Community Health Worker Certification and Financing

Issue Brief

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Issue Brief

Introduction to Community Health Workers

Using multi-disciplinary clinical teams is an important way to increase access to primary care, eliminate health disparities, and achieve the Triple Aim of better quality of care, better health for populations, and lower costs. In particular, community health workers (CHWs) are well positioned to help reduce health inequities and increase providers' cultural competence and quality of care. This document provides an overview of possibilities for CHW certification and financing, and offers recommendations for state and territorial health agencies to cooperate effectively with other stakeholders in planning, policy development, program design, strategy implementation, and evaluation to promote health system transformation and health workforce innovation involving CHWs.

CHWs are frontline public health workers who are trusted members of local communities who have a close understanding of the community served. The strength of these relationships enables CHWs to serve as liaisons or intermediaries between health, social, and community services in order to improve care access and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing patients' health knowledge and self-sufficiency through a range of activities such as community education and outreach, informal counseling, first aid services, social support, and advocacy.[1] For example, a CHW may provide blood pressure screening and education to help a patient control hypertension or diabetes.

CHWs hold core values based in equality, justice, and empathy. They specialize in working with low-income individuals and communities, often with communities of color who are commonly disadvantaged or disenfranchised and experience barriers to accessing health services. The fact that thousands of CHWs work as volunteers, in some cases for decades, is a reflection of these values.

CHWs are valuable to public health and healthcare in part because they are recruited specifically for their strong rapport with low-income and minority communities. However, these qualities also mean that CHWs possess distinctive capabilities that are incredibly valuable, including the following:

Community Health Workers Build Relationships
For most individuals, healthcare is often episodic and remains at arm's-length. Providers may lose patients to follow-up or miss opportunities to provide preventative care because the only patient interactions occur in times of crisis. However, emerging team-based care and medical home models require patients and providers to know and understand one another more deeply. CHWs are in a unique position to facilitate that process because relationship-building is the source of their effectiveness.

Community Health Workers Build Trust
Most clinicians make a sincere effort to gain their patients' trust, but there are limits to what they can do on their own, particularly among low-income communities and

CHWs possess the "Three C's" of Community
Connectedness
CHWs know the community and move freely within it.
Credibility
CHWs are known and trusted as leaders and "natural helpers."
Commitment
CHWs pursue their work out of a sincere commitment to the wellbeing of the community—because it is their community.

people of color. There may be distinctions or differentials in perceived power between provider and patient, as well as a historic legacy of mistrust of institutions, especially hospitals. Meanwhile, CHWs operate on the basis of trust and empathy built on shared life experience.

Community Health Workers Deepen Communication
Emerging healthcare structures will require much greater communication continuity between patients and providers. Patients may require routine follow-up and intensive communication to manage chronic conditions or to assure adherence to treatment, especially during care transitions. Medicaid providers and health plans have often experienced patients being "lost to follow-up," which is not acceptable in the more accountable structures of the future.

Clinicians acknowledge that candid communication is incredibly important to improve the quality of care and achieve accurate and efficient diagnoses. Lack of clarity in patient communication about symptoms can lead to the practice of defensive medicine. There is also extensive anecdotal evidence that patients may tell their doctors that everything is fine, while telling CHWs the truth about medication side effects or non-adherence. The patient-physician power differential is significant, and patients will often say what they think the doctor wants to hear. Therefore, CHWs can inform clinicians, especially in a team-based setting, about the fuller circumstances of a patient's or family's life, including factors that may affect their health directly, inform diagnosis and treatment decisions, or influence the patient's ability to access care or adhere to treatment.

> ### CHW Skills
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> The CHW Core Consensus (C3) Project describes the core skills of CHWs as falling in the following categories:
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> 1. Communication skills
> 2. Interpersonal and relationship-building skills
> 3. Service coordination and navigation
> 4. Capacity building
> 5. Advocacy
> 6. Education and facilitation
> 7. Individual and community assessments
> 8. Outreach
> 9. Professional skills and conduct
> 10. Evaluation and research
> 11. Knowledge base
>
> Several states have used this list as a starting point to create a list of skills required for CHW certification.

Community Health Workers Influence Social and Behavioral Determinants of Health
There is strong evidence that CHWs can affect patients' health-related behaviors due to trust factors and the ability to spend time on coaching and support across an array of locations, including at home, in the community, and in clinical settings. CHWs are ideally situated to play a leading role in addressing the social determinants of health because they move beyond simply imparting information to helping individuals understand and internalize it.

