The Role of Non-Traditional Health Workers in Oregon's Health Care System

Recommendations for Core Competencies and Education and Training Requirements for Community Health Workers, Peer Wellness Specialists and Personal Health Navigators

Developed by
Oregon Health Policy Board
Workforce Committee
Non-Traditional Health Worker Subcommittee

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Executive Summary

In 2011, the Oregon Legislature passed landmark legislation defining Oregon's approach to health care reform. The Oregon Health Authority (OHA), under House Bill 3650, Section 13, established 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.

Additionally, the legislation mandated the OHA, 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.

For ease of documentation, the state grouped these workers under the title "non-traditional health workers."

The Oregon Health Policy Board (OHPB) established and convened the Health Care Workforce Committee's Non-Traditional Health Worker (NTHW) Subcommittee, staffed by the Office of Equity and Inclusion, in September 2011. Key to its success was the high level of expertise and diversity of representation on the Subcommittee.

The Non-Traditional Health Worker (NTHW) Subcommittee embarked on a process to develop recommendations on core competencies and education and training requirements for NTHWs, as well as to advise on additional concepts regarding the role of NTHWs. Briefly, the Subcommittee defined the scope of work under the following four roles:

1. Outreach and Mobilization
2. Community and Cultural Liaising
3. Case Management, Care Coordination and System Navigation
4. Health Promotion and Coaching

In addition to providing specific competencies and education and training recommendations for each of these roles, this report provides an overview of the national and Oregon-specific role of non-traditional health workers; evidence of the effectiveness of the service model, including cost savings; and a description of current practices and certification models in Oregon.

We acknowledge and sincerely thank the members of the NTHW Subcommittee for providing their diverse perspectives, expertise, and wise counsel in the development of these recommendations.

I. Background

House Bill 3650

In 2011, the Oregon Legislature passed landmark legislation defining Oregon's approach to health care reform. The Oregon Health Authority (OHA), under House Bill 3650, Section 13, established 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 the regulatory controls necessary to ensure affordable, quality health care for all Oregonians by 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 role 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. In addition, these "non-traditional health workers" are uniquely placed to work with community members to identify and resolve their own most pressing health issues by addressing the social determinants of health, thus contributing to reducing and eliminating health inequities.

Section 11 of HB 3650 directed 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) established 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 is staffed by the Office for Equity and Inclusion within OHA.
The NTHW Subcommittee has been 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.

The NTHW Subcommittee

Process

The NTHW Subcommittee was convened by the Oregon Health Policy Board as a subcommittee of the OHPB Workforce Committee. Committee members were appointed to represent a broad spectrum of stakeholder organizations, including health systems, insurers, educational institutions, behavioral health and addictions recovery programs, community clinics, social service and advocacy organizations, and practicing non-traditional health workers from the field. A list of the Subcommittee members is provided in Appendix A.

The Subcommittee, convened in September 2011, met over a four-month period to develop their recommendations. The process included conducting a scan of state and national research, existing legislation, published recommendations, and programs currently utilizing NTHWs. The NTHW Subcommittee also disseminated a survey of currently practicing NTHWs in Oregon, resulting in 620 responses. Using this background research, the Subcommittee then identified commonalities and differences among the defined worker types which provided a basis for establishing a scope of work that crosses all worker types and the core competencies necessary to effectively fulfill that scope. From there, education and training requirement recommendations were developed to align with the competencies. Additionally, recommendations were provided for specialized training for specific worker types.

Non-Traditional Health Worker Definitions

House Bill 3650 defines community health workers, peer wellness specialists and personal health navigators. For ease of translation, we have used "non-traditional health workers" to encompass all three worker types:

Community Health Worker means an individual who promotes health or nutrition within the community in which the individual resides, by:

a) Serving as a liaison between communities, individuals and coordinated care organizations;
b) Providing health or nutrition guidance and social assistance to community residents;
c) Enhancing community residents' ability to effectively communicate with health care providers;
d) Providing culturally and linguistically appropriate health or nutrition education;
e) Advocating for individual and community health;

f) Conducting home visitations to monitor health needs and reinforce treatment regimens;
g) Identifying and resolving issues that create barriers to care for specific individuals;
h) Providing referral and follow-up services or 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.

Peer Wellness Specialists

For peer workers providing services in the field of behavioral health and addictions recovery, the State currently provides a definition for Peer Support Specialists only. Peer Support Specialists are those who provide 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 Addictions and Mental Health-approved training program and be:

(a) A self-identified person currently or formerly receiving mental health services; or
(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
(c) A family member of an individual who is a current or former recipient of addictions or mental health services.

The terminology "*peer wellness specialist*" is defined by peer support specialists who seek to expand the role from services focused on behavioral health and addictions recovery to include physical health promotion, and disease prevention and intervention activities for individuals and their families who experience mental health and substance abuse challenges. Peer wellness specialists receive training focused specifically reducing the levels of co-morbidity and shortened lifespan that are endemic among persons with behavioral health issues, and be active participants on primary care health teams.

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 person's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

Evidence of Effectiveness of Service Delivery and Cost Savings

As trusted community members who also understand health issues and the health care system, NTHWs are uniquely positioned to work with communities to identify and address the underlying causes of health problems. Resolving persistent health inequities requires addressing these underlying causes. The need to address health inequities must also drive development of the NTHW model.

Community Health Workers

Many studies show that CHWs contribute to improved health outcomes and overall health system savings through their impact on:

(1) Improved prevention and chronic disease management, which reduces costly inpatient and urgent care costs;

(2) Cost-shifting, with increased utilization of lower cost health services; and
(3) Indirect savings associated with reallocation of expenditures within the health care system, e.g., by appropriate team allocations within the patient centered medical home.[i] [ii] [iii]

The return on investment method has been used to assess the contribution of CHWs to a reduction in Medicaid charges or health system total costs. CHW programs for which the return on investment has been calculated fall in the range of savings or returns of $2.28 to $4.80 for every dollar spent on CHWs.[iv] [v] [vi] For example, CHWs working with underserved men in the Denver Health system were able to shift the costs of care from costly inpatient and urgent care to primary care, achieving a $2.28 return on investment for every $1.00 spent and an annual savings of $95,941.[vii]

Several studies have documented the reduction in emergency care or inpatient services associated with a CHW intervention, with savings ranging from $1,200 to $9,300 per participant in programs with CHWs.[viii] [ix] [x] [xi] [xii] [xiii] In Baltimore, African-American Medicaid patients with diabetes who participated in a CHW intervention had a 40% decrease in emergency room (ER) visits, a 33% decrease in ER admissions, a 33% decrease in total hospital admissions, and a 27% decrease in Medicaid reimbursements. The CHW program produced an average savings of $2,245 per patient per year and a total savings of $262,080 for 117 patients.[xiv]

In New York, New York-Presbyterian Hospital (NYP) has been using CHWs in their childhood asthma program. Over a 12-month period of care coordination, CHWs reduced asthma-related ER visits and hospitalization rates by more than 50%. Hospital lengths of stay were also reduced. Based on these findings, NYP incorporated the costs of CHWs into their operating budget and CHWs are now a permanent part of the community-hospital partnership childhood asthma program.[xv]

The scope of CHW work typically includes a social justice and community organizing component. A variety of studies have suggested that CHWs' role as agents of social change is, in fact, their most important role (Eng & Young, 1992; Farquhar et al., 2008), and that "the true 'value-added' in the CHW model comes when [CHWs] are allowed and encouraged" to play this role (Wiggins and Borb´on, 1998, p. 45)[xvi]

Peer Wellness Specialists

There is ample evidence that a gap exists in the quality of services available for people with mental illnesses.[xvii] This is intricately linked to the overall quality of health services, and the failure to coordinate care across the spectrum of general and mental health care.[xviii] A research base has been established that demonstrates that peer-delivered services are an effective component of mental health care[xix] and that as part of a treatment team have been shown to have a range of favorable results in regards to both patient health outcomes and cost savings.[xx] Studies show:

(1) When peers are part of hospital-based care, the results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs[xxi]
(2) Other studies also suggest that the use of peer support can help improve treatment adherence[xxii] and reduce the overall need and use for mental health services over time[xxiii][xxiv]

Decrease in Hospitalization
Several studies have documented the reduction of days spent in inpatient hospitalization for consumers with serious and persistent mental illness. Peerlink, a peer support initiative in Tennessee and Wisconsin, was able to decrease the number of hospitalization days for program participants from 7.42 to 1.9, a decrease of 73.32 percent in Tennessee. In Wisconsin, the average number of days per month of hospitalization for PeerLink participants was 0.86 or less than a day, according to the report. After involvement in the pilot program, the number of days dropped to 0.48 or by 44.19 percent.

Cost Savings
In 2006, the Georgia Department of Behavioral Health and Developmental Disabilities compared consumers using certified peer specialists as a part of their treatment, versus consumers who received the normal services in day treatment. Consumers using the services of certified peer specialists showed improvement as compared to the control group in each three outcomes over an average of 260 days between assessments in all three areas:

- Reduction of current symptoms/behaviors
- Increase in skills/abilities
- Ability to access resources/ and meet their own needs

In comparing the costs of services, those using the certified peer specialists cost the state $997 per year on average, compared to the average cost of $6,491 in day treatment, a difference of $5,494 per person.[xxv]

Increased Treatment Adherence and Overall Improved Health and Mental Health Outcomes
In studies of persons dually diagnosed with serious mental illness and substance abuse, peer led interventions were found to significantly reduce substance abuse, mental illness symptoms, and crisis.[xxvi] Consumers participating in peer programs had better adherence to medication regimens[xxvii] had better healing outcomes, greater levels of empowerment, shorter hospital stays and fewer hospital admissions (which resulted in lower costs than control group).[xxviii]

Dr. John Rush, primary researcher on the NIMH STAR*D depression study -the largest and most comprehensive study ever done in depression, conducted an evaluation of over 1,000 members participating in peer run programs through the Depression and Bipolar Support Alliance (DBSA). Ninety-five percent of those surveyed described their participation as helping them better communicate with their doctor, 97% of those surveyed described their groups as helping with being motivated to follow instructions, and being willing to take medication and cope with side effects. Those who had been participating for more than a year were less likely to have been hospitalized in the same period.[xxix]

Those who participate in peer delivered services build larger social support networks[xxx] and end up with enhanced self-esteem and social functioning.[xxxi] Peer delivered service participants showed greater levels of independence, empowerment and self- esteem. Over 60% indicated increased development of social supports.[xxxii]

Personal Health Navigators
Many studies show Personal Health Navigators contribute to improved health outcomes and overall

health system savings through their impact on:

- Quality of care, patient experiences, care coordination, and access[xxxiii].
- Reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs. These savings at a minimum offset the new investments in primary care in a cost-neutral manner, and in many cases appear to produce a reduction in total costs per patient.[xxxiv]

In Pennsylvania, The Geisinger Health System, a large integrated delivery system in Pennsylvania, implemented a Patient Centered Medical Home redesign in 11 of its primary care practices beginning in 2007. Their Proven Health Navigator model focuses on Medicare beneficiaries, emphasizing primary care-based care coordination with team models featuring nurse care coordinators, electronic health record decision support, and performance incentives. Program evaluations show:

- **Better quality care:** Statistically significant improvements in quality of preventive (74.0% improvement), coronary artery disease (22.0%) and diabetes care (34.5%) for Patient-Centered Medical Home (PCMH) pilot practice sites.
- **Reduction in costs:** Statistically significant 14% reduction in total hospital admissions relative to controls, and a trend towards a 9% reduction in total medical costs at 24 months. Geisinger estimates a $3.7 million net savings, for a return on investment of greater than 2 to 1.

In Michigan, The Genesee Health developed a PCMH model for its health plan serving 25,000 uninsured adults. The Genesee PCMH model, called Genesys HealthWorks, invested in a team approach to improve health and reduce costs, including a Health Navigator to work with primary care clinicians to support individuals to adopt healthy behaviors, improve chronic and preventive care, and provide links to community resources. Evaluations show:

- **Improved access:** 72% of the uninsured adults in Genesee County now identify a primary care practice as their medical home
- **Better quality:** 137% increase in mammography screening rates; 36% reduction in smoking and improvements in other healthy behaviors
- **Reduction in ER and inpatient costs:** 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6 % lower than competitors.

The following research matrix summarizes published studies of selected measures and costs savings, related to specific heatlh issues impacts.

Study	Health Issue	Outcome Measures	Cost Measures / Cost Savings
Barnes-Boyd, (2001)	Infant mortality reduction	Mortality rates, program retention, health problems identified, immunization rates	Implied cost saving potential in that outcomes with nurse-CHW team at least equal to those of nurse-only team (no calculations)
Beckham, (2004)	Asthma management	Reported symptoms, doctor visits, ED visits	Total per capita costs reduced from $310 to $129; ED costs reduced from $1,119 per participant to $188
Fedder, (2003)	Diabetes management	ED visits, hospital admissions, quality-of-life indicators	Cost to Medicaid reduced an average of $2,245 per patient per year; 27% decrease in mean expenditure
Krieger, (2005)	Asthma (indoor triggers)	Caregiver quality of life; use of urgent health services; symptom days	Urgent care costs were $6,301 to $8,856 less in the comprehensive CHW services group than the minimal CHW intervention group; Estimated decrease in costs over 2-mo period within comprehensive CHW services group was $201 to $334 per child
Liebman, (2007) & unpub. prog. data	Diabetes self-management	Glycemic control – changes in HbA1c levels	Annual self-management program cost: $398,870; Annual cost per patient: $532; Annual program ROI per patient = $318 or 60%; For 165 clients in program, $140,250 reduced costs in 1 year
May, (2007) & unpub. prog. data	Chronic disease	CHW care management program participants' visits to ER, & rates of hospitalization	Average annual cost for care among program participants decreased by $10,000 or 58%; Over a three year period, the ROI for each dollar invested in the program is $3.84
Rodewald, (1999)	Childhood immunizations	Immunization rates	Marginal cost per additional immunization administered = $474. Each $1,000 in program costs also produced additional preventive and other primary care office visits
Sox, (1999)	Cancer screenings for women	Effectiveness of trained Community Health Aides performing clinical exams and Pap smears (Alaska)	Implied cost saving in reduced travel of clinical personnel to remote villages (no calculations)

Weber, (1997)	Mammography	Rates of mammography use	Marginal cost of CHW activity per additional mammography performed = $375, equivalent to $11,591 per year of life saved
Whitley, (2006)	Primary care utilization	Utilization, charges and reimbursements	Care shifted from costly inpatient and urgent care services ($16,872/visit and $934/visit, respectively) to less costly primary care services ($237/visit) – resulted in total decrease in charges of $300,000 over study period; Average service cost savings per month = $14,224; ROI for each dollar invested in the program is $2.28, which equals $95,941 saved/year

Adapted from: http://www.mnchwalliance.org/ and Anthony, S., Gowler, R., Hirsch, G., & Wilkinson, G. (2009). Community Health Workers in Massachusetts: Improving health care and public health. Report of the Massachusetts Department of Public Health Community Health Worker Advisory Council

II. The Role of Non-Traditional Health Workers in Oregon

Oregon has a rich history of groundbreaking NTHW programs. The Indian Health Service in Oregon has employed CHWs since the 1960s. The El Niño Sano Program in Hood River was one of a few seminal programs founded in migrant and seasonal farmworker communities in the late 1980s. During the 1990s, Neighborhood Health Clinics, Inc. employed African American CHWs in Portland. Other programs like the Parish Health Promoter Program of Providence/El Programa Hispano and a series of CHW programs at the Benton County Health Department have continued the Oregon tradition of innovation in the CHW field. The Community Capacitation Center (CCC) of the Multnomah County Health Department is a local expert on the CHW model. The CCC's training curriculum for CHWs is based on the findings of the National Community Health Advisor Study (NCHAS) and has been approved for academic credit by the Oregon State Board of Education. The CCC training program employs the adult education and popular education approach, involves CHWs in training other CHWs, and stresses empowerment as an important aspect of the training process.[xxxv]

The OHA Addictions and Mental Health Division (AMH) works with service population stakeholder groups to develop strategies to increase the use and availability of peer delivered services (PDS). AMH recognizes the indisputable value of PDS in transforming the mental health and addiction service delivery system that is based on a recovery model. Seventeen training programs are providing certification training for peer support and peer wellness specialists. Additionally, the Peer Wellness Program of Benton County Health Services began to develop a wellness-informed training program for both Peer Wellness Specialists and Peer Wellness Coaches. They developed an outcome measurement tool that informs their interventions with individuals being served. This work has been expanded upon

and enhanced by Cascadia Behavioral Health in Portland, where peer wellness specialists are trained to work with primary care community intervention teams, addressing the needs in the community of individuals who frequently use the in-patient and emergency department and other intensive health services. Program leaders anticipate significant cost savings, as well as enhanced quality of life for those serviced.

Appendix B provides a sample listing of NTHW training and certification programs in Oregon.

Home Care Workers as Non-Traditional Health Workers

Nationally, it is estimated that the health care workforce includes 2.5 million home care and personal assistance workers, and that this number is expected to increase at rates four to five times that of jobs overall in the economy. The tremendous growth of this workforce is being fueled by profound structural changes in our society that are fundamentally reshaping long-term services and supports, including life expectancy increases and medical advances that allow individuals with chronic conditions and severe disabilities to live longer.[xxxvi]

In Oregon, the home care workforce is expected to grow by 23% between 2008 and 2018.[xxxvii] Home care and personal assistance workers provide essential daily supports and services to millions of Americans living with functional limitations and needs due to aging-related impairments, chronic disease, and other disabilities.[xxxviii] Based on the NTHW Survey, the Home Care Worker scope of work, competencies and training are closely aligned with that of the NTHWs defined in legislation. Home care workers who meet the competencies and education and training requirements of NTHWs described below will be an important addition to the Non-Traditional workforce.

III. Recommendations

Roles, Competencies and Education and Training Requirements

Role 1: Outreach and Mobilization

Definition: Outreach is the provision of health-related information, including information about health condicitions, resources, and services to community members. Mobilization is working with individuals and their natural support systems to assure that community members who may be underserved or less likely to access health care services (because of barriers such as lack of health insurance, limited English proficiency [LEP], lack of information about available services, or social or physical isolation, such as for seniors and people with disabilities) are informed, served and motivated to take action on an individual, family or community level.

Purpose: The purpose of outreach and mobilization is to support individuals, their identified families, and community members to gain the information and skills needed to effectively engage in healthy behaviors and in the health systems that support them. Non-traditional Health Workers (NTHWs) use outreach and mobilization strategies and methods to connect community members and individuals with

existing supports and services and to bring services to where people reside and work, and at trusted community sites frequented by community members and individuals potentially in need of services.

Competencies: Demonstration of basic outreach and mobilization skills includes the ability to:

- Communicate effectively with individuals and their identified families and community members about individual needs, concerns and assets
- Identify and document needs and health topics relevant to the priority population, including common strengths, barriers and challenges
- Adapt outreach strategies based on population, venue, behavior or identified risks as appropriate to a given population and its self-determined concerns
- Engage individuals and community members in ways that establish trust and rapport with them and their families
- Create a non-judgmental atmosphere in interactions with individuals and their identified families
- Develop and disseminate culturally and linguistically appropriate information to service population regarding available services and processes to engage in services
- Document and help create networks and establish partnerships and linkages with other NTHWs and organizations for the purpose of care coordination, prevention or harm reduction, and enhancing resources
- Support individuals and their identified families and community members to utilize care and community resources
- Effectively utilize various education and communication strategies to inform and educate individuals and community members about health, health interventions, and available health supports and services

Required Core Curriculum: Outreach and Mobilization

- Outreach Methods
- Community Engagement, Outreach and Relationship Building
- Communication Skills, including cross-cultural communication, active listening, and group and family dynamics
- Empowerment Techniques
- Knowledge of Community Resources

Additional Required Curriculum for specific worker types, practice settings, or jobs:

- Self-Efficacy (Community Health Workers, Peer Wellness Specialists)
- Community Organizing (Community Health Workers)
- Group Facilitation Skills (Community Health Workers, Peer Wellness Specialists)

Role 2: Community and Cultural Liaising

Definition: Community and Cultural Liaising means creating and supporting connections among individuals and their identified families, community members, providers, health systems, community based organizations and leaders, within a context of cultural beliefs, behaviors, and needs presented by individuals, their families and communities.

Purpose: To identify and effectively bridge cultural, linguistic, geographic and structural differences which prevent or limit individuals' ability to access health care or adopt health promoting or harm-reducing behaviors.

- Workers must be familiar with and maintain contact with agencies and professionals in the community in order to secure needed care and to build a network of community and professional support for the individuals they serve. They should participate in community, agency, and person-driven health planning and evaluation efforts that are aimed at improving care and bringing needed services into the community. Workers should bring information about individuals' lives that will help the provider team develop relevant helth promotion and disease management strategies.

- When encountering linguistic differences, it is recommended that providers use only qualified and/or certified health care interpreters rather than engaging family members or informal interpreters. This does not preclude NTHWs who are also qualified or certified health care interpreters.

- Workers should understand the impact of social determinants of health on health outcomes and be prepared to include strategies that work to improve health outcomes by assisting providers in identifying culturally, linguistically, and community appropriate steps that reduce or remove barriers that may be uniquely impacting health outcomes in a given community.

Competencies: Demonstration of basic community and cultural liaison skills includes the ability to:

- Advocate for individuals and their identified families, and community groups/populations
- Recognize and define cultural, linguistic, and social differences, such as differing understandings of: family unity, religious beliefs, health-related beliefs and practices, generational differences, traditions, histories, socioeconomic system, refugee and immigration status and government systems
- Educate person-centered care teams and service systems about community needs and perspectives
- Build individual, clinical team, and community capacity to support people who seek and receive care by providing information/education on specific health issues and interventions, including identifying and addressing social determinants of health
- Recognize conflict and utilize conflict resolution strategies

- Conduct individual needs assessments

Required Core Curriculum: Community and Cultural Liaison

- Cultural Competency/Cross Cultural Relationships (including briding clinical and community cultures)
- Conflict Identification and Problem Solving
- Social Determinants of Health
- Conducting individual Needs Assessments
- Advocacy Skills
- Building Partnerships with local agencies and groups

Additional Required Curriculum for specific worker types, practice settings, or jobs:

- Conducting Community Needs Assessments (Community Health Workers)

Role 3: Case Management, Care Coordination, and System Navigation

Definition: Case management, care coordination and system navigation is a collaborative process of assessment, planning, facilitation and advocacy to help people evaluate options and access services.

Purpose: To meet an individual's holistic health needs through available resources in a timely and efficient manner, which may include recognizing and promoting system-level changes needed to meet individual and community needs. To assure the provision of culturally and linguistically appropriate services. To reduce duplicative, damaging or unnecessarily costly interventions that occur through lack of coordination.

Competencies: Demonstration of basic case management, care coordination and system navigation skills includes the ability to:

- Deliver person-centered information and advocacy
- Provide timely and accurate referrals
- Work effectively across multidisciplinary teams
- Demonstrate and communicate understanding of public and private health and human services systems
- Coordinate between multiple providers, provider teams, and systems providing care and services
- Assure follow up care and support individual and providers to maintain connections throughout treatment process
- Disseminate information to appropriate individuals
- Understand and maintain culturally-appropriate ethical boundaries between self and individual or family being served
- Describe individual(s)' rights and confidentiality clearly and appropriately, including informed consent and mandatory reporting requirements

- Utilize crisis management techniques
- Complete accurate and timely documentation of care processes, including effectively using tools such as computer programs, databases, charts and other documentation materials needed by supervisor/care team
- Assist individual (and identified family members as appropriate) to set goals and collaboratively plan specific actions to reach goals
- Assist people with paperwork needed to access services
- Assist people to access basic needs services (e.g. food, housing, employment, etc.)

Required Core Curriculum: Case Management, Care Coordination, and System Navigation

- The Role of Non-Traditional Health Workers
- Roles and Expectations for Working in Multidisciplinary Teams
- Ethical Responsibilities in a Multicultural Context
- Legal Responsibilities
- Paths to Recovery (specific to worker type)
- Data Collection and Types of Data
- Organization Skills and Documentation, Using Health Information Technology
- Crisis Identification, Intervention and Problem-Solving
- Professional Conduct (including culturally-appropriate relationship boundaries and maintaining confidentiality)
- Navigating public and private health and human service systems (state, regional, local)
- Working with caregivers, families, and support systems, including paid care workers

Role 4: Health Promotion and Coaching

Definition: Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health (World Health Organization, 2005).

Purpose: To assist individuals and their identified families in making desired behavioral changes and adopt behaviors that are sustainable, mutually acceptable, promote positive health outcomes, and are understood by families and community contacts. To identify and enhance individual, family, community, and social norms and strengths, as well as barriers to health and healthy behaviors.

Competencies: Demonstration of basic health promotion and coaching skills includes the ability to:

- Define and describe basic disease processes including chronic diseases, mental health, and addictions, basic warning signs and symptoms
- Define and describe basic dynamics of traumatic issues impacting health, such as child abuse, domestic violence, self harm, and suicide

- Motivate individual to engage in behavior change, access needed services and/or advocate for themselves
- Provide coaching and support for behavior change (self-management), including responding to questions and/or fears, offering multiple examples of desired changes and potential outcomes, and using appropriate and accessible formats for conveying health information
- Collect and apply knowledge of individuals' history and background, including experiences of trauma, to inform health promotion and coaching strategies
- Assist individual to set goals and collaboratively plan specific actions to reach goals
- Provide informal emotional or psychological support through active listening, paraphrasing and other supportive techniques
- Support and empower individuals to choose from treatment options where available and support adherence to treatment choice

Required Core Curriculum: Health Promotion and Coaching

- Introduction to Disease Processes including chronic diseases, mental health, and addictions (warning signs, basic symptoms, when to seek medical help)
- Trauma-Informed Care (screening and assessment, recovery from trauma, minimizing re-traumatization)
- Health Across the Life Span
- Adult Learning Principles - Teaching and Coaching
- Stages of Change
- Health Promotion Best Practices
- Self-Care
- Health Literacy Issues

Additional Required Curriculum for specific worker types, practice settings, or jobs:

- Popular Education Methods (Community Health Workers)
- Basic Healthcare Tasks associated with observation and reporting (Community Health Workers)
- Cultivating Individual Resilience (Peer Wellness Specialists)
- Recovery and Wellness Models (Peer Wellness Specialists)
- Healthcare Best Practices (specific to fields of practice)
- Healthcare Best Practices (specific to fields of practice as to be determined by CCO)

The Subcommittee also recommends advanced level training in Motivational Interviewing for Community Health Workers and Peer Wellness Specialists.

