



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

**AGENDA**

September 19, 2011 - 9:00 to 11:30 am  
Portland State Office Building  
800 NE Oregon Street, Room 1E  
Portland, OR 97232

#	Time	Topic	Content	Who
1	20 min 9:00 – 9:20	<b>Welcome and Introductions</b>	<ul style="list-style-type: none"> <li>• 1 minute Intros</li> <li>• Name</li> <li>• Affiliation</li> <li>• One fear, one sign of success</li> </ul>	Co-Chairs: Donna Larson Teresa Rios-Campos
2	15 min 9:20 – 9:35	<b>NTHCW Charter</b>	<ul style="list-style-type: none"> <li>• Description of role of subcommittee</li> <li>• Subcommittee deliverables</li> <li>• Context of Subcommittee/Coordinated Care Organizations</li> </ul>	Carol Cheney and Lisa Angus
3	25 min 9:35 – 10:00	<b>Regulatory Issues Overview</b>	<ul style="list-style-type: none"> <li>• Description of regulatory issues</li> <li>• Key questions to be answered by Subcommittee</li> </ul>	Ralph Summers
4	15 min 10:00 – 10:15	<b>NTHCW Matrix</b>	<ul style="list-style-type: none"> <li>• Review of existing descriptions of NTHCW roles/definitions, standards and training</li> </ul>	Carol
5	10:15 – 10:25	<b>BREAK</b>	<ul style="list-style-type: none"> <li>•</li> </ul>	
5	20 min 10:25 – 10:45	<b>Small Group Work</b>	<ul style="list-style-type: none"> <li>• Cross-pollinated small groups: find 3 – 5 commonalities among three types of health workers and identify challenges in bringing the work together</li> <li>• Report back to whole group</li> </ul>	Carol
6	15 min 10:45 – 11:00	<b>Survey Plan</b>	<ul style="list-style-type: none"> <li>• Feedback on DRAFT NTHCW Survey document</li> </ul>	Carol
7	15 min 11:00 – 11:15	<b>Next Steps</b>	<ul style="list-style-type: none"> <li>• Next meeting date/time/location</li> <li>• Assignment review</li> </ul>	Carol
8	15 min 11:15 – 11:30	<b>Public Comment</b>		Donna Larson and Teresa Rios-Campos

**Meeting Documents For Review (please review prior to meeting)**

- DRAFT Charter
- CCO Fact Sheets
- OHPB Committees, Subcommittees
- NTHCW Roles/Requirement Matrix
- DRAFT Survey (will be sent to you by Friday, 9/16)

**Next meeting**  
TBD

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**Oregon Health Policy Board  
Health Care Workforce Committee  
Non-Traditional Health Worker Subcommittee**

Approved by OHPB Workforce Committee on \_\_\_\_\_, 2011

I. Authority

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The Oregon Health Authority (OHA), under House Bill 3650, Section 13, is establishing a public process to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. This system will deliver integrated health care and services to Oregonians through a Coordinated Care Organization (CCO) model of care, beginning with Oregon Health Plan enrollees and with special attention to coordinating care and services for Medicare beneficiaries who are also on the Oregon Health Plan.

The goal is a health care system where Coordinated Care Organizations (CCOs) are accountable for care management and providing integrated and coordinated health care for each organization's members. CCOs will be managed within fixed global budgets and will provide efficient, high quality, culturally competent care aimed at reducing medical cost inflation. Additionally, Oregon's health care system will maintain regulatory controls necessary to ensure affordable, quality health care for all Oregonians, while supporting the development of regional and community accountability for health and health care equity.

Oregon is experiencing a widespread shortage of its health care workforce and an increasingly diverse population. Building and fostering the utilization of the workforce of community health workers, peer wellness specialists, and personal health navigators by more fully integrating them into health care teams will help to assure high-quality, culturally competent care to traditionally underserved populations within an integrated and coordinated health care system.

Section 11 of HB 3650 directs the Oregon Health Authority, in consultation with the appropriate health professional regulatory boards and advocacy groups, to develop and establish with respect to community health workers, personal health navigators, peer wellness specialists and other health care workers who are not regulated or certified by the state of Oregon:

- (a) The criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and
- (b) Education and training requirements for such individuals.

The criteria and requirements must be broad enough to encompass the potential unique needs of any coordinated care organization and must meet requirements of the Centers for Medicare and Medicaid Services in order that their services are reimbursable under Medicaid.

As the policy-making and oversight body for OHA, the Oregon Health Policy Board (OHPB) establishes the Health Care Workforce Committee's Non-Traditional Health Worker (NTHW) Subcommittee to provide recommendations to the Board that meet the direction of Section 11 of HB 3650. The Subcommittee will be staffed by the Office for Multicultural Health and Services within OHA.

The NTHW Subcommittee will be guided by House Bill 3650, the Board's 2010 report *Oregon's Action Plan for Health*, and by OHA's Triple Aim:

- improving the lifelong health of all Oregonians;
- improving the quality, availability and reliability of care for all Oregonians, and;
- lowering or containing the cost of health care so that it is affordable for everyone.

This charter defines the objectives, responsibilities and scope of activities of the NTHW Subcommittee.

This charter shall expire in March 2012 or when the Board determines that the charter has been fulfilled, whichever is sooner.

## II. Deliverables

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The NTHW Subcommittee is chartered to describe the functions and criteria for non-traditional health workers that may be employed by Coordinated Care Organizations (CCOs) and to establish education and training criteria that are broad enough to encompass the potential unique needs of any Coordinated Care Organization and meet the requirements of the Centers for Medicare and Medicaid Services to qualify for Medicaid reimbursement.

The NTHW Subcommittee will advise the Workforce Committee and the Health Policy Board on the utilization and standards for community health workers, personal health navigators, and peer wellness specialists that may offer services within or in conjunction with CCOs.

The Subcommittee shall deliver to the full Healthcare Workforce Committee, and ultimately to the Board, the following:

- Recommendations for criteria and roles of community health workers, personal health navigators, and peer wellness specialists, including:

- The range of activities (across covered health services) that can be performed by CHWs, personal health navigators and peer wellness specialists and the core/minimum set of such activities that should be performed by such professionals in the context of CCOs.
- The education and training required for CHWs, personal health navigators and peer wellness specialists to: a) work within or in conjunction with CCOs ; and b) meet Centers for Medicare and Medicaid Services criteria to qualify for Medicaid reimbursement.

