**Standards of *Training* and Qualifications for Community Health Workers**

 **Living and Working In Buffalo, New York.**

 ***Rethinking the Paradigm***

 **Group Ministries, Inc.**

 **1333 Jefferson Avenue**

 **Buffalo, New York 14208**

***“Do not go where the path may lead, go instead where there is no path and leave a trail.” -Ralph Waldo Emerson***

**ACKN OWLEDGEMENTS:**

This document is dedicated to the men and women who against all odds have strived to build stronger communities where there is justice, harmony, peace, and healthy environments where they can have safe lives, and a sense of well-being, raise children and be part of the American Dream.

This document is also dedicated to Rev. Arthur Boyd, President and CEO of Group Ministries Inc. for his dedication to building the constructs for change for individuals suffering from HIV/AIDS, substance abuse, and mental health issues in the African-American community of Buffalo, New York.

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Prepared By:

Rev. Fr. Jimmy Rowe

Consultant

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**INTRODUCTION:**

This document represents Goal Two of the Eastside Community Health Workers Project entitled, “Creation and Evaluation of Standards of Training and Qualifications of Community Health Workers”. The Eastside Community Health Workers Project was designed to identify, recruit, and train individuals from Zip Code 14208 to become “feet on the ground” Community Health Workers.

Racial and ethnic minorities and low-income residents in Buffalo, New York, especially in Zip Code 14208, have not historically fared well on various measures of health. Marked health inequities continue as Western New York has become more linguistically and culturally diverse. Community Health Workers have the potential to improve quality, reduce costs, and enhance access for these communities that experience inequalities, yet in the Western New York Community Health Workers do not have a recognized, stable role within the health care system.

For the purposes of this document, we will use the American Public Health Association’s nationally recognized definition of what a Community Health Worker is:

**Community Health Worker (CHW’s) are frontline public health workers who**

**are trusted members of and/or have unusually close understanding of the community**

**served. This trusting relationship enables Community Health Workers to serve**

**as a liaison/link/intermediary between health/social services and the community to**

**facilitate access to services and improve the quality and cultural competence of**

**service delivery. Community Health Workers also build individual and community**

**capacity by increasing health knowledge and self-sufficiency through a range of**

**activities such as outreach, community education, informal counseling, social**

**support, and advocacy.** 1

There has been an increased recognition of Community Health Workers in the last decade by the National Institute of Medicine**2**, the United States Department of Labor**3** and the Affordable Care Act**4**. Because of this increased recognition there has been increased attention to the credentialing and training of Community Health Workers.

Currently there are no national standards for the three types of credentialing for Community Health Workers that sets forth the professional criteria that is used in other professional fields: certification, licensing and registration. Three recent reports and White Paper produced by: The Community Health Foundation of Western and Central New York**5,** the New York State Health Foundation**6**, and Cadwallader & Associates **7**, concurred that there is a lack of standardization as it relates to standards regarding training requirements, certification and licensing.

The French sociologist Pierre Bourdieux made the helpful distinction between two social functions of credentialing: first, the *legitimate* function of attesting to competence; second, the often *sub rosa* function of restricting labor competition or monopolizing a niche in the labor market by requiring a credential that is not truly related to the ability to perform job-related duties. In the second case, the credential in essence functions as a gatekeeper to preserve advantaged labor market positions through exclusion.**8** These distinctions point out that Community Health Workers and their allies need to continue to embrace strategies and methods that can attest to competence. When a not-for-profit organization says that they are competent “to be in the field” this means that they are competent and they will stand the test of time and be true to the principles and ethics entrusted to them.

The challenge is to find a mechanism that will assure competence without excluding the very people most suited to work as Community Health Workers. To strategically approach this issue, Community Health Workers and not-for-profit organizations must have a leading voice in shaping the way credentialing is implemented. In the context of this document, credentialing includes the areas of professional licensing, certifications and registration.

