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# Community Health Worker Credentialing

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State Approaches

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## EXECUTIVE SUMMARY

Community health workers (CHWs) have shown, time and again, that they can improve health outcomes while reducing healthcare costs. Reductions in chronic illness, improved medication adherence, more patient involvement, and better community health have been accompanied by a return on investment of more than \$2 for every dollar invested.<sup>1</sup> Yet several barriers are keeping CHWs from being full participants in the healthcare system. According to a 2002 Institute of Medicine report, inconsistent scope of practice, training and qualifications; lack of sustainable funding; and insufficient recognition by other health professionals are all barriers to the integration of CHWs into the broader system.<sup>2</sup>

One approach states have explored to counteract these barriers is to develop some sort of CHW credentialing system. The goals of credentialing, as described by Carl Rush in 2012, are to achieve greater respect for CHWs among other healthcare professions, improved financial compensation and working conditions, increased job stability, and opportunities for more sustainable funding. The connection between insurance reimbursement and credentialing or standardized training is particularly significant, as both public and private insurance plans are likely to require some form of credentialing in order to pay for CHW services. At the same time, many CHWs are concerned that credentialing will create barriers to entry for the individuals best suited to the job (i.e., members of low-income communities who may not speak English as a first language), and/or take CHWs away from their community connections by focusing on credentialed “skills” over community relationships.<sup>3</sup>

In general, states that decide to implement a community health worker (CHW) credentialing system have several questions to answer:

1. What will be the state’s definition of a CHW? What skills and core competencies will be required? Will the definition address qualifications related to a candidate’s relationship to (or understanding of) the community to be served, which is central to many definitions of the CHW?
2. Will the credentialing be a “certification” system, in which certified CHWs are designated as qualified to work in the field or a “licensure” system, in which only licensed CHWs are permitted to perform CHW tasks?
3. Will the state government create and manage the credentialing system? If so, which state entity will handle these tasks? If not, how will the state recognize a private credentialing program?
4. Will CHWs need the credential in order to practice or only need the credential to receive payment for their services?
5. Will the state establish a state training program or establish standards that private entities must meet in order to operate approved training programs?

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<sup>1</sup> CENTERS FOR DISEASE CONTROL AND PREVENTION, *A Summary of State Community Health Worker Laws*, available at [http://www.cdc.gov/dhdsp/pubs/docs/CHW\\_State\\_Laws.pdf](http://www.cdc.gov/dhdsp/pubs/docs/CHW_State_Laws.pdf).

<sup>2</sup> INSTITUTE OF MEDICINE, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002).

<sup>3</sup> Carl H. Rush, *Basics of Community Health Worker Credentialing* (2012), available at <http://www.chw-nec.org/pdf/Basics%20of%20Community%20Health%20Worker%20Credentialing.pdf>.

6. Will people be able to obtain a credential through completion of a training program, through qualifying work experience, or both?
7. Through what process will the credential and training system be designed? Who will be involved in the process?

Different states and communities have taken different approaches to these questions, as discussed in detail below. The common element in successful systems, however, is a high level of involvement from the CHW community in policy development. With a strong CHW advisory body, ideally in collaboration with other healthcare stakeholders, states can ensure that the answers to these questions meet community needs.

**Summary of Select State Credentialing Policies:**

<b>State</b>	<b>Type of Credential</b>	<b>Site for Policymaking</b>	<b>Training Requirement</b>	<b>“Incumbent” or “Grandfathering”</b>
Massachusetts	Certification; needed in order to represent oneself as a “certified community health worker”	Board of Certification at Department of Public Health	Board approves standards for training programs. 80 hours classroom training and 15 hours continuing education every 2 years.	“Work Experience Pathway,” for those with 4,000 hours experience.
Minnesota	Certification; needed in order to participate in state Medicaid program	State of Minnesota; Medicaid program, state universities, and colleges	Standardized curriculum delivered by community colleges. Developed by Minnesota State University in partnership with stakeholders.	None
Ohio	Certification; needed in order to perform tasks delegated by a nurse	Board of Nursing	Board of Nursing approves training programs. 15 hours continuing education every 2 years	Grandfathering for those employed as CHWs before 2005.
Oregon	Certification	Non-Traditional Healthcare Workforce Committee	Committee approves training courses. 80 hours of training and 20 hours of continuing education every 3 years.	Option for certification based on 3,000 hours of experience and completion of “incumbent” training.
Texas	Certification; needed to receive any	State Department of Health	Department of Health approves training programs.	CHWs with at least 1,000 hours of experience can be

	payment for services		At least 160 hours of instruction.	exempt from training requirements.
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A few themes emerge here. All states have adopted the certification system of credentialing. Certification allows a CHW to identify him or herself as “certified,” signals to employers and payers that the CHW is qualified to perform certain tasks, and in many cases is a requirement for a CHW to receive payment for their work. However, this is distinct from a licensure system under which no one may practice without the license.

In several states CHW advocates have favored “voluntary” certification – to avoid creating barriers to entry – especially for volunteers. However, the term “voluntary certification” may be considered technically redundant, since a mandatory credentialing system is functionally equivalent to licensing. Regardless, licensing boards in certain states such as MA, NY and VA have rejected licensing of CHWs, finding that the risk of harm to the public from “unlicensed practice” does not rise to the standard requiring licensing of a profession.

States typically have ways for CHW experience in the field to count toward training requirements, whether by “grandfathering” practicing CHWs into certification or through a work experience route for new CHWs to enter the field. Final qualification is typically not through a qualifying exam, except in Ohio; Alaska’s Community Health Aide-Practitioners receive more training as clinical care providers than other CHWs and must sit for an exam for this part of their qualification. It is most common for states to set training standards, identifying the skills and core competencies needed for CHW practice and then approving programs that meet these standards. Finally, states typically develop policies with the active participation of CHWs, whether informally or through specific state agencies charged with the task of policy development.

As other states develop CHW credentialing systems, existing programs can provide helpful insight. This paper is designed to review some of the major policies in different states and highlight some of the issues that arise in these programs. There is no single right approach. With sufficient stakeholder engagement, each state can develop policies tailored for its community.

