Community Health Worker (CHW) Certification and Training: A National Survey of Regionally and State-Based Programs

FINAL REPORT TO:

The Office of Rural Health Policy
Health Services and Resources Administration
US Department of Health and Human Services

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Note: The views expressed in this report do not necessarily reflect the views of any of the sponsoring organizations or the authors' home institution.

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Executive Summary

Increased utilization of community health workers (CHWs) in the U.S. is coupled with a growing interest in standardized training of, and formal credentialing requirements for, CHWs on the part of state legislatures and federal agencies. The purpose of this qualitative study is to provide a national overview of state policy and state involvement in more formal training and certification of CHWs, and to analyze the potential effects of these policy trends. The study addresses these topics: certification and/or training program history, structure of certification and/or training programs, goals of the programs, training curricula, program evaluation processes, and impact and future of the certification and/or training programs.

Primary informants for this study were state public health officials, offices of rural health, primary healthcare associations, departments of social services, CHW networks and associations, community colleges with CHW training programs, and service providers who provide on-the-job training for CHW staff. State legislative websites were used to identify legislative bills or laws concerning the training or certification of CHWs.

Seventeen states were selected for in-depth interviews, based on the application of selection criteria related to the scope and nature of the CHW programs: Alaska, Arizona, California, Connecticut, Florida, Indiana, Kentucky, Massachusetts, Mississippi, North Carolina, New Mexico, Nevada, Ohio, Oregon, Texas, Virginia, and West Virginia.

Among the findings are these:

- All seventeen states have some form of training or certification program for CHWs. Often the training is focused on specialized training in a particular form of socio-health problem arena. Additionally, some programs stress the development of skills specifically related to advancing CHWs' capabilities and effectiveness.

- Three states (Alaska, Indiana and Texas) have a systematic, state-sponsored certification program.

- Of the seventeen states, most utilize some form of community college based and/or service agency based training program with some form of standardized curricula.

- Agency level training is most prevalent in states that utilize specialized CHWs.

- Arizona, California, Kentucky, Massachusetts, Nevada, New Mexico, and Ohio are considering state-level certification of CHWs.

- Ohio, North Carolina, and Nevada have established broad-based standards for training at the state level.

- Only nine of these programs are supported by the state financially or through other means.

- Eight programs identify professional development for CHWs as a program goal.

The evolution of standardized training and certification programs for CHWs suggests that initial advocacy comes from local or regional efforts, CHWs, or CHW organizations. Ultimately, program and policy development require the interests and efforts of multiple political and social interest and advocacy groups. Among these are state and local health agencies, service provider professionals and organizations, community-based organizations and other voluntary associations and health advocacy groups, academic and education centers, and other categories of interested parties.

Three major trends are identified related to training and certification in the states:

1. Community college based training provides academic credit and career advancement opportunities through formal education;

2. On-the-job training is offered to improve the capacities of CHWs and enhance their standards of practice; and,

3. Certification at the state level recognizes and legitimizes the work of CHWs, and opens up potential reimbursement opportunities for CHW services.

The rationales given for certification and standardized training of CHWs are defined somewhat differently by different constituents' perspectives:

1. Healthcare system perspective: certification and standardized training of CHWs allows for a broader and more strategically controlled access to health services and better quality of care assurance;

2. Community perspective: certification and standardized training of CHWs translates into access to new healthcare resources and points of service, as well as an enhanced recognition of the CHWs as valuable community human capital; and

3. CHW perspective: certification and standardized training validates the value of the work of CHWs, provides greater opportunities for reimbursement of CHW services, equips them with greater community building capacity, and offers opportunity for personal growth.

Because CHWs are most likely to be ethnically and culturally aligned with the population served, and therefore serve as an effective link to the target communities of various public health programs, CHWs are poised to take on many paraprofessional roles. For example, a CHW may serve as a member of a screening team for diabetes or

hypertension, or of a mental health treatment team. The role of the lay health worker as a member of a research and evaluation team has also been proven useful.

Policy implications of this study emphasize that state standardized training and certification programs must:

1. Consider the definitions, roles, and purposes of CHWs within their sponsoring organizations. Such policies and programs should be informed by a combination of (a) the demands and opportunities within each state implementing training and certification and (b) information and experiences from other states further along in the training and/or certification process.

2. Include a breadth and/or range of substantive and practice skills specializations sufficient to meet the primary expectations and obligations based on the social and health services needs of the communities in where CHWs work. The same consideration is essential in the creation of training curricula.

3. Initiate and be guided by evaluation research specifically targeting:
    a. CHW training settings, methods, and results
    b. CHW certification methods and results
    c. CHW utilization, and
    d. CHW performance measured by
        i. Patient/client satisfaction
        ii. Provider satisfaction,
        iii. Job related metrics,
        iv. Patient/client outcomes (supported by CHWs), and
        v. Cost-effectiveness analysis of CHW programs.

4. Address strategies for making CHW roles sustainable, including but not limited to policies and strategies that:
    a. will *increase the retention rates* of CHWs
    b. facilitate *systemic integration* of CHWs:
        i. as an essential, ongoing component of service provider organizational structures,
        ii. into public and private policies related to access to services, and
        iii. in strategic plans for local, regional and state provisions of social and health services.
    c. identify and establish sources of long-term, systemic funding and the most effective and efficient means for allocating those funds to the local and regional levels.

5. Consider, while systemically integrating CHWs, the nature of what it means to be a CHW drawing on the strengths of the CHW – their attachment to community, cultural and linguistic alignment of the CHWs and the people they serve, the intricate 'local knowledge' that they embody as CHWs, while at the same time expanding the work and reach of CHWs across geographical, social and cultural

domains in pursuit of the need to make their work they do efficient and cost-effective.

Chapter 1

I.1 Introduction

More than a decade ago, the General Accounting Office concluded that home visiting by paraprofessionals is an effective strategy for improving maternal and child health outcomes in hard-to-reach populations (GAO, 1990). Since then, a growing number of community-based health programs and organizations, such as the Centers for Disease Control and Prevention's Division of Diabetes Translation, have recognized the value of the culturally skilled lay health worker as the link between underserved populations and healthcare providers (e.g., CDC, 2004; APHA 2002). Today, there is wide recognition of the role CHW programs can play in enhancing access for vulnerable populations.

With the growing utilization of community health workers (CHWs) in the U.S. has come a growing interest on the part of selected access-to-health programs, state legislatures, and federal agencies to standardize their training and qualifications by creating formal requirements for licensing, certification, or credentialing. This interest raises critical issues among key stakeholders. States wish to assure quality health care while using CHWs to improve access in geographically isolated and other underserved areas. States also wish to contain costs. CHW organizations, however, are concerned about the impact of such policies on their organizational culture and program sustainability. Likewise, there is evidence that "professionalization" changes the ways in which persons perceive themselves, their work, their relationship to others and to their communities.

The fundamental research issue is whether it is possible to take an informal, community-based practice, formalize it through state-mandated training and certification, and still maintain the benefits of the lay health worker and community-based practice. To begin to address this question, understanding of the breadth and scope of state certification and credentialing initiatives is important. To this end, the purpose of this study is to provide a comprehensive description of the types of standardization that are occurring with CHWs, where it is occurring, and an analysis of how and why it is occurring. Secondly, the study analyzes the potential effects of these policy trends on the sustainability and effectiveness of CHW workers, local and regional programs and CHW organizations, and on the formal health care system.

Organization of Report

- Chapter 1 includes the introduction and methodology sections.
- Chapter 2 includes key findings.
- Chapter 3 includes conclusions and policy implications.
- Chapter 4 provides in-depth analyses of the key elements of CHW certification programs for selected states (Alaska, Indiana, and Texas).
- Appendices I and II include the Phase I and II survey instruments.

I. 2. Methodology

This national survey was undertaken to identify CHW training and certification programs of significant size across the United States. The research design includes six selection criteria used to identify certification and training programs for inclusion in this study. The first two criteria identify the scope of training and/or certification programs. To be included in this survey, a program should have:

1. a reach and impact beyond a single, exclusive and/or locally targeted program; have regional impact, e.g., a county-level certification program that draws people into training for certification county-wide, or a program that is located in a single state but conducts trainings and/or certifications beyond that one state;

2. official state involvement and sanction in some form, such as funding, staffing, agency-specific support for training and/or certification; the program may or may not be a state legislated program.

The next four criteria help identify the types of persons included in a program as trainees and certificate recipients. The training and/or certification program should:

1. utilize a definition of 'health' that may be broad or narrow in scope, e.g., community health/healthy communities, early child development, mental health, community building;

2. target community health workers (CHWs), e.g., *Promotores(as)*, lay outreach workers, community health aids, natural helpers, or persons with other designations that clearly indicate inclusion of lay outreach workers;

3. target CHWs who do not have a professional degree or may not have a high school diploma (if they have college experience, it should not be a requirement for their work as CHWs); and

4. be available to CHWs who work in programs under various auspices, e.g., public/private, local/regional/state.

The purpose of applying these criteria is to identify certification and training programs that are more than just local programs providing their local workers with some form of training and/or certificates. There are large numbers of the latter throughout the U.S., as reported in the national survey of CHWs (Rosenthal, 1998). Such local programs, however, do not hold much potential for informing our understanding of policies related to broad-based CHW certification and training. The programs included in this study, in contrast, represent broad-based certification and/or training programs that demonstrate some form of regional and/or state government-based recognition and support, e.g., financial, administrative, legislative, and/or policy from county and/or state government.

Once programs were identified using these criteria, the programs were profiled around five broad topics:

- Nature of the program and its goals, definition of CHWs, and training and/or certification requirements;
- Historical context of the creation and development of the program, including identification of issues (political, social, economic, cultural) surrounding its creation and development and key players as it evolved;
- Structure of the program (administration, funding, and budget);
- Specific design of the training component (curriculum design and evaluation); and,
- Any issues and impact deemed significant in its development and in the future.

Phase I Interviews: Identifying the Programs to be Included

The first task was to determine how to identify programs fitting these criteria. Fifty states were surveyed in two phases: Phase 1 included an initial set of screening interviews; Phase 2 included in-depth telephone interviews with informants knowledgeable about the programs identified in Phase 1 interviews. Phase 1 screening interview informants in each state included one or more persons from: state public health offices and representatives from offices of rural health, primary healthcare associations, departments of social services, CHW networks, CHW associations, community colleges with CHW training programs, and direct service providers who provide on-the-job training for CHW staff. Phase I started by locating an initial informant in each state who was asked to identify persons in the state knowledgeable about CHW training and/or certification programs in their state. Based on these responses, further calls were made. On average, there were two to four referrals in each of the 50 states to reach one or more persons who could provide the information sought. In addition, state legislative websites identified legislative bills or laws concerning the training or certification of CHWs in each state.

The screening interviews asked five questions:

a. Is there a statewide certification program? If not, is there an alternative type of program that serves a similar purpose?

b. If there is no statewide certification program, are there any local or regional types of certification programs?

c. If not, has there been any discussion about initiating a CHW certification program?

d. Who are the informed person(s) to be interviewed in the state?

e. Are there any other persons who should be contacted in order to find out more about state programs for and/or legislation regarding CHWs?

Ultimately, Phase I interviews identified seventeen states (Table 1) with some form of training and/or certification programs that fit the selection criteria stated above.

Table 1: States Meeting Selection Criteria

Column A	Column 1	Column 2	Column 3	Column 4
Programs (by State)	**Training Program?**	**State Legislation**	**Federal Legislation**	**Certification Status**
Alaska	Yes	Yes	Yes	Yes
Arizona	Yes	No	No	Possibly
California-Southern	Yes	No	No	Possibly
California-Bay Area	Yes	No	No	No
Connecticut Community College (CC) Program	Yes	No	No	No
Connecticut HIV/AIDS	Yes	No	No	No
Florida	Yes	No	No	No
Indiana	Yes	No	No	Yes
Kentucky-Home Place	Yes	No	No	Possibly
Massachusetts	Yes	No	No	Possibly
Mississippi	Yes	No	No	No
Nevada	Yes	No	No	Moving Toward

Table 1 (continued)				
Column A	**Column 1**	**Column 2**	**Column 3**	**Column 4**
New Mexico	Yes	No	No	Moving Toward
North Carolina	Yes	No	No	No
Ohio	Yes	Yes	No	Moving Toward
Oregon	Yes	No	No	No
Texas	Yes	Yes	No	Yes
Virginia -Community Health Improvement Program (CHIP)	Yes	No	No	No
West Virginia-Lending a Hand Program	Yes	No	No	No

Table 1 presents the seventeen states having a CHW training program meeting the survey criteria; note also that two states (California, Connecticut,) have two programs identified to us, meaning that the two programs fit the criteria for selection, but operate separately. Column 4 provides information about which programs are CHW certifying programs. First, three states (Alaska, Indiana, and Texas) have statewide, state-sanctioned certification programs; however, they differ. Texas has a statewide certification program initiated by state legislation (HB 1864) in 1999 that includes a state-appointed and state-supported Promotore(a)/CHW Training and Certification Advisory Committee with oversight responsibilities for training and certification of CHWs throughout the state. Likewise, Alaska has a statewide training and certification program which was initiated in 1964. Its certification program is unique in that it trains and certifies lay health workers who provide *basic health services* in addition to general health education and outreach. Indiana's certification program for CHWs specializing in maternal and infant health, alternatively, is statewide focusing on agency-based needs and offers technical assistance through the state Department of Health. (All three certification programs are profiled in the "Model Programs" Section.)

Finally, there are the states of Nevada and New Mexico (currently without certification programs) that are moving toward establishing state-wide, state-supported CHW certification programs, and Arizona, California, Ohio and Kentucky were "considering it" at the time of the survey.

The case of Mississippi is unique. The Center for Sustainable Health Outreach (CSHO), located at the University of Southern Mississippi, is a Mississippi-based CHW training program that conducts CHW trainings throughout the U.S., but the state itself does not have a broad-based CHW training or certification program.

The remaining seven states do not have and do not indicate that they are considering implementation of a certification program at the time of this survey. Finally, Table 1, Columns 2-3, indicate that Alaska's training and certification program is supported by both state and federal legislation, and Texas' training and certification program is supported by state legislation. All other programs are not.

Phase II Interviews

Phase II interviewing followed up Phase I screening in order to gain more complete information. Phase II included 24 in-depth interviews with key informants in each of the seventeen states. Included were twenty-nine open-ended questions about the certification/training program history, structure, goals, curriculum, evaluation, issues and impacts.[1] Analyses of responses provides an overview of the seventeen programs. The key elements addressed include:

1. Goals, populations served and program focus
2. Context of creation and development, key actors involved
3. Structure and organization – training
4. Structure and organization – certification
5. Current and future impacts
6. Policy implications

Chapter 4 of this report concludes with detailed descriptions of the three certification programs identified in this study (Alaska, Indiana, and Texas). A number of training programs were also identified; several of these programs will be made available at the Southwest Rural Health Research Center website in the future.

[1] Phase I and II survey instruments are included in Appendices I and II, respectively.

CHAPTER 2: FINDINGS

OVERVIEW OF SEVENTEEN STATE-BASED TRAINING AND/OR CERTIFICATION PROGRAMS IN THE U.S.

