



Development of Nebraska's Community Health Worker Workforce

Prepared by: Pat Lopez
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EXECUTIVE SUMMARY

During the past year a diverse group of representatives from several organizations and some Community Health Workers joined together to develop a more concise picture of the community health workforce in Nebraska, adopt core competencies for Community Health Workers, identify training and education needs, and develop a sustainability plan. The purpose of this document is to serve as a resource for the development of a sustainable Community Health Worker workforce in Nebraska.

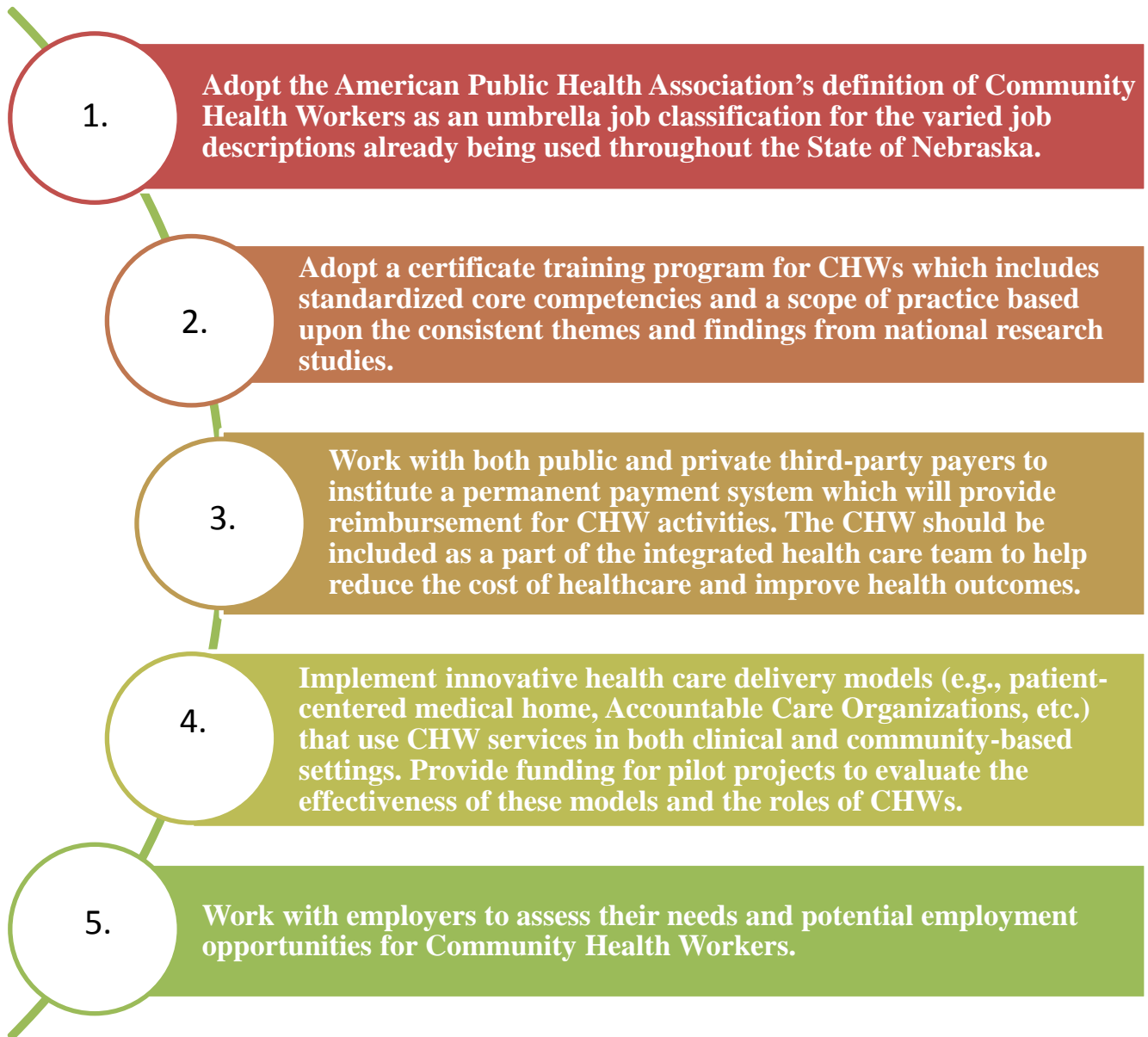
To reduce health care costs and improve health outcomes, access to care for the underserved must be addressed in Nebraska. The lack of timely care often results in a greater use of more expensive hospital emergency rooms. These individuals, who reside in both rural and urban areas, often face a wide range of barriers in attempting to successfully navigate the health care social service systems. The barriers include a lack of understanding of their health condition and an inability to locate essential community resources to assist them in meeting their health needs. In Nebraska, we now have an opportunity to help address the needs of the underserved and reduce health disparities by increasing the use of the Community Health Workers. Community Health Workers use a community- centered approach to improve the health outcomes of underserved populations. They are trained to promote healthy behaviors and manage chronic health conditions, which in turn reduce health care costs and lead to better health outcomes.

Community Health Workers have been part of the Nebraska workforce for more than 20 years. The roles of Community Health Workers have been carried out under several different names and titles, including *promotoras*, lay health ambassadors, outreach workers, and interventionists. They have been used throughout the state by different types of providers such as state, local, and tribal governments, community- based service organizations, faith-based organizations, as well as clinics serving disparate populations (e.g., Federally Qualified Health Centers).

The World Health Organization (WHO) and The American Public Health Association (APHA) have recognized the contributions of Community Health Workers and have recommended that they be part of the solution to help reduce health disparities and more effectively meet the needs of underserved populations. There is strong evidence that Community Health Workers can have a positive impact on health care costs and more importantly, they can serve as agents of change by empowering people and finding solutions that will begin to address the problems associated with the social determinates of health.

RECOMMENDATIONS

In order to establish Community Health Workers (CHWs) as an integral part of Nebraska's health system and workforce, the following policy recommendations should be considered:



NATIONAL PERSPECTIVE

Definition and Role

The American Public Health Association: Community Health Workers Section and Public Health Association of Nebraska's Community Health Worker Section, have adopted an umbrella term that defines CHWs as follows:

“A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/ intermediary between health/social services and the community to facilitate access to services and improve the quality and community capacity by increasing health knowledge and self-efficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.”

The definition of a CHW is an umbrella term that illustrates a health workforce that functions under a wide range of job titles; describing the health workers are not all inclusive:

- Case Coordinator
- Community Coordinator
- Community Liaison
- Community Outreach Worker
- Family Advocate
- Family Support Worker
- Health Coach
- Home Care Worker
- Intake Specialist
- Outreach Advocate
- Outreach Educator
- Outreach Case Manager
- Parent Liaison
- Peer Educator

The workforce of CHWs has adopted core competencies and a scope of practice in Nebraska. In order for CHWs to be recognized in their field, as well as by the state, core competencies will need to be obtained through standard educational curriculums and trainings. Once this step is completed, certification of CHWs can be achieved.

History

Throughout history, Community Health Workers (CHWs) have worked to care for others and better serve their community. CHWs first appeared in the early 17th century during a serious physician shortage in Russia and China. Their goal was to reach out to people living in rural and urban areas to provide primary health care. CHWs are members of the community who work as volunteers or for pay with health and social service systems in both urban and rural environments. They are able to relate to people they serve by sharing their culture, language, socioeconomic status, and life experiences. CHWs offer a wide variety of tasks to the health community. For example, they are able to provide interpretation and translation services, explain health education and information thoroughly, offer care and guidance on health behaviors, and give a few direct services such as blood pressure screening and first aid (HRSA Community Health Workers National Workforce Study 2007).

Community Health Workers continued throughout the centuries providing care to those that did not have access. In the 1950's Promotores worked as Community Health Workers in Latin America. CHWs advocated for and promoted a more equal distribution of health resources and connecting people to health care services. The goal was to empower people they served by advocating for them.

In the United States CHWs first appeared in the 1960's as part of the Great Society domestic programs. The Great Society mission was to end poverty, promote equality, improve education, rejuvenate cities and protect the environment. CHWs were part of this government- created program and were given entry-level positions to further develop their career. The federal government formally supported CHWs through the Federal Migrant Health Act of 1962 and the Economic Opportunity Act of 1964. These Acts created migrant and community health centers across the country.

In 1968, one of the first formal CHW programs was the Community Health Representative (CHR) program. The CHR program works with members of Native American communities to improve health knowledge and behaviors within those communities. Ten years later in 1978, the World Health Organization recognized the use of CHWs. At the same time, there were other CHW programs implemented in several states during the 1980s, and additional programs began in the 1990s.

The American Public Health Association, the National Conference of State Legislatures and the Institute of Medicine have all published reports that document the potential benefits of CHWs. The Health resources and services Administration (HRSA) published a comprehensive workforce study of Community Health Workers in 2007. There is also a growing body of knowledge on the cost-effectiveness, impact, utilization, and disease management benefits related to Community Health Workers. Several states have developed legislative statutes for Community Health Workers (e.g., New Mexico, Massachusetts, California, Texas, and Minnesota). Additionally, states such as Maryland and Illinois are working on developing statutes for the long-term utilization of Community Health Workers related to core competencies, training, certification and financing.

Cost-Effectiveness

Beginning in 1991 the administrators of the Maryland Medicaid program expressed concern about the increasing number of emergency room visits and hospitalizations. In response to this concern, Fedder and colleagues (2003) developed the Community Health Worker Outreach (CHW) program reflecting on the third world model as an intervention. The patients recruited in this program were on the discharge rolls of the University of Maryland Medical System and/or the Maryland Diabetes Care Program. The objective of the CHW program was to improve patients' health behaviors and to reduce more costly ER visits and hospital admissions. In this program, the CHWs were given numerous duties such as linking patients with appropriate primary care and specialty practitioners, monitoring patients' self-care behaviors, monitoring their blood glucose and blood pressure measurement, and diabetic foot inspections, assisting in developing Medicaid eligibility and providing social support to patients, their caregivers and families. This program was highly successful and generated significant saving by decreasing emergency room visits and hospitalizations. After the second year, the emergency room (ER) visits and hospitalizations declined by about 38% and 30% respectively, and ER admissions (visits resulting in a direct hospitalization) were reduced by 53%. Overall, there was a decrease in Medicaid reimbursement by 27% after one year of the CHW intervention. Using direct costs only, the estimated gross savings per CHW was \$80,000 to \$90,000 per year.

A study by Denver Health also demonstrated a positive return on investment when CHWs were used. In this study, CHW interventions reduced urgent care and inpatient and outpatient behavioral health visits by \$6,000 per month. Even though the CHW health services program requires some funding, it is more affordable than treating serious conditions. After evaluating the return on investment for the CHW program, the study found that CHWs saved \$2.28 for every \$1 invested in the program. Primary care visits increased after meeting with a CHW, and expensive urgent and inpatient care decreased (Goodwin and Tobler 2008).

According to Ryabov (2014), type 2 Diabetes is diagnosed in 1 out of 10 adult Americans and in about 2 million people aged 20 years or older each year. Even though diabetes is found in all communities, it is significantly more prevalent in certain ethnic groups. For example, the risk of diabetes is 66% greater among Hispanics, specifically Mexican-Americans, rather than non-Hispanic white adults. With the help of CHW interventions, Mexican-American patients have been improving their clinical reports and health behaviors. CHWs have been effective because they are able to represent their community and advocate on behalf of its patients. With the help of CHWs, Mexican-Americans with type 2 Diabetes have been able to obtain quality care at an affordable cost and improve their clinical outcomes. The intervention program was designed to evaluate the cost-effectiveness of managing type 2 Diabetes with the assistance of CHWs. The results showed an improvement in glycemic control, cholesterol, and more importantly, the cost-effectiveness ratio was below other comparable studies. With the ongoing assistance from CHWs, the long-term cost-effectiveness for patients with type 2 Diabetes will improve.