A CHW can also support a patient or family directly in dealing with social issues, such as housing, environmental, or employment issues, through home visitation, referrals, and advocacy. CHWs have a strong history of addressing broader issues affecting entire communities or neighborhoods, such as access to nutritious foods or public safety concerns that cause stress and affect individuals' ability to engage in physical activity. CHWs can help mobilize the community to pursue action by local or state governments and the private sector to remedy problems.

It is critical to understand CHWs' capabilities in order to inform decisionmaking on CHW certification and financing. CHWs can help stakeholders achieve key objectives that they are already pursuing, such as improved health outcomes and health equity and strengthened linkages between clinical and community services. In particular, CHWs' skills and capabilities complement structures like medical homes and accountable care organizations. CHWs work at the crossroads of public health and healthcare and have a unique ability to affect change at the individual, family, and community levels.

Community Health Worker Certification

Certification is a potential mechanism to help assure stakeholders that CHWs are proficient in certain crucial capabilities. Most states are investigating some way to standardize the occupation. The general trend is toward some form of voluntary certification for individual CHWs based on experience and/or training. Although only a small number of states have formally instituted certification, many more are at some stage of developing it. However, the process of considering CHW certification has not been quick or simple in any state. This may be due in large part to differing perceptions of the definition of CHW, as well as the benefits and challenges that certification may present to various stakeholders.

The term "certification" is now commonly used to discuss occupational standards for CHWs; however, the definition and effects may vary. Certification may be considered a specific form of credentialing, but credentialing options also include licensure, registration, and permitting. Licensure is not an option, since CHWs do not perform clinical duties requiring a license and CHW practice does not pose a significant risk of harm to the public.[i]

Major Structural Options for Certifying Community Health Workers

At the most basic level, certification is a declaration by an issuing authority that an individual has certain qualifications (e.g., training or skills). Certification is not necessarily practice regulation, unless the responsible authority explicitly chooses to make it so, often through legislative action. Further, certification is not automatically a state government function. The issuing authority may be a government agency, an educational institution or program, an independent association, or an employer-based entity. Some states are choosing not to base certification on an assessment of qualifications and are instead opting to administer a registry or database of individuals who have received certification. This is a ministerial function of government and avoids the appearance of government regulation.

In addition, many stakeholders confuse certification with an educational certificate of completion; however, this is not true unless the responsible authority declares it to be so. In general, an educational institution or program is not allowed to confer a title such as "certified CHW" unless that authority explicitly grants it. It is vital that all stakeholders understand this distinction.

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[i] Licensing bodies in Massachusetts, New York, and Virginia have explicitly declined to consider licensing CHWs. Ohio's CHW certification program is managed by the state board of nursing, and includes a provision for delegating certain nursing tasks to CHWs. Alaska regulates community health aides, which are mid-level clinicians whom the state does not consider to be CHWs.

Directly certifying individuals as CHWs may be a voluntary or mandatory practice. Mandatory certification is tantamount to licensure and has not been pursued in the United States.[ii] Again, the distinction is between regulating the use of a title versus regulating the authority to practice as a CHW. For example, in Massachusetts, the 2010 statute creating certification was passed as a title act instead of as a practice act.

Several states have considered certifying CHW employers in lieu of individuals, but no state to date has taken this approach. Certifying employers could accomplish certain public policy objectives with less burden on individual workers, but it would not offer those workers a "portable" proof of qualifications that would transfer across employers.

Most state certification programs to date have also required certification or approval of training programs, curricula, or individual instructors, generally providing that successful completion of an approved program entitles a CHW to individual certification. This in turn requires developing training standards, including for curriculum content.[iii] Where training is used as a benchmark, the individual must usually apply for the actual individual certification, but a state has the option of bypassing that step, in which case the responsible authority (again, not necessarily a state agency) may issue the certification based on graduation records received from approved training programs. States find the education-based option attractive because it places the burden on the training program to assess the individual's proficiency in required skills.

Recommendations to Create a Responsive Certification System

CHWs' duties and skills are fundamentally different from those of other public health professionals. Further, individuals who become CHWs may face particular challenges in their own lives, which must be considered when developing policies and procedures for certification in order to avoid creating unnecessary barriers to entry. Drawing from lessons learned among early adopter states, stakeholders should pay particular attention to the following features of the certification process:

- Required core competencies should reflect the actual CHW experience. It is recommended that stakeholders consider definitions from the CHW Core Consensus Project.[2,3] Stakeholders should also consider variations in skills between CHWs practicing extensively in a community setting versus those practicing in a clinical setting.
- Stakeholders should investigate standards adopted by other states, especially as certification programs become more common and reciprocity with other states becomes increasingly salient.
- There should be multiple paths to entry available, including a path based on experience rather than education, often referred to as "grandparenting."

