

## CHW Call Series: Certification and Licensure - Q&A Responses

March 3, 2016

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

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

**Sergio Matos:** In New York, the Office of the Professions at the State Department of Education is the primary licensing agency. By law, a number of functions are exempt from state regulation. These include advice, support, encouragement and information. For this reason, and those mentioned by Carl, licensure is not a legitimate consideration for CHWs. In addition to the non-clinical tasks mentioned by Carl, the CHW scope of practice includes outreach and community mobilization, community/cultural liaison, case management and care coordination, home-based support, health promotion/coaching, system navigation and participatory research. None of these roles requires a license to practice.

2. Gail: Could you speak more about the dedication of resources to support CHW leadership when you get the chance? Who from, how much?

**Gail Hirsch:** I was referring to resources from the Massachusetts Department of Public Health. This included: 1) Since 2000, support for the development of a statewide CHW association, which was around \$50K a year for three years; 2) Ongoing technical assistance and staff in-kind support since then to support organizational development for MACHW (through my participation as a member of their Board of Directors); 3) Nurturing of MACHW staff from the Office of CHWs to write abstracts, conduct presentations, do fundraising, write policy, as well as from the Commissioner's office; 4) Direct funding to MACHW for the past several years to do CHW town forums and focus groups, educational sessions, develop materials, etc. (ca. \$50-60K per year). We supported MACHW to take a lead on convening the NE CHW Coalition, and to implement the Women's Health Leadership Institute (for CHWs).

3. Question for Sergio: What does it mean to adopt the APHA definition of a CHW but yet embrace your own network's beliefs and values of what this should be?

**Sergio:** The Community Health Worker Network of NYC is a professional association of CHWs that works to advance the CHW practice while preserving the character of the work. The Network has adopted the APHA definition of CHWs in full and as written. Although several states have moved to amend the APHA definition for their particular purposes, we found no such need.

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

**Gail:** In Massachusetts, we have our own definition, which is highly “functional,” in the sense that it was developed to support contract management of MA DPH community-based vendors employing CHWs. At the same time, we recognize the national consensus around the APHA definition, which is slightly broader.

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

**Sergio:** This is the million-dollar question. CHW certification is a controversial issue and one which New York is approaching with due diligence to the national experience, the evidence base and thoughtful deliberation of the meaning and potential consequences. Much interest in certification develops from a desire for recognition, job stability, advancement opportunities and sustainable financing. Although many people believe that certification will meet these workforce needs there is no evidence for this belief. In fact, the limited number of states that have established CHW certification provide more of a cautionary tale than any best practices.

Another force driving the interest in CHW certification is recent efforts to integrate CHWs into emerging healthcare teams – particularly in health reform innovations and DSRIP states. In those instances, certification is a valued norm to the medical members of the healthcare teams.

In general, payers in New York consider the business case for CHWs contributions to improved outcomes, value-added cost-savings and return on investment compelling, even in the absence of any certification. Medicaid is not requiring certification in its recent changes to their preventive services rule concerning reimbursement. Again, there is no evidence that certification alone leads to improved insurance payment, especially in this era of bundled payments, shared risk and team-based care.

Lastly, a state that undertakes a legislative approach to certification has to consider the need to provide a structure that could regulate the credential and most states are reluctant to increase government and/or spending.

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

**Carl:** CHWs and employers in each state should make their own assessment of whether employers are interested or not. It does not appear that CHWs, employers or payers are interested in regulating the

practice of CHWs, but payers (mainly Medicaid) especially want some understanding on skill requirements so they know what they are paying for. Certification does not by itself or automatically lead to integration of CHWs into healthcare financing (we are moving away from the term “reimbursement”). Many CHWs do not work for healthcare organizations; non-healthcare employer certainly may have less concern about standard qualifications. In some states “certification” of clinical occupations is really licensing (regulation), so there may be a better term for what folks really want.

**Gail:** Agreed that there is no evidence yet on much of anything related to certification, we are pioneers. In Massachusetts, there was definitely interest expressed by both policymakers (legislators) and payers (the association of health plans) in certification, BUT – we would not have recommended it had not CHWs been in favor of it and crafted the legislation.

That said, I would like to add that the PROCESS of convening people, with significant CHW involvement, to design the program, serves to build awareness, consensus, and buy-in across sectors.

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

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

**Gail:** In Massachusetts, CHWs see this is a step in their career development and wanted the certification to be individual for that reason (similar to other professions.)

6. Based on NY CHW employer feedback, you report that experienced employers not asking for certification. What do they say about CHW educational standards?

**Sergio:** Several employers surveyed did comment on their desire for CHW educational/training standards – both in content and methodology. They mentioned that the lack of training standards led to much confusion or irrelevant training. Some employers were clear that they were not asking for a standard curriculum but rather for curriculum standards that training institutions could use as guidance.