Using a similar Mexican American population, Prezio and colleagues (2014) examined the long-term cost-effectiveness of managing and educating patients about diabetes. Based on a simulation model incremental cost-effectiveness ratios (ICERs) were estimated at 5-, 10-, 20-year time periods. The results showed after a 20-year time period, the ICER was estimated at \$55 per quality-adjusted life year gained. Not only was it cost-effective, but also the participants also showed lower HbA1c, less foot ulcers, and fewer foot amputations because of education and management training from CHWs.

Impact

An increasing number of states are considering legislation to define community health workers, study the workforce, establish training and certification programs, provide incentives for Medicaid reimbursement, and create Community Health Worker programs. According to Goodwin and Tobler (2008), a 2005 state survey determined that 17 states have already developed some type of training or certification for these workers. Examples of states that have organized a Community Health Worker Workforce Program are Kentucky, Massachusetts, New Mexico, Ohio, Texas, Virginia, and Washington. In many states that have developed a workforce program, cost savings have been estimated. For example, the Kentucky Homeplace Program, which was established in 1994 by the Kentucky General Assembly, and was funded for \$2 million in 2007. In New Mexico the Department of Health was required by the Legislature to conduct a study about the benefits of creating Community Health Worker programs, assess the impact of CHWs on the healthcare delivery system, and examine their effects on patient health. The results from this study show that using CHWs will lead to an improvement in public health outcomes, an increase in access to care, and a reduction in health care costs.

Community Health Workers in Nebraska can offer sustainable benefits that can increase the access to appropriate care for patients and lower medical costs. CHWs can also provide direct assistance to underserved populations and ultimately improve health outcomes.

An assessment of CHWs can be completed by collecting and analyzing several types of data and information. The impact on health can be measured by examining the number additional health screenings, analyzing the managed care Health Effectiveness Data and Information Set, emergency department use, hospitalizations, and prescription drug use. Qualitative measures can be used to evaluate demographic profile information, language barriers and amenities, cultural practices, social barriers, and individual/ community health needs assessments. All of this information should be sufficient to highlight the social determinates of health and the overall economic impact as recommended by the WHO.

Utilization

Previous studies have documented the impact of CHW's on the utilization of care. In 2006, Whitley et al. studied the impact on utilization of health services prior to and after the CHW intervention. They found positive return-on-investment for underserved adult men who had contact with a Community Health Worker. In this study, services were tracked for nine months before contact with a CHW and nine months after contact. They found that the total number of outpatient visits increased for primary care, urgent care, behavioral health care, medical specialty care, and dental care, there was a cost savings due to the decrease in the number of inpatient hospital visits (219 versus 165).

Using the "Pathways" accountability model for the Community Health Access Project in Ohio a study has linked CHW activities to a reduction in low birth weight rates which are associated with significant hospital costs during a LBW baby's first year of life.

Kangovi et.al (2014) found that patients receiving interventions from CHWs were more likely to obtain timely post hospital primary care (60.0% vs 47.9%). The study concluded that the interventions improved access to primary care and helped control recurrent readmissions in a high-risk population. The CHW improved post hospital outcomes by addressing behavioral and socioeconomic drivers of the disease.

Kreiger et.al in 2009 found that a child with asthma living in low-income households and working with Community Health Workers in the home experienced an increase in symptom-free days. The randomized trial provided nurse- only intervention or nurse- plus community health worker intervention. The CHW-provided home environmental assessments, asthma education, social support, and asthma-control resources. Nurses provided the clinical information and referrals.

In a recent study, Ryabov (2014) evaluated the clinical effectiveness and cost effectiveness of a self-management diabetes program involving CHWs in the U.S.-Mexico border region. Individuals received monthly home visits by CHWs who provided an emphasis on patient education and self-management. The evaluation of the clinical effectiveness revealed that the diabetes self-management program delivered using CHWs significantly improved HbA1c, triglycerides, and HDL cholesterol levels in patients in the intervention group at two years of follow-up compared to traditional care.

Disease Management

The Amigos en Salud (Friends in Health) Research Project uses Community Health Workers in Los Angeles to help Hispanic patients with diabetes and co-occurring depression to understand and manage their condition. Patients with these diagnoses usually have high primary care costs. Results showed that patients in this program improved their health by being able to rate their overall health as “good” or “excellent”. For example, the participants were more likely to change their eating habits and switch to eating healthy vegetables rather than fatty foods. The results also showed them working out three or more times each week. Their depression scores, as measured through a patient survey, decreased. At the same time, medical results improved considerably.

Raphael and colleagues (2013) conducted a study that provided effective care to children with chronic diseases such as asthma, diabetes, obesity, and failure to thrive. Within the last four decades, chronic disease in children has quadrupled. CHWs were to provide one-on-one assistance to these children and the care management that they needed. The results showed that CHWs helped reduce care use and decreased the patient’s symptoms.

In New Mexico, Community Health Workers provided community-based support services to enrollees in Medicaid Managed Care who were high users of health resources. They provided patient education, advocacy and social support for six months. Johnson et al. in 2011 found that data from the interventions demonstrated significant savings and reduction in the utilization of emergency room visits, inpatient hospitalizations and pharmacy use during the period 2007-2009. The cost savings was estimated to be \$2,044,465.

Felix and colleagues (2011) established the Community Connector Program in Arkansas to decrease the cost of care for the elderly population with the use of Community Health Workers. The program assists adults eligible for Medicaid. The CHWs provide care services to residents in need of home and community-based long-term care. This allowed the patients to remain in their own home rather than in a nursing home or assisted living facility. The results of the study indicated that from 2005-2008 Medicaid expenditures dropped by \$3.515 million and the net savings to the Medicaid program was \$2.619 million.

Four national research studies, which include The National Community Health Workers Advisory Study (1998), the Community Health Workers Certification and Training: A National Study of Regionally and State-Based Programs (2005), The Community Health Worker National Workforce Study (2007) and National Community Health Workers Advocacy Study (2010) have consistently demonstrated the following roles/ competencies of CHWs in the United States:

National Community Health Workers Roles

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|--|
| I. Bridging/cultural mediation between communities and the health care systems |
| II. Providing culturally appropriate and accessible health education and information |
| III. Assuring that people get the services they need |
| IV. Providing informal counseling and social support |
| V. Advocating for individuals and community needs |
| VI. Providing direct services |
| VII. Building individual and community capacity |
| VIII. Acting as a member of the care delivery team |
| IX. Serving as a navigator |
| X. Screening and health education provider |
| XI. Acting as an outreach/ enrollment/ informing agent |
| XII. Acting as a community organizer |

National Community Health Workers Core Competencies

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|--|
| I. Communication Skills |
| II. Interpersonal Skills |
| III. Capacity Building Skills |
| IV. Advocacy Skills |
| V. Organizational Skills |
| VI. Case Management |
| VII. Knowledge of specific health issues |
| VIII. Documentation |

NEBRASKA PERSPECTIVE

The workforce of Community Health Workers in Nebraska is promoting culturally appropriate health care access. They are considered experts in their understanding of the culture, the community, and the people. They can help change the health seeking habits by encouraging health screenings, reducing inappropriate emergency room use, and providing stability for patients in addressing their own health needs. Nebraska must consider the role of Community Health Workers in reducing health disparities among vulnerable populations and as agents of change who will contribute to lower health care costs at both the state and community levels.

By providing direct services to the Medicaid population, CHWs can reduce these costs even more. The 2012 Nebraska Medicaid Annual Report, concluded that managed care decreased the cost of physician services by 19% and inpatient hospital services declined by 8%. CHWs have the potential to generate additional cost savings by redirecting health seeking behavior and educating patients about using health care services and systems.

In 2006, the Office of Health Disparities and Health Equity (OHDHE) at the Department of Health and Human Services published the Minority Behavior Risk Factor Survey. The report identified the health risks of chronic health conditions, access to care, and life style practices of minority populations. Among the recommendations to address the health inequities, the OHDHE recommended that CHWs be part of an outreach effort to increase access to health screening for minority populations.

Nebraska should resolve to use CHWs to better serve underserved populations. CHWs will provide more equitable and effective health care services by taking into consideration how the social determinates influence poor health outcomes, while reducing the cost to Nebraska's healthcare system.

To begin to explore development of the Community Health Worker workforce in Nebraska, a CHW Steering Committee was formed. The Steering Committee has been addressing many aspects related to defining and sustaining the work of Community Health Workers in Nebraska. One outcome of this work was the formation of the Community Health Worker Section in the Public Health Association of Nebraska.

The Public Health Association of Nebraska received a grant from APHA to develop a policy paper for Community Health Workers in Nebraska. The Association established a team to develop policy recommendations regarding CHWs in Nebraska. The team included the executive officers from the CHW section of PHAN, Policy Chair for PHAN, a representative from the College of Public Health Office of Practice and three local health directors with knowledge about Community Health Workers.

Throughout the development of the policy recommendations from the Association, the work of the existing steering committee was reviewed and there was a focus on how CHWs could be integrated into a multidisciplinary team of health care and public health practitioners that will benefit and promote wellness for all Nebraskans regardless of their birth place or zip code.

The team from the Public Health Association also identified the need for more information directly from Community Health Workers who are practicing in various areas of the state. Key communities were identified across the state for Town Hall meetings to gain information from CHWs and increase awareness of the availability of the PHAN CHW section as a resource for them.

There were six Community Health Worker Town Halls completed. The Town Halls were held in both rural and urban areas of Nebraska (See Appendix). Town Halls were held in the two largest population centers and in rural areas of the state where community health workers are employed.

The scope of work done by the CHW varies by community. Over 50% of those attending the Town Halls reported being trained to take and ask questions related to diabetes and hypertension. Volunteer CHWs are less likely to be trained in these areas. Employed CHWs were more likely to be in community locations such as Health Departments or Community Action Agencies. Their direct contact with physicians varied in frequency depending on the location of CHW.

A standard set of questions was used to stimulate discussion. Those attending were encouraged to speak freely and were assured of the confidentiality of their remarks. Overwhelmingly those participating voiced the desire for a core curriculum that is transferrable, supervision, and the opportunity to interact and network with each other. They also identified the need for education of employers on role and scope of practice of CHW and the employer roles and responsibilities.

Town Hall Themes

- CHWs want a basic level of training to prepare them for their role regardless of where they are employed in Nebraska.
- CHWs feel the availability of access to a supervisor is critical.
- Stable ongoing funding is needed
- The health of many of the individuals they work with is affected by their employment, lack of insurance, and lack of money
- The ability to connect with other Community Health Workers is needed.
- Employers need education on their role, responsibilities and supervision of CHWs

The role of the CHW varies depending on their employer and funder requirements. For example some CHWs only address areas related to clinical care, others may monitor blood pressure, HgbA1c and others still may connect individuals to prevention programs and address social needs to improve access and health status.

Employers Survey Results

A survey of employers related to Community Health Workers focused on:

- Funding/Compensation
- Funding Streams
- Roles and responsibilities
- Training/Education
- Sustainability

A total of nine employers responding to the survey indicated that they employ CHWs in their organization. Over 75% of the respondents identified the following six common job responsibilities of their community health workers: 1) Helping people understand their health condition(s) and develop strategies to improve their health and wellbeing (100%), 2) Linking people to health care/social service resources (88.9%), 3) Helping to build understanding to support healthier behaviors and lifestyle choice (88.9%), 4) Helping individuals, families, groups and communities access to resources, including health insurance, food, housing, quality care and health information (88.9%), and 5) Translating and interpreting for clients and health care/social service providers (77.8%).

All of the respondents indicated that their CHWs have received some type of training. The types of training included a program offered through Nebraska Department of Health and Human Services, Basic CPR, Healthy Families America Training, Domestic Violence Training, Child Abuse Training, and Cultural Sensitivity Training. Almost 90% (88.9%) of the respondents' employed between 1 and 5 CHWs. Additionally, the majority of CHWs working at these sites are paid staff members (n=9) as compared to volunteers (n=4), and all (100%) of the paid staff CHWs receive a salary through a grant instead of a stipend, contract, or fee for services. The need for long-term sustainable funding was identified as requiring support from the legislature.