[ii] Texas began CHW certification in 2002 as a voluntary program, despite a 2001 statute declaring certification to be mandatory for any CHW receiving compensation. However, the bill creating the statute did not provide for enforcement, and Texas has chosen not to invoke the statute or to set penalties for violations.

[iii] Minnesota created a statewide standardized CHW curriculum based in postsecondary education. The curriculum is a competency-based, 14-credit certificate program that creates a pathway for a wide range of health and social services careers.

- The application process should be user friendly, without unnecessary barriers related to education requirements, language, or citizenship status. Some states have decided that education requirements are not necessary, and others require CHWs to have a high school diploma or GED. However, unnecessary educational credentials may create unintended barriers to entry for otherwise highly qualified CHWs.
- Similarly, although background checks may be a general requirement in state occupational regulations, employers generally conduct their own checks, and not all violations are relevant to CHW practice. In fact, CHWs who have been incarcerated for non-violent or drug-related offenses may be especially effective in connecting with other formerly incarcerated individuals or with families of currently incarcerated individuals.
- Any training required for certification should be available in familiar and accessible settings. CHW skills should be taught using appropriate methods, such as adult or popular education. Many programs emphasize the value of hiring experienced CHWs as trainers.
- There should be easy access to continuing education units, including distance learning options.
- The certification system, and the process of developing it, should respect the role and needs of volunteer CHWs. At the very least, the system should not undermine their status or their ability to practice freely.

When convening stakeholders to discuss certification options, it is critical to engage CHWs in leadership roles. Defining and setting standards for any profession requires participation from the practitioners themselves. This should be self-evident, but there have been examples of appointed boards or advisory groups doing this work for CHWs with little or no CHW participation.

In addition, advisory or planning groups are advised to thoroughly understand the nature of CHW practice in order to create policies that are congruent with that practice. (For example, such groups should avoid inserting inappropriate clinical duties into the definition of CHW duties.) Groups are also advised to create policies and procedures that acknowledge and work with the qualities associated with successful CHWs, and should avoid unnecessarily burdensome application processes or high application fees. Advisory groups should have an ongoing and explicit commitment to creating responsive certification policies and procedures that respect the nature of the practice.

Uncovering Stakeholder Beliefs and Preconceptions

Stakeholder attitudes toward certification depend on the nature of the certification process itself. Stakeholder preconceptions may be based on the terminology used; however, in actual practice, certification can mean whatever the sponsoring body declares it to mean. Therefore, groups considering CHW certification need to first ensure stakeholder agreement on the rationale and objectives for certification, as well as address preconceived ideas of anticipated benefits and challenges.[iv]

Expectations and preconceptions vary among stakeholders and often center on their vision of the benefits or problems that certification may create. Such benefits and challenges may arise, but no outcomes are guaranteed. Occupational definitions and standards are only one element of the policies

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[iv] As of this writing, the current pattern is to adopt a voluntary certification process, which only limits the use of the "certified CHW" title and does not limit who may perform the duties of a CHW.

necessary to fully embrace CHWs as integral members of the healthcare workforce.[4,5] The table below summarizes common benefits and challenges anticipated by CHWs, payers, and employers.

	CHWs	Payers and Employers
Anticipated Benefits	• Higher wages. • Improved working conditions. • Increased respect from other professions. • Wider career opportunities. • Stable employment. • Sustainable funding. • Progress in building professional identity. • Increased understanding of the field. • Consistent standards for the field.	• Clear scope of practice boundaries. • Consistent, reliable qualifications among CHWs. • Simplified recruitment and selection, and a more fluid job market. • Reduced on-the-job training costs. • A clearer rationale for integrating CHWs into care teams. • Reduced dependence on short-term funding.
Assumed Negative Impact	• New barriers to entry. • Creation of a "class" system among CHWs. • Making CHW practice more clinical and less connected to the community. • Regulations, restrictions, or changes to what CHWs are allowed to do. • Employing people without strong connections to the community. • Further marginalization of volunteer CHWs.	• Pressure to increase wages. • New regulations and restrictions on their organizations. • Increased overall training costs. • CHWs losing touch with the community, thereby becoming less effective overall.

In order to address these preconceptions, stakeholders should first acknowledge their public policy goals and the values they are pursuing through CHW certification. Stakeholders should identify the driving interests in their own states. Those interests may include establishing a reliable indicator or definition of CHW qualifications, gaining recognition for CHWs as an occupation or profession, or meeting financing requirements.