Our training standards recommendations for New York State are published in our report, “Paving a Path to Advance the CHW Workforce” available on our homepage at [www.chwnetwork.org](http://www.chwnetwork.org)

7. For individuals who are now taking CHW training whether online or in a classroom setting, will certification be available or an option for them? Is it available statewide or is it only available to MiCHWAs? Has it been decided or is it in discussion for now? Is it up to the providers/employers to decide?

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

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

**Gail:** In Massachusetts, we are developing a certification program that will be open to all eligible applicants, who can apply through two pathways: “Training and Work Experience,” or “Work Experience” only. It will be open to everyone.

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

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

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

**Gail:** In Massachusetts we are addressing this concern by having our regulations contain what is mandated by law, and putting a fair amount of the content (in-depth core competencies, for example, into sub-regulatory guidance, which is easier to change.

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

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

**Carl:** Good question – there is a lot of discussion. CHWs in general should probably be paid more, now that employers are discovering their true value, but the truth is that formal policies like certification do

not guarantee better pay. That is why efforts are needed to make use of the evidence of CHW impact and to educate stakeholders on their value to communities and organizations.

**Gail:** I think most people agree that CHWs should be paid more, and advocates can certainly make proposals for fair living wages. It is not tied directly to certification, however.

**Sergio:** CHW salaries tend to vary by geography and local economies. In New York CHWs starting salary is around \$40,000.00 but then again, NY has a relatively high cost of living.

10. What kind of infrastructure development did Massachusetts Dept. of Public Health build/provide the Massachusetts Association of CHWs as they were forming an Association of CHWs?

**Gail:** The MA DPH had a HRSA Maternal and Child Health Bureau grant (through the CISS-COG program) in 2000-2003 to support the salary of a network coordinator, statewide meetings, leadership development and strategic planning. After that time, the Office of CHWs continued to provide technical assistance on organizational development, and the network (MACHW) was in a position to seek a fiscal parent and independent funding.

11. For Sergio (and others): wondering if there was any discussion of protective service, quality or conflict of interest issues when considering the necessity/advisability of CHW certification?

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

**Sergio:** I am not sure I understand the question either, but some of these issues are the responsibility of the employer organization(s), which generally have specific policies and procedures concerning COI, mandated reporting and employee safety. In some settings, compliance with organizational regulations is the purview of the supervisors of CHWs.

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

**Katie:** There are a lot of opportunities for CHW payment beyond grant funding. Several challenges still exist, though. For example, organizations are designing innovations as part of CMS initiatives, including the State Innovation Model, and states are expected to identify sustainability mechanisms as part of their process. To date, this has been very challenging for states. Additionally, the majority of CHW payment options that do exist support CHWs in healthcare settings versus human service or other community settings. In many cases, this is not an issue, but many community agencies are not equipped

or structured to bill services in the same way healthcare entities are. New options are emerging, including health plans contracting with health and human service agencies for CHW services, but these options are still emerging. Michigan has two current Medicaid funding streams for CHWs: one that allows Medicaid managed care health plans to pay for CHW services in a variety of ways and another that is a per member per month payment to a care team that includes CHWs. In neither case is certification required. You can read more at <http://www.michwa.org/resources/policy/>. Also important to note is that many larger agencies, such as health systems, do pay for CHWs out of general fund or community benefit funds.

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

**Gail:** Our sense here in Massachusetts is that even though certification is not yet operational, both the state Medicaid agency and other payers are more interested in discussing payment for CHW services as members of multidisciplinary teams because we are working on developing certification. I think it shows them that major stakeholders are devoting significant resources to CHW workforce development.

**Sergio:** New York has a long history of financially supporting CHW programming through Maternal/Child Health, HIV/AIDS, Chronic Disease and Immunization programming. Although they are government grants to community-based and hospital/CHC organizations, this funding has been consistent over many years. New York is a DSRIP state; therefore, much attention is on building broad comprehensive partnerships which would be financed through bundled payments.

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

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

14. What core competencies did you focus on?

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

**Gail:** in Massachusetts, many stakeholders, have developed the core competencies, over a period of many years, with the most detailed articulation of them currently designed to be the foundation for our impending competency-based certification. They can be found here: <http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/ma-board-of-certification-of-community-health-workers.html>

**Sergio:** In New York, we developed a CHW scope of practice, including roles, tasks and skills, based on our original rigorous research and market analysis in a partnership between the CHW Network and academic research institutions. The scope of practice is therefore evidence-based and responsive to voices of all relevant stakeholder sectors, including CHWs, employers, payers, regulators, legislators, providers and CBO/FBOs. This work is published in the scientific literature and in our report, “Paving a Path to Advance the CHW Workforce” available on our homepage at [www.chwnetwork.org](http://www.chwnetwork.org).

