



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

AGENDA

November 21 2011 - 1:00 – 4:00 pm

Portland State Office Building Room 1E

800 NE Oregon Street, Portland, OR 97232

and

DHS Human Services Building

500 Summer Street, NE, Room 350, Salem, OR 97301

#	Time	Topic	Content	Who
1	15 min 1:00 – 1:15	Agenda Review/ Subcommittee Purpose	<ul style="list-style-type: none"> Welcome Name/Affiliation Introductions Agenda Review and Reminder of Purpose Meeting Goals 	Co-Chair Teresa Rios-Campos
2	20 min 1:15 – 1:35	Survey Updates	<ul style="list-style-type: none"> Update on NTHW Survey (first survey) NTHW Core Competencies Survey 	Carol Cheney
3	30 min 10:00 – 10:15	Core Competencies	<ul style="list-style-type: none"> Review proposal in small groups Small Group Report out Consensus Check and Discussion 	Co-Chair Donna Larson
4	10 min 10:15 – 10:25	Public Comment		Public
5	10 min 10:25 – 10:35	Break		
6	45 min 10:35 – 11:20	Certification	<ul style="list-style-type: none"> Review Sample Recommendations for Certification Options (Training/Individuals) Small Group report out and Discussion 	Teresa Rios-Campos
7	10 min 11:20 – 11:30	Public Comment		Public
8	15 min 11:30 – 11:45	Certification Continued	<ul style="list-style-type: none"> Consensus Check 	Donna Larson
9	11:45 – 12:00	Next Steps	Draft Recommendations/Report Presentation to Workforce Committee?	Co-Chairs

Next meeting

TBD

Contact Person

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Non-Traditional Health Workers: Core vs. Optional SurveyMonkey Competencies

1. Outreach and Mobilization - Please indicate whether the following roles are core or optional position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Program recruitment and case finding (e.g. eligibility & enrollment)	50.0% (5)	50.0% (5)	0.0% (0)	0.0% (0)
Information dissemination	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)
Provision of services in home or community setting	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Encouraging people to use care & community resources	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)
Building partnerships with local agencies and groups	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Program recruitment and case finding (e.g. eligibility & enrollment)	0.0% (0)	75.0% (3)	0.0% (0)	25.0% (1)
Information dissemination	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Provision of services in home or community setting	66.7% (2)	33.3% (1)	0.0% (0)	0.0% (0)
Encouraging people to use care & community resources	100.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)
Building partnerships with local agencies and groups	60.0% (3)	20.0% (1)	0.0% (0)	20.0% (1)

Personal Health Navigator

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	Core	Optional	N/A for this worker	Don't know
Program recruitment and case finding (e.g. eligibility & enrollment)	50.0% (2)	25.0% (1)	0.0% (0)	25.0% (1)
Information dissemination	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Provision of services in home or community setting	66.7% (2)	0.0% (0)	33.3% (1)	0.0% (0)
Encouraging people to use care & community resources	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Building partnerships with local agencies and groups	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)

Other (When stating other roles, please indicate whether they are core or optional for your position)

answered question
skipped question

2. Community & cultural liaison - Please indicate whether the following roles are core or optional position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Community or individual advocacy	100.0% (12)	0.0% (0)	0.0% (0)	0.0% (0)
Translation and interpretation (linguistic or other)	72.7% (8)	27.3% (3)	0.0% (0)	0.0% (0)
Educating service systems about community needs and perspectives	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Build individual and community capacity	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Community or individual advocacy	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Translation and interpretation (linguistic or other)	0.0% (0)	25.0% (1)	50.0% (2)	25.0% (1)
Educating service systems about community needs and perspectives	50.0% (2)	25.0% (1)	0.0% (0)	25.0% (1)
Build individual and community capacity	40.0% (2)	40.0% (2)	0.0% (0)	20.0% (1)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Community or individual advocacy	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Translation and interpretation (linguistic or other)	25.0% (1)	50.0% (2)	0.0% (0)	25.0% (1)
Educating service systems about community needs and perspectives	75.0% (3)	0.0% (0)	0.0% (0)	25.0% (1)

Build individual and community capacity	60.0% (3)	20.0% (1)	0.0% (0)	20.0% (1)
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Other (When stating other roles, please indicate whether they are core or optional for your position)

	answered question
	skipped question

3. Case management and care coordination - Please indicate whether the following roles are core or optional to your position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Referrals, coordination, and follow-up	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Crisis management support	60.0% (6)	40.0% (4)	0.0% (0)	0.0% (0)
Ensuring that appropriate medical records are available as needed	50.0% (5)	40.0% (4)	10.0% (1)	0.0% (0)
Goal setting and action planning	72.7% (8)	18.2% (2)	9.1% (1)	0.0% (0)
Informal emotional or psychological support	81.8% (9)	18.2% (2)	0.0% (0)	0.0% (0)
Documentation	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Referrals, coordination, and follow-up	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Crisis management support	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Ensuring that appropriate medical records are available as needed	0.0% (0)	75.0% (3)	25.0% (1)	0.0% (0)
Goal setting and action planning	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)

Informal emotional or psychological support	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Documentation	60.0% (3)	20.0% (1)	0.0% (0)	20.0% (1)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Referrals, coordination, and follow-up	80.0% (4)	20.0% (1)	0.0% (0)	0.0% (0)
Crisis management support	60.0% (3)	20.0% (1)	20.0% (1)	0.0% (0)
Ensuring that appropriate medical records are available as needed	50.0% (2)	25.0% (1)	25.0% (1)	0.0% (0)
Goal setting and action planning	25.0% (1)	50.0% (2)	0.0% (0)	25.0% (1)
Informal emotional or psychological support	40.0% (2)	40.0% (2)	0.0% (0)	20.0% (1)
Documentation	60.0% (3)	20.0% (1)	0.0% (0)	20.0% (1)

Other (When stating other roles, please indicate whether they are core or optional for your position)

answered question
skipped question

4. System Navigation - Please indicate whether the following roles are core or optional to your

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Information dissemination & education	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)
Translation & interpretation (linguistic or other)	72.7% (8)	27.3% (3)	0.0% (0)	0.0% (0)
Goal setting and action planning	72.7% (8)	18.2% (2)	9.1% (1)	0.0% (0)
Problem solving (direct or coaching)	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Referrals, coordination, and follow-up	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Documentation	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Information dissemination & education	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)
Translation & interpretation (linguistic or other)	0.0% (0)	75.0% (3)	25.0% (1)	0.0% (0)
Goal setting and action planning	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Problem solving (direct or coaching)	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Referrals, coordination, and follow-up	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Documentation	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Information dissemination & education	80.0% (4)	0.0% (0)	0.0% (0)	20.0% (1)

Translation & interpretation (linguistic or other)	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Goal setting and action planning	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Problem solving (direct or coaching)	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Referrals, coordination, and follow-up	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Documentation	75.0% (3)	0.0% (0)	25.0% (1)	0.0% (0)

Other (When stating other roles, please indicate whether they are core or optional for your position)

answered question
skipped question

5. Health Promotion and Coaching (Individual or Group) - Please indicate whether the following core or optional to your position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Basic health services (e.g. BP screening)	18.2% (2)	54.5% (6)	27.3% (3)	0.0% (0)
Health promotion & wellness guidance	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Coaching & support for behavior change or self-management	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Goal setting and action planning	81.8% (9)	9.1% (1)	9.1% (1)	0.0% (0)
Problem solving (direct or coaching)	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)
Treatment adherence support	63.6% (7)	36.4% (4)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Basic health services (e.g. BP screening)	0.0% (0)	75.0% (3)	25.0% (1)	0.0% (0)
Health promotion & wellness guidance	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Coaching & support for behavior change or self-management	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Goal setting and action planning	75.0% (3)	0.0% (0)	25.0% (1)	0.0% (0)
Problem solving (direct or coaching)	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Treatment adherence support	50.0% (2)	25.0% (1)	25.0% (1)	0.0% (0)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know

Basic health services (e.g. BP screening)	0.0% (0)	66.7% (2)	33.3% (1)	0.0% (0)
Health promotion & wellness guidance	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Coaching & support for behavior change or self-management	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Goal setting and action planning	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Problem solving (direct or coaching)	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Treatment adherence support	33.3% (1)	33.3% (1)	33.3% (1)	0.0% (0)

Other (When stating other roles, please indicate whether they are core or optional for your position.)

answered question
skipped question

6. Self-sufficiency promotion - Please indicate whether the following roles are core or optional position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Promote autonomy, self-advocacy, sense of self-worth, etc.	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Encourage informed decision-making	100.0% (11)	0.0% (0)	0.0% (0)	0.0% (0)
Informal emotional or psychological support	90.9% (10)	9.1% (1)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Promote autonomy, self-advocacy, sense of self-worth, etc.	100.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)
Encourage informed decision-making	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Informal emotional or psychological support	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Promote autonomy, self-advocacy, sense of self-worth, etc.	100.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)
Encourage informed decision-making	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Informal emotional or psychological support	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)

Other (When stating other roles, please indicate whether they are core or optional for your position)

answered questio

7. Instrumental assistance in support of health, recovery, or system navigation - Please indicate whether the following roles are core or optional to your position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Assistance with paperwork	63.6% (7)	36.4% (4)	0.0% (0)	0.0% (0)
Health with transport and/or child care	40.0% (4)	50.0% (5)	0.0% (0)	10.0% (1)
Assistance with meeting basic needs (e.g. food, housing, employment, etc.)	63.6% (7)	36.4% (4)	0.0% (0)	0.0% (0)
Assistance with obtaining financial support	45.5% (5)	54.5% (6)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Assistance with paperwork	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Health with transport and/or child care	0.0% (0)	50.0% (2)	50.0% (2)	0.0% (0)
Assistance with meeting basic needs (e.g. food, housing, employment, etc.)	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Assistance with obtaining financial support	25.0% (1)	50.0% (2)	0.0% (0)	25.0% (1)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Assistance with paperwork	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Health with transport and/or child care	25.0% (1)	75.0% (3)	0.0% (0)	0.0% (0)

Assistance with meeting basic needs (e.g. food, housing, employment, etc.)	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Assistance with obtaining financial support	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)

Other (When stating other roles, please indicate whether they are core or optional for your position)

answered question
skipped question

8. Data collection and/or research - Please indicate whether the following roles are core or optional for your position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Assessment or data collection to identify individual or community health needs	45.5% (5)	45.5% (5)	9.1% (1)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Assessment or data collection to identify individual or community health needs	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Assessment or data collection to identify individual or community health needs	25.0% (1)	75.0% (3)	0.0% (0)	0.0% (0)

Other (When stating other roles, please indicate whether they are core or optional for your position)

answered question
skipped question

9. Workforce Development - Please indicate whether the following roles are core or optional to position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Training new or other non-traditional health workers	33.3% (4)	58.3% (7)	8.3% (1)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Training new or other non-traditional health workers	0.0% (0)	80.0% (4)	0.0% (0)	20.0% (1)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Training new or other non-traditional health workers	0.0% (0)	80.0% (4)	0.0% (0)	20.0% (1)

Other (When stating other roles, please indicate whether they are core or optional for your position)

answered question
skipped question

10. Please indicate whether the following competencies are core or optional to your position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Communication skills	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Cultural competency/responsiveness	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Teaching, adult learning, and interpersonal motivation	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Conflict Resolution	70.0% (7)	30.0% (3)	0.0% (0)	0.0% (0)
Crisis intervention skills	70.0% (7)	30.0% (3)	0.0% (0)	0.0% (0)
Outreach	80.0% (8)	20.0% (2)	0.0% (0)	0.0% (0)
Advocacy	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Community organizing and assessment	70.0% (7)	30.0% (3)	0.0% (0)	0.0% (0)
Leadership	80.0% (8)	10.0% (1)	10.0% (1)	0.0% (0)
Organization & documentation	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Ethical and legal responsibilities	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Professional conduct (relationship boundaries, etc.)	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Knowledge of the field (e.g. paths to recovery, best practices for health promotion, etc.)	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Knowledge of the relevant health and social service systems	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Knowledge of social determinants of health	90.0% (9)	10.0% (1)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
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Communication skills	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Cultural competency/responsiveness	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Teaching, adult learning, and interpersonal motivation	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Conflict Resolution	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Crisis intervention skills	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Outreach	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Advocacy	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Community organizing and assessment	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Leadership	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Organization & documentation	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Ethical and legal responsibilities	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Professional conduct (relationship boundaries, etc.)	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Knowledge of the field (e.g. paths to recovery, best practices for health promotion, etc.)	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Knowledge of the relevant health and social service systems	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Knowledge of social determinants of health	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Communication skills	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Cultural competency/responsiveness	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)

Teaching, adult learning, and interpersonal motivation	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Conflict Resolution	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Crisis intervention skills	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Outreach	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Advocacy	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Community organizing and assessment	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)
Leadership	66.7% (2)	33.3% (1)	0.0% (0)	0.0% (0)
Organization & documentation	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Ethical and legal responsibilities	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Professional conduct (relationship boundaries, etc.)	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Knowledge of the field (e.g. paths to recovery, best practices for health promotion, etc.)	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Knowledge of the relevant health and social service systems	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Knowledge of social determinants of health	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)

Other (When stating other competencies, please indicate whether they are core or optional for your position)

answered question
skipped question

11. Please indicate whether the following qualities are core or optional to your position.

Community Health Worker

	Core	Optional	N/A for this worker	Don't know
Similar life experience (community member, experience with recovery, etc.)	70.0% (7)	20.0% (2)	10.0% (1)	0.0% (0)
Respect and value for others, others' perspectives	100.0% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Holistic approach	80.0% (8)	20.0% (2)	0.0% (0)	0.0% (0)

Peer Wellness Specialist

	Core	Optional	N/A for this worker	Don't know
Similar life experience (community member, experience with recovery, etc.)	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)
Respect and value for others, others' perspectives	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Holistic approach	50.0% (2)	50.0% (2)	0.0% (0)	0.0% (0)

Personal Health Navigator

	Core	Optional	N/A for this worker	Don't know
Similar life experience (community member, experience with recovery, etc.)	25.0% (1)	75.0% (3)	0.0% (0)	0.0% (0)
Respect and value for others, others' perspectives	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)
Holistic approach	75.0% (3)	25.0% (1)	0.0% (0)	0.0% (0)

Other (When stating other qualities, please indicate whether they are core or optional for your position)

answered question

Page 2, Q1. Outreach and Mobilization - Please indicate whether the following roles are core or optional to your position.

1	Building individual and community capacity Providing informal counseling and social support Advocating for individuals and communities Ensuring that people get the services they need Providing culturally appropriate and accessible health education and information using popular education methods. Promoting cultural mediation between communities and the health care system	Nov 6, 2011 7:21 PM
2	Community outreach events - core	Nov 5, 2011 11:00 AM

Page 2, Q2. Community & cultural liaison - Please indicate whether the following roles are core or optional to your position.

1	Translation and interpretation: it depends on what kind. Most CHWs interpret medical social services language. but many CHWs are also taken away from their core work; to provide linguistic translation should be provide by trained interpreters.	Nov 14, 2011 3:47 PM
2	Peer Wellness Specialist 1& II work to help individuals being served increase their sense of self-determination. This is partly done by role-modeling self - determined behavior.	Nov 9, 2011 11:16 AM

Page 2, Q3. Case management and care coordination - Please indicate whether the following roles are core or optional to your position.

1	Most CHWs do crisis management but in some settings it could take over a CHWs' life.	Nov 14, 2011 3:47 PM
2	Peer wellness specialists I are part of mental health treatment team. Peer Wellness Specialist II can be part of primary care treatment team. At time a peer wellnesss specialist 1 will funciton also as member of primary care treatment team.	Nov 9, 2011 11:16 AM
3	CHW and health navigator- Core: functioning as part of the primary care team	Nov 8, 2011 6:29 PM
4	Providing direct services (such as: demostrating and reinforcing use of glucometers by patients with diabetes, administrating health screening test, etc.	Nov 6, 2011 7:21 PM
5	Comprehensive Individuall and family needs assessment - core	Nov 5, 2011 11:00 AM

Page 2, Q4. System Navigation - Please indicate whether the following roles are core or optional to your position.

1	Peer Wellness Specialists use a person-driven approach to helping individuals being served create Wellness Action Plans.	Nov 9, 2011 11:16 AM
2	Using Popular education methodology to teach complicated methods in a way that individuals and communities can understand their illness, how to control Popular education methodology empower individuals and communities to take control over their own life and decisions. Leadership Skills development (advocating for their own needs)	Nov 6, 2011 7:21 PM

Page 2, Q5. Health Promotion and Coaching (Individual or Group) - Please indicate whether the following roles are core or optional to your position.

1	blood-pressure screening is core for Peer Specialist II. Optional for Peer Specialist I. Diabetes and cardiovascular risk assessment is core for Peer Wellness Specialist II.	Nov 9, 2011 11:16 AM
2	Prevention activities Community Organizing	Nov 6, 2011 7:21 PM
3	CHW's used to support chronic disease management would provide basic health services under the training and delegation of a registered nurse in our program - core	Nov 5, 2011 11:00 AM

Page 2, Q6. Self-sufficiency promotion - Please indicate whether the following roles are core or optional to your position.

1	I would include "community and individual empowerment" as a core role in this area.	Nov 15, 2011 2:00 PM
2	Use strength-based approach to interventions and interactions with individuals being served--core.	Nov 9, 2011 11:16 AM

Page 2, Q7. Instrumental assistance in support of health, recovery, or system navigation - Please indicate whether the following roles are core or optional to your position.

1	I don't think transportation should be considered a role (core or optional), since it could easily dominate a CHW's life if the organization and the CHW let it.	Nov 14, 2011 3:47 PM
2	Our CHW's are not allowed to transport clients in their own cars, but arrange for transportation and may accompany clients in that mode - core	Nov 5, 2011 11:00 AM

Page 2, Q8. Data collection and/or research - Please indicate whether the following roles are core or optional to your position.

1	Peer Wellness specialists use several outcome measurement tools. Their interventions are outcome -informed.	Nov 9, 2011 11:16 AM
2	Cultural mediation between communities and researchers Assist research to interpret the data from communities.	Nov 6, 2011 7:21 PM

Page 2, Q9. Workforce Development - Please indicate whether the following roles are core or optional to your position.

1	Peer Wellness specialist who have completed the state approved traing and worked in the field for at least a year may elect to go through the process of learning to be a trainier.	Nov 9, 2011 11:16 AM
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Page 3, Q10. Please indicate whether the following competencies are core or optional to your position.

1	CHW and health navigator: principles of prevention and public health theory (Core); health literacy (core);	Nov 8, 2011 6:32 PM
2	Knowledge of basic anatomy and physiology - core	Nov 5, 2011 11:02 AM

Page 4, Q11. Please indicate whether the following qualities are core or optional to your position.

1	Internally strong and courageous, with healthy self-esteem (Core) Open -minded and non-judgmental (core) Patient (core) Motivated and capable of self-directed work (core) Caring, compassionate (core) Honest (core) Committed and dedicated (core) Open and eager to growth, change and learn (core) Dependable, responsible, reliable (core) Flexible and adaptable (core) Desire to help improve their communities (core) Persistent (core) Creative and resourceful (core) Sense of humor (core) Supportive (helping) rather than directive (telling what to do) (core) Emotionally mature (core A model for trying to live healthy lifestyles (core)	Nov 14, 2011 3:56 PM
2	Model coping skills - core	Nov 5, 2011 11:04 AM

Well, I give thanks to God for putting me in this path, and God willing we are going to get a lot of benefit out of this course, out of these discussions, out of these interviews, out of everything we had, we are going to "get the juice out," as they say over there.
Lupe, promotora de salud

Report on the *La Palabra es Salud* (The Word is Health) Study Parish Health Promoter Program

Executive Summary

In the fall of 2008, a study was conducted in the context of the Westside Parish Health Promoter Program (PHPP). The purpose of the study was to compare the relative effectiveness of popular education vs. traditional education as philosophies and methods for training Community Health Workers (CHWs), known in Spanish as *promotores/as de salud* (health promoters). Additionally, this study sought to determine what elements of popular education may contribute to its effectiveness; what elements contribute to the success of a CHW training program, regardless of the methodology that is used in the training; and what benefits and costs may accrue to a CHW training program as a result of being involved in research. The study was conducted by Noelle Wiggins in partial fulfillment of the requirements of the doctoral program in Educational Leadership at Portland State University. The study employed a quasi-experimental design, mixed methods, and a community-based participatory research (CBPR) framework.