### III. Timing

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- The Health Worker Subcommittee shall convene by **September 30, 2011**.
- Assessment of current utilization of community health workers, personal health navigators, peer wellness specialists must be completed by **November 2011**.
- Research on existing education and training models must be completed by **November 2011**.
- Draft recommendations on criteria and descriptions of community health workers, personal health navigators, and peer wellness specialists, and education and training requirements will be completed by **January 2012** by the Subcommittee.
- Solicit community and stakeholder feedback by **February 2012**.
- The final recommendations will be delivered to the Health Policy Board and OHA leadership in **March 2012**.

### IV. Dependencies

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The Health Worker Subcommittee will seek information from and collaborate with a wide range of partners including:

- a. Community health workers, peer wellness specialists, personal health navigators
- b. The Department of Community Colleges and Workforce Development, the Oregon University System, OHSU, and other educational groups
- c. Appropriate health professional regulatory Boards.
- d. Health care employers and providers
- e. The Oregon Office of Rural Health, the Oregon Primary Care Office, and Oregon's Area Health Education Centers (AHECs)
- f. Oregon Primary Care Association
- g. Oregon Health Authority Addictions and Mental Health Division, DHS Seniors and People with Disabilities Division, and Public Health Division
- h. The Oregon Employment Department

- i. SEIU
- j. Mental Health Service Providers
- k. Home Care Commission

#### V. Staff Resources

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The Office of Multicultural Health and Services will work with the Office of Health Policy and Research to facilitate the work of the Health Worker Subcommittee.

##### Lead Staff:

- Carol Cheney, Office of Multicultural Health and Services

##### Healthcare Workforce Committee Staff:

- Lisa Angus, Office of Health Policy and Research

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# Better health and lower costs: Improving Oregon Health Plan services

## Proposed Coordinated Care Organizations

We all have a stake in improving health care for people who count on the Oregon Health Plan for care. Costs are skyrocketing for families, employers and government. While some local communities have done a great job of finding innovative ways to do things better, there hasn't yet been a statewide approach to providing high-quality health care while keeping costs under control.

Today, services such as mental and physical health care are usually offered separately, in fragmented and uncoordinated ways so that patients have gaps in their care. Not all communities experience an equal quality or same benefits of care. Providers are paid for treating illness, not for preventing it. Patients with chronic conditions don't get services that will keep them healthy and help them avoid unnecessary hospitalizations or emergency care.

At the same time, the state's current fiscal reality means that the state is faced with making serious reductions in provider payments in order to achieve budget targets. With this reality is an opportunity to reduce our future costs to OHP, stabilize the system and protect services.

In June of 2011, Governor Kitzhaber and the state Legislature passed a bill that would create coordinated care organizations (CCOs) across the state. These organizations would be responsible for all of the care for Oregon Health Plan patients in their communities.

By February 2012, a draft plan for how CCOs would operate will be presented to the Legislature, with a goal of launching the first CCO in July of 2012.

### GET INVOLVED

Stay informed with updates on CCO work groups and learn about upcoming public meetings. Go to [www.health.oregon.gov](http://www.health.oregon.gov).

## The Coordinated Care Organization Model of Care — keeping people healthier

Coordinated care organizations (CCOs) would manage care for OHP clients by taking the best thinking in Oregon and creating local organizations focused on one thing: reducing the barriers that stand between patients and good health. Because each community is different, there may be different models for a CCO. For CCOs to be successful, providers must want to participate, patients must be satisfied and actively involved with their own care, quality must be excellent which means it must also meet culturally diverse needs and costs must be controlled. The criteria for how CCOs would operate is being developed with input from clients, providers, stakeholders and the public.

## Key elements of coordinated care organizations

As the plans for creating this new model of care are being developed, there are some fundamental elements.

**LOCAL CONTROL:** Because each community is different, there may be different models for a CCO. One model might be a network of health care providers of all types, working with community health workers, providing comprehensive care for patients.

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**COORDINATION:** CCOs would integrate physical health, mental health, and dental health services to create a single point of accountability for the health of the entire population they serve. Providers within a CCO network would have the flexibility and incentive to focus on keeping patients healthier through preventive care and managing chronic conditions before they become severe.

**HEALTH EQUITY:** CCOs would be responsible for addressing avoidable gaps in health care outcomes among culture groups by providing care to an increasingly diverse patient population.

**GLOBAL BUDGETS AND SHARED SAVINGS:** CCOs would be reimbursed for OHP services through a global budget designed to cover all types of care. That would allow opportunities for organizations and providers to be paid in a different way and to allocate resources more strategically through the CCO. The idea is that there would be less pressure for unnecessary services and more ability for providers and health workers to spend time on care that focuses on wellness and prevention. And if a CCO meets performance goals — healthier patients and fewer hospitalizations for instance — there could be opportunities for shared savings among providers and organizations.

**METRICS/PERFORMANCE MEASURES:** Accountability and transparency will be key to the success of this new model. Coordinated care organizations would operate under contracted performance standards and benchmarks in order to ensure that care is being improved while costs are being reduced. Performance standards would include clinical, financial and operational metrics and tracking outcomes by race, ethnicity and other dimensions of Oregon's diversity.

**PRIMARY CARE HEALTH HOMES:** One proposed element of coordinated care organizations is an emphasis on primary care health homes as the center of patients' coordinated care. A primary care health home is not a place. It is a team that works on keeping patients at their healthiest, focusing on preventive care and managing chronic health conditions. By having a primary care home, patients are able to stay healthier and get their needs met by their provider, so they can stay out of the emergency room.

## How Coordinated Care Organizations would affect you

### Proposed start date: July 2012

#### Oregon Health Plan clients

Nothing is changing today. As work is done to create Coordinated Care Organizations, there is a special emphasis on maintaining stability of care for everyone served by the Oregon Health Plan.

Under the CCO model, clients who need it would have access to more personalized, coordinated and culturally sensitive care. Instead of being sent from provider to provider where their records may or may not be available, a client's mental health, physical health, care for chronic conditions and other needs would be provided by a team of people. This team will have electronic access to their patients' health records and the flexibility and incentive to get people the care they need.