## INTRODUCTION

As CHWs become a more significant part of the healthcare workforce, states have taken a variety of approaches to supporting and regulating this group. According to the federal Centers for Disease Control and Prevention (CDC), the following states had enacted at least one provision concerning CHWs as of December 2012:

- Alaska
- California
- The District of Columbia
- Maryland
- Massachusetts
- Minnesota
- New Mexico
- New York
- Ohio
- Oregon
- Rhode Island
- Texas
- Utah
- Virginia
- Washington
- West Virginia.<sup>4</sup>

Three of these states – Ohio, Oregon, and Texas – have highly developed regulatory regimes governing the CHW profession. Massachusetts has an extensive statutory framework governing the profession and is in the process of developing regulations. At least three states—Alaska, Minnesota, and New Mexico—provide Medicaid reimbursement for CHW services.

States with developed CHW laws generally require CHWs to obtain certification from a state board, although certification may only be required in order to receive reimbursement, and not required to practice. Most states require an application fee for certification. States generally require that certificates be renewed periodically, which requires continuing education.

States commonly set guidelines for training programs, and private entities may apply to the certification board for approval of training programs. This model applies in Massachusetts, Oregon, and Texas.

Here, we describe and analyze the statutory and regulatory framework in Massachusetts, Rhode Island, and Oregon, as well as Florida’s proposed legislative approach to CHW workforce development. We also review the CHW policies in Alaska, Minnesota, New Mexico, New York, Ohio, and Texas.

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<sup>4</sup> CENTERS FOR DISEASE CONTROL AND PREVENTION, *A Summary of State Community Health Worker Laws*, available at [http://www.cdc.gov/dhdsp/pubs/docs/CHW\\_State\\_Laws.pdf](http://www.cdc.gov/dhdsp/pubs/docs/CHW_State_Laws.pdf).

# STATE POLICIES ON COMMUNITY HEALTH WORKERS: IN-DEPTH DISCUSSION OF FOUR STATES

## Massachusetts

Massachusetts has an extensive statutory regime governing CHWs.

Massachusetts defines a “community health worker” as “a public health worker who applies his unique understanding of the experience, language and culture of the populations he serves through one or more of the following roles:

- Providing culturally appropriate health education, information and outreach in community-based settings such as homes, schools, clinics, shelters, local businesses and community centers;
- Bridging or culturally mediating between individuals, communities and health and human services, including actively building individual and community capacity;
- Assuring that community members access the services they need;
- Providing direct services, such as informal counseling, social support, care coordination and health screenings;
- Advocating for individual and community needs; and
- Additional roles as may be identified by the board that may emerge in the development of community health worker practice.”<sup>5</sup>

The statute further explains that CHWs “may be distinguished from other health professionals in that they:

- Are employed primarily for their understanding of, and connection with, the populations and communities they serve;
- Conduct outreach during a significant portion of the time they provide services through 1 or more of the roles set forth in this section; and
- Have experience providing services in community settings.”<sup>6</sup>

Next, the state defines the “core competencies” of CHWs as “a set of overlapping and mutually reinforcing skills and knowledge essential for effective community health work in core areas that include, but are not limited to:

- Outreach methods and strategies;
- Individual and community assessment;
- Effective communication;
- Culturally-based communication and care;
- Health education for behavior change;
- Support, advocacy and coordination of care for clients;

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<sup>5</sup> M.G.L.A. 112 § 259.

<sup>6</sup> M.G.L.A. 112 § 259.

- Application of public health concepts and approaches;
- Advocacy and community capacity building;
- Documentation; and
- Professional skills and conduct.”<sup>7</sup>

The state passed legislation in 2010 calling for the inclusion of a Board of Certification for CHWs and formally established this board in 2012.<sup>8</sup> The Massachusetts Department of Public Health (DPH) houses the Board of Certification for CHWs, which includes a delegate of the DPH commissioner and ten appointees of the governor. Four appointments are reserved for CHWs.

The duties of the Board of Certification include:

- “Develop and administer a program of certification” for CHWs, and establish qualifications for certification as a CHW, including standards for practice as a certified CHW;
- Set standards for CHW training programs the successful completion of which makes individuals eligible to apply to the board for certification, and set standards for CHW continuing education programs;
- Adopt “a certification examination *or* other means to assess [CHW] competency in connection with board certification” *if* it believes such action would enhance the profession (emphasis added);
- Establish and implement procedures for the investigation and resolution of complaints related to the practice of CHWs, and to establish and implement disciplinary actions in connection with complaint resolution, which may include a fine, reprimand, probation, censure, or suspension, revocation, or denial of certification.

The Board also may:

- Establish “tiered classes or levels of practice” as a CHW, and “certification requirements for each established class or level;” and
- Certify CHWs to practice in Massachusetts who have been certified under the laws of other states.

The statute also outlines the process of applying to the Board for certification as a CHW. An application must be accompanied by the application fee established by the board and must be renewed every two years. The applicant “shall furnish satisfactory proof that he is at least 18 years old, is of good moral character<sup>9</sup> and has met all the education, training and experience

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<sup>7</sup> M.G.L.A. 112 § 259.

<sup>8</sup> AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *State Legislation Supports Professional Development of Community Health Workers, Leading to Greater Recognition, Enhancements in Training, and Funding*, available at <http://www.innovations.ahrq.gov/content.aspx?id=3744>

<sup>9</sup> This may cover background check requirements. Ohio imposes a background check but Texas does not; in practical terms most employers will have a background check of their own. For some services to previously incarcerated or families of the currently incarcerated, past encounters with the criminal justice system can be an asset rather than a liability.

requirements and qualifications as established by the board.” CHWs must carry proof of certification when practicing the profession, and must present proof of certification upon request.<sup>10</sup>

*a. The current state of CHW funding and organization in Massachusetts*

According to the Bureau of Labor Statistics, Massachusetts is above the national average for CHW employment as a percentage of the workforce and CHW hourly wages.<sup>11</sup> Measures of the racial and ethnic composition of the CHW workforce yield mixed results; a 2007 HHS study found that CHWs in Massachusetts were approximately 80% white, but a 2008 Massachusetts DPH study challenged that figure by presenting that whites make up only 43% of the CHW workforce. According to this study, three minority groups constitute the greatest proportion of the remainder of the workforce: African-American (23.7%), Latino/Hispanic (20.6%), and Asian/Pacific Island (4.9%).<sup>12</sup>

The disparity between the studies in the proportion of minority CHWs reflects the limitations of sampling methodologies used in either study. If the percentage of minority CHWs were closer to constituting  $\leq 20\%$  of the MA population (according to the 2007 study), then the proportion of ethnic minorities in the entire state (19%) is consistent with the proportional makeup of CHWs. However, if the percentage of minority CHWs were  $>50\%$  (according to the 2008 study), then the proportion of minority CHWs is more than double the proportion of ethnic minorities in the state. In this case, the predominance of minority CHWs would signify a greater need among racial and ethnic minority groups for access to health through the employment of community health workers.