Results revealed that both experimental groups made statistically significant gains in health knowledge when compared to a control group. Within-group comparisons showed that the popular education (PE) group made statistically significant improvements in self-reported ability to promote health, critical consciousness, and on a global measure of empowerment, while the traditional education (TE) group made significant gains in critical consciousness, control at the personal level, self-reported health status, and self-reported health behavior. Because the TE group was almost twice as large as the PE group, almost identical changes that achieved significance in the TE group did not achieve significance in the PE group. Results of the qualitative analysis validated the quantitative results, with members of the TE group reporting improvements in health knowledge and behavior while members of the PE group reported increased empowerment and ability to empower others. Our findings suggest that, when compared to traditional education, popular education can help participants develop a deeper sense of empowerment and community and more multi-faceted skills and understandings, with no accompanying sacrifice in the acquisition of knowledge.

Additionally, findings suggested that popular education brings about change by setting the stage, building trust, drawing out and affirming what participants already know, encouraging open communication and assuring understanding, creating an environment of equality, using a variety of interactive techniques, encouraging and balancing participation, and creating a sense of community. Benefits to the PHPP of participation in the study included higher quality sessions, better organization, and the creation of an Advisory Council, while costs included impacts on the relationship between the Coordinator and the participants, some overly ambitious sessions, decreased flexibility, and decreased attention to existing CHWs and parishes. Elements that appeared to contribute to the success of the CHW training course, regardless of the methodology, included a religious or spiritual component, *convivencia* or fellowship, high quality sessions, new and complete information, certain qualities of the facilitators (knowledge, charisma, clarity, use of effective materials, and shared life experience), as well as certain characteristics of the Project Team, such as *personalismo* and shared purpose.

Background to the Study

Popular Education

Popular education, from the Spanish “educación popular,” is a mode of teaching and learning which seeks to bring about more just and equitable social, political, and economic relations. Consistent with the Spanish and Portuguese definitions of “popular” as “of the common people,” popular education emphasizes the value of the knowledge that common people gain through life experience and seeks to create situations in which common people can discover and expand their knowledge and use it to solve problems in their communities. Through the use of interactive techniques such as *dinámicas* (social learning games), *sociodramas* (social skits), brainstorming, simulations, and problem-posing, popular education draws out and validates what participants already know and do, connects their personal experience to larger social realities, and then supports participants to work collectively to change their reality. Unlike traditional or conventional education, where the teacher is considered to be the expert, in popular education students are regarded as having their own expertise. Popular educators are encouraged to create educational settings that prefigure the society they are attempting to create, by treating students as equals and embodying values such as compassion, humility, and commitment to the cause of the people.

Popular Education in Public Health

Popular education (also referred to as Freirian and empowerment education) has been used and documented in public health since the early 1980s (Minkler & Cox, 1980). The use of popular education in public health has been associated with a number of empowerment-related outcomes, including people taking more control over their lives and health, increased self-esteem and self-confidence, undertaking actions to improve the community and help fellow community members, increased participation, increased activity to bring about change through advocacy, development of critical consciousness, and increased perception of riskiness and future orientation. It has also been associated with positive change on a number of *health-related* outcomes, including health behavior change, increased health knowledge, improved health literacy, and improvements in physical markers of health risk factors. Popular education has proved particularly effective when used in concert with the Community Health Worker (CHW) model.

Community Health Workers (CHWs)

CHWs are carefully-chosen community members who participate in training so that they can promote health in their own communities. A variety of studies have demonstrated CHWs’ potential roles in addressing health disparities, whether by changing individual behavior, changing the health care system, or advocating for community level change. A 2006 WHO report (Wallerstein) characterized the CHW model as a “key empowerment strategy” even apart from CHWs’ role in promoting participation, a critical component of empowerment.

Purpose of the Study and Research Questions

The purpose of *La Palabra es Salud* was to rigorously compare the relative effectiveness of popular education and traditional education as methods for increasing skills and knowledge and empowering Community Health Workers (CHWs), known in Spanish as *promotores/as de salud* (health promoters). Additionally, this study sought to determine what elements of popular education may contribute to its effectiveness; what elements contribute to the success of a CHW training program, regardless of the methodology that is used in the training; and what benefits and costs may accrue to a CHW training program as a result of being involved in research. Specifically, the study sought to answer four primary research questions and two secondary research questions:

Primary Questions

1. Is type of instruction (popular education vs. traditional education) associated with any changes in health knowledge and skills, psychological empowerment, self-reported health status, and health behavior among participants in a parish-based Community Health Worker training program? If so, what is the nature and strength of the association?
2. Do any changes from baseline to follow-up among parish-based CHWs who participate in training differ systematically from temporal changes that may occur among members of a comparable parish community who do not participate in any type of training?
3. What changes, if any, do the CHWs perceive in themselves, their families, and their communities as a result of the CHWs' participation in training? Do these self-reported outcomes differ as a result of the type of training that is used?
4. From the perspectives of the participants and the researcher, how does popular education work, if it does? What elements of popular education contribute to its differential effects, if indeed these exist?

Secondary Questions

5. From the perspective of the researcher and the project team, what costs and benefits accrue to a CHW training program as a result of being involved in a research project?
6. From the perspective of the CHWs and the researcher, what elements contribute to the success of a CHW training program, regardless of the methodology that is used in the training?

Methods

Setting and Intervention

The La Palabra study took place in the context of the Parish Health Promoter Program (PHPP). The PHPP attempts to improve the health of the Latino immigrant community in Portland, Oregon and develop local leadership to address the causes of health problems by recruiting and training members of the Spanish-speaking congregations of Catholic and Episcopal parishes as Community Health Workers (CHWs). After completing their training, the CHWs engage in a variety of activities designed to improve the health of people in their parish communities. The Westside PHPP is a project of Providence St. Vincent Medical Center, in collaboration with Catholic parishes. The Eastside PHPP is a partnership between Providence Portland Medical Center and Catholic Charities' El Programa Hispano, in collaboration with Catholic and Episcopal parishes.

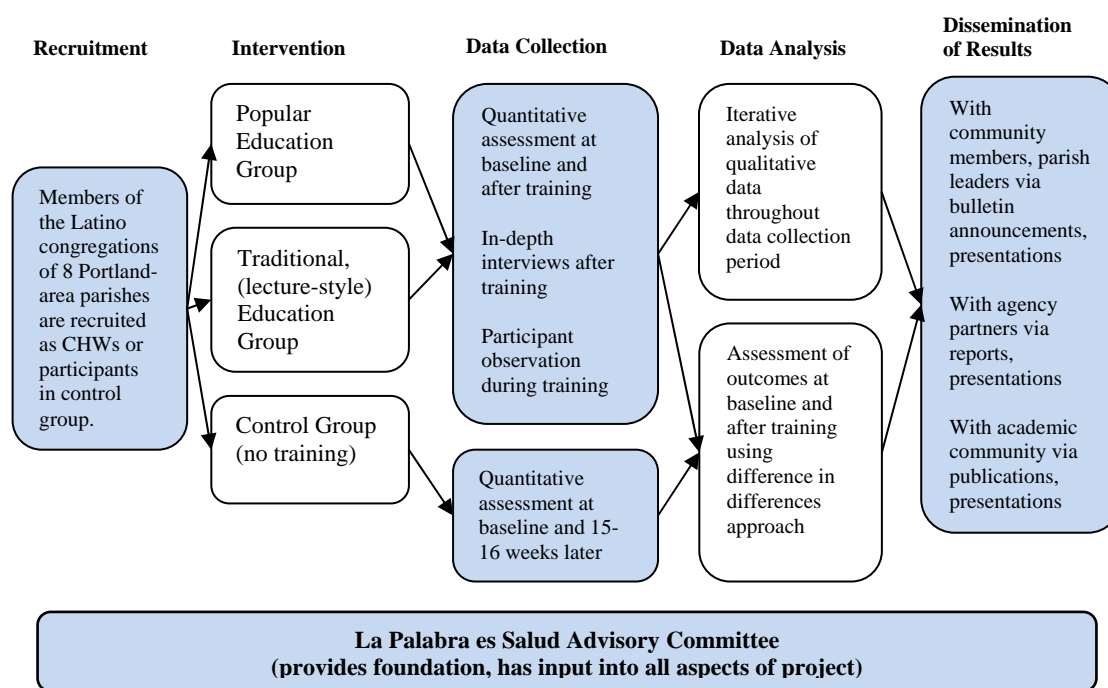
For the purposes of the study, one group of new CHWs participated in an intensive, 14-week training course using popular education (PE group, n=15), while a second group of new CHWs received training of identical duration and content using traditional education (TE group, n=29). Members of a Latino congregation not involved in the intervention and who did not participate in training served as controls (n=24). Topics covered in the courses included: 1) Orientation to the Training Series and the Research Project; 2) Leadership Skills and Role of the Community Health Worker; 3) Teaching Skills; 4) Social Determinants of Health; 5) Exercise Anatomy and Physiology; 6) Nutrition and Food Safety; 7) Diabetes Prevention and Management; 8) Heart Health/Hypertension; 9) Mental and Emotional Health Promotion; 10) First Aid and CPR; 11) Navigating the Health Care System/When to go to the doctor/Vaccines and Fever; 12) CHW Skills: Making referrals, confidentiality, advocacy; 13) Hospital visit/Mission focus/Financial assistance; and 14) *Ceremonia de Compromiso* (Commitment Ceremony)/Project Report-Out.

Research Paradigm and Design

The research paradigm employed in this study was community based participatory research (CBPR). The W.K. Kellogg Foundation Community Health Scholars Program defines CBPR as “a collaborative approach to research that equitably involves all participants in the research process and recognizes the unique strengths that each brings” (2001, n.p.). Pursuant to CBPR principles and practices, the research was guided by a Project Team that included the researcher, PHPP staff, and two experienced CHWs. An Advisory Team composed of all Project Team members, additional experienced CHWs, and parish leaders advised about research methods and helped to interpret study findings.

Outcome variables were assessed before the new CHWs began their training and immediately after the training was complete via a questionnaire. In addition, participant observation and in-depth interviews were conducted to better understand what elements of popular education contributed to its differential effects, if these existed.

Figure 1: Research Design



Data Collection

CHW Questionnaire

The principal quantitative data collection tool was a written self-assessment which CHWs completed in the language of their choice before and after the intervention. It was the primary data source used to determine whether type of instruction was associated with differential changes in the dependent variables: health knowledge, ability to share health information, empowerment, self-reported health status, and health behavior. In addition, information was collected on a number of demographic variables, including age, gender, level of formal education, birthplace, average annual household income, household size, marital status, primary language, and number of years the respondent had been in the U.S. The questionnaire was translated into Spanish and back-translated into English and pilot-tested with 23 community members who were similar to those who would participate in the training.

In-depth Interviews

Semi-structured in-depth interviews were conducted with a purposive sample of 12 CHWs, six from the popular education group and six from the traditional education group. In order to guard against biasing findings in any direction, the researcher developed a purposive sample that was diverse in terms of demographic characteristics (such as age and years in the U.S.) and amount of change from baseline to follow-up on the quantitative variables. The initial list of potential interviewees was also influenced by input solicited from the Project Team. In order to protect participants' confidentiality, aliases were assigned to all of the CHWs who participated in the in-depth interviews. Those aliases are used when results of the interviews are reported.

Interviews with CHWs occurred in January and February, 2009, after completion of the initial training but before a session on February 7, 2009, in which participants from both experimental groups were debriefed about the research. All the interviews took place in participants' homes and lasted between 30 minutes and one hour. Interviews were recorded and then transcribed by a professional transcriptionist in Spanish.

Field Notes

The researcher attended 12 of 14 CHW training sessions (both popular education and traditional education) as a participant observer. In the training sessions and meetings she observed, the researcher took detailed notes on a laptop computer, documenting the content of verbal discussions and nonverbal exchanges or communication. After the classes and meetings, the researcher produced a set of field notes. She also collected and filed any documents or materials distributed at the meeting or capacitation session.

Participant Evaluation Forms

With the exception of one session, Participant Evaluation Forms (PEFs) were distributed and completed by each CHW at the end of every class. In addition to quantitative questions on a five-point Likert-type scale, PEFs included two open-ended questions – “What did you like or find useful about the class?” and “How could the class be improved?” – that were useful in answering the question under consideration in this study.

Data Analysis and Interpretation

Quantitative Data

To develop demographic profiles of the participants at baseline and follow-up, descriptive statistics such as means (with 95% confidence intervals), standard deviations, skewness and kurtosis were calculated. To determine whether the groups differed significantly on the continuous demographic variables at baseline, one-way ANOVA was used. To obtain the same information for the categorical demographic variables, hi-square statistics were calculated. To assess changes within and between the three groups from baseline to follow-up, mixed factorial ANOVA was used. To test for simple effects for the within subjects factor in the case of a significant interaction, paired t tests were conducted. Paired t tests were also used to test for significant changes among members of the two experimental groups in the absence of a significant interaction. Cronbach's alphas were computed to investigate the internal reliability of the scales and sub-scales included in the questionnaire for which there were no right and wrong answers. To investigate the correlation of scales in the questionnaire, correlation analysis was used. For the Likert scale items on the Participant Evaluation Forms, means were computed for each question for each session, and then an overall mean score for that session was computed. Next, sessions were ranked for both groups separately from most favorable to least favorable.

Qualitative Data

The researcher began conducting the analysis manually in Microsoft Word. After doing open coding on five interview transcripts, the researcher entered the data into Atlas ti and conducted the remainder of the analysis in this qualitative data analysis (QDA) program. Using the QDA program allowed the researcher to retrieve quotations more quickly.

As much as possible, the researcher began to code field notes soon after they had been created, and before the next participant observation session. This was not possible for the in-depth interview transcripts because of the time frame within which interviews had to be conducted. The researcher used an approach to coding which fell somewhere between the classic “grounded” approach (Strauss and Corbin, 1990) and the pre-structured approach described by Miles and Huberman (1994). Early in the analysis, the researcher developed a coding scheme based on a list of higher-level codes drawn from the research questions.

In the case of the three open-ended questions on the Participant Evaluation Forms, a report was prepared which included all the comments, organized by session and respondent (although responses were anonymous). After reviewing all the data to identify patterns and trends, the researcher created a matrix in which she listed the most frequent responses by session for each experimental group. She created additional matrices for each experimental group that were not divided by session but rather identified the most common responses. Creating both matrices helped the researcher to distinguish between comments which were specific to particular sessions, and comments which were common across sessions, and thus representative of reactions to the two methodologies.

Results

Q1. Is type of instruction (popular education vs. traditional education) associated with any changes in health knowledge and skills, psychological empowerment, self-reported health status, and health behavior among participants in a parish-based Community Health Worker training program? If so, what is the nature and strength of the association?

Type of instruction was not significantly associated with any changes in the outcome variables. However, paired t tests revealed that participants in the PE group made statistically significant gains in four domains: health knowledge, self-reported ability to promote health, critical consciousness, and a global measure of empowerment. Participants in the TE group improved significantly in five domains: health knowledge, control at the personal level (self-efficacy), critical consciousness, self-reported health status, and self-reported health behavior. When considering these results, it is important to keep in mind that the TE group was almost twice as large as the PE group. This meant that almost identical gains among participants in the PE and TE groups on some scales (such as self-reported health status) reached statistical significance in the TE group but not in the PE group. All members of the PE group increased their health knowledge from baseline, while this was not the case for members of the TE group.

Q2. Do any changes from baseline to follow-up among parish-based CHWs who participate in training differ systematically from temporal changes that may occur among members of a comparable parish community who do not participate in any type of training?

Members of both experimental groups made statistically significant increases in health knowledge compared to members of the control group.

Q3. What changes, if any, do the CHWs perceive in themselves, their families, and their communities as a result of the CHWs' participation in training? Do these self-reported outcomes differ as a result of the type of training that is used?

Results of the analysis of the three qualitative data sources, combined with the results of the quantitative analysis, suggest that participants in the PE group experienced a more pronounced increase in empowerment, while improvements in health behavior were more common among members of the TE group. On a wide range of domains, changes in the PE group were more multi-faceted, while changes in the TE group were more focused on health, strictly defined. PE participants spoke more frequently than members of the TE group about improvements in their general empowerment and used more evocative language to describe the changes. In addition, PE participants made statements related to increases in collective efficacy and participation, while TE participants did not. The interviews also suggested that participants tended to internalize the spoken or unspoken values and assumptions associated with both methodologies, with TE participants being more judgmental of themselves and others while PE participants exhorted each other to participation.

Two quotations – one from a PE participant and one from a TE participant – seem to sum up the difference in the changes that occurred in members of the two groups. Hilario, a TE participant, summarized the changes he had experienced this way: “The difference [between how I was before the course and how I am now] I would locate it in the knowledge. That’s the difference: in the knowledge that we have now.” For her part, Lupe, a PE participant, characterized her own changes like this: “I have learned a lot of things that have made my life more full . . . most of all, how to be able to help people, how to participate . . .”

Overwhelmingly, when TE participants were asked what they had learned or how they had changed as a result of participating in the CHW training course, they spoke about the *facts about health* that they had learned, and how they were putting these facts to use personally and in their families. When PE participants were asked the same questions, they were much more likely than the TE participants to talk about changes in their own feelings of capacity, and how these feelings of increased capacity had led them to do things that they had never thought they could do. In addition, they talked about how they were passing on their newfound skills to others in their community.

Q4. From the perspectives of the participants and the researcher, how does popular education work, if it does? What elements of popular education contribute to its differential effects, if indeed these exist?

Results of in-depth interviews with the participants, Participant Evaluation Forms, and participant observation suggested that popular education brings about change by setting the stage (through mechanisms such as posting an agenda and seating participants in a semi-circle), building trust (using methods like *dinámicas* and developing group norms), drawing out and affirming what participants already know, encouraging open communication (by validating contributions and assuring all questions are answered), creating an environment of equality, using a variety of interactive techniques, encouraging and balancing participation, and creating a sense of community. Even though they were not exposed to popular education as such, participants in the TE group requested some of these same practices and commented appreciatively when they were present.

Q5. From the perspective of the researcher and the project team, what costs and benefits accrue to a CHW training program as a result of being involved in a research project?

Participating in *La Palabra es Salud* produced both benefits and costs for the PPHP and its staff. On the programmatic level, benefits included higher quality sessions, better organization, and the creation of an Advisory Council, while costs included impacts on the relationship between the Coordinator and the participants, ambitious sessions that occasionally overwhelmed participants, decreased flexibility, and decreased attention to existing CHWs and parishes. On a personal level, the primary cost was additional stress for all team members, especially the Coordinator. Benefits

included new skills and knowledge, personal growth, and mutual support which helped to allay the stress.

Q6. From the perspective of the CHWs and the researcher, what elements contribute to the success of a CHW training program, regardless of the methodology that is used in the training?

Data from the in-depth interviews, the Participant Evaluation Forms, and field notes suggested that the elements that contribute to the success of a CHW training course in the Latino immigrant community, regardless of the methodology, include a religious or spiritual component, *convivencia* or fellowship, high quality sessions, new and complete information, certain qualities of the facilitators (knowledge, charisma, clarity, use of effective materials, and shared life experience), as well as certain characteristics of the Project Team, such as *personalismo* and shared purpose.

Other Results

The qualitative methods provided additional information about topics that were not specifically addressed in the research questions. For example, the prevalence and health impacts of stress in the Latino community was a topic of high interest and concern among the CHWs, who undertook both individual and collective actions to reduce stress in their own lives and in their community. Responses in the in-depth interviews made it clear that the parish health promoter training course held a special significance in the lives of the popular education participants. They expressed gratitude and determination to use what they had learned to help their communities, stated that the course had changed their lives, and showed willingness to be involved as role models and guides for future CHWs.