POLICY RECOMMENDATIONS

Based on the information from the community health workers, employers, the steering committee, and past research, several areas need to be addressed in order to establish Community Health Workers as an integral part of Nebraska's health system. Policy recommendations to initiate a sustainable Community Health Workforce for the State of Nebraska are:

- Adopt the American Public Health Association's definition of Community Health Workers as an umbrella job classification for the varied job descriptions already being used throughout the State of Nebraska.
- Adopt a certificate training program for CHWs which includes standardized core competencies and a scope of practice based upon the consistent themes and findings from national research studies.
- Work with both public and private third-party payers to institute a permanent payment system which will provide reimbursement for CHW activities. The CHW should be included as a part of the integrated health care team to help reduce the cost of healthcare and improve health outcomes.
- Implement innovative health care delivery models (e.g., patient-centered medical home, Accountable Care Organizations, etc.) that use CHW services in both clinical and community-based settings. Provide funding for pilot projects to evaluate the effectiveness of these models and the roles of CHWs.
- Work with employers to assess their needs and potential employment opportunities for Community Health Workers

NEBRASKA CHW DEFINITION, ROLES, AND CORE COMPETENCIES

(Adopted by the NE CHW Coalition Steering Committee, April 29, 2014.)

The definition of a Community Health Worker (CHW) is an individual who:

- Serves as a liaison/link between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors
- Conducts outreach that promotes and improves individual and community health
- Facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska.

A CHW is a trusted member of, or has a good understanding of, the community they serve. They are able to build trusting relationships and are able to link individuals with the systems of care in the communities they serve. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. CHW is an umbrella term used to define other professional titles.

Nebraska Community Health Workers Roles -Functions/Responsibilities/Activities

I. Ability to work within the Nebraska CHW Association code of ethics

II. Serve as a Cultural Health Liaison or Facilitator
III. Empower clients through advocacy and education
IV. Conduct outreach activities
V. Raise awareness of health and wellness needs
VI. Provide disease prevention education
VII. Provide social support
VIII. Build community capacity
IX. Community resources navigation

CHW Knowledge Base

CHWs demonstrate knowledge on a variety of topics based on the needs of the communities, clients, families, and service systems. They provide culturally appropriate health education to individuals they serve. The foundation for CHW practice includes:

Nebraska Community Health Knowledge Base

I.	Basic knowledge about social determinants of health
II.	Basic knowledge of public health principles
III.	Knowledge of community definition, resources, organization
IV.	Health and social service systems knowledge
V.	Health education knowledge
VI.	Cultural Competency and Health Literacy
VII.	Interpretation and Translation - understand the role of medical interpreters and boundaries for practice
VIII.	Understand the scope of practice of Community Health Worker practice
IX.	Ethics and practice
X.	Educational and facilitation techniques
XI.	Minimal definition of health, disease and well being
XII.	Basic knowledge of specific health topics when they are related to their scope of activities

Nebraska Community Health Workers Core Competencies: Skills and Qualities

ROLE I	Communication Skills <ul style="list-style-type: none"> • Ability to use Active Listening • Ability to communicate in writing • Ability to communicate verbally 	ROLE V	Advocacy Skills <ul style="list-style-type: none"> • Ability to be assertive and respectful • Ability to listen and ask questions • Ability to advocate at different professional levels • Ability to identify and manage risky situations • Ability to strengthen social support networks
ROLE II	Interpersonal Skills <ul style="list-style-type: none"> • Ability to build relationships • Ability to work as part of a team • Ability to understand and work within cultural dynamics 	ROLE VI	Organizational Skills <ul style="list-style-type: none"> • Ability to develop plans and set goals • Ability to manage time and determine priorities • Ability to manage a budget • Ability to report and evaluate in community settings
ROLE III	Capacity Building <ul style="list-style-type: none"> • Understanding of and ability to apply leadership • Ability to develop additional skills • Ability to develop and manage resources • Ability to use planning skills • Ability to produce complete, accurate reports • Understanding of needs assessments 	ROLE VII	Service Coordination <ul style="list-style-type: none"> • Ability to identify and access resources • Ability to make appropriate referrals when needed • Ability to network, form partnerships, and work with others in planning efforts
ROLE IV	Teaching Skills <ul style="list-style-type: none"> • Ability to teach one-on-one and/or in group settings • Ability and willingness to learn and be proficient with information being presented • Ability to lead classes or educational sessions • Recognize need to continue education • Ability to adapt teaching style to audience needs 	ROLE VIII	Outreach Methods and Strategies <ul style="list-style-type: none"> • Ability to engage others • Ability to foster collaborative relationships • Ability to build trust within the community
ROLE IX	Client and Community Assessment <ul style="list-style-type: none"> • Ability to understand basic surveys, interviews, and observational methods • Ability to understand living process of communities • Ability to understand population health data 		

Description of Core Competencies

Communication Skills

The CHWs will communicate with varied populations, individuals, other community health workers, and professionals in a manner that is appropriate for the audience. Effective cross cultural communication is a central aspect of CHW activity in all areas. They must be able to use relevant languages, be respectful, and demonstrate knowledge of the cultural group(s) they are engaging. They must be able to convey their knowledge base of basic health and social concerns that are meaningful to the clients and families, especially when behavior patterns are deeply rooted in traditions. Sensitivity must be used when attempting to discuss options and reasons for change.

CHWs are required to write and prepare clear reports on their clients, activities, and assessments of individual and community needs. They will be expected to give presentations regarding the needs and concerns of their clients and communities. Competence in writing and technical skills is expected to increase with experience. CHWs are encouraged to be able to read and write in English, but it may not be essential depending upon their area of focus.

Interpersonal Skills

CHWs work with a diverse group of individuals including community members and professionals. They must be able to develop and maintain relationships at all levels. They must be able to work as part of a team, and consider, understand, and respect various perspectives to meet the needs of others.

Capacity Building

CHWs will increase the capability of their community to be empowered to care for themselves. They will also work collectively with community members and stakeholders to develop plans to increase resources in the community and to expand public awareness of community needs.

Teaching Skills

CHWs teach and provide health and social service information and education to individuals they assist. They will effectively support and engage clients and their families in making behavioral changes, following treatment suggestions, and identifying barriers to change that are mutually acceptable and understood by the client, families, and community contact. They will have the ability to make appropriate referrals when needed.

Advocacy Skills

CHWs must be able to advocate effectively with others so that the individuals they serve are able to receive the services they need. They provide information and support to others and teach them how to advocate for their own needs. They must have knowledge and tools for conflict resolution.

Organizational Skills

CHWs must have good organizational skills to help support the individuals and families they serve. They must be able to help and teach others to set and achieve goals. They help individuals and families set appointments, follow up with care plans and help address barriers, and complete reporting requirements.

Service Coordination

CHWs help coordinate the care of their clients. They will be familiar with the agencies and professionals in the community they serve in order to assist clients and families to secure needed care. They understand the need for, and boundaries of, medical interpretation and ability to be a patient advocate. They are able to network, participate in community and agency planning and evaluation efforts directed at improving care, and bring needed services into the community.

Outreach Strategies and Methods

CHWs must be committed to outreach efforts that are directed at “meeting the people where they are”. Outreach means furnishing health-related information and services to a population that has not been served or is underserved. CHWs use outreach strategies and methods in order to provide these services to populations or groups where they live, work, play, and congregate (such as churches, parks, grocery stores, community centers, etc.). They assist the community in finding, using, creating, and supporting resources among community members and systems of care.

Client and Community Assessment

CHWs must continue to identify community and individual needs, concerns, and assets. They will use standard knowledge of basic health and social indexes to clearly define the needs of the community they are serving. CHWs will engage clients and their families in ongoing assessment of their needs and develop plans and strategies for clients, a targeted population, or community.

Nebraska Community Health Workers Scope of Practice: Roles and Related Tasks

Adapted from: Paving a Path to Advance the CHW Workforce in New York State (October 2011). Matos, S., Findley, S., Hicks, A., Legendre, Y., Canto, L.

ROLE I	<ul style="list-style-type: none"> • Outreach and Community Mobilization • Preparation and distribution of materials • Case-finding and recruitment • Community strengths/needs assessment • Home visiting • Promoting health literacy • Advocacy 	ROLE IV	<ul style="list-style-type: none"> • Home-based Support • Family engagement • Home visiting • Environmental assessment • Promoting health literacy • Supportive listening • Coaching on problem-solving • Action plan implementation • Treatment adherence • Documentation
ROLE II	<ul style="list-style-type: none"> • Community/Cultural Liaison • Community organizing • Advocacy • Translation and interpretation* (see role V) • Community needs/strengths assessment 	ROLE V	<ul style="list-style-type: none"> • Health Promotion and Health Coaching • Translation and interpretation* (While informal translation will take place, there is a certification process for becoming a translator. Translation is not a primary duty of a CHW. Not all CHWs will become translators.) • Preparation and distribution of materials • Teaching health promotion and prevention • Coaching and problem-solving • Modeling behavior change • Promoting health literacy • Adult learning methods selection • Harm reduction • Treatment adherence • Leading support groups • Documentation
ROLE III	<ul style="list-style-type: none"> • Case Management and Care Coordination • Family engagement • Individual strengths/needs assessment • Addressing basic needs-food, shelter, etc. • Promoting health literacy • Coaching and problem-solving • Goal-setting and action planning • Supportive listening • Coordination, referrals, follow-ups • Feedback to medical providers • Treatment adherence • Documentation 	ROLE VI	<ul style="list-style-type: none"> • Participatory Research • Preparation and distribution of materials • Advocacy • Interviewing • Computerized data entry and web searches • Documentation

TRAINING AND EDUCATION

At this time CHWs receive training from a variety of sources and on the job. Their duties cover a wide range of activities. A comprehensive education and training program will advance and define the role of the CHW. Nebraska needs to establish and adopt a standard approach to CHW training to meet the requirements of funders, eliminate health disparities, improve access to care, and reduce the cost of health care in the state.

The Standards Workgroup of the Nebraska Community Health Worker Steering Committee examined a number of different curricula and modes of delivery for training, education, and certification of community health workers.

Similarities of Training Programs	Differences of Training Programs
Use a standard set of core competencies	Modes (in person, online, mix)
Use case studies and quizzes to evaluate learning	Delivery (Colleges/University's, Area Health Education Centers (AHECs), health departments, other non-profits)
Use a practicum requirement	Duration (Ranges from 8-16 weeks of instruction and field work of 3-6 months)
Charge a fee	Opt out of certification process with experience
Approved training programs	Use of levels (most only have one level but a few offer an advanced training)

Through this review, the workgroup has discovered that the established scope of practice and core competencies is in line with other training programs throughout the nation. In addition, it was also discovered that there is not a standard mode of delivery used in existing training programs. However, there were common similarities, and all have their unique strengths, weaknesses, similarities and differences

The Nebraska CHW Steering Committee reviewed certification efforts in a number of states including Massachusetts, Minnesota, Texas, and Oregon. Seventeen states currently have certification. Developing a successful process for Nebraska will involve a multistep process and require consideration of the unique needs of CHWs and CHW employers.

It is important to avoid narrowing the scope of CHW practice through certification. In development of the standard curriculum, recognition should be given for experience, communication skills and community standing.

The capacity of CHWs to work flexibly and holistically helps to define the field and the value CHWs bring to the health care and public health systems. Likewise, it is vital to avoid making the certificate process a barrier to entry for people who seek to practice community health activities.

Training and Education Recommendations:

- Develop a curriculum that addresses the core competencies and scope of practice for CHWs that is similar to the one in Minnesota.
- Establish a competency-based framework for CHW education and training that includes recognition for experience, communication skills and community standing
- Develop, pilot, and implement a process to obtain a certificate for completion of curriculum
- Establish a process for oversight of the curriculum and certificate process

Documentation of the skills and competencies of CHWs has the potential to advance the field and maximize the contributions CHWs can make to improve the health of our communities. A certificate process should be part of a comprehensive statewide systemic policy initiative to recruit, train, and sustain a well-prepared and effective workforce. The state approaches for Community Health Worker Credentialing developed by the Harvard Law School is a useful tool to explore what other states have done (See Appendix).