#### Providers

Nothing is changing today. During this time of budget reductions it will be important to set up Coordinated Care Organizations in a way that makes things better for front line providers and allows them to practice care with more flexibility and control.

Having metrics would allow for providers and CCOs to be paid based on patient outcomes. There would be opportunities for shared savings and more incentive and help for preventive care.

As the criteria and standards for CCOs are being developed, OHP clients, providers, advocates and stakeholders can stay involved and informed. Go to [www.health.oregon.gov](http://www.health.oregon.gov) to learn more.

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# Coordinated Care Organizations: Frequently Asked Questions

We all have a stake in improving health care for people who count on the Oregon Health Plan (OHP) for care. Costs are skyrocketing for families, employers and government. The Oregon Health Plan serves more than 600,000 Oregonians and the increasing cost of health care far exceeds the rate of inflation.

In June 2011, Governor Kitzhaber and the Legislature passed a bi-partisan bill (House Bill 3650) that proposes a statewide system of Coordinated Care Organizations (CCOs). These organizations would manage all of the care for Oregon Health Plan patients in their communities. The goal of the legislation is to create a new model of health care that will improve health. The vision is also aimed at beginning to lower the high cost of care by emphasizing prevention, reducing waste, improving efficiencies and eliminating avoidable differences in quality and outcomes.

**As the criteria and standards for Coordinated Care Organizations are being developed, OHP clients, providers, advocates and stakeholders can stay involved and informed. Go to [www.health.oregon.gov](http://www.health.oregon.gov) to learn more.**

## What's being proposed?

House Bill 3650 proposes organizations in Oregon that would coordinate care for OHP clients. The idea is to take the best thinking in Oregon and creating local organizations focused on one thing: reducing the barriers that stand between patients and good health. Because each community is different, there may be different models for CCOs. The criteria for how CCOs would operate are being developed with input from clients, providers, stakeholders and the public.

## Under the proposal, when would this change happen?

The proposal is being developed and will be presented to the Legislature in February 2012. The goal would be to start approving CCOs for the Oregon Health Plan in July of 2012.

## Who would this change affect?

Oregon Health Plan clients and their families, local providers of care, hospitals, and managed care plans.

## How would things be different than they are today for OHP clients?

Today, if you are an Oregon Health Plan client, especially one with a chronic illness, you can face a dizzying array of barriers to good care. You find yourself being handed off from specialist to primary care provider and back again to address your health needs, often in an uncoordinated and fragmented way, sometimes receiving duplicative tests and procedures. Resources are scarce for community health workers to help you manage your disease.

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If you have a mental health provider and a physical health provider, they don't have the means to communicate about your overall health and health care needs. Under the CCO model, all these providers would have incentives and infrastructure to work together for your health. Additionally, HB 3650 specifically emphasizes the need for health care tailored to the cultural needs of Oregon Health Plan clients.

## **How would things be different than they are today for OHP providers?**

Under the proposal, local providers would have the means and incentive to work together for the population they serve. There would be more flexibility for preventive care, chronic disease management and culturally competent care. The CCO would manage a global budget and if performance standards were met, providers could share in the savings.

## **How would mental health care for OHP/Medicaid clients change under the CCOs?**

Mental health for Medicaid/OHP clients would be integrated with physical health care. The patient's primary care providers would work as a team with the patient's mental health professional to ensure that the client receives the right care at the right time. The CCO's vision would be to give local providers the flexibility they need to focus on a patient's overall wellness.

## **Would all OHP patients get their care through a CCO?**

Wherever possible. It won't happen overnight but as CCOs are developed across the state, clients will benefit from this new model of care. The goal is that as many OHP patients as possible would get care from their local CCO.

## **What exactly would a CCO look like?**

The vision is that CCOs would be a community-based network of patient-centered care, driven by local need. The legislation provides for flexibility to set them up in a way that will work best locally because health care needs may be different from community to community.

## **What's next and how can I get involved?**

Governor Kitzhaber has called together work groups to help develop the CCO plan, chartered by the Oregon Health Policy Board. The work groups will be focusing on CCO criteria, global budget methodology, outcomes, quality and efficiency metrics, and Medicare-Medicaid integration of care and services. They will meet until November 2011.

In addition, the Oregon Health Policy Board will continue to hold monthly meetings and there will be other statewide meetings with opportunity for public involvement.

## **How would CCOs be different than the managed care organizations that exist today?**

Today more than 80 percent of Oregon Health Plan clients receive physical and mental health through a type of managed care organization that receives a set rate per patient for health care. The MCOs contract with local providers for the care and they have done a good job over the years.

Under the CCO model, a couple of key things would change. First of all, a CCO in a community would be responsible for coordinating all of the mental, physical and dental care for OHP clients through collaborative relationships. Under the proposal, a CCO also would be paid differently than MCOs are today. There would be a global budget for all care, rather than a set rate or a "capitated rate" for each different type of care. At the same time, the CCO would have more flexibility to manage dollars in a

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way that pays for improved health rather than having to rely on approved billed services. Performance measurements for CCOs would provide incentives for better care. And CCOs would be accountable for addressing avoidable population differences in health care outcomes.

## **As a provider, I am already seeing reduced rates for Medicaid patients. Will this reduce them even more?**

The goal of creating local coordinated care organizations is to improve care and reduce costs so deeper reductions won't be necessary. Providers would have more flexibility in treating their patients. Metrics would allow for providers and CCO to be paid based on patient outcomes, instead of by just the number of services provided. For example, by keeping patients at their healthiest and out of high-cost emergency rooms, providers would be paid more than if their patients' health did not improve. There are opportunities for shared savings when patients are healthy and not in need of high-cost care such as emergency room visits.

## **What is a global budget and how would it be determined? How is it different than capitated rates?**

A global budget would be provided to each CCO to provide high-quality coordinated health care to the population it serves. Providers would have more flexibility in how they use this budget, so they can work to keep patients healthier in the ways that best meet their patients' and community's needs.

Global budgets also provide opportunities for shared savings when providers and CCOs meet their goals.

## **Where can I get more information?**

Go to [www.health.oregon.gov](http://www.health.oregon.gov).