1. Program Goals, Foci, and Populations Served

Training and/or certification programs vary in their goals, target populations and intended outcomes. Table 2 contains information about populations targeted (Columns 3 and 4), program content (Columns 5-11), whether focus is urban/rural/both (Columns 1-2), and the geographical reach (Column 12).

Table 2:Program Goals, Foci, Populations Served

	column	column	column	column	column	column	column	column	column	column	column	column
Column A	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Programs (by State)	**Rural (Q4)**	**Urban (Q4)**	**Target Population/Ethnic (Q4)**	**Target Population/Program (Q4)**	**Health Education and Outreach (Q4)**	**Health/ Specialized (Q4)**	**CHW Provides Basic Health Services (Q4)**	**Community Building (Q4 Q21, Q22)**	**Professional Development (Q4, Q27)**	**Educating other Agencies (Q1, Q4)**	**Strengthen Families (Q4)**	**Geographical Scope (Q11)**
Alaska	X		5		X	X	X					1
Arizona	X		1		X				X			1
California-Southern	X	X	1, 3		X				X			2
California-Bay Area	X	X		6	X				X	X		2
Connecticut Community College (CC) Program	X	X		6	X				X			2
Connecticut HIV/AIDS	X	X		2	X	X						1

TABLE 2 *continued*

Column A	column 1	column 2	column 3	column 4	column 5	column 6	column 7	column 8	column 9	column 10	column 11	column 12
Florida	X	X		6	X				X		X	2
Indiana	X	X	2	3	X	X						1
Kentucky-Home Place	X			6	X	X						1
Massachusetts	X	X		6	X				X			2
Mississippi	X			1, 3, 5	X	X				X		3
Nevada	X	X	1, 5		X							1
New Mexico	X	X	1		X	X						2
North Carolina	X			4	X							1
Ohio	X	X	1, 2, 6	1	X	X						1
Oregon	X	X	1, 2, 3, 4		X			X	X			2
Texas	X	X	1, 2, 3, 4	1, 3, 4,	X	X		X	X	X	X	1
Virginia-Community Health Improvement Program (CHIP)	X	X		3	X						X	1
West Virginia-Lending a Hand Program	X			3	X			X				1

Legend for Column 3
1. Hispanic/Latino
2. African American
3. Asian
4. Filipino
5. American Indian
6. Amish/Appalachian

Legend for Column 4
1. Maternal and Infant Health (MIH)
2. AIDS/HIV
3. Medicaid/Low Income Families
4. Migrant/Seasonal Workers
5. Cancer
6. Unspecified

Legend for Column 12
1. State wide
2. Regions of state
3. National

Certification and/or training programs in the seventeen states serve a diverse set of targeted ethnic populations (Table 2, Column 3) – Hispanic, African American, Asian, Filipino, American Indian, and Amish, and types of client populations (Column 4) – migrant workers, seasonal workers, Medicaid recipients, maternal and infant health clients, populations at risk for AIDS/HIV, and populations in need of healthcare services in a certain geographic region. Each program has its particular focus, sometimes more than one focus. Programs may differ in the types of communities they serve – rural and/or urban (Column 1 and 2). Service to rural populations is dominant, a factor that plays heavily into why CHW programs exist and why there is a move toward institutionalizing them through systematic training and certification. All seventeen states provide some types of certification and/or training for CHWs in rural settings, and thirteen do so in both urban and rural.

Geographical reach ranged from a national to a regional audience (Column 12). Eleven states (Alaska, Arizona, Connecticut-HIV/AIDS, Indiana, Kentucky, Nevada, North Carolina, Ohio, Texas, Virginia and West Virginia) indicate that their programs reach state-wide, one (Mississippi) serves a national clientele (a training program), six have a regional focus.

Program goals varied in each state, but all seventeen states identified general health-related education and outreach as one of their purposes (Column 5), but only one (Alaska) has CHWs providing basic health services. Eight programs identify professional development for CHWs as a program goal. Three (California-Bay Area, Mississippi and Texas) said that they have "educating other agencies/staff" as a goal, and three (Florida, Texas and Virginia) have a specialized focus on strengthening families.

2. Historical Context and Related Issues

The training and/or certification programs appear to have begun in two distinct time periods. One set of states (Indiana, North Carolina, Virginia, California Bay-Area, New Mexico, Kentucky, and Massachusetts) got their start in the early to mid-1990s. Other states (Connecticut, California (southern), West Virginia, Nevada, Arizona, Ohio, Texas, Oregon, Mississippi, Florida, and West Virginia) initiated their programs in the late 90s, early 2000s. An exception is Alaska. Although its training and certification program in its current form was initiated in 1998, it evolved from a 1950s program of the Indian Health Service (IHS).

The evolving nature of certification and training programs characterizes most of the programs selected. That is, the current, systematic training and/or certification represents a formalizing of earlier, less systematic activities related to CHWs. Many of these programs were initiated by local and regional grassroots advocacy. The continuing efforts of CHWs, CHW organizations, and their allies, offered impetus toward formalization. This comment from a respondent representing the California (southern) program is typical: "The process started many years ago…we started with finding out

what the CHWs wanted and what the community wanted; there were focus groups with CHWs. [They] wanted a central place, a neutral place, a place to grow and learn; they wanted a place to get training for all CHWs….Now the CHW network is a statewide organization…." Historically, the development of broad-based training and certification programs tends to be a bottom-up process.

At some point, however, political and social advocates became involved, often one, two, or a few well-placed advocates in a governmental position. This engagement was crucial for the eventual establishment, development and legitimization of the grassroots efforts. Support from persons in decision making positions, with a communication network of influence, is essential to the eventual establishment, development and legitimization of grassroots efforts in CHW training and/or certification. Table 3 summarizes the variety of these support advocates.

Table 3. Variety of Support Advocates

Service Providers/Providers Network
Community Non-Governmental Organizations
Area Health Education Centers
State Political Advocates
Federal Political Advocates
State Health Departments
County Health Departments
Local and Regional Health Clinics
Federal Agencies
Physicians
Academic (faculty, staff, centers, colleges)
Private Foundations
Private Health Advocacy Organizations (e.g. Planned Parenthood, American Red Cross)
Community Colleges
Professional Associations (health related & non-health related)
Hospitals
Local Businesses

It is also the case that the reasons given for broader support tend to be varied, according to stakeholder interests and perspectives. Table 4 summarizes these rationales.

Table 4
Why Training and Certification?

A Governmental/Health Care System Perspective:

1. Access to and more strategic control of outreach workforce
2. Systematic training and systemic recognition
3. Broader health care access and affordability
4. Access to financial resources for reimbursing CHWs
5. Quality of care assurance

A Community Perspective:

1. Access to new health care resources
2. New access to services points
3. Recognition and acceptance of the CHWs – ease and comfort

A CHW Perspective:

1. Career advancement
2. Validate significance of CHWs' work/greater recognition
3. Greater community building capacity
4. Personal satisfaction and growth
5. Greater opportunities for receiving reimbursement/payment

Not surprisingly, *political and health care system administration* representatives take a systemic perspective, i.e., they are looking for more and better avenues by which to disseminate services and potential new sources of reimbursement for CHW services (e.g. Medicaid). This latter point is particularly crucial. For example, in its legislative run-up to the Texas training and certification program, the legislature requested a systematic analysis of the potential for accessing Medicaid funding if the state proceeded to pass legislation establishing certification of CHWs. The legislature, therefore, charged a study committee with "…identifying and developing a strategic plan to address the barriers encountered by recipients of benefits under the state Medicaid program in accessing prenatal and neonatal health care services" (PPDC, 2000; pg.vii). That committee then concluded in one of its final reports:

> The capacity of Promotores(as) or CHWs to improve health and health care access in underserved communities in Texas is recognized and highly valued by those represented by the PPDC. The effectiveness of prevention, reduction of cultural and linguistic barriers to care, assisting community residents to successfully navigate complex systems, and improving the quality and cost-effectiveness of care are well documented (Rosenthal, 1998). While this local service delivery model has been effectively used in

> other state health and human services programs, the approach has yet to be universally translated to the Texas Medicaid program (Rosenthal, 1998: vii).

The Committee's Report recommended that the legislature authorize the use of CHWs to assist residents in accessing Medicaid services. However, beyond the potential value for CHW certification to provide new financial resources is the value-added opportunity to improve access to a broad range of human services, thereby improving the health of individuals and communities in the state. Finally, state officials also recognize that with greater standardization of training comes more control over the skill proficiencies of the CHWs whom they utilize, as well as greater capabilities for systematically assessing their competencies.

Local community leaders perceive state-supported CHW training and/or certification as a new and highly effective resource for accessing and improving individual and community health. Moreover, legitimating CHWs – nearly all of whom are community based – gives recognition to the importance of community input and direction, i.e., a new sense that the community is a significant locus of concern and authority with input into decision making.

Last, but not by any means least, CHWs recognize the value of state-supported training and certification to the communities in which they live and work; they also believe that systematic CHW training and/or certification is important to personal and professional development (May, et. al., Promotora Study, 2004). Formal training and/or certification provides them new and marketable skills, new levels of education and recognition in their communities, and, if they desire, a step onto a career ladder. As important, certification endows them with a validation of skills and the opportunity to be reimbursed by the employer agencies or government payors, which was not possible before certification, as in the case of Indiana and Texas.

3. Structure and Organization Within the Three Certification Programs

Phase I screening interviews identified three state-sponsored certification programs – Alaska, Texas and Indiana – each with its own distinct character. Phase II interviews uncovered in-depth information about these three programs. Each is briefly sketched here.[2]

a. Alaska – Community Health Aide Program (CHAP). Alaska's tribal health care system has developed a unique program to address the problem of access to primary health services in its most remote, frontier communities serving Alaska Natives. It is called the Community Health Aide Program (CHAP), now celebrating almost 35 years in existence. The CHWs are called CHA/Ps, Community Health Aides/Practitioners. The program trains local residents – mostly Alaska Native women – to act as non-physician, primary care providers in the remote communities where they reside. By training local

[2] Each of these state certification programs is profiled in the Model Programs section (Chapter 4) of this report and will be only briefly described here.

residents, the issue of recruitment to practice in frontier communities that plagues many other health professions becomes less of an issue. Further, local residents are more likely to speak the native language, provide culturally sensitive services, and be considered acceptable by the local community. Community Health Aides/Practitioners (CHA/Ps) are often the sole source of medical care in their communities and have become the backbone of Alaska's rural and remote health system for Alaska Native people. The CHAP is both a certification and a training program.

Certification: While CHAP has historically included some forms of certification, that has changed substantially. Previously, CHA/Ps were considered "certified" after they had completed all four sessions of basic training, a 30-week-minimum preceptorship of supervised clinical experience, completion of a critical skills list, completion of both a written and practical exam, documentation of the completion of at least 15 patient encounters as the primary provider, and an evaluation of the CHA/P's clinical performance by an approved evaluator. This credential is bestowed by the CHAP training centers on qualified health aides and must be renewed every six years. There is no state license required for CHA/Ps to practice.

Training: The training program consists of two parts. The first prepares CHA/Ps to deliver some basic health care, along with the personal and professional support and care, for communities. CHA/P training sessions are specifically designed to accommodate the unique needs of health aides. The training sessions are designed to be fairly short in duration with the health aides returning to their village to practice in limited scope between sessions. The health aides assume responsibilities in their positions prior to the completion of their basic training program. This distinctive feature of the training program serves several purposes. Most health aides have family commitments that make it difficult to leave the village for long periods of time. Also, returning to the village allows health aides to practice their new skills between training sessions and provide necessary services in the community that would otherwise be unavailable. Finally, the training scheme helps to minimize "brain drain" where indigenous people are sent to urban areas for training and never return to their community to practice.

An emerging corollary to CHAP is the Dental Health Aide Program (DHAP). The DHAP emerged to address the high rate of dental disease and low number of providers in rural Alaska. Out of the State's 27 boroughs, 17 qualify as Dental Health Professional Shortage Areas (HPSAs). The DHAP is expected to intersect with CHAP in many ways. In some regions, the CHAP Coordinator/Instructor or Supervisor/Instructor (CI/SI) will provide support and oversight of the dental health aides (DHAs) in addition to the CHA/Ps. Standards for the two programs have been integrated, and one certification board governs both types of health aides. Importantly, CHA/Ps will also continue to receive training in dental care and provide services to patients with emergency dental issues in villages without higher-level dental health aides.

The training curriculum (for both CHAP and DHAP) is standardized across the state. The CHAP utilizes a series of four training centers across the state, each using a common curriculum. All training involves four intensive, 3-4 week sessions. Each time a CHA/P

completes one of the four sessions, s/he receives a certificate for completing that set of skills and knowledge. It is only after completing the full set of four training sessions that the CHA/P can be certified as a fully trained CHAP. Because of the limited time for training, the content is geared primarily at patient assessment, with special emphasis given to the diseases most prevalent in rural Alaska.

While the curriculum is standardized, it also allows for the training centers in different locations to introduce specific, localized issues/questions into the training. In addition, differences in languages and cultures in different centers are taken into consideration.

The primary oversight agency is the Indian Health Service through the Alaska Native Health System, which consists of the Native Health Corporations. The certification process is managed and overseen by a Certification Board established in 1998. The regional corporation hires the CHA/Ps, pays their salaries and benefits, helps assure that CHA/Ps receive training and support, and in many cases provides operation and maintenance funds for the village clinics. The native village council selects the CHA/P that is to be hired to work locally.

For the Dental Health Aide Program, a dental academic review committee (DARC) has developed training regimens for each level of dental health aide and standards are in place to govern qualifications and scope of work at each practice level. A dental provider has been added to the CHAP Certification Board allowing dental health aides to be certified by the same body as CHA/Ps. A remote dentist located in a hub community will clinically supervise village-based dental health aides.

Physicians employed by the IHS or a tribal organization provide medical supervision of CHA/Ps and have the legal responsibility for care provided by CHA/Ps under their supervision. In addition to medical supervision, each health aide is also provided with a coordinator/instructor or supervisor/instructor (CI/SI) who provides day-to-day supervision and support related to non-medical tasks to health aides in his or her region.

CHAP is a collaborative effort between the federal government through the IHS, local regional Native health corporations, individual villages, and the State of Alaska; each partner plays a crucial role in the program's success. Local villages and village councils also play an important role in the CHAP program. In an effort to make sure that the CHA/P is acceptable to the village where they will practice, the native village council selects the CHA/P that is to be hired to work locally.

b. Indiana – Community Health Worker Program. In 1990, a Medicaid reimbursable Prenatal Care Coordination program was in place, but Medicaid did not reimburse CHWs. The city of Indianapolis, in collaboration with state legislators, the State Department of Health, Indiana University School of Nursing, local hospitals, and others, forged an agreement that the City of Indianapolis would provide $3 million over three years (1990-1993) to establish the Indianapolis Healthy Babies Foundation, which in turn funded the founding of the Prenatal Care Coordination Program that includes CHWs. The community health worker program was established in 1994 as a statewide

program. The addition of CHWs to the Administrative Rule in 1994 allowed for CHWs to provide limited Medicaid reimbursable services under the supervision of a certified prenatal care coordinator.

The statewide program operates through prenatal care coordination teams, each consisting of a Registered Nurse, Social Worker, and CHW. While the program focuses on prenatal care, outreach, case identification and management, health education, risk assessment and monitoring, the CHWs focus primarily on outreach, support, monitoring of care plan, education and referral follow-up.