 **NATIONAL PERSPECTIVES OF STANDARDS AND CERTIFICATION**

* As of December 31, 2012, 15 states and the District of Columbia had enacted laws addressing Community Health Worker infrastructure, professional identity, workforce development, or financing. These states were: AK, CA, MD, MA, MN, NM, NY, OH, OR, RI, TX, UT, VA, WA, WV and DC.
* Seven state legislatures created an advisory body or ordered a study to investigate the impact of Community Health Workers on achieving health care savings or eliminating health disparities. These states are: MA, NM, OR, RI, TX, UT, VA.
* Of the eight states that codify a Community Health Worker scope of practice, three specify a role for Community Health Workers in chronic disease prevention and care. For example, Rhode Island established the Commission of Health Advocacy and Equity in 2011, which engages Community Health Workers to reduce disparities in disease prevention, chronic diseases, and family services. These states are: AK, MA, NM, OH, OR, RI, TX, and WA.
* Five states have enacted workforce development laws that create a certification process or require Community Health Workers to be certified. These states are: MA, MN, OH, OR and TX.
* Five states and the District of Columbia authorize the creation of standardized curricula on the basis of core competencies and skills. These states are: MA, OH, OR, TX, WA and the District of Columbia.
* Seven states have laws authorizing Medicaid reimbursement for some Community Health Worker services. These states are: AK, MD, MA, MN, NY, NM, OR, WA, and WV.
* In 2012, as part of an effort to address health disparities, Maryland authorized the creation of health enterprise zones in which Community Health Workers and their employers are eligible for tax incentives.
* Six states have authorized Community Health Workers into team-based care models for at least some health care organizations or services. These states are: CA, MA, NM, NY, OR, WA, and WV.

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State Law Fact Sheet can be accessed at [www.cdc.gov/dhdsp/pubs/policy\_resources.htm](http://www.cdc.gov/dhdsp/pubs/policy_resources.htm).

**LOCAL PERSPECTIVES: COMMUNITY HEALTH WORKERS IN BUFFALO, NEW YORK:**

In 2008, a group of community advocates based in urban Buffalo working in health care, public health, and community development began to coalesce around issues of health equity and a desire to address this issue from the perspectives of root causes and with a bottom-up approach. The idea of this effort was to address social determinants of health in a practical, hands-on way. This first Buffalo group partnered with the Community Health Worker Network of New York City, housed at Columbia University Mailman School of Public Health. Bolstered by the ability to utilize this training program at Columbia University as an educational and organizing tool, the Buffalo Groups had its starting point. The Buffalo Group became known as the Community Health Worker Network of Buffalo. They began to engage urban folks who represented a diverse cross-section of urban Buffalo (by race, ethnicity, gender, age, target population, etc.). This first group of Community Health Workers worked mostly in community-based organizational settings with clients who were experiencing poor health outcomes and were low on the scale of social determinants of health.**5**

Currently, the Community Health Worker Network of Buffalo is the only organization locally to offer ongoing, formalized training for Community Health Workers. To date, 300 plus individuals have been trained in the four-day intensive Core Competency Curriculum. In 2012, D’Youville College developed and implemented a training program (80 hours) for Community Health Workers employed through a grant-funded initiative that utilizes Community Health Workers in the Emergency Rooms of two Buffalo hospitals.**7**

Community Health Worker Programs currently operate at:

* Buffalo Prenatal-Perinatal Network. The Community Health Worker Program reaches out to families in “high-risk” areas having high infant mortality and poor socioeconomic status. Its goal is to achieve optimal health status among Buffalo’s pregnant and parenting women.
* The New American Project and Buffalo Green and Healthy Homes Initiative (BGGHI). The Community Foundation for Greater Buffalo administers the BGGHI and also serves as administrator for the New American Project. Through the project, Jericho Road Community Health Center will employ Community Health Workers with the language and cultural skills to reach out to the Burmese and Nepali communities on the West Side of Buffalo.
* Group Ministries Incorporated operates the Eastside Community Health Worker Project since 2013. Its focus is on recruiting and training individuals in Zip Code 14208 to become “feet-on-the-ground” Community Health Workers. It has focused on training individuals to interface with the Jefferson Family Medicine and the Lighthouse Free Clinic.