SUSTAINABILITY

Organization and certification of Nebraska community health workers supports the IHI Triple Aim framework developed by the Institute for Healthcare Improvement (IHI) to optimize health system performance. Triple Aim supports new healthcare designs that pursue three dimensions:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Community Health Workers are gaining acceptance in the US health care system, but some critics have challenged the "cost-effectiveness" of using them. However, this perception is shifting because of a growing body of evidence that has been published in peer reviewed journals and other reputable studies although much of the evidence is still unpublished. Return on investment analysis for CHWs must consider a range of possible CHW roles and stakeholder points of view. Current trends suggest that we may be entering a new era of acceptance in which a generally lower threshold of evidence is required to support the employment of CHWs.

In 2006, the National Fund for Medical Education developed a report entitled *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. This report identifies key models of financing the work of CHWs, including: 1) charitable foundations; 2) (state/city) government agencies; 3) Medicaid government general fund; and 4) private companies. No single model alone is likely to provide adequate funding for Community Health Workers. More likely, the funding will come from a mix of these funds – with foundations and grants being the predominate funder in the early stages of the development and funding from Medicare and private insurance companies becoming the main funding stream in later stages.

When considering the pay range and value, a successful Community Healthcare Worker model in Nebraska likely would include two types of workers – 1) those with formal Community Health Worker education and 2) informal community health workers with knowledge, experience and community trust. Both types will be needed in the workplace.

Minnesota has developed codes for Medicaid payment in Minnesota Community Health Workers: Policy and System Approaches. The billing regulations for CHW services for patient education and care coordination must be: billed in 30 minute units, limit 4 units per 24 hours per recipient, no more than 8 units per calendar month per recipient.

Minnesota CHW	Rates
98960	18.50/Unit (Individual)
98961	4.16/Person/Unit (2-4 persons) x 6
98962	1.92/Person/Unit (4-6 persons) x 6
One unit = 30 minutes 4 Units/Person/24 Hours 8 Units/Person/Calendar Month	

Presently, many healthcare providers in Nebraska need to be convinced by measureable outcomes that the CHWs can improve patient health and provide cost savings. The high costs associated with emergency room visits and the lower Medicare and Medicaid reimbursement to hospitals for 30-day readmission are areas of cost concerns to hospitals. Both present opportunities to demonstrate how CHWs can improve patient health outcomes and generate cost savings. The 2014 "Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings" report from the Sinai Urban Health Institute is a resource that will be helpful for this process (See http://www.suhichicago.org/files/chw%20bpg_full_final.pdf). Community Health Workers can help the patient 1) understand physician instructions, 2) become more compliant, 3) navigate their local healthcare system, 4) learn more about their ailment, 5) use medications safely and more effectively and 6) learn to become self-dependent.

Sustainability Policy Recommendations

To achieve long-term sustainability the following strategies and policies are recommended:

- Reach out to stakeholders to build a shared knowledge and develop an action plan.
- Develop a strategy for health improvement with nonprofits, health departments and primary care providers that incorporates CHWs.
- Assess training needs of mainstream providers to take optimal advantage of CHWs.
- Adopt a Medicaid payment model similar to the Minnesota.

There is a growing body of knowledge that addresses the financing, roles, and responsibilities of CHWs. The statereform, an online network for health reform implementation, released a chart on February 15, 2015, that summarizes the activities and actions that states are taking to integrate CHWs into evolving health systems in areas such as financing, education, and legislation. This is a valuable

resource that can be used by advocates and policymakers to move the CHW agenda forward in Nebraska. In addition, a few states such as New Mexico and Maryland have developed legislation related to Community Health Workers (See <http://hsia.dhmf.maryland.gov/Documents/Afternoon%20presentations%209.22.14.pdf>).

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REVIEWED CERTIFICATION EFFORTS AND CURRICULUM

Central AHEC, Hartford CT – Community Health Worker/Patient Navigator Program http://www.centraltahec.org/CHW-PN-Training.aspx
Southwestern AHEC, Trumbull CT http://www.swctahec.org/
Massachusetts
Community Health Education Center of the Boston Public Health Commission http://www.bphc.org/whatwedo/outreach-education-training/chec-community-health-education-center/Pages/CHWC-Fees-and-Descriptions.aspx
Minnesota
Community Health Worker Alliance http://mnchwalliance.org/explore-the-field/education-2/
Minneapolis Community and Technical College https://mctc.decisionacademic.com/Catalog/ViewCatalog.aspx?pageid=viewcatalog&topicgroupid=197&topicid=110&loaduserredits=False
Iver Hills Community College https://www.inverhills.edu/Departments/CMHW/
Ohio
Approved Training Programs http://www.nursing.ohio.gov/PDFS/CHW/CHW_Programs091914.pdf
Oregon
Rogue Community College Community Health Worker Training http://www.roguecc.edu/alliedhealth/CHW/
Community Health Worker Training Temple University http://chpsw.temple.edu/cspcd/node/257
Penn Center for Community Health Workers http://www.pennmedicine.org/
Rhode Island
Community Health Innovations of RI – CHW Certificate Course http://chi-ri.org/programs/certificate/
Texas
Over 40 different organizations offering training http://www.dshs.state.tx.us/chw/Training-Announcements.aspx
Washington
Healthy Communities Washington http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem

APPENDIX 1: CHW TOWN HALL FLYER

Bienvenidos
Welcome **ahlan WA sahlán**
hoan hgnénnh

To The Movement

Town

Hall Gathering

**Help Shape the Future
Of Community Health
Workers in Nebraska**

When

Saturday, October 25

9.30am– 11.30am

Town Hall Gathering &
CHW Networking



Where

Christie Heights Community Center

Senior Hall

5105 S 37th Street (37th & P)

Omaha, NE

Goal

If you are a Community Health Worker, we want to hear from you!

- Come share your experiences!
- Tell us what's working and what you need to be successful.
- Learn about resources that are available .

Free and Open to the Public

- Refreshments will be served.
- Childcare provided.

ADVOCATES FOR A
HEALTHY NEBRASKA

PHAN
PUBLIC HEALTH
ASSOCIATION
OF NEBRASKA

NEBRASKA **Community
Health Worker
Association**
advocate | educate | connect

Core Competencies

Community Health Workers (CHW) Coalition of Nebraska CHW Definition and Roles



You are a Community health Worker (CHW) if you are an individual who:

- Serves as a liaison/link between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors
- Conducts outreach that promotes and improves individual and community health
- Facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska.

A CHW is a trusted member of, or has a good understanding of, the community they serve. They are able to build trusting relationships and are able to link individuals with the systems of care in the communities they serve. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. CHW is an umbrella term used to define other professional titles.

Core Competencies of Community Health Worker (skills and qualities)

A. Communication Skills

- Ability to use Active Listening, communicate in writing, communicate verbally

B. Interpersonal skills

- Ability to build relationships, work as part of a team, understand and work within cultural dynamics

C. Capacity Building

- Understanding of and ability to apply leadership, develop additional skills, develop and manage resources
- Ability to use planning skills, produce complete, accurate reports
- Understanding of needs assessments

D. Teaching Skills

- Ability to teach one-on-one and/or in group settings
- Ability and willingness to learn and be proficient with information being presented
- Ability to lead classes or educational sessions and adapt teaching style to audience needs
- Recognize need to continue education

E. Advocacy Skills

- Ability to be assertive and respectful and advocate at different professional levels
- Ability to listen and ask questions
- Ability to identify and manage risky situations and strengthen social support networks

F. Organizational Skills

- Ability to develop plans and set goals, manage time and determine priorities
- Ability to manage a budget
- Ability to report and evaluate in community settings

G. Service Coordination

- Ability to identify and access resources and make appropriate referrals when needed
- Ability to network, form partnerships, and work with others in planning efforts for care, and bring needed services into the community.

H. Outreach Methods and Strategies

- Ability to engage others, foster collaborative relationships, and build trust within the community

I. Client and Community Assessment

- Ability to understand basic surveys, interviews, and observational methods
- Ability to understand living process of communities and population health data

To learn more about getting involved with the association and meeting times, please contact our secretary:

Mary Lentini

402.471.0158

Fax: 402.471.0913

necommunityhealthworkers@gmail.com

NEBRASKA **Community Health Worker Association**
advocate | educate | connect

APPENDIX 2: STATE COMMUNITY HEALTH WORKER MODELS

State Community Health Worker Models

*Chart updated February 23, 2015

Sara Kahn Troster

As states transform their health systems many are turning to Community Health Workers (CHWs) to tackle some of the most challenging aspects of health improvement, such as facilitating care coordination, enhancing access to community-based services, and addressing social determinants of health. While state definitions vary, CHWs are typically frontline workers who are trusted members of and/or have a unique and intimate understanding of the communities they serve. This chart highlights state activity to integrate CHWs into evolving health care systems in key areas such as financing, education and training, certification, and state definitions, roles and scope of practice. The chart includes enacted state CHW legislation^[1] and provides links to state CHW associations and other leading organizations working on CHW issues in states. [Click here](#) for more details on how states are financing the work of CHWs.

Like all State Refor(u)m research, this chart is a collaborative effort with you, the user. We are actively researching state CHW activity and will be updating this chart regularly. Know of something we should add to this compilation? Your feedback is central to our ongoing, real-time analytical process, so tell us in a comment, or email ksheedy@nashp.org with your suggestions.

State	Financing [2]	Education	Certification	State CHW Legislation	CHW Organizations	CHW Roles in State
	<i>Source of funding for CHW work</i>	<i>Training requirements and core competencies</i>	<i>Requirements for state CHW certification</i>	<i>Enacted state CHW legislation</i>	<i>State association or leading organization</i>	<i>State definition of a CHW and key roles</i>
AK	Community Health Aide Program (CHAP) funding support through Indian Health Service, the Denali Commission (a federal agency) or federal Community Health Center funding (p.12).	Board-certified 3-4 week intensive training course; completion of designated number of practice hours and patient encounters; post-session learning needs and practice checklists; 200 hours village clinical experience; preceptorship; 80% or higher on CHAP exam, and 100% on statewide math exam. Four regional training centers.	Certification necessary to participate in the Community Health Aide/Practitioner program, and the Alaska Native Tribal Health Consortium.	HB 209 (enacted 1993): Community Health Aide Program (CHAP) provides grants for third parties to train community health aides as Community Health Practitioners with an exam at the end of training.	Alaska Community Health Aide Program	CHWs function as Community Health Aides and Practitioners, Dental Health Aides, and Behavioral Health Aides, each of whom is subject to specific standards of practice defined by Certification Board and in the CHAP manual .
AZ				Not currently.	Arizona Community Health Outreach Workers Network	
AR	Funding for CHWs in potential as care coordinators as defined in State Innovation Model Narrative.	Not currently.	Not currently.	Not currently.	Arkansas Community Health Worker Association	Potential role for CHWs in patient centered medical homes (PCMH); AR has nine CHWs employed by STAR Health Program , which promotes maternal and child health, oral health and chronic disease management in three counties.
CA	Funding for CHWs included in SIM plan as part of care team of health homes for complex patients (p.30), in the discussion of Community		The SIM Workforce Group is specifically addressing CHW	Section 6332 of the California Labor Code includes definition	Vision y Compromiso California Association of	As defined in Section 6332 of the California Labor Code: Community health care worker is an individual who

	Transformation Grants (p.38-39), and in the discussion of workforce building (p. 40-45).		training and credentialing.	of a CHW.	Community Health Workers.	provides health care or health care-related services to clients in home settings.
CO	CHWs in SIM plan (p.145-6, 158); work group looking at core competencies, licensing requirements and certification, and sustainable funding .			Not currently.	Colorado Community Health Worker and Patient Navigator Work Group	
CT	Funding through SIM proposal (p. 10) discusses integrating CHWs into community health teams, creating training, and certification standards for CHW.	Southwestern CT AHEC offers CHW training.		Not currently.		
DC	Pursuing Medicaid State Plan Amendment.			Not currently.	CHW Professional Association of Washington, DC	
FL	CHWs hired by community based organizations (CBOs), universities, FQHCs, and insurance payers who run managed care organizations. Hiring at CBOs and universities based on grant availability.	The Florida CHW Coalition (FCHWC) CHW Certification Implementation Team has developed 28 CHW tasks in five performance domains . The Florida AHEC network and community colleges around the state provide training. Many organizations working with CHWs have developed their own training program such as: MHP Salud, Rural Women's Health Project, Healthstreet, ConnectFamilias .	FCHWC moving towards voluntary certification, administered by the Florida Certification Board . Written exam will be developed in 2015, with full credentialing in 2016. Grandfathering period for experienced CHWs includes 500 hours of documented paid or volunteer experience providing CHW services; at least 30 hours of training in core competencies and two letters of reference.		Florida Community Health Worker Coalition	
GA				Not currently.	Georgia Community Health Advisor Network	
HI		Healthcare Innovation Plan includes CHW training (p.27).		Not currently.		
ID	Funding through SIM plan/proposal (p.11, 29-30, 32-34); CHWs as part of the workforce for PCMHs, especially in	SIM plan/proposal intends to develop training program for CHWs and community emergency services personnel to increase opportunities for		Not currently.		

