic Factors

- **Lack of affordable housing, transportation**
- “Diverse” education system
- Increasing refugee population
- Immigration status
- SES factors – increased need for access, food deserts, low education attainment
- Employment rates low in some communities
- Low income – 13 county area – 60% of rural population
- Urban areas –potential for model replication

Health System

- **Health disparities are significant**
- **CCM and other reimbursements**
- **CHWs vs. navigators**
- **Recognition within healthcare system – Do people within the system recognize CHW certification?**
 - CHWs are often viewed as just a volunteer without credentials

- Confusion over CHWs role within the clinical community – leads to different ways of using CHWs, haphazard way of implementing
- Multiple permutations of CHW - HIV/AIDS, peer support MH; all trained as CHWs but not called that CHWs
- GA is divided by public health districts
- Southeast – most unhealthy
- Rural – only 1 health network
- Competing health systems
- HIV/AIDS a prevalent issue
- Changing insurance industry and trends
- Training – i.e. hospital navigators
 - How to “hand- off”
 - How much training and what it looks like?
 - Training whole care team
- Scope of practice issues and competition with other healthcare workers (i.e. nurses)
- EMR systems not communicating with one another – consider the potential of Georgia Health Information Network (GaHIN)
- Policy – administrative in result of ACA (hospital navigators)
- Health system partnering with organizations to provide CHW services instead of hiring CHWs
- Community oriented primary care is implemented largely with the help of CHWs
- Rate of uninsured
- Breaking down silos – access one another’s resources to collaborate to best serve the patient
- Addressing HIPAA concerns to help smooth out the coordination

Early CHW work

- **Political considerations with implementing agency**
- **Need for core competency standards**
- **Navigators play a role in the system and it is confusing who does what and accesses what information**
- **What CHWs do and what they are called is influenced by funders**
- **Work setting matters – clinical, nonprofit, research, etc.**
- **Lack of knowledge about who a CHW is** among HCP, politicians, patients
- Faith based potential
- Multiple CHW trainings, disease, models in GA
- Ensuring trusted CHWs reach the needy populations
- DFCS staff and CHWs may be confused for one another at times
- Extension in community
 - Provide linkage
 - Create balance with providers, etc.
 - No duplication
- Some school-based CHWs were engaged to reduce absenteeism – worked with nurses and CHOA to use visitation services at some schools and engage parent liaisons

- Already defined what we are and do; now we should focus on how to certify CHWs in GA
- Politics – justification and uses, who? Why?
- Is it volunteered or paid – FTE
- Compensation – job classifications, credentials, etc.
- Population size – need more for certain areas. May be able to build relationships easier in smaller communities
- How CHW view themselves – I do the work, but no one calls it CHW – large population
 - personal experience as a driver or community
 - may lose trust due to affiliations/connections
- What drives philanthropic investment in CHW
- CHW's employed by health systems, hospitals, non-profits
- State contracts supporting (or not) CHW as a job/role; billable services (ICD 9/10)
- CMS – Consider where CMS is with CHW (Healthy communities grant)

Recommendations and Concerns

- **What is the “credible agency” to sponsor this effort?**
 - Should Morehouse, GHPC, DPH, or another entity take on this role?
 - Administrative home in Georgia?
 - Pull in funding
 - Policy role in state platform
 - Accountable body that makes sure we are making progress
 - Noted, credible, with adequate infrastructure, steering committee: public health, research/academic policy
- **Training may vary to meet the needs of the local community**
- **Clarify role confusion (coordinators, navigators, etc.)**
- “We are repeating a conversation”
- Certification is becoming a goal (for wage improvement)
- Differentiate between degree-granting and certification
- Consider difference in approach rural and suburban populations.
- Focus on self-management (person-centered) find needed supports
- Develop technical assistance resource network for the state - “sponsor” at state level to coordinate supports and resources for CHW
- Local resource connections and be networked
 - Consider geographical competency within cultural competency.
- Need to come up with some rigor – needs to be a part of the definition
- Need to be intentional about who is making decisions
- Should be more CHWs present – some people are not paid so they are not engaged
- Need a more centralized contact list
- CHWs face some barriers as population – i.e., travel expense to this meeting
- Certification (lack of) → Proactive peer support counselors
- Get the Model going – awareness in Georgia is not high