According to the 2008 DPH survey of CHW employers, less than half of the CHW workforce has received formal training,<sup>13</sup> and a large majority of employers report that most of their CHW employees lack formal training.<sup>14</sup> At the time of that study, CHW training was only available in three locations, though only 19.3% of employers reported that lack of regionally available CHW education programs was a barrier to training.<sup>15</sup> Employers reported that finding convenient times for training (29.9%) and dealing with CHWs’ busy schedules (27.3%) were the largest barrier to CHW formal training, though 29.4% of employers reported no barriers to formal training.<sup>16</sup>

At present, many CHWs in Massachusetts depend on grant-funded programs from government and philanthropy. This “soft money” presents a major problem for CHWs, since grants are an

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<sup>10</sup> M.G.L.A. 112 § 260.

<sup>11</sup> BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, May 2013: Community Health Workers*, <http://www.bls.gov/oes/CURRENT/oes211094.htm>.

<sup>12</sup> MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH COMMUNITY HEALTH WORKER ADVISORY COUNCIL, *Community Health Workers in Massachusetts: Improving Health Care and Public Health* 27 (Dec. 2009), available at <http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf>.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Id.* at 28.

<sup>16</sup> *Id.* at 27.



inherently unstable and unpredictable source of funding.<sup>17</sup> Some CHWs feel that this instability and uncertainty keeps potential CHWs out of the profession.<sup>18</sup> Along similar lines, the inherent problem of unstable funding might also cause talented CHWs to leave the field.

*b. Planned next steps for regulation, funding, and organization*

In its most recent meeting for which minutes are publicly available,<sup>19</sup> the Board of Certification of Community Health Workers voted unanimously to set the Work Experience Pathway at 4,000 hours, based on recommendations from its Advisory Working Group. This will require uncertified CHWs to have approximately two years of full-time work experience to be certified. The Board of Certification put off the question of whether the Work Experience Pathway would transition to a full, combined training and work pathway to CHW certification.

At the same meeting, the Board of Certification approved standards for hours of classroom instruction and continuing education. The Board unanimously agreed to 80 hours of classroom instruction, with 80% of time spent on ten “core competencies” and 20% dedicated to “special health topics.”<sup>20</sup> To maintain certification, the CHW is required to obtain 15 hours of continuing education every two years. Rather than assessing competency through a certification examination, the Board is exploring other means to assess competency through work experience, successful completion of training, and letters of recommendation.

*c. Benefits and costs of the intended approach, according to CHW feedback*

According to interviews with Lorezna Holt, a member of the Massachusetts Association of Community Health Workers Board of Directors, the current process has been very inclusive and productive from a CHW’s point of view. She praised the Board of Certification chair, Geoffrey Wilkinson, as a gift to the CHW community, and noted his inclusive approach and deep understanding of the problem.<sup>21</sup>

CHW advocates attending the Board of Certification meetings noted tension between the core competencies and classroom requirements and the needs of immigrants and community members that are less comfortable with written learning. However, Holt emphasized that the discussion of potential barriers weighed against potential benefits had been inclusive and highly satisfactory.<sup>22</sup>

*d. Resources*

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<sup>17</sup> Id. at 28.

<sup>18</sup> Telephone Interview with Lorenza Holt (Apr. 3, 2014).

<sup>19</sup> The meeting took place on January 14<sup>th</sup>, 2014. The Board of Certification has since held a meeting in March but the minutes are not published at this time. Its next meeting is Tuesday, May 13<sup>th</sup>.

<sup>20</sup> These core competencies are: 1) Outreach Methods & Strategies, 2) Individual and Community Assessment, 3) Effective Communication, 4) Cultural Responsiveness and Mediation, 5) Education to Promote Healthy Behavior, 6) Care Coordination and System Navigation, 7) Use of Public Health Concepts and Approaches, 8) Advocacy and Community Capacity Building, 9) Documentation, and 10) Professional Skills and Conduct.

<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/ma-board-of-certification-of-community-health-workers.html>.

<sup>21</sup> Telephone Interview with Lorenza Holt (Apr. 3, 2014).

<sup>22</sup> Id.

- *Report of the Massachusetts Department of Public Health Community Health Worker Advisory Council* (2009), <http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf>.
- AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *Policy Innovation Profile: State Legislation Supports Professional Development of Community Health Workers, Leading to Greater Professional Recognition, Enhancements in Training, and Funding*, (2013), <http://www.innovations.ahrq.gov/content.aspx?id=3744>.
- *Minutes of the Board of Certification of Community Health Workers* (July 2012-Jan. 2014), <http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/about/minutes-and-agendas-of-previous-board-meetings.html>.
- THE NEW ENGLAND COMPARATIVE EFFECTIVENESS PUBLIC ADVISORY COUNCIL, *Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England* (July 2013), <http://cepac.icer-review.org/wp-content/uploads/2011/04/CHW-Final-Report-07-26-MASTER2.pdf>.
- *Winning policy change to promote community health workers: lessons from Massachusetts in the health reform era*, AM. J. PUBLIC HEALTH (2011), <http://www.ncbi.nlm.nih.gov/pubmed/22021281>.