	workforce shortage areas.	coordinated primary care in rural and underserved areas.				
IL		The Community Health Worker Act creates minimum core competencies for CHWs; an Advisory Board can consider other competencies.		HB 5412 (enacted 2014) creates an Advisory Board in Department of Public Health. Board must develop core competencies for training and certification of CHWs. Prohibits CHWs from performing services requiring a professional license.	Chicago CHW Local Network	The Community Health Worker Advisory Board Act uses the American Public Health Association's (APHA) definition of a CHW.
IN		Integrated Care Community Health Worker and Certified Recovery Specialist Training and Certification Program, approved by the Indiana Division of Mental Health and Addiction and the State Department of Health.	Individuals must be 18 years old, resident of Indiana and have at least a high school diploma or GED. Three-day training and final exam. Certified CHWs may serve in outpatient medical/behavioral settings, including hospitals, medical clinics, schools, churches, and community centers.	Not currently.	Indiana Community Health Workers Association	Follows APHA's definition.
KY	Pursuing Medicaid State Plan Amendment.			Not currently.		
LA				Not currently.	Louisiana Community Health Outreach Network	
ME	CHWs are explicitly listed (p.4) as potential members of Community Care Teams (CCT) in Maine's Health Homes program. The CCTs are reimbursed through Medicaid Health Homes. SIM grant (p.17) includes five CHW pilot sites.			Not currently.	Maine Community Health Worker Initiative	Maine's SIM narrative (p.17) includes five CHW pilot sites to "Demonstrate the value of integrating CHWs into the health care team; Provide models for state-wide replication; Build a core group of experienced CHWs who can provide leadership for ongoing development of the system."
MD	Financed primarily through grant funding. CHWs are key element of SIM plan.	No state-sponsored infrastructure for CHW training; programs training CHWs develop their own competencies and curricula.		Workgroup on Workforce Development for Community Health Workers established by HB 856; workgroup is charged with developing recommendations on CHW training,	Community Outreach Workers Association of Maryland Maryland CHW Association disbanded but is presently reforming and held an inaugural	Scope of practice and roles are not mentioned in HB 856, the workgroup is looking at this issue as part of their overall efforts.

				credentialing, and financing.	meeting in November 2014.	
MA	<p>Primarily grant funding, but in some cases a combination of grants, core operating funds and other resources such as federal, state and local governments, private foundations, other nonprofit funding and some health plan funding. Medicaid supports a small amount of CHW services through an 1115 waiver for high-risk pediatric asthma and a demonstration project for dually eligible adults. Department of Public Health and other partners exploring Medicaid State Plan Amendment.</p> <p>CHWs were included in several aspects of the 2012 payment reform law.</p>	<p>Training offered by CBOs, AHEC, local health department, and a university school of public health. Training programs address ten core competencies. 80 hours of online and in-person training; no practicum required, but CHWs applying for certification must have 2,000 hours of relevant work experience. Graduates of training programs eligible to apply for state CHW certification.</p>	<p>Board of Certification of CHWs will begin certifying both paid and volunteer CHWs in 2015. Process will consist of a paper application, submission of three professional references, completion of an approved training program, and 2000 hours of relevant work experience. There will be a grandparenting period for the first 3 years of certification; CHWs with 4000 hours of relevant work experience will be eligible to apply without training.</p>	<p>Chapter 58, Acts of 2006 – Section 110; and Chapter 224, Acts of 2012.</p> <p>HB 4692 (enacted 2010) to establish a board in the Department of Public Health to certify CHWs.</p> <p>A law in 2007 created a seat on the Public Health Council for a representative from the Massachusetts Association of Community Health Workers.</p>	<p>Massachusetts Association of Community Health Workers</p> <p>MA Office of Community Health Workers</p>	<p>Roles include outreach, health education, client advocacy and empowerment, as well as health system navigation; hired primarily for their special connection to and understanding of the populations and communities they serve, conduct outreach a significant portion of the time, and have experience providing services in community settings.</p>
MI	<p>Results of a 2014 program survey (p.27) conducted by the Michigan Community Health Worker Alliance (MiCHWA), show CHW funding sources.</p> <p>CHWs were included in Michigan's SIM planning award report in 2014.</p>	<p>MiCHWA's Education and Workforce working group develops training with active participation from CHWs. Training is primarily employer-sponsored; CHWs return to positions when training is complete. Internship/practicum required for individuals not employed.</p>	<p>Not currently; curriculum MiCHWA is piloting may become the basis for certification. MiCHWA's Steering Committee voted to support MiCHWA as a certifying body for statewide certification.</p>	<p>Not currently.</p>	<p>Michigan Community Health Worker Alliance (MiCHWA)</p>	<p>MiCHWA endorses seven roles for CHWs: case management and care coordination; community-cultural liaison; health promotion and health coaching; home-based support; outreach and community mobilization; participatory research; and system navigation.</p>
MN	<p>Federal approval in December 2007 for CHWs to participate in Medicaid program and receive payment for their services; MN's SIM Grant (p.7) includes the use of emerging health professions, such as CHWs, as part of interdisciplinary teams in</p>	<p>State-wide standardized, competency-based educational program based in accredited post secondary school; overseen by MN Department of Human Services. 14-credit program includes classroom and field-based learning for individuals with a high school diploma or GED, at a minimum. Certificate (or at least 5 years supervised</p>	<p>Not currently.</p>	<p>HF 1078 Subd. 49 allows CHWs to participate in Medicaid program and receive payment for services. CHW must have certificate or at least 5 years supervised experienced with an enrolled clinician. CHWs must then work</p>	<p>MN CHW Peer Network</p> <p>Minnesota Community Health Worker Alliance</p>	<p>Roles for CHWs: bridge the gap between communities and the health and social service systems; navigate the health and human services system; advocate for individual and community needs; provide direct services; build individual</p>

	Accountable Care Organizations (ACOs).	experience) required for payment through state Medicaid program. Continuing education opportunities available.		under the supervision of one of these clinicians.		and individual and community capacity.
MS	In 2015, Medicaid in MS will begin to cover CHW services, however, it is under the auspice of "general education," and not a specific billing code. Other funding is private and includes specific clinic or grant funding.	A past initiative to standardize the state definition of a CHW and to establish formal guidelines for CHW training and certificate programs failed due to legislative opposition.	Tougaloo College, Central Mississippi Area Health Education Center and state Department of Health joined together in 2012 to establish a CHW certification program .	Not currently.	Not currently.	The State Department of Health and other partners have formulated a definition, but the Board of Health has not had the opportunity to approve it for promotion across the state. CHWs provide services such as conducting home visits, helping navigate the health system, and connecting individuals to resources.
MO	Funded by health care entities or community organizations.	Metro Community College offers CHW certificate training program. Adapted Minnesota's CHW curriculum; Department of Health and Senior Services to decide if the curriculum will become the state standard. Requirements: 160 hours and 60 service (practicum) hours. Core competencies include communication, organization and resources, life style choices, cultural beliefs and healthcare, legal and ethical considerations, and employability skills. Individuals or health systems pay for the training program.	Department of Health and Senior Services is establishing a pilot project in Kansas City area to certify CHWs and standardize curriculum; tuition reimbursement will be available for those enrolling in CHW Certificate program. CHWs who enroll and pass the curriculum receive certificates.	Not currently.	Not currently. Department of Health and Senior Services has a dedicated staff person assigned to the CHW pilot project who spends time networking, researching and implementing the project.	Department of Health and Senior Services definition includes the APHA definition and adds that CHWs are liaisons with resources in the communities they serve and play a vital role in improving Missouri's health by providing a connection between health systems and community resources, as well as education on how to reduce behavioral health risk factors.
MT	Funding through Frontier Community Health Care Coordination Demonstration Grant (p.14).	Training developed by Montana Office of Rural Health and State AHEC office (p.15).		Not currently.		CHW care coordinators are non-clinical paraprofessionals focusing on chronic disease management and linking patients with services to achieve selected health outcomes and decrease hospitalizations and emergency room visits (p.15).
		NE CHW Coalition				

NE	Grants to local hospitals and Department of Health and Human Services (NDHHS) Division of Public Health.	NE CHW Coalition has assessed training program and developed recommendations for core competencies and scope of practice recommendations, number of hours of classroom/online instruction and practicum requirement, and consideration of grandfathering CHWs. NDHHS offers patient navigation training for CHWs which includes a full-day, face-to-face training; then 10 weeks of computer-based learning; a second full-day face-to-face training; plus a practicum.	Not currently. Indian Health Service certifies Community Health Representatives. The NE CHW Coalition Steering Committee Standards Workgroup developed certification recommendations.	Not currently.	In December 2014, the Public Health Association of Nebraska approved a CHW Section . This section will develop as a statewide association.	Follows the APHA definition .
NV	Leverages funds from sister programs at Nevada Division of Public and Behavioral Health (NDPBH), including Maternal and Children's Health, Women, Infants, and Children (WIC), Chronic Diseases, and HIV. Medicaid does not reimburse for CHW services.	Nevada System of Higher Education developed training curriculum; currently offered at two colleges. Programs must address APHA's core competencies ; 56 hours of classroom instruction and no practicum required. CHW program also recommends Washington State's training program . The NDPBH will recognize this curriculum for a CHW certificate of completion.	Not currently.	Bill Draft Request (BDR) places regulation and oversight to certify individual CHWs in Nevada within the Bureau of Health Care Quality and Compliance (HCQC, and also includes training standards according to CHW core competencies.	Efforts to establish CHW association underway to assist with promotion and understanding of CHW workforce and further help oversee standards, guidelines, and requirements.	Follows the APHA definition .
NH	Primarily funded through grants.	The Southern NH Area Health Education Center (AHEC) offers a CHW training program which includes a variety of topics .	Not currently.	Not currently; potential legislation in 2016.	Southern NH AHEC NH CHW Coalition formed in January 2015.	No formal definition adopted; follows the APHA definition .
NM	Through a Medicaid 1115 Waiver, Centennial Care has leveraged contracts with Medicaid managed care organizations (MCOs) to support the use of CHWs in serving Medicaid		Certification is voluntary and through Department of Health. Applicants must complete a Department-approved training program and demonstrate proficiency in CHW core competencies. Specialist certification will be	SB 58 , Community Health Workers Act, creates a voluntary, statewide	New Mexico Community Health Worker Association	Centennial Care contracts define CHWs as lay members of communities who work either for pay or as volunteers in association with the local health care system in Tribal, Urban, Frontier, and Rural areas and usually share ethnicity, language, socioeconomic status and life experiences with