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## **Oregon Health Policy Board**

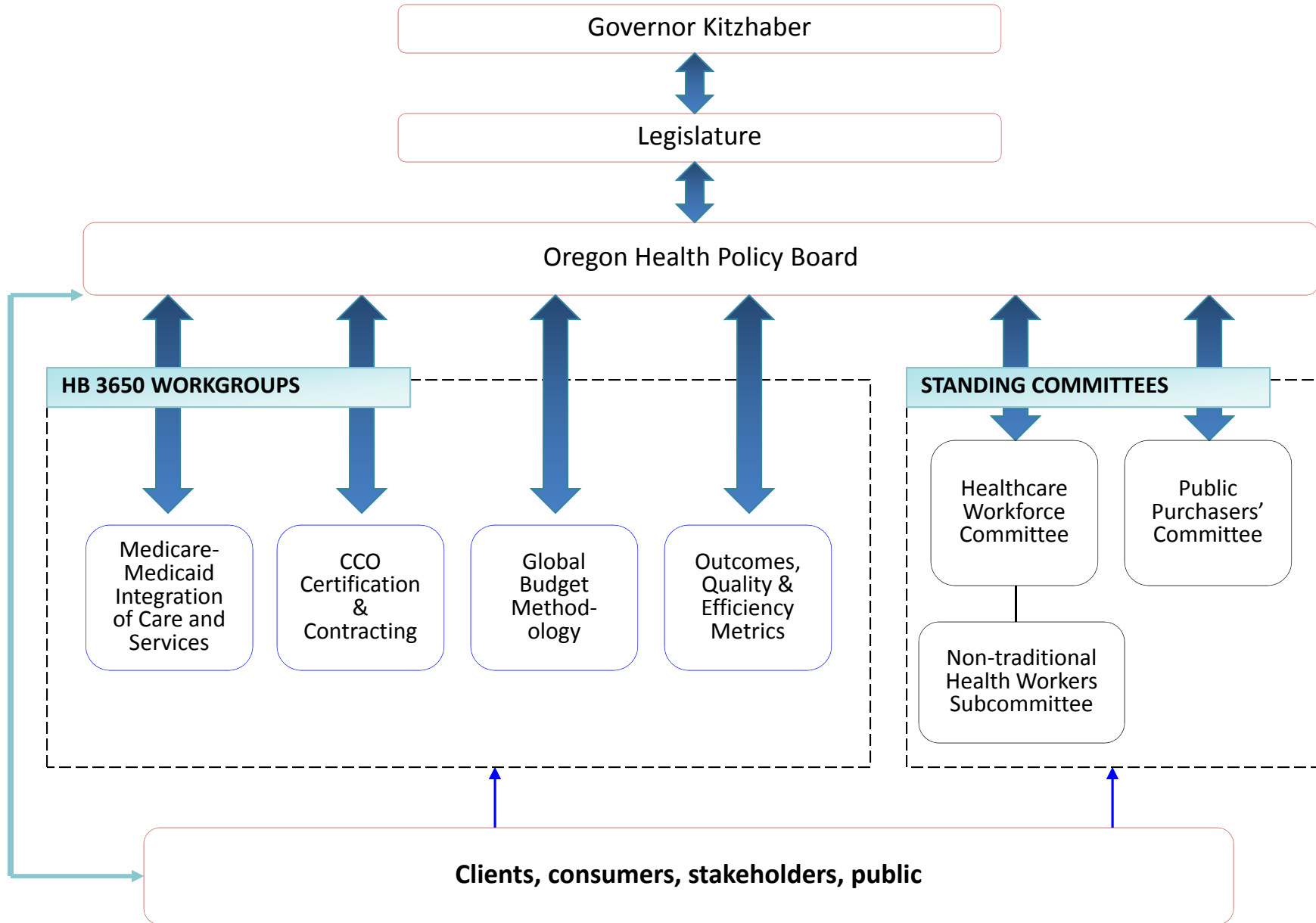
The Oregon Health Policy Board is a nine-member citizen board serving as the policy-making and oversight body for the Oregon Health Authority. It is responsible for improving access, cost and quality of the health care delivery system, and the health of all Oregonians. OHPB was established through House Bill 2009.

[www.oregon.gov/OHA/OHPB/contact\\_us.shtml](http://www.oregon.gov/OHA/OHPB/contact_us.shtml)



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Oregon Health Policy Board Committees and Workgroups (Fall 2011)



	<b>Community Health Workers</b>	<b>Peer Wellness Specialist/Peer Support Specialist</b>	<b>Patient Health Navigator</b>
<b>Definition</b>	<p><b>US Department of Labor:</b></p> <p>Standard Occupational Classification Adopted in 2009</p> <p>21-1094 Community Health Workers: 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 resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091).</p>	No definition under US dept of Labor	No definition under US dept of Labor
	<p><b>State of Oregon:</b></p> <p>"Community health worker" means an individual who promotes health or nutrition within the community in which the individual resides, by:</p> <ul style="list-style-type: none"> <li>(a) Serving as a liaison between communities, individuals and coordinated care organizations;</li> <li>(b) Providing health or nutrition guidance and social assistance to community residents;</li> <li>(c) Enhancing community residents' ability to effectively communicate with health care providers;</li> <li>(d) Providing culturally and linguistically appropriate health or nutrition education;</li> <li>(e) Advocating for individual and community health;</li> <li>(f) Conducting home visitations to monitor health needs and reinforce treatment regimens;</li> <li>(g) Identifying and resolving issues that create barriers to care for specific individuals;</li> <li>(h) Providing referral and follow-up services or</li> </ul>	<p><b>State of Oregon:</b></p> <p>"Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete an AMH approved training program and be:</p> <ul style="list-style-type: none"> <li>(a) A self-identified person currently or formerly receiving mental health services; or</li> <li>(b) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or</li> <li>(c) A family member of an individual who is a current or former recipient of addictions or mental health services.</li> </ul>	<p><b>State of Oregon:</b></p> <p>"Personal health navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes</p>