## Oregon

Oregon law defines a CHW as someone who:

- “Has expertise or experience in public health;
- Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;
- To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;
- Assists members of the community to improve their health and increases the capacity of the community to meet the health needs of its residents and achieve wellness;
- Provides health education and information that is culturally appropriate to the individuals being served;
- Assists community residents in receiving the care they need;
- May give peer counseling and guidance on health behaviors; and
- May provide direct services such as first aid or blood pressure screening.”<sup>23</sup>

In 2012, Oregon established the Non-Traditional Healthcare Workforce Committee, a body charged with designing certification protocols for the state’s CHWs. To obtain CHW

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<sup>23</sup> O.R.S. § 414.025.

certification, an individual must complete a training course approved by the Oregon Health Authority, or have worked as a CHW in Oregon for at least 3,000 hours prior to the date of application and successfully complete incumbent worker training.<sup>24</sup> Prospective CHWs must complete at least 80 hours of training.<sup>25</sup>

Oregon's approach to CHW regulation is significant in part for its recent §1115 Medicaid waiver that allows for the creation of Community Care Organizations, locally-based networks of providers coordinating to provide health care. In accordance with the CCOs' vision of coordinated preventative and chronic disease care, CHWs can receive reimbursement and employment through these organizations.<sup>26</sup>

In order to receive Medicaid funding, CCOs must provide "assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of ... community health workers."<sup>27</sup> The Oregon Health Authority is responsible for promulgating rules with respect to the criteria and descriptions of CHWs that may be used by CCOs, as well as education and training requirements for such individuals.<sup>28</sup>

The Oregon Health Authority is required to "[d]evelop, test and evaluate community-based strategies that utilize community health workers to enhance the culturally competent and linguistically appropriate health services provided by patient centered primary care homes in underserved communities."<sup>29</sup> However, CHW advocate Lizzie Fussell, Director of Policy and Research of the Oregon CHW Association (ORCHWA), has noted that Oregon's attempts to maintain its ACA Marketplace have been a major distraction from other issues of public health, including CHW-focused efforts.<sup>30</sup>

*a. The current state of CHW funding and organization in Oregon*

Oregon CHWs have several avenues for organization and resource-sharing, of which ORCHWA is a primary resource. Fussell provided commentary, background information, and access to front-line CHWs in Oregon. As health reform in Oregon continues, more CHWs are expected to find employment in CCOs, where they will manage chronic diseases and public health in coordination with other healthcare professionals.

Currently, over half of CHWs who graduate from formal training in Oregon do so through the Community Capacitation Center run by the Multnomah County Health Department.<sup>31</sup> The Center is currently in the process of licensing its curriculum and spreading it throughout the state.

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<sup>24</sup> OAR 333-002-0310.

<sup>25</sup> OAR 410-180-0350; 333-002-0370.

<sup>26</sup> OREGON HEALTH POLICY BOARD, *Oregon's Medicaid Demonstration*, <http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>

<sup>27</sup> O.R.S. § 414.625.

<sup>28</sup> O.R.S. § 414.655.

<sup>29</sup> O.R.S. § 413.260.

<sup>30</sup> Telephone Interview with Lizzie Fussell (Apr. 7, 2014).

<sup>31</sup> *Id.*

*b. Planned next steps for regulation, funding, and organization*

In 2012, the Non-Traditional Healthcare Workforce Committee issued its recommendations regarding CHW training and certification. It recommended an 80-hour training program, 20 hours of continuing education every three years, “grand-parenting” existing CHWs into the system, limiting the cost of training programs, and establishing oversight by the state and an advisory panel that includes non-traditional health workers.<sup>32</sup> The report is notable for its explicit recognition that higher barriers to participation might change the makeup and character of the CHW community in ways that defeat the basic purpose of CHW approach.<sup>33</sup> When these recommendations are in place, the certification would allow a CHW to enroll as a “provider” for reimbursement.<sup>34</sup> These recommendations became proposed regulations in 2013.<sup>35</sup>

*c. Benefits and costs of the intended approach, according to CHW feedback*

One major obstacle to CHW certification is the required background check. Many low-income and immigrant community members have expressed fears that a background check will disqualify them or raise flags regarding immigration status.<sup>36</sup> For this reason, the state of Texas does not require declaration of immigration status or taxpayer ID for CHWs to acquire certification. Fussell suggested that employer background checks, rather than government background checks, would better allay fears that CHW certification would be used against the applicant. She also drew analogies to Peer Support Counselors, recovering addicts who assist in counseling other recovering addicts, and an alternate background check process that ensures they have the confidence to get certified.<sup>37</sup>

Fussell also identified the healthcare industry as the state government’s primary concern for implementing CHW regulation, which may slow down the innovative and transformative potential of CHWs. Fussell noted that the state should consider promulgating its own model and soliciting comments rather than letting traditional, existing players design the new system.<sup>38</sup>

Regarding CHW training, Fussell posited that community colleges were not the optimal place for certification training because they may “over-medicalize” the workers instead of focusing on empowerment and social justice functions of CHWs.<sup>39</sup>

*d. Resources*

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<sup>32</sup> OREGON HEALTH AUTHORITY, *The Role of Non-Traditional Health Workers in Oregon’s Health Care System* 17, available at <http://www.oregon.gov/oha/oei/Documents/nthw-report-120106.pdf>.

<sup>33</sup> *Id.* at 16. The report noted fears of “[l]oss of holistic and culturally based approaches key to reducing health disparities and promoting health equity... [e]xclusion of community members and currently practicing NTHWs from their own field... [c]reation of barriers for new NTHWs to enter the field.”

<sup>34</sup> *Id.* at 17.

<sup>35</sup> OREGON HEALTH AUTHORITY, *Health System Transformation Update: Non-Traditional Health Workers*, available at <http://www.oregon.gov/oha/amh/rule/NTHW-BriefwithRules.pdf>

<sup>36</sup> Telephone Interview with Lizzie Fussell (Apr. 7, 2014).

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

- OREGON HEALTH AUTHORITY, *Health System Transformation Update: Non-Traditional Health Workers* (2013), <http://www.oregon.gov/oha/amh/rule/NTHW-BriefwithRules.pdf>.
- OREGON HEALTH AUTHORITY, *The Role of Non-Traditional Health Workers in Oregon's Healthcare System* (2012), <http://www.oregon.gov/oha/oei/Documents/nthw-report-120106.pdf>.
- OREGON NURSES ASSOCIATION, *Community Health Workers: An Position Statement* (2013), <http://www.oregonclho.org/uploads/8/6/1/7/8617117/05.15.2013.onapositionstament.pdf>.
- *Multnomah County: Community Health Worker Capacitation*, <http://web.multco.us/health/community-health-worker-capacitation>.