Certification: Certification is provided by the Indiana State Department of Health (ISDH). After training at the local level, CHWs attend a one-day certification workshop at the State Department of Health and take an exam, which if passed, qualifies them for certification.

Training: Training is conducted under the auspices of the State Department of Health. Initially a packaged curriculum was used (InMed Mother Net America), but increasing costs demanded that a curriculum be created internally. It is being standardized.

The curriculum consists of three sections. Section 1 incorporates understanding the law, guidelines and definitions and how to conduct outreach and home visits. Section 2 focuses on the technical aspects of pregnancy, prenatal care, anatomy, physiology, SIDS, preterm labor, low birth weight, health risk behaviors, disease, admission to the hospital, labor and delivery, breastfeeding, post partum care, finding a pediatrician, immunizations and well child care. Section 3 highlights mental health, cultural competency, communication, and working with families. While the primary focus is on prenatal health, other emphases have been added that incorporate the whole family.

Training is conducted across the state through local agencies. Local agencies receive a packet of training materials developed by the Department of Health and sign a provider agreement assuring that the CHW will be trained according to ISDH guidelines. They have an established deadline to complete the training and are encouraged to get technical assistance from the State Department of Health staff throughout the training as needed. The State Health Department trains the trainers who in turn conduct the trainings in the local agencies. CHWs are then trained at the agency level; including classroom and on-the-job-experiences.

The CHWs qualify for Medicaid funding because they work as a part of a team that includes professionally trained RNs and Social Workers and because the target population is high risk Medicaid qualified pregnant women throughout the state.

The ISDH does not conduct a regular, comprehensive evaluation of the program. Currently, outcome reports, with demographic data, pregnancy data, birth outcome data, post-pregnancy data and infant health data are completed on each participant. However, the data are not analyzed, primarily because of lack of funds and staff.

c. Texas - Promotore(a)/CHW Training and Certification Program. Crucial to the ultimate creation of the Texas training and certification program was grassroots advocacy, particularly from CHWs and their organizations on the Texas-Mexico border, but other places in the state as well. The major grassroots activity and concentration of Promotoras were on the border and one of the major grassroots Promotora organizations was in the LRGV – the South Texas Promotora Association (STPA). The STPA played a significant role in bringing training and certification to the attention of these legislators and in sustaining that interest once it had kindled. Complementing the grassroots activity was a small but active group of state legislators representing constituencies on the Texas-Mexico border. These legislators early on were listening to the grassroots advocates and, in fact, were included in much of the grassroots activity.

Certification: Three pieces of legislation were important in establishing the Texas certification program. In the first legislative bill, the Texas legislature created the Promotora Program Development Committee PPDC. This committee promulgated a set of Rules and Regulations regarding the training and certification of Promotores(as) or CHWs. The PPDC, in turn, established The Training and Certification and Advisory Committee (TCAC) which is responsible for oversight of the certification and training process as prescribed by the rules and regulations of the PPDC. The TCAC is staffed by the Office of Promotore(a)/CHW Training and Certification (PTC), located administratively within the Office of Public Health Practices, in the Texas Department of Health.

The PPDC created a multi-dimensional array of certifications, each necessary before a full certification program can be established. Certification is necessary for Promotores(as)/CHWs, training instructors, and institutions intending to offer training. The specific requirements for certification of providers, trainers, and institutions are included in Chapter 4.

Training: Development of a training curriculum/training curricula lies at the heart of quality certification. Consequently, the PPDC set forth broad and carefully stated guidelines for curriculum development. These guidelines regarding required skills, competencies, training, and approval of programs are described in-depth in Chapter 4.

The implication of the PPDC's guidelines is that one standard curriculum would be developed. However, the TCAC revised this implication in its implementation of the training curriculum to allow for certification of curricula that have basic core competencies, with room for tailoring to reflect local and regional needs, cultural competencies, and service specialty requirements.[3]

4. Structure and Organization within the Training Programs

[3] A more in-depth discussion of the Texas program is found in Chapter 4. In addition, this national study also conducted an intensive case study of the Texas training and certification program. Analysis of the case study data is completed and a report is in progress. That study will be available in the near future through the Texas A&M School of Rural Public Health, Southwest Rural Health Research Center.

As Phase I screening interviews unfolded, it became apparent that few states – only three as it turns out - actually have some form of state-sponsored, state-supported programs for CHW **certification**. Far more common are state-sponsored, state-supported **training** programs for CHWs. These represent training programs that are systematic and extend regionally or beyond. These training programs are considered a best practice toward consistent improvement of CHW skill preparation and more effective integration of CHWs into a state's delivery of services. This section discusses several characteristics that profile what and how CHW training programs are implemented. The basis for the information presented here follows the set of questions asked of all respondents using the interview protocol. Question numbers appearing after each topic in parentheses correspond to the actual question used in the interview protocol.

1. Is yours a training program, a certification program, or both? (Q2&Q3)
2. Is the training program certified, and, if so, by whom? (Q2)
3. Is there legislation that mandates training for CHWs? (Q3)
4. What agency/organization is in charge of the implementation and administration of the training? (Q10)
5. Is the training local, regional, state-wide? (Q11)
6. Is systematic training required of all CHWs? some CHWs? (Q5 &Q6)
7. What funding sources do you have? (Q13)
8. Does the training program include an evaluation component? state-mandated? (Q14 & Q15)
9. Do you require a curriculum design? (Q18)
    a. Is it standardized? (Q19)
    b. If so, is it flexible or adaptable to local/regional contexts? (Q20)
    c. Did you use a 'model' from another program? (Q21)
10. What is/are the focus/foci of the training? (Q4 &Q23)
11. Who provides the training? (Q24 to Q26)

As seen in Table 1, all seventeen states have state-supported training programs that function regionally or beyond. This section provides an overview of the nature of the state-sponsored training programs.

Table 1 indicates that state-supported CHW training programs are not commonly underwritten by state legislation. Ohio is one exception. It is the only state (without a state-supported certification program)[4] that has legislation related to its CHW training. The Ohio Department of Health has implemented standardized training for "community care coordinators" through funding by HRSA. Ohio currently has six demonstration sites, geographically distributed throughout the state; in addition it has developed web based training modules for supervisors and is planning to develop a web based training module for the community care coordinators (CHWs).

State-supported CHW training programs without supporting legislation are the more common type. These programs are commonly located in, developed by, and financially

[4] Ohio will be establishing a certification for CHW by 2005.

supported and supervised by one or more state agencies. Occasionally, they might be located in a not-for-profit organization outside a state agency, but supported by the state. One example of this is Kentucky's Homeplace, a direct service program that provides training for the CHWs called Family Health Care Advisors (FHCA). They are lay health workers, culturally competent for the communities they work in, required to have a GED or have finished high school, and have experience with the state health insurance (Medicaid and SCHIP). Another example of a state supported program is Nevada's "Feet on the Street" program. It is administered through the Great Basin Primary Care Association in partnership with the state of Nevada. The state was involved in the creation of the training program that trains CHWs mainly to carry out outreach to increase Medicaid enrollments in their communities.

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Program Characteristics. Let's turn now to look at other characteristics of the CHW training programs identified in Table 5.

TABLE 5a:Training and Program Characteristics (columns 1-5)					
Column A	**Column 1**	**Column 2**	**Column 3**	**Column 4**	**Column 5**
Programs (by State)	**Training Emphases (Q23)**	**Training required of CHWs? (Q5 & Q6)**	**Prerequisites for Training (Q1)**	**Certified Trainers (Q25)**	**Trainer Selection Criteria (Q24)**
Alaska	Healthcare delivery: primary and emergency care including patient assessment	1	3	2	Not specified
Arizona	Health education and outreach; core competencies	4,3	3	2	Selected by community college faculty/staff
California-Southern	Health outreach, community development and mental health	4	3	1	Indigenous to area served
California-Bay Area	Social determinants of health, health education and outreach	4	3	3	Experienced CHWs from the field with Masters degree
Connecticut CC Program	Health outreach and access	4	3	3	Part-time college faculty in health/human services
Connecticut HIV/AIDS	HIV/AIDS prevention; community health education	4	3	3	Agency staff and specialized consultants
Florida	Family development and health outreach	4	3	1	Community college and University faculty/staff

TABLE 5a (cont.): Training and Program Characteristics (columns 1-5)					
Column A	**Column 1**	**Column 2**	**Column 3**	**Column 4**	**Column 5**
Programs (cont.)	**Training Emphases (Q23)**	**Training required of CHWs? (Q5 & Q6)**	**Prerequisites for Training (Q1)**	**Certified Trainers (Q25)**	**Trainer Selection Criteria (Q24)**
Indiana	Maternal and Infant health with inclusion of whole family	2,3	3	2	Certified care coordinator (RNs) at agency level
Kentucky-Home Place	Health outreach and mental health	1	1	2	Expertise/specific fields, e.g. RNs and MDs, and seasoned lay health workers
Massachusetts	Health outreach	1	3	3	Based on agency needs
Mississippi	General health promotion (CHAN); Cancer; Maternal and Infant Health (MIHOW)	2,3	3	2	Center for Sustainable Health Outreach (CSHO)
Nevada	Health access and outreach; Medicaid enrollment	1	2	2	Expertise/specific fields, e.g. RNs and home health workers
New Mexico	Health education and outreach	4,3	3	3	Based on agency needs
North Carolina	Farm worker health, health outreach and education	3	3	2	Agency staff with specialty expertise and on-site consultants
Ohio	Health education and outreach; care coordination	3	3	2	Education director at state department of health selects trainers

TABLE 5a (cont.):Training and Program Characteristics (columns 1-5)

Column A	Column 1	Column 2	Column 3	Column 4	Column 5
Programs (cont.)	**Training Emphases (Q23)**	**Training required of CHWs? (Q5 & Q6)**	**Prerequisites for Training (Q1)**	**Certified Trainers (Q25)**	**Trainer Selection Criteria (Q24)**
Oregon	Capacitation of CHWs	4,3	3	3	Knowledge of CHW work and popular education methodology
Texas	Health education and outreach; core competencies	4 (certification required for paid CHW)	3	1 (through state department of health)	State certification for trainers through state department of health encouraged
Virginia CHIP	Comprehensive health investment; Community outreach; child health and wellness	1	3	3	Expertise in content area; experienced trainers in CHIP
West Virginia-Lending a Hand Program	Volunteer based community development, social support and health	4	3	3	Agency staff; cancer experts; public health students; community-based experts,e.g. MDs

Legend for column 2
(Training Required for CHWs?)
1. Yes, CHWs employed by program
2. Yes, only specialized CHWs
3. Yes, contract agencies
4. No

Legend for column 3
(Prerequisites for Training?)
1. Yes, HS diploma or GED
2. Yes, specific technical skills; prefer Bachelor degree
3. No

Legend for column 4
(Trainers Certified?)
1. Yes, program specific
2. Yes, through their own professional organization
3. No

TABLE 5b:Training and Program Characteristics (columns 6-10)					
Column A	**Column 6**	**Column 7**	**Column 8**	**Column 9**	**Column 10**
Programs (by State)	**Training Curricula (Q18)**	**Curricula Standardized (Q19)**	**Curricula Flexible (Q20)**	**Training Certified (Q2)**	**Agencies Providing Training (Q26)**
Alaska	Yes	1,2	3	No	State supported training centers
Arizona	Yes	1	2	Yes as part of the curriculum of a community college; receive academic credit	Four community colleges throughout the state and some of the AHEC centers
California-Southern	No; handbook on specific subjects	4	1	No	Local agencies, mental health services, environmental agencies and nutrition experts
California-Bay Area	Yes	1	1	Yes; by the college	San Francisco Community College, and Blue Cross & Blue Shield; program provides training for other agencies
Connecticut CC Program	Yes	1	2	Yes; by the college	Three Rivers Community College
Connecticut HIV/AIDS	Yes	1	1	No	Department of Public Health staff, CDC, Planned Parenthood, Red Cross
Florida	Yes	1	4	Yes; through Cornell University	Florida Golf Coast University (credentialing agency), and future community colleges

TABLE 5b (cont.):Training and Program Characteristics (columns 6-10)					
Column A	**Column 6**	**Column 7**	**Column 8**	**Column 9**	**Column 10**
Programs (cont.)	**Training Curricula (Q18)**	**Curricula Standardized (Q19)**	**Curricula Flexible (Q20)**	**Training Certified (Q2)**	**Agencies Providing Training (Q26)**
Indiana	Yes	1	3	No (training developed by the ID department of health)	Not-for-profit agencies (health clinics) provide prenatal care services; agency trainers are trained by state department of health; trainers train CHWs at agency level.
Kentucky-Home Place	Yes	1	1	No	KY Medicaid program, family practice program at the COM, substance abuse and prevention program, sheriff's department, and housing authority
Massachusetts	Yes	4	1	No	Community based agencies.
Mississippi	Yes	1,2	1	Yes, Center for Sustainable Health Outcomes	Multiple-agencies contract with CSHO and receive training or CHAs receive training from CSHO
Nevada	Yes	1	1	No	NV state welfare, Medicaid office, NV SCHIP, NV department of human resources, and other partners
New Mexico	Yes	4	1	No	Through New Mexico Department of Health agencies; AHEC

TABLE 5b (cont.):Training and Program Characteristics (columns 6-10)

Column A	Column 6	Column 7	Column 8	Column 9	Column 10
Programs (cont.)	**Training Curricula (Q18)**	**Curricula Standardized (Q19)**	**Curricula Flexible (Q20)**	**Training Certified (Q2)**	**Agencies Providing Training (Q26)**
North Carolina	No	4	1	No	State agencies such as immunization department, advocacy organizations, domestic violence, department of labor, department of agriculture
Ohio	Yes	1	4	No	OH department of health, CAP
Oregon	Yes	1,2	1	No	Portland Community College
Texas	Yes	5	1	Yes, by Texas Department of Health	Through certified training centers located regionally
Virginia CHIP	Yes	1	3	No	Contracted by state agencies, other organizations for specialized training
West Virginia-Lending a Hand Program	Yes	1	3	No	WV University Morgantown and state department of health

Legend for column 7 (Curricula Standardized)
1. Standardized across all sites (general)
2. Standardize across all sites (specialized)
3. Not standardized; have specialty curricula
4. No
5. No, but guidelines must be followed and the curriculum certified by state

Legend for column 8 (Curricula Flexibility)
1. Yes, based on local site needs
2. Yes, in the electives at the CC
3. Not in core training, but specialized information can be added to core
4. Not in core training, but faculty may add materials and/or practicum provides for tailoring