	<p>otherwise coordinating health and social service options; and  (i) Proactively identifying and enrolling eligible individuals in federal, state, local, private or nonprofit health and human services programs.</p>		
	<p><b>Other Definitions:</b></p> <p><b>Oregon Community Health Worker Advisory Council:</b>  Community Health Workers (CHWs) are trusted community members who participate in training so that they can promote health in their own communities.</p>	<p><b>Other Definitions:</b></p> <p><b>Hawaii:</b>  A person in recovery from mental illness and possibly with co-occurring substance abuse who has taken the Hawaii Certified Peer Specialist Training and successfully passed the written and oral examinations, and who has been awarded a Certification Diploma.</p> <p><b>Pennsylvania:</b>  Peer Support services are specialized therapeutic interactions conducted by trained professionals who are self-identified current or former consumers of behavioral health services. On an ongoing basis, individuals receiving the service are given the opportunity to participate in and make decisions about the activities conducted. Services are self-directed and person-centered with a recovery focus. Peer Support services facilitate the development of recovery skills. Services are multi-faceted and include, but are not limited to, individual advocacy, crisis management support, and skills training.</p> <p><b>Maine:</b>  Certified Intentional Peer Support Specialist (CIPSS) means an individual who has completed the DHHS Office of Adult Mental Health Services (OAMHS) curriculum for CIPSS and receives and maintains certification. The training is 58 hours.</p> <p><b>Minnesota:</b></p> <ol style="list-style-type: none"> <li>1. Non-clinical Peer Support counseling</li> <li>2. Wrap around continuum of services.</li> <li>3. Individualized to the consumer</li> <li>4. Promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, maintenance of skills learned in other support</li> </ol>	<p><b>Other Definitions:</b></p> <p>***Note:</p> <ul style="list-style-type: none"> <li>• Patient Navigators often defined as a subset of community health worker an/or used interchangeably with the term CHW.</li> <li>• The concept of patient navigation originated for the purpose of eliminating barriers to timely cancer screening, diagnosis, treatment, and supportive care. Currently the patient navigation model has been expanded to include the timely movement of an individual across the entire health care continuum from prevention, detection, diagnosis, treatment, and supportive, to end-of-life care.</li> </ul>

		<p>services.</p> <p><b>Wisconsin:</b>  A peer specialist is a staff person who:</p> <ol style="list-style-type: none"> <li>1. Is at least 18 years old,</li> <li>2. Shall have successfully completed 30 hours of training during the past two years in recovery concepts, consumer rights, consumer centered individual treatment planning, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, and consumer confidentiality.</li> <li>3. Has a demonstrated aptitude for working with peers.</li> <li>4. Has a self identified mental health disorder or substance use disorder.</li> </ol>	
<b>Scope of Practice</b>	<p><b>Oregon:</b>  Multnomah County Capacitation Center:</p> <ul style="list-style-type: none"> <li>• Bridging Cultural Mediation Between Communities and the Health and Social Service Systems <ul style="list-style-type: none"> <li>○ Educating community members about how to use the health care and social service systems</li> <li>○ Educating the health and social service systems about community needs and perspectives</li> <li>○ Information gathering among clients</li> <li>○ Interpretation and translation</li> </ul> </li> <li>• Providing Culturally Appropriate Health Education and Information <ul style="list-style-type: none"> <li>○ Teaching concepts of health promotion and disease prevention</li> <li>○ Helping to manage chronic illness</li> <li>○ Training other CHWs</li> </ul> </li> <li>• Assuring that People Get the Services They Need <ul style="list-style-type: none"> <li>○ Case Finding</li> <li>○ Making Referrals</li> <li>○ Motivating and encouraging people to</li> </ul> </li> </ul>	<p><b>New Hampshire:</b></p> <ol style="list-style-type: none"> <li>1. Foster recovery from mental illness by helping individuals identify and achieve personal goals while building an evolving vision of their recovery;</li> <li>2. Foster self-advocacy skills, autonomy, and independence;</li> <li>3. Foster the ability of people with mental illness to: <ol style="list-style-type: none"> <li>a. Fully participate in their families;</li> <li>b. Fully participate in their communities; and</li> <li>c. Be employed;</li> </ol> </li> <li>4. Emphasizes mutuality and reciprocity as demonstrated by: <ol style="list-style-type: none"> <li>a. Shared decision making;</li> <li>b. Strong conflict resolution;</li> <li>c. Non-medical approaches to help; and</li> <li>d. Non-static roles, such as, staff who are members and members who are educators;</li> </ol> </li> <li>5. Offers alternative views on mental health, mental illness and the effects of trauma and abuse;</li> <li>6. Encourages informed decision-making about all aspects of people’s lives;</li> <li>7. Supports people with mental illnesses in challenging perceived self-limitations, while</li> </ol>	<p><b>Institute for Alternative Futures report, The DRA Project: Patient Navigator Program Overview:</b>  Patient navigators help patients and their families navigate the fragmented maze of doctors’ offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided by patient navigators vary by program and the needs of the patient, but often include:</p> <ul style="list-style-type: none"> <li>• Facilitating communication among patients, family members, survivors and healthcare providers.</li> <li>• Coordinating care among providers.</li> <li>• Arranging financial support and assisting with paperwork.</li> <li>• Arranging transportation and child care.</li> <li>• Ensuring that appropriate medical records are available at medical appointments.</li> <li>• Facilitating follow-up appointments.</li> <li>• Community outreach and building partnership with local agencies and groups.</li> <li>• Ensuring access to clinical trials.</li> </ul> <p>Examples of some of the frequently encountered barriers</p>