## Rhode Island

Rhode Island does not require licensure or certification, although the state does officially recognize certain CHW training programs. However, the Rhode Island Department of Health has close relationships with CHW associations, and many public health programs have language providing roles for CHWs.<sup>40</sup>

Rhode Island defines a CHW as “any individual who assists and coordinates services between providers of health services, community services, social agencies for vulnerable populations,” and who assists people in “navigating the health and social services system.”<sup>41</sup> State law further provides that CHWs are “individuals who have direct knowledge of the communities they serve, and of the social determinants of health, and can assess the range of issues that may impact an individual’s, a family’s or a community’s health and may facilitate improved individual and community well-being and should include, but not be limited to:

- Linking with services for legal challenges to unsafe housing conditions;
- Advocating with various state and local agencies to ensure that the individual/family receives appropriate benefits/services;
- Advocating for the individual/family within the health care system. This could be done in multiple settings (community-based organization, health care setting, legal service setting);
- Connecting the individual or family with the appropriate services/advocacy support to address those issues such as:
  - Assisting in the application for public benefits to increase income and access to food and services;

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<sup>40</sup> JENNIFER ALVISUREZ ET AL., *Funding Community Health Workers: Best Practices and the Way Forward* 16, available at [http://www.healthreform.ct.gov/ohri/lib/ohri/sim/care\\_delivery\\_work\\_group/funding\\_chw\\_best\\_practices.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/sim/care_delivery_work_group/funding_chw_best_practices.pdf).

<sup>41</sup> Gen. Laws 1956, § 23-64.1-2.

- Working with community-based health agencies and organizations in assisting individuals who are at-risk for or who have chronic diseases to receive better access to high-quality health care services;
- Anticipating, identifying and helping patients to overcome barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding; and
- Coordinating with the relevant health programs to provide information to individuals about health coverage, including RItecare and other sources of health coverage;
- Assisting the department of health, other agencies, health clinics, healthcare organizations, community clinics and their providers to implement and promote culturally competent care, effective language access policies, practices and disseminate best practices to state agencies;
- Training of health care providers to help patients/families access appropriate services, including social services, legal services and educational services;
- Advocating for solutions to the challenges and barriers to health that a community may face.”<sup>42</sup>

The state requires the Commission for Health Advocacy and Equity to “make recommendation for the coordination of state, local and private sector efforts to develop a more racially and ethnically diverse health care workforce,” which shall include the development of the community health workforce.<sup>43</sup>

*a. The current state of CHW funding and organization in Rhode Island*

Rhode Island has a relatively low density of CHWs with a location quotient significantly below the national average.<sup>44</sup> The Bureau of Labor Statistics counts only 120 CHWs active in Rhode Island as of 2013; however, it seems to severely undercount the actual employment: the Rhode Island Department of Labor and Training set the statistic at over 3,350 in 2009, with almost 2000 of them being full-time employees.<sup>45</sup> This discrepancy may exist because 2013 was the first year that Rhode Islanders were able to classify themselves as CHWs using the labor code.<sup>46</sup>

The CHW Association of Rhode Island, or CHWARI, is a training and networking organization for the state’s CHWs. Beth Lamarre, the director, has been involved in CHW interests since planning a conference for CHWs with other stakeholders, which led to the establishment of CHWARI in 2010.<sup>47</sup> CHWARI reaches over 350 contacts through its distribution list and is considered a particularly well-established and successful association.

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<sup>42</sup> Gen. Laws 1956, § 23-64.1-8.

<sup>43</sup> Gen. Laws 1956, § 23-64.1-8.

<sup>44</sup> BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, May 2013: Community Health Workers*, <http://www.bls.gov/oes/CURRENT/oes211094.htm>.

<sup>45</sup> RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING, *Community Health Workers in Rhode Island*, available at <http://www.dlt.ri.gov/lmi/pdf/communityhealth.pdf>.

<sup>46</sup> Telephone Interview with Beth Lamarre (Apr. 1, 2014).

<sup>47</sup> Id.

CHWARI provides the only state-endorsed training program for CHWs in Rhode Island. The curriculum costs \$500 and offers 30 hours of classroom learning and 80 hours of field experience.<sup>48</sup> Lamarre estimates that only 25% of CHWs pay for the program out of pocket, while the other 75% of CHWs are covered by their employers.<sup>49</sup> There is also a course from Community Health Innovations of Rhode Island, which provides a CHW certificate after 15 classroom sessions and a six-month internship.<sup>50</sup> According to the Rhode Island Department of Labor and Training, 51% of full-time CHWs in Rhode Island have a Bachelor's degree, while part-time CHWs are almost evenly split between Bachelor's, vocational training, GEDs, and Associate's degrees.<sup>51</sup> This information is based on a survey, which means that the data is all self-reported. In addition, the survey population included both social workers and nurses that perform some CHW duties, which suggests that some of the degrees identified here are held by professionals who are not working exclusively as CHWs.

*b. Planned next steps for regulation, funding, and organization*

In partnership with a four-year college's office of adult education, CHWARI is currently developing a longer and more costly program that includes remedial education and computer training.<sup>52</sup> The college will provide the remedial education and computer training, while CHWARI continues to provide the same training it currently offers. There are few signs of state-level action toward certification or licensure requirements.

*c. Benefits and costs of the intended approach, according to CHW feedback*

At this stage, the CHW Association of Rhode Island appears to have taken an "anti-regulatory" approach and is comfortable with no state-imposed requirements.<sup>53</sup> CHWARI has a close partnership with regulatory agencies, and does not see a pressing need for certification.<sup>54</sup>

*d. Resources*

- THE CHW ASSOCIATION OF RHODE ISLAND, <http://chwassociationri.wix.com/chwari>.
- RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING, *Community Health Workers in Rhode Island* (2009), <http://www.dlt.ri.gov/lmi/pdf/communityhealth.pdf>.
- CENTER FOR HEALTH INNOVATION RHODE ISLAND, *Become a CHW: Certificate Program*, <http://chi-ri.org/programs/certificate/>.

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<sup>48</sup> Id.

<sup>49</sup> Id.

<sup>50</sup> COMMUNITY HEALTH INNOVATIONS OF RHODE ISLAND, *Become a CHW*, <http://chi-ri.org/programs/certificate/>

<sup>51</sup> RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING, *Community Health Workers in Rhode Island*, available at <http://www.dlt.ri.gov/lmi/pdf/communityhealth.pdf>.

<sup>52</sup> Telephone Interview with Beth Lamarre (Apr. 1, 2014).

<sup>53</sup> Id.