TABLE 5c: Training and Program Characteristics (columns 11-17)							
Column A	Column 11	Column 12	Column 13	Column 14	Column 15	Column 16	Column 17
Programs (by State)	Agency(ies) Impl/Admin (Q10)	Partner Imp/Adm (Q10)	Funding Sources (Q13)	Exclusive Budget (Q12)	Evaluation Conducted ? (Q14)	Home Agency	Year created (Q7)
Alaska	Indian Health Service thru Alaska Native Health System (latter have Native Health Corps)	Collaborative: IHS (federal) thru local/regional Native Health Corps, individual villages and State of Alaska	Indian Health Services (HIS); Local and national foundations; Medicaid and regional support of Health Corps	Yes ($54M, $30M/state; $24M/HIS-Fed	3	AK Center for Rural Health	1950s
Arizona	State Univ. of AZ, AHEC (ASU) and Community College System	CCs; all agencies who employ CHWs; State Dept of Health Service Providers	Dep. of Education and HRSA Bureau of Public Health	Not presently; did for the 3 years of the initial grant	1	AZ AHEC and University of AZ	1999
California-Southern	Community Health Improvement Partners (CHIP)	Project Concern International, Neighborhood Health Care, Por la Vida; AHEC may soon be involved	EPA, Community Health Improvement Partners (CHIP); CA Endowment and ETNA	Yes; depends of grants	2 (one of the collaborative partners does the evaluations)	CHW Regional Development Center, an Diego, CA	1997
California-Bay Area	Reps from SF City College and SFSU; Admin by SFCC and Health Services Dept(Dpt Pub Health, SF)	Santa Rosa Community College	US DOE; SF Community College; local foundations	Yes	1	San Francisco State University, Community Health Works	1992
Connecticut CC Program	Eastern AHEC, State Board of Higher Education, and Three Rivers Community College		Community Colleges	Yes; each community college develops budget	3	CT Eastern AHEC	2003

TABLE 5c (cont.): Training and Program Characteristics (columns 11-17)							
Column A	Column 11	Column 12	Column 13	Column 14	Column 15	Column 16	Column 17
Programs (cont.)	Agency(ies) Impl/Admin (Q10)	Partner Imp/Adm (Q10)	Funding Sources (Q13)	Exclusive Budget (Q12)	Evaluation Conducted ? (Q14)	Home Agency	Year created (Q7)
Connecticut HIV/AIDS	CT Dpt of Public Health, AIDS Div and Chronic Disease Div	Red Cross; Planned Parenthood	CDC (but not for training; State AIDS prevention funds (used for training)	Yes	3	CT Dept. of Public Health, AIDS Prevention Program	1999
Florida	RCMA and East Coast Migrant Head Start Project	Florida Gulf Coast U	Head Start; State School Readiness Program;	No	3	Redlands Christian Migrant Association (RCMA)	2003
Indiana	State Dept of Health thru its not-for-profit agencies (health clinics, health depts., hospitals providing. prenatal care services	IV Tech CC; Health Visions of IL (working in IN)	Title 5 funds; State Medicaid; initial seed funds from municipal sources; initially from March of Dimes	No	3	IN State Departmen t of Health, Maternal and Child Health Services	1994
Kentucky-Home Place	Center for Rural Health	Steering Committee	State Health Department	Yes; line item in Governor's budget- $1.9M	2 (through the steering committee)	Center for Rural Health, Lay Health Worker Division	1994
Massachusetts	State Dept. of Public Health		State Department of Public Health funds agencies providing training	Each partner agency has its own budget	3	MA Departmen t of Public Health	1993
Mississippi	U. of Miss	Georgetow n Univ., Vanderbilt Univ., Univ. of Alabama, Birmingham	HRSA/ORHP; RWJF and Kellogg; self-generated funds through national trainings; in-kind from U.of Southern Mississippi	Yes	1	CSHO, Georgetow n University	1998

TABLE 5c (cont.): Training and Program Characteristics (columns 11-17)							
Column A	Column 11	Column 12	Column 13	Column 14	Column 15	Column 16	Column 17
Programs (cont.)	Agency(ies) Impl/Admin (Q10)	Partner Imp/Adm (Q10)	Funding Sources (Q13)	Exclusive Budget (Q12)	Evaluation Conducted ? (Q14)	Home Agency	Year created (Q7)
Nevada	Great Basin Primary Care Association (not-for-profit-federal funds)	State of Nevada; Corp. for National Service; Americorp; various service providers	Corp. for National Service; Americorp; RWJF	Yes	1	Great Basin Primary Care Association "Feet on the Street"	1999
New Mexico	State Off Border Health; each individual org responsible for its own admin	Immigrations and Naturalization Services; NM Dpt Health; NM Dpt Human Services (Medicaid); schools; NMSU-Col Health Sciences; UNM-Col. Health Sciences; Families and Youth Inc	individual program budgets thru grants they receive	No	3	Border Health Office	1991
North Carolina	Office of Rural Health (Research Demonstration and Rural Health Development)	NC Primary Healthcare Assoc; Farmworker Alliance; state alliance of advocates to improve health of migrant workers; provider agencies under state contract	HRSA Bureau of Primary Healthcare; State Div of Pub Health; Environmental Trust Fund	Yes	1 (participant evaluation)	Office of Rural Health (Research and Demonstration)	1993

TABLE 5c (cont.): Training and Program Characteristics (columns 11-17)							
Column A	Column 11	Column 12	Column 13	Column 14	Column 15	Column 16	Column 17
Programs (cont.)	Agency(ies) Impl/Admin (Q10)	Partner Imp/Adm (Q10)	Funding Sources (Q13)	Exclusive Budget (Q12)	Evaluation Conducted ? (Q14)	Home Agency	Year created (Q7)
Ohio	Ohio Department of Health, Bureau of Community Health Services and System Development ; Community Action Program (CAP)	Community Action Program (CAP); Bur of Child and Family Health; Community Health Access Program (CHAP); Cleveland City Health Dpt; FQHCs; Rural Opportunities Inc (ROI); Planned Parenthood of Youngstown/ Mah Valley; Columbus City Dpt Health	HRSA, CAP; State Office of Mental Retardation; Osteopathic Heritage Foundation; civic groups; Ohio Dpt Health	Yes	1 (demonstra tion program evaluation)	OH Departmen t of health, Community Action Program (CAP)	1999
Oregon	County Health Department	several community based organizations and Portland Community College	CDC, "Program for Help" and contractual training service fees	Yes	1 (CDC requires evaluation)	Community Capacitatio n Project (CAP), Multnomah County Health Departmen t	1998
Texas	Texas Department of Health	State Legislators, CHW organizations and leaders	Texas Department of Health	No	2 (course evaluations at agency and community college level)	TX Departmen t of Health, Promotoras Program	1999

TABLE 5c (cont.): Training and Program Characteristics (columns 11-17)

Column A	Column 11	Column 12	Column 13	Column 14	Column 15	Column 16	Column 17
Programs (cont.)	Agency(ies) Impl/Admin (Q10)	Partner Imp/Adm (Q10)	Funding Sources (Q13)	Exclusive Budget (Q12)	Evaluation Conducted ? (Q14)	Home Agency	Year created (Q7)
Virginia CHIP	Total Action Against Poverty (TAAP) at outset; now CHIP of VA-independent not-for-profit	State Dept of Health, Dept of Social Services, Dept. Medical Assistance Services; local community partners, e.g. hospitals, CAAs, pub health depts	TNF; Title 4E Social Security; Foster Care Prevention Funds; State general discretionary fund; County-local program funding; local NGOs with grants; local faith-based, civic groups	Yes	1	Comprehe nsive Health Investment Project (CHIP) of VA	1992
West Virginia-Lending a Hand Program	WV Univ	Mary Rudolph Cancer Ctr; State Health Dept	CDC-Prevention Research Center	No	1	Partners in Health Network, New River Health Association	2000

Legend for column 15 (Evaluation conducted?)
1. Yes, through specific grants
2. Yes, other
3. Nothing systematic

Table 5, Column 1 indicates that training programs have diverse emphases including health outreach, education, healthcare access, specialized health services, and community capacity-building. Some – Arizona, California-Southern, Connecticut's Community College Program and Texas – provide general CHW skill preparation, with Ohio doing both general and specialized training. Some states specialize – Alaska, Connecticut's HIV/AIDS prevention program, Indiana's Maternal and Infant Health program, Virginia's Comprehensive Health Improvement Program– their CHW training. Ohio does both general and specialized training. Overall, the substantive emphases are related to health – individual and/or communal. It is also of interest that TEN of the seventeen states (Table 5, Column 2) do not require generally that CHWs have training in order to work as a CHW. (i.e. training is voluntary). Other states do require it, under special circumstances, e.g. specific programs might require it for their particular programs only, or a state might require it for any program contracting with their agencies. Three states – Arizona, New Mexico and Oregon – do not require it generally of CHWs, but have agencies (employers) that do require it. North Carolina requires that all staff CHWs employed by a state funded agency attend at least three training workshops offered by the state Department of Health. Other programs did not specify requirements. Prerequisites

are generally focused on cultural and ethnic background and competencies; issues surrounding pre-requisites for training, and especially for practicing as a CHW, are important policy issues. (A more in-depth discussion of this is in the Texas Model Program included in Chapter 4 of this report.)

Eight of the seventeen state-supported training programs do not require that the trainers be certified (Table 5, Column 4). Trainer-selection criteria vary (Table 5, Column 5). Three states (Arizona, Connecticut Community College Program, and Florida) specify college faculty status as a criterion. Others (Alaska, Indiana, Kentucky-Home Place, Nevada, New Mexico, North Carolina, Virginia Comprehensive Health Improvement Program [Virginia CHIP]) require that trainers be expert in some field, e.g. RNs, agency staff, related to the substantive emphasis of the program. Finally, California-Southern, California-Bay Area, Oregon and Texas emphasize that trainers know the work of CHWs and/or be indigenous to the area in which the training is being conducted. In general, it seems correct to conclude that CHW training programs that are generalist in nature privilege the field-based, experience-based CHW trainer. More specialized training programs privilege the specialized expertise in addition to cultural competencies.

Table 5, Column 6 shows overwhelmingly that all seventeen states in the survey have training curricula. In all but four states, the training curriculum is standardized across sites – both general and/or specialized curricula (Table 5, Column 7). New Mexico and North Carolina do not specify a standardized curriculum. Texas has a mixed curriculum requirement. It includes a 'core curriculum' that must be taught in all training sites, with any specialized curriculum beyond the core not required to be standardized. However, Texas does require that all sites around the state planning to do training must prepare a formal curriculum and have it recommended for approval by the state's Promotore(a)/CHW Training and Certification Advisory Committee (TCAC). At the same time, and very importantly, all state-standardized curricula have built-in flexibility (Table 5, Column 8). Flexibility is afforded by a variety of means:

- based on CHWs' requests for information
- special site needs
- program specified needs
- in the number of electives allowed (in the case of college-based training)
- special requests by agencies carrying out training
- tailored for each group being trained, and
- college training faculty determination of training needs.

Moreover, Table 5, Column 9 indicates that, of the six states requiring that the curriculum to be certified, the means of certifying differ – as part of a college curriculum (Arizona, California-Bay Area, Connecticut CC program, Florida), by a nationally-oriented training program (Mississippi CSHO), and by a state certifying committee (Texas).

There are several means by which training is accomplished (Table 5, Column 10). These include formal training centers (Alaska, Ohio, Texas), community colleges (Arizona, California-Bay Area, Connecticut CC, Florida), free-standing, not-for-profit agencies or

organizations (Massachusetts, Indiana, Mississippi, New Mexico) and train-the-trainers process (Indiana). Columns 11-12 show more specific information about the agencies involved in the training delivery. Column 12, in particular, indicates the extent of the collaborative nature of the CHW training network. A large number of states have taken the approach of establishing strong agency-based, direct service programs and then collaborating with other organizations and agencies in both healthcare delivery and training of CHWs.

Unusual in its methods of implementing training is the Center for Sustainable Health Outreach (CSHO) in Mississippi. The CSHO (located at the University of Southern Mississippi) is a nationally recognized and nationally focused training center; it is also engaged in developing a CHW support network. CSHO works with and through community based outreach agencies and organizations around the U.S. to conduct CHW trainings and offer technical assistance. CSHO works as both a train-the-trainer program and a direct CHW training program. It conducts training on-site, usually by contracting with an agency; some training is done in collaboration with area community colleges. Training for CHWs is based on community and agency needs and preferences, as well as on the philosophy and substantive focus of the particular program for which the training is conducted. The states in which CSHO has set up one of their three CHW programs (general health promotion, cancer, and maternal and infant health) do not usually administer their own state-supported CHW training program.

Training program budget sources and sizes vary widely (Table 5 Columns 13-14). Twelve of the seventeen state programs have their own budgets; two – Alaska and Kentucky – have sizeable state and/or federal budgets. Federal funding sources include HRSA's Community Access Program (CAP), Environmental Protection Agency, and The Centers for Disease Control and Prevention (CDC). Generally, the sources of funding lie heavily in state and federal public funding; nevertheless many of the programs do generate private and local funding.

Finally, Table 5, Column 15 reveals that seven states lack systematic evaluation of the CHW training programs. Lack of funding and staff to perform pre-post training evaluations and skill assessments is the usual explanation. In addition, eight of the states having some form of evaluation indicated that evaluations are done as a part of the requirement from the funding agency/organization, or are supported by a separate external grant. No indication was given as to how may of these evaluations were summative, formative, or both.

5. Typology of CHW Certification and Training Programs

For summary purposes, we array the seventeen states with CHW certification and/or training programs across a nine-cell table (Table 6), based on the preceding discussion. Focus first on the specialized programs cell in the lower right hand corner of Table 6. Mississippi is a national training program for CHWs specializing in maternal and infant health, cancer, or general health services, but our judgment is that although it does not fit into the program typology criteria, it should be noted as a training program. The West Virginia case, called the "Lending a Hand Program," is a voluntary CHW program which is federally funded through the CDC Prevention Research Center. Located in the West Virginia University, its focus is on training outreach workers to do community development throughout the state. The program has state-wide impact and is supported by the WV Department of Health through client referrals and collaborative efforts. West Virginia may be referred to as a special case – due to the voluntary nature of the work of CHWs. West Virginia also has a Center for Sustainable Health Outreach (CSHO) based Maternal and Infant Health Outreach (MIHO) program in which they have five programs spread across six of the counties in the state. It is completely independent of governmental agencies and is its training program is accredited through Vanderbilt University. It is an example of a non-state-supported training program that has a larger-than-local reach.

Oregon is located in the bottom cell, second column, because it is a program that does not receive state or federal funds, but does receive some financial support from the county in which it is located. This program is a general skills training program for CHWs that began when a group of CHWs with Familia Sana in Portland concluded that they wanted to connect academic credit with all the training they were receiving over time. They arranged with Portland Community College to provide academic credit. In 1994 the Oregon Public Health Association founded a CHW Committee and started conversations about developing a CHW training program that would be portable, would increase CHW credibility, and would provide a professional network for CHWs. A person was hired to develop the program together with the support of the Oregon Public Health Association CHW committee. A new Center was created from this Center and now conduct training in eight counties in Oregon, with plans to expand its reach.

Table 6 Topology of Certification Programs		
	Certification Program	**Training Program**
State and/or Federally Legislated / Required by State	**TX, AK, IN**	**OH, NC, NV**
Supported by State and/or Federal (financially or in some other way)	**--**	**AZ, CA, CT, KY,** MA, **NM, VA,** FL**, WV**
Not Supported by the State/Agency based	**--**	OR, **MS**
States appearing in **BOLD**: program impact is larger than regional.		

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CHAPTER 3
Conclusions and Policy Implications

One-third of U.S. states have some form of state-sponsored training program for CHWs. Often the training is specialized in a particular form of socio-health problem. Additionally, some programs stress the development of skills specifically related to advancing CHWs' capacities and effectiveness. Three states (Alaska, Indiana and Texas) have a systematic, state-sponsored certification program. These three states, plus the fourteen states with broad-based CHW training programs afford a wealth of policy insights, strategies, and administrative models to other interested states.

