**Fact Sheet: Community Health Worker (CHW) Certification**

**Introduction**

Most states are at least investigating some form of standardization of the CHW occupation. The general trend is toward some form of voluntary certification of individual CHWs, based on experience and/or training. While only a small number of states have formally instituted certification, many more are at some stage of developing it. The process of considering CHW certification, however, has not been quick or simple in any given state. This may be in large part due to differing perceptions of the definition of CHW, and the “pros and cons” of certification itself.

Certification is mainly about the roles or activities performed by CHWs, and the skills required to perform them. However, it’s vital not to lose sight of some things that contribute to CHWs’ effectiveness that do not fall within the definition of roles and skills.

The term “certification” is now in common use when talking about occupational standards for CHWs. This may be considered a specific form of “credentialing.” Credentialing options also include licensure, registration (registry) and permitting. Licensure has specifically been ruled out as an option, since CHWs do not perform clinical duties requiring a license,[[1]](#footnote-1) and CHW practice does not pose a significant risk of harm to the public; licensing bodies in Massachusetts, New York and Virginia have explicitly declined to consider licensing of CHWs.

Stakeholders will often tend to be focused on results, but in the case of CHWs, it is important how you achieve those results. We can discuss the evidence of CHW effectiveness in achieving many key outcomes of value to public health and the healthcare system, but that is not the purpose of this paper. Certification is about how CHWs help achieve those outcomes.

**Why are CHWs effective?**

CHWs’ effectiveness rests on several pillars: first, CHWs **specialize in working with low-income individuals and communities**, often with communities of color, who are commonly disadvantaged, disenfranchised and with barriers to accessing services. These populations have commonly experienced socioeconomic stress, discrimination and racism, contributing to feelings of powerlessness and mistrust of “the system.” Individuals providing services similar to those provided by CHWs, but to broader or less distressed populations, may hold titles such as “health coach” or “patient navigator, but they do not necessarily possess key skills and qualities required of CHWs.

CHWs operate on the basis of ***trust* based on *shared life experience***, creating a strong sense of empathy and allowing for unusually open communication with the individuals and families they serve.

Compared to clinicians, CHWs are able to **spend** **more time** with individuals and families in home and community as well as clinical settings. This enables them not only to impart information, but to also coach individuals on understanding and internalizing it, and on putting desired behaviors into practice.

CHWs possess the “Three C’s” of community:

* **Connectedness**: they know the community and move freely within it
* **Credibility**: they are known and trusted as leaders and “natural helpers”
* **Commitment**: they do what they do out of sincere commitment to the wellbeing of the community – because it is their community

CHWs commonly hold certain **core values** based in equality, justice, and empathy. The work of CHWs is often described as “a calling, not just a job.” The fact that thousands of CHWs do this work as volunteers, in some cases for decades, is a reflection of these values.

**Focus on results**

In discussing other policy concerns such as financing of CHW services, it is often important to show the potential of CHWs to help stakeholders achieve key objectives they are already pursuing in public health and the “brave new world” of health care reform. This is also true in the context of credentialing. CHWs’ skills and capabilities can be very compelling when looking at the expectations of new structures like medical homes and accountable care organizations. They work at the crossroads of public health and health care systems – in a sense they “work both sides of the street,” being adept at work on both the individual/family and community levels. This suggests that certification should also help stakeholders by assuring them that CHWs are proficient in these crucial capabilities.

Some of the most prominent current needs of public health and healthcare reform which CHWs can help to address include:

* Improving health outcomes & reduce disparities for racially and ethnically diverse communities and individual patients, as well as patients with—or at risk for—high cost, complex conditions
* Simultaneously improving access to services, and the quality and cost of those services.
* Linking clinical services and community resources.
* Being more accountable for population health (at the community level) as well as effective and efficient delivery of services.

**CHW Skills**

The core skills of CHWs have been described as falling in the following categories:

1. Communication Skills
2. Interpersonal and Relationship-Building Skills
3. Service Coordination and Navigation Skills
4. Capacity Building Skills
5. Advocacy Skills
6. Education and Facilitation Skills
7. Individual and Community Assessment Skills
8. Outreach Skills
9. Professional Skills and Conduct
10. Evaluation and Research Skills
11. Knowledge Base [[2]](#footnote-2)

Note that these are almost entirely non-clinical skills; employers and certification programs differ on the types and extent of clinical knowledge required as part of “knowledge base,” but it is generally quite limited compared to the knowledge required for clinical occupations. This list of skills has been used as a starting point in a number of states in creating a list of skills required for certification.