Limitations of the Study

This study possessed a number of limitations. First among those was the small sample size, particularly in the popular education group, which made it harder to detect statistically significant changes, especially between the two experimental groups in the mixed factorial ANOVA. The small sample size also made it impossible to assure that the assumptions of normality, homogeneity of variance, and independence of observations were met, casting doubt on the statistical conclusions.

A second important limitation was our inability to follow the CHWs over time. We were able to assess their feelings about changes in themselves, their families and their communities, but only immediately after the training. Will these feelings remain stable or change over time? Will motivation to use what they had learned increase or decrease? Will some of the differences in emphasis and learning between the two groups lead them to act in different ways in their communities? We cannot answer these questions because we only collected data at two time points.

Perhaps the most important limitation of this study was the inability to assess changes among community members. Experienced CHWs involved in the project repeatedly emphasized that the real test of the effects of the two methodologies would come when the CHWs began their work in their communities. We can make some hypotheses about differences we might have seen on the basis of what members of the two groups said about how they would approach their work. Members of the TE group spoke of informing, educating, and telling people to do the right thing, while members of the PE group intended to offer options that community members could try and suggest pathways to arrive at better health. These phrases suggest that members of the two groups will approach their work in different ways. However, in the absence of data from the community members served by the program, we can neither test these hypotheses, nor determine whether different ways of working affect community members in different ways.

A final limitation of the study was the lack of a systematic way to assess fidelity to both methodologies. This limitation made it harder to attribute changes in each group to the

methodology that was used in that group. It also made it impossible to explore any sort of “dose-response” effect, e.g. whether closer adherence to either model enhanced or strengthened the observed changes in that group.

Conclusion

Results of this research suggest that popular education can be *at least as effective* as traditional education for increasing knowledge. At the same time, study results suggest that popular education can be *more effective* than traditional education for achieving a variety of other goals, including increasing empowerment and sense of community and producing multi-faceted skills and understandings. Findings demonstrate, further, that popular education achieves its aims through particular practices that can be intentionally taught and applied. Although the study involved significant limitations, this research demonstrated that popular education has the potential not only to improve health knowledge and health behaviors of Community Health Workers, but also to increase the skills and broaden the perspectives of potential leaders. This element deserves further study, over a longer period of time, in order to examine the potential for long-term changes in community health, the ultimate goal of Community Health Worker programs.

Appropriate Citation:

Wiggins, N. (2010). *La Palabra es Salud: A Comparative Study of the Effectiveness of Popular Education vs. Traditional Education for Enhancing Health Knowledge and Skills and Increasing Empowerment Among Parish-Based Community Health Workers (CHWs)* (Doctoral dissertation). Retrieved from *Dissertation and Theses*. (AAT 3407867.)

Non-Traditional Health Worker Survey October 2011

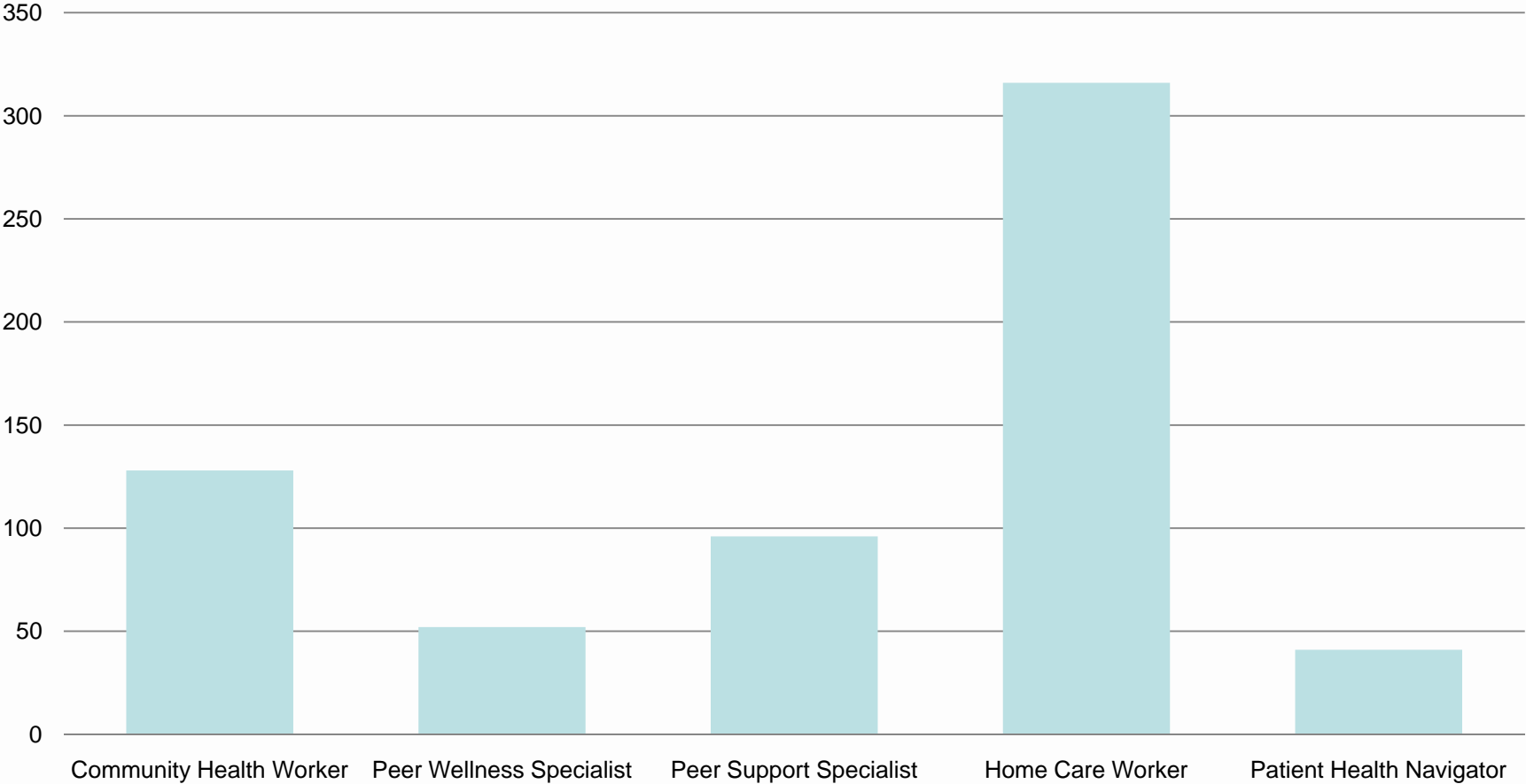
Presented to the OHPB Workforce Committee
NTHW Subcommittee



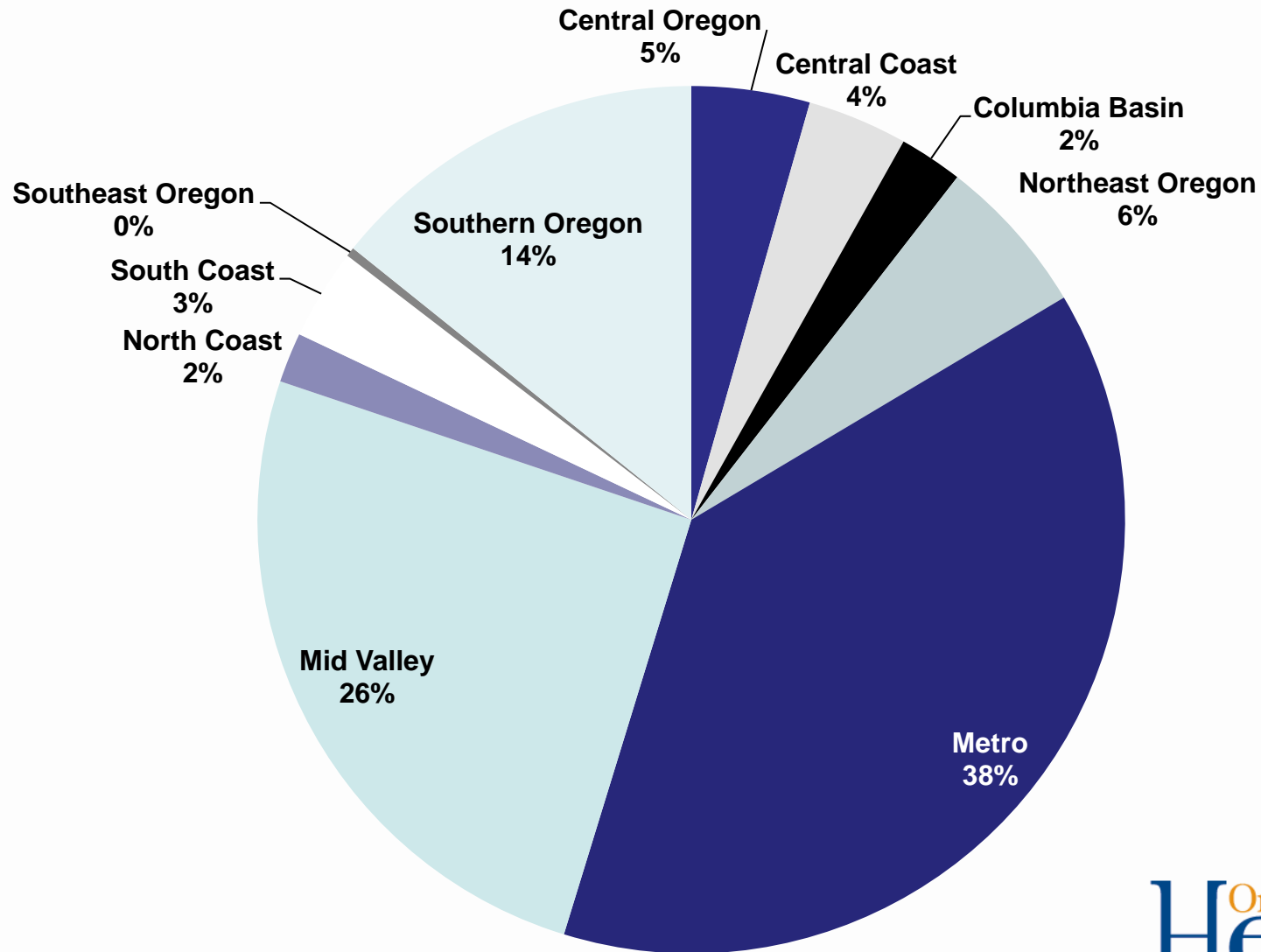
Survey Method and Results Overview

- **Distribution via email and paper copies to Subcommittee, key stakeholders**
- **Collection method:**
 - **Survey Monkey**
 - **Paper submissions manually entered into Survey Monkey**
- **English and Spanish versions available**
- **Total Started Survey: 620 (as of Oct 26, 2011)**
- **Total Completed Survey: 562 (90.6%)**

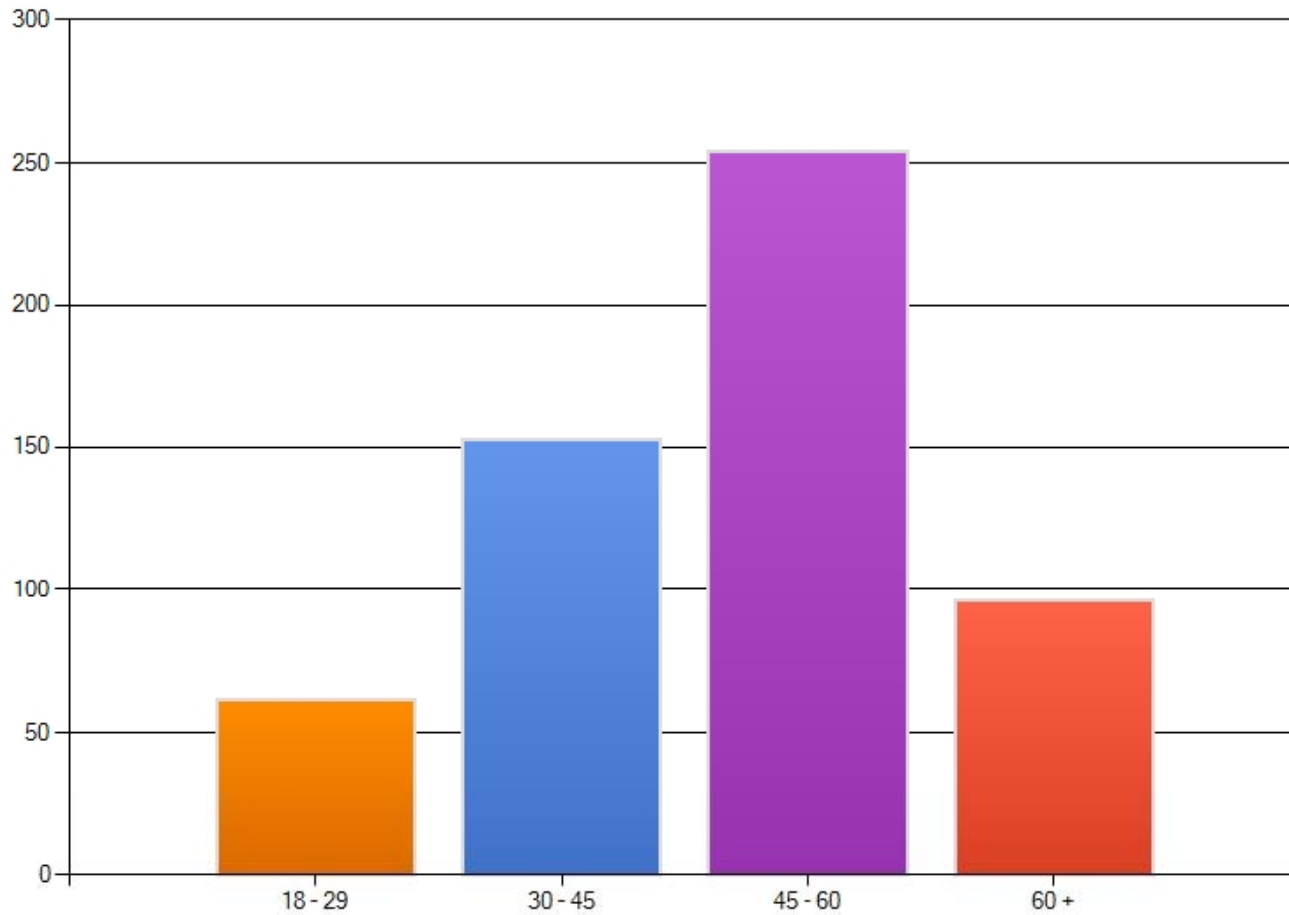
Who responded? Worker Type



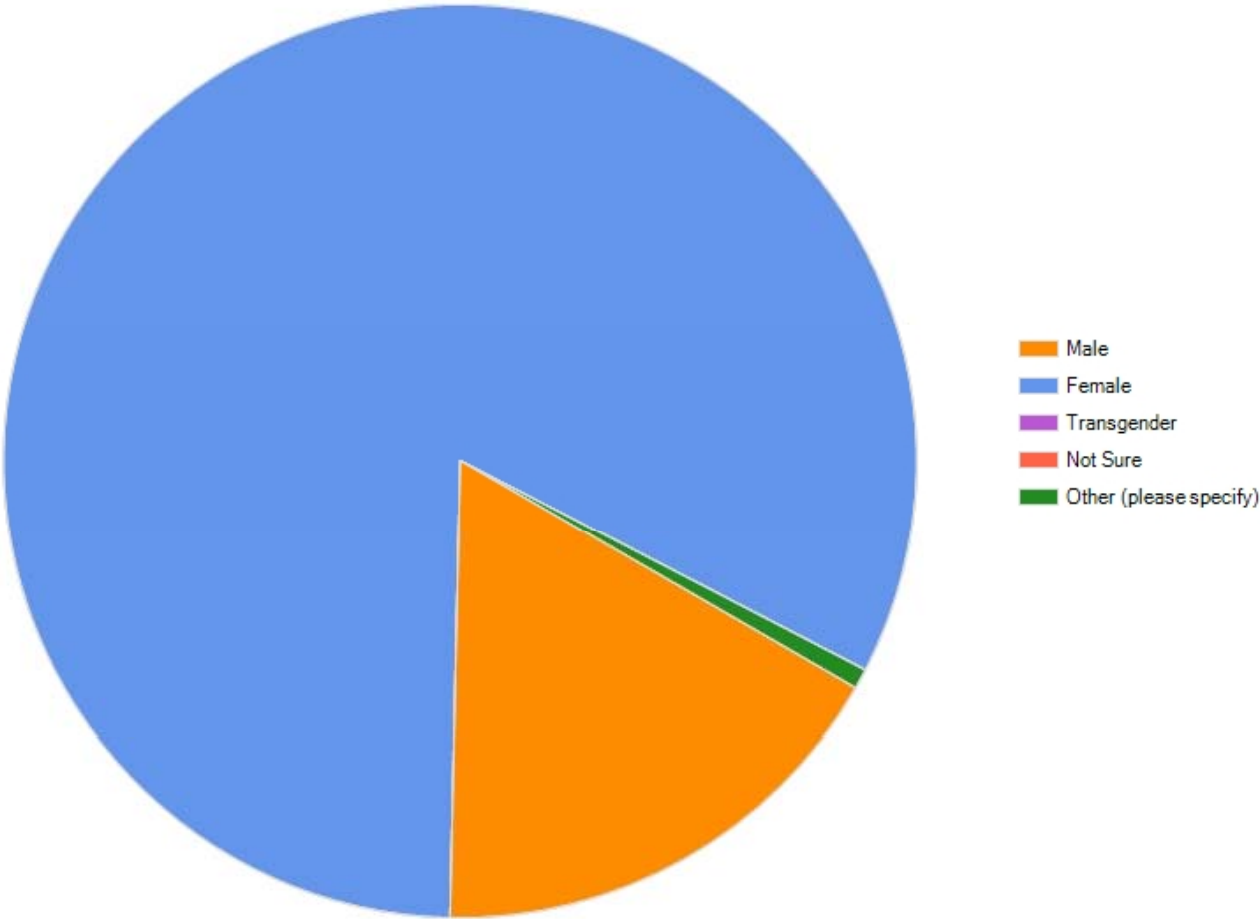
Regional Representation of Respondents



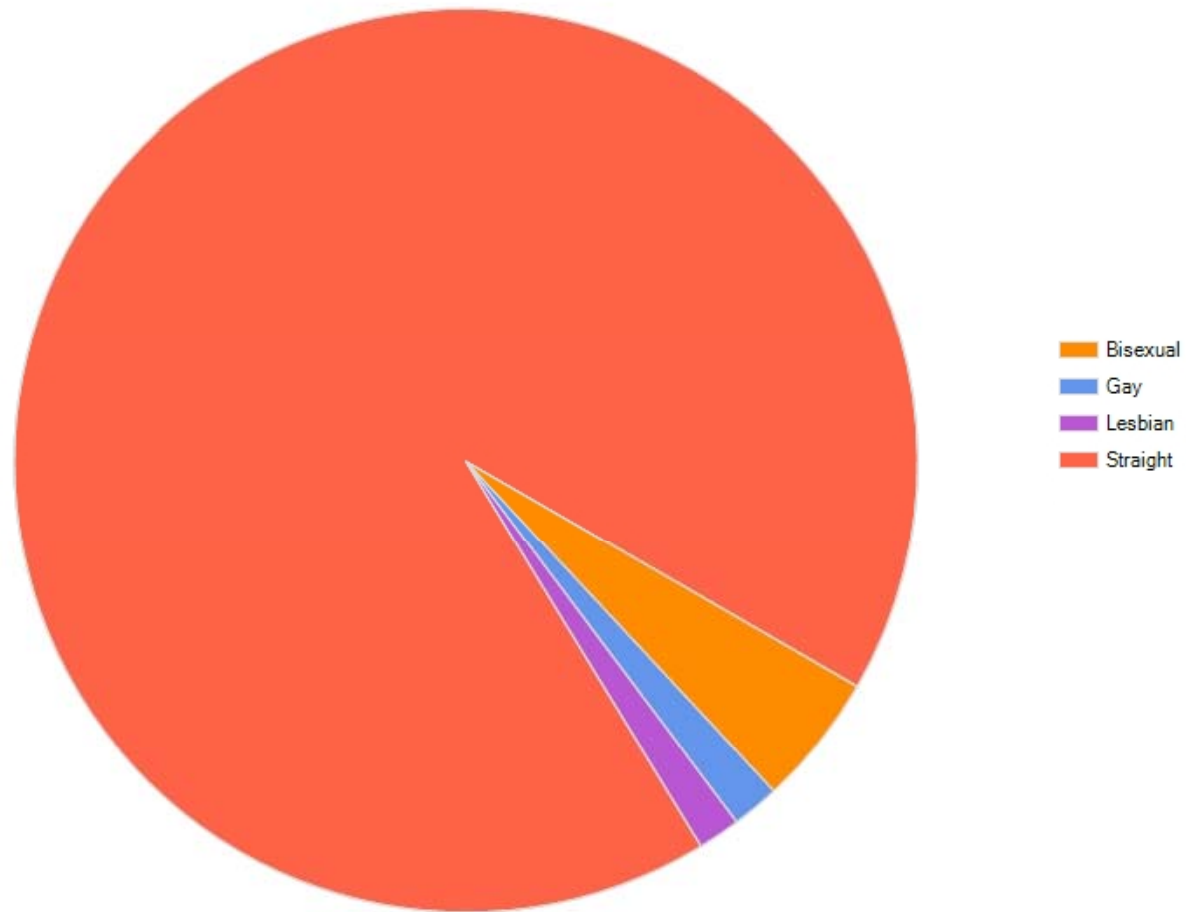
Who responded? Age



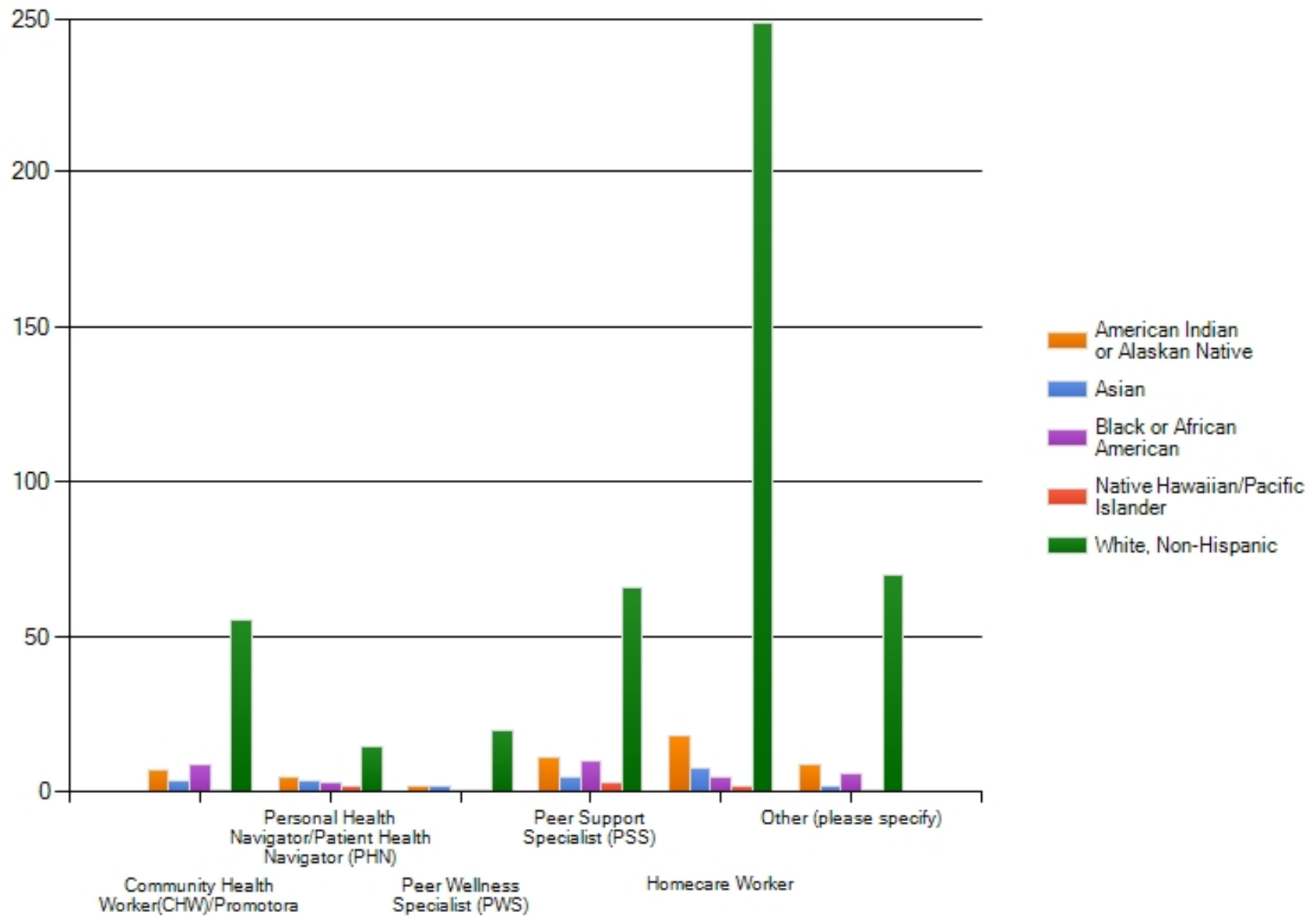
Who responded? Gender



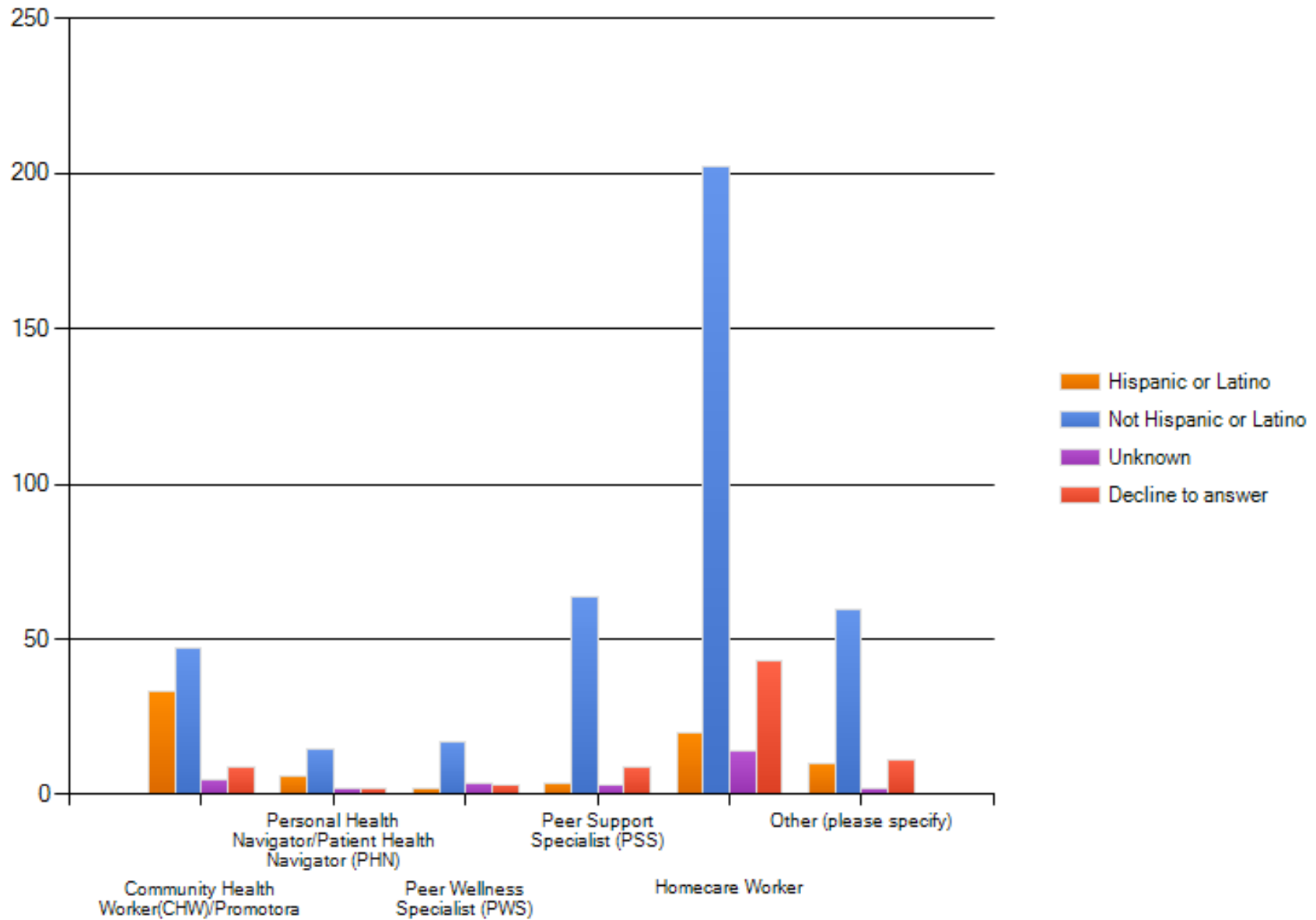
Who responded? Sexual Orientation



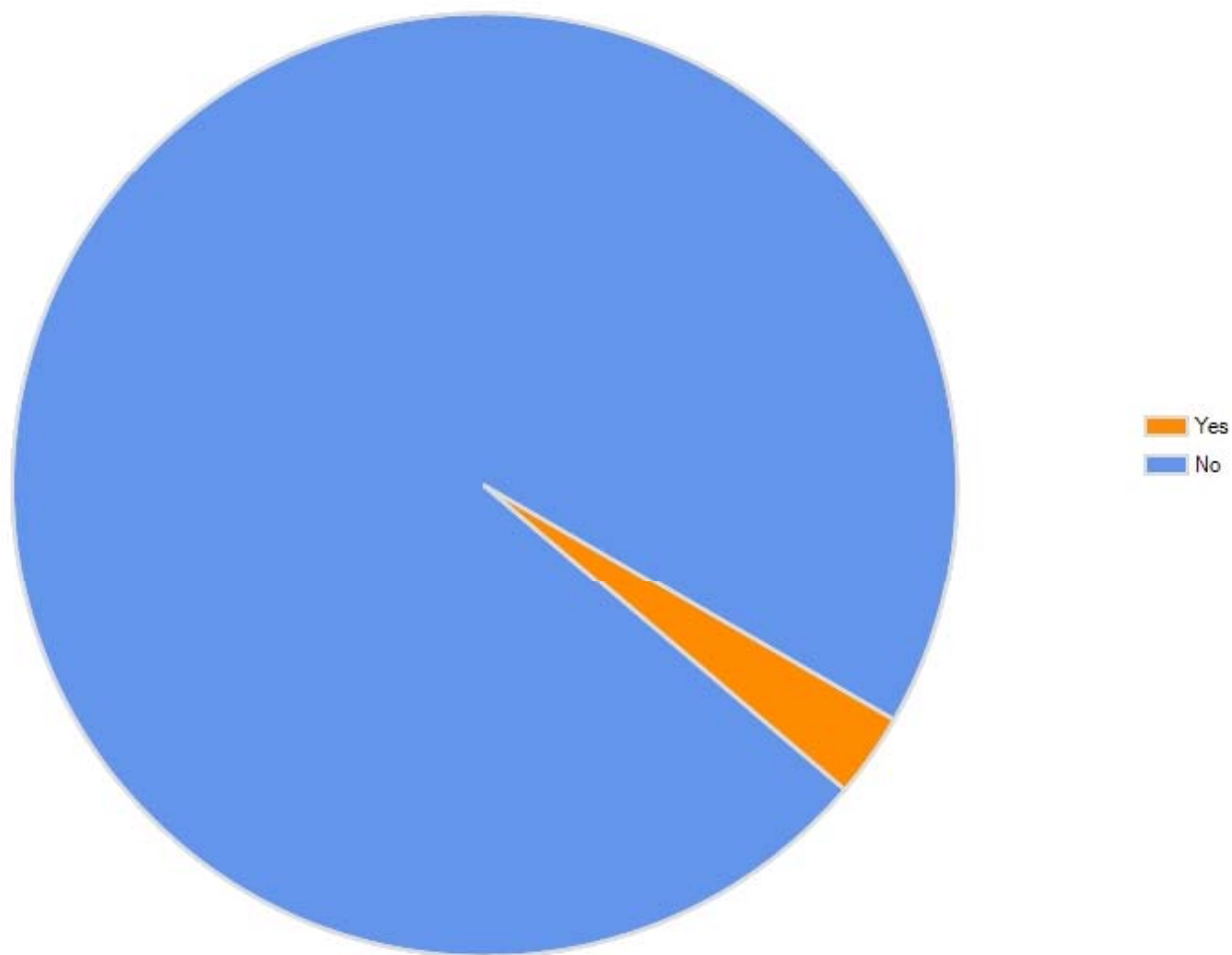
Race by Worker Type



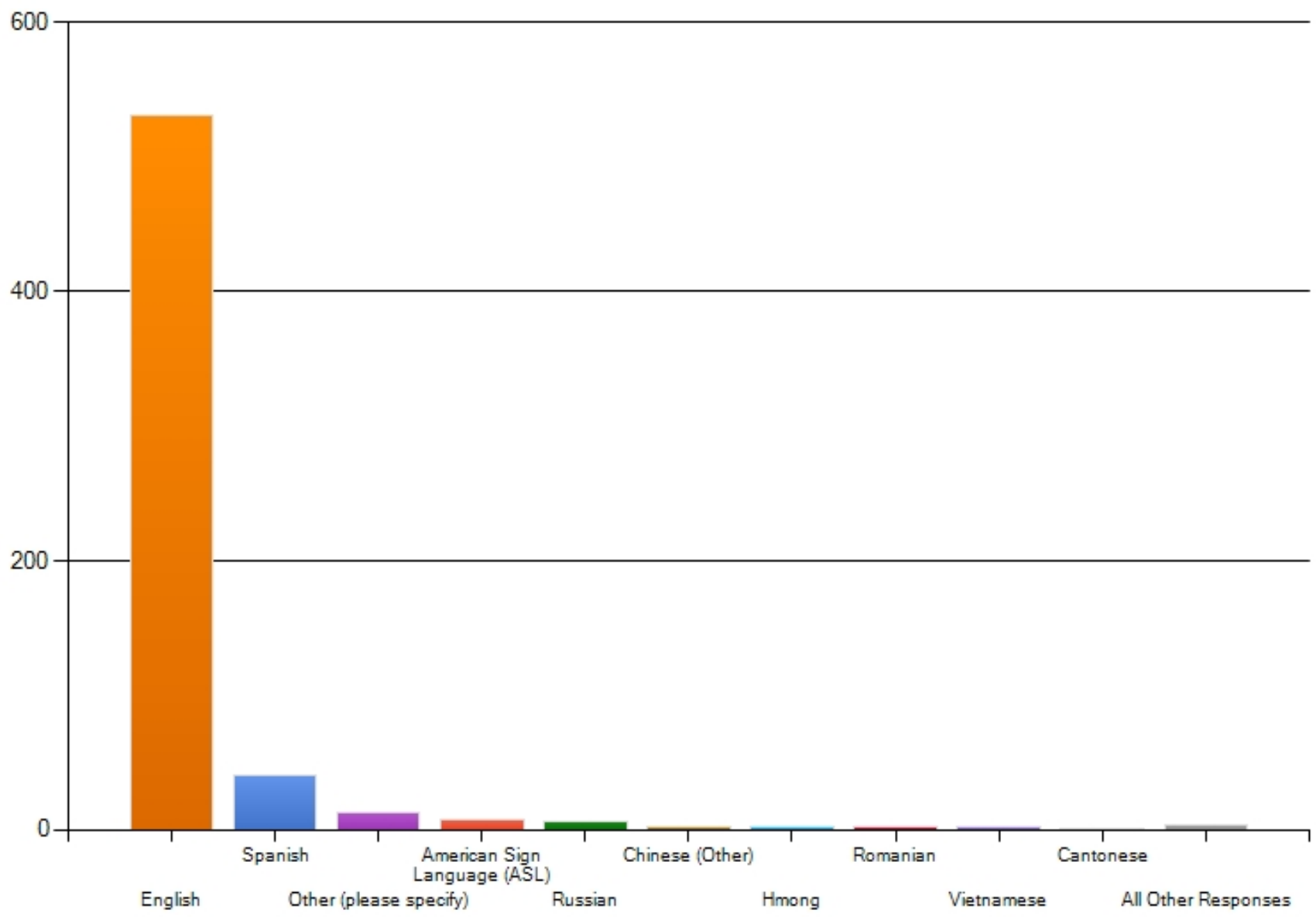
Ethnicity by Worker Type



Enrollment in American Indian/Alaska Native Tribe