	enrollees. CHW salaries, training, and service costs are MCO administrative costs and embedded in capitated rates paid to Medicaid managed care organizations.		available. Background check required and certificates valid for two years. Continuing education required for recertification. Process to recognize and certify existing CHWs based on experience.	certification program for CHWs through the Department of Health.	New Mexico Office Of Community Health Workers.	the Members they serve. CHWs include, among others, community health advisors, lay health advocates, promotoras, outreach educators, community health representatives, peer health promoters, and peer health educators.
NY	CHWs can be optional team members of Health Home care teams .	Department of Health's CHW Program trains CHWs to provide health education, referrals, and support for individuals navigating the health system.		Not currently.	Community Health Worker Network of New York City	CHW Program serves communities with high rates of infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income women.
OH		Training program must be state approved; at least 100 hours of classroom instruction and 130 hours of clinical instruction, standard training exam.	Board of Nursing issues and renews certificates biennially; continuing education required. Individuals must be at least 18 years old, have a high school diploma, complete the CHW training program, and pass criminal background check. CHW must be supervised by a health professional and is restricted from performing services requiring a professional license.	HB 95 (enacted 2003) to require Board of Nursing to issue and renew CHW certificates.	Ohio Community Health Worker Association	
OR	State Plan Amendment (SPA) created Patient-Centered Primary Care Homes (PCPHs) explicitly includes CHWs in description of providers for four of the six core Health Home services. Only certified CHWs reimbursed . Oregon's SIM grant (p. 2) designed to build on Community Care Organization (CCO) Model. CCOs must include "non-traditional healthcare providers like	OR committed to training 300 new CHWs by 2015 (p. 8-9); 80 hours of training and 20 hours of continuing education required every 3 years. Core competencies include outreach and mobilization; community	Only certified CHWs participate in Health Homes. CHWs can apply for certification after completing an OHA-approved training program. Must be at least 18 years old; criminal background check required. Grandfathering	HB 3650 (enacted 2011) mandated OHA to develop education and training requirements that also meet federal requirements to qualify for financial participation. Oregon Health Policy Board established the Non-Traditional Health Worker Subcommittee to create core competencies, education and training requirements.	Oregon Community Health Workers Association	

	workers—like CHWs on their care teams. A health professional must supervise a CHW in order for Medicaid to reimburse for services provided. Only CHWs certified by the Oregon Health Authority (OHA) and included on a registry, are eligible to be funded by Medicaid.	liaising; care management, care coordination, and system navigation; and health promotion and coaching.	available to those who have worked over 3,000 hours in the past five years, and completed additional training.	HB 3407 (2013) established the Traditional Health Worker Commission, which oversees CHWs, Peer Support and Peer Wellness Specialists, Personal Health Navigators, and Doulas.		
PA	Medicaid is the biggest source of payment for CHWs. PA provides Medicaid coverage for Peer Support Services (PSS) in the mental health field, and some PSSs are considered CHWs.	Academic institutions, health organizations and health systems offer CHW training as well as Area Health Education Centers (AHECs). PA Department of Health's CHW Project Strategy includes recommending the eight core skills in the National CHW Workforce Study	Not currently.	Not currently.	A state-wide CHW symposium planned for May, 2015. PA Department of Health is the lead state agency for CHW issues.	No official definition of CHWs; discussing options and working on adopting a standard job title for CHWs to unify the workforce and educate partners. Common roles of CHWs : assuring people get the services they need; providing culturally appropriate accessible health education and information; providing informal counseling and social support; and advocating for individual and community needs.
RI	Grant funding (especially those working on disease-specific programs) or incorporated into the operating budgets of agencies. Some CHWs may bill services under a portion of their jobs (specific licensure or services approved for reimbursement). State is exploring Medicaid waivers for CHW billable services.	Training paid for by the trainees or their employers. Committee of CHW employers and supporters developed the curriculum, using standards approved by national CHW interest groups, as well as needs defined by RI stakeholders. Requires 30 hours of classroom learning and 80 hours of field experience in the field.	Certification is available for all CHWs (paid or volunteer), but is not mandatory. The Community Health Worker Association of Rhode Island (CHWARI) offers certification training for CHWs. The Rhode Island Department of Health endorses, promotes and supports certification. Participants must successfully complete the program classes, assignments and work experience to receive certification. There is no “grandfathering” process.	H 5633 (enacted 2011) established the Commission for Health Advocacy and Equity. Commission must make recommendations for increasing diversity of health care workforce, which may include recruitment, training and employment of CHWs.	Community Health Worker Association of Rhode Island	No formal definition. CHWARI promotes the APHA definition of CHWs.
	South Carolina Department of Health and Human Services (SCDHHS) CHW pilot program		SCDHHS is the			

SC	<p> pilot program pays for primary care services provided by CHWs. Practices selected to participate in the SCDHHS CHW program received \$6,000. Two codes authorized for CHW service reimbursement; a group and individual encounter code. SCDHHS working with statewide partners to secure funding to expand CHW program. Plans to submit a Medicaid State Plan Amendment (SPA) to CMS; SCDHHS certification is necessary for Medicaid reimbursement. </p>	<p> Training curriculum developed by SCDHHS and Midlands Technical College includes 120 classroom hours and 120 practice hours; internship/mentorship requirement. Core competencies included in certification training program. </p>	<p> only body certifying CHWs for Medicaid reimbursement during pilot phase. For the pilot program, 14 primary care practices participated in the certification program; Grandfathering if CHW candidate has at least 3 years experience with community outreach; documentation from employer is required, and the CHW candidate must pass the CHW certification exam. </p>	<p>Not currently.</p>	<p> The first SC CHW Association meeting took place in December 2014 and was attended by community-based organizations and CHW leaders across SC. </p>	<p> SCDHHS has a draft policy in progress outlining the definition, scope of service and program guidelines for CHWs; an FAQ document outlines current role of CHWs in SC. </p>
TX	<p> Most paid CHW positions funded through grants or core budget funding. CHW positions not funded through state; contracts within Department of State Health Services (DSHS) Expanded Primary Health Care allow for reimbursement of CHW outreach services. Medicaid contracts with Managed Care Organizations (MCOs) and includes CHWs in administrative costs in order to receive reimbursement. CHW included in Medicaid 1115 waiver allows for reimbursement. </p>	<p> Community colleges, other academic institutions AHECs, Federally Qualified Health Centers (FQHCs), a CHW network, and community-based organizations train CHWs. 160 hours and eight standardized core competencies. Other activities may serve as proxies for demonstration of core competencies; eligibility based on experience is ongoing. </p>	<p> DSHS established and operates Promotor(a) or Community Health Worker Training and Certification Program for CHWs and instructors. Certification is for 2 years. DSHS reviews and approves all certification, training and continuing education. </p>	<p> Texas Health and Safety Code Chapter 48 provides authority to DSHS to establish and operate a certification program for CHWs. </p> <p> SB 1051 (enacted 1999) requires DSHS establish CHW training program- only mandatory for CHWs compensated for services. </p> <p> HB 2610 (enacted 2011) requires DSHS to establish statewide advisory committee to provide recommendations on CHW training, funding and employment. </p>	<p> CHW Advisory Committee and regional organizations but no statewide CHW organization. </p>	<p> Definition included in Texas Health and Safety Code Chapter 48; CHWs are employed by a variety of organizations, including clinics, hospitals, health or social service nonprofits, area health education centers, schools or universities, local health departments, health plans, and others. </p>
VT	<p> CHWs are part of Vermont's Community Health Teams (CHTs); an integral part of the SIM narrative. CHTs paid out of Vermont's Multi-Payer Advanced Primary Care Practice Demonstration pilot, which involves a monthly care management fee for beneficiaries receiving primary care from advanced primary </p>			<p>Not currently.</p>		<p> As part of Community Health Teams, CHWs assist patients with insurance applications, following treatment plans, managing stress, and working toward personal wellness or disease-management goals. CHWs may accompany patients to </p>

	advanced primary care (APC) practices. Costs shared among Vermont's major insurers, as well as Medicare and Medicaid.					patients to appointments and help find transportation or childcare.
VA				Not currently.	Virginia Community Health Worker Task Force	
WA	Washington's State Plan Amendment allows CHWs to participate in Health Homes and receive funding through Medicaid for each patient served.	Training through the Department of Health establishing core competencies for CHWs. 8-week program may be completed online or in-person, and training is conducted quarterly. CHW receives a certification of completion.		Not currently.	Washington Community Health Worker Network	CHW participating in Health Homes provide administrative support for the Health Home Care Coordinator, such as mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator.
WV	CHWs are optional members of Behavioral Health Health Home care teams (p. 5), which are financed by Medicaid through pre-set payments per member.			Not currently.	FutureWV participates in some state CHW activity.	Optional members of Behavioral Health Health Home care teams.

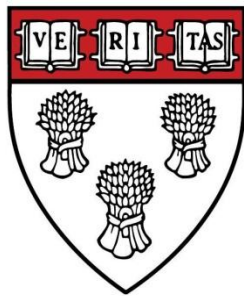
Notes:

[1] The Association of State and Territorial Health Officials (ASTHO) provides real-time legislative tracking on Community Health Workers on [this page](#) under "Licensure & Certification."

[2] [Click here](#) for more details on how states are financing the work of CHWs.

Chart produced by [Sara Kahn-Troster](#) and [Kaitlin Sheedy](#)

APPENDIX 3: COMMUNITY HEALTH WORKER CREDENTIALING STATE APPROACHES



CENTER FOR HEALTH LAW
& POLICY INNOVATION
Harvard Law School

Community Health Worker Credentialing

State Approaches

Peyton Miller, Taylor Bates, and Amy Katzen

6/16/2014

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.¹ 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.²

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.³

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?

¹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *A Summary of State Community Health Worker Laws*, available at http://www.cdc.gov/dhds/pubs/docs/CHW_State_Laws.pdf.

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

³ 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:

State	Type of Credential	Site for Policymaking	Training Requirement	“Incumbent” or “Grandfathering”
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.⁴

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.

⁴ 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.

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.”⁵

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.”⁶

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;

⁵ M.G.L.A. 112 § 259.

⁶ M.G.L.A. 112 § 259.

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

The state passed legislation in 2010 calling for the inclusion of a Board of Certification for CHWs and formally established this board in 2012.⁸ 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 character⁹ and has met all the education, training and experience

⁷ M.G.L.A. 112 § 259.

⁸ 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>

⁹ 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.¹⁰

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.¹¹ 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%).¹²

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,¹³ and a large majority of employers report that most of their CHW employees lack formal training.¹⁴ 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.¹⁵ 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.¹⁶

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

¹⁰ M.G.L.A. 112 § 260.

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

¹² 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>.

¹³ Id.

¹⁴ Id.

¹⁵ Id. at 28.

¹⁶ Id. at 27.

inherently unstable and unpredictable source of funding.¹⁷ Some CHWs feel that this instability and uncertainty keeps potential CHWs out of the profession.¹⁸ 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,¹⁹ 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.”²⁰ 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.²¹

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.²²

d. Resources

¹⁷ Id. at 28.

¹⁸ Telephone Interview with Lorenza Holt (Apr. 3, 2014).

¹⁹ The meeting took place on January 14th, 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 13th.

²⁰ 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>.

²¹ Telephone Interview with Lorenza Holt (Apr. 3, 2014).

²² 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.”²³

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

²³ 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.²⁴ Prospective CHWs must complete at least 80 hours of training.²⁵

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.²⁶

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."²⁷ 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.²⁸

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."²⁹ 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.³⁰

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.³¹ The Center is currently in the process of licensing its curriculum and spreading it throughout the state.

²⁴ OAR 333-002-0310.

²⁵ OAR 410-180-0350; 333-002-0370.

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

²⁷ O.R.S. § 414.625.

²⁸ O.R.S. § 414.655.

²⁹ O.R.S. § 413.260.

³⁰ Telephone Interview with Lizzie Fussell (Apr. 7, 2014).

³¹ *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.³² 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.³³ When these recommendations are in place, the certification would allow a CHW to enroll as a “provider” for reimbursement.³⁴ These recommendations became proposed regulations in 2013.³⁵

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.³⁶ 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.³⁷

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.³⁸

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.³⁹

d. Resources

³² 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>.

³³ 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.”

³⁴ Id. at 17.

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

³⁶ Telephone Interview with Lizzie Fussell (Apr. 7, 2014).

³⁷ Id.

³⁸ Id.

³⁹ 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.⁴⁰

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.”⁴¹ 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;

⁴⁰ 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.

⁴¹ 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.”⁴²

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.⁴³

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.⁴⁴ 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.⁴⁵ This discrepancy may exist because 2013 was the first year that Rhode Islanders were able to classify themselves as CHWs using the labor code.⁴⁶

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 2010.⁴⁷ CHWARI reaches over 350 contacts through its distribution list and is considered a particularly well-established and successful association.