	<ul style="list-style-type: none"> <li>○ obtain care <ul style="list-style-type: none"> <li>○ Taking people to services</li> <li>○ Providing follow-up</li> </ul> </li> <li>● Providing Informal Counseling and Support <ul style="list-style-type: none"> <li>○ Providing individual support and informal counseling</li> <li>○ Leading support groups</li> </ul> </li> <li>● Advocating for Individual and Community Needs</li> <li>● Providing Direct Services <ul style="list-style-type: none"> <li>○ Providing clinical services</li> <li>○ Meeting basic needs (ie/enough food, adequate housing, clothing and employment)</li> </ul> </li> <li>● Building Individual and Community Capacity <ul style="list-style-type: none"> <li>○ Assessing individual and community needs</li> </ul> </li> </ul> <p><b>Minnesota:</b></p> <ol style="list-style-type: none"> <li>1. Bridge the Gap between communities and the health and social services systems</li> <li>2. Navigate the health and human services system</li> <li>3. Advocate for individual and community needs</li> <li>4. Provide direct services</li> <li>5. Build Individual and community Capacity</li> </ol>	<p>encouraging the development of beliefs that enhance personal and relational growth; and</p> <ol style="list-style-type: none"> <li>8. Emphasizes a holistic approach to health that includes a vision of the “whole” person.</li> </ol> <p><b>Illinois</b></p> <ol style="list-style-type: none"> <li>1. Mentoring</li> <li>2. Recovery Support</li> <li>3. Advocacy</li> <li>4. Professional Responsibility (ie/Respond appropriately to risk indicators to assure the consumer's welfare and physical safety.)</li> </ol> <p><b>Pennsylvania:</b></p> <ol style="list-style-type: none"> <li>1. Provide opportunities for individuals receiving services to direct their own recovery and advocacy process.</li> <li>2. Teach and support acquisition and utilization of skills needed to facilitate the individual's recovery.</li> <li>3. Promote the knowledge of available service options and choices.</li> <li>4. Promote the utilization of natural resources within the community.</li> <li>5. Facilitate the development of a sense of wellness and self worth.</li> </ol>	<p>that may be eliminated through patient navigation are the following:</p> <ul style="list-style-type: none"> <li>● Financial barriers (including uninsured and under insured)</li> <li>● Communication barriers (such as lack of understanding, language/cultural)</li> <li>● Medical system barriers (fragmented medical system, missed appointments, lost results)</li> <li>● Psychological barriers (such as fear and distrust)</li> <li>● Other barriers (such as transportation and need for child care)</li> </ul>
<p><b>Roles and Competencies</b></p>	<p><b>Minnesota:</b></p> <ul style="list-style-type: none"> <li>● Core Competencies <ul style="list-style-type: none"> <li>○ Role, Advocacy and Outreach</li> <li>○ Organization and Resources</li> <li>○ Teaching and Capacity Building</li> <li>○ Legal and Ethical Responsibilities</li> <li>○ Coordination and Documentation</li> <li>○ Communication and Cultural Competency</li> </ul> </li> <li>● Health Promotion Competencies <ul style="list-style-type: none"> <li>○ Healthy Lifestyles</li> <li>○ Heart and Stroke</li> <li>○ Maternal Child and Teens</li> <li>○ Diabetes</li> <li>○ Cancer</li> <li>○ Oral Health</li> </ul> </li> </ul>	<p><b>The National Association of Peer Support Specialists:</b></p> <ul style="list-style-type: none"> <li>● Mutual Responsibility: <ul style="list-style-type: none"> <li>○ Ability to demonstrate the equality in a relationship even though there is power involved.</li> <li>○ Self awareness</li> <li>○ Ability to own one' s part</li> <li>○ Ability to negotiate the rules of the relationship</li> <li>○ Ability to self reflect (demonstrate critical awareness of patterns)</li> <li>○ To be able to see perspectives as just that (rather than seeing things as right or wrong)</li> <li>○ Communicating respectfully and responsibility.</li> </ul> </li> <li>● Mutual Learning and Growing Together</li> </ul>	<p><b>American Cancer Society:</b></p> <p>PNs vary with respect to educational and health care experience. Generally, they fall into two main categories:</p> <ul style="list-style-type: none"> <li>● Professional (e.g., registered nurse, licensed social worker)</li> <li>● Peers or lay persons: <ul style="list-style-type: none"> <li>○ Patient Navigation Research Project requires minimal education, at least a high school diploma or GED,</li> <li>○ Some basic computer skills,</li> <li>○ and fluency in English, whereas</li> </ul> </li> <li>● The ACS Patient Navigator Program employs, primarily but not strictly, professional (Bachelors degree or higher) level staff including nurses, social workers, and cancer survivors.</li> </ul>