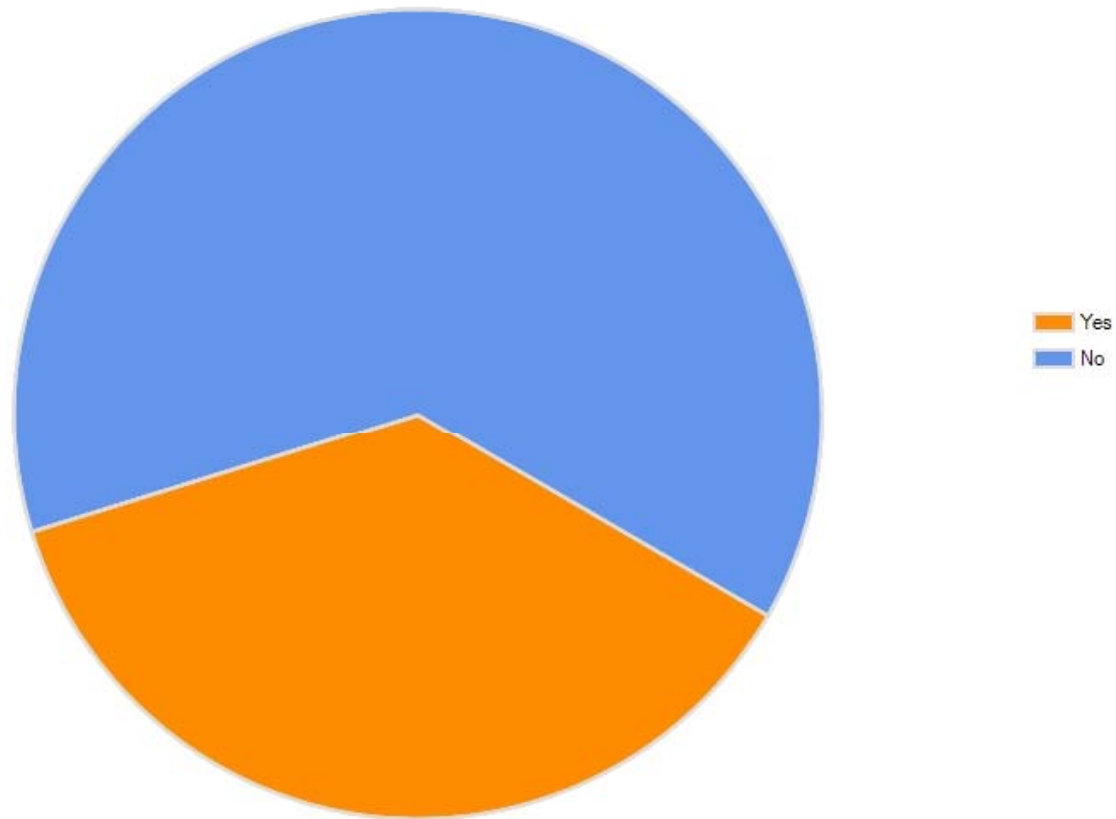


Preferred Language

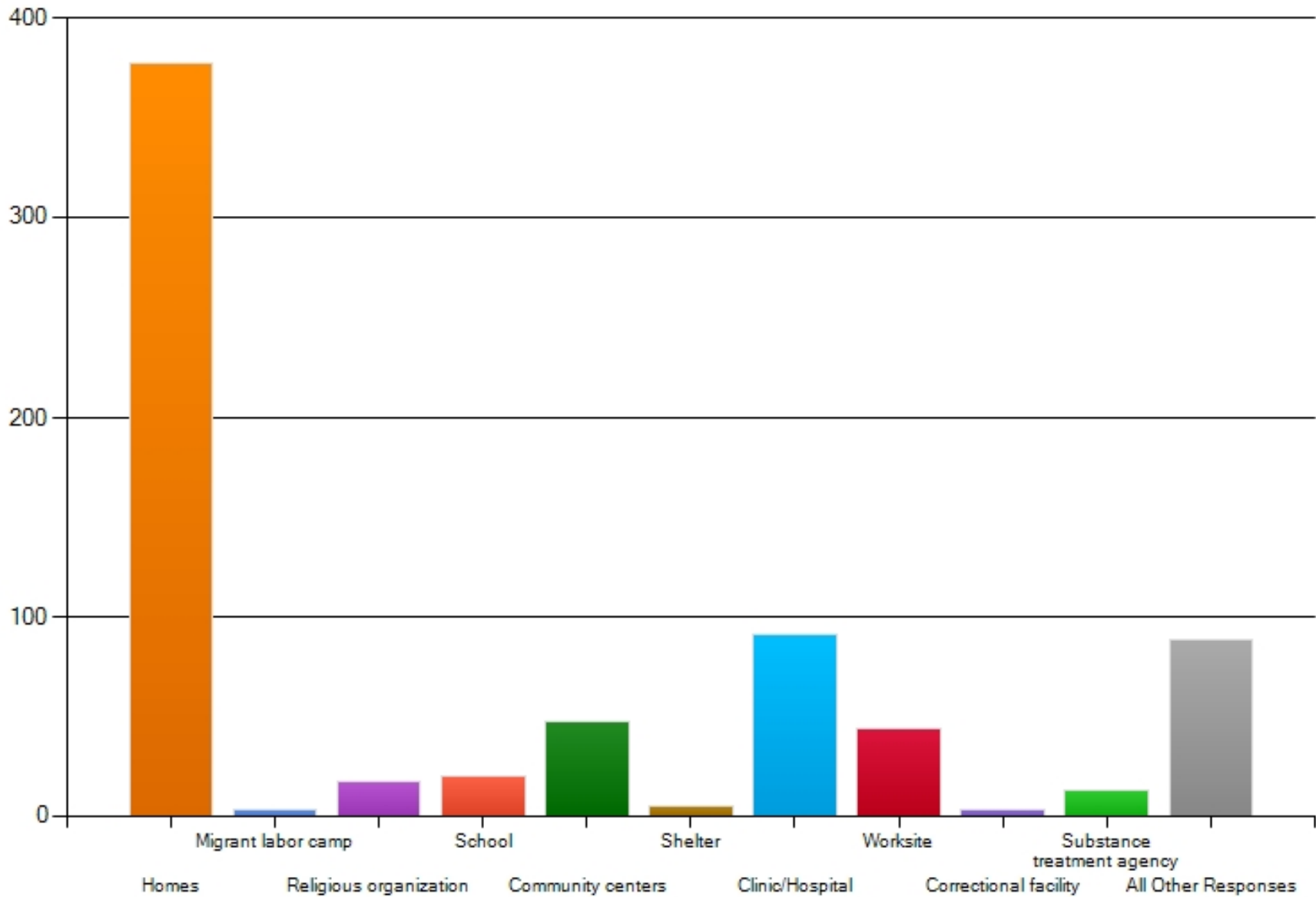


Part of Personal Recovery Plan

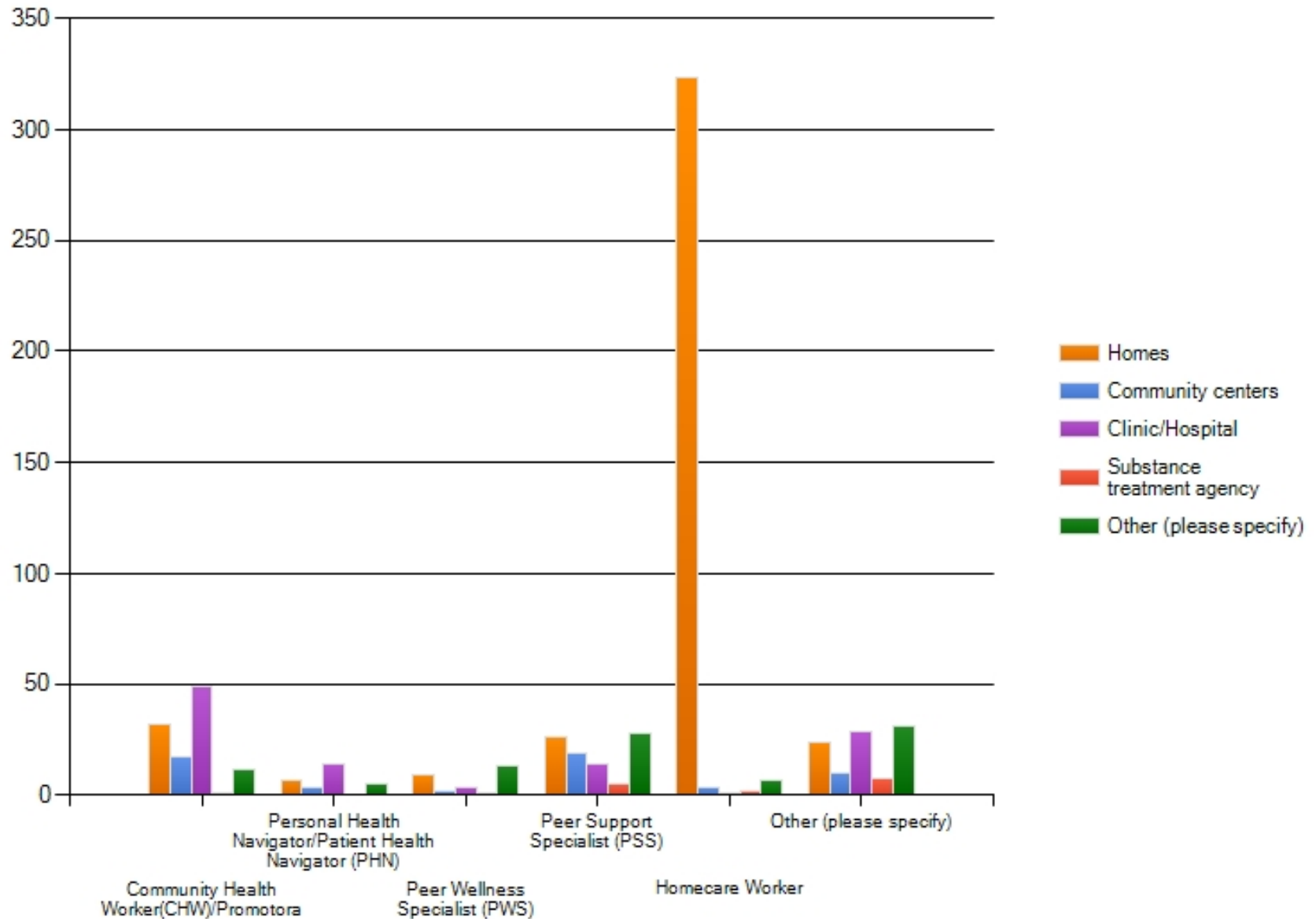
Some individuals join the non-traditional health care workforce as part of a personal recovery plan. Because of their life experience, such persons have expertise that professional training cannot replicate. Do you currently, or have you previously, received services around personal disability, mental health or chemical dependency issues?