<sup>54</sup> Id.



- ALVISUREZ ET AL., *Funding Community Health Workers: Best Practices and the Way Forward* (2013), [http://www.healthreform.ct.gov/ohri/lib/ohri/sim/care\\_delivery\\_work\\_group/funding\\_chw\\_best\\_practices.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/sim/care_delivery_work_group/funding_chw_best_practices.pdf) (study of CHW funding streams that includes interviews of Rhode Island CHWs).

## Florida

Florida currently has an active and engaged community of CHWs, but does not currently have laws defining a CHW or a regulatory structure for moving toward state-level CHW certification. Bills have been proposed that would create a state-level task force to develop recommendations to integrate CHWs into the healthcare delivery systems, to provide guidance for a certification process, and to support the adoption of a statewide credentialing pathway. So far, these bills have died in committee. In practice, employers and not-for-profit organizations (i.e., faith-based groups) regulate the CHW community through their hiring decisions for both paid and pro bono positions.<sup>55</sup>

### *a. The current state of CHW funding and organization in Florida*

Florida has the fifth-highest absolute number of CHWs operating within its borders, with an estimated 2,120 CHWs actively employed in the state.<sup>56</sup> The state has a relatively low density of workers, however, and Florida CHWs are paid a below-average mean wage of \$15.74 per hour.<sup>57</sup>

At present, there is no formal, state-recognized licensure or certification procedure for CHWs in Florida. CHWs receive training through community colleges,<sup>58</sup> conferences and continuing education modules,<sup>59</sup> or career training programs. At present, there are only three formal programs that award CHW training certificates in one year or less.<sup>60</sup> More programs are being developed as the path for certification gains momentum.

The Florida CHW Coalition serves as a nexus for the CHW community, aggregating resources and advocating on behalf of CHWs in policy matters. CHW Coalition board members and advisors serve on one of four working groups: policy, curriculum development, networking/sustainability, and research/grant writing. The Coalition is currently transitioning to 501(c)(3) status and pursuing more grant funding and donations to continue its activities.<sup>61</sup>

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<sup>55</sup> Telephone Interview with Shelia McCann (Apr. 16, 2014).

<sup>56</sup> BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, May 2013: Community Health Workers*, <http://www.bls.gov/oes/CURRENT/oes211094.htm>.

<sup>57</sup> Id.

<sup>58</sup> MY NEXT MOVE, *Community Health Workers: Florida*, <http://www.mynextmove.org/profile/ext/training/21-1094.00?s=FL>.

<sup>59</sup> FLORIDA COMMUNITY HEALTH WORKER COALITION, *Past Education and Training Opportunities*, <http://floridachwn.pharmacy.ufl.edu/edu-training/past-educ-train/>.

<sup>60</sup> MY NEXT MOVE, *Community Health Workers: Florida*, <http://www.mynextmove.org/profile/ext/training/21-1094.00?s=FL>. The programs are available at Florida International University, Hillsborough Community College, and College of Central Florida.

<sup>61</sup> Telephone Interview with Brendaly Rodríguez (Apr. 11, 2014).



*b. Planned next steps for regulation, funding, and organization*

Florida CHW Coalition Co-Chair Brendaly Rodríguez emphasized the importance of achieving state-level certification and cited 2015 as the target date.<sup>62</sup> In October of 2013, Florida State Senator Oscar Braynon introduced SB 306, an act creating a Task Force responsible for developing licensing procedures and certification of CHWs in Florida. Unfortunately, this bill died in the Education Committee the next year.<sup>63</sup>

Rodríguez listed as primary topics to consider for certification: the process for “grand-parenting” existing CHWs into the state certification program; the availability and design of the certification exam; the code of ethics and its enforcement; and the ongoing recertification process.<sup>64</sup>

A 2012 study of CHW curricula in Florida and other states included a proposed course of study to receive CHW certification. This course involved 21-24 credit hours at a community college or university, or 720 hours of training at a post-secondary vocational school. Sample courses included “On Being a CHW,” “Introduction to Core Roles,” “Introduction to Core Competencies,” a practicum, a course on health topics, a required field experience, and various electives.<sup>65</sup>

*c. Benefits and costs of the intended approach, according to CHW feedback*

Brendaly Rodríguez emphasized the need to have a wide variety of institutions granting CHW credentials recognized by the state ~~in addition to the state~~. She envisioned online testing, satellite locations across the state, and employment-based paths for becoming a certified CHW, training/education centers (such as community colleges and Area Health Education Centers), and public health organizations.<sup>66</sup> This process would be available in multiple languages, would not be mandatory to practice as a CHW (at least for the first few years of certification process), and would include a proper way to “grandparent” currently practicing CHWs into the system.<sup>67</sup>

Shelia McCann, the Director of Strategic Clinical Programs for the Health Choice Network of Florida, discussed the need for reimbursement to FQHCs for their CHW workforce, since grant funding was inherently unstable and on a year-to-year basis.<sup>68</sup> According to McCann, an ideal certification program would be available over the Internet and be provided in English, Spanish, and Haitian Creole.<sup>69</sup> Based on current CHW training curricula, she believes that adding more outreach skills and help with setting ethical boundaries would improve current training, as well as more intensive training and specialization within a chosen field.<sup>70</sup>

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<sup>62</sup> Id.

<sup>63</sup> The Florida Senate, *CS/SB 306: Community Health Workers*, <https://www.flsenate.gov/Session/Bill/2014/0306>.

<sup>64</sup> Telephone Interview with Brendaly Rodríguez (Apr. 11, 2014).

<sup>65</sup> DAPIC Consulting, *Final Report on the Training of Community Health Workers*, 2012. On file with Taylor Bates and Amy Katzen.

<sup>66</sup> Telephone Interview with Brendaly Rodríguez (Apr. 11, 2014).

<sup>67</sup> Id.

<sup>68</sup> Telephone Interview with Shelia McCann (Apr. 16, 2014).

<sup>69</sup> Id.

<sup>70</sup> Id.