Certification

Certification Concepts

While many Oregon entities have developed strong programs to train and, in some cases, certify non-traditional health workers, no standard core curriculum for all NTHWs has been identified. This lack of standardization creates potential challenges for the field including:

- Lack of clarity of NTHW role
- Lack of optimal integration of NTHWs by health care providers
- Lack of sustainable funding, including missed opportunities for payment options through Medicaid/Medicare
- Limited recognition of the value of NTHWs
- Limited options for individual development along health care career paths

Key to others states' certification processes is the intentional minimization of requirements that could create unintended consequences, including:

- Loss of holistic and culturally based approaches key to reducing health disparities and promoting health equity
- Exclusion of community members and currently practicing NTHWs from their own field
- Creation of barriers for new NTHWs to enter the field

Recommendations

In order to reduce barriers and unintended consequences through certification, the NTHW Subcommittee provides the following recommendations:

- Certify training programs that include the required core competencies and core curriculum. Exact number of hours and method of training are still under discussion by the Subcommittee; however, a minimum 80 core curriculum contact hours are currently recommended and both didactic and on-the job hours are under consideration, with additional contact hours adequate to cover the supplemental training recommended for specific worker types, practice settings, or jobs.

- Require statewide oversight of training programs through a yet to be determined mechanism, review and approve curriculum, review program educational methodologies to ensure inclusion of accepted adult learning strategies for high quality training, maintain registry and/or certification records, including potential ethics violations, advocate for and promote NTHW professions, including the provision of training for health care providers and systems on the effective utilization of NTHWs.

- Develop statewide training advisory panel to provide guidance and support to statewide entity given responsibility for training oversight to ensure that appropriate technical assistance, guidance and feedback can be provided to ensure that uniform statewide standards for training

programs produce trained individuals who can easily move between organizations and carry certification of standardized competencies, knowledge and skills to work in any CCO across the state. This training advisory panel should include experienced NTHWs in large enough numbers to ensure that the integrity of the model is retained and supported.

- Develop strategies for all training partners to assess the needs of NTHWs for continuing education, to design and develop programs to meet those needs, and to implement and evaluate programs on an ongoing basis.

- Provide individuals completing the approved training program with a certificate of completion. The certification is required to enroll as a provider for reimbursement.

- Limit the cost of enrolling in training programs for NTHWs.

- "Grandparent" NTHWs who also participate in an "incumbent worker" training. Specific "grandparenting" provisions for number of practice years in the field are to be determined, with the acknowledgment that there may need to be differences based on the worker type due to length of time that the job category has been in existence. Incumbent worker training curricula are to be determined by the statewide entity in collaboration with the advisory group to ensure that NTHWs that were trained in the past have a clear understanding of the Oregon roles, competencies and can demonstrate skills to perform at the level required in the set forth standards.

- Review and renew NTHW certificate programs every three years to assure quality, relevance and compliance in meeting curriculum requirements, teaching standards and performance outcomes.

- Provide incentives for Coordinated Care Organizations to develop internal agency plans for the supervision and support of NTHWs, including developing strategies within the global budget to support training development, career pathways, and retention of NTHWs on health care teams. Require supervision of NTHWs by licensed health care professionals, licensed behavioral health professionals, and Masters level public health workers.

IV. Endnotes

[i] Whitley EM, Everhart RM, Wright RA*. Measuring return on investment of outreach by community health workers*. Feb 2006

[ii] Walker DG, Jan S. *How do we determine whether community health workers are cost-effective? Some core methodological issues*. Jun 2005

[iii] Cherrington A, Ayala GX, Amick H, Scarinci I, Allison J, Corbie-Smith G*. Applying the community health worker model to diabetes management: using mixed methods to assess implementation and effectiveness*. Nov 2008

[iv] Whitley EM, Everhart RM, Wright RA. *Measuring return on investment of outreach by community health workers*. Feb 2006

[v] Felix HC, Mays GP, Stewart MK, Cottoms N, Olson M. *The Care Span: Medicaid savings resulted when community health workers matched those with needs to home and community care*. Health Affairs. 2011

[vi] Miller A. *Georgia firm's blueprint for taming health costs*. Georgia Health News. 2011.

[vii] Whitley EM, Everhart RM, Wright RA. *Measuring return on investment of outreach by community health workers*. Feb 2006

[viii] Norris SL, Chowdhury FM, Van Le K, et al. *Effectiveness of community health workers in the care of persons with diabetes*. Diabet Med. May 2006.

[ix] Viswanathan M, Kraschnewski J, Nishikawa B, et al. *Outcomes of community health worker interventions*. Evid Rep Technol Assess (Full Rep). Jun 2009.

[x] Fedder DO, Chang RJ , Curry S, Nichols G. *The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension*. Ethn Dis. Winter 2003;

[xi] Culica D, Walton JW, Harker K, Prezio EA. *Effectiveness of a community health worker as sole diabetes educator: comparison of CoDE with similar culturally appropriate interventions*. Nov 2008.

[xii] Parker EA, Israel BA, Robins TG, et al. *Evaluation of Community Action Against Asthma: a community health worker intervention to improve children's asthma-related health by reducing household environmental triggers for asthma*. Jun 2008

[xiii] Ibid.

[xiv] Fedder DO, Chang RJ , Curry S, Nichols G. *The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension*. Winter 2003.

[xv] Peretz P, Matiz L, Findley S, Lizardo M, Evans D, McCord M. *Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative*. Am J of Public Health. 2011.

[xvi] Rosenthal E. Lee, Wiggins Noelle Wiggins, Ingram Maia, Mayfield-Johnson Susan, Guernsey De Zapien Jill. *Community Health Workers Then and Now: An Overview of National Studies Aimed at Defining the Field. Am J of Ambulatory Care Management*. 2011.

[xvii] *New Freedom Commission Report*, 2006; Institute of Medicine, 2006

[xviii] Ibid.

[xix] Davidson et. al., 2003; Felton, et. al, 1995; Mead & MacNeil, 2006

[xx] Davidson et al., 2003; Felton, Stanstny, Shern, Blanch, Donahue, Knight & Brown, 1995; Mead & MacNeil, 2006.

[xxi] Chinman, Weingarten, Stayner & Davidson, 2001

[xxii] National Association of Peer Specialists

[xxiii] Chinman, et. al, 2001; Klein, Cnaan

[xxiv] Whitecraft, 1998; Simpson & House, 2002

[xxv] SAMSHA National Mental Health Block Grant and Data Conference 2007

[xxvi] Magura, Laudet, Rosenblum, & Knight, 2002).

[xxvii] Magura, S., Laudet, A., Mahmood, D., Rosenblum, A. & Knight, E.

[xxviii] Dumont, J. & Jones, K. 2002

[xxix] Lewis, 2001

[xxx] Carpinello, Knight, & Janis, 1991; Rappaport, Seidman, Paul, McFadden, Reischl, Roberts, Salem, Stein, & Zimmerman, 1985.

[xxxi] Markowtiz, DeMassi, Knight, & Solka, 1996; Kaufmann, Schulberg, & Schooler, 1994.

[xxxii] Van Tosh, L. & del Vecchio, P. 2000.

[xxxiii] Grumbach, Bodenheimer, Grundy, 2009, Patient Centered Primary Care Collaborative

[xxxiv] Ibid.

[xxxv] [xxxv] http://web.multco.us/health/community-capacitation-center

[xxxvi] Seavey, Dorie and Marquand Abby. *Caring in America: a comprehensive analysis of the nation's fastest-growing jobs: home health and personal care aides*. Paraprofessional Health Care Institute. December 2011.

[xxxvii] Ibid.

[xxxviii] Ibid.

Appendix A: Non-Traditional Health Worker Subcommittee

Co-Chairs

- Donna Larson, *Dean of Allied Health*, Mt. Hood Community College
- Teresa Rios-Campos, *Community Health Worker*, Multnomah County Community Capacitation Center

Members

- Maria Avila, *Community Health Worker*, Providence/Catholic Charities Parish Health Promoter Program
- Herman Bryant, *Executive Director*, Miracles Club of Portland (Dionne Preston, *alternate*)
- Debra Buck, *Nurse Consultant*, Oregon State Board of Nursing
- Arika Bunyoli, *Community Health Worker*
- Rhonda Busek, *Director, Medicaid Programs*, PacificSource
- Meghan Caughey, *Senior Director of Peer Wellness Services*, Cascadia Behavioral Health
- Erin Fair, *Senior Manager of State & Federal Regulatory Policy*, Care Oregon
- Kris Anderson, *Training & Curriculum Development Director*, Oregon Family Support Network
- Alisha Fehrenbacher, *Executive Director*, Health Matters of Central Oregon
- Alison Frye, *Program Supervisor*, Multnomah County Health Department
- Jalaunda Granville, *Workforce Development Specialist*, Oregon Primary Care Association
- Ann Kasper, *Peer Support Specialist*, Women with Disabilities Health Equity Coalition
- Cheryl Miller, *Executive Director*, Oregon Home Care Commission
- Susan Pinnock, *RN, BSN*, Washington County Public Health Nurse, Oregon Nurses Association
- Catherine Potter, *Program Director*, Providence/Catholic Charities Parish Health Promoter Program
- Vinay Prasad, *Market Insight Analyst*, Regence Blue Cross Blue Shield
- Carole Romm, *Director, Community Partnerships and Strategic Development*, Central City Concern
- John Saito, *Dean of Allied Health Professional Training*, Portland Community College
- Jennifer Valentine, *Executive Director*, Cascades East AHEC
- Kelly Volkmann, *Health Navigation Program Manager*, Benton County Health Department
- Crucita White, *Peer Support Specialist*, Association of Oregon Community Mental Health Programs
- Judith Woodruff, *Program Director Health Workforce*, Northwest Health Foundation
- Jean Yamamoto, *Researcher*, SEIU Local 503

Committee Staff

- Carol Cheney, *Equity Manager*, OHA Office of Equity and Inclusion
- Lisa Angus, *Policy Analyst*, OHA Office for Policy and Research
- Shawn Clark, *Peer Delivered Services Coordinator*, OHA Addictions and Mental Health Division

Appendix B: Existing NTHW Certification Programs in Oregon

Multnomah County Community Capacitation Center

The Multnomah County Community Capacitation Center provides training and technical assistance for organizations that desire to establish or strengthen their community health worker programs, including:

- Designing, conducting, and evaluating community health worker programs
- Recruiting, hiring, training, and supervising CHWs
- Formulating and advocating for policies supportive of the CHW model
- Providing leadership in the CHW field

Over the course of the last 10 years, the CCC has provided CHW training courses for more than 25 organizations and has trained more than 530 CHWs. For a complete list of participating organizations, please contact the CCC.

Curriculum

Curriculum is based on findings in Chapter 3 (Roles and Competencies) of the National Community Health Advisor Study (Wiggins and Borbón, 1998). It has 3 components:

- Skill base
- Orientation to the health and social service system
- Health issues

Academic Credit

An 80-hour basic curriculum was approved for academic credit by the Oregon State Board of Education. Through an agreement with the Portland State University's Early Childhood Training Center, the Capacitation Center offers academic credit (for an additional fee, paid to PSU) for participation in our courses.

Program Development and Certification

Community-based organizations and community health centers can receive technical assistance when they are in the process of establishing a CHW program, including:

- the development of training curriculum
- the recruitment and hiring of CHWs
- the development of CHW job descriptions
- support and supervision of CHWs.

Length

18 hours - 240 hours, depending on the complexity of the work CHWs will be expected to do, availability of the CHWs for training, and the resources of the contracting organization.

International Center for Traditional Childbearing Doula Program

Curriculum

- 27.5 hours total training hours, include:

- labor and postpartum doulas services
- newborn care
- taking blood pressures
- infant mortality prevention
- breastfeeding support
- entrepreneurial, self-management skills

Certification Requirements

- Certification occurs 24-months post-training.
- Students must complete:
  - five births
  - five postpartum visits
  - two-hour breastfeeding class
  - four-hour childbirth preparation
  - CPR card
  - food handlers card
  - three book reports from the ICTC reading list
    -
- Recertification occurs every three years with of 24 CEU's and attendance at one ICTC conference.

Central Oregon Community College

Curriculum

(1) classroom instruction
   - 36 hours of in-classroom instruction that focuses on the
     - development of effective communication skills
     - building collaborative relationships with individual clients and community providers conducting preliminary psychosocial analysis
     - coordinating services
     - establishing professional boundaries,
     - advocating for individuals and communities towards healthy lifestyles

(2) Community resource development:
   - Student-directed community based project

Minimum Requirements:

- High school education or GED
- General knowledge of verbal and written skills,
- Capable of self-directed work
- Interest in promoting healthy lifestyles.

Outcomes

- Students will be able to demonstrate effective listening skills and interview techniques with

clients and community practitioners.

- Students will be able to conduct preliminary biopsychosocial assessment with referral to appropriate services.
- Students will be able to utilize the CHAP Project Pathways Model to identify and coordinate community resources.
- Students will become aware of and practice personal safety to maintain their health and enhance their capacity to assist clients.
- Students will be able to advocate on behalf of their clients and community in order to promote healthy living.
- Students will be prepared for entry-level work as a community health worker in various health and school-based settings.

Peer Wellness Specialists

State of Oregon Addictions and Mental Health Peer Delivered Services
The Oregon Health Authority Addictions and Mental Health Division (AMH) has established requirements for groups seeking to provide certified curriculum/training. Curriculum must meet the following requirements:

- **Principles**
  - Culturally Appropriate
  - Informed Choice
  - Partnership
  - Person Centered
  - Strengths-Based
  - Trauma Informed
- **Elements**
  - Communication
    - Crisis Intervention
    - Listening Skills
    - Problem-Solving Skills
    - Relationship Building
  - Education
    - Provide basic information of the arena you are preparing people to serve in: Adult Mental Illness, Addiction or Children's Mental Health
    - Provide basic information of the arena you are preparing people to serve in: Strengths-Based and/or Recovery Processes and Tools
  - Ethics
    - Boundaries
    - Development of a Personal Support system
    - Role of Peer Delivered Services
  - Knowing the Law

        - Americans with Disabilities Act, Civil Rights and Fair Housing
        - Confidentiality
        - Documentation
        - Mandatory Reporting
    - Resources
        - Understanding the Service Delivery System in the program arena
        - Finding Community and Support Services i.e. Disability, Childcare
        - Agencies Advocating for Rights and Services
        - Wellness: Including tobacco cessation resources

Eighteen (18) Peer Delivered Services trainings, operated by the following organizations, have been approved through AMH.

Adult Mental Health

1. Jackson County Mental Health Department - *"Age Wise, Age Well"*
2. Crystal Dimensions, Incorporated
3. *"Intentional Peer Support (IPS)"*
4. Oregon State Hospital – "*OSH Peer Education Enhancing Recovery Support"*
5. Lutheran Community Services - *"Peer Specialist Curriculum"*
6. Project ABLE, Inc. - *"Peer Support Specialist and Wellness Training"*
7. Benton County Health Services - *"Peer Wellness Specialist Training"*
8. *Center for Family Development and Amigos Multicultural Services Center - "Entre Dos Mundos Support Group Program"*

Children and Family Mental Health

9. Cascadia Behavioral Healthcare – "*Peer Wellness Specialist Training"*
10. Oregon Family Support Network - *"Introduction to Family Navigator Program"*
11. Oregon Family Support Network and Youth MOVE Oregon - *"The Basics" (for family members and young adults)*

Addictions Recovery

12. Miracles Recovery Support Services – *"Each One, Teach One Recovery Support Curriculum"*
13. *"Above the Influences Mentoring Program"*
14. Parents Anonymous of Oregon and Morrison Child and Family Services Program, *"Parent Mentor Program, Training Curriculum"*
15. ADAPT - *"Peer Delivered Services Training"*
16. Central City Concern - *"Recovery Coach Training Program"*
17. Relief Nursery, Inc. – *"Accessing Success"*
18. Willamette Family, Treatment Services, Inc. – "*Peer Support Service Model"*

Appendix C: State Comparison of Certification

The National Community Health Advisor Study (NCHAS), funded by the Annie E. Casey Foundation, produced the first and, to date, the only comprehensive list of CHW roles and competencies. NCHAS identified seven core roles of CHWs:

1) Providing cultural mediation between communities and the health care and social service system
2) Providing culturally-appropriate and accessible health education and information
3) Assuring that people get the services they need
4) Providing informal counseling and social support
5) Advocating for individual and community needs
6) Providing direct service
7) Building individual and community capacity[1]

The list of roles and sub-roles identified in NCHAS was reproduced almost exactly in the 2005 CHW National Workforce Study, conducted by the Health Resources and Services Administration (HRSA).[2] It was further endorsed by the Massachusetts Department of Public Health's 2002 Policy Statement on CHWs and the American Public Health Association's 2009 Policy Statement on CHWs.[3]

Of the existing programs in the nation, the Minnesota model has been particularly successful in preserving and building in the full complement of roles and competencies as described in the National Community Health Advisor Study. The state has developed and clearly articulated the scope of practice for Minnesota CHWs, demonstrating a strong understanding of the importance of retaining the social justice and advocacy components of the CHW model.

The Minnesota CHW Alliance has defined the scope of practice as including the five following roles:

1) Bridging the gap between communities and the health and social service systems
2) Navigate the health and human services system
3) Advocate for individual and community needs
4) Provide direct services
5) Build individual and community capacity[4]

The NCHAS also identified a list of eight skills clusters, as follows:

1) Communication Skills
2) Interpersonal Skills
3) Teaching skills
4) Service Coordination Skills
5) Advocacy Skills
6) Capacity-Building Skills
7) Knowledge Base
8) Organizational Skills

[1] Rosenthal, E.L.,Wiggins, N., Brownstein, J.N., Johnson, S., Borbón I.A., …De Zapien, J.G. (1998). *The Final Report of the National Community Health Advisor Study: Weaving the Future.* Tucson, AZ: University of Arizona.

[2] http://bhpr.hrsa.gov/healthworkforce/chw/3.htm

[3] http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1393

[4] http://www.mnchwalliance.org

The NCHAS recommended that this list of skills be used as the basis for training programs and certification systems for CHWs. Texas CHW legislation, passed in 2001, codified the list of competencies.[5]

The table below describes certification criteria and policies adopted by various states, including Minnesota.

[5] http://www.dshs.state.tx.us/library/chw.shtm

Comparison of State Certification Programs for CHWs

	Texas	Ohio	Alaska	Minnesota	Indiana	Massachusetts (recommendations only)	New York (recommendations only)
Who	Applies to Community Health Workers seeking payment	Applies to individuals who would like to use the title "Certified Community Health Worker" or "Community Health Worker"	Only applies to workers in Community Health Aide Program	Only applies to individuals that would like receive Medicaid reimbursement	Only applies to individuals in Prenatal Care Coordination program (service to high-risk, Medicaid-qualified pregnant women)	Specific recommendation not yet developed	Specific recommendation not yet developed
Administered By	Texas Department of State Health Services	Board of Nursing	• Indian Health Service, Community Health Aide Program Certification Board • Federal certification administered by Alaska Native Tribal Health Consortium	Minnesota Department of Human Services	Indiana State Department	The Governor should appoint, within the DPH Division of Health Professions Licensure, a Community Health Worker Board of Certification to be charged specifically with regulatory oversight of training, development and implementation of a CHW and CHW trainer certification model, and recommendations regarding career pathways to promote the professional development of the CHW workforce.	• Recommendation that CHWs and consumers of CHW services be involved in developing and implementing any potential statewide certification process. • CHWs be guaranteed a minimum of 25% representation on any group that governs the CHW certification or the practice in general.

Requirements	• Proof of completion of an approved 160-hour competency-based Community Health Worker training program certified by DSHS • Completion of Application, including applicant's photo sent to DSHS	• Completion of accredited training program, consisting of at least 100 hours of classroom instruction and 130 hours of clinical instruction • Completion of standard training, exam. • Submission of application	• Completion of board-certified 3-4 week intensive training course • Completion of designated number of practice hours and/or patient encounters, and • Completion of Post Session Learning Needs (PSLN) and a Post Session Practice Checklist • Completion of 200 hours of village clinical experience (must be completed prior to moving on to the next training session) • Completion of an approved preceptorship, • Achieve a score of 80% or higher on the statewide written CHA certification Examination • Achieve a score of 100% on the • statewide Medical Math Exam, • Successful completion of evaluation on clinical performance and	• Submission of application • Completion of 11-credit certification program • Completion of Application	• One day workshop prior to taking exam. • Completion of standard training, exam	• The CHW Board should develop and oversee implementation of standards for training of Massachusetts CHWs, guidelines and requirements for the qualifications of training entities, minimum hours of required training, and graduation requirements. • Applicants for certification should be required to demonstrate experience and capacity to provide high quality CHW training programs. • Training entities duly recognized by the CHW Board should be authorized to issue certificates of completion to graduates (individual CHWs) who attain graduation requirements.	

			judgment by direct supervisor or other approved evaluator				
Medicaid Reimbursement	No direct reimbursement - Texas health and human service agencies are required to use certified community health workers for outreach and education programs for medical assistance			To qualify for reimbursement, workers must complete state certification. Upon completion, individuals become eligible to enroll in the Minnesota Health Care Plan as a Medicaid provider authorized to serve under the supervision of approved billing providers.	Receives Medicaid reimbursement due to CHWs being paired with licensed providers,		• Recommendation that CHWs be recognized as health professionals and members of healthcare teams, in agreement with the PPACA. • Recommendation that CHWs be integrated into patient centered medical homes (PCMHs), accountable care organizations (ACOs), and health homes by officially listing CHWs as integral members of these health care teams. • Recommendation that CHW scope of practice developed in these recommendations be used when integrating CHWs in PCMHs, ACOs and health homes. • Recommendation that New York State encourage providers to use PCMH incentives to finance CHW services for the CHW roles identified in the recommended scope of practice. (PCMHs can receive an incentive of up $21 per patient per month

							(PMPM) for level three of the National Committee for Quality Assurance recognition program). • Recommendation that New York State introduce financial incentives for use of CHWs and CHW services with the elderly, disabled, and those with multiple chronic conditions, who will see improved health outcomes from CHW services. • Recommendation that New York State provide financial incentives (e.g., through increased capitation rates or pay-for performance mechanisms) to encourage Medicaid Managed Care plans to integrate CHWs into their care models and care teams. • Recommendation that Medicaid Managed Care plans finance outcomes-based programs which align with any of the CHW scope of practice roles. For example, United Health Group is reimbursing YMCAs for offering the

							Diabetes Prevention Program if they achieve performance measures (attendance, weight loss goal, etc.). The YMCAs can use CHWs or other individuals to deliver the program
Grandfathering	• Six (6) years experience prior to application for certification • Must have "preformed CHW services for no less than 1000 cumulative hours between July 1997 to January 2005."	Must have "worked in a capacity that is substantially similar to a community health worker at some point within the three years immediately prior to February 1, 2005.	N/A	• Five (5) years experience prior to application for certification • Must pass assessment to measure competencies. (Testing period: May 1st, 2009, through October 31st, 2009, Fee: $125)	Information unavailable	Yes	Yes
Specifies curricula	• No – 20 training programs available that meet the standards • Training must be conducted by certified instructor	Must be state approved training - 3 approved training programs	Board-certified training by IHS, tribe, or tribal organization operating a community health aide program in Alaska. Additional certification paths are in place for dental health service.	State-accredited 11-credit community health worker certificate program – Currently available at 5 sites	Information Unavailable		No

Reciprocity	N/A	Yes (by endorsement)	N/A	N/A	Information Unavailable	Information Unavailable	Yes
Fees	None	Application Fee: $35	Application Fee: $400	• Application Fee: $25 • Standard of Practice Examination: $75	Information Unavailable	Specific recommendation not yet developed	Recommend minimal cost barriers
Citizenship Status Reporting	No	Yes	No	Information Unavailable	Information Unavailable	Specific recommendation not yet developed	No
Mandatory?	• Anyone who is compensated under the title "Promotor(a)" or "Community Health Worker" must be certified. • Anyone who volunteers as a "Promotor(a)" or "Community Health Worker" has the option to be certified. • No protected scope of practice.	• Anyone who uses the title "Certified Community Health Worker" or "Community Health Worker" must be certified. Certain nursing related tasks and activities require delegation by a registered nurse. No protected scope of practice.	"Community Health Practitioners" employed by IHS, tribes, or tribal organizations in Alaska.	Anyone who seeks Medicaid reimbursement	Individuals seeking reimbursement through involvement in Family Care Coordination program (service to high-risk, Medicaid-qualified pregnant women)	Specific recommendation not yet developed	Yes

A National Analysis of "Addiction Recovery Mentor" Competencies and Credentialing Prerequisites

ACCBO, 2010

National Analysis of "Addiction Recovery Mentor" Competencies and Pre-requisites to Registration/Credentialing

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ACCBO, December 2010

Recovery Oriented Systems, Mental Health Peers, and Addiction Recovery Peers
Over the past decade much has been written regarding "Recovery Oriented Systems of Care." Most of these documents describe "systems" vs. individual competencies or credentialing standards. These documents tend to describe the attributes of systems, organizations and agencies that have a "recovery orientation." Of those documents/standards that apply to "recovery mentors, most pertain to either mental health recovery solely or refer to co-occurring recovery. For the purposes of this analysis we have focused on those standards most reflective of "addiction recovery" or "co-occurring recovery."

