

**OHPB Workforce Committee
Non-Traditional Health Worker Subcommittee**

**Meeting Summary
October 27, 2011 Meeting
9:00-11:30 a.m.**

Committee Members In Attendance:

- Donna Larson (Co-Chair)
- Teresa Rios-Campos (Co-chair)
- Lisa Angus
- John Saito
- Susan Pinnock
- Debra Buck
- Kelly Volkmann
- Meghan Caughey
- Rhonda Busek
- Ann Kasper
- Jean Yamamoto
- Alison Frye
- Maria Avila
- Catherine Potter
- Vinay Prasad
- Erin Fair
- Kris Anderson
- Carole Romm
- Yvette Marinosky
- Eca Wasongolo
- Maria Antonia Sanchez
- Cheryl Miller
- Jennifer Valentine
- Charles Robertson

Committee Members Present (by phone)

- Arika Bunyoli
- Dori Stanton

OHA Staff in Attendance

- Carol Cheney
- Rachel Gilmer
- Lisa Angus

Public Present

- Shawn Clark
- Judy Rinkin
- Ralph Summers
- Melissa McKinney
- Jeanine Meyer Rodriguez
- Jack Dempsey
- Mark Stevens
- Cara Railsback
- Cristina Schwartz

**Meeting Summary
(Committee actions or decisions in bold)**

Teresa Rios-Campos convened the meeting.

Regulatory Issues Overview

Ralph Summers provided context for the subcommittee's charge to help develop specific, yet standardized NTHW roles that the state/federal government reimbursement structure can pay for.

Placeholder language is needed ASAP in order to engage with CMS so changes can be made by next summer. (Language used in today's discussion will be captured in a report for Ralph). As we develop initial, detailed concept papers quickly, we will need your help with informing this language. We can go back and modify language as needed. Items which need description include:

- Description of each worker type (using terms within HB 3650); two short paragraphs of each type of role (i.e. CHW, PHN, PWS)
 - What is their scope of practice? What do they do?
- What are the “credentialing requirements” (education/competencies, training & supervision requirements)?
 - How do we know when an individual meets these requirements?

Final language will most likely require compromises given the diverse perspectives on what each worker type does. The goal is to have the specific roles clearly articulated and associated terms used pervasively.

The following questions/responses resulted from Ralph's presentation:

- In order to engage more people in this process, accessibility of these sessions/breakout sessions could be improved by: locating them closer to communities, utilizing VCON or Illuminate system capabilities, and being mindful of computer access issues.
- While our work is broader, our immediate task is to come up with these paragraphs now, which will help inform final documents by January, within one month's time of the legislative session.
- While there are a variety of regulatory approaches/authorities which may ultimately involve this work (i.e. waivers, state plans, different sections to plans, etc.), it is premature to focus here now. Instead, our main objective is to first articulate what we want to do, as a whole. Once this is understood, the various needed authorities will reveal themselves.
- We will provide an opportunity (meeting) for community members to ensure that we captured community feedback/language accurately and did not mistranslate the meaning within our world of technical language.
- Why do we have to translate back? We should try to speak in a way in which all of our communities understand, without needing translation between community and technical language.
- Yes, the information your subcommittee provides needs to fit within a couple paragraphs, which is typical in requesting permission to standardize roles through Medicaid.

Teresa reviewed the purpose, timeline and goals of the subcommittee (See handout).

NTHW Survey

Carol Cheney thanked the group for their efforts to distribute the survey and provided a brief review of the preliminary survey results. The survey closes tomorrow. The survey was collected through Survey Monkey in both English and Spanish. At least 620 people started to take the survey, with 90.6% completing the survey. There were 5 types of workers who responded to the survey: home care

worker, community health worker, peer support specialist, peer wellness specialist, and patient health navigator. Home care workers were the largest group of responders with over 300 respondents. (See power point presentation).

Some issues for follow-up include:

- Person centered language
- Difference in ethics and boundaries vs. staying within boundaries
- Issues of defining environmental health
- Avoid data skew of Home Care Commission respondents
- Large package will be sent to CMS

Core Competencies [~52 min]

Lisa Angus provided a brief overview on the group's process of developing core competencies. Ultimately, we want to be able to roll up this information so it's not super high or granular. Some homework for the group for the next 2 weeks (by the next meeting)--determine what's core to my work function vs. something I like, but is not core. We can cross validate this information with the survey. Per our discussion, from the CHW perspective, we will make sure that the 14 nationally recognized competencies are included.

OEI staff will send a reminder of this exercise to the group and will also assemble a list of resources and links for the group to utilize, including related information from the Department of Labor (DOL).

Answer questions based on your knowledge, but if you don't know, but feel that it's core, you can include it.

Certification Discussion

What is the best way to approach certification? Do we want to certify the training? Or individuals?

Factors/highlights from discussion included:

- Determining requirements, if any, by CMS
- Determining related health plan requirements
- Avoiding certain bodies regulating certification of individuals which create additional challenges for lay people involving testing, licensure fees, etc. (i.e. Board of Nursing regulating Community Health Workers)
- Competency based training and make sure that training meets standards. We want to be as inclusive
- Training certification should be the approach and community should define training content
- Training should ensure a demonstration of knowledge and skills
- We can set up the training that requires competency based exams, and show they can meet competencies, part of the training program. Knowledge dump kind of training is not what we want.

- Trainings should happen within an agency
- We need some legitimized, standardized training
- Question: If workers have gone through training already, how much work on existing groups would be required?
- internal conflict – we’ve been doing for years, participated in research project, reviewed capacitation. We looked at “what are our health promoters learning?” We don’t use “competency-based” language. We know that we have a training that works for the workers in the settings in which they work.
- We have a tendency to teach the way our communities learn. Methodology is important.
- Look to national training that provide best practices and content
- For PWS’s, we combined classroom, written assignments, weekly quizzes, personal wellness activities, internship period (hours based on level)
- There needs to be a certification body, so that employers can know person has achieved the person has received a certain level of competency. Oregon does not have certification at this point. I think that’s the next step for our state. Next step would be to have a certifying body.
- Create a state training for a program that we all have to do, then individual programs expand on the training.
- There might be people entering the CHW field who are in the process of recovery, maybe they don’t have their GED, are coming in at a disadvantage – don’t want to rule them out and enable them to enter into the field comfortably. Like the model of training certified and have competencies certified within the training.
- Nurses love to talk about competencies = had an experience years ago to talk to CHWs – had to use popular education. I learned a lot – that kind of education is what we’re looking for – I have seen CHWs giving information that is inaccurate – education/training has to be relevant, but there are certain areas where people’s health is safe.
- People come into the field at different levels – the strength is the diversity. We do have to know that people are demonstrating skills.
- It’s my responsibility as rep of an agency to assure that workers are able to perform their duties.
- It’s also the responsibility of the CHW to perform.

Public Comment

Mark Stevens – EMS Division Chief for Tualatin Valley Oregon Fire Chiefs As the pre-hospital industry we are discussing what happens

911 as safety net for health care – we’ll look for more options than we currently have. We would much rather treat them as persons and prevent them from becoming “patients”

No EMS people in the table – added EMS people by county counts. There may be some places to combine training so EMS/community needs are met. Many curricula out there from formal community paramedic training, associate degrees, first responder level training – competencies can blend in. Happy to help at local level.

We share a lot of the same competencies and are in every community in Oregon, though we do a lot of same things as CHWs. Don't go in unless called by 911.

Augment the EMS training with CHW training.

Next Steps

- Send out proposed meeting dates for mid-November
- Set up a resources list on web -