 **COMMUNITY HEALTH WORKER PROGRAM MODELS**

In order to understand the scope of the challenge in establishing standardization of training designs and that of certification, licensing and registration; one must first understand the different programs that are currently utilized in communities across America. What are the different Program Models? **9**

* ***Promotora de Salud/Lay Health Worker Model:***

Model Description: In the promotora/lay health worker model, Community Health Workers are members of the target population that share many of the same social, cultural and economic characteristics. As trusted members of their community, promotoras provide culturally appropriate services and serve as a patient advocate, educator, mentor, outreach worker, and translator. They are often the bridge between the diverse populations they serve and the health care system. The promptora model has been applied in the United States to reach Hispanic communities in particular.

* ***Member of care delivery Team Model:***

Model Description: In this model, Community Health Workers render direct health services in collaboration with a medical professional. They may measure blood pressure and pulse and provide first aid care, medication counseling, and health screenings, among other basic services. In programs with a holistic approach or a medical home model Community Health Workers may work alongside a team comprised of a physician, nurse or allied health worker, or assistant to deliver health education or basic screening services while the provider conducts a medical exam. This model is often used when Community Health Workers work with providers in a mobile clinic setting.

* ***Care Coordinator/Manager Model:***

Model Description: As a care coordinator or care manager, Community Health Workers help individuals with complex health conditions to navigate the health care system. They liaise between the target population and a variety of health, human, and social services organizations. They may support individuals by providing information on health and community resources, coordinating transportation, and making appointments and delivering appointment reminders. Additionally, Community Health Workers may work with patients to develop a care management plan and use other tools to track their progress over time (e.g., food and exercise logs).

* ***Health Education Model:***

Model Description: In this model, Community Health Workers deliver health education to the target population related to disease prevention, screenings, and healthy behaviors. Community Health Workers may teach educational programs in the community about chronic disease prevention, nutrition, physical activity, and stress management, and also provide health screenings. Additionally, in rural communities or along the US-Mexican border where families live in close proximity to agricultural fields, Community Health Workers often provide trainings on pesticide safety and environmental hazards.

* ***Outreach and Enrollment Agent Model:***

Model Description: The outreach and enrollment model is similar to the health educator model with additional outreach and enrollment responsibilities. In this model, Community Health Workers conduct intensive home visits to deliver psychosocial support, promote maternal and child health, conduct environmental health and home assessments, offer one-to-one advice, and make referrals. They also help individuals to enroll in government programs. Community Health Workers that serve in this capacity often require additional education about eligibility requirements for State and Federal programs.

* ***Community Organizer and Capacity-Builder Model:***

Model description: As community organizers and capacity-builders, Community Health Workers promote community action and garner support and resources from community organizations to implement new activities. Community Health Workers may also motivate their communities to seek specific policy and social changes. They build relationships with public health organizations, grassroots organizations, health care providers, faith-based groups, universities, government agencies, and other organizations to develop a more coordinated approach to serving their target population. Community Health Workers may also participate on the larger program Steering Committee to network, increase the knowledge about the program, and strengthen their professional skills. In this model, a Community Health Worker may be employed by a health provider, community organization or other entity.

 **SUMMARY OF CURRICULUM MODELS:**

There is no standardized training curriculum for Community Health Workers. Many States have training programs at academic institutions and direct services agencies, though the content, focus and organization of these programs vary. One of the challenges in developing a standardized curriculum for Community Health Workers is that each community’s needs are different; thus, trainings differ from program to program.

Paulo Freire’s empowerment approach to learning from his book entitled, “Pedagogy of the Oppressed”**10** has guided much of the development of training for Community Health Workers. The basic tenet of Freire’s approach is that the teachers learn from the group and the learners in the group also can be teachers.