KEY CHW ROLES

Primary

- Assessors
- Resource Connectors
- Coaches/Psychosocial Supporters
- Advocates

Secondary

- System Access Navigators
- Educators
- Communicators

General

- Roles depend on community needs assessment (which might influence primary and secondary roles; the separation of roles into primary and secondary might not be valid)
- Must be able to communicate with community (i.e. language)
- Influence change at individual and provider level
- Relationship built on support and trust
- Not requiring certain education level; be inclusionary
- *Remove counseling and change to social and emotional support in definition*
- *Remove first aid and blood pressure screening as not all CHW do these type of medical services*

Primary Roles

Assessors

- Help identify those who need services
- Assessment
- Collect data
- Build resource network

Resource Connectors (Upstream and Downstream)

- Provide info and education in cultural competent way and link to services (“bridge”)
- Connect to resources -> medical home
- Connect to community resources, knowledgeable about what resources are available
- Link between community and providers
- Facilitator
- Foster and manage relationships throughout community housing, food bank, etc.

- Improve patient “total well-being”
- Prevention focused
- Linkage to SDOH resources

Coaches/Psychosocial Supporters

- Address needs of patients and help find solutions for barriers
- Health coach – keep it broad
- Psychosocial support
- Listen and link
- Motivator
- Care decisions – CHW is the “eyes and ears” on ground – “the scout”; requiring CHWs to be multi-lingual could be a barrier to recruiting CHWs that are from the community and it costs to become multilingual

Advocates

- Systems advocate
- Advocacy on behalf of patient
- Advocate of health equity
 - Knowledge and understanding SDOH
 - Build literacy
 - Build capacity for patients to navigate the system themselves and live productive lives

System Access Navigators

- Facilitate access to care – medical home
- Removing barriers to accessing care
- System navigation
- Work with or on care team to address SDOH to facilitate access to care
- Follow-up

Educators

- Provide education to improve health literacy and chronic disease management
- Counseling, building capacity for patients to self-manage
- Educating the providers – cultural competence, increase understanding of the population
- Assist in implementation of health education program i.e. advertising program

Communicators

- identifying and communicating the patients goals
- Motivational interviewing
- Translate and address health literacy (“jargon-busters”)
- Communicating and collaborating with providers and orgs
-

SKILLS, TRAITS and QUALIFICATIONS

IDENTIFIED SKILLS

- **Effective Communicator**

KEY CHW SKILLS/TRAITS

- Effective Communicator
- Investigative mindset
- Organized
- Interpersonal Skills
- Active listener
- Able to teach
- Tenacious
- Adaptable
- Non judgmental
- Compassionate/Empathetic

KEY CHW QUALIFICATIONS

- Community connectedness
 - Experience
 - Knowledge and Aptitude
 - Fit
 - Certification
-
- **Investigative mindset**
 - **Organized**
 - **Interpersonal skills**
 - **Active listener**
 - Cultural competency
 - Critical thinking
 - Educator
 - Conflict resolution skills
 - Teach basic skills
 - Computer skills

- Basic research skills
- Basic technical skills
- Advocacy
- Team player
- Networking skills
- Discernment
- Facilitator
- Interviewing
- Data collection

