**CHW Call Series: Certification and Licensure**

**March 3, 2016**

**Q&A Responses**

1. Could Carl define "provider of clinical care" further? Could you tell us more about non-clinical tasks/things that may require a license to practice?

**Carl**: Generally licensure prohibits performing certain “clinical” tasks without a license. These are tasks that directly affect diagnosis or treatment of illness or injury, including administering or interpreting lab tests, prescribing or dispensing medications, or professional psychological counseling. So conversely, most non-clinical tasks do not require a license, even though they may support the provision of care by licensed individuals. Non-clinical tasks may involve appointment making and reminders, coaching on nutrition and following provider instructions, referrals for non-medical services, and supporting communication between different providers serving the same patient.

1. Gail: Could you speak more about the dedication of resources to support CHW leadership when you get the chance? Who from, how much?
2. Question for Sergio: What does it mean to adopt the APHA definition of a CHW but yet embrace your own network's beliefs and values of what this should be?

**Carl**: a group may support the APHA definition in general terms and still be free to express their own interpretation of what it means. The APHA CHW Section encourages all parties to be mindful of certain principles such as self-determination by CHWs and resisting pressure to “medicalize” the CHW role.

1. Why are we worried about certification when it appears that employers are not terribly interested in certified CHWs and where there is not a lot of evidence that certification leads to insurance reimbursement?

**Katie**: In many states, discussions around reimbursement by health plans or others have turned the conversation to certification. For some payers, there is a desire to have a standard set of qualifications that makes a CHW eligible for payment. In some case, states are calling for this. There are some employers interested, but it depends on type of employer, state political climate, and status of CHW payment. In Michigan, we have also heard some employers express interest in certification because a baseline level of knowledge, including concepts of liability, could be required.

**Carl**: CHWs and employers in each state should make their own assessment of whether employers are interested or not. It does not appear that CHWs, employers or payers are interested in regulating the practice of CHWs, but payers (mainly Medicaid) especially want some understanding on skill requirements so they know what they are paying for. Certification does not by itself or automatically led to integration of CHWs into health care financing (we are moving away from the term “reimbursement”). Many CHWs do not work for health care organizations; non-healthcare employer certainly may have less concern about standard qualifications. In some states “certification” of clinical occupations is really licensing (regulation), so there may be a better term for what folks really want.

1. Might it not make more sense to certify an organization to train and use CHWs in a way that improves care and lowers cost instead of certifying CHWs? CHWs would only be certified to perform activities that insurance would support? In other words, payers might offer a global payment to an organization to use CHWs to do specific tasks that have been shown to impact their costs and improve member health as opposed to fee for service such as is happening in MN.

**Katie**: There are some advocates who have called for organization or program-level certification. There are a lot of advantages to this model. However, it could be a challenge to achieve certification in smaller agencies with limited funding or in larger agencies with significant bureaucracy. As quality measures continue to move organizations to make larger changes, however, there could be a greater emphasis on certifying agencies as a part of larger quality and reimbursement conversations. There are also many benefits to individual certification, which do need to be kept in mind. For example, CHWs in Michigan continually express a desire to have your certification follow you. Since many programs are still grant funded, CHWs want to make sure their certification isn’t solely tied to their current employer. There are arguments for and against both models, and existing CHW, employer, and state preferences will matter. The Pathways to Better Health model (Drs. Mark & Sarah Redding) certifies agencies that serve as Community HUBs and employ CHWs, which is one example of a program-level certification currently up and running.

1. Based on NY CHW employer feedback, you report that experienced employers not asking for certification. What do they say about CHW educational standards?
2. How can we continue to be involved? CHWAR?
3. For individuals who are now taking CHW training whether online or in a classroom setting, will certification be available or an option for them? Is it available statewide or is it only available to MiCHWs? Has it been decided or is it in discussion for now? Is it up to the providers/employers to decide?

**Katie**: In Michigan, we are still figuring out what our grandparenting mechanism will look like. Grandparenting will include some component of previous training experience.

**Carl**: if you are considering certification in your state, fairness may require that you provide for a pathway for individuals who completed formal training programs before standards are developed. One option is to offer a special continuing education program to cove skills that were not included.

1. Why can't you have a certification system that is more fluid and that can respond to changing needs and scope of work? So then is does not limit scope of work?

 **Katie**: Certification systems can be fluid, but it depends on what type of governance and structure they are under. What entity manages and administers certification matters, as well as what laws or other regulations the entity is subject to.