⁴² Gen. Laws 1956, § 23-64.1-8.

⁴³ Gen. Laws 1956, § 23-64.1-8.

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

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

⁴⁶ Telephone Interview with Beth Lamarre (Apr. 1, 2014).

⁴⁷ 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.⁴⁸ 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.⁴⁹ 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.⁵⁰ 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.⁵¹ 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.⁵² 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.⁵³ CHWARI has a close partnership with regulatory agencies, and does not see a pressing need for certification.⁵⁴

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/>.

⁴⁸ Id.

⁴⁹ Id.

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

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

⁵² Telephone Interview with Beth Lamarre (Apr. 1, 2014).

⁵³ Id.

⁵⁴ 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 (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.⁵⁵

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.⁵⁶ 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.⁵⁷

At present, there is no formal, state-recognized licensure or certification procedure for CHWs in Florida. CHWs receive training through community colleges,⁵⁸ conferences and continuing education modules,⁵⁹ or career training programs. At present, there are only three formal programs that award CHW training certificates in one year or less.⁶⁰ 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.⁶¹

⁵⁵ Telephone Interview with Shelia McCann (Apr. 16, 2014).

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

⁵⁷ Id.

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

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

⁶⁰ 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.

⁶¹ 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.⁶² 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.⁶³

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.⁶⁴

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.⁶⁵

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.⁶⁶ 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.⁶⁷

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.⁶⁸ According to McCann, an ideal certification program would be available over the Internet and be provided in English, Spanish, and Haitian Creole.⁶⁹ 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.⁷⁰

⁶² Id.

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

⁶⁴ Telephone Interview with Brendaly Rodríguez (Apr. 11, 2014).

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

⁶⁶ Telephone Interview with Brendaly Rodríguez (Apr. 11, 2014).

⁶⁷ Id.

⁶⁸ Telephone Interview with Shelia McCann (Apr. 16, 2014).

⁶⁹ Id.

⁷⁰ 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.⁷¹ McCann noted that employers frequently require employees to fund or pay for their own certifications and licenses.⁷²

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
- DAPIC CONSULTING, *Florida CHW Curriculum Review* (2012). (On file with The Center for Health Law and Policy Innovation.)

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

⁷² 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)⁷³ and for Medicaid reimbursement of services provided by community health aides.⁷⁴ 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.⁷⁵ 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.⁷⁶

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);

⁷³ AS § 18.28.010.

⁷⁴ Regulation 7 AAC 155.020.

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

⁷⁶ 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 certificates⁷⁷ and to levy fees pertaining to the issuance of certificates to CHWs and written verification of CHW certification.⁷⁸ The board may also deny, revoke, or suspend a CHW certificate.⁷⁹ The state requires that CHW training programs be approved by the board and reapproved every two years.⁸⁰

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

⁷⁷ R.C. § 4723.06.

⁷⁸ R.C. § 4723.08(A)(7) and 4723.88(J).

⁷⁹ R.C. § 4723.86.

⁸⁰ R.C. § 4723.87.

community needs that enables them to develop culturally appropriate solutions to problems and translate the solutions into practice.”⁸¹

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.⁸² 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.⁸³

An individual must apply to the board of nursing to be certified as a CHW.⁸⁴ 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 \$35.⁸⁵

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.⁸⁶

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

Texas

Texas defines a CHW or a promotora as

⁸¹ R.C. § 4723.81.

⁸² R.C. § 4723.82.

⁸³ OAC 4723-26-07–09.

⁸⁴ R.C. § 4723.83.

⁸⁵ OAC 4723-26-02.

⁸⁶ R.C. § 4723.84.

⁸⁷ R.C. § 4723.85.

⁸⁸ 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.”*⁸⁹

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.⁹⁰ The training program consists of a 160-hour curriculum that must be approved by the state as meeting general criteria.⁹¹

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.⁹² Prospective CHWs must apply to the Department of State Health Services for certification.⁹³ 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.⁹⁴

⁸⁹ V.T.C.A., Health & Safety Code § 48.001.

⁹⁰ V.T.C.A., Health & Safety Code § 48.051.

⁹¹ 25 TAC § 146.8.

⁹² V.T.C.A., Health & Safety Code § 48.052.

⁹³ 25 TAC § 146.4.

⁹⁴ 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.

APPENDIX 4: MINNESOTA CHW CURRICULUM

Minnesota CHW Curriculum

The Minnesota Community Health Worker curriculum is based on the **core competencies** that are identified in Minnesota's CHW "Scope of Practice." The curriculum also incorporates **health promotion competencies** as an introduction to a broad range of individual, family and population health needs. The internship is the centerpiece of the curriculum's **practice competencies**. It enables CHW students to fully apply and integrate what they have learned in the program to ensure an effective transition to the CHW role.

PHASE 1 -- Role of the CHW - Core Competencies (9 credits)

1. Role, Advocacy and Outreach

- Credits = 2 credits in classroom
- Description: This course focuses on the role of the community health workers personal safety, self care, and personal wellness and the promotion of health and disease prevention for clients.
- Objectives:
 - Define scope of practice for community health worker
 - Identify and use 9-1-1 system appropriately and ethically
 - List personal safety strategies
 - Create a personal safety plan
 - Identify and recognize signs of stress
 - Identify and utilize coping strategies for managing stress and staying healthy
 - Define outreach and identify ways to connect with community
 - Identify strategies to provide clear, accurate agency information to clients in the community
 - Define advocacy
 - Discuss strategy for effective advocacy work

2. Organization and Resources: Community and Personal Strategies

- Credits = 1 credit classroom
- Description: The course focuses on the community health worker's knowledge of the community and the ability to prioritize and organize work. Emphasis is on the use and critical analysis of resources and on problem solving.
- Objectives:
 - Identify ways to gather information about community resources
 - Prioritize client information into an effective plan or time line
 - List benefits of time management
 - Analyze own time management style and present to others
 - Identify sources of current information about health issues
 - Find information on cultural beliefs
 - Discuss ways to use information to promote health of self, families and clients
 - Define critical thinking; discuss critical thinking as it relates to the community health worker role

3. Teaching and Capacity Building

- Credits = 2 classroom credits

- Description: This course focuses on the community health worker role in teaching and increasing capacity of the community and of the client to access the health care system. Emphasis is on establishing healthy lifestyles and clients developing agreements to take responsibility for achieving health goals. Students will learn and practice methods for planning, developing and implementing plans with clients to promote wellness.
- Objectives:
 - Collect client data specific to healthy behaviors, safety and psychosocial issues.
 - Provide clients with information based on individual needs and desires.
 - Construct a contract with clients that promote health care and social responsibility.
 - Develop a list of community resources to act as incentives for clients' health goals.
 - Utilize a variety of teaching strategies with clients.
 - Construct health promotion activities to address community needs.
 - Employ effective communication skills when collaborating with client and other members of service team.
 - Act as a role model for clients regarding self-care and healthy behaviors.

4. Legal and Ethical Responsibilities

- Credits = 1 classroom credit
- Description: This course focuses on the legal and ethical dimensions of the community health worker role. Included are boundaries of the CHW position, agency policies, confidentiality, liability, mandatory reporting and cultural issues that can influence legal and ethical responsibilities.
- Objectives:
 - Define policy and explain why they are important and what implications of policy are.
 - Define confidentiality, HIPPA and ethical aspects of confidentiality.
 - Explain principles of a helping relationship.
 - Define role of community health worker and boundaries of community health worker.
 - Describe legal responsibility of community health worker in mandatory reporting.
 - Discuss cultural brokering.
 - Discuss impact of culture in the context of full disclosure.
 - Define liability and malpractice.
 - Discuss how ethics influence the care of clients.

5. Coordination, Documentation, and Reporting

- Credits = 1 classroom credit
- Description: This module focuses on the importance and ability of the CHW to gather, document and report on client visits and other activities. The emphasis is on appropriate, accurate and clear documentation with consideration of legal and agency requirements
- Objectives:
 - List types of forms that comprise a client record
 - Explain what kinds of information must be included in client record
 - State reasons for timeliness of documentation and its practical applications
 - Accurately uses health care terminology in client record
 - Create and maintain records following legal principles when documenting
 - Identify, create and maintain organized system of community resources

6. Communication and Cultural Competence

- Credits = 2 classroom credits
- Description: This course provides the content and skills in communication to assist the Community Health Worker in effectively interacting with a variety of clients, their families and a range of healthcare providers. Included are verbal/non-verbal communication, listening and interviewing skills, networking, building trust and working in teams. Communication skills are grounded within the context of the community's culture and the cultural implications that can affect client communication.

- Objectives:
 - Use a range of effective communication skills to interact with clients and provide accurate and relevant information/documentation.
 - Interact effectively within the community and its culture by building trust, being culturally responsive and working within diverse team settings.
 - Network within the community and throughout the healthcare system to provide needed services and resources for clients and their families.

Phase 2 -- Role of the CHW - Health Promotion Competencies (3 credits)

1. Healthy Lifestyles

This course focuses on the knowledge and skills a CHW needs to assist clients in realizing healthy eating patterns, controlling their weight, integrating exercise into their lives, taking their medications, talking with their health providers, controlling substances such as tobacco, managing stress, achieving life balance and attaining personal and family wellness. Emphasis is on learning strategies that can be used to aid in client awareness, their education and incorporation of health into their daily lives. This course also provide information and activities in which the CHW can assimilate these concepts into their own lives.

2. Heart Disease & Stroke

This course focuses on CHWs working with clients and community members in preventing heart disease and stroke as well as working with those who already have heart disease or have experienced a heart attack or stroke. Emphasized is an understanding of the physiology of the heart, risk factors and warning signs for heart disease and stroke, emotional and socio-economic impact of heart disease and stroke and common treatments. Also included are strategies for CHWs to work with clients on prevention, achieving healthy lifestyles and accessing needed resources.

3. Maternal, Child and Teen Health

This course emphasizes the needs and requirements to support the health of mothers, children and teens. Emphasis is on knowledge and skills related to the stages of motherhood including pregnancy and prenatal care, labor and delivery, the post-partum experience and the cultural implications of birthing. Also included are the benefits of breastfeeding and the nutritional needs of mothers and infants. Emphasis is also on the healthy development of the child from infancy through adolescence including developmental stages and their tasks. Issues such as sexuality, family planning, sexually-transmitted diseases, substance abuse and domestic violence as well as the resources needed by mothers and their children are also discussed.

4. Diabetes

This course focuses on the role of the CHW in working with clients with diabetes. Emphasis is on understanding diabetes, its risk factors, signs and diagnoses and its long term complications. Strategies for assisting diabetic clients with balancing their lives to achieve the highest level of wellness is a primary focus. The role of the CHW in diabetes prevention, control, resource identification and education is also included.

5. Cancer

This course focuses on the role of the CHW when working with cancer patients and their families. Emphasis is on understanding cancer, its risk factors, screening and tests for detection and diagnosis, and the types of cancer treatments. Understanding the emotional factors involved in a cancer diagnosis and its treatment as well as cultural considerations are included. Also covered is the role of CHWs to help identify resources, facilitate client access to those resources as well as give aid and support to cancer clients and their families.

6. Oral Health

This course focused on a broad range of topics needed to understand and promote oral health. Included are dental anatomy, infection control, oral hygiene instruction and care plus a guide for parents, use of fluoride and dental caries prevention as well as nutrition required for good oral health. Access to dental coverage for dental care and oral health

is covered along with the identification of resources that can be provided by CHWs to promote optimal levels of oral health for their clients, their families and in their communities.

7. Mental Health

This course provides CHWs with an introduction to mental health and illness. Emphasis is on the CHW role in promoting mental health across cultures and decreasing the stigma of mental illness. Specific knowledge and skills focus on recognizing possible signs of mental illness and early intervention, being aware of the ethical and legal aspects of working with clients with mental illness, identifying mental health resources, referring clients and assisting them with access to resources. This course also provides opportunities for the CHW to promote the mental health of self, clients, families and communities.