Nine States have produced Competency statements and/or credentialing standards regarding "Addiction/Co-occurring Peer Recovery Support"
A review of literature, including the works of William White, national credentials and recovery mentor occupational descriptions from California, Florida, Illinois, Missouri, New Mexico, New York, Oklahoma, Oregon and Pennsylvania - reveal common ground for articulating "Core Competencies" and registration prerequisites for "Addiction Recovery Mentors."

Overview of State Registrations/Credentials and Peer Support Training

(Mental Health-oriented credentials or A&D/Co-occurring-oriented credentials)

Peer Support Credentials by State

(A&D/Co-occurring Credentials highlighted)

State	Organization	Credential	Primarily M.H.	A&D/Co-occurring
Alabama	Pillars of Peer Support	Certified Peer Support Specialist	Mental Health	None
Alaska	Various agencies have peer support - Peer Specialist Alliance of America	Certified Peer Specialist	Mental Health	None
Arizona	Community Partnership	Recovery Support Specialist	Mental Health	None
Arkansas	None	None	None	None
California	**CAARR founded 1972**	**Certified Addiction Recovery Specialist**		**Looks like entry level counselor certification**
California	**CAADAC**	**Registered Recovery Worker**		**A&D Peer Recovery Worker**
Colorado	None	None	None	None
Connecticut	Connecticut Certification Board	Certified Recovery Specialist	Mental Health Requires psych dx	Mentions A&D but appears to be MH primary
Delaware	Institute for Recovery and Community Integration	Certified Peer Specialist	Mental Health Requires hx of being mental health consumer	None
D.C.	None	None	None	None
Florida	**Florida Certification Board**	**Certified Recovery Support Specialist**		**A&D/Co-occurring**
Georgia	Georgia Certified Peer Project	Certified Peer Specialist	Mental Health	None
Hawaii	Peer Specialist Alliance of America	Certified Peer Specialist	Mental Health	None
Idaho	Family Passages	Certified Peer Specialist	Mental Health	None
Illinois	**Illinois Alcohol and Other Drug Abuse Professional Certification Association**	**Certified Recovery Support Specialist**	**Mental Health and**	**A&D/Co-occurring (Seems equally divided A&D-MH)**
Indiana	None	None	None	None
Iowa	None	None	None	None
Kansas	Peer Specialist Alliance of America	Certified Peer Specialist	Mental Health	None
Kentucky	Kentucky Mental Health	Certified Peer	Mental Health	None

	Program Office	Specialist		
Louisiana	Appalachian National Empowerment Center	Certified Peer Specialist	Mental Health	None
Maine	Office of Adult Mental Health Services	Intentional Peer Support Specialist	Mental Health	None
Maryland	Maryland Association of MAPPS Peer Specialist	Certified MAPPS Peer Specialist	Mental Health	None
Massachusetts	Mass Department of Mental Health	Certified Peer Specialist	Mental Health	None
Michigan	Michigan Department of Health	Certified Peer Support Specialist	Mental Health	None
Mississippi	Mississippi Mental Health Department	Certified Peer Specialist	Mental Health	None
Missouri	**Missouri Substance Abuse Credentialing Board**	**Recovery Support Specialist**		**A&D/Co-occurring**
Montana	Montana Behavioral Health Network	Certified Peer Specialist	Mental Health	None
Nebraska	Under development	Peer Association – no current credentialing	Mental Health	Mentions A&D, but appears to be primarily mental health
Nevada	Nevada Division of Mental Health and Developmental Disabilities	Peer Specialist Training	Mental Health	None
New Hampshire	MentalHealthPeers.com	Intentional Peer Support Specialist	Mental Health	None
New Jersey	The Certification Board, Inc.	Peer Support Specialist – Mental Health Core Certification	Mental Health	None
New Mexico	**New Mexico Credentialing Board for Behavioral Health Professionals**	**Certified Peer Support Specialist**	**Mental Health**	**A&D/Co-occurring (Seems equally divided A&D-MH)**
New York	**OASAS**	**Recovery Coach Certificate**		**A&D/Co-occurring**
New York	Mental Health Empowerment Project	Certified Peer Support Specialist	Mental Health	
North Carolina	NC Department of Mental Health	Certified Peer Support Specialist	Mental Health	None
North Dakota	None	None	None	None
Ohio	Ohio Department of Mental Health	Certified ACT Peer Support Specialist	Mental Health	None
Oklahoma	**Oklahoma Department of Mental Health**	**Recovery Support Specialist**	**Mental Health**	**A&D/Co-occurring (Seems equally divided A&D-MH)**
Oregon	**Central City Concern**	**Recovery Mentor Training**		**A&D/Co-occurring**
Pennsylvania	**Pennsylvania Certification Board – subcontracted through PRO-ACT**	**Certified Recovery Specialist**		**A&D/Co-occurring**
Rhode Island	Peer Specialist Alliance of America	Peer Support Specialist training	Mental Health	None
South Carolina	Peer Specialist Alliance of America	Peer Support Specialist training	Mental Health	None

South Dakota	System of Care Pilot Project	Peer Support Specialist training	Mental Health	None
Tennessee	Department of Mental Health and Developmental Disabilities	Certified Peer Support Specialist	Mental Health	None
Texas	Texas Mental Health Resource	Certified Peer Support Specialist	Mental Health	None
Utah	Developing a Mental Health Peer certification			None
Vermont	Vermont Department of Mental Health	Certified Peer Support Specialist	Mental Health	None
Virginia		Peer Support Specialist training	Mental Health	None
Washington	Washington Mental Health Division	Certified Peer Support Specialist	Mental Health	None
West Virginia	Mental Health	Peer Support Specialist training	Mental Health	None
Wisconsin	Mental Health	Mental Health Peer Support Specialist	Mental Health	None
Wyoming	Department of Health	Peer Support Specialist	Mental Health requires a psychiatric history	A&D/Co-occurring appears to be primarily mental health

The National Averages of Nine States with A&D/Co-occurring Registrations/Certifications

(See appendi#1 for overviews of referenced state competencies)

State	Certification	Description	Fees
California	Registered Recovery Worker	- No pre-requisite ed - 10 CEU's annually - must be working towards CADC	$40 application fee $40 renewal per year
Florida	Certified Recovery Support Specialist	-HS/GED -40 Education Hours -1,000 Experience Hours -Examination -10 CEU's annually	$100 application $20 crim hx check $__ exam
Illinois	National Certified Recovery Specialist	-120 Education hours -2,000 Experience Hours -Examination	$75 application fee $125 exam fee $120 renewal x2 years
Missouri	Missouri Recovery Support Specialist	-HS/GED -36 Education Hours -1,000 Experience Hours -10 CEU's annually	$75 application $35 renewal annually
New Mexico	Certified Peer Support Specialist	-HS/GED -Specialized training program -Examination	$100 application
New York	Recovery Coach	-40 Education Hours	Unpublished on website
Oklahoma	Recovery Support Specialist	-HS/GED -40 Education Hours -Examination -12 CEU's annually	Unpublished on website
Oregon	Recovery Mentor Training	-Training through Central City Concern – no existing certification	No fees
Pennsylvania	Certified Recovery Specialist	-HS Diploma/GED -54 hours of education/training -Exam -25 CEU	$100 application $___ exam fee $75 renewal x 2 years

Prerequisite Recovery: An Average of 1-3 years of Recovery

Most states either describe directly or implicitly that an individual needs 1-3 years of abstinence from drugs and alcohol to be an alcohol and drug recovery mentor. Most states imply that recovery itself is a prerequisite for registration/certification. In the case of mental health recovery mentors, many states require the recovery mentor to have a documented psychiatric diagnosis as a prerequisite. One state, New Jersey, explicitly allows non-recovering people to serve as Recovery Mentors.

Criminal History Check: Many states require this for Recovery Mentors

Many states require a criminal history check and have various disqualifying crimes for registration/credentialing of recovery mentors.

Prerequisite Education: An Average of 46.25 hours of Education

The average number of prerequisite education hours is 46.25, based on the average of 8 national credentials/registrations for addiction/co-occurring recovery mentors. Most states require a High School Diploma or GED.

Common elements among Prerequisite Educational Courses include:

- **Advocacy** (aggressive engagement, assistance navigating systems, case management assistance, etc.)
- **Interpersonal Communication**, Motivational Enhancement, Crisis/risk assessment
- **Legal** Obligations (Informed Consent, Client Rights, Civil Rights, ADA, Confidentiality, Mandatory Reporting)
- **Recovery Education**, Recovery Management & Relapse Prevention
- **Life Skills** (employment, housing, referral to community services, etc.)
- **Special populations** (Cross-cultural, Trauma, Co-occurring, and Medication issues)
- **Ethics and Boundaries**, Scope of Duties (Role definition)

Certification Fees: An Average of $81.66 Application Fee, not including Examination Fee (if any)

States have an average expense of approx $81.66 to become "registered/certified" and that does not include a criminal history check. Some states also have an exam and additional examination fee. About half of the states have an examination. Illinois, Pennsylvania and Florida appear to have a psychometric examination. NAADAC has produced a "Basic Level Examination" that appears to be a lesser version of the NCAC I examination with only 125 questions. NAADAC is marketing the examination for use with "recovery mentors," however it appears to have content areas one would not expect for recovery mentors, especially counseling theory.

(see appendix#2 to review Pennsylvania sample test questions)

Renewal Fees: An average of $43.12 annually, $86.24 every two years

Four states had published renewal fees with an average of $43.12 annually.

Renewal Continuing Education Hours: An average of 20 hours every two years.

Some states have no continuing education requirements. Some states require as many as 40 hours of continuing education every two years.

Basic outline of Core Competencies for A&D/Co-occurring Recovery Mentors

Six states/ and one Portland organization (Central City Concern) have articulated core competencies (duties) for alcohol & drug recovery mentors. The items below represent a synthesis of common duties articulated in these 7 sets of competencies. Several state/national organizations offer certification for recovery mentors but do not have an established list of competencies.

Common Core Competencies

ROLE MODEL

____ Maintain one's own abstinence and recovery. Serve as a role model for recovery.
____ Instill hope through encouragement and positive regard for the client.
____ Model and encourage pro-social behavior (lawful behavior, paying taxes, continued employment, voting, paying bills on time, being a "good neighbor," etc.).

COMMUNICATE, ENGAGE &RESPOND

____ Establish a peer relationship. Build trust. Use aggressive engagement strategies.
____ Use basic interpersonal skills, active listening and motivational enhancement skills to establish a helpful relationship.
____ Assess "risks": relapse risk, harm to self or others, etc. and report those to the treatment team or other professionals. Respond in emergencies if necessary by contacting appropriate authorities and comply with mandatory reporting requirements.

PROBLEM SOLVE and ADVOCATE

____ Assess strengths and barriers to recovery, including financial, transportation barriers, etc. Work with client to increase their recovery assets. Be aware of recovery resources to assist clients in overcoming barriers (bus passes, other services, etc.)
____ Serve as an advocate for the client. Educate clients on their rights and empower clients to make choices to take ownership of their recovery and promote self-determination. Work with the client's treatment team and other community professionals.

EDUCATE

____ Educate client and professionals on the recovery process, disease of addiction and family dynamics commonly associated with substance abuse.
____ Assist clients with life skills (money management, time management, employment, nutrition, hygiene, grooming, personal care habits, etc.).
____ Assist client in developing a recovery maintenance program (mutual self help attendance, sponsorship, volunteer activities, relapse prevention plan, on-going and evolving self-reflection and continued interpersonal and pro-social growth).

CONNECT

____ Facilitate client connection with mutual self-help groups and the larger recovering community (A.A., N.A., Women for Sobriety, Celebrate Recovery, Rational Recovery, recovery social activities, retreats, etc.)
____ Assist clients in developing a support system including family members and the larger recovery community, promote acquisition of a sponsor. The recovery mentor should not foster dependency from the client, rather they should promote enlarging the client's support system.

COMPLY WITH LEGAL, MORAL and PROFESSIONAL DUTIES

____ Maintain legal and ethical compliance, including confidentiality.
____ Document activities/encounters, maintaining secure records, according to state, federal and employer requirements.
____ Maintain appropriate boundaries, do no harm, and operate within the mentor scope of duties.

Appendix #1
Various competency documents:

a. ATTC – Great Lakes
b. California
c. Florida
d. Illinois
e. Missouri
f. New Mexico
g. New York
h. Oklahoma
i. Oregon
j. Pennsylvania

Appendix #2
Sample Test Questions from Pennsylvania

ATTC – "Core Functions"

Great Lakes Addiction Technology Transfer Center
By William White
Peer Based Recovery Support Services - CORE FUNCTIONS

The functions of the P-BRSS specialist vary widely by role, clientele, and organizational setting, but collectively reflect the following functions:

- Assertive outreach to identify and engage those in need of recovery—what Malcolm X referred to as "fishing for the dead" and Reiff and Riessman called "reaching the hitherto unreached"
- Minimization of harm to self, family, and community in the transitions through identification, engagement, destabilization of addiction, and recovery initiation
- Recovery capital/needs assessment for individual/family/community
- Recovery education and coaching for individual/family (normative recovery information, encouragement, support, and companionship; enhancement of recovery self-management skills), often delivered in the natural environment of the individual/family
- Community-level recovery education
- Recovery resource identification, mapping, and development, including volunteer recruitment
- Recovery resource mobilization (activating a state of readiness to respond to the needs of an individual/family at a particular point in time)
- Community-level recovery resource development
- Assertive linkage to communities of recovery (support groups and support institutions)
- Assertive linkage to and systems navigation within addiction treatment and allied human services
- Liaison (bridging, brokering/negotiating, partnering) between individual, family, organization, and community
- Recovery-focused skill training aimed at full community participation (education, employment, housing, leisure, worship and pro-recovery family and social relationships)
- Companionship and modeling of recovery lifestyle, including participation in leisure activities that would be judged a breach of ethics for addiction counselors, e.g., eating together at a restaurant, attending or participating in a sporting event, attending a social event such as a concert or recovery celebration event
- Problem-solving to eliminate obstacles to recovery, e.g., linkage to resources for child-care, transportation, community re-entry from jail/prison
- Recovery check-ups (sustained monitoring, support/companionship, and recovery promotion)
- Recovery advocacy for individual/family needs (empower individuals and family members to assert their rights and needs)
- Recovery advocacy for aggregate community needs
- Recovery leadership development
- Conducting a regular self-inventory of personal and organizational performance via reflection, dialogue with service constituents, and analysis of recovery-focused service benchmark data

CALIFORNIA – "Role Description"

ROLE OF THE REGISTERED RECOVERY WORKER

Under general supervision of appropriately qualified staff, the Registered Recovery Worker shall:

A. Assist and support clients with alcohol/drug abuse or dependence, their family members and others to:

- attain and maintain abstinence as appropriate,
- develop a program tailored to the individual in support of a recovery process affect an improved quality of living.

Under general supervision of appropriately qualified staff, the Registered Recovery Worker shall:

B. Provide quality assistance and support for clients with alcohol/drug abuse or dependence, their family members and others by the following means:

- Providing current and accurate information and education on the disease of alcoholism and other drug dependency issues and recovery processes,
- Assisting in identifying and understanding the defense mechanisms that support addiction,
- Facilitating in self-exploration the consequences of alcoholism and other drug dependence,
- Utilizing the skills and knowledge in screening, intake, orientation, referral, consultation, case management, crisis intervention, client, family & community education, and report & record keeping,
- Assisting in relapse prevention planning and recognizing relapse symptoms and behavior patterns,
- Providing current and accurate information and education to identify and understand the roles of family members and others in the alcoholism/drug dependency system,
- Educating on how self-help groups, such as Alcoholics Anonymous, Al-Anon, Women for Sobriety, Narcotics Anonymous, Secular Organization for Sobriety, Co-dependents Anonymous, etc., complement alcoholism/drug addiction or dependency treatment as well as the unique role of each in the recovery process,
- Assisting clients in establishing life management skills to support a recovery process,
- Facilitating problem solving and the development of alternatives to alcohol/drug use or abuse and related problems of family members and others,
- Utilizing the appropriate skills to assist in developing sobriety life management and communication skills that support recovery, including: Active Listening Intervention Leading Confrontation, Summarizing Feedback Reflection Concreteness, Empathy Education
- Maintaining appropriate records in a confidential manner,
- Providing all services in accordance with the Registering Authority

C. Providing support as part of a treatment team and referring clients, family members and others to other appropriate health professionals as needed.

FLORIDA- "Role Delineation Study"

Performance Domains, Job Tasks, and KSAs

Domain 1: Advocacy

Job Tasks that should be performed by the Certified Adult Recovery Peer Specialist in the Advocacy domain are:

- Serve as the consumer's individual advocate.
- Advocate within systems to promote consumer centered recovery support services.
- Assure that the consumer's choices define and drive their recovery planning process.
- Promote consumer‐driven recovery plans by serving on the consumer's recovery oriented team.

Knowledge, Skills and Abilities that the Certified Adult Recovery Peer Specialist should possess in order to perform the tasks identified in the Advocacy domain are:

- Define system‐level advocacy.
- Explain why self‐advocacy is the foundation of recovery.
- Identify the consumer's individual support systems.
- Promote the principles of individual choice and self‐determination.
- Explain how and why consumers should establish an Advanced Directive.
- Explain how to advocate within the mental health system.
- Define consumer‐driven recovery.
- Use "person‐centered" language that focuses on the individual, not the diagnoses.
- Demonstrate non‐judgmental behavior.

Domain 2: Professional Responsibility

Job Tasks that should be performed by the Certified Adult Recovery Peer Specialist in the Professional Responsibility domain are:

- Respond appropriately to risk indicators to assure the consumers welfare and physical safety.
- Immediately report suspicions that the consumer is being abused or neglected according to 415.1034(1)(a), Florida Statute.
- Maintain confidentiality.
- Communicate personal issues that impact your ability to perform job duties.
- Assure that interpersonal relationships, services, and supports reflect the consumer's individual differences and cultural diversity.
- Document service provision as required by the employer.
- Gather information regarding the consumer's personal satisfaction with their progress toward recovery goals.

Knowledge, Skills and Abilities that the Certified Adult Recovery Peer Specialist should possess in order to perform the tasks identified in the Professional Responsibility domain are:

- Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).
- Define the concept of a wellness‐focused approach to consumer recovery.
- Explain the fundamental concepts related to cultural competency.
- Understand the concept of accountability.
- Explain basic federal, state, employer regulations regarding confidentiality.

- Explain what, where, when, and how to accurately complete all required documentation activities.
- Explain the concept of decompensation.
- Identify the consumers risk indicators, including individual stressors, triggers, and indicators of escalating symptoms.
- Explain basic de‐escalation techniques.
- Explain basic suicide prevention concepts and techniques.
- Identify indicators that the consumer may be experiencing abuse and/or neglect.
- Identify and respond appropriately to personal stressors, triggers, and indicators.

Domain 3: Mentoring

Job Tasks that should be performed by the Certified Adult Recovery Peer Specialist in the Mentoring domain are:

- Serve as a role model of a consumer in recovery.
- Establish and maintain a "peer" relationship rather than a hierarchical relationship.
- Promote social learning through shared experiences.
- Teach consumers life skills.
- Encourage consumers to develop independent behavior that is based on choice rather than compliance.
- Assure that consumers know their rights and responsibilities.
- Teach consumers how to self advocate.

Knowledge, Skills and Abilities that the Certified Adult Recovery Peer Specialist should possess in order to perform the tasks identified in the Mentoring domain are:

- Explain the concept of mentoring.
- Explain the concept of role‐modeling behaviors.
- Define social learning.
- Define self‐advocacy.
- Define life skills.
- Understand basic adult learning principles and techniques.
- Use adult learning techniques to teach life skills.
- Explain the concept of healthy, interdependent relationships.
- Establish a respectful, trusting relationship.
- Use active listening skills.
- Use empathetic listening skills.
- Demonstrate non‐judgmental behavior.
- Demonstrate consistency by supporting consumers during ordinary and extraordinary times.
- Promote the development and use of Advanced Directives.

Domain 4: Recovery Support

Job Tasks that should be performed by the Certified Adult Recovery Peer Specialist in the Recovery Support domain are:

- Serve as an active member of the consumer's recovery‐oriented team(s).
- Assure that all recovery‐oriented tasks and activities build on the consumer's strengths and resiliencies.
- Help the consumer identify their options and participate in all decisions related to establishing and achieving recovery goals.

- Help the consumer develop problem‐solving skills so they can respond to challenges to their recovery.
- Help the consumer access the services and supports that will help them attain their individual recovery goals.

Knowledge, Skills and Abilities that the Certified Adult Recovery Peer Specialist should possess in order to perform the tasks identified in the Recovery Support domain are:

- Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by SAMHSA.
- Explain the concept of a strength‐based approach to recovery.
- Promote self‐determination and consumer choice‐driven recovery.
- Use active and empathetic listening skills with the consumer.
- Use Motivational Interviewing skills with the consumer.
- State the stages of change.
- State the stages of recovery.
- Identify the consumer's current state of change and/or recovery.
- Help the consumer develop problem‐solving skills by working together to identify and discuss options, alternative, and possible consequences.
- Explain the typical process that should be followed to access and/or participate in community mental health and related services.
- Identify circumstances when it is appropriate to request assistance from other professionals to help meet the consumer's recovery goals.
- Identify the consumer's strengths, resiliencies, and challenges to recovery.
- Promote the consumer's empowerment by assuring that they are informed of their options and participate in all decision‐making that will affect their lives.
- Help the consumer request appropriate referrals and/or access needed resources.

ILLINOIS – "Role Delineation Study"

ILLINOIS ROLE DELINIATION STUDY

National Certified Recovery Specialist (NCRS), PERFORMANCE DOMAINS:

1. **Legal and Professional Responsibility**
   - Perform all job tasks according to professional, legal and ethical standards.
   - Maintain participant confidentiality according to state and federal laws.
   - Assure that Client's Rights are maintained.
   - Demonstrate healthy behaviors expected of a person in recovery.
   - Document all interactions with participants according to agency policy and procedure.
   - Participate in on-going education and training to maintain competency and certification.
   - Request assistance from supervisors as necessary and appropriate.
2. **Re-Engagement, Crisis Support and Safety**
   - Perform participant follow-up activities according to agency policy and procedure.
   - Re-engage the participant in their treatment/recovery plan.
   - Recognize crisis situations and respond appropriately.
   - Recognize risks to participant's recovery and/or personal safety and respond appropriately.
   - Implement strategies and techniques to maintain recovery and/or personal safety.
3. **Resource Linkage and Follow-Up**
   - Verify that consent and release of information forms are current and complete, and make sure the participant understands the release prior to making contact with community resources and recovery support services.
   - Access appropriate community resources and recovery support services.
   - Teach participants the necessary processes to access available community resources and recovery support services.
   - Arrange transportation for participants to community resources and recovery support services.
   - Verify participant attendance and/or compliance with treatment/recovery plan referrals.
   - Document resource linkage and follow-up activities according to agency policy and procedure.
4. **Practical Living Skills and Social Development**
   - Introduce or expose participants to new healthy social activities, people and places.
   - Assist participants to establish and maintain personal care habits, including but not limited to personal hygiene, nutrition, time management and money management skills.
   - Assist participants to establish and maintain social responsibility habits, such as paying taxes, gaining and maintaining legal employment, voting, paying bills on time and acting as a "good neighbor."
   - Assist participants to establish/reestablish and maintain healthy interpersonal relationships with persons such as family members, significant others, friends and/or family members of choice.
   - Encourage and assist participants to volunteer in the community.
5. **Recovery Management**
   - Perform appropriate program activities, such as intake and orientation.
   - Engage and assist participants to move through the stages of recovery and develop recovery capital.
   - Apply strategies designed to enhance participants' motivation to change.
   - Assist and motivate participants to navigate the array of services available to achieve and maintain recovery.
   - Observe participant behaviors to determine risk to maintaining recovery.
   - Recognize the signs and symptoms of a lapse/relapse and respond appropriately.
   - Daily, reinforce reasons why recovery is a viable and achievable path.

MISSOURRI – "Role Domains"

MRSS Domains Defined

1. **Recovery Mentoring/Coaching:**
   - Serve as a role model to a consumer in recovery
   - Establish and maintain a peer relationship
   - Teach life skills
   - Assure consumers know their rights and responsibilities
   - Teach consumers how to self-advocate
2. **Recovery Support Services:**
   - Help the consumer identify options to achieve recovery goals
   - Help the consumer develop problem solving skills
   - Help the consumer access the services of substance abuse professionals when needed to sustain their recovery
   - Help a consumer identify their strengths and how to use those strengths to maintain recovery

New Mexico – "Role Description"

- Comprehensive Community Support Services
- Assistance in the development and enhancement of people's interpersonal, community coping and functional skills including adaptation to home school and work environments which includes: social skills, daily living; school and work readiness activities; education in co-occurring illness.
- Promotion in the development and linkage of natural supports in workplace and school environments.
- Assistance in teaching symptom monitoring and illness self management in order to identify and minimize the negative effects of symptoms which interfere with daily living and supports employment and school tenure.
- Assistance in enhancing individuals' abilities and skills to obtain and maintain stable housing.
- Assistance in the development of the individual's recovery/resiliency plan.
- Support in crisis situations.
- Necessary follow-up to determine if the services have adequately addressed the person's needs.

New York – "Role Description"

Recovery Coaches:

- help to initiate and sustain an individual/family in their recovery from substance abuse or addiction;
- promote recovery by removing barriers and obstacles to recovery; and
- serve as a personal guide and mentor for people seeking, or already in recovery.