Three major trends related to implementing CHW training and certification were identified in the states: 1) community college based training providing academic credit and career advancement opportunities through formal education; 2) on-the-job training to improve the capacitation of CHWs and enhance their standards of practice; and 3) certification at the state level that recognizes and legitimizes the work of CHWs, and opens up potential reimbursement opportunities for CHW services.

The ability to recruit, train, certify, and place CHWs in productive and sustainable positions is directly affected by the actions on the part of state governments, and governmental and private agencies that provide services. Agencies and provider organizations are key in determining whether to include CHWs in their organization and in considering policies that do not just 'hire' CHWs, but that are designed to improve the vertical mobility and career advancement of CHWs. Policies, for example, that enhance CHW advancement might include subsidizing school-based CHW education, providing stable jobs for CHWs, and/or supporting and finding new sources of substantial reimbursement of trained and certified CHWs.

It is entirely possible that the lack of a more extensive development of systemic training and certification programs for CHWs is a result of a too limited understanding of who they are and what they do. As the programs highlighted in this report, and the findings in a recent study on Promotora organizations (May, et.al., 2004) indicate, CHWs perform a wide range of tasks – information and referral, education, informal counseling and emotional support, advocacy, provision of some basic services, and cultural brokerage between providers and recipients. A broader, more inclusive understanding of CHWs' work would assert that a systematically trained and/or certified CHW is a potential new health professional or paraprofessional who can help improve healthcare access and utilization among underserved populations. Such paraprofessionals can play a standardized role, for example, in a screening team for diabetes or hypertension or in a mental health treatment team. The role of the lay health worker, as a member of a research and evaluation team, has also proven successful.

Further research that focuses on the evolving roles of CHWs, the impact of CHW training and certification programs on access to and utilization of services, and on community health outcomes is essential. This research must progress parallel to and integrally

related to the development of programs and policies supporting CHWs training and certification.

Policy Recommendation 1: Policies and programs for training and certification must carefully consider the definitions, roles, and purposes which CHWs are to fulfill within their sponsoring organizations. Such policies and programs should be informed by a combination of (a) the demands and opportunities within each state implementing training and certification and (b) information and experiences from other states further along in the training and/or certification process.

Programs supporting CHW training and certification must establish policy and programmatic clarity about the purposes to be fulfilled by CHW enhancement programs. This study identifies varied purposes for CHW training and certification across states including, most generally, to enhance general health education and outreach, to facilitate professional development of CHWs, to educate service agencies/staff about the target populations they are, or could be, serving to strengthen families, and (as in one state) to provide care.

These varied purposes imply a need for quite varied training and certification programs. Further, programs supporting CHW training and certification must offer clarity about the "value added" when CHWs are involved in social and health services delivery. For example, extreme sensitivity is required to charges that CHWs are lower-paid and lesser trained health workers being substituted for more costly health professionals. Such assertions impede the inclusion of CHWs and the enhancement of their professional and personal development.

Policy Recommendation 2: Advocacy and development of policies and programs for training and certification programs within states should include attention to a breadth and/or range of substantive and practice skills specializations sufficient to meet the primary expectations and obligations that they are expected to fulfill. The same consideration is essential in the creation of training curricula.

The evolution of training and certification programs suggests that initial advocacy comes from local or regional efforts of CHWs and/or CHW organizations. Development of training programs was based largely upon what CHWs and their organizations identified as being needed to help CHWs better do their job. Ultimately, program and policy development enlisted the interests and efforts of multiple political and social interest groups and advocacy groups. Among these are state and local health agencies, service provider professionals and organizations, community-based organizations and other voluntary associations and health advocacy groups, academic and education centers, and other categories of interested parties.

Different interest and advocacy groups provide very different perspectives on why training and certification should be considered. Government agencies and provider organizations, for example, tend to emphasize that training and certification affords

important access to and quality control of CHWs, improved access to and affordability of services, and new sources of reimbursement and quality of care, among other issues. Voluntary associations and community organizations emphasize more access to additional health resources, because CHWs provide additional points of access to services, with greater ease. CHWs and groups supporting their interests may identify greater recognition and legitimacy, personal and professional growth and development, and/or improved opportunities for increased pay, among others.

Finally, the evolution of training programs across the states reflects a wide variety of groups that CHWs are intended to serve. These groups might be classified by ethnicity, groups served by particular governmental programs, or particular illnesses among other categories. Expectations for the work that CHWs do will vary widely, according to the nature and needs of the groups served, the nature of the organizations in which CHWs work, and the availability of other service access points in the area. This variety suggests the following policy recommendation.

Policy Recommendation 3: CHW training and certification policy and program development and implementation should be guided by ongoing evaluation research. Policies should encourage evaluation of CHW training, certification, utilization, performance, and outcomes. In particular, evaluation should target:

- CHW training settings, methods, and results
- CHW certification methods and results
- CHW utilization
- CHW performance measured by
    - patient/client satisfaction
    - provider satisfaction
    - Job related metrics
- Patient/client outcomes (supported by CHWs)
- Cost-effectiveness analysis of CHW programs

The findings of this study should be interpreted in the context of the larger health care system and changes taking place within it. New roles for CHWs in a changing health care delivery system are emerging; accompanying these expanding roles is a need for both a standardized and, in some cases, a specialized training program and curriculum (as in the case of Alaska and Indiana). The training and certification of CHWs provides greater opportunities for reimbursement of CHW services through Medicaid and, therefore, calls for future investigation of CHW reimbursement costs, healthcare delivery cost savings made possible by CHWs, and the impact of CHWs on the quality of care delivery. Further, it is important to identify areas where CHW practices could enhance other lines of health care practices. For example, the specialized practices of CHWs in maternal and infant care, HIV/AIDS, and mental health and substance abuse areas have progressed on a parallel with, but largely separate from, program developments for disease management programs. The latter developments could well benefit from an

expanded CHW workforce that is community based and culturally aligned with disease management populations.

As the utilization of CHWs intensifies and their roles and responsibilities expand in health outreach and in health care across culturally and socio-economically hard to reach communities, more attention should be given to establishing systematic evaluation focused on their training and performance. The national survey data indicate that the majority of the CHW training and certification programs do not yet have a comprehensive evaluation component in place. The same appears to be the case for service programs relying upon CHWs. Some direct service programs gather patient outcome data and CHW utilization data. None, however, has had the resources needed to integrate and systematically analyze the data and make subsequent formative adjustments to the programs. Other training programs, such as the community college programs, only conduct course evaluation surveys.

Policy Recommendation 4: Interview results suggest that careful consideration should be given to means for making CHWs' roles sustainable. The study interviews show that a major part of the work of CHW organizational staff is to locate and secure public and private funding sources that will support the basic program and work of CHWs. As one CHW program director put it: "When I started this program, I could be involved with the CHWs in their work and in their basic training. Now, there is no way that I can do that because I am constantly looking for the next source of funding just to keep some semblance of the program going, let alone expand it." This condition is common across nearly all programs – not enough resources, time, or systemic support.

Several considerations are relevant to enhancing sustainability and moving beyond a piecemeal, fragmented approach to the work of CHWs.

1. First, development of policies and programs should address methods for *increasing the retention rates* of CHWs. As it is now, the retention rate is far from satisfactory and turnover is high. Although retention rates are crucial in any job arena, this problem is exacerbated when the employees are low-income (as is the case in most CHW programs).

2. Second, retention rates are directly a result of the degree to which there is systemic integration of CHWs
    a. as an essential, ongoing component of service provider organizational structures,
    b. into public and private policies related to access to services, and
    c. in strategies for local, regional and state provisions of social and health services; two states have begun this process of systemic inclusion of CHWs in their state policy infrastructure.

3. Third, sources and means of allocation of long-term funding need to be identified. A dominant cause of problematic retention rates is specifically tied to weaknesses in existing funding models.
4. The extent to which retention rates and sustainability are addressed in policies and programs reflects the extent to which the work of CHWs is considered effective and an asset to the delivery of social and health services in states.

Recommendation 5: Training and certification policy development must consider both the "community" dimension and the "work" dimension of CHWs' contribution to the health of multiple populations. Policies and programs must draw on the community strengths of the CHW – the attachment to community, cultural and linguistic alignment of the CHWs and the people they serve, the intricate 'local knowledge' that they embody as CHWs. At the same time, the policy must find ways to involve CHWs across geographical, social and cultural domains in order to extend their service related work and enhance both their efficiency and effectiveness.

Previous studies (e.g. May, et.al, 2004; Rosenthal, 1998) have made clear the degree to which the work of CHWs is understood by CHWs to be 'of whole cloth,' that is, their work is inclusive of the many roles they play and not just one role performed now, another tomorrow, another at another time. Many CHWs define their work as fundamentally connected to the "home" communities in which they serve. State policies and programs that focus on how to train CHWs in service-related skills that are required to integrate CHWs into the service provision infrastructure must carefully consider the community dimension of the CHW.

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Finally, central to the continued development of CHW training and certification is an improved system of communication and collaboration. Such improvements should occur within policy and program development within states and agencies. Also, such communication and collaboration is needed across states in advancing the effective development and utilization of CHWs. The information included in this report is intended to facilitate the communication and collaboration process.

CHAPTER 4
Model Programs: Certification

This chapter contains comprehensive profiles of the three certification programs identified in this study.

IV.1 MODEL PROGRAMS: CERTIFICATION

A. TEXAS

Texas is the first state in the U.S. to legislate a state-wide mandatory Promotore(a)/CHW training and certification program.

Program Name: Promotore(a)/CHW Training and Certification Program.
Crucial to the ultimate creation of the Texas training and certification program was grassroots advocacy, particularly from CHWs and their organizations on the Texas-Mexico border, but other places in the state as well. The major grassroots activity and concentration of Promotores(as) were on the border. One of the major grassroots Promotora organizations was in the Lower Rio Grande Valley (LRGV) – the South Texas Promotora Association (STPA). The STPA played a significant role in bringing training and certification to the attention of these legislators and in sustaining that interest once it was kindled. Complementing the grassroots activity was a small but active group of state legislators representing constituencies on the Texas-Mexico border. These legislators early on were listening to the grassroots advocates and, in fact, were included in much of the grassroots activity.

Legislative Foundation. Three pieces of legislation form the foundation of the Texas program: HB 1864, SB 751 and HB 1051.

HB 1864

- HB 1864, the first legislation passed in May, 1999, did not literally create the training and certification program, but laid the groundwork by creating a committee – the Promotora Program Development Committee (PPDC). Its purpose was to transform the legislation into a working set of rules, guidelines and policies. Specifically it stated: "The department [Texas Department of Health, hereafter 'the department'] shall establish the committee to study the development of a framework for a promotora development program and to advise the department, the governor, and the legislature regarding its findings and recommendations."

The charge to the PPDC included seven tasks:

> (1) Reviewing and assessing Promotora programs currently in operation around the state;
> (2) Studying the feasibility of establishing a standardized curriculum for promotores(as);

> (3) Studying the options for certification of Promotores(as) and the settings in which certification may be appropriate;
> (4) Assessing available methods to evaluate the success of Promotora programs;
> (5) Creating, overseeing, and advising local pilot projects established under this article, subject to the availability of appropriations that may be used for this purpose; and
> (6) Evaluating the feasibility of seeking a federal waiver so that Promotora services may be included as a reimbursable service provided under the state Medicaid program.
> (7) In addition to its other duties, the committee shall identify, and develop a strategic plan to address the barriers encountered by recipients of benefits under the state Medicaid program in accessing prenatal and neonatal health care services.

The last two tasks belie the state's strong desire to find ways in which it can draw on Medicaid as one of the primary sources of reimbursement for Promotores(as)/CHWs.

SB 751

The second piece of legislation – SB 751, passed in May, 2001 - added 'guts' to HB 1864 and the work of the PPDC. Shepherded through the legislature by Senator Shapleigh (El Paso), the bill sought to impress upon the state's health and human services agencies the importance of certification and training. SB 751 amended the Health and Safety Code to read that "The Health and Human Services Commission *shall require health human services agencies to use certified promotoras to the extent possible in health outreach and education programs for recipients of medical assistance under Chapter 32, Human Resources Code*."

HB 1051

This bill – effective in September, 2001 – moved further in facilitating the certification of Promotores(as)/CHWs and making that certification further required by amending the original legislation to read:

> (b) *Participation in a training and education program* established under this section *is voluntary for a promotora or community health worker who provides services without receiving any compensation and mandatory for a promotora or community health worker who provides services for compensation*. The board may adopt rules to exempt a promotore(a) or community health worker from mandatory training who has served for three or more years or who has 1,000 or more hours of experience. (HB 1051:2-8 to 2-15)

<u>Promotora Program Development Committee</u>

The PPDC held its first meeting in October, 1999 and met monthly (on average) through April, 2002. The PPDC formed subcommittees, each of which addressed at least one of

the specified tasks in the legislation: curriculum development, definitions, evaluation, development, identifying pilot projects, and prenatal and neonatal health care services. Two final documents were produced:

1. "Feasibility of Voluntary Training and Certification of Promotores(as) or Community Health Workers,"
2. "Barriers Encountered by Medicaid Recipients in Assessing Prenatal and Neonatal Health Care Services."

In its "Feasibility of Voluntary Training…," the PPDC set forth fifteen (15) recommendations subsumed under its six charges from the Governor:

Charge 1: Review and assess Promotore(a) or CHW programs currently in operation around the state.

a. Recommendation: further assess existing and emerging CHW programs beyond those initially identified through the PPDC.
b. Recommendation: initiate and coordinate local, regional and statewide leadership opportunities for CHWs and Promotore(a) or CHW programs to share the "best practices."

Charge 2: Study the feasibility of establishing a standardized curriculum for Promotores(as) or CHWs.

c. Recommendation: require the TDH to establish Promotore(a) or CHW curriculum guidelines based upon a minimum number of course hours to ensure all certified CHWs practicing in Texas have mastered a core set of competencies as per Texas Board of Health Rules.
d. Recommendation: require TDH to administer a certification program, which operates in accordance with the Rules Regarding Training and Certification of Promotores(as) or CHWs as adopted by the Texas Board of Health.
e. Recommendation: require the TDH to gather feedback from instructors, sponsoring institutions and training programs regarding the scope, relevance and utility of the curriculum framework; collect data at the conclusion of the first year in which the curriculum is used; and report outcomes to the Promotore(a) or CHW Training and Certification Advisory Committee.
f. Recommendation: the 77th Texas Legislature should fund the TDH exceptional item request concerning the administration of the Promotore(a) or CHW Training and Certification program and the designation of the coordinating office to support the Promotore(a) or CHW Training and Certification Advisory Committee and the initiatives as set forth in these recommendations.

Charge 3: Study the options for certification of Promotores(as) or CHWs and the setting in which certification may be appropriate.

g. Recommendation: fully implement the Rules Regarding Training and Certification of Promotores(as) or CHWs adopted by the Texas Board of Health and supported by the PPDC in July, 2000.
h. Recommendation: promote training and certification to potential employers of Promotores(as) or CHWs, health care professionals and representatives of health and human services agencies.