Second, stakeholders should ensure agreement on the meaning and definition of CHW certification. Many states have learned, often late in the certification process, that stakeholders may have differing preconceptions and beliefs about what certification is, how it works, and what its positive or negative effects will be. In addition, stakeholders joining the process at later stages may slow or even halt progress due to differing beliefs and preconceptions. Groups would be well advised to thoroughly and openly discuss their beliefs and preconceptions as a condition of participation. (Appendix A of this document provides an overview of guiding questions that can facilitate discussions on certification options and ensure that stakeholders create responsive systems).

Community Health Worker Financing

Ensuring sustainable financing for CHWs is a continuing challenge that has led CHW membership organizations and allied stakeholder coalitions to pursue policy, program, and practice changes to financially support CHWs under emerging public health and healthcare systems. State and territorial health agencies can support these efforts by:

- Contracting with established CHW associations and helping develop and support CHW networks.

- Convening multi-sector coalitions that link partners in government, community-based organizations, contracted agencies, and healthcare.
- Supporting internal policy and program development and cooperation with intragovernmental partners, such as state Medicaid officials.
- Applying for federal demonstration grants with private, nonprofit sector partners.
- Providing direct funding for CHW programs through state and territorial health agencies.
- Conducting research, including collecting and sharing data and disseminating policy and practice models from other states.[v]

Healthcare reform now makes it possible for new stakeholders to approach healthcare providers and payers to expand CHW coverage. Under non-fee-for-service payments, payers calculate costs for a range of services for a population or an individual and make payments in a lump sum. Healthcare organizations may then decide which services and staff can most effectively deliver care and improve health. The mechanisms detailed below are increasingly available to enable (although, not necessarily to require) coverage for CHWs.

Medicaid

Medicaid is the largest payer of healthcare for low-income individuals and families and is a major resource for expanding sustainable financing for CHWs. Medicaid also influences other payers and providers, and its acknowledgement and inclusion of the CHW workforce could help to legitimize CHWs and promote financing from other sectors. States have several financing options through Medicaid, and combinations of these options may be appropriate, depending on the state's goals.

Medicaid provides high-level policy mechanisms to innovate and demonstrate effectiveness of new forms of healthcare delivery and payment. These include Section 1115 waivers from CMS, which state Medicaid offices commonly use to meet the Triple Aim goals of healthcare reform. Changes approved under a Section 1115 waiver are temporary and usually cover a demonstration period of three to five years. One form of Section 1115 waivers, Delivery System Reform Incentive Payments (known as DSRIP), were originally used to fund hospital safety net care and now provide major funding for innovative health system reforms.[vi]

In addition, states may wish to pursue a Medicaid state plan amendment (SPA). Unlike a Section 1115 waiver, an approved SPA results in a permanent or lasting change in the state Medicaid program. For example, in 2012 North Dakota secured CMS approval for an SPA that it implemented in 2016 authorizing payment for community health representatives to deliver targeted case management services using their existing core skills plus specialization training.[vii]

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[v] ASTHO's Community Health Workers web page includes further information and a variety of resources.
[vi] To date, nine states have been approved for DSRIP funding as part of their CMS Medicaid waivers: California, Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, Texas, and Washington state.
[vii] Community Health Representatives are CHWs employed in tribal health programs supported by the Indian Health Service.

In 2014, a Medicaid rule change allowed states to begin pursuing SPAs to cover clinical preventive services delivered by non-licensed providers if they are recommended by a physician or licensed practitioner. Several state Medicaid offices have explored this idea, but as of this writing, no state has submitted such an SPA. Several states have expressed concerns about whether this change would lead to additional expenses for Medicaid at a time when cost reductions are expected and often required. State Medicaid offices' hesitancy to pursue such a goal through a SPA has brought diminished attention to this strategy, but it remains a potential policy tool.

States may also use SPAs to implement a Medicaid health home state plan, allowing states to design health homes that provide comprehensive care coordination for Medicaid beneficiaries with multiple chronic conditions. In this case, states would need to explicitly include language regarding coverage of unlicensed providers for preventive services. To take advantage of this rule change after a health homes SPA has already been approved, even if CHWs are engaged in other roles, states may need to develop a separate SPA.[viii]

Additional financing options available under Medicaid include:

- Dual eligible programs for individuals who are eligible for both Medicare and Medicaid.
- Managed care capitated payments, under which CHWs may be covered as administrative costs.
- Federally Qualified Health Centers, which provide many Medicaid and uninsured patients with comprehensive clinical services. Prospective and alternative payment mechanisms allow these centers to use innovative service delivery options, and they may request adjusted rates for new services.