Oklahoma – "Competencies"

1. **An understanding of the skills to provide recovery support to their peers.**

   - Understand possible RSS job activities (which vary based on where you are employed).
   - A clear understanding of the RSS Code of Ethics.
   - Understand the meaning of peer support and the role of Credentialed Recovery
   - Support Specialists including an understanding of dual relationships. Understand the difference in treatment goals and recovery goals and promote recovery goals and personal life goals.
   - Be able to facilitate a variety of activities that support and strengthen recovery including starting and maintaining self-help/mutual support groups.
   - Be able to help problem-solve and help a person learn to self advocate, the meaning of self determination, teach others to advocate for the services that they want and to use naturally occurring community supports.
   - Be able to help a person served articulate, set and accomplish his/her personal life goals.
   - Be able to assist in the facilitation of recovery plans and plans of action, i.e. WRAP, Psychiatric Advanced Directives, etc.

2. **An understanding of the recovery process and how to use their own recovery story to help others.**

   - Understand the recovery process and what is helpful and not helpful.
   - Understand the role of peer support in the recovery process.
   - Understand the power of beliefs/values and how they support or work against recovery.
   - Understand the basic definition and dynamics of empowerment and self-directed recovery.
   - Be able to articulate what has been helpful and what is not helpful in his/her own recovery in services and interventions.
   - Be able to use their recovery story as it relates to the peer relationship as well as the needs of the mental health system in the provision of services.

3. **An understanding of and the ability to establish healing relationships.**

   - Understand the meaning and importance of cultural competency and spirituality in the recovery environment.
   - Be able to interact thoughtfully and successfully with people of other cultures and belief systems.
   - Be able to personally cope with conflict and difficult interpersonal relations in the workplace.
   - Be able to identify ways to help make the environment more recovery oriented and comforting to the people served.

4. **An understanding of the importance of and the ability to take care of oneself.**

   - Understand the dynamics of stress and compassion fatigue.
   - Be able and willing to discuss his/her own tools for taking care of him/herself.

Oregon – "Duties"

Central City Concern
Recovery Mentor Program

1. Essential Duties and Responsibilities:

The Recovery Mentor requires a flexible approach to client treatment support. Specific duties include but are not limited to:

- Relationship/trust building with treatment staff.
- Developing an intervention plan for clients identified by Hooper Center and other institution social workers.
- Escort and provide transportation for clients to initial treatment episodes, to primary care provider assessment when appropriate and to mental health assessment when appropriate.
- Follow-up referral resources to determine outcome of intervention. Documentation of mentor activities.
- Collection of client demographic and program outcome data.

2. Description of Other Duties:

- Utilizing proven intervention techniques on individual clients.
- Introduce clients to appropriate twelve-step support.
- Perform other duties as assigned.

3. Skills & Abilities:

- Ability to communicate clearly and concisely both orally and in writing.
- Ability to work in an environment where people may be hostile or abusive.
- Ability to manage time and meet deadlines.
- Ability to work courteously and communicate effectively with the general public, tenants/clients, medical personnel, corrections personnel and co-workers.
- Ability to maintain accurate records and necessary paperwork.
- Ability to learn and apply training instruction.
- Knowledge of de-escalation methods or ability to be trained in de-escalation methods.
- Knowledge and skills in chemical dependency and crisis intervention.
- Ability to provide leadership.
- Sufficient manual dexterity and physical ability to perform assigned tasks.
- Ability to understand and follow oral and written instructions.

PENNSYLVANIA- "Duties and Functions"

PRO-ACT PCB CONTRACTOR DEFINITIONS
Duties and Functions:

1. Recovery Education

- Provide recovery education for every phase of the recovery journey from pre-recovery engagement, recovery initiation, recovery stabilization, and sustained recovery maintenance.
- Provide vision driven hope and encouragement regarding opportunities for varying levels of involvement in community based activities (e.g., work, school, relationships, physical activity, self-directed hobbies, etc.).
- Provide a model for both people in recovery and staff by demonstrating that recovery is possible.
- Educate professional staff about the recovery process, the damaging role that stigma can play in undermining recovery.

2. Assist Peers to Assess Unique Strengths and Abilities

- Identify Recovering Persons' abilities, strengths and assets (both internal and external) and assist them to recognize these strengths and use them to achieve their goals.

3. Community Integration and Recovery Goal Development and Planning

- Assist recovering persons to identify their personal interests and goals in relationship to recovery and to "getting the life they want" in the community.
- Assist recovering persons in developing their own plans for advancing their recovery.
- Assertively support connections to community based, mutual self-help groups.

4. Promote Self-Advocacy

- Assist recovering persons to have their voices fully heard and their needs, goals and objectives established as the focal point of rehabilitation and clinical services.
- Support recovering persons to identify their area of need for professional supports and services.

5. Assertive Linkage to Professional Assessment/Treatment Services

- Link individuals to appropriate professional resources when needed.

6. Identify Community Resources

- Identify community resources (communities of recovery, educational, vocational, social, cultural, spiritual resources, etc) that support the recovering person's goals and interests. This will involve a collaborative effort including the recovering person, as well as agency staff and other relevant stakeholders.
- Identify barriers (internal and external) to full participation in community resources and developing strategies and with other stakeholders work to overcome those barriers.

7. Community Liaison

- Develop relationships with community groups/agencies in partnership with others in the agency.

8. Connect Persons to Community Resources

- Discuss with recovering persons possible matches and opportunities between their interests and community resources.

- Link recovering persons to sponsors, self help and mutual support groups that exist in the community.
- Visit community resources with recovering persons to assist them in becoming familiar with potential opportunities.
- Teach recovering persons, in real world settings, the skills they need to successfully utilize community resources.
- Coach recovering people in the independent use of community supports.

9. Recovery Planning

- Facilitate (via personal coaching) the transition from a professionally directed service plan to a self-directed Recovery Plan. The goal should be to transition from professionally assisted recovery initiation to personally directed, community supported recovery maintenance.

10. Long-term Engagement, Support, and Encouragement

- Maintain contact by phone and/or e-mail with recovering person after they leave the program to insure their on-going success and to provide re-engagement support in partnership with others in the agency if needed.

Appendix #2
Sample Test Questions

1. A good definition of denial is:
    A. a common defense mechanism.
    B. conscience lying.
    C. the ability to turn down a drink or a drug.
    D. minimizing the amount you drank or used.
2. What are common signs of alcohol withdrawal syndrome?
    A. Body aches, disorientated, and agitated
    B. Sweating, nausea, and increase in body temperature
    C. Tremors, sweating, mild agitation, anxiety, increased heart rate and blood pressure
    D. Increase heart rate, increase blood pressure, and cold sweats
3. The most commonly abused substance is:
    A. marijuana.
    B. nicotine.
    C. herion.
    D. cocaine.
4. Adolescents often resist treatment because of:
    A. a lack of employment.
    B. peer pressure.
    C. a lack of education.
    D. the stigma of addiction.
5. A boundary violation is committed when an individual:
    A. develops a social relationship with the client after services end.
    B. accepts gifts from the individual receiving the services.
    C. has a dual relationship with a client.
    D. all of the above.
6. What are the only exceptions to breaking confidentiality?
    A. The life of the client or someone else is at risk
    B. The person is diagnosed with HIV
    C. The client's mother/father asks for information
    D. Discussing the client with your sponsor

Appendix D: NTHW Survey

The NTHW Subcommittee disseminated a survey of currently practicing NTHWs in Oregon, resulting in 620 responses. Using this background research, the Subcommittee then identified commonalities and differences among the defined worker types which provided a basis for establishing a scope of work that crosses all worker types and the core competencies necessary to effectively fulfill that scope. Results of the survey are attached below in a presentation format.

Non-Traditional Health Worker Survey October 2011

Presented to the OHPB Workforce Committee

NTHW Subcommittee

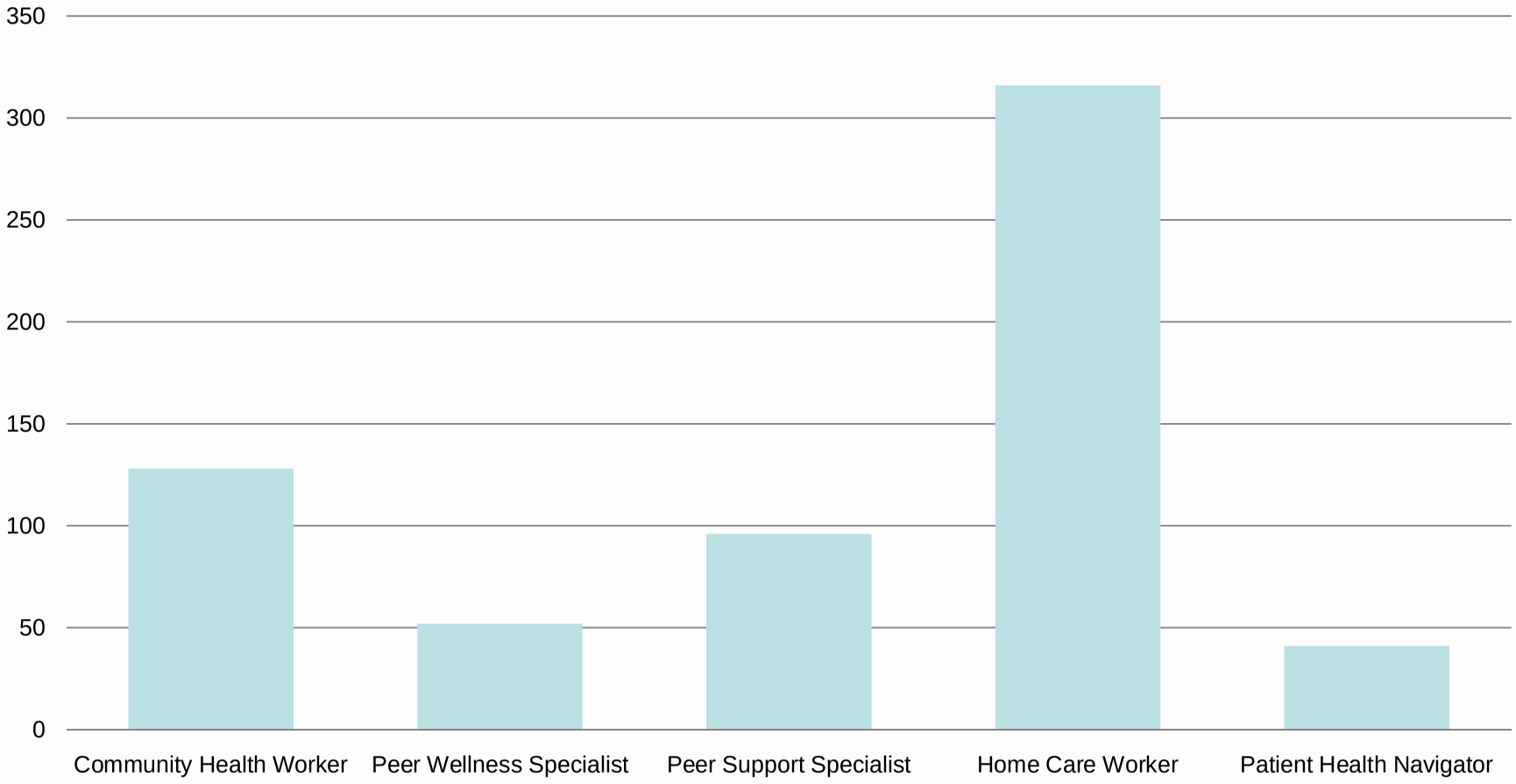
Survey Method and Results Overview

- **Distribution via email and paper copies to Subcommittee, key stakeholders**

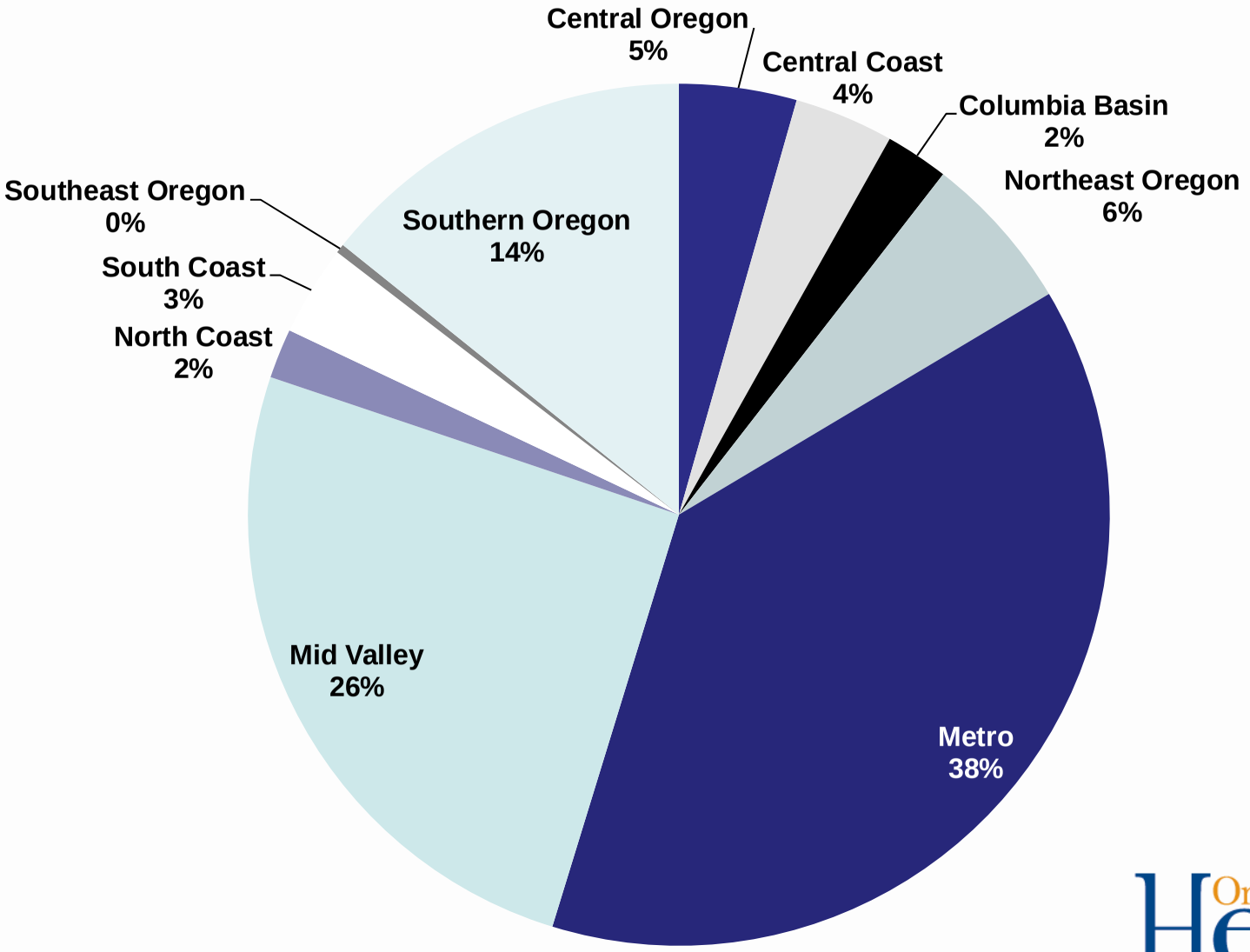
- **Collection method:**
  - **Survey Monkey**
  - **Paper submissions manually entered into Survey Monkey**

- **English and Spanish versions available**
- **Total Started Survey: 620** (as of Oct 26, 2011)
- **Total Completed Survey: 562 (90.6%)**

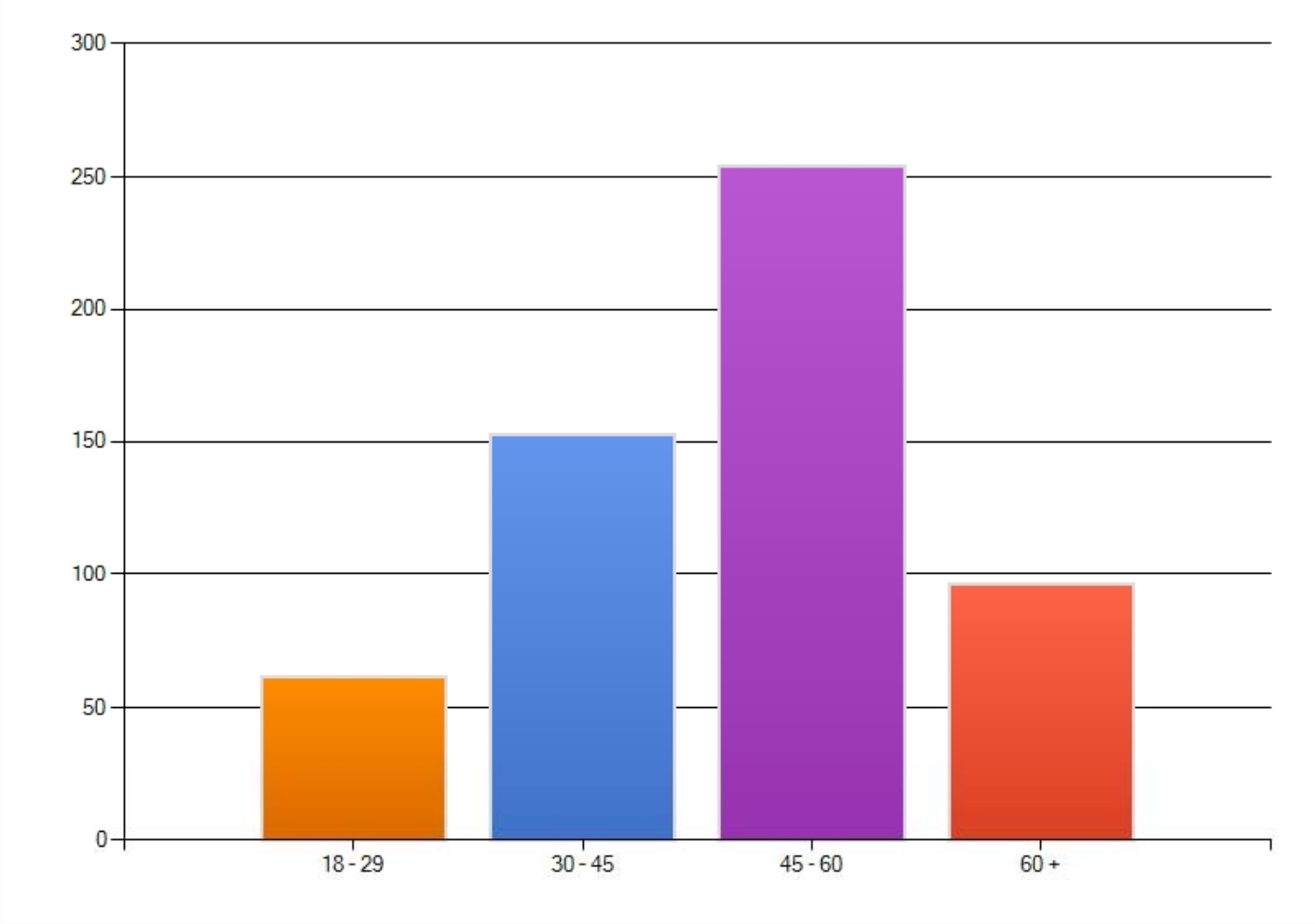
Who responded? Worker Type



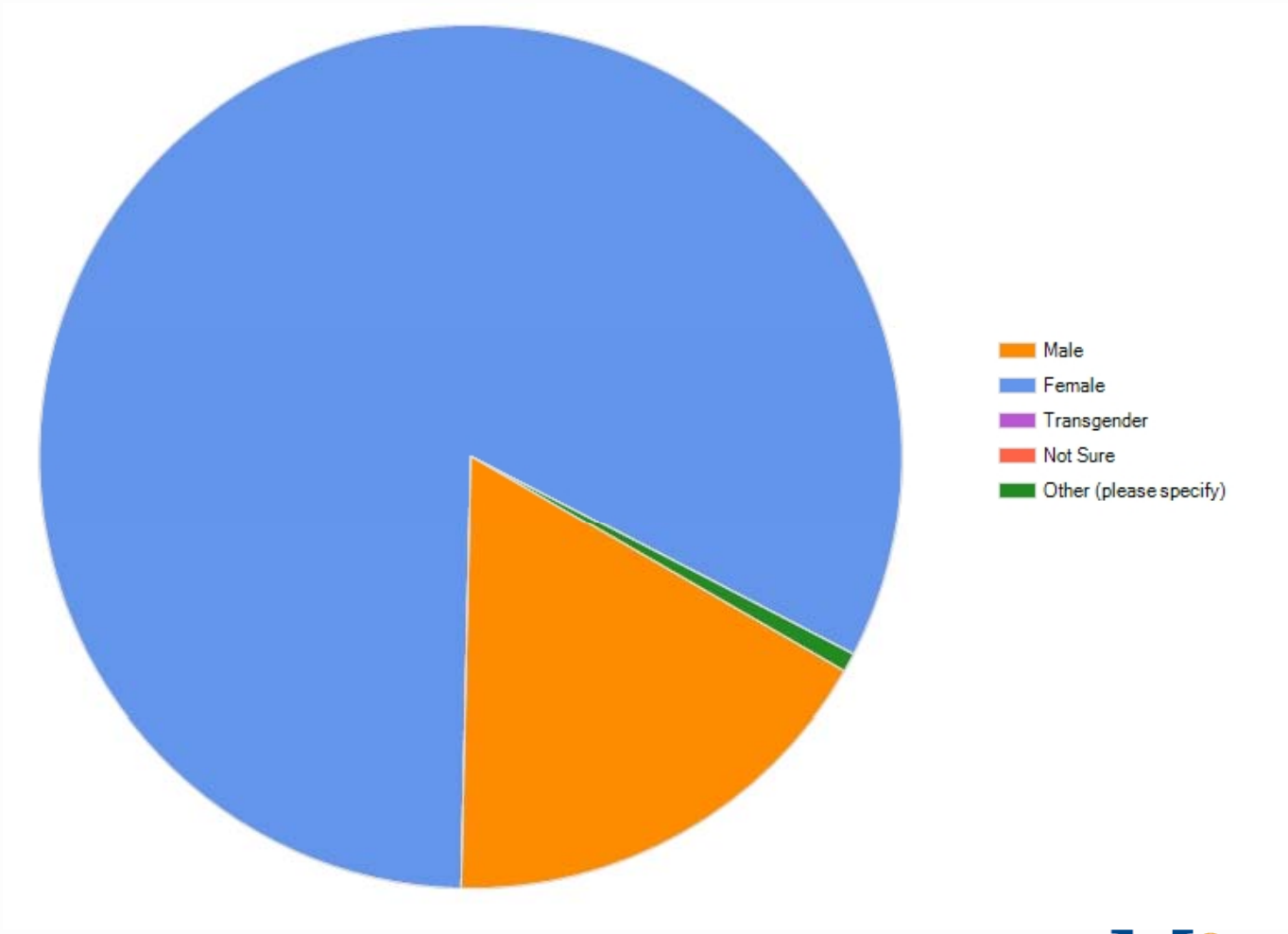
Regional Representation of Respondents



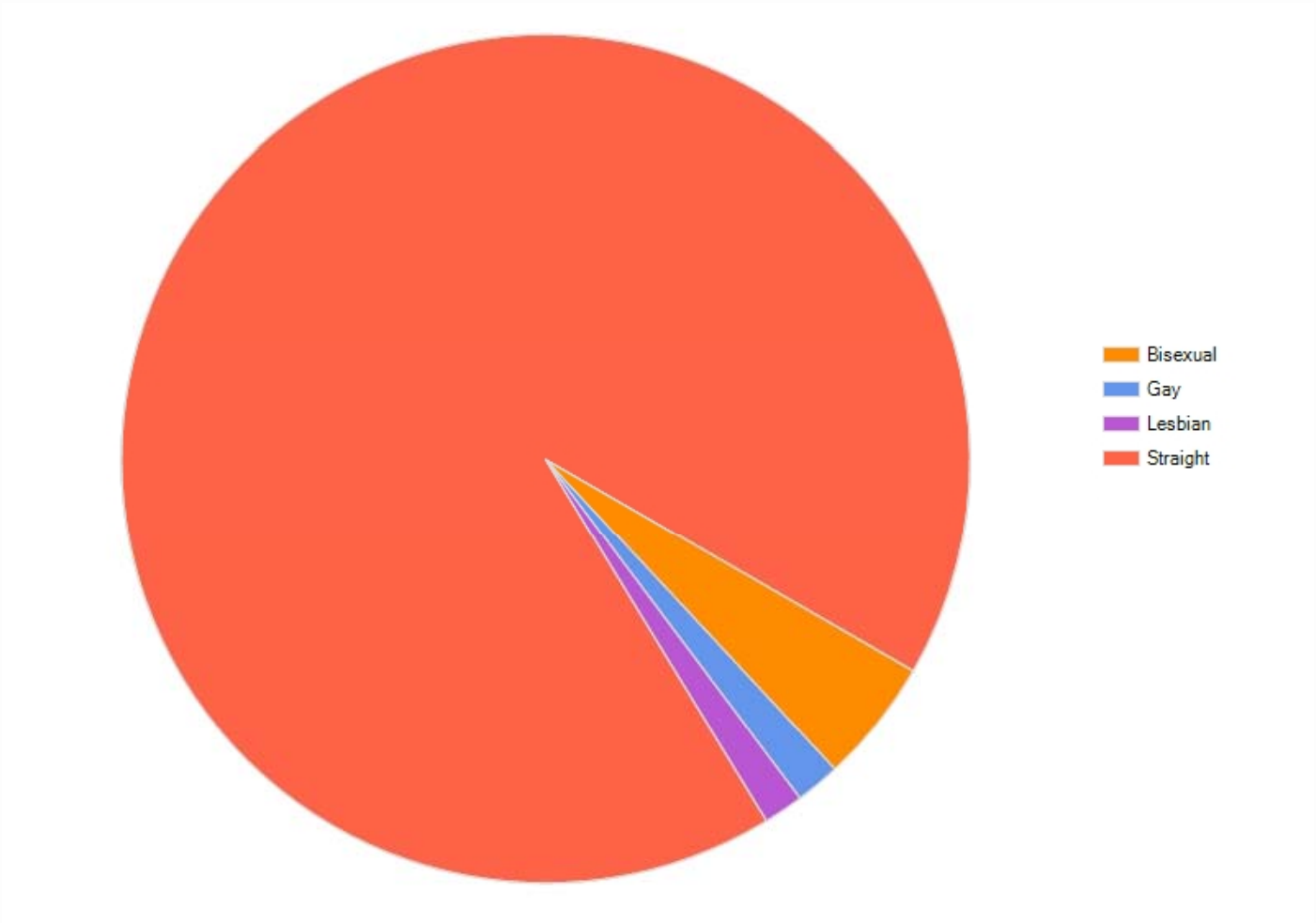
Who responded? Age



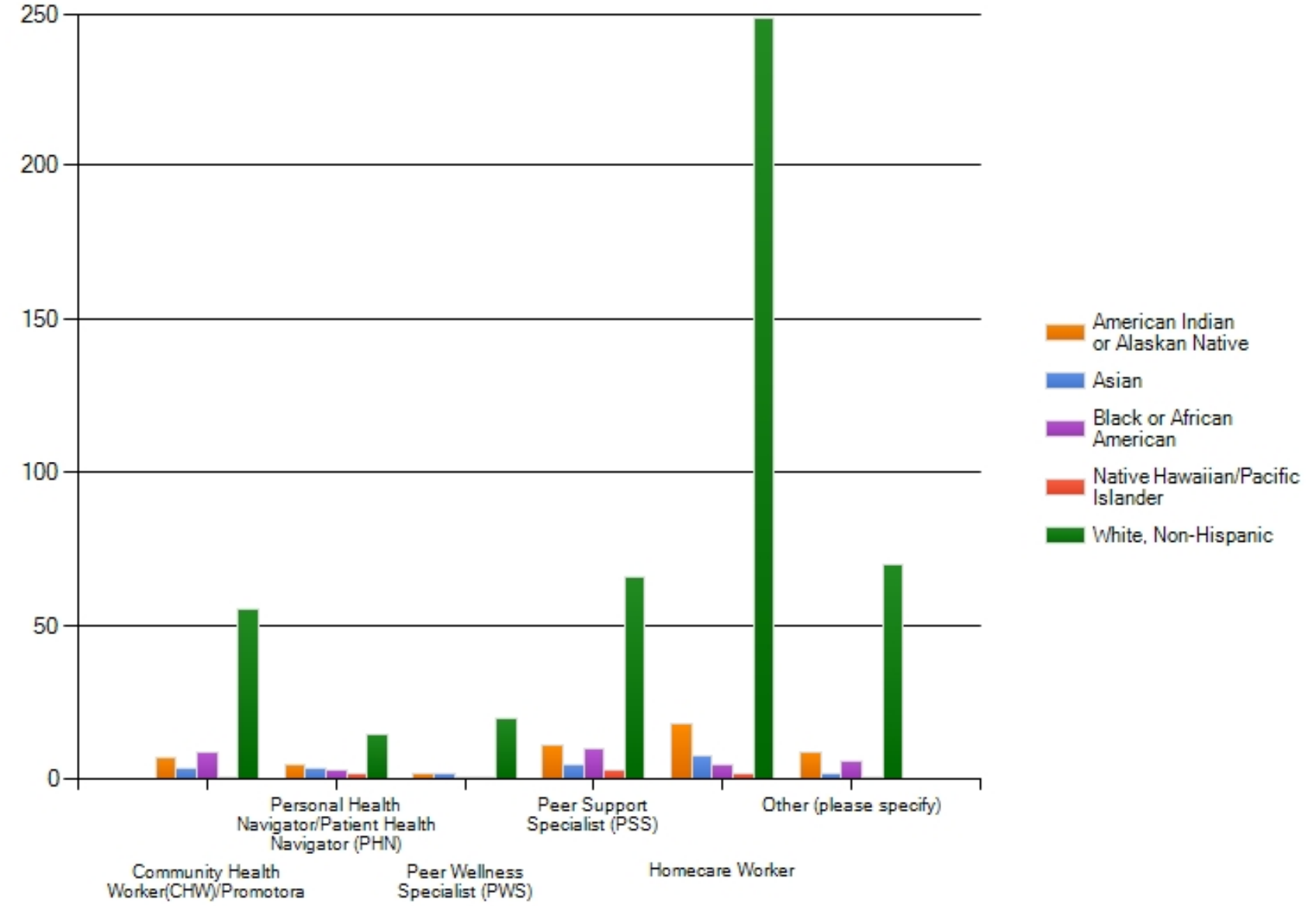
Who responded? Gender



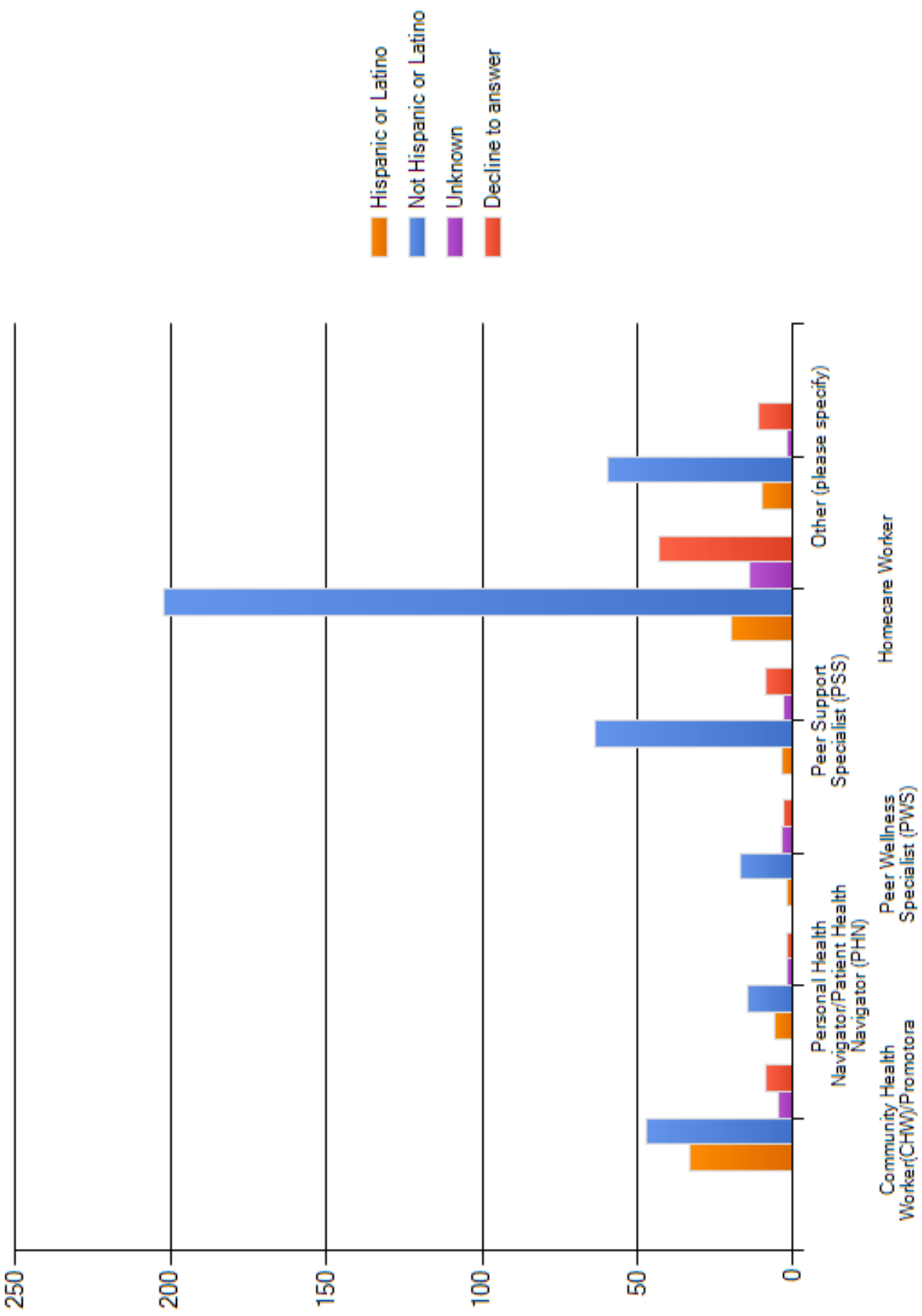
Who responded? Sexual Orientation



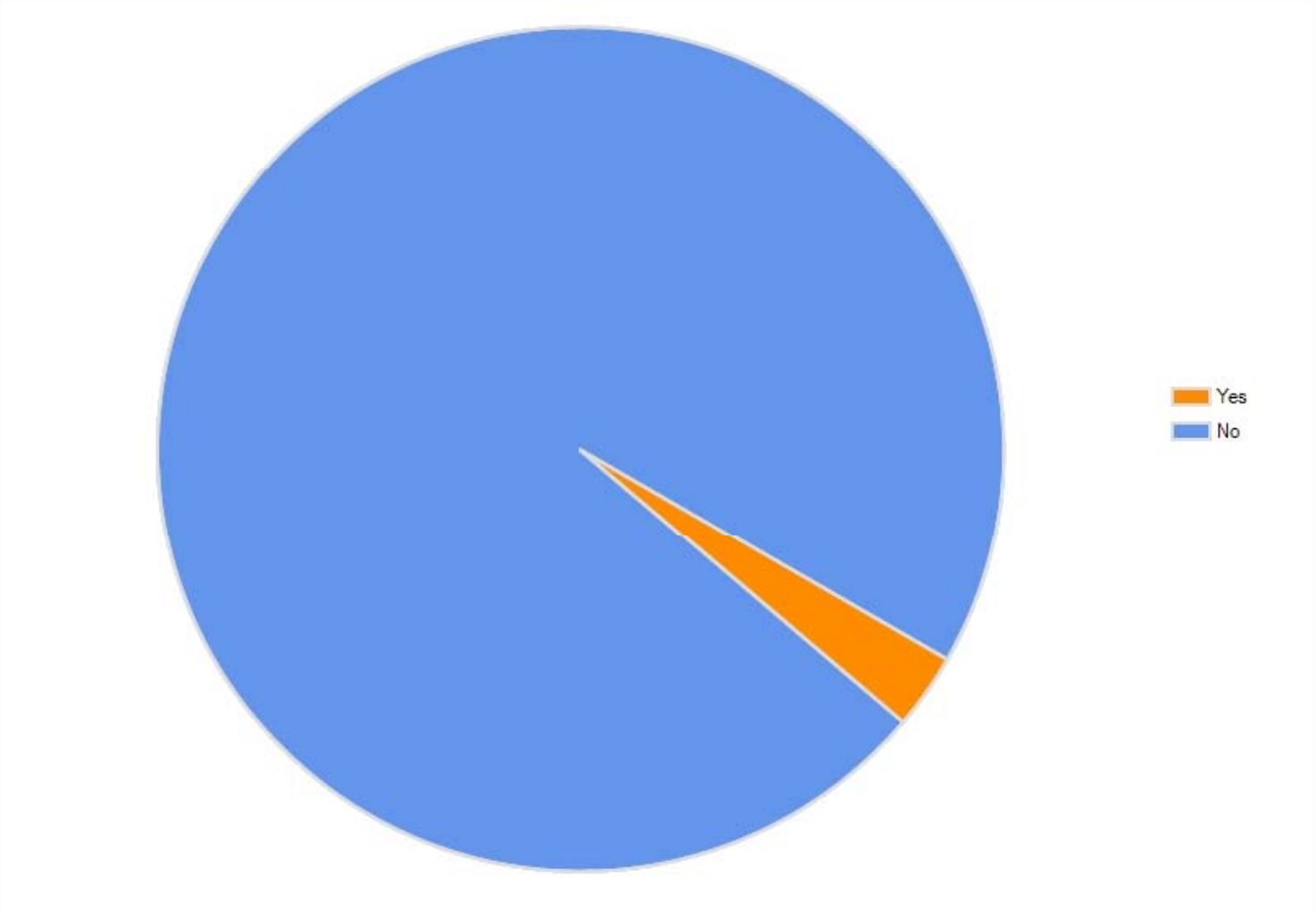
Race by Worker Type



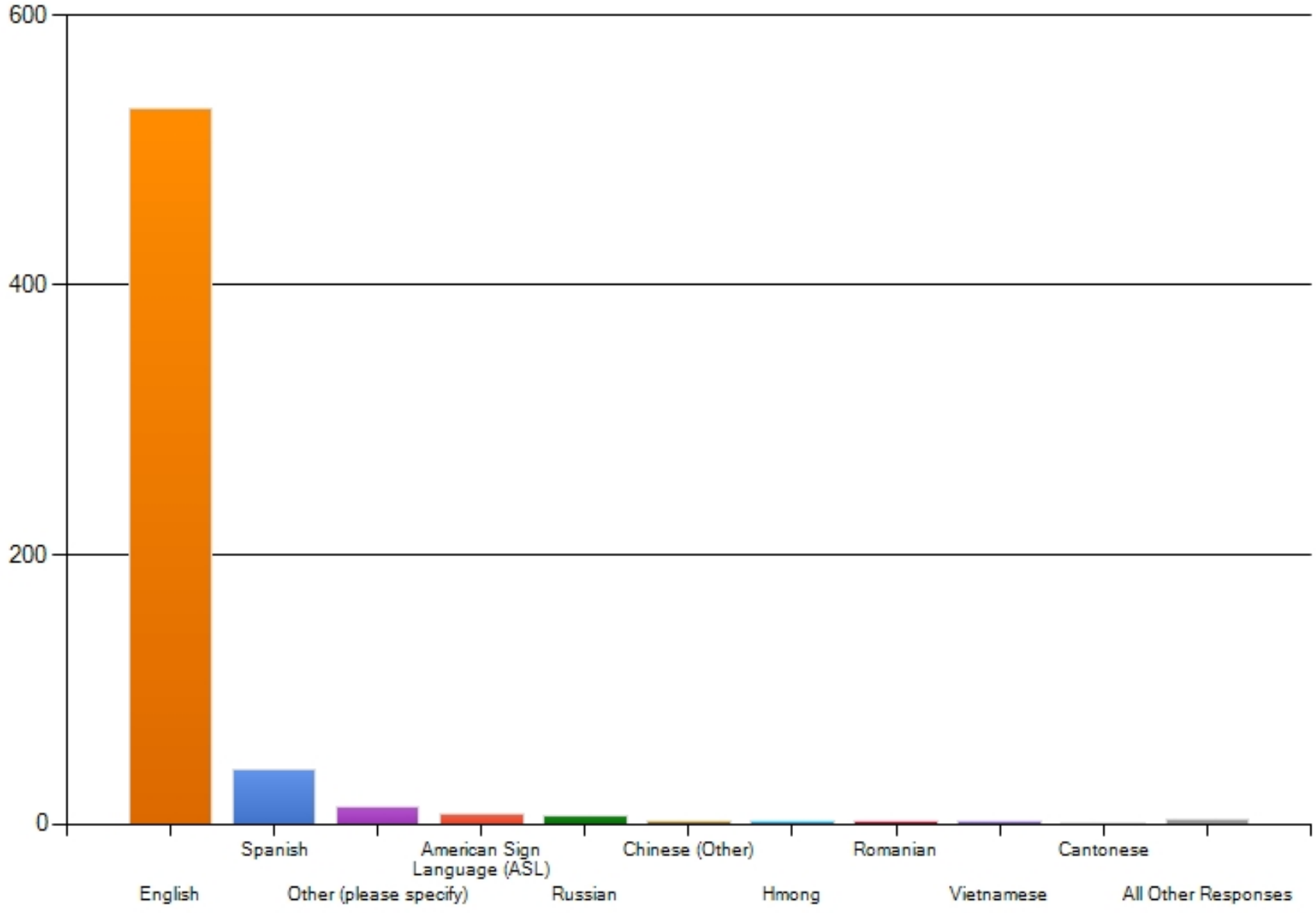
Ethnicity by Worker Type



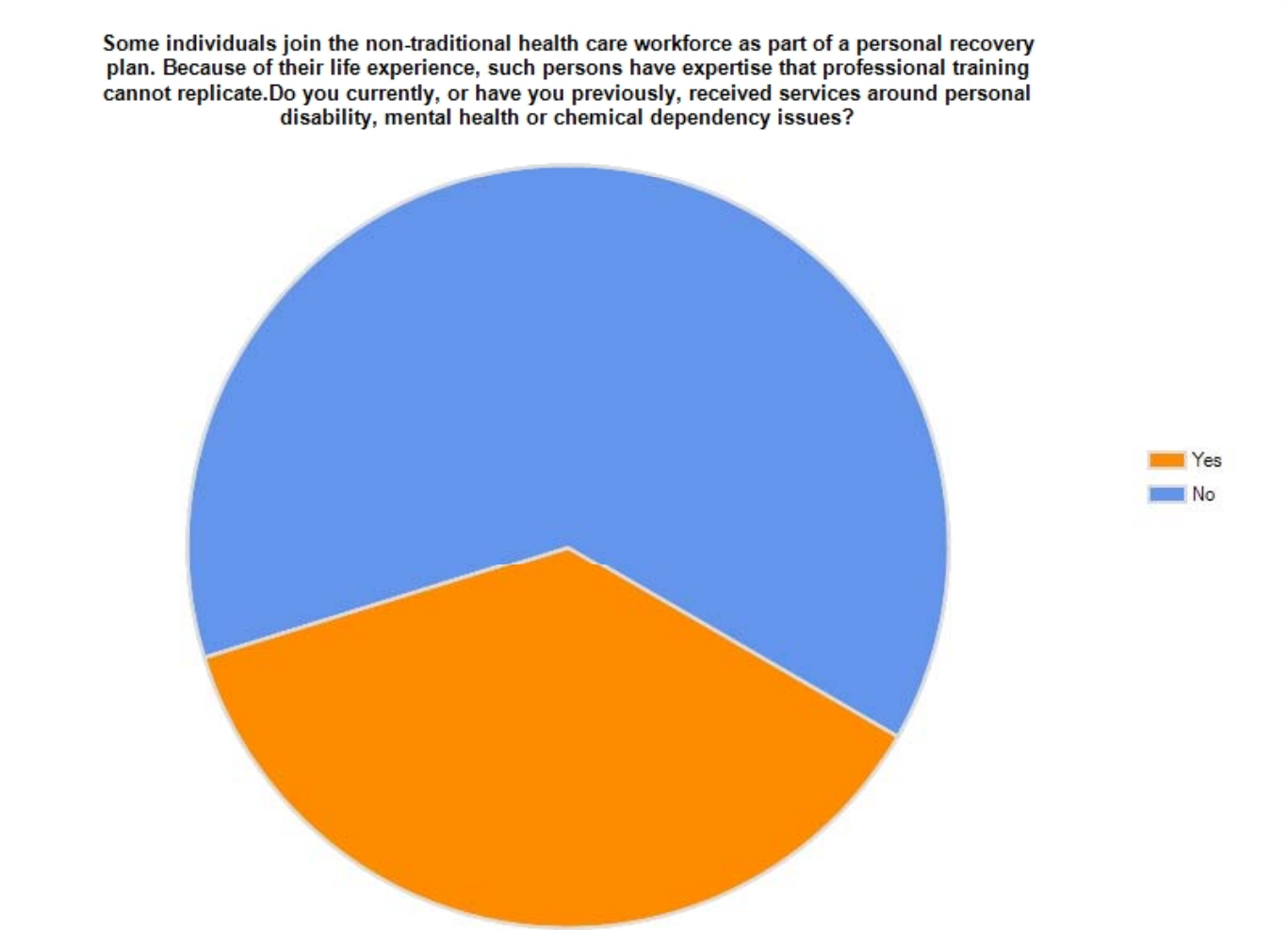
Enrollment in American Indian/Alaska Native Tribe