Charge 4: Assess available methods to evaluate the success of the Promotore(a) and CHW programs.

i. Recommendation: require Promotore(a) or CHW training programs to implement an evaluation component consistent with the concepts set forth in the *CHW Evaluation Tool Kit* developed by the National Community Health Advisor Research Project.
j. Recommendation: develop effective evaluation tools through collaboration with operating CHW programs.
k. Recommendation: recruit college and university students who are willing and able to volunteer their time to assist with creating evaluation tools for operating CHW programs.
l. Recommendation: modify existing tools to gather and measure program specific data for operating CHW programs.

Charge 5: Create, oversee, and advise local pilot projects established under this article, subject to the availability of appropriations that may be used for this purpose.

m. Recommendation: administer neighborhood-based pilot projects with funding from TDH programs and other state partners.
n. Recommendation: award funds to start-up and continuation projects based upon the selected program's ability to perform according to the requirements identified by the PPDC.

Charge 6: Evaluate the feasibility of making a federal waiver so that Promotore(a) or CHW services may be included as a reimbursable service provided under the state Medicaid program.

o. Recommendation: explore and investigate all practical sources of funding within the state that could be used to support community health worker services.

The Training and Certification Advisory Committee (TCAC)

The third major entity in the creation and development of the training and certification program is the Promotore(a)/CHW Training and Certification Advisory Committee (TCAC). In its Rule 146.2, the PPDC directed that: "An advisory committee shall be appointed under and governed by this section. (1) The name of the committee shall be the Promotore(a) or Community Health Worker Training and Certification Advisory Committee… The purpose of the committee is to review applications and to recommend

to the Department qualifying applicants as sponsoring institutions, training instructors or as Promotores(as) or CHWs" (p. 24 of "Feasibility Report…"). The TCAC's powers are advisory through the Texas Department of Health (TDH) to the Texas Board of Health, which has oversight responsibilities. TCAC's tasks are (1) to advise the Board of Health concerning rules to implement standards adopted under Chapter 46 relating to the training and regulation of persons working as Promotores(as) or CHWs, and (2) recommend to TDH sponsoring institutions or training programs, instructors and Promotores(as) or CHWs who are qualified for certification, plus (3) any other tasks that the Board of Health may ask it to do.

Organizational Structure and Administration

A. Administration and Oversight. The Promotor(a)/CHW Training and Certification (PTC) program is located administratively within the Regional and Local Services, which in turn is located within the Texas Department of State Health Services. PTC has one full-time Program Administrator and one full time public health technician.

B. Funding. The PTC does not have a budget of its own; rather the expenses incurred are absorbed into the budget of its parent, DSHS. Although the PPDC recommended that a Training and Certification Advisory Committee (TCAC) be established, funds were not appropriated to support the program as a separate entity. Starting November of 2003, however, appropriations were made to reimburse the four certified CHWs serving on the CAC to cover travel expenses.

C. Rules and Regulations. PPDC promulgated a set of Rules and Regulations regarding the training and certification of Promotores(as) or CHWs. Sixteen pages of rules and regulations pertain to: (a) creation of a training and certification advisory committee, (b) application requirements and procedures for certification, (c) eligibility for training and certification, (d) standards for training curricula, (e) issuing certification certificates and renewals, and (f) continuing education requirements.

D. Training Design and Curriculum

a. Training

The PPDC created a multi-dimensional array of certifications, each necessary before a full certification program can be established. Certification is necessary for Promotores(as)/CHWs, certification training instructors, and institutions intending to offer training. Requirements for certification are as follows.

- For Promotores(as) or CHWs certification, the primary requirement is that they have completed an approved competency-based training, that they have not engaged in unethical conduct and do not have an incapacity that would prevent them from practicing Promotore(a) or CHW services with reasonable skill, competence and safety. It is also the case that Promotores(as) who had 1000 or

more hours of practice between 1997 and 2004 would be 'grandmothered' into certification.

- For instructor certification, the primary requirement is "the appropriate training or experience" to qualify as an instructor, has not engaged in unprofessional conduct, and does not have an incapacity that would prevent them carrying out their responsibilities. The TCAC has devoted concentrated attention to this topic and it is important to note the importance of experience.

- For institutional and training program certification, current and previous experience with training and sponsoring training for Promotores(as) or CHWs is a primary requirement. In addition, an institution must show curricula and collateral materials, educational and training qualifications of staff, and specified workplace assurances.

b. Curriculum

Development of a training curriculum/training curricula lies at the heart of quality certification. Consequently, the PPDC set forth these broad and carefully stated guidelines for curriculum development:

- Assure that the eight core skill and knowledge competencies, identified in the *National Community Health Advisor Study*, June 1998 for Promotores(as) or CHWs, including communication, interpersonal skills, service coordination, capacity-building, advocacy, teaching and organizational skills and knowledge base are addressed;
- Include at a minimum 20 clock hours of knowledge and skill-building per core competency for Promotores(as) or CHWs and include at a minimum 20 clock hours for instructor training in each of the core competencies that affect Promotores(as) or CHWs;
- Evaluate and document the acquisition of knowledge and mastery of skills by the individual and the success of the training program according to the performance measures framework established within the *National Community Health Advisor Study*, June 1998;
- Be approved by the Department and offered within the geographic limits of the State of Texas;
- Be submitted to the Department at least ten weeks prior to the starting date of the program to be offered by a sponsoring institution;
- Be submitted to the Department along with supporting materials in a three-ring binder with all pages clearly legible and consecutively numbered with a table of contents and divided with tabs identified to correspond to the core competencies, including evaluation materials and other programmatic information and assurances required within this section;
- Provide a list of approved instructors, facilities and locations for the training program;

- Provide a yearly calendar of scheduled training events by dates, times and locations;
- Identify the method for recruiting persons to the program;
- Report the names of individuals to the Department who have successfully completed the training program within 30 days of program completion;
- Maintain an accurate record of each person's attendance and participation for not less than five years;
- Be live and interactive and directed by an approved instructor or delivered by an approved instructor through interactive technology in real time; and
- Focus on the eight core roles of the Promotore(a) or CHW as noted in the definition of Promotore(a) or CHW.

The PPDC promulgated a curriculum framework, serving as

> "a standardized guideline of what is considered the basis for an approved curriculum to train Promotores(as) or CHWs. Recognizing that a standardized curriculum may not be the one size that fits all given the diversity and location of sponsoring institutions or training programs in the state of Texas, the Promotora Program Development Committee (PPDC) established minimum standard learner-centered objectives for each competency. By doing so, the PPDC can better assure uniformity and transferability of knowledge and skills regardless of where the Promotor(a) or CHW practices." ("Report on the Feasibility…")

This curriculum framework allows for certification of curricula that have basic core competencies, but with room for *tailoring* that reflects local and regional needs, cultural competencies, and service specialty requirements. Discussions in the PPDC around developing a training curriculum were intense and informative regarding the philosophies of what training of Promotores(as)/CHWs is and how it should be carried out. The central questions were: "Who should conduct the training, using what curriculum?" At the heart of this discussion were really two issues: (a) what individuals and what sponsoring institutions should be certified to conduct training, and (b) what curriculum should be used and who should develop it? Should it be one standardized curriculum, used by all trainers and sponsoring institutions, or multiple curricula?

Another issue concerned the *amount of training* that should be required. The PPDC's research on curricula revealed a wide range of hours contained in the curricula, from 18 hours to 800 hours. One curriculum – set in a community college – required two years and 64 academic credits, excessive in some TCAC members' thinking. A partial solution chosen by the TCAC was logical and practical. The PPDC recommended in its final report that whatever curriculum was eventually produced, it should incorporate a set of eight skill-sets put forward by a national study entitled, "The Final Report of the Community Health Advisors Study" (1998). That study identified eight skill-sets essential to assure the efficacy of Community Health Advisors' work. The PPDC made these eight skill-sets the heart of its curriculum design. TCAC's solution is tantamount to

creating a "core curriculum" for Texas' Promotore(a)/CHW training, because these eight skill-sets do not require teaching a specialized, content-specific knowledge to fit every local or regional need; rather the PPDC curriculum guidelines emphasize process-based professional skills needed to work effectively in any community.

The PPDC core curriculum solution also helped answer the question "Who should do the training and where it should be done?" Making the curriculum core the eight skill sets makes it more likely that the training can be conducted in diverse locations, by diverse trainers, and diverse institutions. The specialized, content-specific training can then be done by specialized trainers and institutions serving the resources and needs of the specific geographic and ethnic location.

To assure that the training is carried out according to their design guidelines, the PPDC established the three-dimensional certification program – for CHWs, trainers and for institutions. The TCAC has authority to review and recommend for certification (to the DSHS) what trainers and sponsoring institutions, as well as what curricula, should be certified. In each sponsoring institution's application for certification, it must provide a curriculum design that it proposes to use, showing how the core skill-sets, as well as the content-specific training, will be taught. This allows, therefore, for a wide range of institutions to be certified to train – from a local Promotora(e)/CHW organization with a track record of community-based work, to a community college and its educational training experts. The key is, of course, that they have a track record and are able to show convincingly to the TCAC that they have the resources and community sensitivity needed to carry out what it proposes.

Evaluation

The TCAC has worked with DSHS staff to develop an evaluation tool and how it will be conducted. In 2003 and 2004, the TCAC priorities focused on creating and shaping the criteria, applications and processes required for Promotore(a)/CHW, trainer, and sponsoring institution certification.

While none of the legislative bills – HB 1864, SB 751, HB 1051 – specifically addressed evaluation of the training and certification program, the PPDC did, however, address evaluation on two fronts. First, Charge 2 to the PPDC required that it study the feasibility of establishing a standardized curriculum. PPDC's recommendation was to: "Require the DSHS to gather feedback from instructors, sponsoring institutions and training programs regarding the scope, relevance and utility of the curriculum framework; collect data at the conclusion of the first year in which the curriculum is used; and report outcomes to the Promotore(a) or CHW Training and Certification Advisory Committee." (PPDC, Feasibility…., p. 5).

In addition, PPDC addressed the matter of evaluating the whole of the training and certification program – its infrastructure, processes and outcomes – in response to Charge 4, which was to "Assess available methods to evaluate the success of Promotore(a) or CHW programs." The PPDC recommended that the

DSHS should:

- Require Promotore(a) or CHW training programs to implement an evaluation component consistent with the concepts set forth in the *CHW Evaluation Tool Kit* developed by the National Community Health Advisor Research Project. (An evaluation plan is now in place for individuals and training sites.)
- Develop effective evaluation tools through collaboration with operating CHW programs.
- Recruit college and university students who are willing and able to volunteer their time to assist with creating evaluation tools for operating CHW programs. (Currently, an intern is working in Public Health Statistics, working on further development of the evaluation plan and forms.)
- Modify existing tools to gather and measure program-specific data for operating CHW programs.[5]

Issues Important to Policy Considerations

Several issues surfaced as the Texas certification and training program was developed, all of which have potential policy implications. A brief description of each is presented here.

a. Changing the Nature of Promotores(as)/CHWs

In the words of one respondent:

> So – the goals and objectives of the certification program for Promotoras. You know, one of the things that I felt and still feel is that it's like a double-edged sword, because I believe that the reason why promotoras' work [is successful] is because they are so non-traditional. And the efforts to build capacity and skills of the promotoras are so non-traditional. The training is non-traditional. And so, someone got a hold of that amazing thing and now wants to put it in this box – like, let's certify this group of people so that they can continue to do their work. But we haven't had enough discussion about what happens to us. And I speak for myself. What happens to us when we become licensed or certified? We have to now become a part of the traditional system, that looks at our credentials and we have to go to a certain type of training and we have to have this certain level of language and we have to have all these things. So we now become a part of this box. And then, when we come out, we are still being expected to be non-traditional? (97:24-53)

b. Intimidation

The issue is framed in this way. Most of the Promotoras(es)/CHWs have had limited experience with a professional world other than their experience with the professionals to whom they go if they need something. Professionals are viewed as highly knowledgeable

[5] Because the Texas certification program is continually evolving, you are directed to www.tdh.state.tx.us/ophp/chw for the latest information.

and authoritative, with a lot of education, and a great deal of power. It is a world apart from the world of most Promotoras(es)/CHWs. Thus, when presented with the idea of becoming certified and having to meet certain training criteria, certification begins to look formidable.

c. The Content of Training Curriculum and Location of Training

The issue of who will do the training required for certification, where it will be done, and what the content will be was a concern. With regard to who would do the training, the issue has two dimensions – *who*, meaning what criteria should be used in certifying institutions that will carry out training, and *who*, meaning what criteria should be used in certifying trainers. In certifying institutions, should it be professional organizations who conduct training as one of their primary functions, community colleges and their faculty, or Promotora(e)/CHW programs (who have done their own training for years)? Certification of individual trainers presented a major question – should Promotoras(es)/CHWs with years of experience be the trainers, or should educated individuals, who know curriculum, how to write curricula, and how to implement training serve in this role?

d. Competition with other Professional Groups

There is also the concern that certifying Promotoras(es)/CHWs will gain outside resistance because they threaten some other professionals, e.g. social workers and nurses. As one focus group discussion put it: "Their biggest issue was an impact from the health care district when we came in, because the social workers thought we were stepping on their toes. You know, how are these non-degreed personnel or people know more than we know?"

e. Sustainability

A major concern is with how the certification program will sustain itself as a state-wide, state-supported program. In the creation of the legislation, there was no direct funding appropriation provided. Further, it is important to distinguish the question of sustainability of the training and certification program (TCAC and its staff) and the question of how the work of promotoras(es)/CHWs will be sustained. The legislature took a direct approach to the sustainability of certified Promotores(as)/CHWs by asking in HB 1864 for a study of what barriers might exist for accessing Medicaid resources and how those could be surmounted. In effect, these two questions of sustainability are tied together. Even though it may be possible to access Medicaid funds to support financially the work of certified Promotores(as)/CHWs, if funding to sustain the TCAC is not forthcoming, or the training and certification program's infrastructure is removed in some way, there will be no certified Promotores(as)/CHWs to receive Medicaid funding.

f. Stratification and Status Among Promotores(as)/CHWs

One respondent (a program director) raised a concern that those who are certified will be seen as, and may actually see themselves as, different, creating conflict within the organization.

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B. ALASKA

Program Name. Community Health Aide Program (CHAP)/Dental Health Aide Program (DHAP). Amidst a background of major geographical separation and maldistribution of health workers, Alaska's tribal health care system has developed a unique program to address the problem of ensuring access to primary health services in its most remote, or frontier communities serving Alaska Natives. It is called the Community Health Aide Program (CHAP), now celebrating nearly 35 years in existence. It emerged from a 1950s program of the Indian Health Service (IHS) that successfully employed the use of local, native village workers to distribute medications to combat the tuberculosis epidemic. The successful demonstration of the use of local, indigenous peoples as health care providers in the village directly led to the eventual formation of the CHAP concept and formalization of the CHAP program. It received its formal recognition and federal funding in 1968.

CHWs. CHWs, in this program, are called community health aides/practitioners (CHA/Ps). The program trains local residents – mostly Alaska Native women – to act as non-physician primary care providers in the remote communities where they reside. By training local residents, the issue of recruitment to practice in frontier communities that plagues many other health professions, becomes less of an issue. Further, local residents are more likely to speak the native language, provide culturally sensitive services, and be considered acceptable by the local community. CHA/Ps and Dental Health Aides (DHAs) are often the sole source of medical and dental care in their communities and have become the backbone of Alaska's rural and remote health system for Alaska Native people.