**Distinctive CHW *Capabilities***

As noted above, CHWs are valuable to public health and health care in part because they are recruited specifically for their rapport with low income and minority communities. However, these qualities also mean that CHWs possess distinctive capabilities that are incredibly valuable for the new requirements of public health and health care reform.

It’s important to talk about these distinctive capabilities in the context of Certification for several reasons:

First, if the conversation is focused only on what CHWs actually do, out of context, the day to day tasks they perform, some other professionals will understandably respond that they “do those things,” and it can be an impediment to the decision process if this leads to extensive discussion of this overlap. In the process of creating certification, stakeholders will still need to be reminded continually about the true value of CHWs, and as noted below, their distinctive capabilities are integral to understanding their value.

There are four main capabilities of CHWs that stakeholders need to appreciate; the first three of these are interrelated:

1. For most of us, our **relationship** to health care is like our relationship to a vending machine: we walk up, put in a card, get a service and walk away. That relationship is episodic, often crisis-oriented, and arm’s-length. The new world of team-based care and medical homes means getting to know each other a lot better. CHWs are in a unique position to facilitate that process; relationship is their M.O., their raison d’être, the source of their effectiveness.
2. The second capability is **trust**. Most clinicians make a sincere effort to gain the trust of their patients, but there are limits to what they can do on their own. Remember we are talking mainly about low-income communities and people of color. In these situations there will always be distinctions or differentials in perceived power between provider and patient, which the provider is unlikely to overcome. There is also a historic (legacy of) mistrust of institutions, especially hospitals, in these same communities. An individual clinician is again unlikely to be able to overcome that mistrust.
3. Third is **communication**. Emerging health care structures and systems will require a much greater continuity of communication between patient and provider – more than waiting for the patient to call for an appointment, or sending a robo-call appointment reminder message. Routine follow-ups or more intensive communications may be needed for management of chronic conditions or assuring adherence to treatment, especially in situations involving care transitions. Medicaid providers and health plans also have often had the experience of a patient being “lost to follow-up.” That finding is simply not acceptable in the more accountable structures of the future.

Candid communication from patients is of course related to trust, but clinicians acknowledge that it is incredibly important to the provision of quality care, especially in achieving accurate and efficient diagnoses. Lack of clarity in patient communication about symptoms can lead to practice of defensive medicine. We have also all heard anecdotes about patients telling their doctor, “yes, I’m taking my meds, everything’s fine,” and then telling their CHW, “I had to stop taking it – the side effects were terrible.” Again, the power differential is significant – low-income patients will often say what they think the doctor wants to hear. The CHW, however, is “one of us” or “looks and talks like me,” so they can engender more honest and open conversation.
4. The fourth capability on our list is **social and behavioral determinants**. The evidence is clear that CHWs can influence health-related behaviors, because of the trust factors and the ability to spend time on coaching and support, especially in home and community settings where the patient feels more in control.

Fortunately, the medical world is also coming to recognize the importance of social determinants as factors explaining individual health status, as well as the limitations of clinicians’ ability to influence those determinants. CHWs are in an ideal position to play a leading role in addressing SDOH.

CHWs can bring several key capabilities in this area:
5. The CHW can inform clinicians, especially in a team setting, about the fuller circumstances of a patient or family’s life, including factors which may affect their health directly, may help to inform diagnosis and treatment decisions, or may influence the patient’s ability to access care or adhere to treatment. This can be especially helpful in a team-based care setting where they can serve as the “SDOH expert.”
6. The CHW can support the patient or family directly in dealing with those social issues, such as housing, environmental issues or employment, through home visiting, referrals and advocacy.
7. On broader issues affecting entire communities or neighborhoods, such as access to nutritious foods, or public safety concerns which cause stress and affect the ability to engage in physical activity, the CHW can help mobilize the community to pursue action by local or state governments and the private sector to remedy the situation.

So it can be very valuable to incorporate discussion of these capabilities in both the design and promotion of certification efforts.