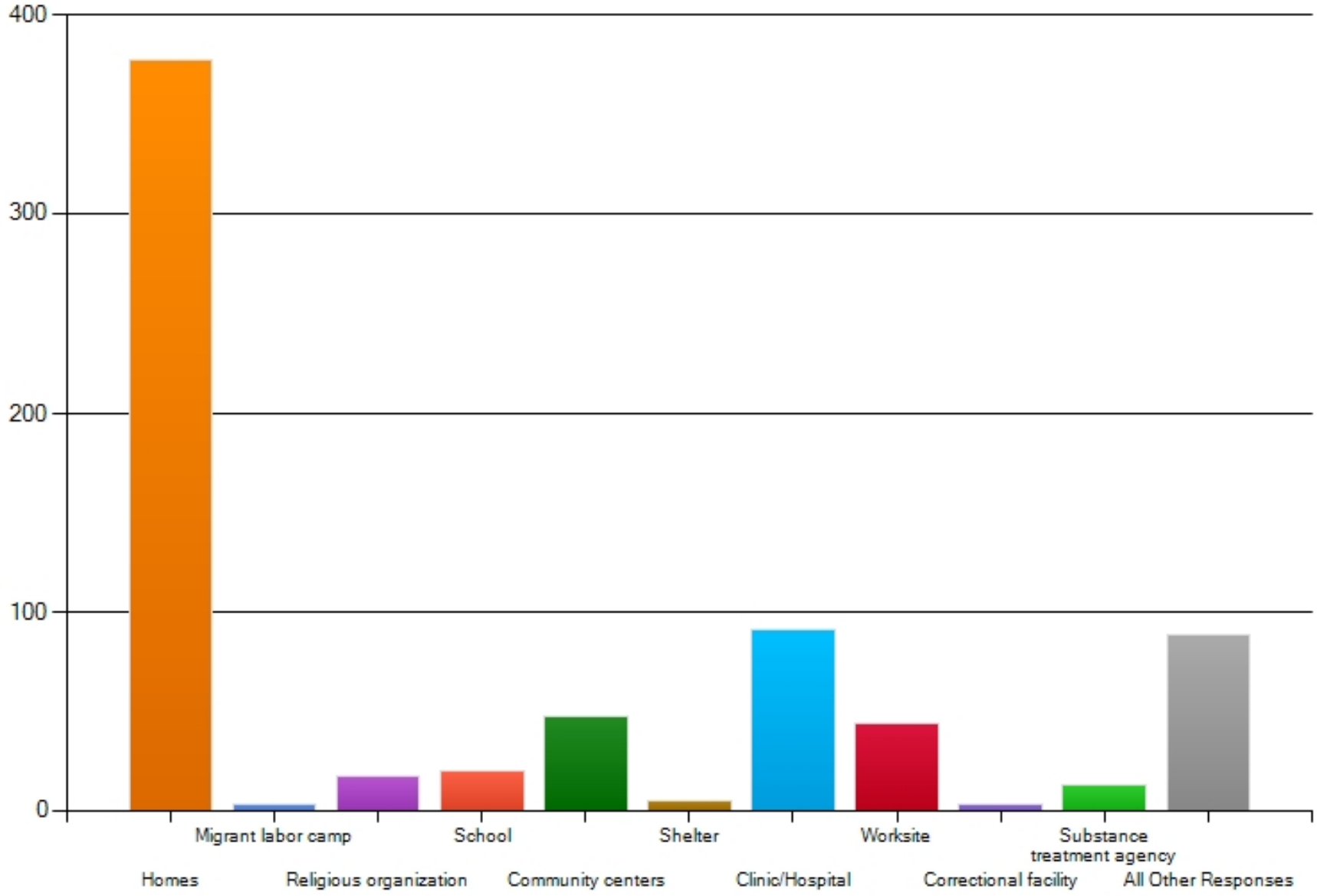
Preferred Language



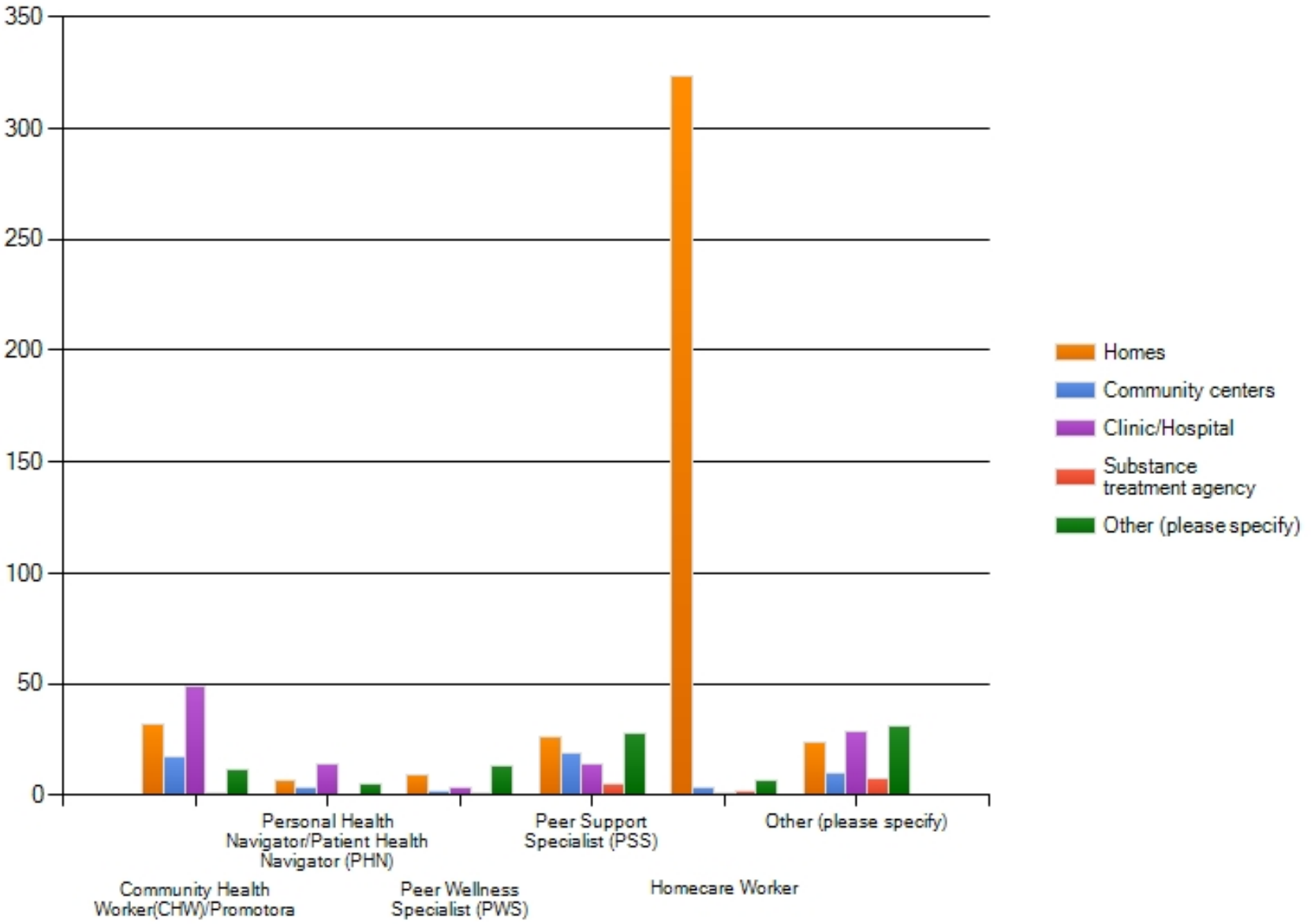
Part of Personal Recovery Plan



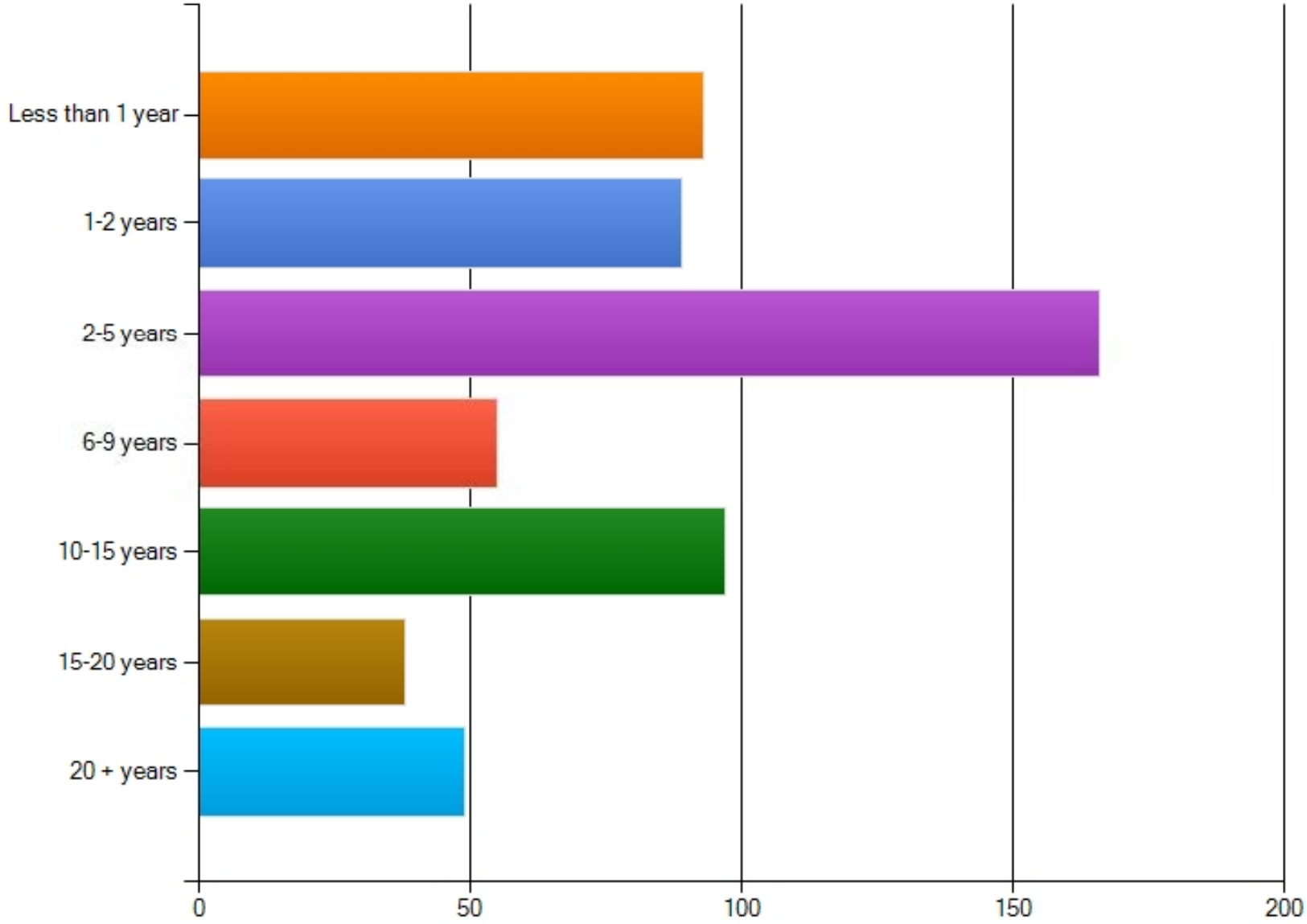
Worker Settings



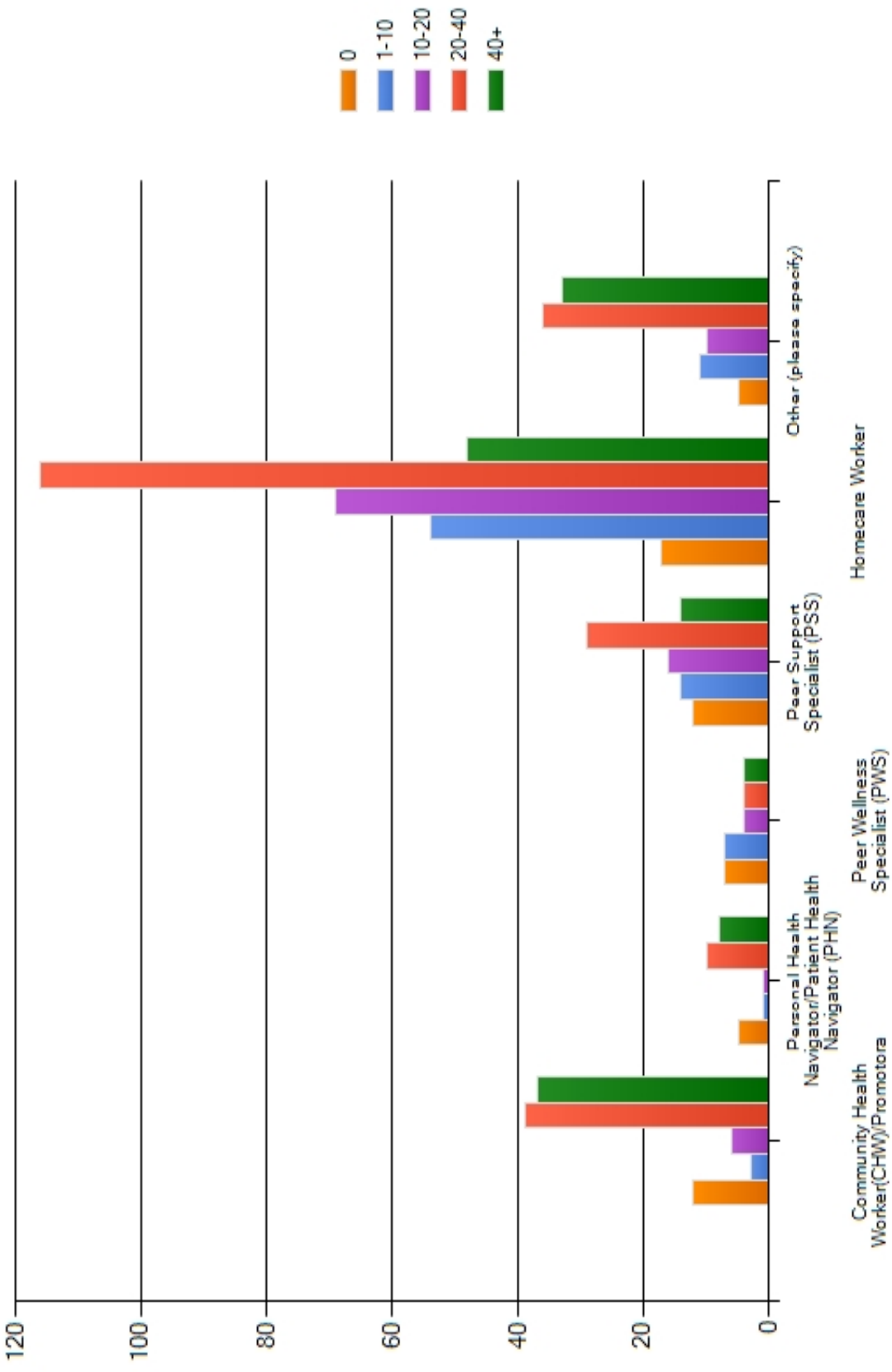
Work Settings by Worker Type



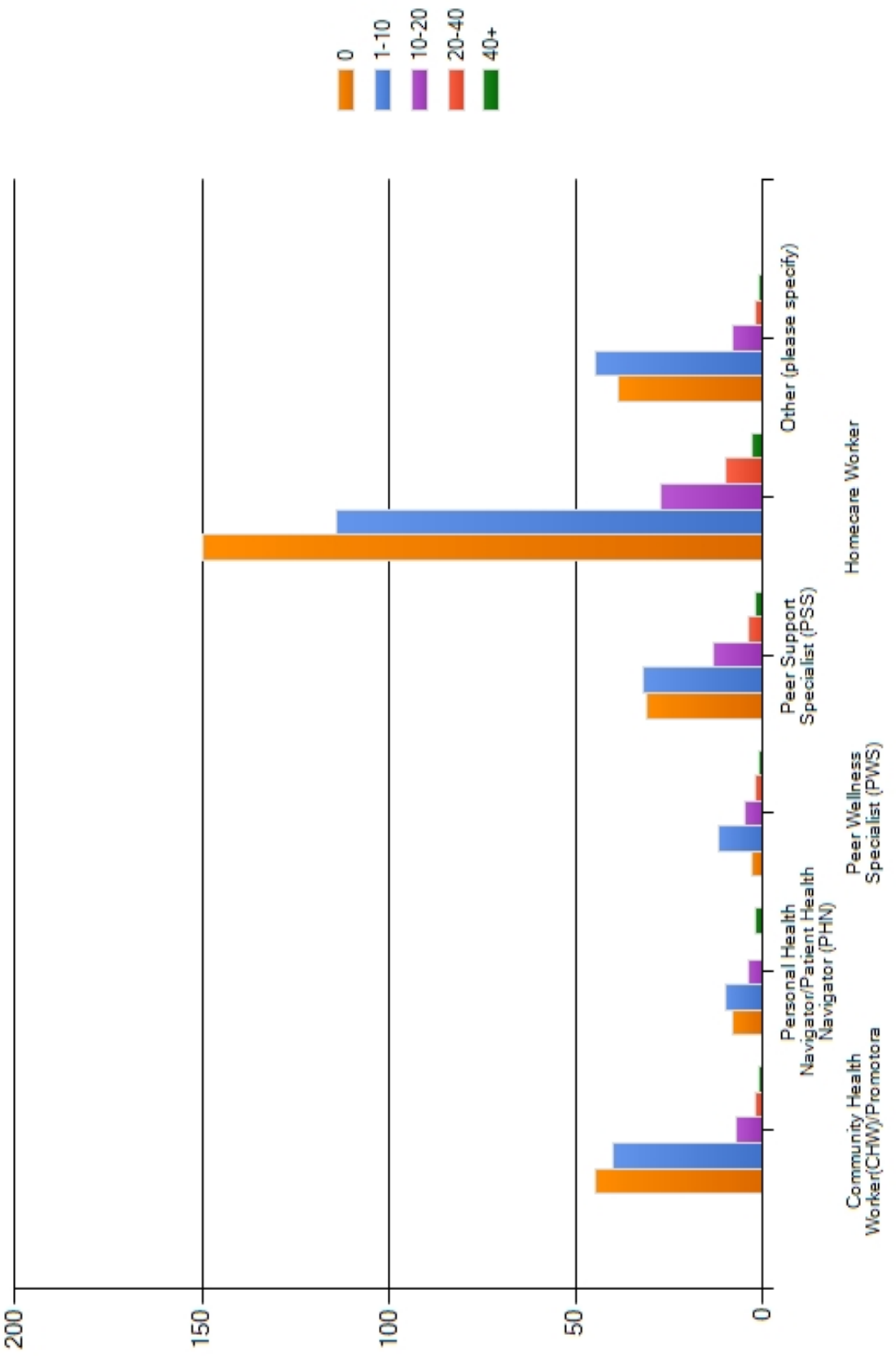
Years in Field



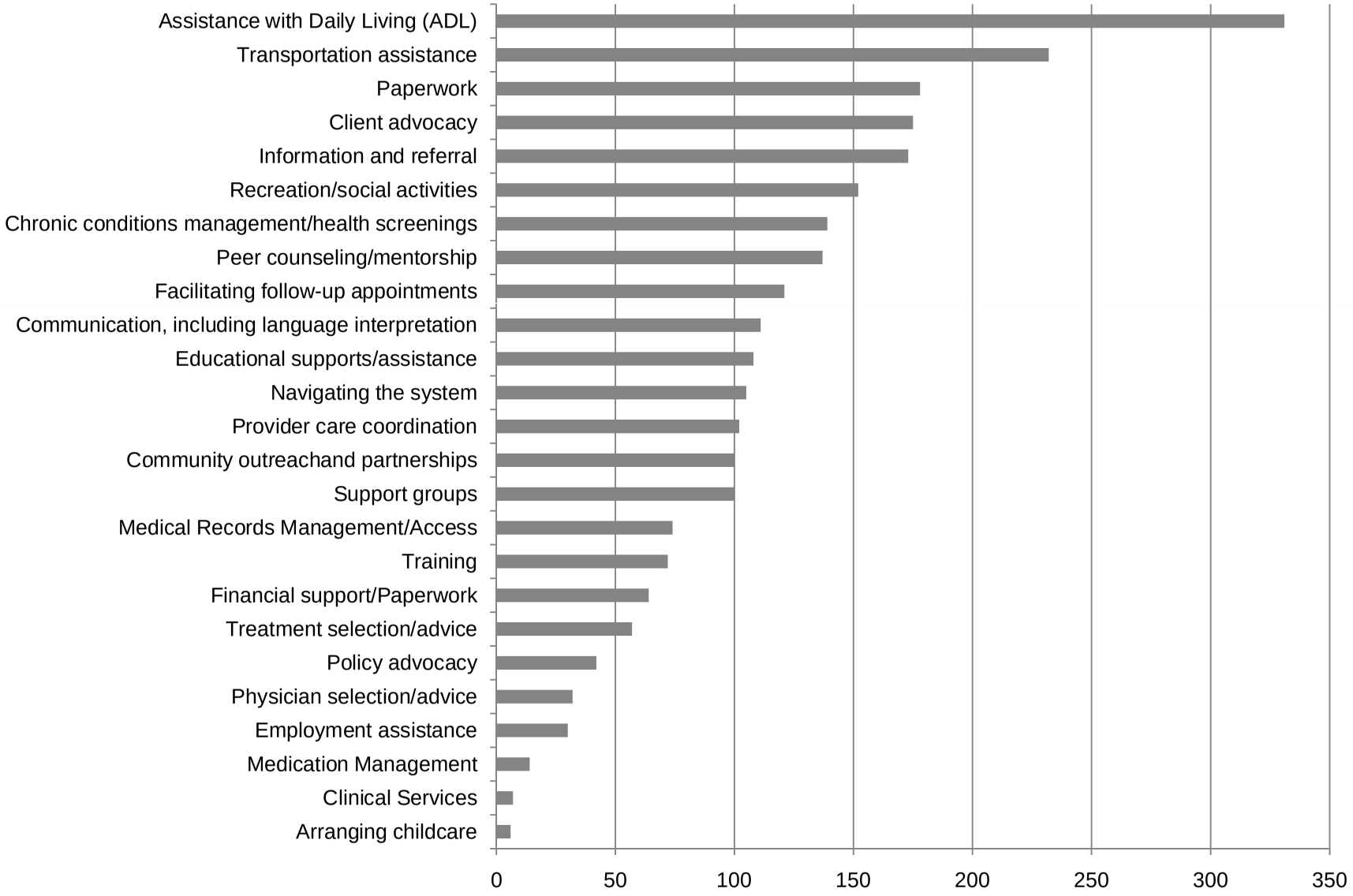
Paid Hours by Worker Type



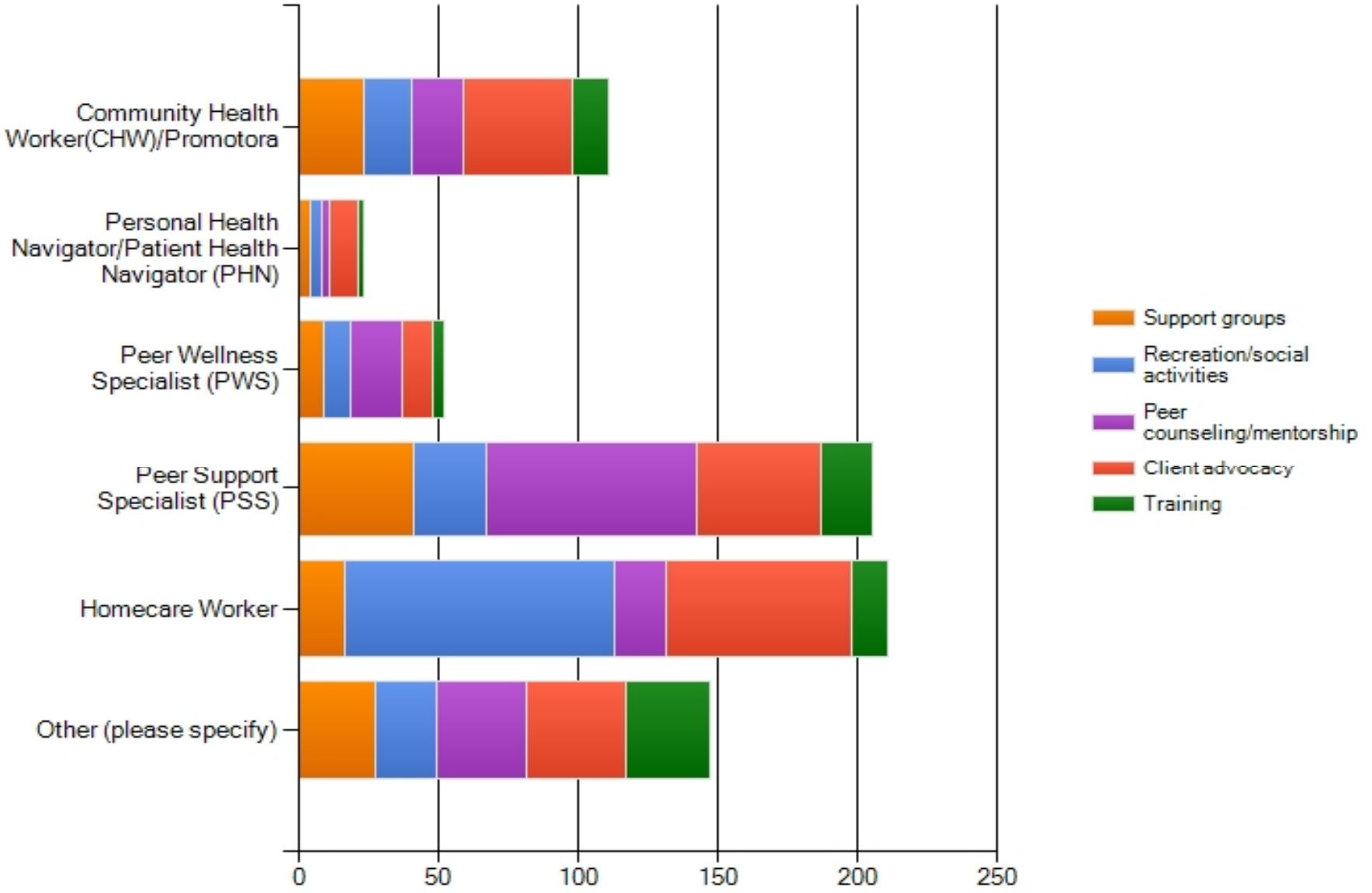
Volunteer Hours by Worker Type



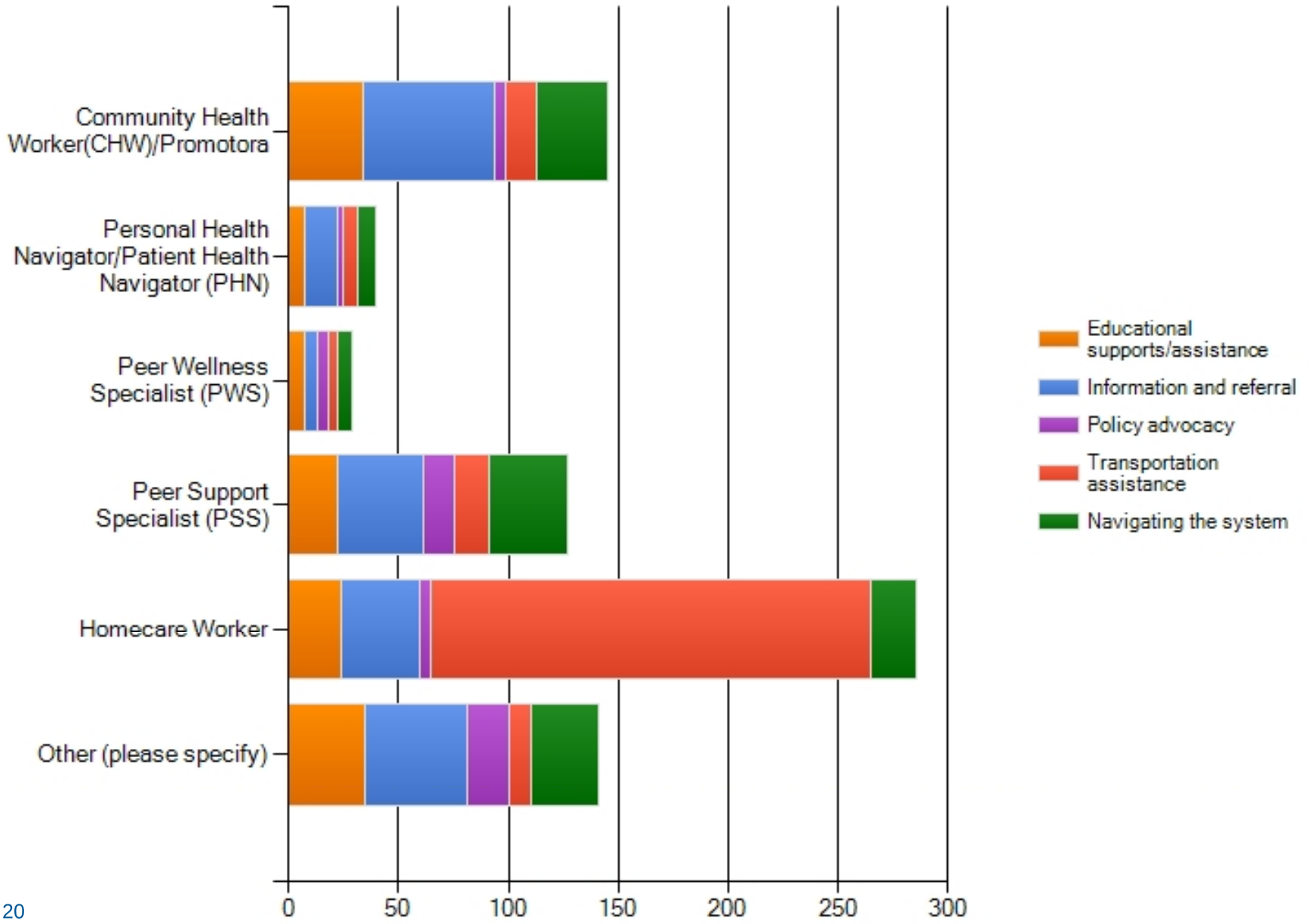
Type of Services Provided



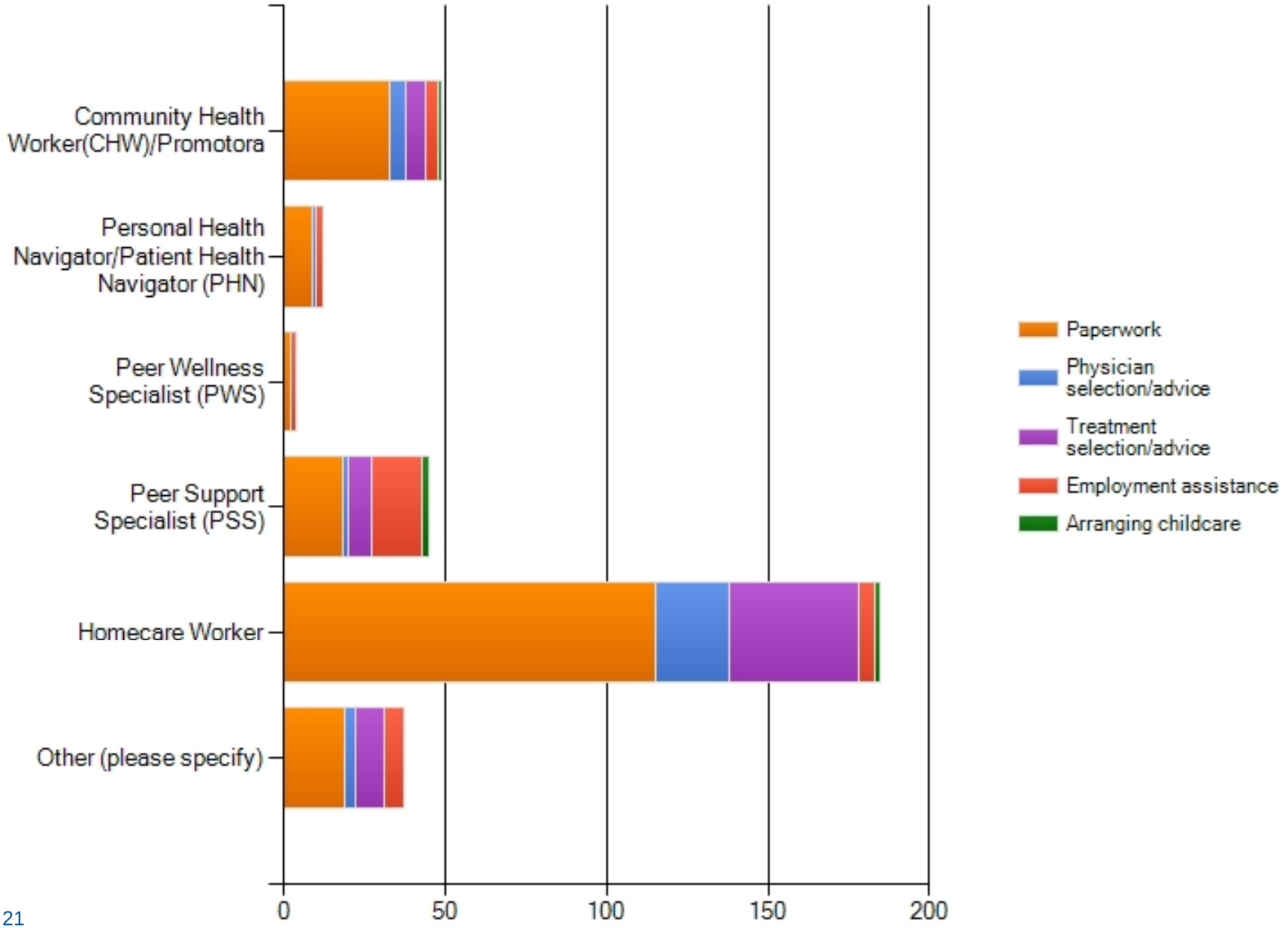
Types of Services by Worker Type Slide 1