**Carl**: since we are not talking about licensing, certification really does not limit the CHW’s scope of practice as licensing would. CHWs still cannot perform duties that require licensing under another occupation. It is still a good idea for CHWs and other stakeholders to review their definitions and procedures on a regular basis, at least every 5-10 years, to make sure they are responsive to current realities. For an unlicensed occupation like CHWs, scope of practice definitions are mainly meant to help everyone reach a common understanding of what CHWs do, but even on a day to day basis the world of the CHW is fluid; licensure is too rigid to reflect this reality.

1. Is there discussion surrounding how much CHW is paid?

**Katie**: Many state level surveys address CHW payment. Payment varies significantly by state and region.

**Carl:** Good question – there is a lot of discussion. CHWs in general should probably be paid more, now that employers are discovering their true value, but the truth is that formal policies like certification do not guarantee better pay. That is why efforts are needed to make use of the evidence of CHW impact and to educate stakeholders on their value to communities and organizations.

1. What kind of infrastructure development did Massachusetts Dept. of Public Health build/provide the Massachusetts Association of CHWs as they were forming an Association of CHWs?
2. For Sergio (and others): wondering if there was any discussion of protective service, quality or conflict of interest issues when considering the necessity/advisability of CHW certification?

**Carl**: If I’m interpreting the question correctly, some employers and payers are concerned about quality of care and potential liability since CHWs do not receive significant clinical training. Certification alone does not address this concern. But the concern reflects an incomplete understanding of the role of CHWs. If liability were a real concern, licensure would be required, but some states have determined that it is not, because the work of CHWs poses little or no risk of harm to the public. Neither I nor any of my colleagues have ever heard of an employer being sued as a result of actions by a CHW. Quality of “care” is best assured through negotiation between CHWs and their supervisors on how best to assure the best quality work with individuals and families in key situations.

1. Is there any realistic chance of moving beyond grant-based funding for CHWs (e.g., in integrated care teams) without CHW certification in the context of changing payment models under ACA?

**Katie**: There are a lot of opportunities for CHW payment beyond grant funding. Several challenges still exist, though. For example, organizations are designing innovations as part of CMS initiatives, including the State Innovation Model, and states are expected to identify sustainability mechanisms as part of their process. To date, this has been very challenging for states. Additionally, the majority of CHW payment options that do exist support CHWs in health *care* settings versus human service or other community settings. In many cases, this is not an issue, but many community agencies are not equipped or structured to bill services in the same way health care entities are. New options are emerging, including health plans contracting with health and human service agencies for CHW services, but these options are still emerging. Michigan has two current Medicaid funding streams for CHWs: one that allows Medicaid managed care health plans to pay for CHW services in a variety of ways and another that is a per member per month payment to a care team that includes CHWs. In neither case is certification required. You can read more at <http://www.michwa.org/resources/policy/>. Also important to note is that many larger agencies, such as health systems, do pay for CHWs out of general fund or community benefit funds.

**Carl:** huge question – no simple answers, and Katie has given a great response. There is some promise in the ability of managed care organizations to do a lot with CHWs without specific authority, but new models like Health Homes, ACOs and other “value-based payment” structures have plenty of flexibility to include CHWs, and also offer the promise to involve CHWs as the community level s well as working directly with individuals.

1. Tell us more about MiCHWA's model for managing CHW certification in the state

 **Katie**: We’re still figuring it out ourselves! Take a look at our fact sheet on Certificate vs Certification, available here: <http://www.michwa.org/wp-content/uploads/MiCHWA-Certificate-Certification-Overview.pdf>.

1. What core competencies did you focus on?

**Katie**: Michigan’s core competencies are based off Minnesota’s, available here: <http://www.michwa.org/about/training/>.

1. How many states have undergone this certification process to date other than Tx and Minnesota?

**Carl:** the following other states have implemented certification, each in a different way: MA, OH, NM, RI, FL, IN and OR. Minnesota technically does not have certification, and they deliberately chose not to call it that. They have a standard training program that qualifies CHWs to register as Medicaid “providers,” although they cannot bill directly for their services. Similarly, OR certification is only required within their “Coordinated Care Organizations.” A number of other states are moving in the direction of some kind of standard setting, probably voluntary certification, and the process is mandated by statute in IL and MD.