IDENTIFIED TRAITS

- **Tenacity**
- **Flexible**
- **Non-judgmental**
- **Compassionate/Empathetic**
 - People person
 - Passion for helping people
 - Personable
- Ability to simplify concepts
- Self-aware
- Respectful
- Affable, warm
- Stamina
- Independent
- Responsive
- Innovative
 - Thinking outside the box – creative
- Consistent
- Honest /Dependable
- Uniqueness
- Passionate – keep them from burning out
- Language that matches the community
- Peers for certain conditions – or linking to peer networks and supports
- Good judgment
- Warm personality
- Supportive
- Resourceful
- Organized
- Discernment
- Patient

QUALIFICATIONS

Key themes from the discussion on qualifications included:

- Community connectedness:
 - **Closely connected and from the community** (*resident)
 - literacy in language of community
 - Familiar with community
 - Extensive knowledge/experience in community
 - Aligned to the environment in which you work (clinical, community)
- Experience:
 - Volunteered w/or work with at risk, vulnerable pop.
 - Health literacy
- Knowledge and Aptitude:
 - **High school diploma or GED or some tech/college**
 - **Motivational interviewing**
 - **Awareness of health system functioning**
 - Could be part of recognition or career pathway
 - Computer literate/word processing
- Fit (How to ensure they will stay):
 - Emotional strength
 - Match to the population
 - Young and more established
 - Public health preferred and years of experience (1-3 yrs.) in relation to need of CHW (required)
- Certification:

For CHWs not from the community they serve:

- Ability to work in and within the community
- Degree of life-high school diploma/GED
- Basic computer skills
- Driver's license, with a dependable driving record

Additionally, some stakeholders believed that there should be some flexibility in the required qualifications given the diversity of potential roles and communities. They recommended that the model consider flexible qualifications around experience and education, with a greater focus and emphasis on competency.

Session Summary - Recommendations and Meeting Feedback

HIGH LEVEL FEEDBACK

At the end of the meeting participants were asked to provide the guiding committee with some input on opportunities and next steps prior to completing evaluation forms for the event. A summary of the feedback is provided below and the formal evaluation results are included in the appendix to the document.

Recommendations

- Establish steering committee with the right, motivated people
- Design of future meetings should:
 - ensure next meeting happens in 4-6 months
 - address the systems and supports that need to be in place for creating successful CHWs in GA
 - ensure that goals and timeline are set
 - ensure that a large number of CHWs have the opportunity to participate
 - be used as a planning session to review and/or develop next steps for CHWs; certification should be discussed in detail.
 - Devote time to discussing the CHW role in more detail and finding ways to understand and clarify the distinction between CHWs and other care team member roles
- Include rural focus in planning and development of program and CHW role definition
- Engage others as part of the effort:
 - FQHCs
 - Neighborhood Associations/NPUs
 - Public Health Department beyond the Chronic Disease Program Section
 - GA Department of Education/Technical Colleges and Career, Technical and Agricultural Education (CTAE) institutions
 - GA Department of Corrections/re-entry programs
 - GA Department of Labor
 - County/city representatives
 - State HIV community
 - Homeless/housing community
- Identify funding for regional centers for CHWs

Forum feedback

- Meeting was kept moving
- Liked videos on physicians expressing CHW role makes a difference
- Roundtable/Panel – *(should have been)* CHWs from the field
- Might have had more time/opportunity for participants to meet each other
- Could have benefitted from more time for Jill to provide greater detail about her efforts

Opportunities

- Certification, if proposed, should help to lift up CHWs value to create an exclusionary category of profession.
- Choose Health (CHW program) should be a part of the mission to move (advance) the certification process
- Focus on recruiting CHWs to attend the next forum/discussion
- Avoid the following pitfalls: making criteria to restructure; taking too long between meetings and limiting members of task force
- Convene smaller group of organizations who are currently using CHWs to compile roles and discuss opportunities for stream lining process and sharing resources
- How do we pay for the infrastructure to support CHW development in Georgia?
- Identify an entity to be the administrative home to keep work moving forward beyond the meeting
- Identify a minimum of 3 funding sources for the model development and support
- Develop a tangible timeline and evaluation Implementation plan