The New York State Community Health Worker Initiative **6** established in 2010, was a partnership between the Community Health Workers Network of New York City, the New York State Health Foundation, the Mailman School of Public Health at Columbia University and Community Health Workers from across the State. The purpose of this partnership was to advance the Community Health Workers practice by establishing stable financial models. Their mission was to establish three objectives:

* Establish a New York standard scope of practice for Community Health Workers,
* Develop statewide training standards and credentialing process for Community Health Workers, and
* Identify stable financial streams and reimbursement mechanisms for Community Health Workers.

The Community Health Worker training that resulted from this initiative was unique in that it was created by Community Health Workers in direct response to the documenting needs of Community Health Workers and the business community in New York City. The Community Health Worker leadership of this effort resulted in the creation of a training program that was unique in both content and pedagogy and was responsive to the distinctive character of Community Health Workers and their scope of practice.

In this training design**12**, Community Health Workers were trained using a 105-hour curriculum, including 70 hours of training in core competencies and 35 hours of health-specific training in the following:

* Asthma education, treatment, management and control
* Diabetes management, prevention and treatment
* Hypertension treatment and prevention
* Nutrition

The Cornell Family Development Curriculum has been adapted as a “default” credential by over 3,000 workers in New York State. It consists of 90-hours of training divided into 10 modules, and mentoring by “Portfolio Advisors”. It is also used as a basis of training for maternal/child health Community Health Workers in Florida. This curriculum is no longer operated by Cornell University. Two national centers: Temple University-Harrisburg and the University of Connecticut can provide access to this curriculum.**11**

**New York State – Comprehensive Training in Core Competencies for CHWs**

**Module 1:** Essentials of Community Health Workers (7 Hours)

* Lesson 1a: Orientation and Introductions
* Lesson 1b: Participants’ Expectations
* Lesson 1c: Course Expectations, Learning Methods, Course Schedule, Journals
* Lesson 1d: Guidelines for a positive Experience
* Lesson 2: Community Health Worker History
* Lesson 3: CHW Identity, Core Values and Code of Ethics
* Lesson 4: CHW Skills, Roles and Qualities

**Module 2:** Community Health Worker Approach (14 Hours)

* Lesson 1a: Adult Cognitive Development
* Lesson 1b: Adult Learning Methods
* Lesson 1c: Adult Dimensional Development
* Lesson 1d: Kolb Learning Style Inventory
* Lesson 1e: Adult Learning Style
* Lesson 1f: Multiple Intelligences
* Lesson 2: Family Assessment Paradigm Shift
* Lesson 3a: Popular Education Philosophy and Methods
* Lesson 3b: Traditional “Banking” Approach vs. Liberation Education
* Lesson 4a: Empowerment Approach
* Lesson 4b: Service Model vs. Development Model
* Lesson 5: Community Health Workers as Mentors
* Lesson 6: Conversations to Empower

**Module 3:** Health Care Systems (10 Hours)

* Lesson 1: Determinants of Health – Public Health
* Lesson 2: treatment and Prevention
* Lesson 3: Prevention, Acute Care & Chronic Care
* Lesson 4: Health Care facilities and Services (Formal & Informal)
* Lesson 5: How Health Insurance Works
* Lesson 6: Public Benefits & Social Services, Entitlements
* Lesson 7: Community and National Resources
* Lesson 8: Community Health Worker Roles