CHW Roles. CHA/Ps serve slightly different roles in different villages, depending on the availablity of other medical professionals in the community, and policies of individual regional tribal health centers. In many Alaskan communities, the CHA/P plays a number of roles that in urban communities would be divided among a variety of medical personnel -- combining the roles of physician assistant, public health nurse, health educator, clinic administrator, mental health counselor, nutrition aide, and even travel agent since the CHA/P helps coordinate travel for patients requiring a higher level of medical care in another community. CHA/Ps are recognized as having a distinctive role as the provider of preventive, acute, chronic, and emergency care services for both children and adults. The exact role played by each CHA/P depends on the village – both in terms of the local needs, local resources, and the competency of the individual CHA/P.

CHA/Ps are in charge of maintaining regular clinic hours, while providing on-call and emergency services 24 hours a day, 7 days a week, 365 days a year. CHA/Ps are trained in patient assessment, and with the aide of remotely located IHS/tribal physicians and standing orders found in the Community Health Aide Manual (CHAM), they develop and implement patient care plans.

Training Program. There are two parts to the CHAP and its training program. The first is training related to preparing CHA/Ps to deliver some basic health care, along with the personal and professional skills needed to do that. The second is training to prepare dental health aides (DHA) in the Dental Health Aide Program (DHAP) to deliver basic oral health care.

CHA/P training sessions are specifically designed to accommodate the unique needs of health aides. The training sessions are designed to be fairly short in duration. Each session lasts between 3-4 weeks with the health aides returning to their village to practice in limited scopes between sessions, and health aides assume responsibilities in their positions prior to the completion of their basic training program. This distinctive feature of the training program serves several purposes. Most health aides have family commitments that make it difficult to leave the village for long periods of times. Also, returning to the village allows health aides to practice their new skills between training sessions and provide necessary services in the community that would otherwise be unavailable. Finally, the training scheme helps to minimize “brain drain” where indigenous people are sent to urban areas for training and never return to their community to practice.

A second part of the training program was added after 1999 when the Alaska program added a Dental Health Aide Program (DHAP). Just as the impetus for the original CHAP program was the dearth of primary care providers in frontier Alaska, so the DHAP emerged due to the high rate of dental disease and scarcity of providers in rural Alaska. Out of the State’s 27 boroughs, 17 qualify as Dental Health Professional Shortage Areas (HPSAs). The idea, using the CHAP model, first appeared during a 1999 statewide meeting of dental chiefs within the Alaska Native Health System. It was included as one of a series of approaches being recommended for improving dental access for Alaska Natives statewide and won statewide approval by the dental chiefs as a model to pursue.

Using grant monies from the IHS to support coordination, training, and curriculum development, the program has quickly moved from a suggestion to reality. The effort has now gained the financial support of a number of local and national philanthropic foundations.

The DHAP program is underwritten by the same enabling federal legislation as for the CHAP, and it follows a similar model in terms of care delivery, liability, certification, supervision, and oversight. DHA/Ps are hired and supervised by a local regional native health corporation and receive training and certification to practice at a given level.

Training Curricula. The CHAP utilizes a series of four (4) training centers across the state. Each of these centers uses a common curriculum. Further, all training involves four intensive, 3-4 week sessions. Each time a CHA/P completes one of the four sessions, s/he receives a certificate for completing that set of skills and knowledge. It is only after completing the full set of four training sessions that the CHA/P can be certified as a fully trained CHA/P.

For varieties of reasons, not all CHA/Ps who start the training will complete all four sessions. Staff (both local and at the training centers) work with each CHA/P to make it possible to complete all four sessions and to help them see the value in doing so. However, often personal and other issues make it extremely difficult to complete the training.

While there is a common curriculum, it also allows for individuals from different locations to introduce specific, localized issues/questions into the training. The instructors will make every effort to assure that these individual issues/questions are addressed. In addition, there is a difference in languages and cultures in different centers. These differences are also taken into consideration.

CHAP Curriculum Content

Training methods for CHA/Ps include a combination of didactic and clinical methods with instructors employing a wide variety of approaches including classroom lectures, skills practice sessions, and practical clinical experience. Training sessions are tightly organized and scheduled to oblige the large curriculum that CHA/Ps must learn in a relatively short period of time to perform their duties. CHA/Ps receive training in a wide field of primary and emergency care in a very short period (currently approximately 520 hours). Comparatively, paramedics receive training in a more narrow clinical scope of emergency care over the course of 1000 hours.

While the training centers have flexibility in how they train students, the actual curriculum is standardized statewide. The specifics of curriculum taught in each training session have changed through the years and are documented in the literature based on what was accurate for the time of publication. Current training curriculum is summarized in Table 7.

Table 7: CHAP Training Curriculum Summary			
Session	**Body of Knowledge**	**Learning Goal**	**Duration**
Session I	Basics of problem-oriented visit Vital signs Lab procedures Medicine skills Some body systems Use of the CHAM Clinics emphasize acute care	Familiarity and awareness	4 weeks + 20 patient encounters after session
Session II	Remainder of body systems Additional lab skills Charting and reporting skills Dental care Mental health	Performing skills and understanding concepts with guidance of an instructor	4 weeks + 200 hours/60 patient encounters
Session III	Maternal and Child Health Substance abuse	Independent performance of skills and understanding of concepts	3 weeks + 200 hours/60 patient encounters
Session IV	All body systems reviewed Elder care and chronic care Environmental/injury control	Independent performance of skills and understanding of concepts	4 weeks + 200 hours/60 patient encounters

Health aides are taught to distinguish between routine and minor disease and those that are more complex requiring follow-up from a higher-level provider. They are also trained to treat routine and minor illnesses, and to stabilize patients with complex needs while preparing them for referral and/or transfer to a higher level of care. College credit for training courses is provided through the University of Alaska for those wishing to pursue a degree, with the entire basic training program usually requiring 2-3 years to complete.

DHAP Curriculum Content

Training regimens for DHAs were developed by a dental academic review committee for each level of dental health aide and standards are in place to govern qualifications and scope of work at each practice level. There are currently 6 levels of dental health aides, each with their own scope of work and standards. The levels of dental health aides, their scopes of work, and the current training and deployment status of each are summarized in Table 8:

TABLE 8: DHA Scope of Work and Training Status	
Level and Title	**Scope of Work**
PDHA I – Primary Dental Health Aide I	A PDHA-1 provides primary preventive services and is village based. These services include: toothbrush prophylaxis, oral hygiene instruction, dietary education, oral cancer screening, and topical fluoride applications.
PDHA II – Primary Dental Health Aide II	A PDHA-II may provide all the services of a PDHA-1 and may also provide sealants, dental prophylaxis, oral x-rays, and atraumatic restorative treatment. They also perform dental triage and manage dental emergencies in the village.
EFDHA I – Expanded Functions Dental Health Aide I	Dental Health Aides with this training function under direct or indirect supervision of the dentist or DHT in the clinic. This training enables them to provide basic restorations after the dentist/DHT has prepared the teeth; may also perform dental prophylaxis.
EFDHA II – Expanded Functions Dental Health Aide II	Dental Health Aides with this training are able to perform complex restorations.
DHAH – Dental Health Aide Hygienist	These are Dental Health Aides who enter the program with training from a recognized hygiene program. This training makes it possible for them to perform services under general supervision as opposed to direct/indirect supervision working in the same office with the dentist.
Dental Health Aide Therapist	Mid-level provider who can provide all of the services of PDHAs and DHAHs and can provide local anesthetic and restore and extract teeth under general supervision.

Although the dental health aide program has a different clinical focus from the CHAP program, the two parts of the Alaska program are expected to intersect in many ways. In some regions, the CHAP Coordinator/Instructor or Supervisor/Instructor (CI/SI) will provide support and oversight of the DHAs in addition to the CHA/Ps. Standards for the two programs have been integrated, and one certification board governs both types of health aides. Importantly, CHA/Ps will also continue to receive training in dental care and provide services to patients with emergency dental issues in villages without higher-level dental health aides. For instance, a patient in a village who has a dental abscess requiring emergency evacuation would likely utilize the village CHA/P unless there is an appropriately trained local DHA.

The Certification Program. Although CHA/Ps have always had a certification process, that process has changed substantially. Previously, CHA/Ps were considered "certified" after they had completed all four sessions of basic training, a 30-week minimum preceptorship of supervised clinical experience, completion of a critical skills list, completion of both a written and practical exam, documentation of the completion of at least 15 patient encounters as the primary provider, and an evaluation of the CHA/P's clinical performance by an approved evaluator. This process is still in place, but is now referred to as credentialing rather than certification. This credential is bestowed by the CHA/P training centers to qualified health aides and must be renewed every six years.

The new CHA/P certification process is an additional layer of quality assurance that does not decrease any of the earlier CHA/P requirements. The new system developed in 1998 as tribal management under the "Indian Self-Determination and Education Act" (Public Law 93-638) progressed. One impact of tribal management was the administrative decentralization of the CHAP program away from the IHS. The creation of the certification board and the concept of ongoing certification were developed to provide a form of centralized quality assurance. Under the new system, a CHA/P may pursue certification along each step of the training process instead of needing to wait until after the completion of all basic training requirements. CHA/Ps are eligible to begin the certification process after completing Session 1 of their training course. The CHA/P and her employer may apply to the CHA/P Certification Board, pay a fee, and document that the applicant meets all standards for certification at the requested level. As the CHA/P progresses through the training process, she may upgrade her certification at no additional fee, at which time she will be certified to the higher level of practice. Certification lasts for two years, after which the health aide must be re-certified. To be re-certified the CHA/P must have at least 48 hours of continuing education credits over the past two years.

This process for CHA/P certification is unique. Most professionals are overseen by a state licensing board. For most health professions the applicant completes their schooling, takes a test, submits paperwork, is approved by a State Board, and secures a job. The CHAP program takes the reverse approach, which corresponds with the unique hiring and training processes employed by the program. CHA/Ps are hired for the position first, put on the payroll, and begin working in their position before training begins. They are then trained while continuing to do their job and certified at each stage along their training by a Federal Board. There is no state licensing required for CHA/Ps to practice.

Administration. The primary oversight agency is the Indian Health Service through the Alaska Native Health System, which consists of the Native Health Corporations.

The CHAP Program. This certification process is managed and overseen by a Certification Board that was established in 1998 under the authority of 25 U.S.C. Section 1616, and directives and circulars of the US Department of Health and Human Services, Indian Health Service and the Alaska Area Native Health Service. It is a federal board comprised of 11 permanent members representing different aspects of the statewide CHAP. The board meets approximately three times a year to review applications with the purpose to assure that each applicant is in compliance with program standards for the level at which the CHA/P is applying.

The regional corporation hires the CHA/Ps, pays their salaries and benefits, helps assure that CHA/Ps receive training and support, and in many cases provides operation and maintenance funds for the village clinics. They also employ the CHA/P Instructor/Supervisors, who provide daily on-going supervision of CHA/Ps, and the physicians who exercise medical control and clinical supervision of CHA/Ps. Many health corporations also manage the regional Native hospitals under the authority of

ISDEAA. Because each regional corporation administers their own CHAP program, there are some regional differences in CHA/P salaries, hiring procedures, and medical supervision.

The DHAP. For the Dental Health Aide Program, a dental academic review committee (DARC) has developed training regimens for each level of dental health aide and standards are in place to govern qualifications and scope of work at each practice level. A dental provider has been added to the CHAP Certification Board allowing dental health aides to be certified by the same body as CHA/Ps. A remote dentist located in a hub community will clinically supervise village-based dental health aides. Some dental health aides will also practice in the regional hub facilities with dental support provided locally. Like CHA/Ps, certified dental health aides have been approved for reimbursement for eligible services by Alaska's Medicaid program and are covered for medical liability under the umbrella of the Federal Tort Claims Act (FTCA).

Supervision. Medical supervision is a particularly important element of the program. Physicians employed by the IHS or a tribal organization provide medical supervision of CHA/Ps and have the legal responsibility for care provided by CHA/Ps under their supervision. The physicians are generally physically located in a "hub" rural community and have telephone contact with CHA/Ps on a systematic, scheduled basis –usually daily. Physicians advise CHA/Ps on patient care plans and determine which patients should be transferred to the regional hub for additional diagnostic treatment. The importance of this physician link cannot be overemphasized. CHA/Ps begin treating patients at a certain level after completing their first 4-week training course and physician involvement is critical to quality assurance and helping the newly trained CHA/P improve her skills and gain confidence. The technical infrastructure allowing for CHA/Ps to maintain close communication ties to remotely located physicians has improved dramatically since the program's early inception, when unreliable radio traffic was the only technology for communication.

Medical supervision is slightly different between physicians and tribal organizations in different regions, although the CHA/P's relationship with a physician forms the crux of the CHA/P's authority to practice. Some tribal organizations require CHA/Ps to gain the authorization of a physician before administering any medications. Other regional organizations and their physicians provide greater leeway to CHA/Ps to treat common illnesses using standing orders under protocols provided in the CHAM. The CHAM is an important resource for CHA/Ps in the field, serving as a combination of training manual, standing orders (if authorized by a physician), practical reference guide, and protocols. The CHAM was developed specifically to meet the needs of the working CHA/P in the village and an effort is made for it to be written at a sixth grade reading level.

DHAP supervision. In addition to medical supervision, each health aide is also provided with a coordinator/instructor or supervisor/instructor (CI/SI) who provides day-to-day supervision and support to health aides in his or her region. A midlevel provider generally occupies this position, although some regional health corporations have found

that promoting CHA/Ps into this position brings unique and valuable characteristics to the role. The CI/SI makes fairly frequent, scheduled visits to each village to observe the CHA/P in the field to provide field instruction to help them improve their clinical skills and confidence. They also act as a liaison and advocate for the CHA/P within the village or at the regional corporation headquarters as well as provide ongoing emotional support to CHA/Ps. The State of Alaska provides funding to support additional personnel for this function.

A remote dentist located in a hub community will clinically supervise village-based dental health aides. Some dental health aides will also practice in the regional hub facilities with dental support provided locally. Like CHA/Ps, certified dental health aides have been approved for reimbursement for eligible services by Alaska's Medicaid program and are covered for medical liability under the umbrella of the Federal Tort Claims Act (FTCA).

Working as a Partnership. The Alaska program is a collaborative effort between the federal government through the IHS, local regional Native health corporations, individual villages, and the State of Alaska – with each partner playing an important and crucial role in the program's success. During the 1990's, IHS transferred Alaska's health programs to local regional Native health corporations, who manage their own tribal programs under the provisions of the ISDEAA. The IHS now acts more as a contracting agent than as a direct provider of care. However, because budget and funding comes through the IHS, they still remain an important player in the provision of care of Alaska Natives, including the CHAP program.

The regional Native health corporations use monies coming through IHS contracts to manage their own local CHAP programs, including the duties of hiring, firing, and supervising CHA/Ps in their region.