Based on review of the Florida Certification Board fee schedule, there could be significant upfront costs for low-income people seeking CHW certification. While there will not be a set fee schedule for CHW certification until it becomes standardized statewide, Recovery Peer Specialists—laypeople who share their experiences combating addiction to help recovering addicts and who have been compared to CHWs for their role as laypeople in the medical profession—must pay \$125 for certification, \$65 for their examinations, and \$50 for a yearly renewal of their credentials.<sup>71</sup> McCann noted that employers frequently require employees to fund or pay for their own certifications and licenses.<sup>72</sup>

*d. Resources*

- Florida Community Health Worker Coalition, <http://floridachwn.pharmacy.ufl.edu/>
- Florida Community Health Worker Coalition: Meetings 2011-2013, <http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/fl-chw-coalition/meetings.html>
- National Association of Chronic Disease Directors, Community Health Worker Plan for Florida, 2010, [http://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/cvh/fl\\_chw\\_plan.pdf](http://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/cvh/fl_chw_plan.pdf)
- DAPIC CONSULTING, *Florida CHW Curriculum Review* (2012). (On file with The Center for Health Law and Policy Innovation.)

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<sup>71</sup> THE FLORIDA CERTIFICATION BOARD, *Certified Recovery Support Specialist*, available at <http://flcertificationboard.org/wp-content/uploads/CRSS-Application-March-2014.pdf>.

<sup>72</sup> Telephone Interview with Shelia McCann (Apr. 16, 2014).

## STATE POLICIES ON COMMUNITY HEALTH WORKERS: BRIEF DISCUSSIONS

### Alaska

Alaska provides grants for qualified regional health organizations to be used for training community health aides (i.e., CHWs)<sup>73</sup> and for Medicaid reimbursement of services provided by community health aides.<sup>74</sup> The Community Health Aide Training and Supervision program provides four training sessions, each of which is three-to-four weeks long; trainees complete clinical training between the four sessions. After the training sessions and completion of a “clinical skills preceptorship and examination,” the community health aide becomes qualified as a Community Health Practitioner. However, a community health aide at any training level may apply to the Community Health Aide Program Certification Board for certification.<sup>75</sup> Note that this level of qualification allows the CHW/P to perform certain clinical care duties under physician supervision and standing orders, including dispensing some classes of prescription drugs.

### Minnesota

Minnesota’s Medicaid program, Medical Assistance, covers services provided by a CHW who:

- has completed the state’s standard CHW training program;
- Has at least five years of supervised experience with an enrolled physician, RN, advanced practice RN, mental health professional, or dentist, or at least five years of supervised experience with a certified public health nurse operating under the direct authority of an enrolled unit of government; and
- Works under the supervision of one of the professionals listed above.<sup>76</sup>

This means that a CHW must be certified in order to be enrolled in Minnesota’s Medicaid program. In particular, he or she must “[h]ave a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demonstrating that the [CHW] has completed approved community health worker curriculum.” The type of certification here refers to a certification of program completion.

Minnesota Health Care Programs (MHCP) covers diagnosis-related patient education services provided by a CHW, so long as the services satisfy the following criteria:

- The CHW is supervised by an MHCP-enrolled physician or APRN, certified public health nurse, dentist, or mental health professional;
- A physician or APRN, certified public health nurse, dentist, or mental health professional orders a CHW to provide the patient education service(s);

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<sup>73</sup> AS § 18.28.010.

<sup>74</sup> Regulation 7 AAC 155.020.

<sup>75</sup> *About the Alaska CHAP Program*, ALASKA COMMUNITY HEALTH AIDE PROGRAM, <http://www.akchap.org/html/about-chap.html> (last visited May 12, 2014).

<sup>76</sup> M.S.A. § 256B.0625, Subd. 49.

- The service involves teaching the patient how to effectively self-manage his or her health in conjunction with the healthcare team;
- The service is provided face-to-face with the recipient (individually or in a group) in an outpatient, home or clinic, or other community setting;
- The content of the educational and training program is a standardized curriculum consistent with established or recognized health or dental health care standards. The curriculum may be modified as necessary for the clinical needs, cultural norms, and health or dental literacy of the individual patients.

MHCP does not cover social services provided by a CHW, such as enrollment assistance, case management, or advocacy, nor does it cover interpreter services in conjunction with CHW services.

Reimbursement for CHW services is based on units of time and can include up to eight patients per session. Enrolled CHWs are considered “non-pay” to the provider, so their services must be billed by an eligible MHCP enrolled billing provider to receive payment. CHWs cannot bill Medicaid directly for their services. The following entities are eligible billing providers:

- Advance Practice Registered Nurse (APRN)
- Clinic
- Community Health Clinic
- Critical Access Hospital
- Dentist
- Family Planning Agency
- Federally Qualified Health Center (FQHC)
- Hospital
- Indian Health Service (IHS) Facility
- Mental Health Professionals
- Physician
- Public Health Clinic Nurse
- Rural Health Center (RHC)
- Tribal Health Facility

Minnesota also supports CHWs through other, non-Medicaid systems. M.S.A. § 145A.17 provides funding for family home visiting programs to promote “family health.” To receive funding for such programs, community health boards and tribal governments must collaborate with CHWs. M.S.A. § 256B.0755 (effective August 1, 2013) authorizes “a demonstration project to test alternative and innovative health care delivery systems.” To be eligible to participate in the demonstration project, a health care delivery system must “adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of ... community health workers.”

## **New Mexico**

N.M.S.A. 1978, § 27-2-12.15 (effective May 19, 2010) establishes a medical home program within Medicaid and S-CHIP. Components of the medical home model may include “implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system, including the use of community health workers or promotoras.” NM Senate Bill 58 (2014) has created a Board of Certification for CHWs.

## **New York**

Under McKinney’s Public Health Law § 2959-a, New York makes enhanced payments to “primary care clinicians and clinics statewide that are certified as medical homes for the purpose of improving health care outcomes and efficiency through improved access, patient care continuity and coordination of health’s services.” The state may make payments to “entities that provide services to health care providers to assist them in meeting medical home standards under the program such as the services of community health workers.”

The New York State Health Foundation convened a statewide CHW policy initiative and produced in 2011 detailed recommendations on the scope of practice and training requirements. The summary report, *Paving a Path to Advance the Community Health Worker Workforce in New York State*, recommends statewide standards pertaining to the scope of practice, training, certification and financing mechanisms that can help integrate CHWs in the health care and social service systems.