**Module 4:** Community Health Worker Skills 1 – Communication (14 Hours)

* Lesson 1: Establishing Partners
* Lesson 2a: Introduction to Communication
* Lesson 2b: Introduction to Non-Violent Communication
* Lesson 2c: Communication Skills Outline
* Lesson 3a: Compassionate Communication
* Lesson 3b: Cognitive Approach to Compassionate Communication
* Lesson 4a: Making Observations
* Lesson 4b: Conversation Blockers – Zingers
* Lesson 4c: Making Observation Exercises
* Lesson 5a: Identifying Feelings
* Lesson 5b: Expressing Feelings
* Lesson 6a: expressing Needs Clearly – Positive Action Wants
* Lesson 6b: Making Suggestions – Not Demands
* Lesson 7: Magic Formula – “I” Statements
* Lesson 8: Typical responses to “I” Statements
* Lesson 9: Communication “Do’s and Don’ts – Health Literacy & Pictures
* Lesson 10: Giving Thanks

**Module 5:** Health Promotion & Behavior Change (14 Hours)

* Lesson 1: Health Promotion
* Lesson 2: Healthy Lifestyle Choices – Not Just A Few Pills
* Lesson 3a: Behavior Change – Transtheoretical Model
* Lesson 3b: Process of Change
* Lesson 3c: Adults in Transition
* Lesson 3d: Transition and Cognitive Development
* Lesson 4a: Supportive Communication vs. Didactic Teaching
* Lesson 4b: Facilitation vs. Lecturing
* Lesson 4c: Communication for Family Empowerment – Facilitation
* Lesson 4d: Communication for Group empowerment – Facilitation
* Lesson 5: Strategic Thinking for Problem identification & Resolution
* Lesson 6a: Tailing Communication to Individual Stage of Change
* Lesson 6b: Communicating for Empowerment: Getting Past The Fears

**Module 6:** Community Health Worker Skills 2 (14 Hours)

* Lesson 1a: Informal Counseling – Role of Community Health Worker
* Lesson 1b: Power & Privilege
* Lesson 1c: Ethical Power
* Lesson 2a: Informal Counseling - Building Trusting Relationships
* Lesson 2b: Informal Counseling - Personal & Professional Boundaries
* Lesson 3a: Informal Counseling - Active Listening
* Lesson 3b: Informal Counseling – Non-Verbal Communication
* Lesson 4a: Prejudice, Bias and Labels 1
* Lesson 4b: Prejudice, Bias and Labels 2
* Lesson 5: Goal Setting & Negotiation

**Module 7:** Outreach Methods and Strategies (14 Hours)

* Lesson 1a: Making and Confirming Appointments
* Lesson 1b: Making the Phone Work for You
* Lesson 2a: Home Visiting
* Lesson 2b: Home Visiting Safety (Self & Others)
* Lesson 2c: Introducing Yourself and Your Program
* Lesson 2d: Handshake and a Smile
* Lesson 3a: Interviewing Skills
* Lesson 3b: Minimizing Paperwork – Keeping People First
* Lesson 4: Facilitating Meetings
* Lesson 5: Organizing Events and Workshops

**Module 8:** Advocacy and Responsibility (10 Hours)

* Lesson 1: Medical Terminology & Adaptive Communication
* Lesson 2: Professional Conduct – Ethical and Legal Responsibility
* Lesson 3: Mandatory Reporting
* Lesson 4: Crisis Intervention
* Lesson 5: Confidentiality, Respect and Dignity
* Lesson 6: HIPPA and Talking About Medical/Registry Records
* Lesson 7a: Advocacy 101 – What is Advocacy?
* Lesson 7b: What is Policy
* Lesson 7c: Legislative Bodies & Processes – Federal , State and Local

**Module 9:** Working for Long-Term Goals (7 Hours) - Required for Chronic Disease Modules

* Lesson 1a: Orientation and Introduction
* Lesson 1b: Participants’ Expectations
* Lesson 1c: Course Expectations, Learning Methods, Corse Schedule
* Lesson 1d: Guidelines for a Positive Experience
* Lesson 2a: Review Communication Essentials
* Lesson 2b: Review of Behavior Change Models
* Lesson 2c: Review of Goal Setting and Negotiation
* Lesson 3a: Strategies for Progressive Change: Promotion of Childhood Immunizations
* Lesson 3b: Incorporating Immunization Reminders Into Routing Work

