Care Coordination 7-19-2023

Group Meeting Norms

- When you join, please chat-in or say your name.
- State your name before speaking.
- Verbalize messages in chat.
- Speak for yourself only, using "I" statements: "I do not like…" instead of "we do not like…"
- Raise your hand to speak and use your camera when possible.
- Closed Captioning is available through Teams by clicking on More Actions and selecting "Turn on live captions".
- Meeting notes will be sent in pdf format at the end of each meeting.
- All meetings will be recorded

Vision

An equitable, just, and well Baltimore where everyone has the opportunity to be healthy and to thrive.

LHIC Purpose

- The coalition's purpose is to identify and address Baltimore City's most pressing structural health disparities by bringing together a multisector group, with representation from community, health, and government.
- Requires the shared leadership of healthcare, government, organizations, community members, and representatives from underserved communities.
- Each LHIC identifies 3 health priorities and works to address through a diversity of perspectives, collaboration, and pooling resources.

Care Coordination Goals

1. Improve access to healthcare, services, and resources for Baltimore City residents.
2. Improve the quality of healthcare, services, and resources for Baltimore City residents.

Objectives

- By December 2023, build four new referral pathways between health providers and community organizations.
- By January 2024, implement 1-2 policies in support of community health workers.
- By June 2024, coordinate the sharing of health-related social needs data across 85% of healthcare systems.

Activities

- Convene healthcare and community partners with CRISP, Maryland's Health Information Exchange.
- Work with healthcare partners to identify values, needs, and challenges related to data sharing.
- Recruit community organizations to share referral information.

- Test data sharing methods between 2-3 organizations to build upon data sharing processes.
- Share learnings and build community relationships through LHIC meetings.

GOAL	Activities	Members	Today's Discussion Topics	Next Steps
New Members	Call for new Members or Topics		1. Introductions: Do we have any new members? Please share your name, role/ title, why joined the LHIC, what you hope to gain and what you hope to contribute	Barbara Van de Castle – University of Maryland School of Nursing Marguerite Woods – state chapter president of National Federation of the Blind. Can share resources with LHIC as well. Important for LHIC to connect with community as well (e.g. opportunity to attend state convention) William Haskett – representing a medical services training company in Baltimore; background doing community work in Baltimore.
Community Informed Definition	Host focus groups, engage the community	BCHD, Ijeoma Eke, Lynell Medley	1. UPDATE: We are recruiting 12 community members. 2. CALL TO ACTION: bring 1 community member to this group, or invite to a full LHIC meeting	Community member: • A person who lives in Baltimore City • Who wants to engage outside of their professional work Pay: $30/hour via gift card Looking for 12 people: • Disability community • Older adults • Youth • LGBTQ+ Make a referral!!
Policy Work/ Advocacy	2 areas of potential: 1. CHW reimbursement, 2. Advocacy with HSCRC	BCHD, Lorena de Leon, Tracy	Overview of CDC Work. **1.** Review and discuss how this workgroup can support work to **a.** Build and Learn about multi-directional referral pathways **b.** Design and learn about utilizing incentives to develop referral pathways and CBO engagement **c.** Develop CHW policy initiatives	

Data Sharing	All of the Health Systems and FQHCs share social needs data.	MPC, BCHD, Marik Moen, CRISP, Steven McGaffigan	1. Announcements	

Goals	**Workgroups**	**Required Members**	**Key Activities**	**Early Milestones**
Increase the capacity of CHWs to participate in diabetes education by building a diabetes education curriculum and spreading it to at least 4 CHW associations or groups, the people they serve.	Diabetes + Care Coordination	MDH CHW reps	Provide feedback to curriculum builders	By Sept. onboard consultant (who will build out training) By Dec. develop a review panel to give feedback on curriculum
Increase the number of multi-directional communication workflows between diabetes clinical sites and community resources from zero to 5, utilizing financial incentive to support the participation of community based organizations.	Care Coordination + Diabetes	CRISP MDH PG County DRPs Care Coordination groups 5 Food/CBOs	Meet Bi-weekly/Monthly to: 1. Explore best technology 2. Explore incentives 3. Identify areas of shared learning 4. Pilot workflows	By Sept. identify potential technology and out of city stakeholder and convene initial meeting By Dec. complete an analysis of technology and referrals needs
Increase access to CHWs by developing one CHW reimbursement policy strategy and introducing at least one piece of legislation.	Diabetes + Care Coordination	MDH CHW reps	Provide feedback and input on the strategy	By Sept. onboard consultant and landscape analysis begins

Questions about CDC goals

Diabetes curriculum:
Barbara – is the purpose to increase capacity by building a diabetes database or are the health workers meant to participate in the education? Training CHWs or training community? Answer is that we are going to train the CHWs with the end goal of them educating the community about diabetes.
Marguerite – are you talking to blind and low-vision individuals as community workers? Be sure to loop Marguerite in going forward.

Multi-directional communication:
Barbara – interested in tech and helping with that. Is the goal to retain communication and follow it over time? Do we want to track and save those or is it a one-and-done text message, for example? **Our goal is to create a trackable communication.**
Lorena – very interested in partaking in this. What are we envisioning this communication to do? **We mean a referral. Example: DPP provider could refer a participant to a community organization. Organization would confirm with provider that patient received the resource they needed.**

- State met with MCOs about a standard questionnaire for referrals
- Not every DPP is contracted with every MCO, need to be cognizant of where we refer people
- Many DPP programs are funded through HSCRC program, but not all contracted with every MCO (competition)
- Also a question of integration with EMRs
- There is a lot of complexity around a diabetes-related referral given what state, CRISP, more or trying to do.

Marik – Meals on Wheels and CRISP may have a lot to capitalize on based on what they've already done

Reimbursement policy:
Lorena – wants to make sure that we are coordinating with other alliances (e.g. Latino Health Equity Alliance is also working on something like this)

- Samantha Sailsman has also done work in this area (sits on the MD CHW advisory board and also MAHEC)
    - AHEC is an organization through the state of MD that trains CHWs and provides health education to others throughout the state
    - There are three in the state, all run by different directors
    - IPHI also has classes online that are accessible to community health workers and educators (Institute for Public Health Innovation)
    - Latino Health Equity Alliance Advisory group – Kelly Umana (sp?) has effectively brought the Latino groups together and would be a great advocate
        - Samantha willing to make an introduction to Kelly
    - Lorena is going to make an introduction to Dr. Gabriella Loomis (sp?) and Paula Blackwell (MAHEC)

Links to AHEC shared in the chat:
https://www.medschool.umaryland.edu/mahec/
https://centralmarylandahec.org/
https://www.medschool.umaryland.edu/mahec/
https://www.medschool.umaryland.edu/mahec/Community-Health-Worker-Training-Program/
https://www.medschool.umaryland.edu/media/SOM/Research-General/MAHEC/docs/2021-2022-Annual-Report-Highlights.pdf