## **Ohio**

The Ohio Board of Nursing has authority to issue and renew CHW certificates<sup>77</sup> and to levy fees pertaining to the issuance of certificates to CHWs and written verification of CHW certification.<sup>78</sup> The board may also deny, revoke, or suspend a CHW certificate.<sup>79</sup> The state requires that CHW training programs be approved by the board and reapproved every two years.<sup>80</sup>

The statute requires the state board of nursing to establish and operate a certification program for CHWs:

*“The certification program shall reflect the board’s recognition of individuals who, as community representatives, advocate for individuals and groups in the community by assisting them in accessing community health and supportive resources through the provision of such services as education, role modeling, outreach, home visits, and referrals, any of which may be targeted toward an individual, family, or entire community. The certification program also shall reflect the board’s recognition of the individuals as members of the community with a unique perspective of*

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<sup>77</sup> R.C. § 4723.06.

<sup>78</sup> R.C. § 4723.08(A)(7) and 4723.88(J).

<sup>79</sup> R.C. § 4723.86.

<sup>80</sup> R.C. § 4723.87.

*community needs that enables them to develop culturally appropriate solutions to problems and translate the solutions into practice.”<sup>81</sup>*

The statute notes that certification is not required for an individual to perform any of the functions that may be performed by a CHW. However, CHWs may perform activities related to nursing care only pursuant to the delegation of an RN acting in accordance with the rules under this statute, and CHWs may perform other health-related activities only under the supervision of a health professional acting within the scope of the professional’s practice.<sup>82</sup> In particular, only an RN may supervise a CHW when performing delegated activities related to nursing care. Ohio regulations explain that the basic requirements of delegation of nursing tasks to a CHW are that the delegated task must be relatively simple and low-risk, and that the delegating nurse must supervise performance of the task. Further, a nurse cannot delegate the administration of medications, and a CHW cannot delegate to someone else a task that was delegated to the CHW by a nurse.<sup>83</sup>

An individual must apply to the board of nursing to be certified as a CHW.<sup>84</sup> To obtain a CHW certificate, an applicant who satisfies the requirements of the statute (below) must submit a completed application to the board of nursing with an application fee of \$35.<sup>85</sup>

To be eligible to receive a CHW certificate, an applicant must meet several conditions, including:

- Be 18 years of age or older;
- Possess a high school diploma or equivalent, as determined by the board;
- Meet one of the following criteria:
  - Successfully complete a CHW training program approved under R.C. § 4723.87, or
  - Be employed in a capacity substantially the same as a CHW before February 1, 2005, meet the requirements specified in rules adopted by the board under R.C. § 4723.88, and provide documentation from the employer attesting to the employer’s belief that the applicant is competent to perform activities as a certified CHW.<sup>86</sup>

CHW certificates must be renewed every two years, which requires completion of continuing education requirements.<sup>87</sup> Specifically, a CHW must complete 15 hours of continuing education.<sup>88</sup>

## **Texas**

Texas defines a CHW or a promotora as

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<sup>81</sup> R.C. § 4723.81.

<sup>82</sup> R.C. § 4723.82.

<sup>83</sup> OAC 4723-26-07-09.

<sup>84</sup> R.C. § 4723.83.

<sup>85</sup> OAC 4723-26-02.

<sup>86</sup> R.C. § 4723.84.

<sup>87</sup> R.C. § 4723.85.

<sup>88</sup> OAC 4723-26-05.

*“a person who, with or without compensation, provides a liaison between health care providers and patients through activities that may include activities such as assisting in case conferences, providing patient education, making referrals to health and social services, conducting needs assessments, distributing surveys to identify barriers to health care delivery, making home visits, and providing bilingual language services.”<sup>89</sup>*

The Department of State Health Services is to establish and operate a training program for promotoras and CHWs. Participation in this program is voluntary for promotoras and CHWs who provide services without compensation and mandatory for those who provide services for compensation. The mandatory nature of certification was established by a single-purpose bill (SB 1051) in 2001, but the Texas statutes do not specify enforcement procedures or penalties for practicing without certification. The commissioner of state health services may exempt a promotora or CHW from mandatory training who has served for three or more years or who has 1,000 or more hours of experience.<sup>90</sup> The training program consists of a 160-hour curriculum that must be approved by the state as meeting general criteria.<sup>91</sup>

Texas requires that the State Health Services commissioner adopt rules that provide minimum standards and guidelines (including participation in a training program) for the issuance of CHW certification.<sup>92</sup> Prospective CHWs must apply to the Department of State Health Services for certification.<sup>93</sup> Certification is not required for a person to act as a promotora or CHW without compensation, but is required for those who receive compensation. The commissioner must require health and 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.

The statute further requires the Department of State Health Services to establish a Promotora and Community Health Worker Training and Certification Advisory Committee, composed of representatives from relevant entities appointed by the commissioner, to advise the department on matters related to CHW training and funding for CHW employment.<sup>94</sup>

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<sup>89</sup> V.T.C.A., Health & Safety Code § 48.001.

<sup>90</sup> V.T.C.A., Health & Safety Code § 48.051.

<sup>91</sup> 25 TAC § 146.8.

<sup>92</sup> V.T.C.A., Health & Safety Code § 48.052.

<sup>93</sup> 25 TAC § 146.4.

<sup>94</sup> V.T.C.A., Health & Safety Code § 48.101.

## CONCLUSION

Community health workers are an expanding and crucial component of the healthcare system across the United States. States that wish to explore opportunities to enhance the role of CHWs through certification can learn from the states already engaged in this work. Key insights gained from the research for this paper include:

1. Community health workers must be full participants in system design, including identifying skill and core competency requirements, training standards, and certification requirements.
2. Training and certification standards should be flexible enough to accommodate those who may already have been in the field for some time, and those for whom classroom and written learning may be challenging. This includes “work experience” or grandfathering solutions, as well as appropriate language training.
3. Some risks of certification – the potential to exclude some members of the traditional CHW group through background checks or insufficient training locations – may be mitigated through careful design and sufficient stakeholder identification of such concerns before policies are adopted.
4. States have not yet incorporated into credentialing standards any criteria related to the candidate’s relationship to or knowledge of the community, despite wide acceptance of such qualifications as essential to the CHWs role. This aspect of standard-setting may represent the greatest public policy challenge in future efforts to codify CHW qualifications.

Ongoing work in this area thus clearly requires extensive communication and collaboration. Fortunately, these are two areas in which community health workers are extremely well qualified to help states establish the most suitable protocols for certification.