**Module 10:** Chronic Disease Management – Asthma (Optional) (14 Hours)

* Lesson 1: What Do We Know About Asthma? A Definition
* Lesson 2: Asthma Facts and Myths
* Lesson 3: Asthma Physiology – How We Breathe
* Lesson 4: The Asthma Experience – How Asthma Feels
* Lesson 5: Asthma Triggers
* Lesson 6: Asthma Trigger Control
* Lesson 7: Home Environmental Assessment
* Lesson 8: Integrated Pest Management
* Lesson 9: Asthma Medication
* Lesson 10: Asthma Equipment
* Lesson 11: Asthma Classification
* Lesson 12: Asthma Treatment Adherence
* Lesson 13: Asthma Self-Management and Working With Parents
* Lesson 14: Asthma Action Plan

**Module 11:** Chronic Disease Management- Diabetes (Optional) (14 Hours)

* Lesson 1: what Do You Know About Diabetes? A Definition
* Lesson 2: Diabetes Facts & Myths
* Lesson 3a: Biology of Diabetes
* Lesson 3b: Diabetes Signs and Symptoms
* Lesson 3c: Complication of Diabetes
* Lesson 4: Diabetes Risk Factors
* Lesson 5: Diabetes Management & Control
* Lesson 6: Diabetes Prevention
* Lesson 7: Nutrition and Activity

**Module 12:** Chronic Disease management – Hypertension (Optional) (7 Hours)

* Lesson 1: What Do We Know About Hypertension? A Definition
* Lesson 2: Hypertension Facts & Myths
* Lesson 3a: Biology of Hypertension
* Lesson 3b: Hypertension Signs and Symptoms
* Lesson 3c: Complications of Hypertension
* Lesson 4a: Hypertension Risk Factors
* Lesson 4b: Early Detection – Screening
* Lesson 5: Hypertension Management and Control
* Lesson 6: Prevention of Hypertension
* Lesson 7: Nutrition and Activity

**Module 13:** Nutrition (Optional) (14 Hours)

* Lesson 1: Nourishment and Nutrition
* Lesson 2: Dietary Guidelines and food Pyramid
* Lesson 3a: Portion Control and Portion Distortion
* Lesson 3b: Conscious Eating
* Lesson 4: Big-ticket Items – How Much Sugar, Salt and Fat?
* Lesson 5: Food Labels
* Lesson 6: Review of Goal Setting

 **The Three Types of Credentialing: Certification, Licensing and Registration**

The first known use of the word “credential” was in the 15th Century. It meant a quality, skill, or experience that makes a person suited to do a job. Recently, Professor Carl H. Rusk, Professor of Health Policy at the University of Texas, defined credentialing “as a process of documenting a person’s qualifications to perform the duties of an occupation or profession”.**11**

For the purposes of this document, The **Overview of Terms** seeks to facilitate a common language framework to understand the three elements that comprise the process of “credentialing”.**13**

**Overview of Terms:**

**Certification:** is the process by which an authorized body, either a governmental (e.g., NYS Department of Health) or non-governmental organization (i.e., Group Ministries, Inc) has authority to offer said certification. When applied to individual practitioners, certification means that someone “certifies” that you are *qualified* to perform the scope of practice as a Community Health Worker. At the bare minimum individuals should have completed the Comprehensive Training in Core Competencies for Community Health Workers.

**Licensure:** is the process by which a governmental authority (i.e., NYS Health Department) grants permission to an individual practitioner or health care organization to operate or engage in the profession of Community Health Worker. Licensure to individual practitioners is usually granted after some sort form of examination or proof of education or professional competence. Licensure in other health professions and professional groups have also benefited, including (1) payment of services by third-party payers, (2) enhanced economic benefits for practitioners, (3) increased status, (4) protection of the reputation of the profession , and (5) symbolic respectability.