Phase 3 -- Practice Competencies - Internship (2 credits)

1. Internship

- Credits =2 credits
 - Description: 72-80 hours of supervised practical experience that allows opportunities for the student to prepare for independent work in the Community Health Worker (CHW) role.
- Objectives: During the internship, the student will:
 - Review agency policies related to the role of Community Health Worker
 - Integrate content from CHW classes into the Internship experience
 - Work within agency program/design to participate in some aspect(s) of the CHW role. (Mentor considers student's background and abilities and works with student to meet course objectives.)
 - Promote personal safety and safety of client.
 - Adhere to agency policies, such as confidentiality.

APPENDIX 5: NEW MEXICO COMMUNITY HEALTH WORKER LAW

2014 New Mexico Laws Ch. 49 (S.B. 58)

NEW MEXICO 2014 SESSION LAWS

SECOND REGULAR SESSION OF THE 51ST LEGISLATURE (2014)

Additions and deletions are not identified in this document.

Vetoed are indicated by ~~Text~~ ;

stricken material by Text .

Ch. 49

S.B. No. 58

AN ACT RELATING TO HEALTH CARE; ENACTING THE COMMUNITY HEALTH WORKERS ACT; PROVIDING FOR DEPARTMENT OF HEALTH CERTIFICATION OF COMMUNITY HEALTH WORKERS; PROVIDING FOR RULEMAKING, FEES, CRIMINAL BACKGROUND SCREENING AND DISCIPLINE RELATING TO CERTIFIED COMMUNITY HEALTH WORKERS; CREATING A BOARD OF CERTIFICATION OF COMMUNITY HEALTH WORKERS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. SHORT TITLE.—This act may be cited as the “Community Health Workers Act”.

SECTION 2. DEFINITIONS.—As used in the Community Health Workers Act:

- A. “applicant” means an individual applying to be certified or recertified as a community health worker;
- B. “board” means the board of certification of community health workers;
- C. “certificate” means the document issued by the department to qualified applicants for certification as community health workers;
- D. “certification” means the voluntary process by which the department grants recognition and use of a credential to individuals who are eligible to practice as certified community health workers;
- E. “certified community health worker” means a community health worker to whom the department has issued a certificate to practice as a certified community health worker;
- F. “community health worker” means a public health worker who applies an understanding of the experience, language and culture of the populations that the individual serves and who provides direct services aimed at optimizing individual and family health outcomes, including:
 - (1) informal and motivational counseling and education;
 - (2) interventions to maximize social supports;
 - (3) care coordination;
 - (4) facilitation of access to health care and social services;
 - (5) health screenings; and

(6) other services that the secretary defines by rule;

G. “department” means the department of health;

H. “recertification” means a renewal of certification; and

I. “secretary” means the secretary of health.

SECTION 3. RULEMAKING—COMMUNITY HEALTH WORKER CERTIFICATION—RECERTIFICATION—FEES.—

A. The secretary shall adopt and promulgate rules relating to the following:

(1) establishment and administration of a voluntary program for certification of community health workers, including criteria for:

(a) minimum education;

(b) training;

(c) experience; and

(d) other qualifications that the secretary deems appropriate in accordance with the provisions of the Community Health Workers Act;

(2) forms and procedures for the receipt, review and action upon applications for initial community health worker certification and for biennial recertification;

(3) establishment of standards for continuing education and other requirements that the secretary deems appropriate for biennial recertification;

(4) procedures for disciplinary action relating to applicants or certified community health workers. Department rules shall include guidelines for:

(a) disciplinary action;

(b) reprimands;

(c) probation;

(d) the denial, suspension or revocation of certification or recertification; and

(e) applicants' appeal rights;

(5) the determination, assessment and collection of certification fees, recertification fees and disciplinary fines; and

(6) other matters that the secretary deems appropriate to carry out the provisions of the Community Health Workers Act.

B. The department shall apply any fee it collects pursuant to the Community Health Workers Act to cover the costs of administering the community health worker certification program established pursuant to that act.

SECTION 4. BOARD OF CERTIFICATION OF COMMUNITY HEALTH WORKERS—CREATION—MEMBERSHIP—DUTIES.—

A. The “board of certification of community health workers” is created. The board is administratively attached to the department and shall meet at least once quarterly at the call of the chair.

B. The board shall consist of nine members who shall be:

- (1) residents of the state;
- (2) appointed by and serve at the pleasure of the secretary; and
- (3) composed of:
 - (a) the secretary or the secretary's designee, who shall serve as chair of the board; and
 - (b) eight additional members, at least three of whom shall be community health workers.

C. In determining the membership of the board, the secretary shall endeavor to appoint community health worker stakeholders such as health care providers, individuals from institutions of higher learning and members of the community from various geographic regions of the state.

D. The secretary shall adopt and promulgate rules that establish the board's membership, duties and the conduct of meetings. At a minimum, the board's duties shall include making recommendations to the secretary on the following matters:

- (1) standards and requirements for the establishment of community health worker education and training programs in the state, the successful completion of which shall qualify an individual as eligible to apply to the department for certification as a certified community health worker;
- (2) standards and requirements for approval or acceptance of continuing education courses and programs as the board may require for the biennial renewal of a community health worker certificate;
- (3) minimum education, training, experience and other qualifications that a certified community health worker shall possess to qualify as a trainer in any education, training or continuing education program for community health workers;
- (4) a means to acknowledge, document and assess relevant education, training and experience or other qualifications acquired by community health workers practicing in the state before the effective date of the Community Health Workers Act for purposes of certification while waiving minimum training and experience requirements established pursuant to Paragraph (1) of Subsection A of Section 3 of the Community Health Workers Act; and
- (5) the type of certification examination or other means to assess community health worker competency in connection with certification that the department shall require if the secretary determines that a certification examination would enhance the advancement of the practice and profession of community health workers.

SECTION 5. REQUIREMENTS FOR CERTIFICATION—RECERTIFICATION.—

A. An applicant for certification or recertification shall submit an application for registration in accordance with department rules.

B. A certified community health worker shall carry the certified community health worker's certificate and present it upon request.

C. The department shall issue certificates that shall be valid for two years to certified community health workers. A certificate may be recertified in accordance with department rules.

SECTION 6. USE OF CERTIFIED COMMUNITY HEALTH WORKER DESIGNATION—UNAUTHORIZED PRACTICE.

A. In order to use the title “certified community health worker”, the initials “CCHW” or other designation indicating that the individual is a certified community health worker, an individual shall be certified pursuant to the provisions of the Community Health Workers Act.

B. To ensure compliance with the provisions of the Community Health Workers Act or any rule that the secretary has adopted and promulgated pursuant to that act, the department may issue cease-and-desist orders to persons violating the provisions of the Community Health Workers Act.

C. A certified community health worker shall engage only in those activities authorized pursuant to the Community Health Workers Act and by rules adopted and promulgated pursuant to that act. While engaging in practice as a certified community health worker, an individual shall not engage in or perform any act or service for which another professional certificate, license or other legal authority is required. Nothing in this section shall be construed to prevent or restrict the practice, service or activities of any individual simultaneously certified as a community health worker and licensed, certified, registered or otherwise legally authorized in the state to engage in the practice of another profession if that individual does not, while engaged in the authorized practice of another profession, use any name, title, the initials “CCHW” or other designation indicating that the individual is a certified community health worker.

SECTION 7. CRIMINAL HISTORY SCREENING.—

A. The department is authorized to obtain the criminal history records of applicants and to exchange fingerprint data directly with the federal bureau of investigation, the department of public safety and any other law enforcement agency or organization. The department shall require fingerprinting of applicants for the purposes of this section.

B. The secretary shall adopt and promulgate rules to:

- (1) require criminal background checks for applicants;
- (2) identify the information from a criminal background check that may form the basis of a denial, suspension or revocation of certification or any other disciplinary action; and
- (3) otherwise carry out the provisions of this section.

C. The department shall comply with applicable confidentiality requirements of the department of public safety and the federal bureau of investigation regarding the dissemination of criminal background check information.

D. An applicant whose certification or recertification is denied, suspended or revoked, or who is otherwise disciplined based on information obtained in a criminal history background check, shall be entitled to review the information obtained pursuant to this section and to appeal the decision pursuant to rules promulgated by the department.

E. The applicant shall bear any costs associated with ordering or conducting criminal background checks.

F. The provisions of the Criminal Offender Employment Act shall govern any consideration of criminal records required or permitted by the Community Health Workers Act.

Approved March 9, 2014.

APPENDIX 6: TEXAS COMMUNITY HEALTH WORKER LAW

HEALTH AND SAFETY CODE

TITLE 2. HEALTH

SUBTITLE B. HEALTH PROGRAMS

CHAPTER 48. PROMOTORAS AND COMMUNITY HEALTH WORKERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 48.001. DEFINITIONS. In this chapter:

- (1) "Advisory committee" means the Promotora and Community Health Worker Training and Certification Advisory Committee.
- (2) "Commission" means the Health and Human Services Commission.
- (3) "Commissioner" means the commissioner of state health services.
- (4) "Compensation" includes receiving payment or receiving reimbursement for expenses.
- (5) "Department" means the Department of State Health Services.
- (6) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.
- (7) "Promotora" or "community health worker" means 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.

Added by Acts 1999, 76th Leg., ch. 857, Sec. 2.01, eff. Sept. 1, 1999.
Renumbered from Sec. 46.001 and amended by Acts 2001, 77th Leg., ch. 946, Sec. 1, eff. Sept. 1, 2001 and Acts 2001, 77th Leg., ch. 1420, Sec. 21.001(72), eff. Sept. 1, 2001.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. [2610](#)), Sec. 2, eff. September 1, 2011.

SUB CHAPTER B. TRAINING AND REGULATION OF PROMOTORAS AND COMMUNITY HEALTH WORKERS

Sec. 48.051. PROMOTORA AND COMMUNITY HEALTH WORKER TRAINING PROGRAM. (a) The department shall establish and operate a program designed to train and educate persons who act as promotoras or community health workers. In

establishing the training program, the department, to the extent possible, shall consider the applicable recommendations of the advisory committee.

(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 executive commissioner may adopt rules to exempt a promotora 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.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. [2610](#)), Sec. 2, eff. September 1, 2011.

Sec. 48.052. CERTIFICATION PROGRAM FOR PROMOTORAS AND COMMUNITY HEALTH WORKERS. (a) The department shall establish and operate a certification program for persons who act as promotoras or community health workers. In establishing the program, the executive commissioner shall adopt rules that provide minimum standards and guidelines, including participation in the training and education program under Section [48.051](#), for issuance of a certificate to a person under this section. In adopting the minimum standards and guidelines, the executive commissioner shall consider the applicable recommendations of the advisory committee.

(b) Receipt of a certificate issued under this section may not be a requirement for a person to act as a promotora or community health worker without receiving any compensation and is a requirement for a person to act as a promotora or community health worker for compensation.

(c) The commission shall 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.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. [2610](#)), Sec. 2, eff. September 1, 2011.

Sec. 48.053. RULES. The executive commissioner shall adopt rules for the administration of this subchapter.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. [2610](#)), Sec. 2, eff. September 1, 2011.

SUBCHAPTER C. MAXIMIZING BENEFITS FROM EMPLOYMENT OF
PROMOTORAS AND COMMUNITY HEALTH WORKERS

Sec. 48.101. PROMOTORA AND COMMUNITY HEALTH WORKER TRAINING AND CERTIFICATION ADVISORY COMMITTEE. (a) The department shall establish a statewide Promotora and Community Health Worker Training and Certification Advisory Committee composed of representatives from relevant entities appointed by the commissioner. The commissioner shall appoint a member of the advisory committee as presiding officer of the advisory committee.

(b) The advisory committee shall:

(1) advise the department and the commission on the implementation of standards, guidelines, and requirements under this chapter that relate to the training and regulation of promotoras and community health workers;

(2) advise the department on matters related to the employment and funding of promotoras and community health workers; and

(3) provide to the department recommendations for a sustainable program for promotoras and community health workers consistent with the purposes of this subchapter.

(c) Chapter 2110, Government Code, applies to the advisory committee.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. [2610](#)), Sec. 2, eff. September 1, 2011.