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

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

16. To Gail Hirsch- What part has open enrollment community colleges played in the discussion around certification? Is a College certification of Completion equal a certification?

**Gail:** Community colleges with CHW core competency programs will be eligible to apply for approval as core Training Programs by the Massachusetts Board of Certification of CHWs. We are working with them and other CHW training programs in the state as they gear up for when certification becomes operational. College certification alone will never equal CHW certification in the sense that CHWs who apply to be certified must also have work experience.

17. Gail can you further discuss title act versus practice act? Thanks.

**Gail:** To my understanding, a title act means that in order to call yourself a “Certified CHW” you must go through the certification process, and if you do not go through it, you can still practice as a CHW (without the “Certified” title). A practice act requires certification (or, more commonly licensure) in order to practice, and CHW advocates in Massachusetts felt very strongly about NOT creating anything mandatory. Thus, our certification law was a “title act.”

18. How do states differentiate CHW roles with case or care management which may be provided by a variety of other entities and have their own training and standards around care navigation, increasing access to health and social determinants and patient engagement in health related activities?

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

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

**Gail:** System navigation and care coordination are included as one of our ten core competencies, and described in detail as relates to CHWs in our Core Competencies. Clearly, other healthcare occupations may have those skills but that does not mean that they have the attributes of a CHW, which make them so effective when using those skills in their communities. See the link above to read our Core Competencies.

**Sergio:** This is a great question. Care coordination is a role (or task) conducted by a number of different disciplines for various reasons. Care coordination conducted by CHWs has its own set of activities and skills. These parameters described fully in the NYS CHW scope of practice.

19. For Sergio. Is DISRIP requiring any formal training for CHWs?

**Sergio:** DSRIP is not yet requiring any specific raining for CHWs. A limited number of DSRIP awardees are operationalizing their own CHW staff but most are collaborating with existing CBOs that already have CHW programming. However, there is very active discussion of this topic in our state Medicaid Redesign Group that has a Workforce Development Workgroup on which I serve.

20. This is for Mr. Matos and Ms. Hircsh in terms of the CHW Advisory Boards what were lessons learned if any in terms of maintaining self-determination and making sure the voice of the CHWs was heard in the process?

**Gail:** This is the most important part of the process. As I indicated on the webinar, I feel that unless CHWs are engaged, there is no point to doing any of this, and thanks for the question! Those of us who are not CHWs do not know what the needs of the workforce are. The lessons we have learned include that CHWs need to be invited and encouraged to attend meetings, to have a place at the table, to speak up, to have permission from their employers to engage in the process (which we have supported through our work with CHW employers), financial resources to support representation from the CHW association at meetings, nurturing, and respect. Basically it is important to convey to everyone involved that CHWs must be at the table, and that often requires asking other people to stop talking for periods of time (to be blunt).

**Sergio:** I completely agree with Gail’s points and in her thanks for the question. This is a critical component. In New York, we established a leadership advisory group (LAG) made up of statewide representatives of all relevant stakeholder sectors, including local/regional CHW associations. The LAG established three workgroups and each was co-chaired by a CHW and a stakeholder.

21. After completion of training, how do CHW access jobs?



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

**Gail:** In Massachusetts currently only those CHWs are employed get trained. That may change as certification becomes available and more training opportunities open up. Of course, this could negatively impact recruiting CHWs from the community so we are trying to be mindful of that possibility and prepare for dealing with it.

**Sergio:** In New York, local and regional CHW associations generally distribute job opportunities through email lists and websites. Employers also post their job opportunities through various media outlets.

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

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

23. Can your criminal history stop you from getting a job?

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

**Gail:** The Board of Certification is developing guidelines around this right now. The Board recognizes that some of the most effective CHWs may have a criminal record and is working hard to adopt policies that respect that fact, while also ensuring that the public is protected adequately. Stay tuned for further developments.

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

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

**Gail:** To my knowledge, not in Massachusetts. It has come up in the past occasionally, but other initiatives, such as training, certification and financing have taken priority.

**Sergio:** In New York, CHWs are not unionized, although our local hospitals employees union is making moves to take on the practice. This is a very active discussion among CHWs as they view it as potentially helping with job security and wages. There is also a lot of interest in considering CHWs a skilled trade and establishing a guild model where practitioners themselves govern their practice – similar to carpenter, plumbers, screen actors, etc.

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

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

**Gail:** I would direct you to our Core Competencies (link above), which we believe addresses the core skills needed by CHWs working in both clinical and community-based settings. We recognize that CHWs who work in certain settings will definitely need additional specialty training.

**Sergio:** I think it is important to recognize that CHWs who work in a medical setting still do NOT conduct medical roles. Although the medical practices do have their own set of unique circumstances, our scope of practice applies to CHWs working in all settings, even including those working in research.