**Registration:** is the least restrictive form of credentialing, usually requiring individual practitioners to file their names, addresses, and qualifications with a government agency (i.e., NYS Health Department) before practicing their occupation. It may include a filing fee. Registration provides a “title” more than anything else because individuals do not have to pass examinations to be registered.

One major policy decision that must be considered is in deciding what credentialing element that you elect to support, whether it be certification, licensing or registration - must be made in consultation with Community Health Workers. Certification should be encouraged as a means to standardize and improve the training and the skills of Community Health Workers. Certification is important for increasing recognition of Community Health Workers and to continue to demonstrate standards to payers in order to promote a sustainable model for reimbursement.**14**

One of the foremost national experts on Community Health Worker policy and practice, Carl H. Rush, MRP, at the University of Texas – Houston Institute for Health Policy**11** said that what is required for a credentialing system is the following five elements:

* All options require a definition of the Community Health Worker occupation and skill requirements.
* Someone will have to administer it.
* Choose how you will assess whether someone is qualified: Direct testing of skill? or Completion of standardized education requirements?
* Renewal and continuing education requirements.
* Community Health Workers must be involved in design and implementation of the system.

**RECOMMENDATIONS**

This report makes it clear that in order for Community Health Workers to maintain and grow that they have to grapple with two key, interrelated issues – credentialing and financing. It is these two areas that we present our recommendations.

* Scope of Practice: As a prelude to the process of credentialing, one must have a very clear standardized scope of practice that provides the elements of minimum standards of competence and knowledge needed to become “foot-on-the ground” practitioners. The New York State – Comprehensive Training in Core Competencies for Community Health Workers meets those standards. This training design is unique in both content and pedagogy and is responsive to the distinctive character of Community Health Workers and their scope of practice.
* Community Health Worker Program Sustainability: The Community Health Worker Projects located in Buffalo, New York have not developed the prerequisite intra-structure to accomplish long-term program sustainability. All current Community Health Worker programs are supported by short-term funding, except for the Buffalo Prenatal-Perinatal Network. This short-term funding basically comes from grant-supported funding ranging from one to three year duration. Only the Buffalo Prenatal-Perinatal Network has a more stable funding base, because of its affiliation with the New York State Department of Health.
* What are some other considerations that should be placed on the table for possible sustainability:
1. The creation of “Health Enterprise Zones” similar to the Maryland Health Improvement and Disparities Reduction Act of 2012. This Act was used as an innovative public health strategy to reduce health disparities, such as the use of Community Health Workers that could be supported by grants awarded under this Act.
2. Utilization of Community Benefit for Charity Care Afforded to Hospitals. Community benefit is the value that a hospital provides toward improving the community’s health. Charity care has been used in the following benefit areas:
* Community health services
* Financial contributions
* Community building activities
* Community benefit operations could include Community Health Workers. According to the Public Health Institute, community benefits should extend beyond the traditional inpatient and emergency room care and free and discounted care to services that will address and reduce the unmet health needs of a community. Hospitals would be smart to consider utilizing a portion of the community benefit money to hire Community Health Workers to reach patients with preventable diseases to avoid ER visits and expensive impatient care. Even more importantly to reduce re-admission rates. This may be a very viable strategy to further research.
1. Medicaid Reimbursement continues to be a viable way in which Community Health Workers can be funded over the long-term. The Buffalo Prenatal-Perinatal Network is a good example of sustainability.
2. Utilizing Community Health Workers in the emerging Medical Home Model. This is a logical way to deal individual patient who need support and encouragement in dealing chronic disease conditions.

**CONCLUSION**

If the problems are in the community, the solutions are in the community. The only problem with this statement is that many communities don’t have the expertise regarding programmatic funding and sustainability or in public policy development. It is these tools that will be needed to forge the strategic relationships necessary to leverage support from governing entities to further the professional development for Community Health Workers. The biggest challenge for the Community Health Worker profession is not to become discouraged by the constant effort required to keep services funded.

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