Local villages and village councils also play an important role in the CHAP program. In an effort to make sure that the CHA/P is acceptable to the village where they will practice, the native village council selects the CHA/P that is to be hired and working locally. In addition, some villages have elected to administer their own CHAP programs, rather than having them administered by their regional health corporation. In these cases, the village is in charge of hiring, firing, supervision, and funding for the local health clinic.

Geographic Reach. The CHAP program exists in 178 villages; the DHAP program has the potential to go into the 178 villages, plus the hub communities. It is statewide.

Budget and Funding. The CHAP and DHAP each have their own budget of approximately $54 million; $30 million is from the state, the remainder from IHS. DHAP operates on grant money from IHS, Medicaid. The IHS plays a significant role both by funding the CHAP program, and by funding the Native health system in Alaska that provides the referral system and medical supervision essential for the CHA/Ps to do their work.

Evaluation. The General Accounting Office notes that there are no rigorous studies measuring the overall effect of the program. However, available data indicates that CHA/Ps are accepted by the communities they serve and playing a role in the improvement of the health status of rural Alaska Natives.

Overall health for Alaska Natives has improved dramatically since the inception of the CHAP program. The neonatal infant mortality rate has decreased by 27% in the last decade, while the accidental death rate decreased by 40%. In addition, there are reportedly significant improvements in infant mortality, life expectancy, hospitalization rates, and hospital length of stay. These health improvements are likely due to a number of factors, including improved housing and sanitation in the villages that has occurred over the last several decades, in addition to the introduction of local health providers through the CHAP program.

The few studies that have looked at specific, focused health outcomes from CHA/P interventions have found generally positive results, e.g. that specific training provided to CHA/Ps to perform Pap tests resulted in high quality cytological tests and increased pap rates among women in eight remote villages that were overdue for such testing. Another study found that the utilization of a medical team that included local CHA/Ps helped to significantly increase the number of pregnant women accessing prenatal care during the first trimester.

Another type of outcome measure has been used to monitor the CHAP program. Utilizing satisfaction surveys, researchers simultaneously polled health aides, consumers, and CHA/P supervising physicians to determine perspectives on satisfaction with health aide services within the Yukon-Kuskokwim Delta region in Western Alaska. The survey showed that 74% of supervising physicians rated the CHA/Ps work as good or excellent. Consumers also showed satisfaction with their local CHA/Ps, rating the quality of care they received from CHA/Ps as similar to care provided by other types of medical professionals. Importantly, 40% of respondents stated that their local CHA/P clinic was their preferred source of medical care, compared with 36% who selected Bethel Hospital with access to midlevel and physician providers.

While evaluations are not mandated, data and information must be available to present to state agencies responsible for supervising the CHAP, and for the legislature. This is primarily done on a location-by-location basis. In addition, statistical and other kinds of information are collected to allow for the completion of periodic summative evaluations.

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C. INDIANA

Program name: Community Health Worker (CHW) Program. In 1990 Indiana Medicaid began supplemental reimbursement for prenatal care coordination to high-risk Medicaid eligible pregnant women. The prenatal care coordination program had been piloted in 2 rural counties. In 1990, Joanne Martin, with the school of nursing at Indiana University, had the idea of utilizing CHWs in an urban care coordination program, but discovered that Medicaid would not pay for the work of CHWs. She, along with the Indiana University School of Nursing, Senator Richard Lugar and his wife, physicians, hospitals, local and state health department convinced the city of Indianapolis to put up $3 million as seed money to create a three year pilot project that utilized CHWs from identified high-risk neighborhoods. The city council established the Indianapolis Healthy Babies Foundation to distribute the money and oversee the development of the program.

By 1994, the initial program had proven successful and from that pilot evolved the current Community Health Worker program. In July of 1994, the Office of Medicaid Policy and Planning passed a rule allowing lay home visitors called Community Health Workers (CHW) to make Medicaid reimbursable visits to high risk pregnant women under the guidance of a certified care coordinator. The care coordinator must make the initial home visit assessment and the postpartum home visit assessment but the community health worker can make the remaining visits, up to five reimbursable visits, under the supervision of the care coordinator.

The current program has CHWs working as an integral part of a care coordination team. The team includes a RN, social worker, and CHW. CHWs live in the neighborhood in which they work and focus on outreach, education and support, monitoring of the client care plan and referral follow-up. Agencies that work with the program include stand-alone non-profit agencies, health clinics, health departments, and hospitals that provide direct prenatal care services.

Training Program. The goal of the training is to prepare CHWs to provide care coordination and outreach to high-risk prenatal populations, particularly high-risk Medicaid populations throughout the state, in both rural and urban areas. The program training is done by the agencies through which the program works. The Department of Health provides technical assistance and a training packet to the agencies.

Training Curriculum. Indiana Administrative Code requires community health workers to be certified and successfully complete a care coordination training program approved by the State Department of Health. The DOH originally decided to use the InMed Mother Net America curriculum out of Virginia, but rising costs made the curriculum prohibitive. The DOH then created its own curriculum adding chapters on culture, perinatal risks, families, and Maslow's hierarchy of needs.

The DOH is in the process of standardizing the curriculum across sites, with the curriculum designed to be flexible and adaptable to different locations' needs. Each

county is autonomous in Indiana. The training is to be provided on site by the agency employing the CHW and conducted by a certified care coordinator and/or agency supervisor using training program. The DOH gives advice and lays out the standards. Consequently, the core is there, but the local and regional agencies heave flexibility in the implementation of the curriculum.

Curriculum Content. The curriculum emphasis is on prenatal health up to 60 days post partum. The first section of the curriculum pertains to the relevant laws, guidelines, definitions, how to do outreach and conduct home visits. The second section focuses on pregnancy, prenatal care, anatomy, physiology, nutrition, SIDS, health risk behaviors, preterm labor, low birthweight, labor and delivery, old wives tales related to child bearing, admission to hospital, breastfeeding, post partum care, immunizations, finding a pediatrician, and well child care. Finally, the third section introduces the CHWs to topics about culture, communication, Maslow's hierarchy of needs, working with families, mental health, and use of resource materials.

While training is conducted through this office, as is certification, the approach is one of train-the-trainers. The DOH provides technical training assistance to agencies in the counties that are reimbursable through Medicaid. They, in turn, conduct the training with the CHWs in their region. The CHWs must take and pass 12 chapter tests after which the CHWs come to the DOH for a one-day review and certification test. When the CHWs successfully complete this exam, they are certified to work in the program and provide reimbursable services.

Certification. The DOH has certified CHWs since 1994, and the training program is required for CHWs to be certified for prenatal care coordination. Certification is required by the DOH in any agencies through which the prenatal care coordination program operates. Trainers are not currently certified by the DOH as trainers. They have to be persons who are certified care coordinators (RNs) at the agency level, and someone familiar with the agency. The DOH is now considering certifying trainers as part of the re-planning and re-institutionalizing of the prenatal care coordination program.

Administration. The program is administered by the Indiana Department of Health. The reach of the program is statewide. Currently there are 300 certified CHWs working in 11 rural and 10 urban counties throughout the state.

The program does not have a budget of its own; all costs come under the State Maternal and Child Health program. The DOH keeps the costs for training and certification as low as possible for the CHWs, who pay no more than $35. The participating agencies pay for the training and the CHW is guaranteed to have a job after the training and certification. The DOH has partnered with the Northwest IVY Technical Community College and Health Visions of Illinois (now in Indiana) to create a generalized CHW Level 3 major, with a prenatal care component for which CHWs can receive certification and 3 credit hours. The cost of the IVY Technical Community College 3 credit course is $165, and they do not guarantee a job. For this, and other reasons, conducting training through the Technical Community College has not been successful.

Funding sources include federal Title V funds and Medicaid. The DOH covers the administrative costs after the initial three years of seed money were completed). In some cases the DOH provides grants to collaborative agencies; some agencies receive support from local health departments or hospitals. At the outset of the program, the program received some funding from the March of Dimes Foundation.

Evaluation. No true evaluation exists largely due to limited resources, in this case staffing and funding, to evaluate the data. An early outcome report form, used for billing, could be used somewhat for evaluation but it was never used for that purpose. The outcomes report provided some data on demographics as well as pregnancy, infant birth, and post-pregnancy outcomes data. An expanded outcome report has been created to capture programmatic, and outcome data. The DOH is working with the office of Medicaid Policy and Planning and Indiana MCOs to set up a system for collection and analysis of the new outcome reports.

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APPENDICES

APPENDIX 1

PHASE I: Screening Questions

NATIONAL SURVEY SCREENING INTERVIEW
Phone Script

a. Do you have a state-wide certification program in your state? If no, do you have an alternative type program that serves similar purposes? Can you please describe it briefly?

b. If you do not have a state-wide program, are there 'local' or 'regional' types of certification programs?

c. If not, has there been any discussion about initiating a CHW certification program?

d. (If a, b, or c is answered affirmatively, ask) "Can you please provide me with the name(s) of the informed person(s) to whom we should talk?

e. If a, b, and c are answered negatively, but you discern some uncertainty in the answers, ask) "Would you suggest that I ask anyone else about existing programs, polices and legislation?"

f. If a. b, and c are answered with definitive negative responses, thank the person and then…

APPENDIX 2

Phase II: INTERVIEW PROTOCOL
NATIONAL SURVEY

Semi-structured interview instrument

Interviewer:

Interviewee:

Name:
Agency:
Position in Agency:

Program:

Certification ____
Training ____
Both ____

Date:

Identification of the Program:

1. My understanding is that in the state there is a _____program. Could you please give a brief introduction to that program?

Definition of CHW used by the program:

2. Is the program a "training Program"?

YES _____
NO _____ (go to question #3)

If yes, is the training program certified?
YES _____
NO _____

If yes, who is the certifying body? _____

NO _____
If no, are there any plans for certification of a training program?

3. Is the program a "certification program"?

YES _____
NO _____ **(If No, go to Q. 4, right column)**

If yes:

a. Who is the certifying body? _____

b. Who do you or the certifying body certify?
_____ CHWs
_____ Trainers
_____ Training Institutions

c. Are there training requirements with your certification program?
YES _____
NO _____
If no, are there plans to include training requirements?
YES _____
NO _____

Certification Program	**Training Program**
4. What is the main focus of the certification program? - Goals: - Population targets (urban/rural): - Program focus (**Probes if needed:** CHWs/Communities/Healthcare providers): More notes of Program Focus and Goals:	4. What is the main focus of the training program? - Goals: - Population targets (urban/rural): - Program focus (**Probes if needed:** CHWs/Communities/Healthcare providers): More notes of Program Focus and Goals:

Certification Program	Training Program
5. Do you require certification of all CHWs? [If YES, go to #7] a. Yes b. No c. DK d. N/A Explain:	5. Do you require training of all CHWs? [If YES, go to #7] a. Yes b. No c. DK d. N/A Explain:
6. Do you require certification from <u>any</u> CHW? a. Yes b. No c. DK d. N/A If Yes, which CHWs:	6. Do you require training from <u>any</u> CHW? a. Yes b. No c. DK d. N/A If Yes, which CHWs:

II. History of the Program

Certification Program	Training Program
7. When was the program created?	7. When was the program created?
8. Do you know what issues/concerns/interests motivated the creation of the program? a. YES b. No c. N/A Explain:	8. Do you know what issues/concerns/interests motivated the creation of the program? a. YES b. No c. N/A Explain:

9. Who were the actors involved in the creation of the CHW Certification Program? a. Legislators b. State agencies c. Service providers d. Advocacy groups e. Key players Explain:	9. Who were the actors involved in the creation of the CHW Training Program? a. Legislators b. State agencies c. Service providers d. Advocacy groups e. Key players Explain:

III. Structure and Organization of the Program

Certification Program	**Training Program**
10. What state agency/organization is in charge of the implementation and administration of the program? Implementation: Administration: Any partners (inter-organizational picture):	10. What state agency/organization is in charge of the implementation and administration of the program? Implementation: Administration: Any partners (inter-organizational picture):

11. What is the geographic reach of the program? a. Local b. Regional c. State-wide Explain:	11. What is the geographic reach of the program? a. Local b. Regional c. State-wide Explain:

Certification Program	**Training Program**
12. Does the program have a budget of its own? a. Yes b. No c. DK d. N/A Explain:	12. Does the program have a budget of its own? a. Yes b. No c. DK d. N/A Explain:
13.What are the funding sources for the program? <u>Public:</u> a. Federal ( ) _____ b. State ( ) _____ c. County ( ) _____ d. Municipal ( ) _____ e. Other ( ) _____ <u>Private:</u> a. Foundation ( ) _____ b. Private donor ( ) _____ c. Church ( ) _____ d. Civic group ( ) _____ e. Other ( ) _____	13.What are the funding sources for the program? <u>Public:</u> a. Federal ( ) _____ b. State ( ) _____ c. County ( ) _____ d. Municipal ( ) _____ e. Other ( ) _____ <u>Private:</u> a. Foundation ( ) _____ b. Private donor ( ) _____ c. Church ( ) _____ d. Civic group ( ) _____ e. Other ( ) _____

Notes on the nature of agencies/organizations:	Notes on the nature of agencies/organizations:

Certification Program	**Training Program**
14. Does the program include an evaluation component? [If answer is NO, go to #18] a. Yes b. No c. DK d. N/A Explain:	14. Does the program include an evaluation component? [If answer is NO, go to #18] a. Yes b. No c. DK d. N/A Explain:
15. Is it a state-mandated evaluation? a. Yes b. No c. DK d. N/A Explain:	15. Is it a state-mandated evaluation? a. Yes b. No c. DK d. N/A Explain:
16. Is there an evaluation being currently conducted? a. Yes b. No c. DK d. N/A Explain:	16. Is there an evaluation being currently conducted? a. Yes b. No c. DK d. N/A Explain:
17. Who does/will do the evaluation (evaluation criteria)?	17. Who does/will do the evaluation (evaluation criteria)?

IV. Training *(refer to Question # 2 and 3c* **to determine whether to ask questions 18 through 26***)*

You noted that you have a training program or require a training program for CHWs in your state …

18. Does the program require a training curriculum?
    a. Yes
    b. No
    c. DK
    d. N/A

    Explain:

19. Is the program's training curriculum standardized across sites?
    a. Yes
    b. No
    c. DK
    d. N/A

    Explain:

20. Is the training curriculum flexible enough in order to take into consideration local contexts?
    a. Yes
    b. No
    c. DK
    d. N/A

21. Was there a <u>particular existing model</u> used for the development of the training curriculum?

22. Please tell us something about the content of the training curriculum.

23. Having described the curriculum, would you say that it has a particular emphasis or emphases?

<u>Probes:</u>

Health
Community Development
Mental Health
Leadership

24. Please tell us about the criteria for selecting trainers.

25. Are trainers certified?
    a. Yes
    b. No
    c. DK
    d. N/A

Explain:

26. Please name the agencies that provide CHW training for your program.

State Agencies:

Other Organizations:

V. Impact and Future of the Program

Certification Program	Training Program
27. In your opinion, what has been / will be the program's impact? Probes: a. State health/mental health delivery system b. CHW's performance c. Individual CHWs	27. In your opinion, what has been / will be the program's impact? Probes: a. State health/mental health delivery system b. CHW's performance c. Individual CHWs
28. What is, in your opinion, the future direction of the certification program in your state?	28. What is, in your opinion, the future direction of the training program in your state?

29. Are there other training/certification programs in your State that we should look at?

Final notes and comments: