COMMUNITY HEALTH WORKER (CHW) WORKGROUP

CHAIR: JUDY HASSELKUS, INDIANA DEPARTMENT OF WORKFORCE DEVELOPMENT

CO-CHAIR: LAURA HEINRICH, INDIANA STATE DEPARTMENT OF HEALTH

NOVEMBER 8, 2018

Welcome

Updates from Indiana State Department of Health

DR. KRISTINA BOX, COMMISSIONER, INDIANA STATE DEPARTMENT OF HEALTH

Review of Minutes and Roll Call of Workgroup Members

Discussion of Next Steps

Immediate Need: Moving from Recommendation to Implementation for Grandfathered Individuals

A process will need to be created and implemented to allow individuals who will be grandfathered to join the registry.

Therefore, next steps:

- *Finalizing recommendations for all application components*

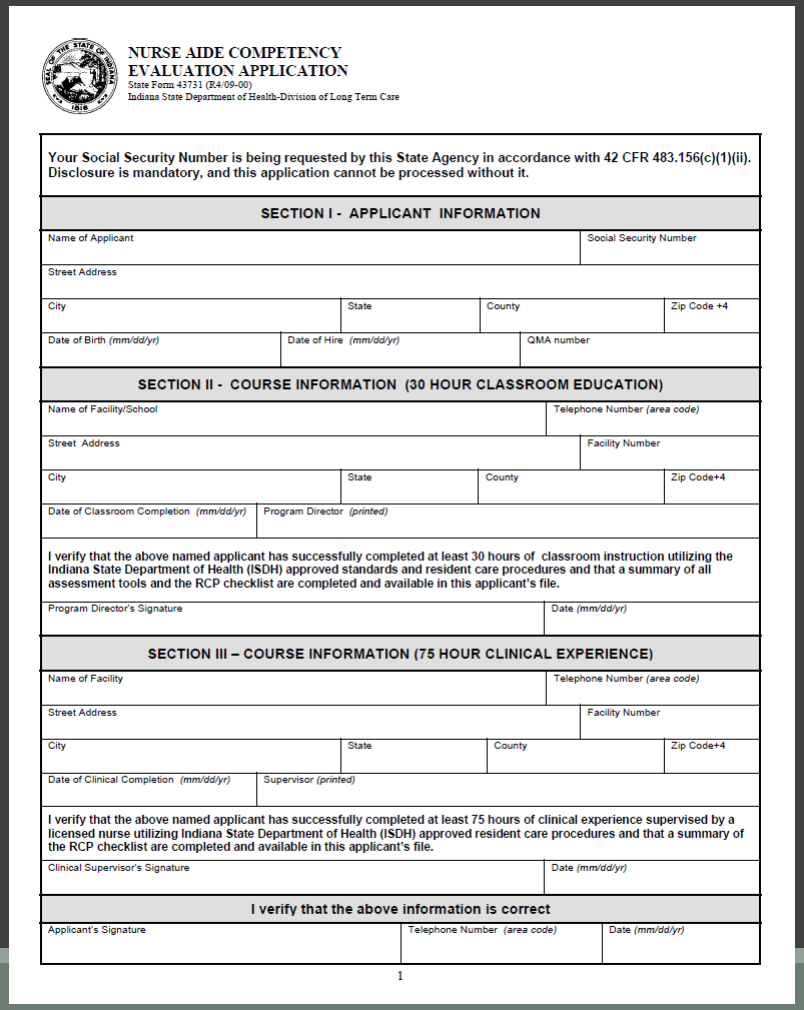
Application Components – Examples from other certified occupations (CNA)

1. Information to be collected/maintained on applicants

2. Qualifying Training

3. Qualifying Experience

4. Examination



NURSE AIDE COMPETENCY EVALUATION APPLICATION
State Form 43731 (R4/09-00)
Indiana State Department of Health-Division of Long Term Care

Your Social Security Number is being requested by this State Agency in accordance with 42 CFR 483.156(c)(1)(ii). Disclosure is mandatory, and this application cannot be processed without it.

SECTION I - APPLICANT INFORMATION

Name of Applicant | Social Security Number
Street Address
City | State | County | Zip Code +4
Date of Birth *(mm/dd/yr)* | Date of Hire *(mm/dd/yr)* | QMA number

SECTION II - COURSE INFORMATION (30 HOUR CLASSROOM EDUCATION)

Name of Facility/School | Telephone Number *(area code)*
Street Address | Facility Number
City | State | County | Zip Code+4
Date of Classroom Completion *(mm/dd/yr)* | Program Director *(printed)*

I verify that the above named applicant has successfully completed at least 30 hours of classroom instruction utilizing the Indiana State Department of Health (ISDH) approved standards and resident care procedures and that a summary of all assessment tools and the RCP checklist are completed and available in this applicant's file.

Program Director's Signature | Date *(mm/dd/yr)*

SECTION III – COURSE INFORMATION (75 HOUR CLINICAL EXPERIENCE)

Name of Facility | Telephone Number *(area code)*
Street Address | Facility Number
City | State | County | Zip Code+4
Date of Clinical Completion *(mm/dd/yr)* | Supervisor *(printed)*

I verify that the above named applicant has successfully completed at least 75 hours of clinical experience supervised by a licensed nurse utilizing Indiana State Department of Health (ISDH) approved resident care procedures and that a summary of the RCP checklist are completed and available in this applicant's file.

Clinical Supervisor's Signature | Date *(mm/dd/yr)*

I verify that the above information is correct

Applicant's Signature | Telephone Number *(area code)* | Date *(mm/dd/yr)*

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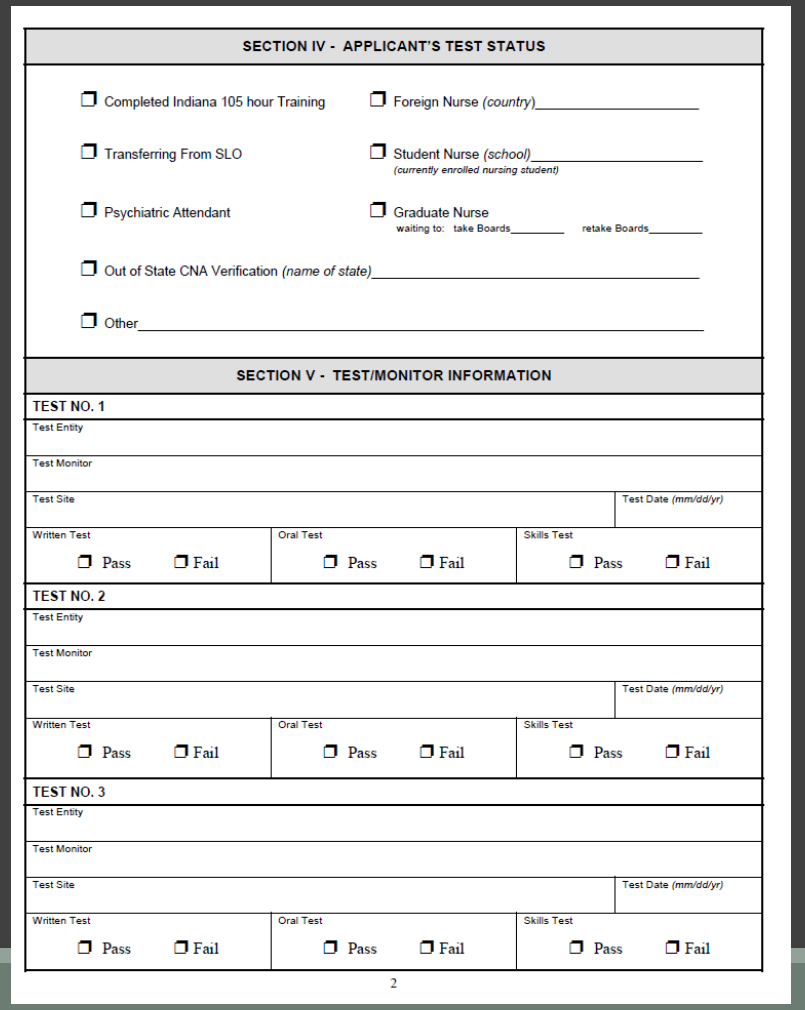

SECTION IV - APPLICANT'S TEST STATUS

- ❒ Completed Indiana 105 hour Training
- ❒ Foreign Nurse *(country)*_____
- ❒ Transferring From SLO
- ❒ Student Nurse *(school)*_____ *(currently enrolled nursing student)*
- ❒ Psychiatric Attendant
- ❒ Graduate Nurse waiting to: take Boards_____ retake Boards_____
- ❒ Out of State CNA Verification *(name of state)*_____
- ❒ Other_____

SECTION V - TEST/MONITOR INFORMATION

TEST NO. 1

Test Entity
Test Monitor
Test Site | Test Date *(mm/dd/yr)*

Written Test	Oral Test	Skills Test
❒ Pass ❒ Fail	❒ Pass ❒ Fail	❒ Pass ❒ Fail

TEST NO. 2

Test Entity
Test Monitor
Test Site | Test Date *(mm/dd/yr)*

Written Test	Oral Test	Skills Test
❒ Pass ❒ Fail	❒ Pass ❒ Fail	❒ Pass ❒ Fail

TEST NO. 3

Test Entity
Test Monitor
Test Site | Test Date *(mm/dd/yr)*

Written Test	Oral Test	Skills Test
❒ Pass ❒ Fail	❒ Pass ❒ Fail	❒ Pass ❒ Fail

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1. Information Collected/Maintained on Applicants

Recommendation already generated and approved by Governor's Health Workforce Council:

- Name
- Date of Birth
- Social Security Number or evidence of work authorization
- Address
- qualifying education/training provider information [name, address, date of completion, director's signature],
- examination information.

Information made publicly available for verification of certification:

- Name
- Certification Number
- Occupation Title
- Certification Status
- Certification Issue Date
- Certification Expiration

2. Qualifying Training

Next Steps: Identify or create a tool for reviewing program alignment with adopted competencies.

Example of a tool created for program review (Oregon):

https://www.oregon.gov/oha/OEI/Documents/THW-Training-Application-2015.pdf

3. Qualifying Experience

Next Steps: Conduct research on experience requirements in other states with certified CHWs. Review research at subsequent CHW Workgroup meeting.

4. Examination

Next Steps: Identify or create a tool for assessing the acquisition of knowledge and mastery of skills by each individual seeking certification as a CCHW

Closing

Next Meeting

To Be Determined

Workgroup members are invited and encouraged to attend other workgroup meetings:

State Loan Repayment Program Workgroup

Tomorrow, November 9th

10:00am-11:30am

Indiana Government Center South, Conference Room A

Governor's Health Workforce Council

Thursday, December 6th

1:00pm-3:00pm

Indiana Government Center South, Conference Rooms 4&5