1. To Gail Hirsh- What part has open enrolment community colleges played in the discussion around certification? Is a College certification of Completion equal a certification?
2. Also does anyone have information on the CHW training that took place at the Baltimore Health Department in November 2015? I would like to contact the person/ company that presented,
3. Gail can you further discuss title act versus practice act? Thanks.
4. How do states differentiate CHW roles with case or care management which may be provided by a variety of other entities and have their own training and standards around care navigation, increasing access to health and social determinants and patient engagement in health related activities?

**Katie**: In many cases, agencies differentiate case and care management at the program level. It completely depends on the agency and the program. MiCHWA supports case management as part of the CHW role but also acknowledges that other professionals may also participate in case management. In a similar way, navigation is a role.

**Carl:** my impression is that “care management” and “care coordination” are mainly terms applied to health care, but “case management” is very prevalent in social services such as child welfare. CHWs may be involved in many aspects of these services, but the clinical assessments required for care planning are usually reserved for licensed clinical personnel such as nurses or social workers. “Patient navigation” can be done by CHWs, nurses, social workers and others, depending on program design.

1. For Sergio. Is DISRIP requiring any formal training for CHWs?
2. This is for Mr. Matos and Ms. Hirsh in terms of the CHW Advisory Boards what were lessons learned if any in terms of maintaining self-determination and making sure the voice of the CHWs was heard in the process?
3. After completion of training, how do CHW access jobs.

**Carl**: interesting and important point. Because of the central importance of core qualities of individuals who become CHWs, especially connection to the community, the pathway is not a conventional one. These qualities can’t be “trained.” In general, individuals do not complete training without ever having worked as a CHW. It is more common for employers to recruit “the right people” (who may have been volunteer CHWs) and then make skills development available to them. There are many anecdotal examples of people completing training and then being unable to find a job as a CHW. This is not in anyone’s interest.

1. This is for Carl Rush. Can you share in terms of the C3 Project outreach you shared that AHA and ANA are groups that will provide input to what extent? Is there a concern that their input impede the value of self-determination and open the doors for a requirement of an MPH or Higher degree which takes away from the core of who they are?

**Carl:** a legitimate concern, but there is already fairly wide agreement that CHWs do not require a degree. The core skills necessary to work as a CHW are not “academic” in nature. It is true that health care organizations are biased in favor of higher education requirements, but imposing such requirements would start to encroach on other professions, which nobody wants. (Our contacts so far with the ANA suggest that this is not going to be an issue for them.) At this point stakeholders are mainly being asked to endorse the recommended core roles, skills and qualities that have been vetted by many CHWs. The outreach process is making clear that the Project is not at all interested in “medicalizing” these roles and skills, and any suggestions for changing the recommendations will have to meet a very high bar. The purpose of the outreach is also in part to educate stakeholders who have an incomplete or inaccurate understanding of CHWs

1. can your criminal history stop you from getting a job

**Carl**: great question; could be a long answer, but the shor answer is “yes.” The reality is that many employers require background checks for all employees, or at least for those in sensitive roles, like doing home visits. Employers would be well advised to use recruitment and selection processes that reveal whether the community trusts and respects the CHW candidate. It is questionable whether certification needs to include a background check if employers are going to do their own. Texas does not have a background check requirement; they considered it during “sunset review” in 2010, even the possibility of overlooking nonviolent offenses, but it would have been too complicated. It should also be noted that experience with criminal justice and corrections systems can be a useful qualification for a CHW in certain settings. My suggestion for state policy makers is to leave decisions on background checks to employers.

1. Is there any thought about the impact of having CHWs unionize

**Carl**: they indeed are already unionized in a number of states. While it could be beneficial in terms of pay and working conditions, I have seen some situations where different types of CHW positions were created at various times with different qualifications, and when the employer wanted to unify internal policies across these positions, union agreements made any changes very difficult. As we have all seen, some states are more receptive to union organizing than others.

1. Would have liked to hear about the different skills needed for CHW's placed in the medical setting... can some comments be sent regarding this?

**Carl**: that is also a big question, but CHWs in a medical setting tend to be asked to master more basic information about common medical conditions, as well as skills in reinforcing and coaching on adherence to treatment, especially medications; care coordination and working with different types of provider organizations; medical records and documentation; and helping clinical personnel understand social determinants of health. Where CHWs become part of patient care teams, they also need to adapt to the communication styles of team conferences or “huddles” – while most CHWs are compelling storytellers, there is a discipline to delivering essential information very succinctly in team meetings. It is interesting to see that New Mexico’s new certification system has a basic set of core skills and a “Level 1 specialization” qualification called “clinical support skills.” This may be a model for other states to consider.