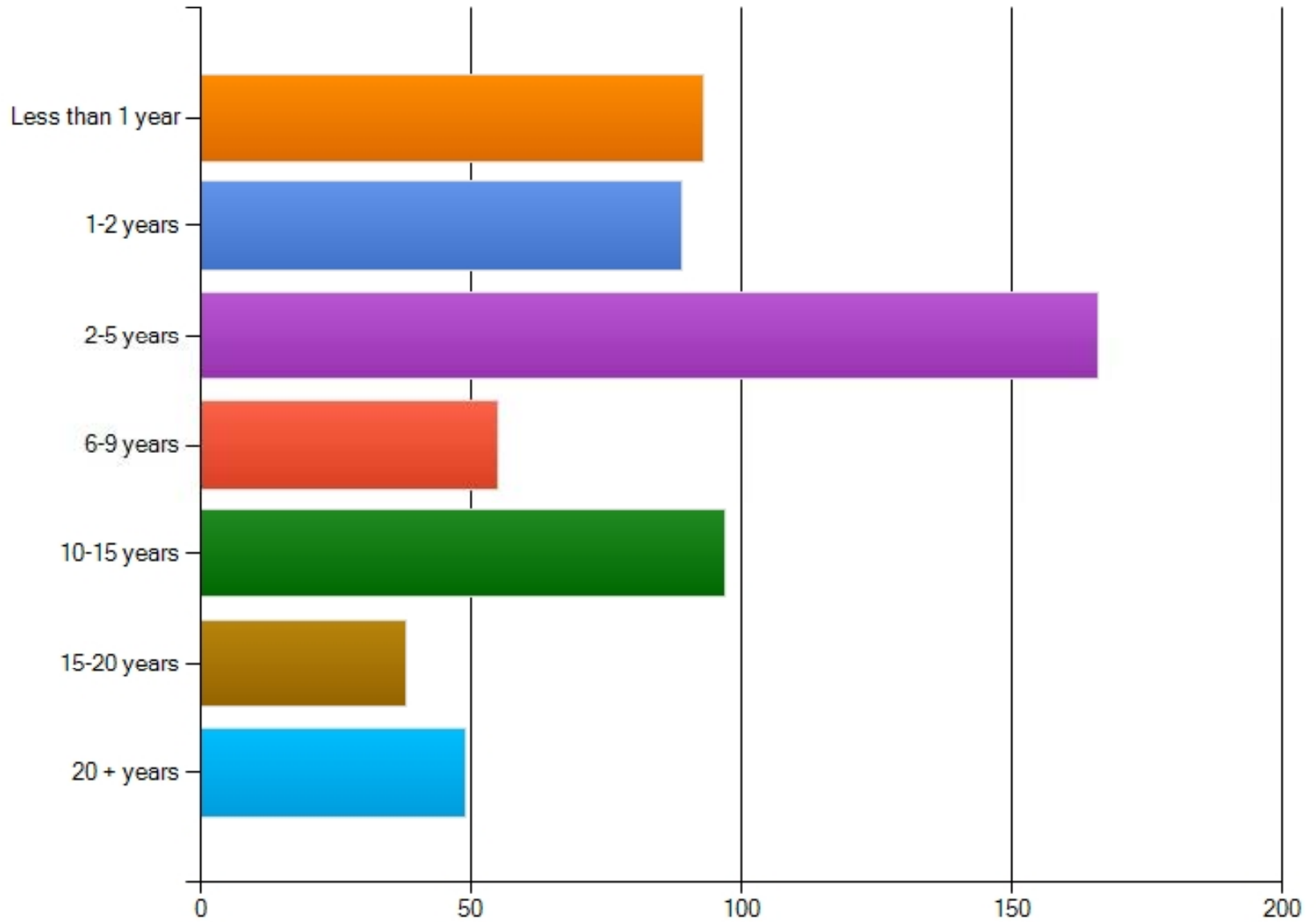
Worker Settings



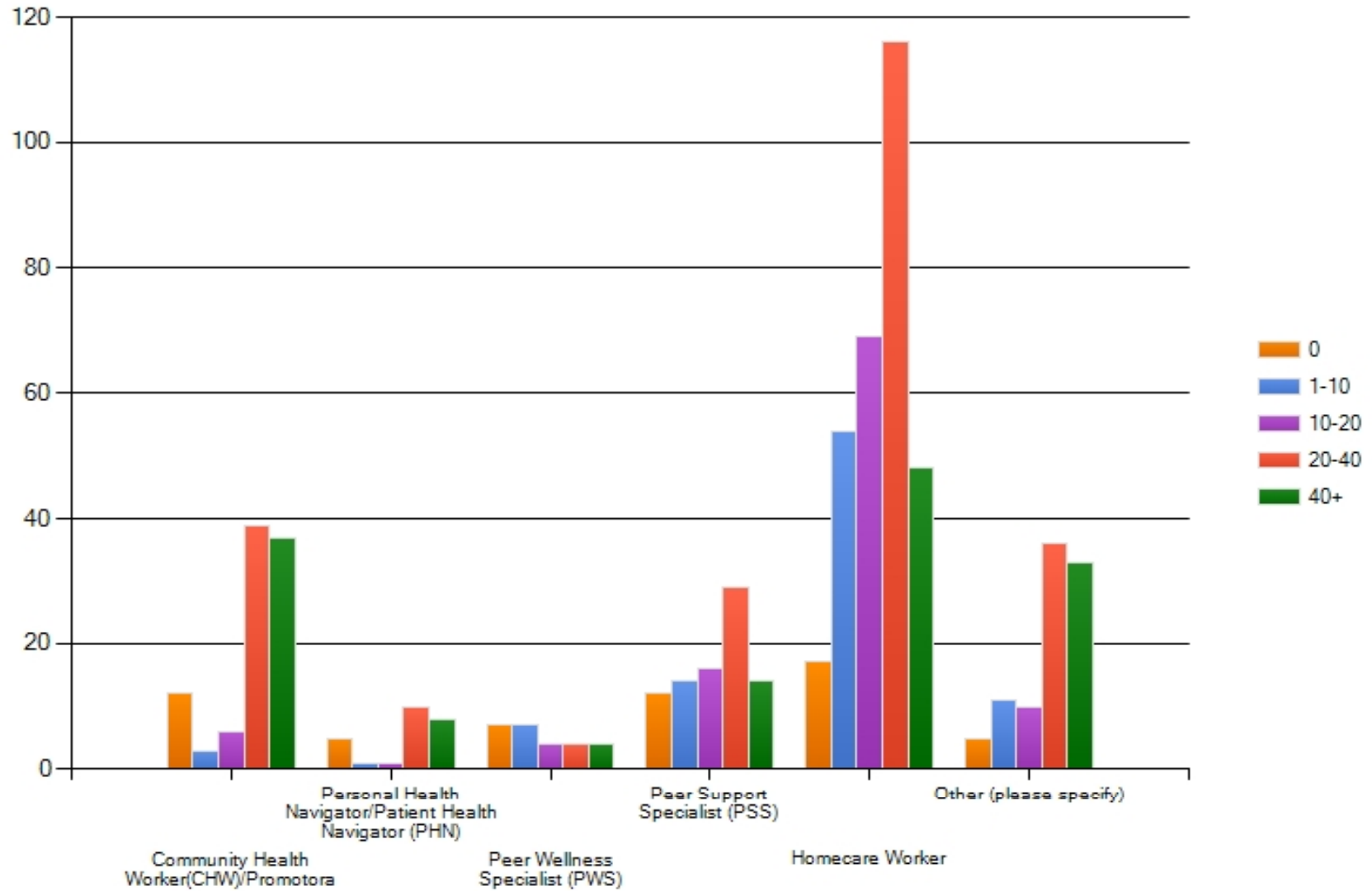
Work Settings by Worker Type



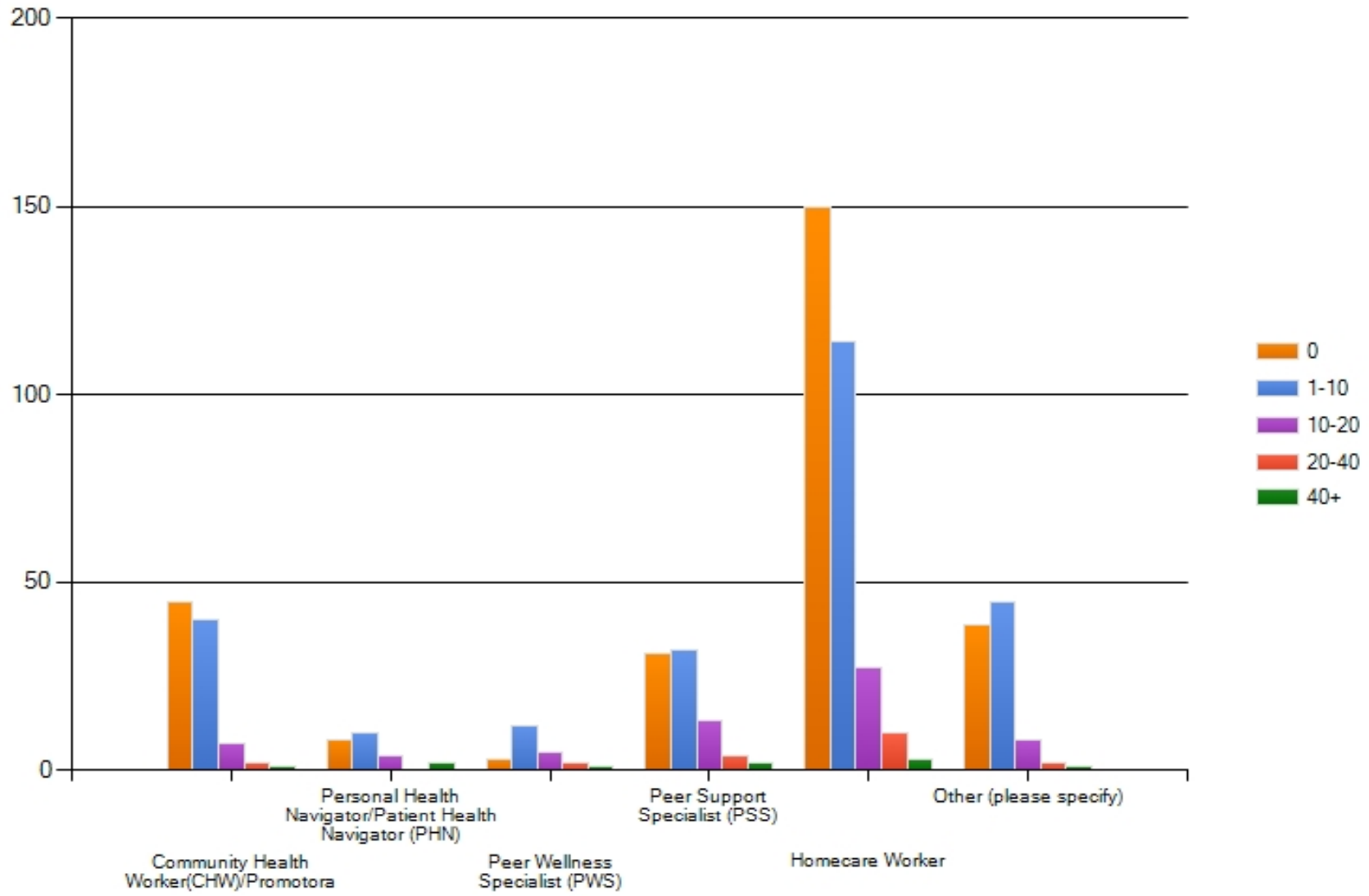
Years in Field



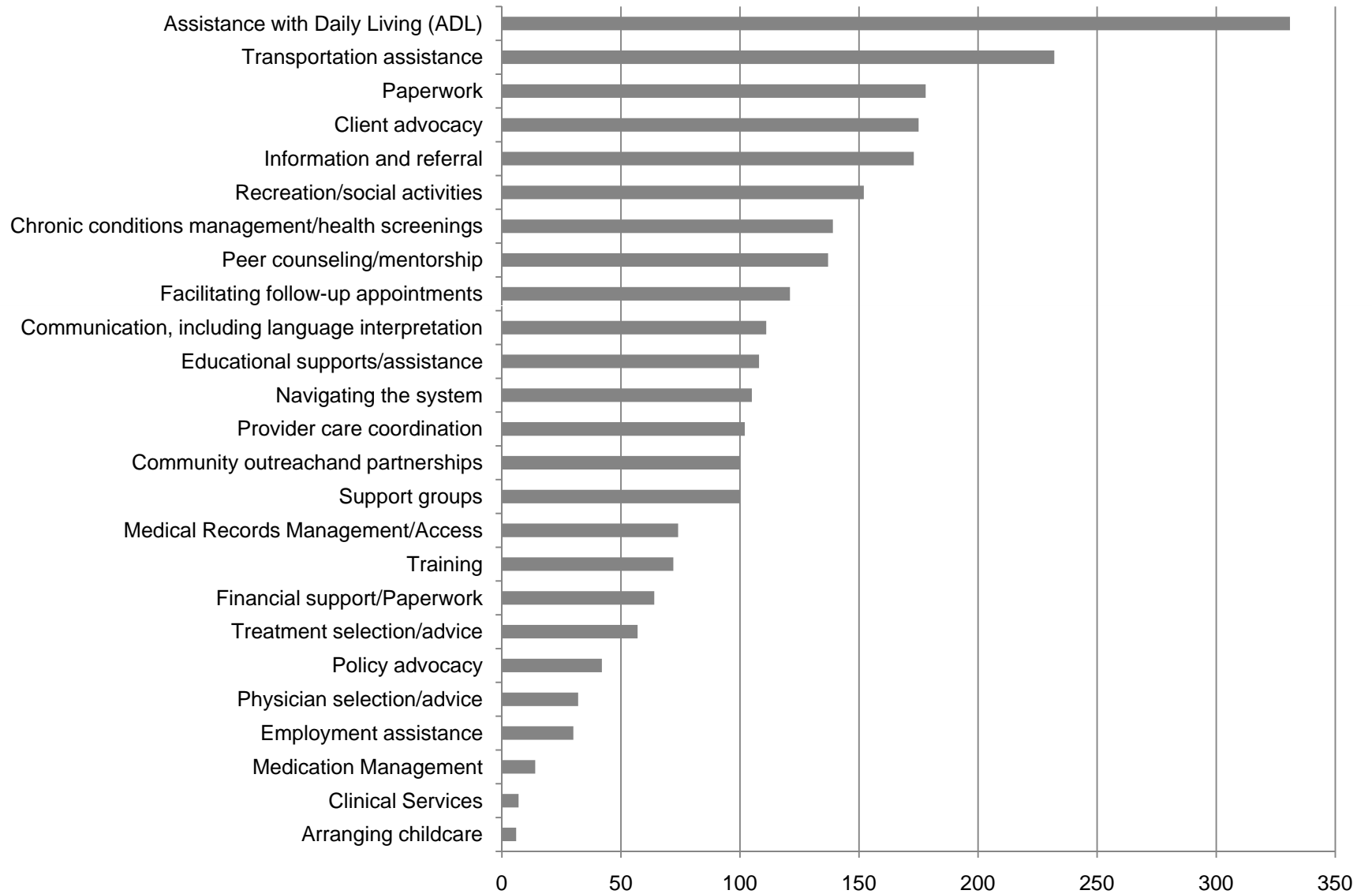
Paid Hours by Worker Type



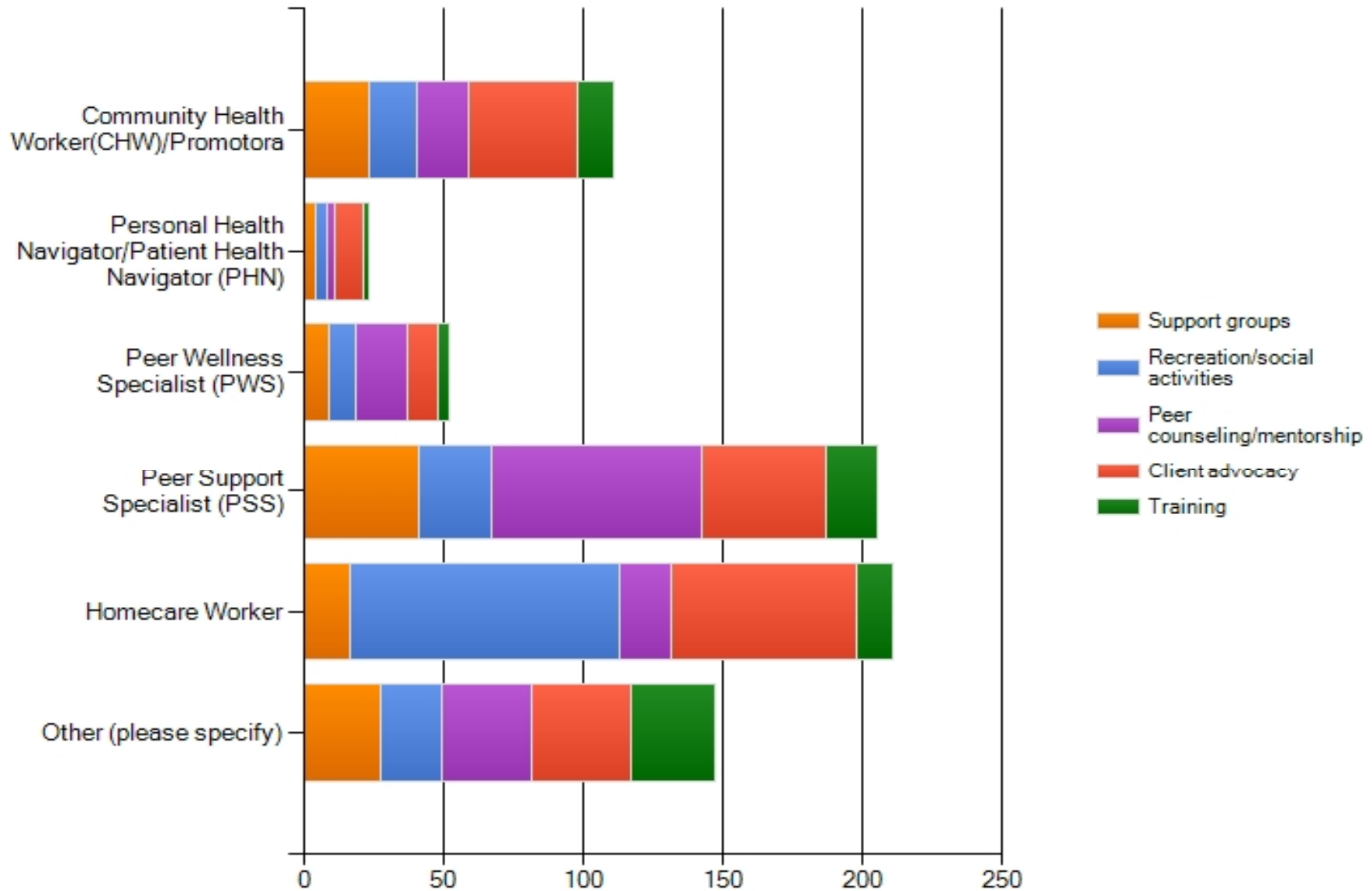
Volunteer Hours by Worker Type



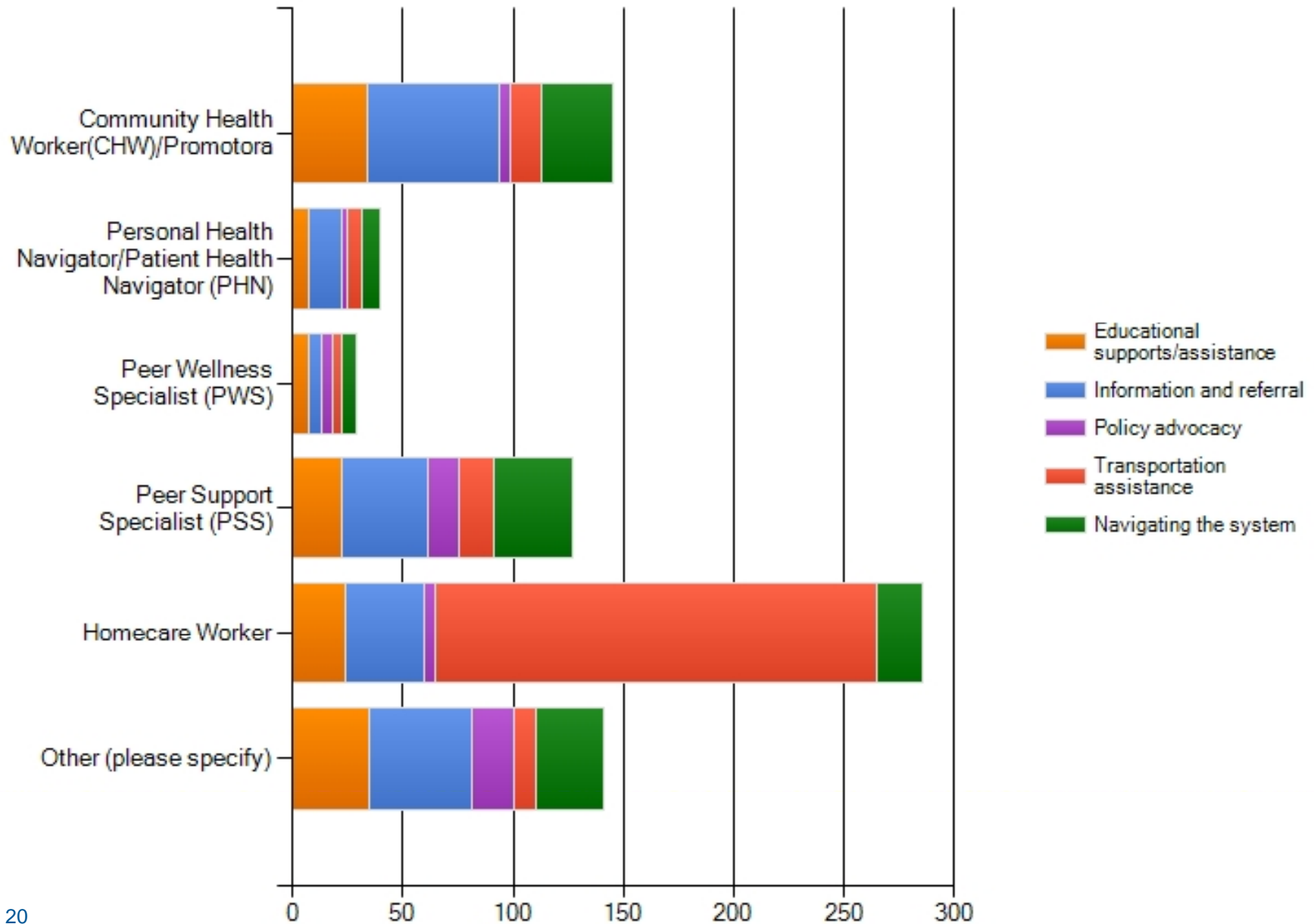
Type of Services Provided



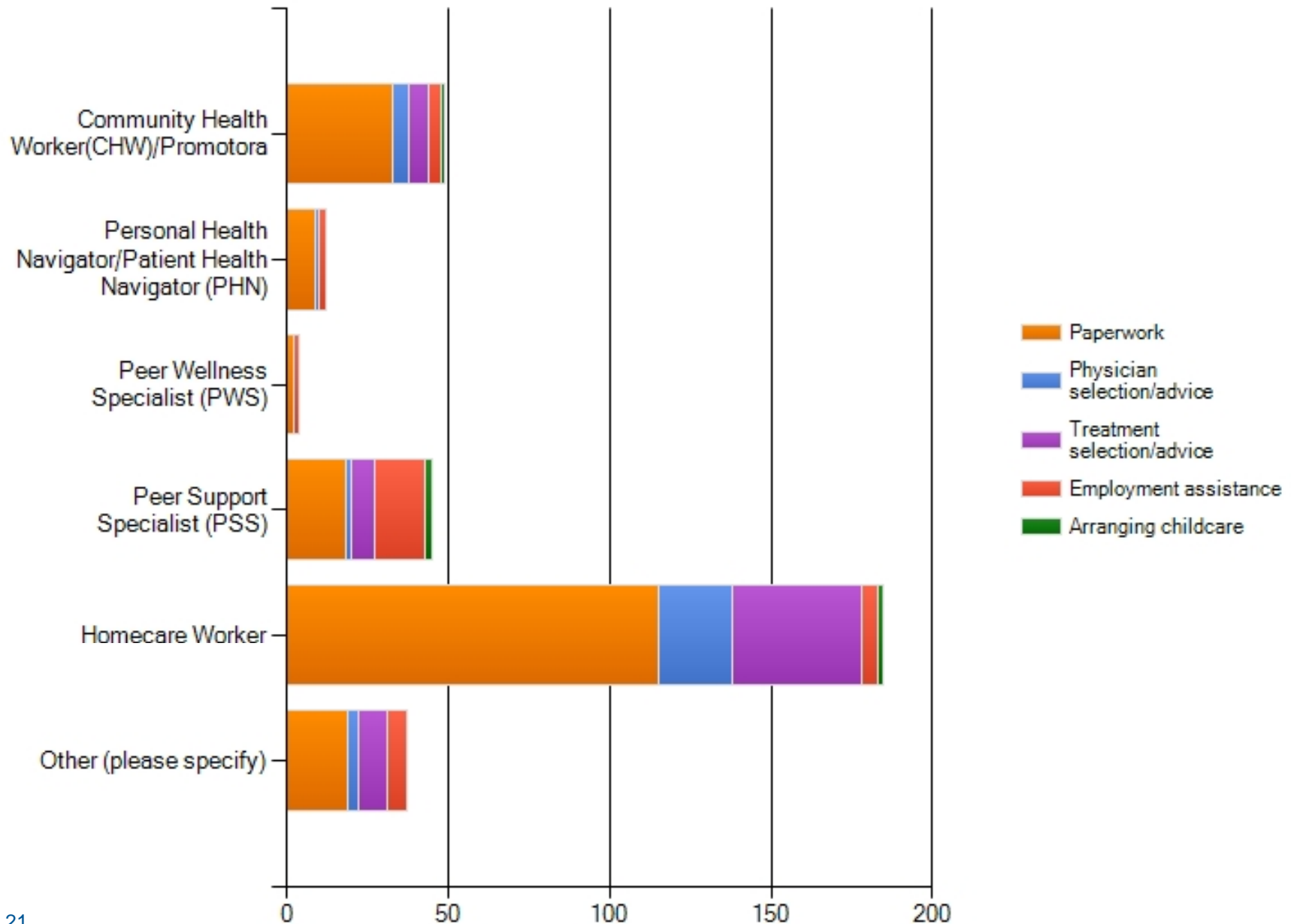
Types of Services by Worker Type Slide 1