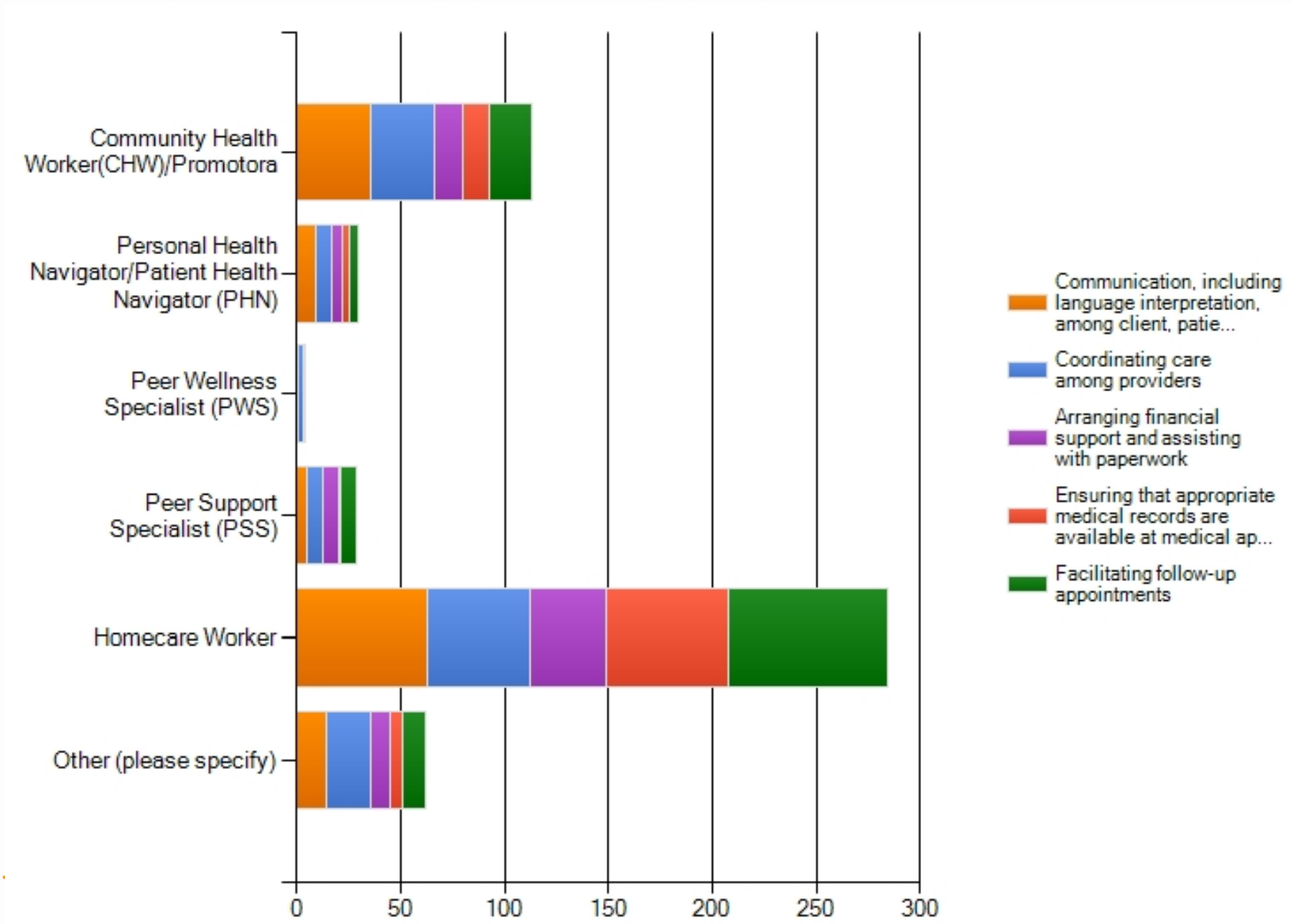
Services by Worker Type Slide 2



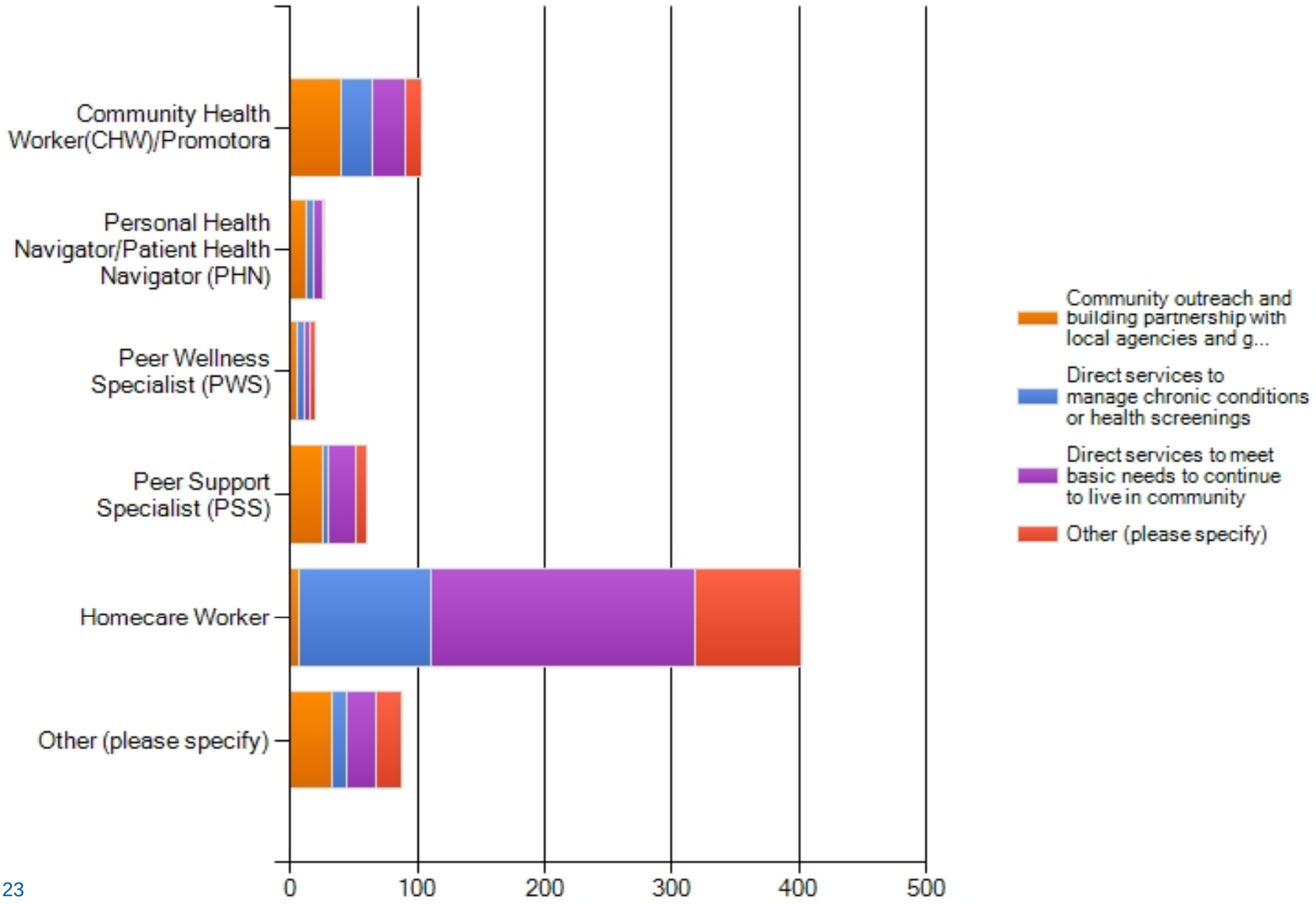
Services By Worker Type Slide 3



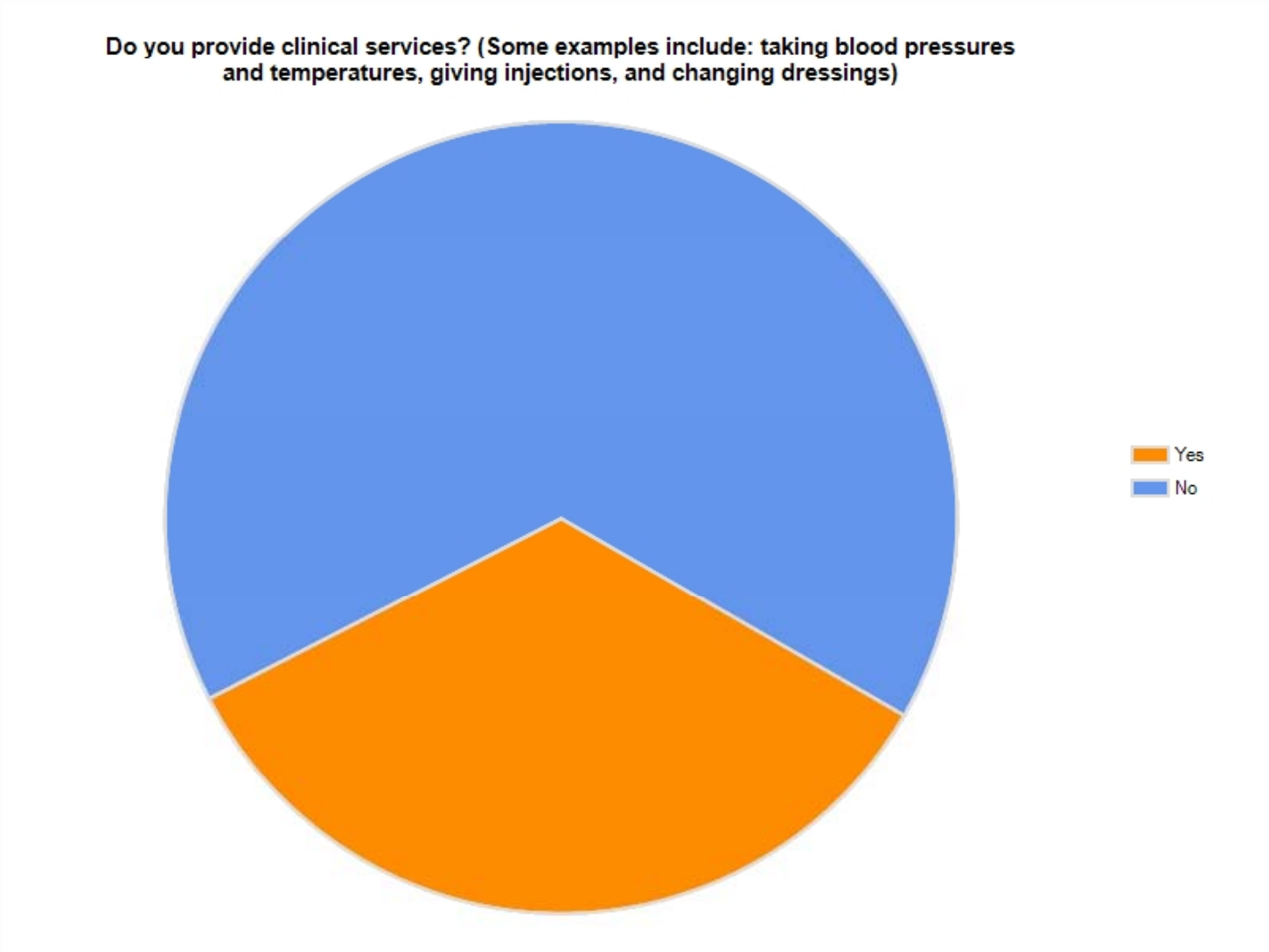
Services By Worker Type Slide 4



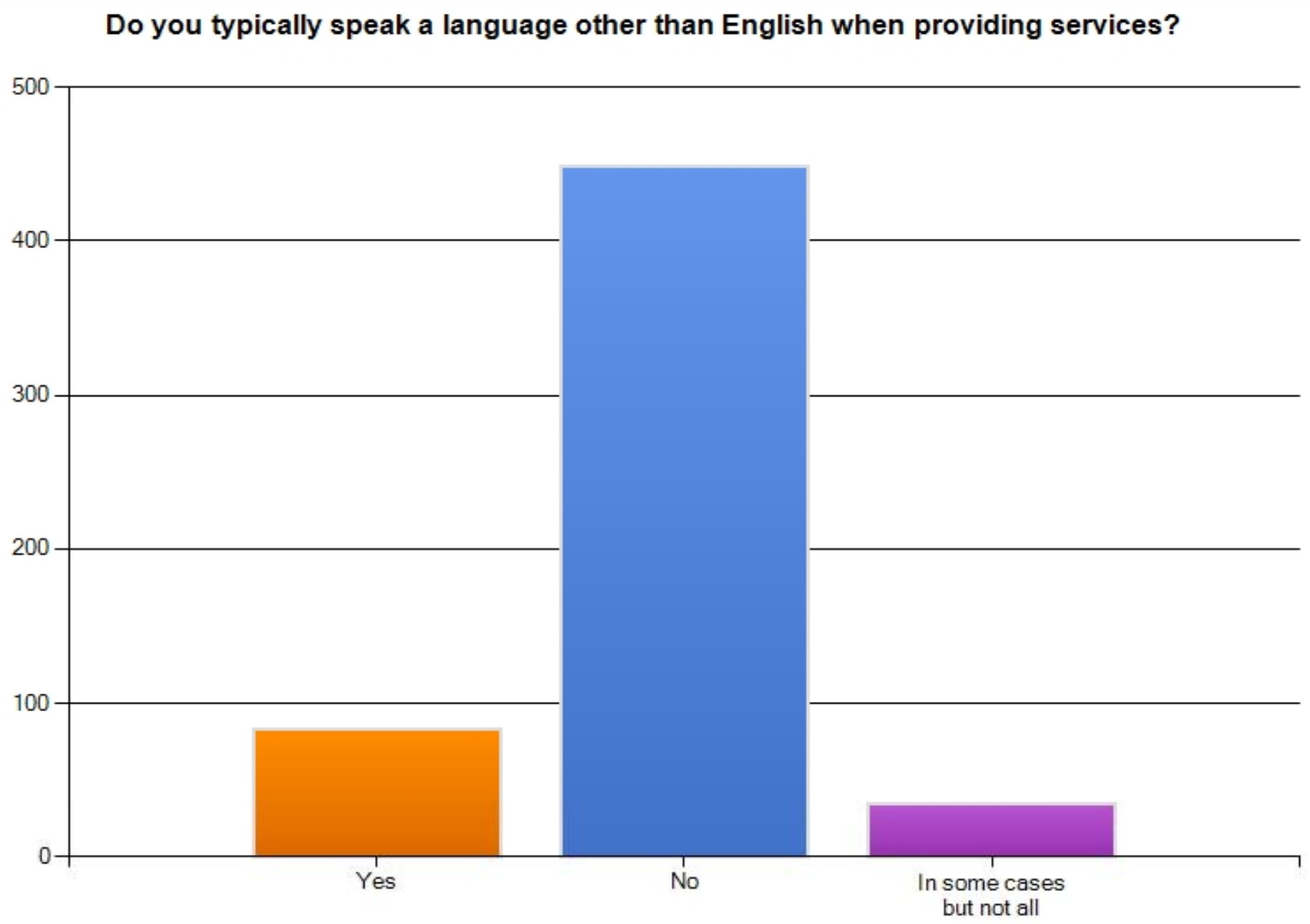
Services by Worker Type Slide 5



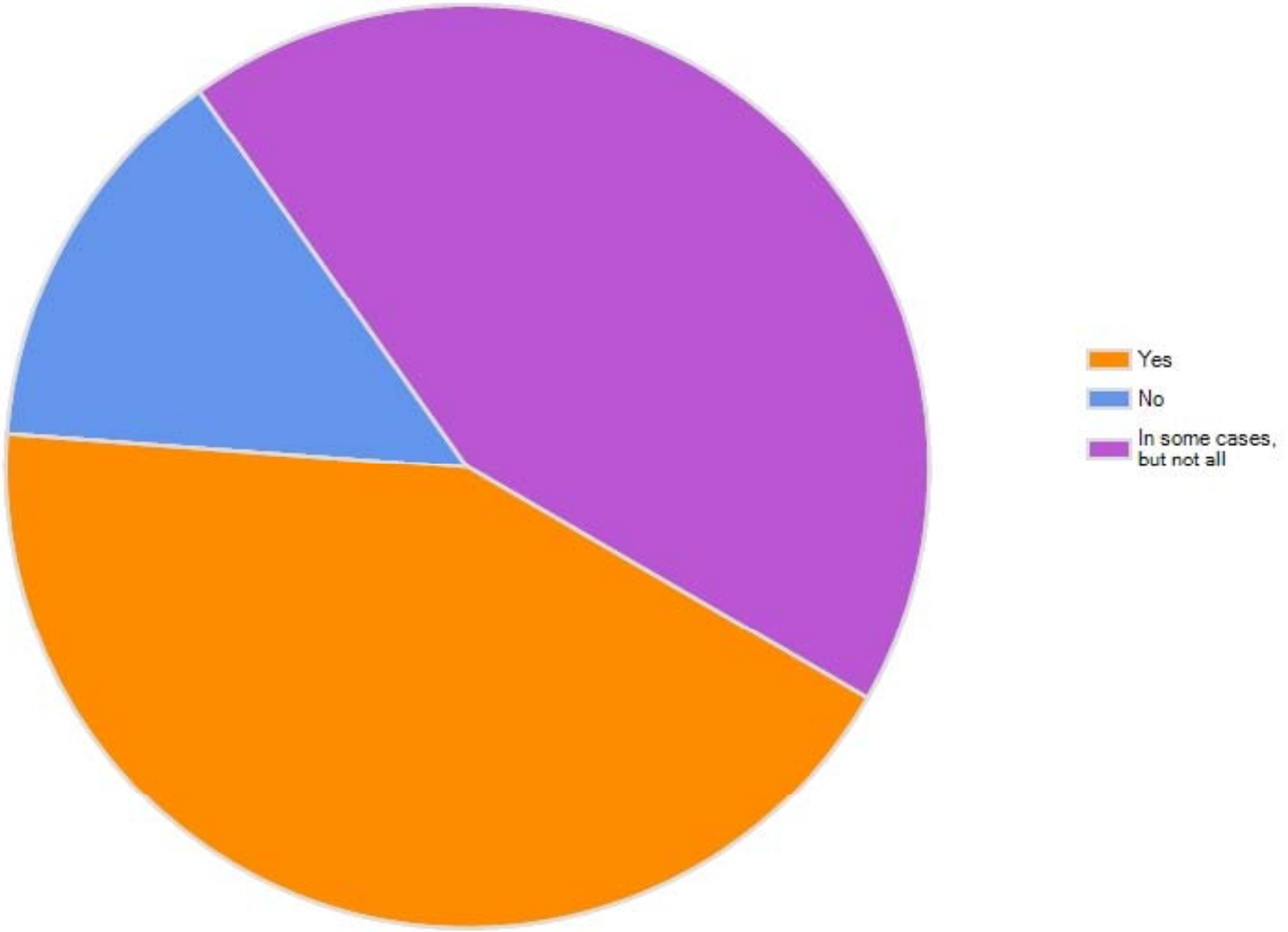
Provision of Clinical Services



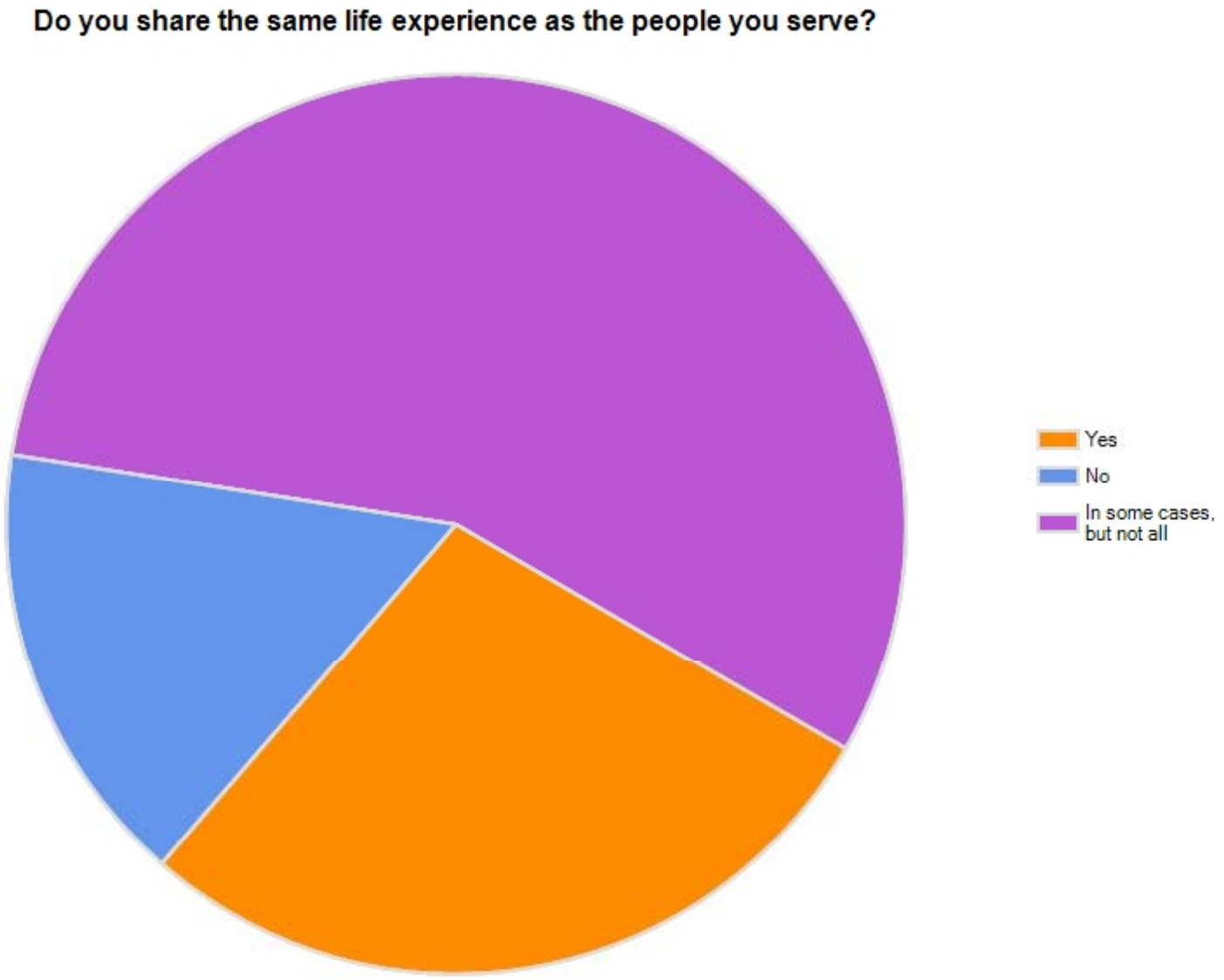
Language-Specific Services



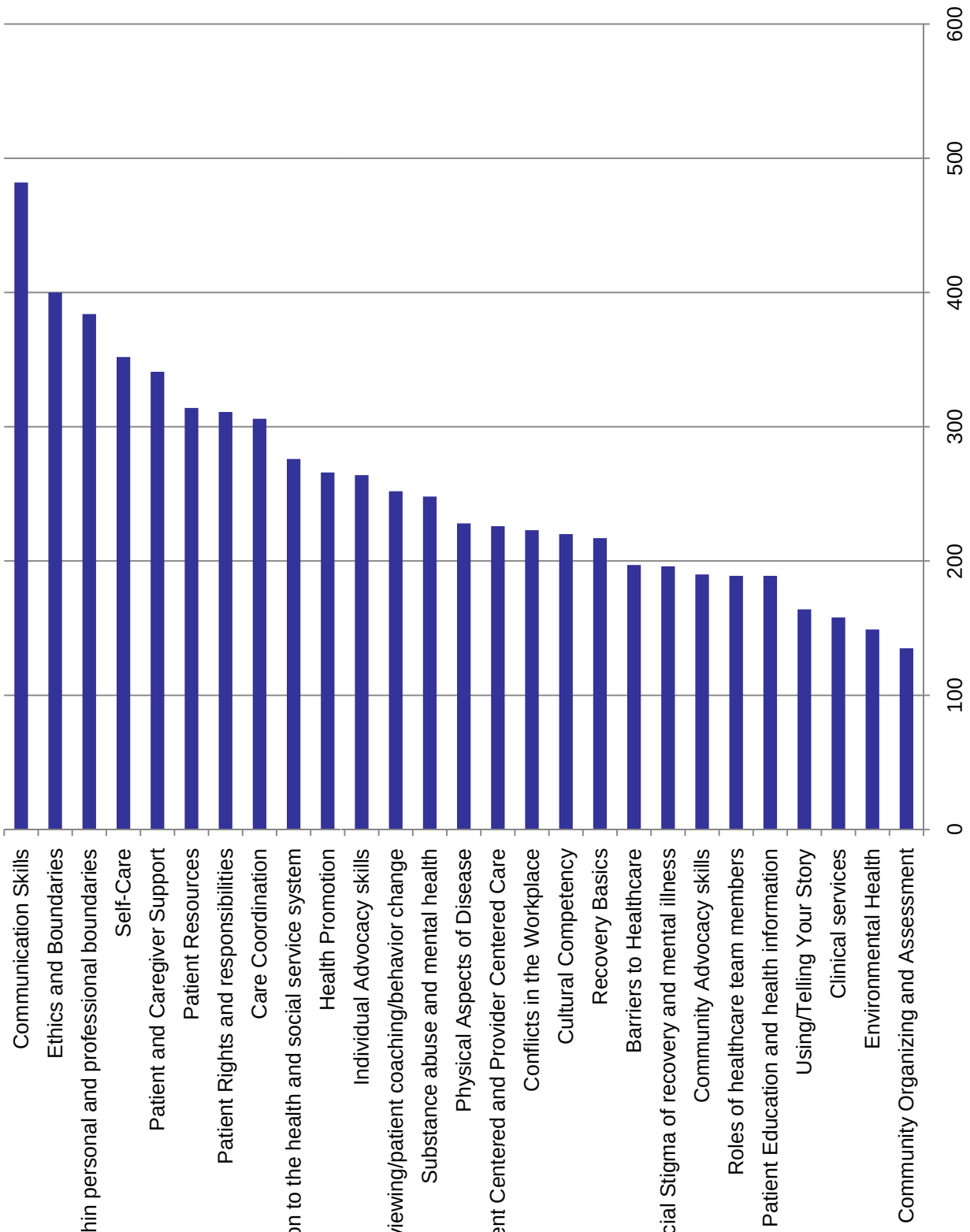
Race/Ethnicity Shared with Clients