	<ul style="list-style-type: none"> <li>○ Mental Health</li> </ul> <p><b>The National Community Health Advisor Study (1998), funded by the Annie E. Casey Foundation:</b></p> <ul style="list-style-type: none"> <li>● Providing cultural mediation between communities and the health care and social service system</li> <li>● Providing culturally-appropriate and accessible health education and information</li> <li>● Assuring that people get the services they need</li> <li>● Providing informal counseling and social support</li> <li>● Advocating for individual and community needs</li> <li>● Providing direct service</li> <li>● Building individual and community capacity</li> </ul>	<ul style="list-style-type: none"> <li>○ Knowledge and value of many paths to recovery</li> <li>○ Communication skills</li> <li>○ Conflict resolution</li> <li>○ Demonstrate learning from each other</li> <li>○ Be able to challenge each other</li> <li>○ Being able to transcend roles of helper and helpee</li> <li>○ Understanding that when “Help” is one-sided, it can perpetuate learned helplessness.</li> <li>○ Understanding that “help” is best when it is born out of a relationship that both people have nurtured (like a pot latch). “We have both added capital to this supportive relationship. We can both draw on it for support when we need it. We are both responsible for continuing to add to it.”</li> <li>● Whether or not one of us is a paid employee, we are equal: <ul style="list-style-type: none"> <li>○ in our ability to contribute to the relationship</li> <li>○ in our ability to share personal experience and feelings</li> <li>○ in the way we contribute strengths and ideas</li> <li>○ in the way we help one another learn and grow</li> </ul> </li> <li>● Respect <ul style="list-style-type: none"> <li>○ Ability to hold multiple perspectives</li> <li>○ Demonstrate acceptance of each individual.</li> <li>○ Demonstrate understanding that all “truths” are equal Ability to communicate in a way that someone else can hear • Use language that is positive and strength based and that presumes recovery will happen.</li> <li>○ Use language that reflects, “You are the expert in your own experience.”</li> <li>○ Use language that is non-clinical, natural and human.</li> <li>○ Use language that is individualized to the</li> </ul> </li> </ul>	
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		<p>person's uniqueness, avoids labels, and does not perpetuate stigma or double standards.</p> <ul style="list-style-type: none"> <li>• No Assumption of a Problem. Being with You and not Having to Fix You <ul style="list-style-type: none"> <li>○ Strengths based recovery.</li> <li>○ Wellness and well-being</li> <li>○ Self awareness of need to problem solve</li> <li>○ Understanding that others have learned to focus on problems</li> <li>○ Ability to shift problem into vision</li> </ul> </li> <li>• Self Awareness and Continuous Critical Learning (and unlearning) <ul style="list-style-type: none"> <li>○ Flexible boundaries and setting limits</li> <li>○ Sharing my story</li> <li>○ Recognize the presence of power</li> <li>○ Ability to use feedback and supervision. Demonstrate ability to “step back” from one’s perspective</li> <li>○ Willingness to try on other views</li> <li>○ Ability to acknowledge patterns and old notions of help</li> <li>○ Ability to celebrate resistance and multiple viewpoints</li> <li>○ Understanding that each person has the best knowledge about him or herself.</li> </ul> </li> <li>• Shared Risk <ul style="list-style-type: none"> <li>○ Avoiding extremes when there seems to be risk concerning a person’s life or livelihood -- not abandoning people when there may be such risk and not “taking over” either</li> <li>○ Celebrating a person’s willingness to take risks toward new growth.</li> </ul> </li> <li>• Creating Community <ul style="list-style-type: none"> <li>○ Diversity</li> <li>○ Recovery environment • Focus on community type relationship as opposed to service/provider type relationship</li> <li>○ Demonstrate Flexible boundaries</li> <li>○ The relationship is about 2 valuable experts. You are the expert on yourself and I am the expert on myself. We can orchestrate our strengths, learn and grow from one another,</li> </ul> </li> </ul>	
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		<p>and both be wiser from the process.</p> <ul style="list-style-type: none"> <li>○ Because we believe we are both experts who are strong, we don't try to fix one another or make conclusions about one another.</li> <li>● Trauma Informed <ul style="list-style-type: none"> <li>○ The power of resilience.</li> <li>○ Not see things from a diagnostic perspective</li> <li>○ Demonstrate an understanding of the impact of trauma and abuse on actions, beliefs, behaviors and relationships</li> </ul> </li> <li>● Hope <ul style="list-style-type: none"> <li>○ Believes in anyone's recovery/healing/growth</li> <li>○ Ability to create hope inducing conversations (but not patronizing)</li> </ul> </li> <li>● Holistic <ul style="list-style-type: none"> <li>○ Understand the extent to which the mental health system has reinforced reductionism</li> <li>○ Be able to advocate beyond reductionism</li> <li>○ See things as interconnected (mental health connected to physical, emotional, spiritual etc)</li> </ul> </li> <li>● Empowerment <ul style="list-style-type: none"> <li>○ Knowledge of the power dynamics that exist in various settings and contexts.</li> <li>○ Ability to negotiate and share power.</li> <li>○ Avoids arbitrary rule making and protectionism that denies others their power and right to choose.</li> <li>○ Role models personal responsibility and accountability avoiding the attitude of entitlement.</li> </ul> </li> <li>● Cultural Competence <ul style="list-style-type: none"> <li>○ Know that culture is a very encompassing concept</li> <li>○ Be self aware of ethnocentrism</li> <li>○ Demonstrate ability to understand someone else's cultural experience</li> </ul> </li> <li>● Staying Peer <ul style="list-style-type: none"> <li>○ Ability to negotiate power/conflict/safety</li> <li>○ Have awareness of falling into assessment</li> </ul> </li> </ul>	
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<b>Training Curriculum</b>	<p><b>Oregon:</b> Multnomah County Capacitation Center: Curriculum is based on findings in Chapter 3 (Roles and Competencies) of the <u>National Community Health Advisor Study</u> (Wiggins and Borbón, 1998). It has 3 components:</p> <ul style="list-style-type: none"> <li>▪ Skill base</li> <li>▪ Orientation to the health and social service system</li> <li>▪ Health issues</li> </ul> <p><b>Other:</b> The Central Massachusetts Area Health Education Collaborative Outreach Worker Training Institute</p> <ul style="list-style-type: none"> <li>• Curriculum focuses on a range of competencies, including: <ul style="list-style-type: none"> <li>o Communication</li> <li>o community assessment</li> <li>o advocacy skills</li> <li>o environmental health</li> <li>o substance abuse</li> <li>o and mental health.</li> </ul> </li> </ul> <p>The Community Health Education Center at the</p>	<p><b>Oregon:</b> AMH has established requirements for groups seeking to provide certified curriculum/training. Curriculum must meet the following requirements:</p> <p>Principles</p> <ul style="list-style-type: none"> <li>• Culturally Appropriate</li> <li>• Informed Choice</li> <li>• Partnership</li> <li>• Person Centered</li> <li>• Strengths-Based</li> <li>• Trauma Informed</li> </ul> <p>Elements</p> <ul style="list-style-type: none"> <li>• Communication <ul style="list-style-type: none"> <li>o Crisis Intervention</li> <li>o Listening Skills</li> <li>o Problem-Solving Skills</li> <li>o Relationship Building</li> </ul> </li> <li>• Education <ul style="list-style-type: none"> <li>o Provide basic information of the arena you are preparing people to serve in: Adult Mental Illness, Addiction or Children’s Mental Health</li> <li>o Provide basic information of the arena you are</li> </ul> </li> </ul>	<p><b>Oregon:</b> <b>Northwest Area Indian Board:</b></p> <ul style="list-style-type: none"> <li>• Funded by the Center to Reduce Cancer Health Disparities</li> <li>• Expanding an existing navigation project into five diverse tribal communities and provide breast, cervical, prostate and colorectal cancer navigation services, in partnership with tribal health centers.</li> </ul> <p><b>Other:</b> <b>NCI Center to Reduce Cancer Health Disparities, American Cancer Society, and the NCI Program Evaluation Contractor, NOVA Research Company:</b></p> <ul style="list-style-type: none"> <li>• Only national training program</li> </ul> <p>Key Topics</p> <ul style="list-style-type: none"> <li>• Overview of Health Disparities/Cancer Disparities <ul style="list-style-type: none"> <li>o The inception of patient navigation (PN) and patient assistance programs</li> <li>o Types of PN programs (community based, telephone based, hospital based)</li> <li>o Information about three national programs of navigation: NCI Patient Navigator Research Program</li> </ul> </li> </ul>