**Considering CHW certification: process issues**

Experience in multiple states suggest that the process of considering and developing certification includes several common elements:

1. Engagement of CHWs in leadership roles: defining and setting standards for any profession requires participation of practitioners themselves. This should be self-evident, but there have been examples of appointed boards or advisory groups doing this work for CHWs with little or no participation by CHWs.
2. Stakeholder agreement on rationale and objectives: a group considering CHW certification should acknowledge their public policy goals, and the values they are pursuing by the mechanism of certification. What are the driving interests in your state? They might include:
* Establishing a reliable indicator/definition of CHW qualifications?
* Gaining recognition for CHWs as an occupation/profession?
* Meeting requirements for payment through ongoing sources?
1. Stakeholder agreement on meaning/definition of certification: an important lesson learned in a number of states has been the discovery, often late in the process, that stakeholders may have differing preconceptions and beliefs about what certification is, how it works, and of equal importance, what the effects of certification will be (positive or negative). It is also common that stakeholders joining the process at later stages may slow or even halt progress due to their beliefs and preconceptions. Groups discussing CHW certification would be well advised to set a ground rule of “checking your guns at the door,” or thoroughly discussing beliefs and preconceptions as a condition of participation. (More on this topic below.)
2. Commitment to create *responsive* certification policies and procedures that respect the nature of the practice: advisory or planning groups would also be well-advised to thoroughly understand the nature of CHW practice, in order to create policies that are congruent with that practice (e.g., avoiding the insertion of inappropriate clinical duties into the definition of CHW duties), and to create policies and procedures that acknowledge and work with the qualities associated with successful CHWs (e.g., avoiding unnecessarily burdensome application processes or high application fees). This topic will also be treated in further detail below.

**Uncovering stakeholder beliefs and preconceptions**

Stakeholder expectations and preconceptions often center on their vision of the benefits or problems that certification may create. Naturally, these beliefs vary among stakeholders, but CHWs may anticipate that certification will lead to certain benefits such as:

* Higher wages;
* Improved working conditions;
* Increased respect from other professions;
* Wider career opportunities;
* Stable employment;
* Sustainable funding;
* Progress in building professional identity;
* Increased understanding of the field;
* Consistent standards for the field.

Such benefits may arise, but they are not guaranteed. As noted in a recent paper, occupational definitions and standards are only one element of policy necessary to fully embrace CHWs as a workforce.[[3]](#footnote-3),[[4]](#footnote-4)

Similarly, CHWs may have some negative beliefs about the impact of certification, such as expecting it to:

* Create barriers to entry;
* Create a “class” system among CHWs;
* Make CHW practice more clinical, less connected to the community;
* Regulate, restrict, or change what CHWs can do;
* Lead to employment of people without strong connection to the community;
* Further marginalize volunteers.

While it is difficult to generalize across different types of stakeholders, it appears that employers and payers hold certain expectations about the potential benefits of CHW certification, such as beliefs that it will lead to:

* Clear scope of practice boundaries;
* Consistent, reliable qualifications among CHWs;
* Simplified recruitment and selection, and a more fluid job market;
* Reduced on the job training (OJT) costs;
* A clearer rationale for integration of CHWs into care teams; and
* Reduced dependence on short term funding.

Again, these do not automatically result from establishing certification, but they may under certain conditions.

And of course employers and payers often hold negative beliefs about certification, such as expecting that it will lead to:

* Pressure to increase wages;
* New regulations and restrictions on their organizations;
* Increased overall training costs; or
* CHWs losing touch with the community, thereby becoming less effective overall.

Stakeholder attitudes toward certification also focus on the nature of a certification process itself. Differing views are to be expected within a planning group about what certification “should” look like, but differing beliefs about what certification “is” can impede a thorough discussion of what it “should be.” Preconceptions may be based on the definitions of terminology used; in actual practice certification can mean whatever the sponsoring body declares it to mean. As noted earlier, the pattern this far (as of this writing) is to adopt “voluntary certification,” which limits only the use of a title such as “Certified CHW,” and does not limit who may perform the duties of a CHW.

Here are some fundamental facts, which may be useful discussion points for groups considering certification.