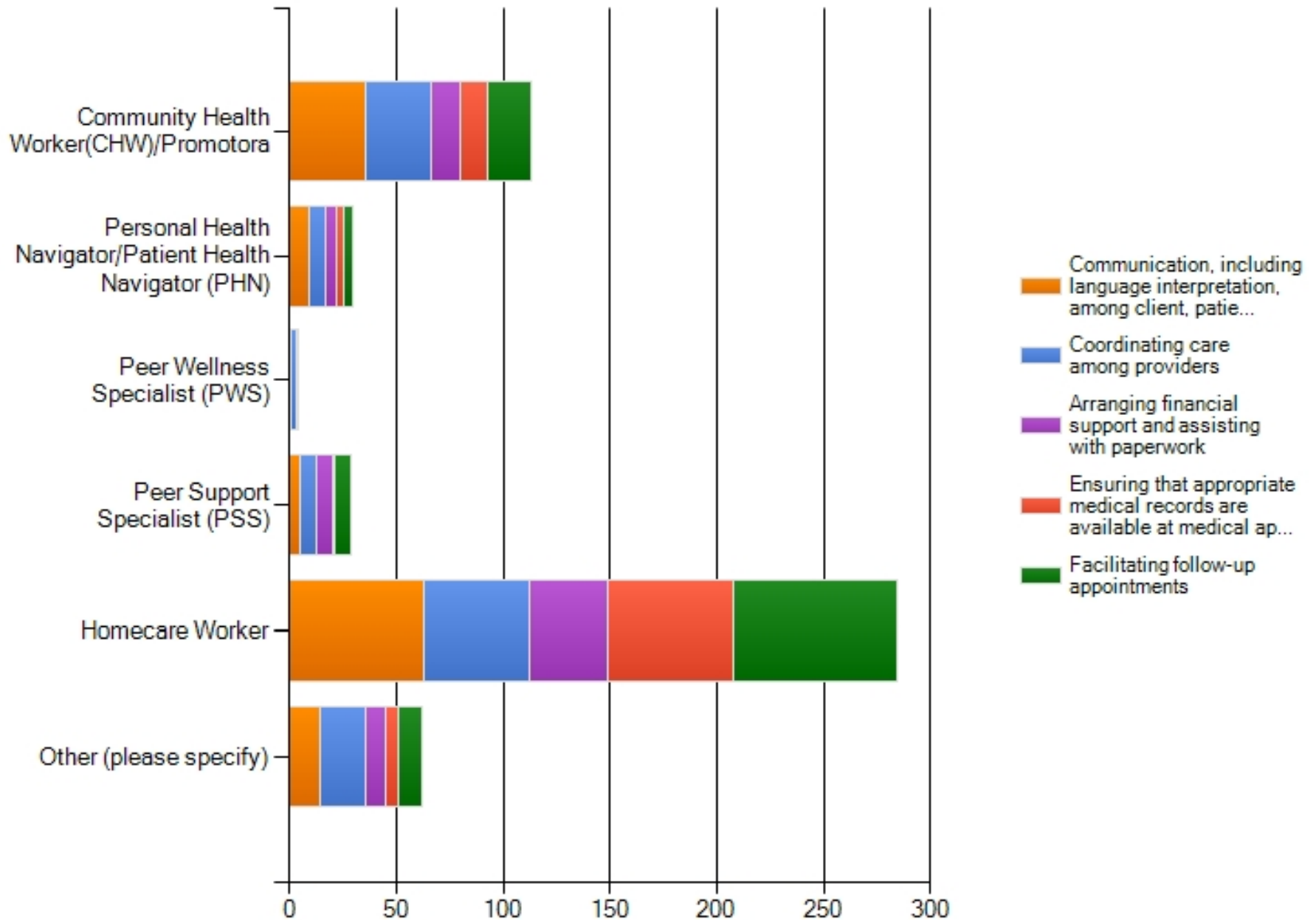
Services by Worker Type Slide 2



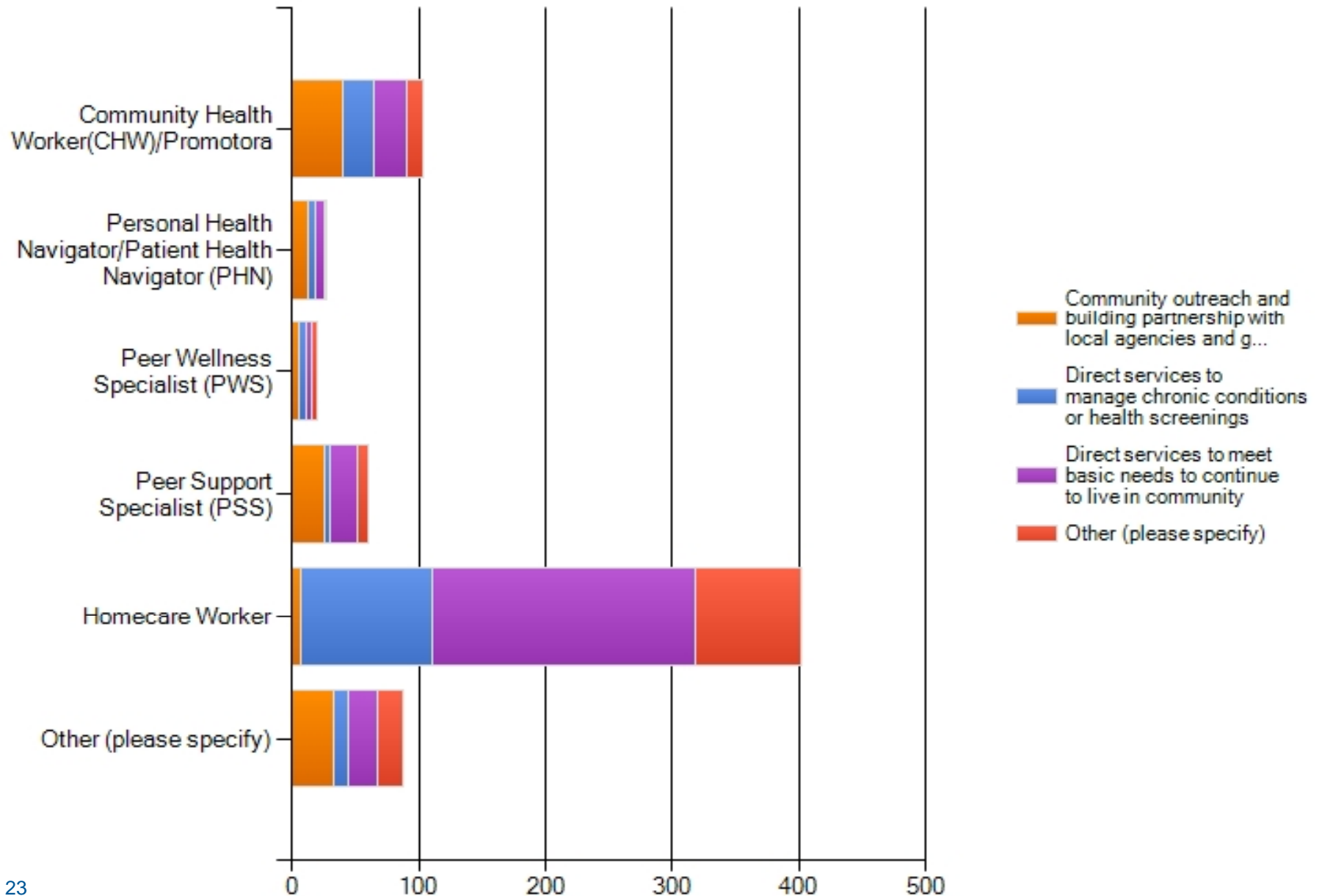
Services By Worker Type Slide 3



Services By Worker Type Slide 4

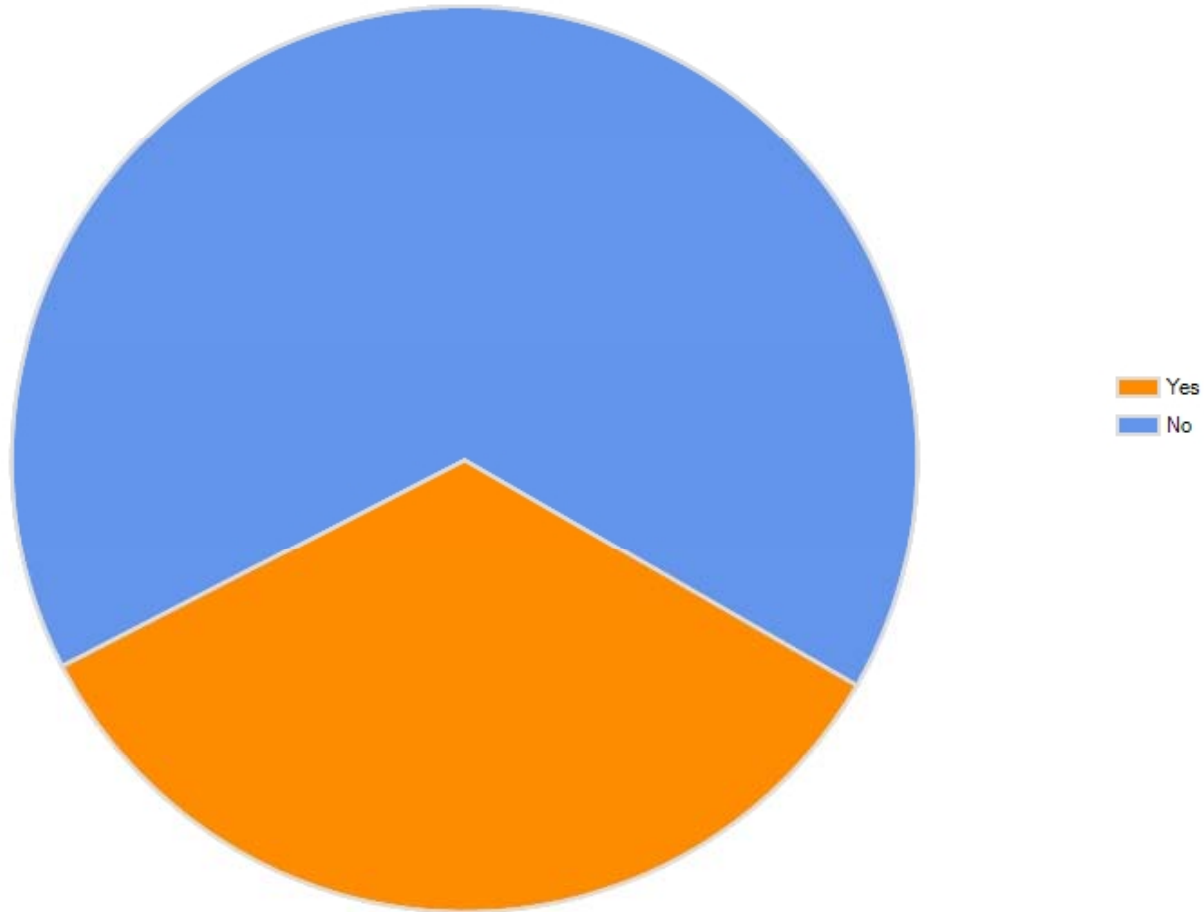


Services by Worker Type Slide 5



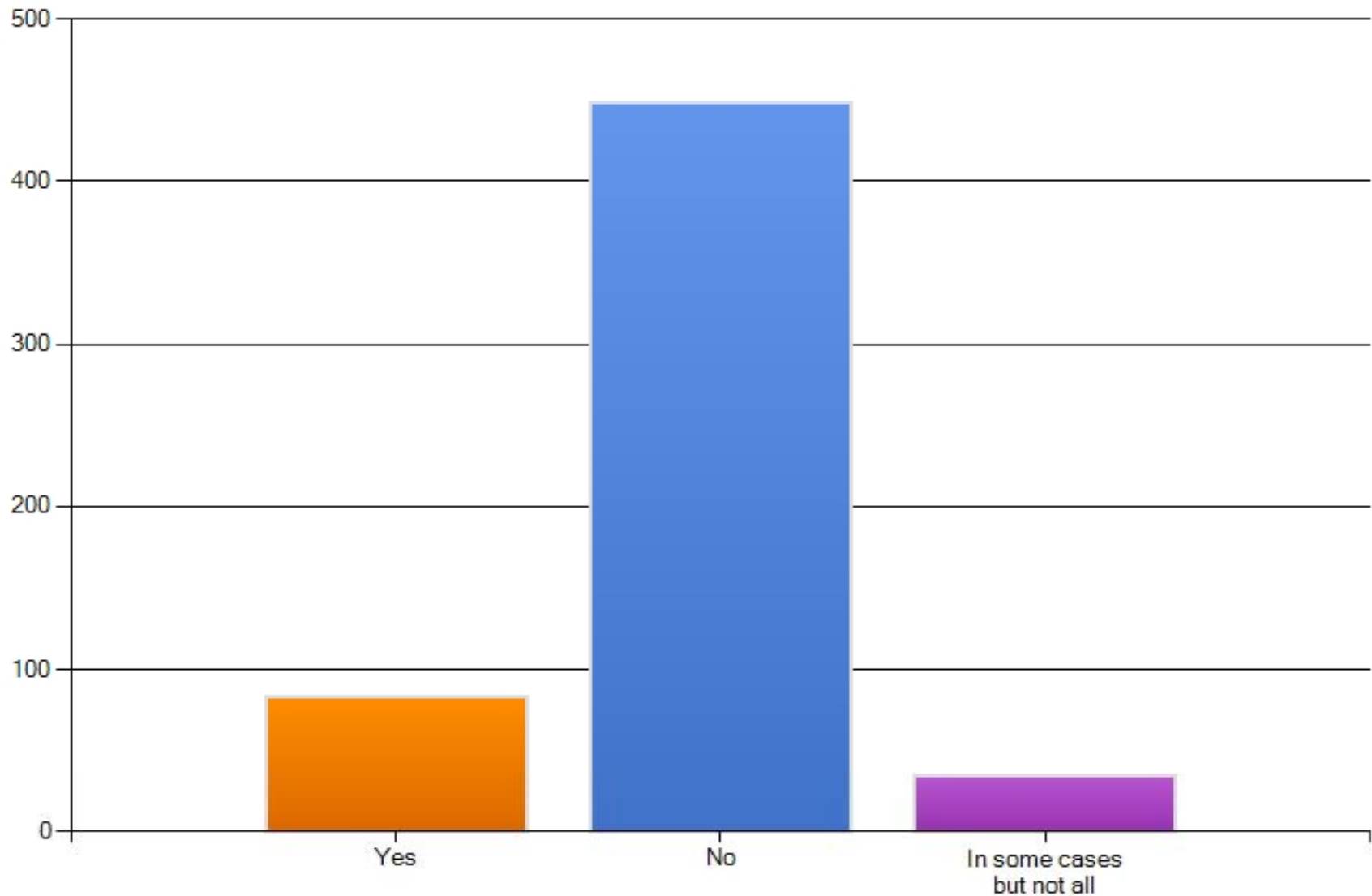
Provision of Clinical Services

Do you provide clinical services? (Some examples include: taking blood pressures and temperatures, giving injections, and changing dressings)

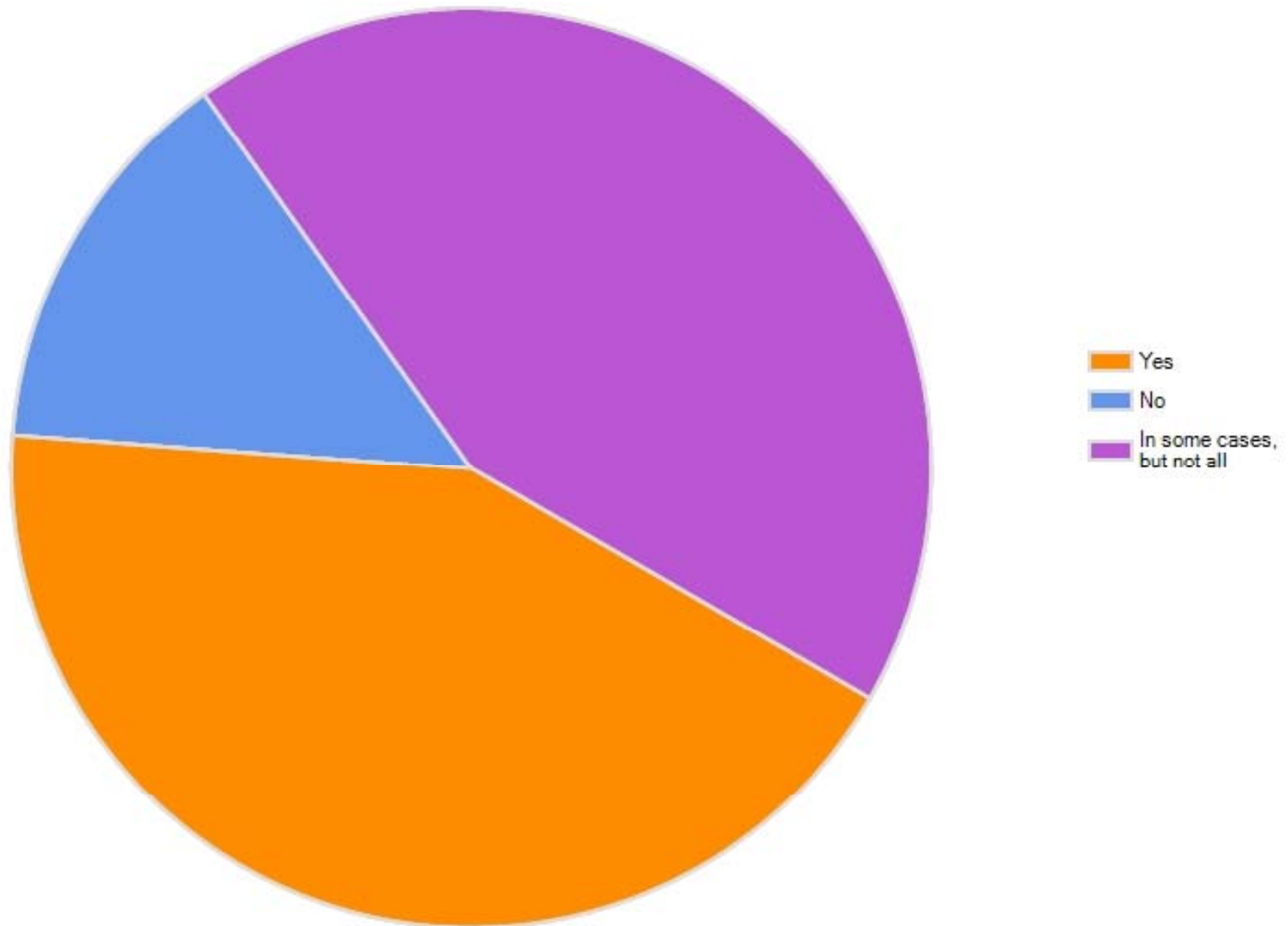


Language-Specific Services

Do you typically speak a language other than English when providing services?