	<p><b>Boston Public Health Commission:</b></p> <ul style="list-style-type: none"> <li>• leadership</li> <li>• cultural competence</li> <li>• community organizing and assessment.</li> <li>• As with its counterpart program the OWTI, participants can earn academic credit in local universities and colleges.</li> </ul> <p><b>Minnesota Community Health Worker Alliance:</b></p> <ul style="list-style-type: none"> <li>• Blends classroom and field-based learning</li> <li>• Curriculum consists of six (1 and 2 credit) required courses <ul style="list-style-type: none"> <li>○ The Community Health Worker Role: Advocacy and Outreach</li> <li>○ Organization and Resources: Community and Personal Strategies</li> <li>○ Community Health Worker's Role in Teaching and Capacity Building</li> <li>○ The Community Health Worker: Legal and Ethical Responsibilities</li> <li>○ Community Health Worker: Coordination, Documentation and Reporting</li> <li>○ Communication Skills and Cultural Competence</li> </ul> </li> <li>• Offered at five educational sites</li> </ul>	<p>preparing people to serve in: Strengths-Based and/or Recovery Processes and Tools</p> <ul style="list-style-type: none"> <li>• Ethics <ul style="list-style-type: none"> <li>○ Boundaries</li> <li>○ Development of a Personal Support system</li> <li>○ Role of Peer Delivered Services</li> </ul> </li> <li>• Knowing the Law <ul style="list-style-type: none"> <li>○ Americans with Disabilities Act, Civil Rights and Fair Housing</li> <li>○ Confidentiality</li> <li>○ Documentation</li> <li>○ Mandatory Reporting</li> </ul> </li> <li>• Resources <ul style="list-style-type: none"> <li>○ Understanding the Service Delivery System in the program arena</li> <li>○ Finding Community and Support Services i.e. Disability, Childcare</li> <li>○ Agencies Advocating for Rights and Services</li> <li>○ Wellness: Including tobacco cessation resources</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ The need for research to test PN models</li> <li>• Patient Navigation: Roles and Responsibilities <ul style="list-style-type: none"> <li>○ Describe roles, responsibilities, and core competencies</li> <li>○ Review common barriers to accessing health care within health care systems</li> <li>○ Personal barriers; environmental barriers; societal barrier</li> </ul> </li> <li>• Overview of Cancer, Cancer Screening, and Cancer Treatment <ul style="list-style-type: none"> <li>○ Prevalence of cancer in the United States</li> <li>○ Health disparities by incidence, prevalence, and mortality data</li> <li>○ Definition and nomenclature of cancer types</li> <li>○ Etiology of most common types of cancer</li> <li>○ Risk factors and prevention</li> <li>○ Myths and misconceptions about cancer and causes of cancer</li> <li>○ Cancer control (primary, secondary, and tertiary prevention strategies)</li> <li>○ Introduction to screening and early detection methods for common cancers</li> <li>○ Overview of the most common treatments for cancer</li> </ul> </li> <li>• Culture and Diversity <ul style="list-style-type: none"> <li>○ Cultural competency skills development</li> <li>○ Communication</li> </ul> </li> <li>• Understanding the role of communication in the assessment of patient needs <ul style="list-style-type: none"> <li>○ Communication techniques to facilitate identification and reduction of barriers</li> </ul> </li> <li>• Introduction to Clinical Research <ul style="list-style-type: none"> <li>○ Definition and importance of research in health care</li> <li>○ Types of clinical research</li> <li>○ Roles and responsibilities in the research process</li> <li>○ Protection of subjects in research</li> <li>○ Data management in clinical research</li> </ul> </li> <li>• Mapping Resources <ul style="list-style-type: none"> <li>○ Health system and community assessment</li> </ul> </li> </ul>
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<b>Training bodies and hours of training</b>	<p><b>Oregon:</b>  Multnomah County Community Capacitation Center</p> <ul style="list-style-type: none"> <li>• 80 hours</li> </ul> <p>International Center for Traditional Childbearing Doula Program</p> <p>Indian Health Services</p> <p>☑ El Niño Sano Program</p> <p>☑ Neighborhood Health Clinics, Inc.</p> <p>☑ Parish Health Promoter Program of Providence/El Programa</p> <p>Benton County Health Dept Hispano, CHW Program</p> <p><b>Other:</b></p>	<p><b>Oregon:</b>  State of Oregon Addictions and Mental Health</p> <p><b>Other:</b>  National Federation’s Family</p> <p>Hand to Hand training from the National Alliance on Mental Illness (NAMI).</p> <p>University of Washington in conjunction with the Washington Institute for Mental Illness Research and Training</p> <ul style="list-style-type: none"> <li>• 40 hours/8 class sessions)</li> </ul> <p>State of Maine</p> <ul style="list-style-type: none"> <li>• 58 hours</li> </ul> <p>Recovery Opportunity Center (META) and Recovery Innovations Training (Pennsylvania and North Carolina)</p>	<p><b>Oregon:</b>  Northwest Area Indian Health Board</p> <p><b>Other:</b>  University of Colorado</p> <ul style="list-style-type: none"> <li>• Level 1 Patient Navigation: 4 day</li> <li>• Level 2 Patient Navigation: 6 weeks, 4-6 per week</li> </ul> <p>American Cancer Society</p> <p>Centers for Medicare and Medicaid Services</p> <p>Clinical Directors Network</p> <p>Harlem Hospital</p> <p>Long Island College Hospital</p> <p>Men as Navigators for Health</p>

	<p>The Central Massachusetts Area Health Education Collaborative Outreach Worker Training Institute</p> <ul style="list-style-type: none"> <li>• 45-hour certificate course, with classes for three-hours per week over fifteen weeks</li> <li>• Participants can earn academic credit.</li> </ul> <p>The Community Health Education Center at the Boston Public Health Commission</p> <ul style="list-style-type: none"> <li>• 55-hour, 15-session program</li> </ul> <ul style="list-style-type: none"> <li>• The State of Minnesota</li> </ul>	<ul style="list-style-type: none"> <li>• 80 hour training</li> <li>• Uses Peer Employment Training Workbook, 3<sup>rd</sup> Edition</li> <li>• Largest and most comprehensive training globally</li> </ul>	<p>National Association of Social Workers</p> <p>Nova Scotia</p> <p>Pfizer</p> <p>University of Miami: The Alfus Patient Advocacy Online Certificate Program</p>

## Community Health Worker/Patient Navigation Model and Training Programs