1. At the most basic level, certification is a declaration by the issuing authority that an individual has certain qualifications (e.g., training, skills).
2. Certification is NOT necessarily regulation of practice, unless the responsible authority explicitly chooses to make it so (which often requires legislative action).
3. Many stakeholders confuse certification with an educational “certificate of completion” – this is not true UNLESS the responsible authority declares it to be so. In general, an educational institution or program is not allowed to confer a title such as “Certified CHW” unless it has been explicitly granted that authority. It is vitally important that all stakeholders understand this distinction.
4. Certification is NOT automatically a state government function: the issuing authority MAY be a government agency, an educational institution/program, an independent association or an employer-based entity. Some states are choosing not to get into assessing qualifications or issuing certification, but they are opting to administer a **registry** or database of individuals who have received certification. This is considered a “ministerial” function of government, and avoids the appearance of “government regulation.”

**Major structural options for certification of CHWs**

Direct certification of individuals as CHWs may be voluntary or mandatory. Mandatory certification of individuals is tantamount to licensure, and has not been pursued.[[5]](#footnote-5) Again, the distinction is between regulating use of a title versus regulating the authority to practice as a CHW; in Massachusetts, the 2010 statute creating certification was passed as a “title act” instead of a “practice act.”

A number of states have considered certifying employers in lieu of individuals, but no state to date has taken this approach. Certification of employers could accomplish certain public policy objective with less burden on individual workers, but it would not offer those workers a “portable” proof of qualifications.

Most state certification programs to date have also required certification or approval of training programs or curricula, and/or individual instructors, generally providing that successful completion of an approved program entitles a CHW to individual certification. This in turn requires development of standards for training, including curriculum content.[footnote MN use of single standard curriculum] Where training is used as a benchmark, the individual must usually make an application for issuance of the actual individual certification, but a state has the option of bypassing that step, in which case the responsible authority (again, not necessarily a state agency) may issue the certification based on graduation records received from approved training programs. The education-based options have been attractive to states because it places the burden on the training program to assess the individual’s proficiency in required skills.

**Basic components of a certification program**

Any certification system will have certain elements which are necessary for it functioning. These include:

* Definition of the occupation and core competencies;
* Scope of practice: the full range of CHW duties (understanding that a specific CHW position may have a more limited job description), and boundaries with other professions
* Practice standards (these may be defined in varying levels of detail, and may be promulgated separately by a state CHW association) – violations may be grounds for revoking a certification;
* Process/methods for assessing applicant's proficiency in required skills;
* Eligibility criteria and application process;
* Administrative home: an important consideration is how to finance the cost of administering the certification program;
* Continuing education requirements; and
* Procedures to renew, to revoke (for cause or failure to renew), and for applicants to appeal an adverse decision.

**Creating a *responsive* certification system**

As noted earlier, the duties and skills of the CHW are fundamentally different from those of other occupations. Further, the kinds of people who become CHWs may face particular challenges in their own lives which must be considered in developing policies and procedures for certification, in order to avoid creating unnecessary barriers to entry. As lessons learned from early adopter states, attention should be paid to the following features of the certification process:

* Multiple paths to entry should be available, including a path based on experience (“grand-parenting”);
* The application process should be user friendly, without unnecessary barriers of education requirements, language, citizenship status;
* Any training required for certification should be available in familiar, accessible settings;
* CHW skills should be taught using appropriate methods (e.g., adult/popular education; many programs emphasize using experienced CHWs as trainers);
* There should be easy access to CEUs, including distance learning options; and
* The system, and the process of developing it, should respect the role and needs of volunteer CHWs; at the very least, the system should not undermine their status or their ability to practice freely.

**Key decision points for design of a certification system**

Beyond the inclusion of basic features and the qualities of responsiveness just described, the design of a system for certification of individual CHWs should consider certain crucial issues such as the following:

* Required core competencies: should be reflective of the actual experience of CHWs – and should consider standards adopted by other states, in part for discussion of reciprocity – including the variations in skills between practicing exclusively in a community setting vs. in a clinical setting. We recommend reference to the CHW Core Consensus Project[[6]](#footnote-6) for defining CHW core roles and skills.
* Work experience requirements: may be in addition to required training and/or in lieu of training
	+ If providing for “grand-parenting” based on experience – will this option be available permanently (as in Texas) or for a limited introductory period (as in most other states)?
	+ “Look back” period for required experience – how long? Experience suggests it should not be open-ended;
* Education requirements (some states have decided they are not necessary, or may specify a high school diploma/GED; unnecessary educational credentials may create unintended barriers to entry for otherwise highly qualified CHWs);
* Assessment of proficiency in core skills
	+ How will the process evaluate ability to use CHW core competencies (references may be used, as in Massachusetts, absent administrative resources to support direct observation)?
	+ How will the process validate the “3 Cs” of community connectedness, credibility, and commitment as a qualification (experience suggests this is difficult to specify in policy as a requirement)?
	+ When assessing work experience, who may serve as reference to attest to the applicant’s proficiency in core competencies?
* Reciprocity with other states: this is expected to become increasingly salient as more states adopt CHW certification programs;
* Background checks: may be a general requirement in any state occupational regulations, but employers generally do their own, and not all violations are relevant to CHW practice – indeed, CHWs who have been incarcerated for non-violent drug related offenses, for instance, may be especially effective with other formerly incarcerated individuals, or with families of the currently incarcerated;

Since most states regulate the **provision of training** to CHWs in some fashion, here are some considerations for decisions in this area:

* Form of regulation or certification of training services: will you be certifying training organizations, individual trainers/facilitators, curricula? All of the above?
* Will you require that training providers employ current/former CHWs to serve as instructors or co-trainers?
* Will you impose standards of fiscal, management, and legal integrity for training organizations?
* Will training organization be required to show prior connection to community and familiarity with CHWs?
* How will you assess the quality of curriculum and program design?
* How will you assess the qualifications, background and capacities of faculty and program administrators
* What methods will you use to evaluate the quality and effectiveness of training programs in operation?
* What accountability (including reporting) will you require from approved training programs?

Finally, the following are key considerations in designing the **administrative structure** for a certification program:

* What will be the issuing authority? There are pros and cons for multiple options here, but a key point is again that it is not necessary that state government administer the issuance of individual certifications. At this writing several states have opted for ”outside” bodies to administer
* Engagement of CHWs in ongoing operation and monitoring of the certification program – what will be their role(s) and their level of authority?
* Engagement of other stakeholders – what will be the balance of participation with CHWs, and which stakeholders need to be included on an ongoing basis—employers, payers, trainers, other professions?
* If the state (especially the health department) is involved administratively, what will be the internal lines of communication between operational program units employing CHWs (e.g., Medicaid office, chronic disease programs) and the unit responsible for certification
* Capacity for assessing individual and training program qualifications: what resources will be required to actually administer the certification program?
* Capacity for administering continuing education and renewals: what resources will be required to promote and assure participation in continuing education for CHWs? What will be required not just to process renewals but to remind and encourage CHWs to renew?
* Streamlining application processes: how will you balance the need for quality assurance and accountability with the need for timely handling of applications?
1. Ohio’s CHW certification program is under the state Board of Nursing, and incudes provision for delegation of certain nursing tasks to CHWs (Ohio Revised Code Chapter 4723-26; [http://codes.ohio.gov/oac/4723-26)](http://codes.ohio.gov/oac/4723-26%29). Alaska regulates “Community Health Aides” which are mid-level clinicians and not considered by the State to be CHWs. [↑](#footnote-ref-1)
2. Source: CHW Core Consensus (C3) Project, http://c3report.chwsurvey.com [↑](#footnote-ref-2)
3. Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, Willaert AM, Scott JR, Holderby LR, Fox DJ. *Community Health Workers, Part of the Solution.* Health Affairs, July 2010. [↑](#footnote-ref-3)
4. American Public Health Association. Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities (Policy Statement 2009-1). http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities [↑](#footnote-ref-4)
5. Texas began certification in 2002 as a voluntary program, despite a 2001 statute declaring it to be mandatory for any CHW who receives compensation. The bill creating the statute was the work of one State Senate leader, but it did not provide for enforcement, and the State has chosen not to invoke the statute or to set penalties for violations. [↑](#footnote-ref-5)
6. Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field at: : <http://files.ctctcdn.com/a907c850501/1c1289f0-88cc-49c3-a238-66def942c147.pdf?ver=1462294723000> [↑](#footnote-ref-6)