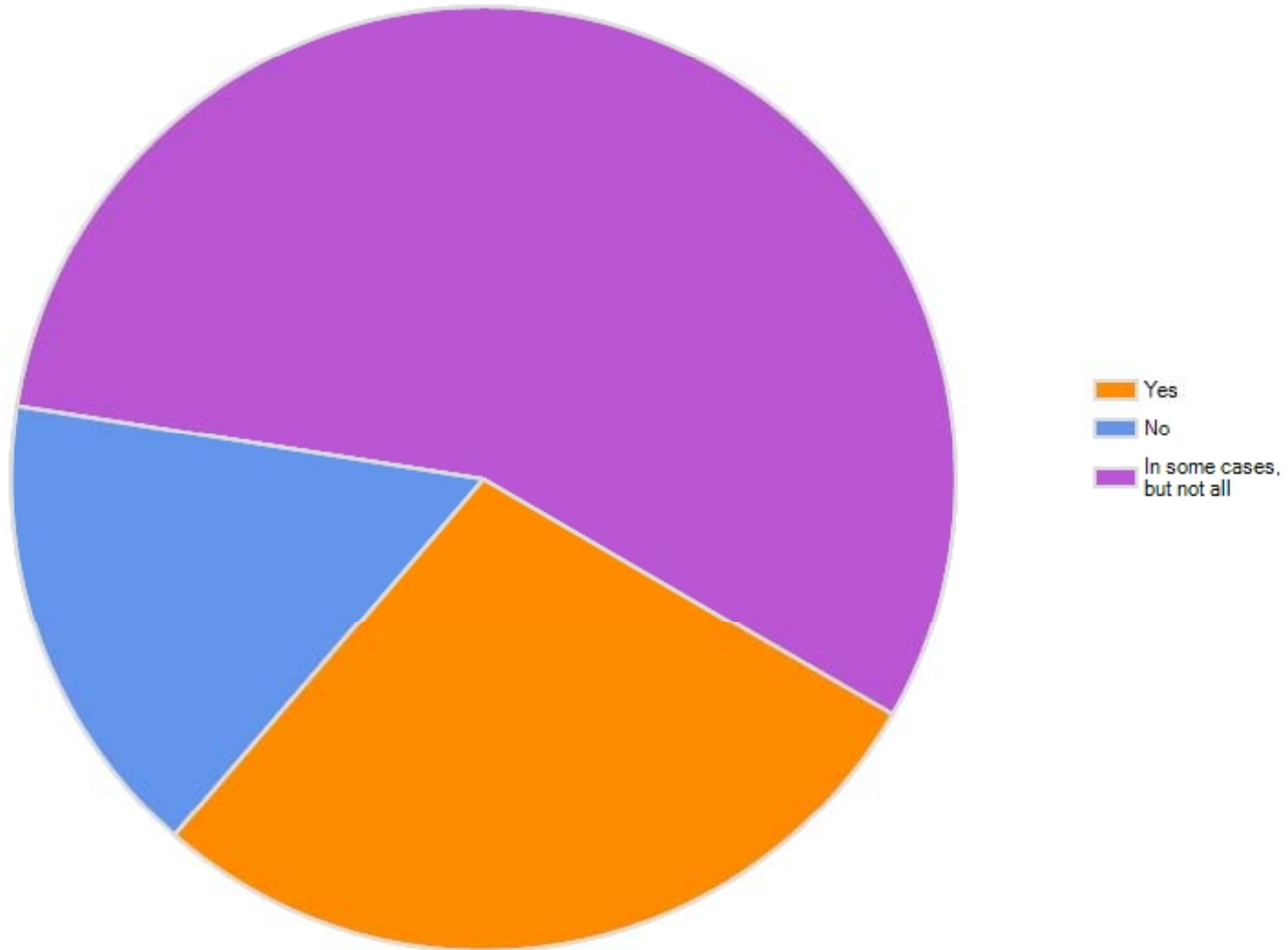


Race/Ethnicity Shared with Clients

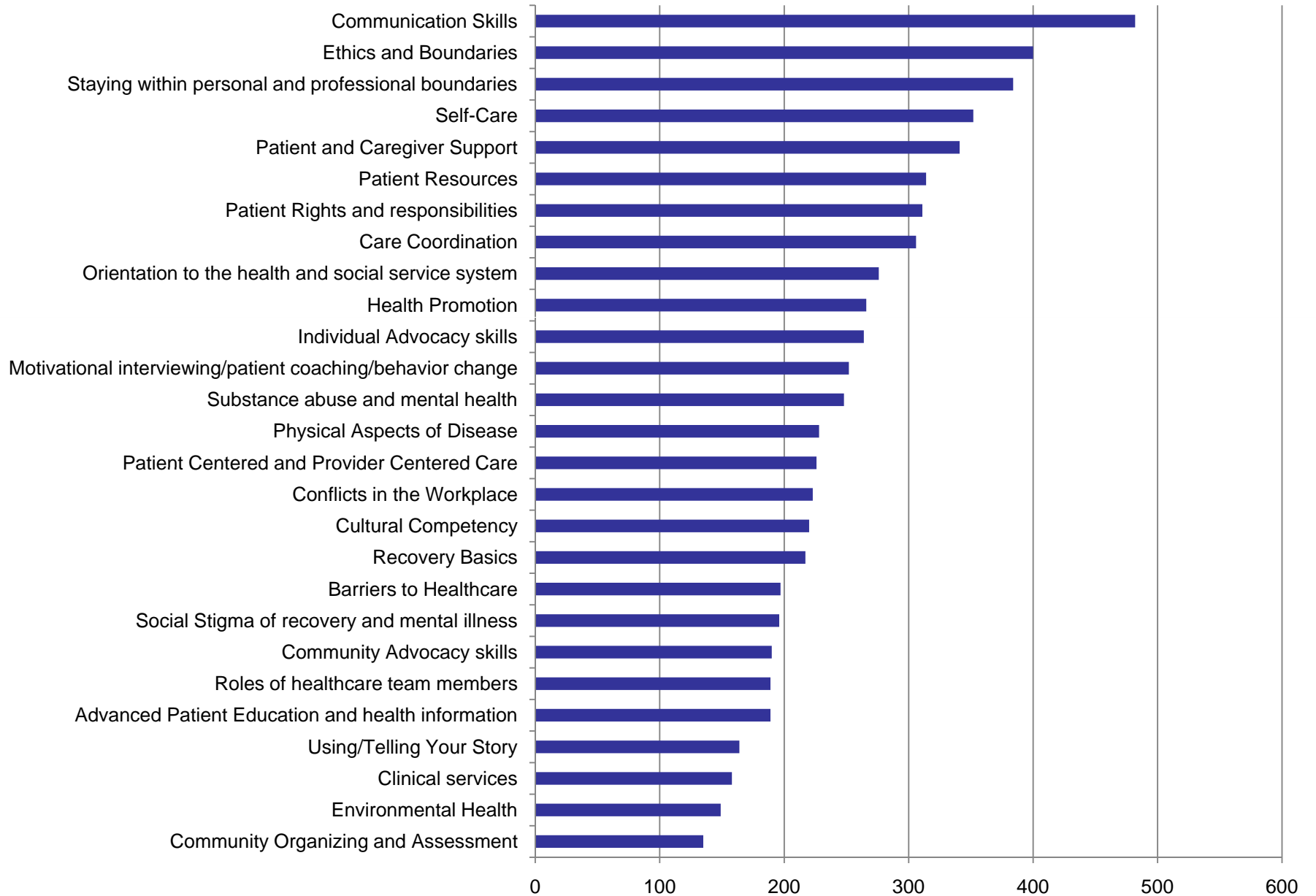


Shared Life Experience

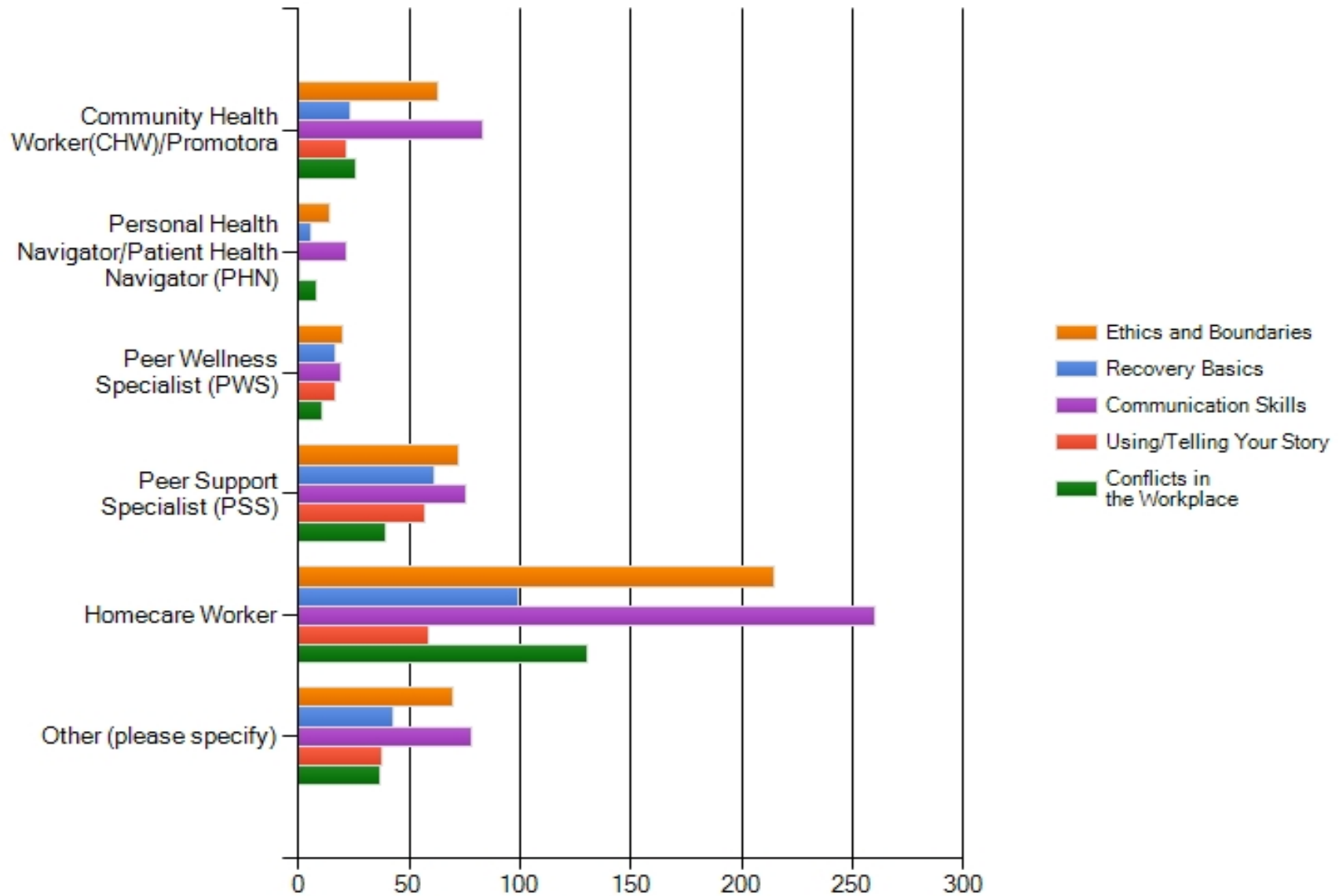
Do you share the same life experience as the people you serve?



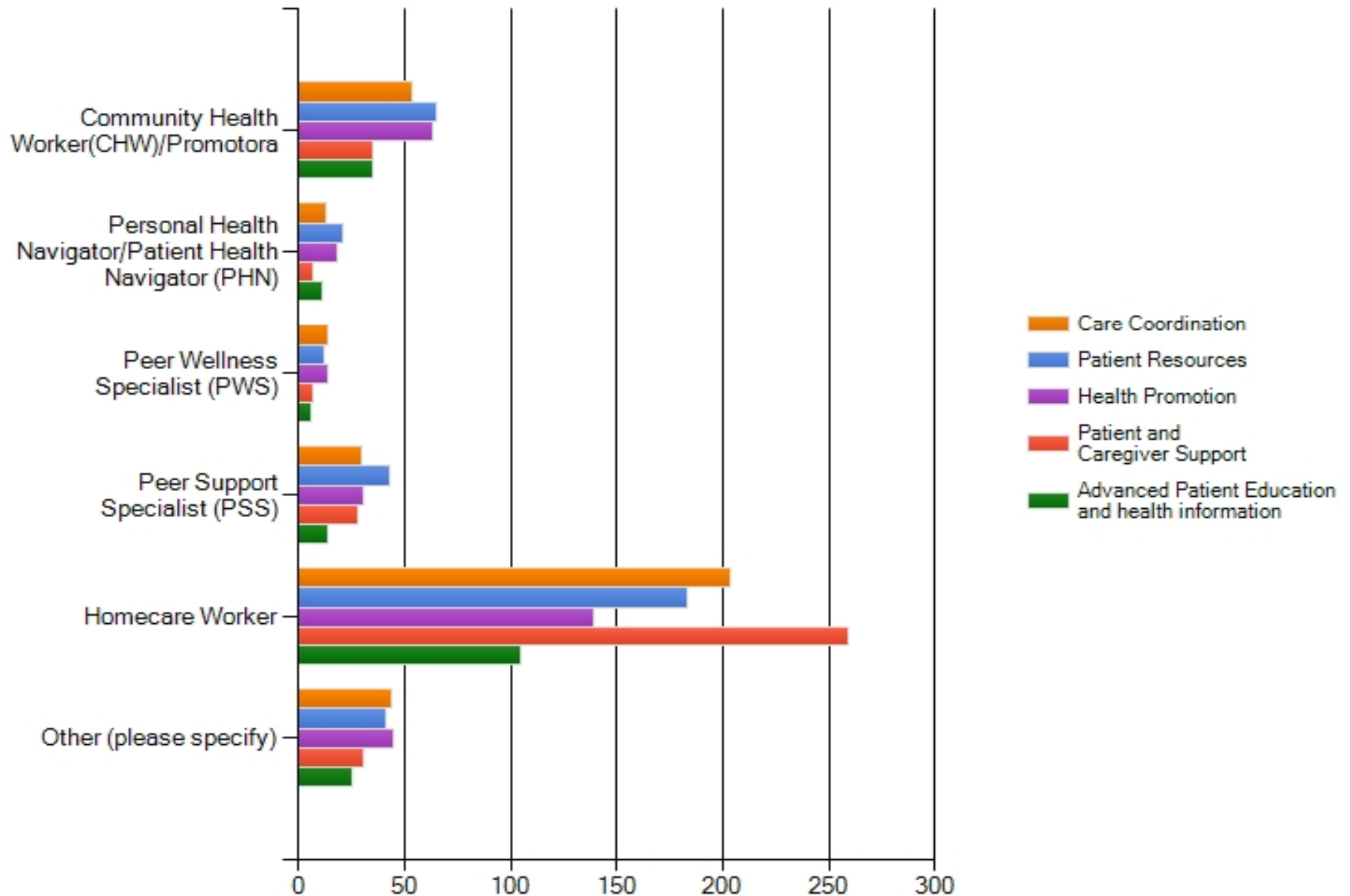
Training Topics



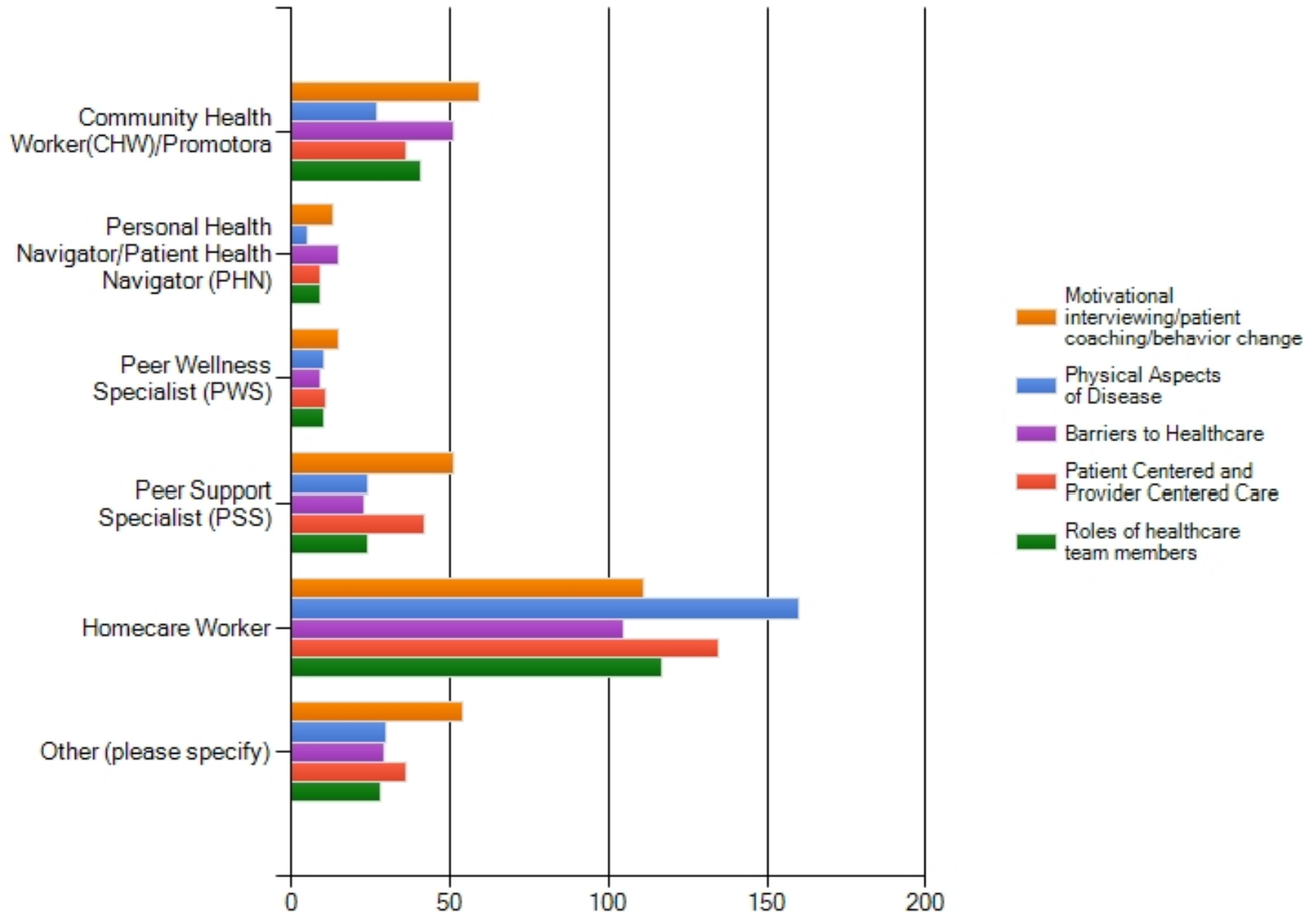
Training By Worker Type Slide 1



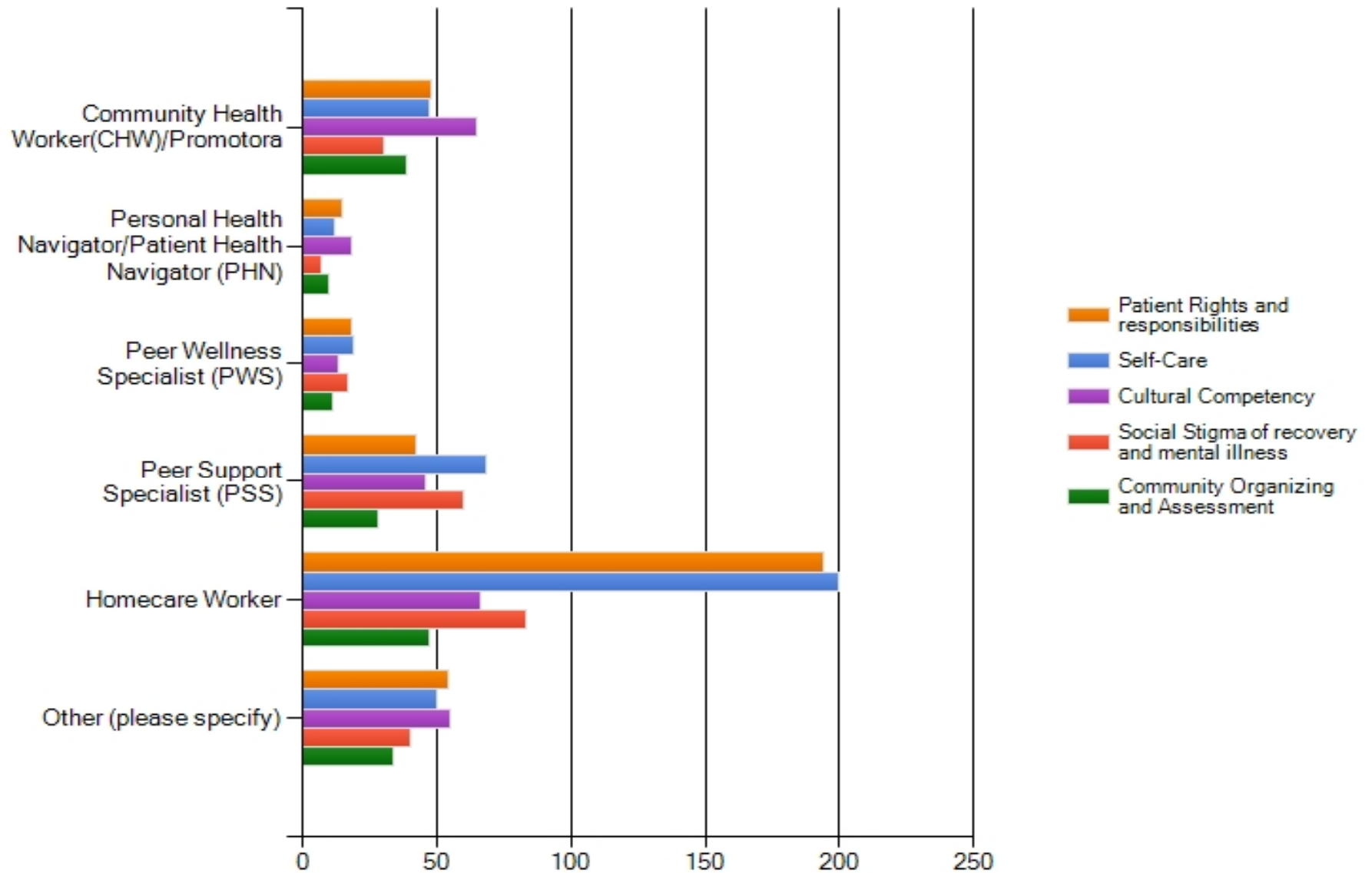
Training By Worker Type Slide 2



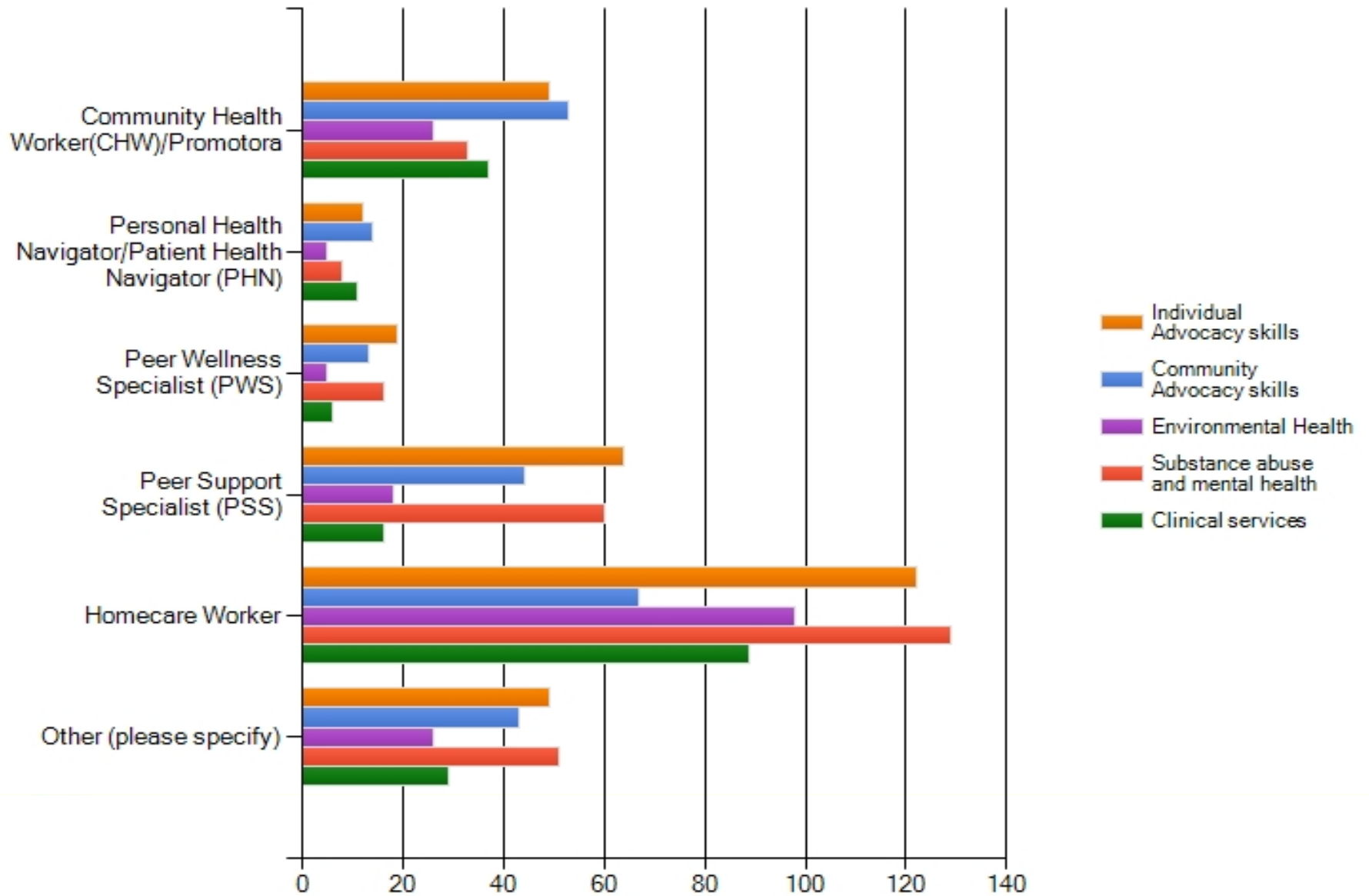
Training By Worker Type Slide 3



Training by Worker Type 4



Training By Worker Type Slide 5



Training By Worker Type Slide 6