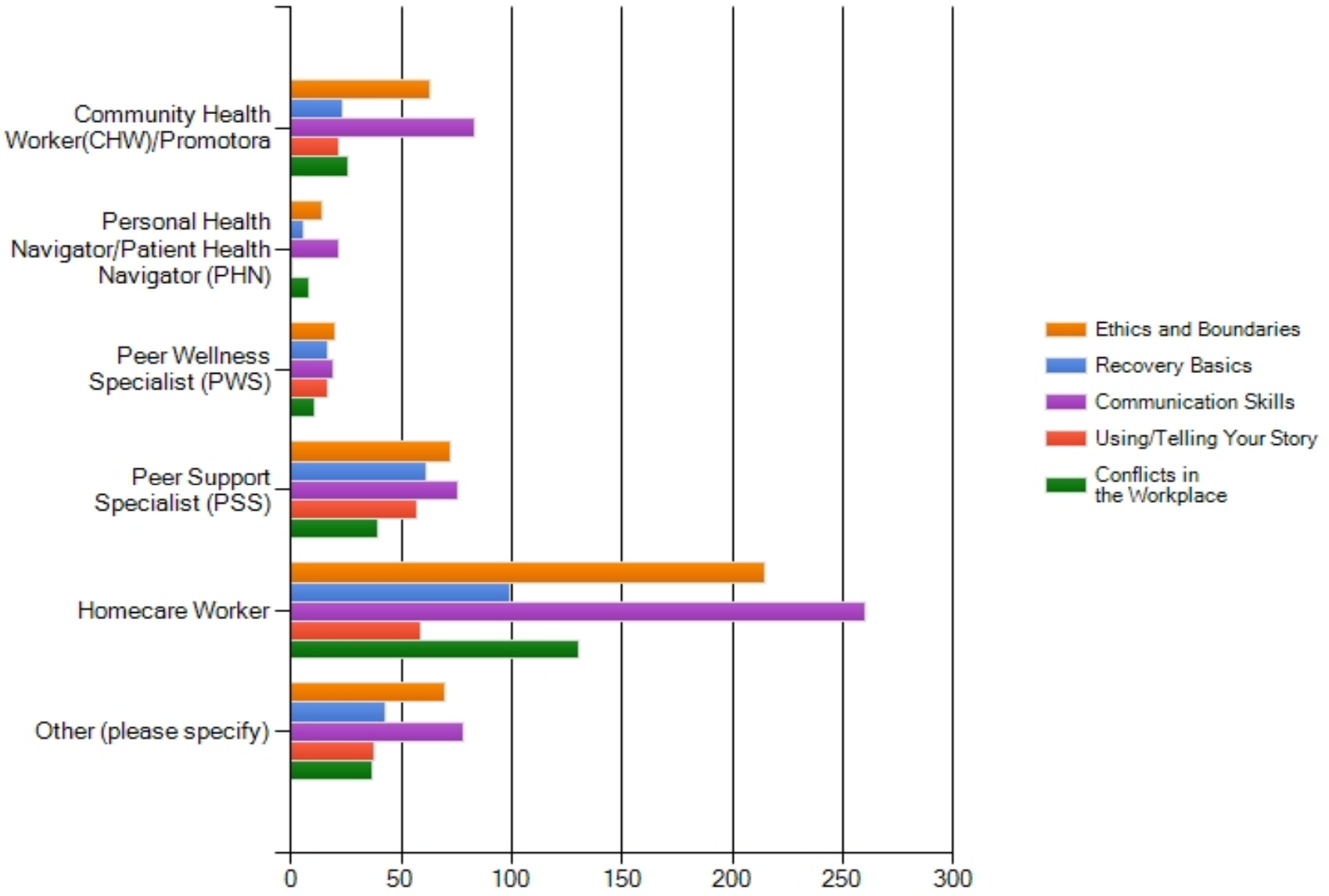
Shared Life Experience



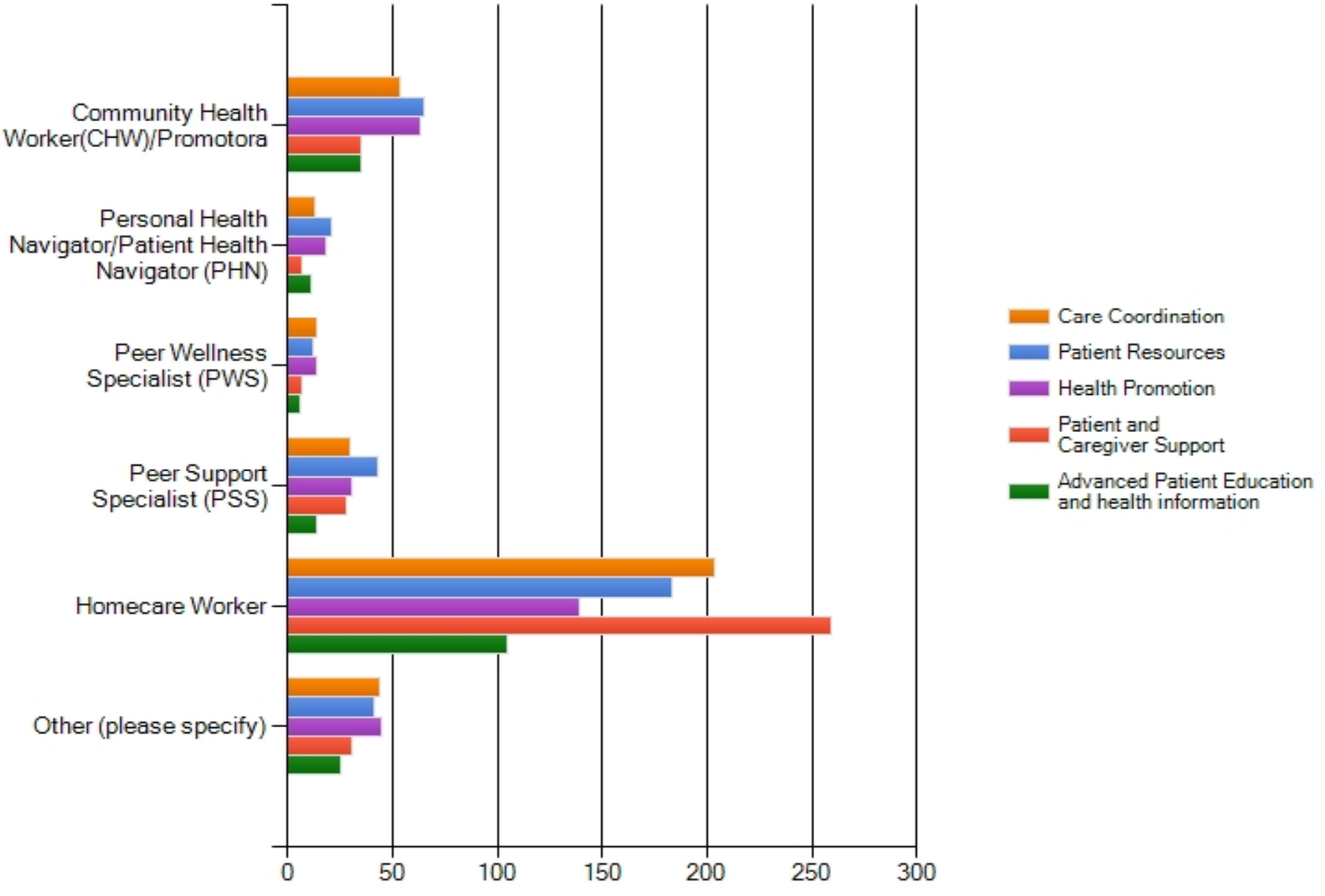
Training Topics



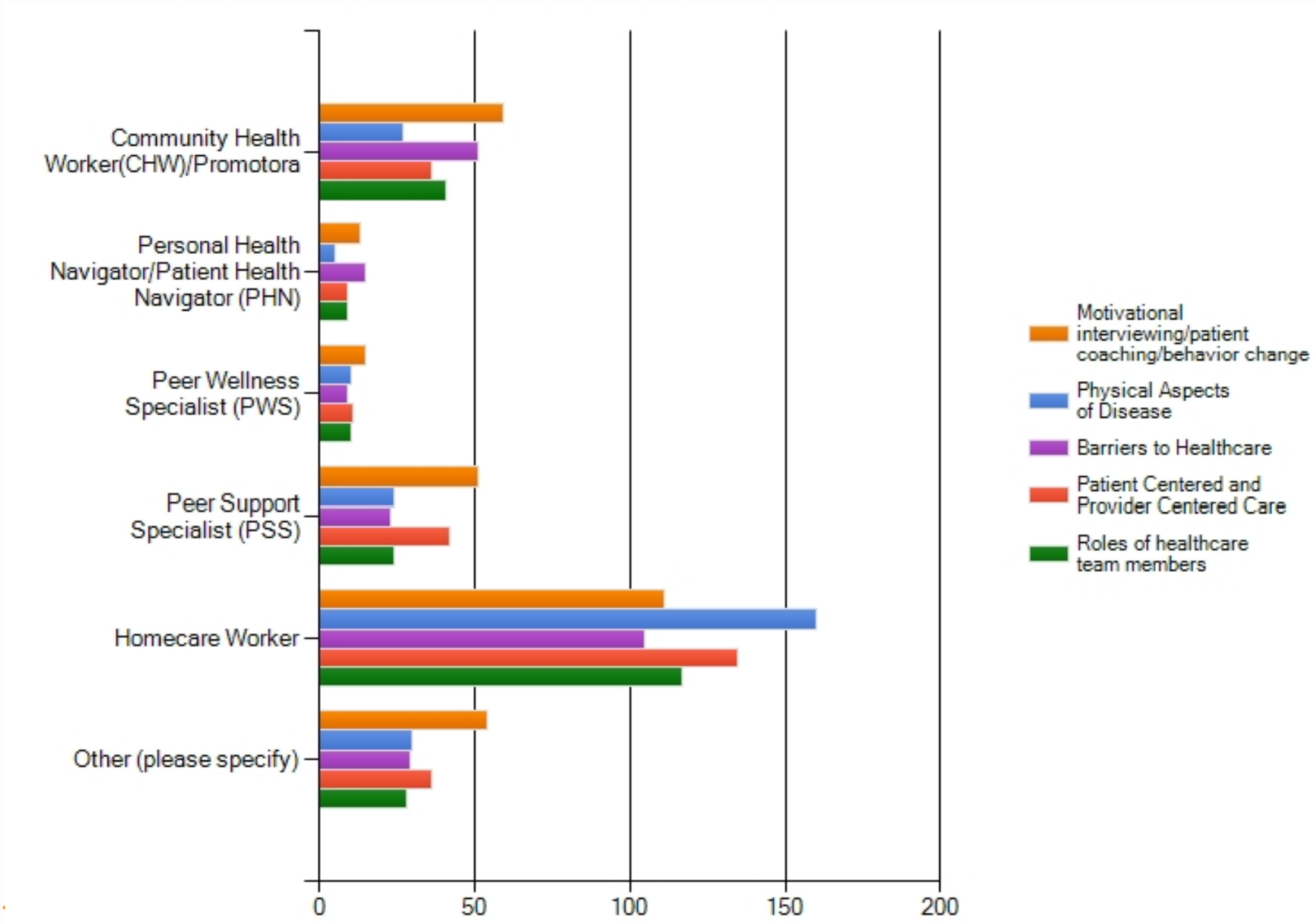
Training By Worker Type Slide 1



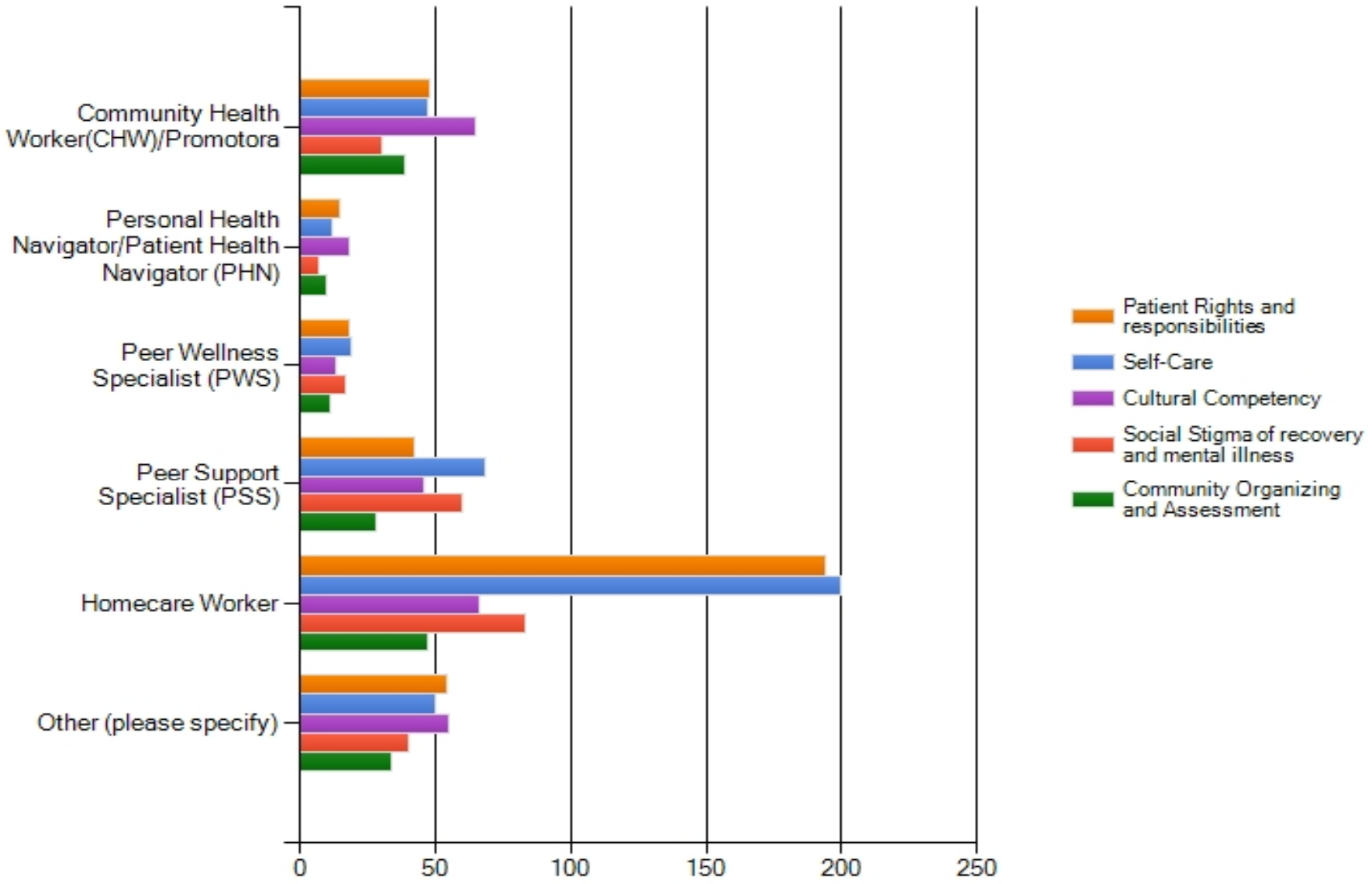
Training By Worker Type Slide 2



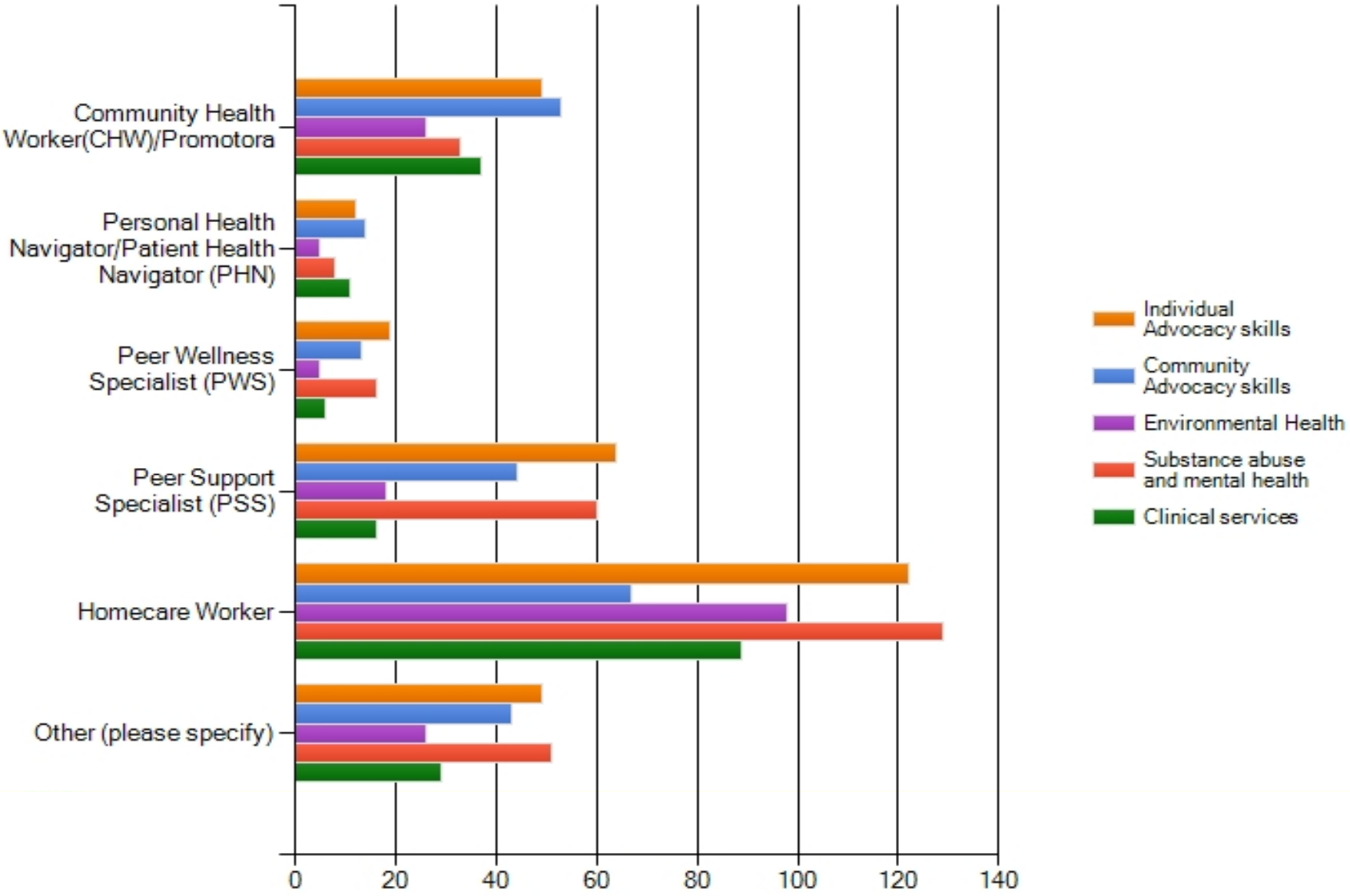
Training By Worker Type Slide 3



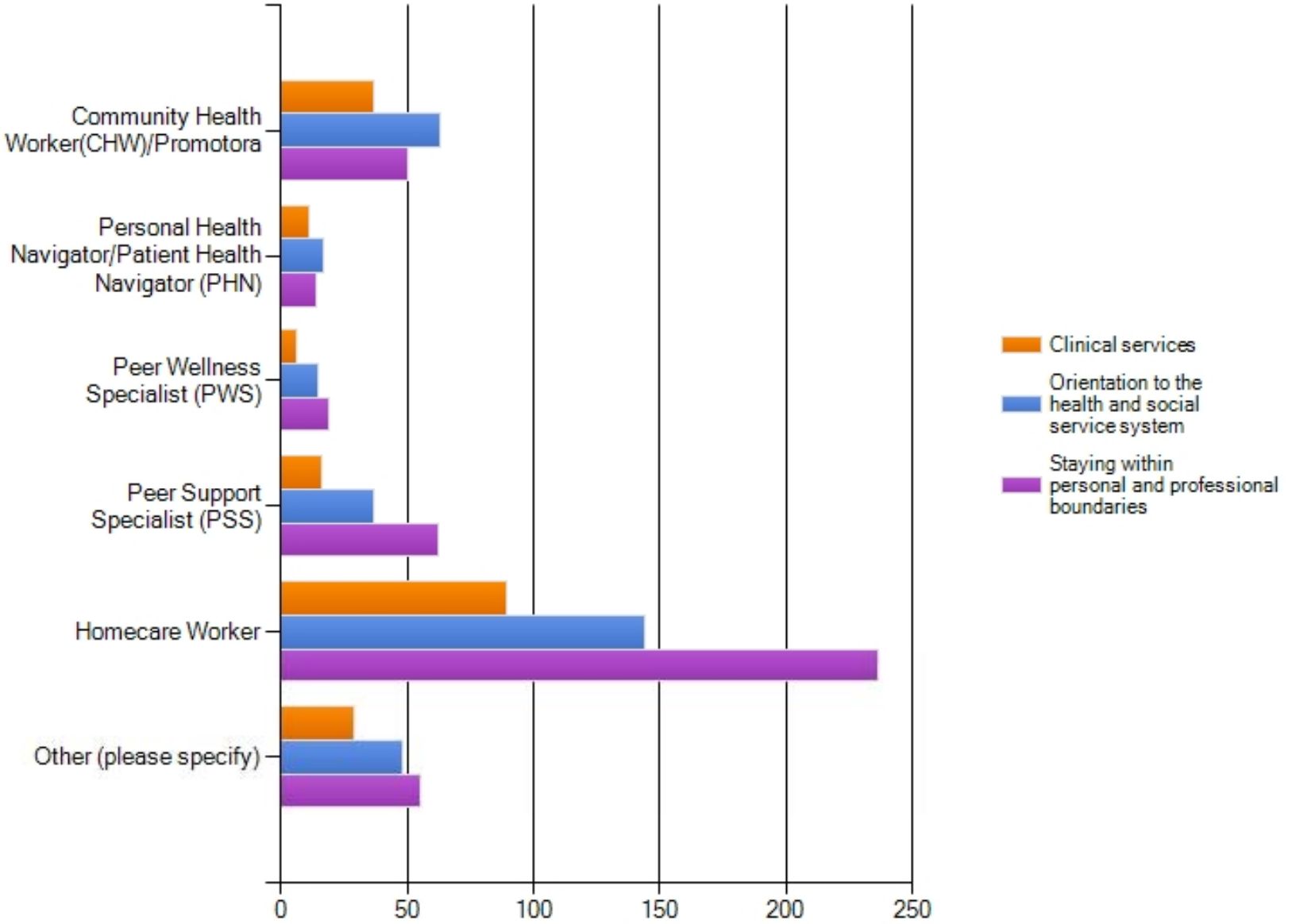
Training by Worker Type 4



Training By Worker Type Slide 5



Training By Worker Type Slide 6



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