Medicaid Challenges for Community Health Worker Financing
Medicaid has traditionally and legally focused on paying solely for "medically necessary" services, which has meant primarily clinical services. It has also traditionally paid for services to individuals and has not addressed the costs of providing public health interventions targeting populations or communities. However, the Affordable Care Act and healthcare reform have expanded opportunities to support population health approaches for members affected by prevalent chronic conditions.

"Reimbursement" is a term that implies fee-for-service payments. In the context of the cost saving pressures of healthcare reform, asking for reimbursement for CHW services is likely to be interpreted as a proposal for a new class of provider who can directly bill for services. This in turn raises the specter of increased rather than decreased costs to payers. "Coverage" is a more timely term appropriate for emerging payment systems.

Public payers such as Medicaid have historically paid lower rates to providers than have private payers. This has placed financial constraints on many healthcare provider organizations, which can discourage their openness to experimenting or taking risks by adding new services or workforces.

[viii] Several states have implemented health home models, including Maine, Michigan, Missouri, and New York. None of these states has invoked the 2014 Medicaid rule change concerning covering unlicensed providers offering preventive services as part of the SPA.

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Administrative Expenditures in Managed Care

State Medicaid offices and their approved health plans already have the flexibility to use Medicaid administrative expenditures for services that are not approved clinical interventions. It is common for health plans with Medicaid-covered members to directly employ CHWs or pay other organizations for CHW services and treat these as administrative expenditures.

CMS has urged states to impose limits on the percentage of a health plan's expenditures that can be classified as administrative versus provision of care, known as the medical loss ratio. However, this may not impose a challenge to expanding CHW employment. In fact, there are signs that CMS may offer health plans and providers greater flexibility for covering CHWs by allowing the cost of some CHW services to be treated as part of the cost of quality improvement.

State Health Reform Payment Innovations

State health reform payment innovations may offer an opportunity for CHW financing, such as through pooled funds required from third party health payers (which requires state legislation). State examples include:

- Massachusetts Prevention and Wellness Trust Fund: Fees on large hospitals and health plans cover community-based secondary prevention and promote linkages between providers and community organizations.
- Vermont Blueprint for Health: All payers in a given region must pay into a fund to support community health teams, which serve patients for all primary care providers in the area.

Global or other alternative payments may offer another opportunity for CHW financing, including:

- Bundled payments for episodic or encounter-based care for conditions (e.g., asthma) which involve multiple services. These may or may not be global payments.
- Supplemental enhanced payment for specific purposes (per member per month wraparound services for target populations).
- Value-based payments, where providers in a system can be awarded a share of savings arising from improved care and population health, or receive lowered payments depending on whether they reach quality, health, or cost benchmarks.

Internally Financing Community Health Workers Via Healthcare Providers or Other Employers

Healthcare providers can be powerful allies in efforts to expand adoption of CHW-involved or CHW-led care models, whether the aim is to engage employers as champions within health policy or payer institutions or to make a strong business case to expand CHW intervention models. In addition, larger policy change mechanisms, such as Section 1115 waivers and SPAs, are allowing state Medicaid offices to change how they organize, pay for, and incentivize health plans and providers serving low-income populations to meet the Triple Aim of healthcare reform. Healthcare providers are being incentivized or required to become part of integrated care systems with shared responsibility for improving health and

reducing costs. Accountable care organizations and value-based payments place new expectations on healthcare provider organizations that can make CHWs' strengths and value more compelling, particularly as part of models to serve people experiencing complex health or social challenges.

Even prior to current Medicaid and other system changes, health plans and provider systems serving primarily low-income and otherwise disenfranchised populations have hired CHWs to expand their understanding of how to work with these communities. The motivations have been the same—to better engage and improve healthcare access for disenfranchised or vulnerable people and communities in order to improve health (often, saving money in the process).

Often, healthcare providers (e.g., hospitals, managed care organizations, and primary care or specialty clinics) receive grants or use internal resources to test interventions that include CHWs. In many cases, once providers have established that these interventions bring cost savings and other improvements, they decide to include CHWs in the organizations' ongoing budgets.

Recommendations to Develop a Financing Vision and Facilitate Strategic Planning

Before employers invest their own resources in CHW integration and financing, they must understand the workforce's capabilities and value and how CHWs can help achieve management's organizational objectives. State and territorial health agencies can play a variety of roles to facilitate this process, and engaging external partners—including CHW leaders and advocates—may help achieve positive results.

Stakeholders may use the process below to help educate and engage potential employers to expand the CHW workforce in their organizations. The stages are intended to summarize a complex process of learning, program design, and implementation that may not unfold as depicted. The actual process may vary depending on the employer's service delivery models, history, and approach to community engagement.
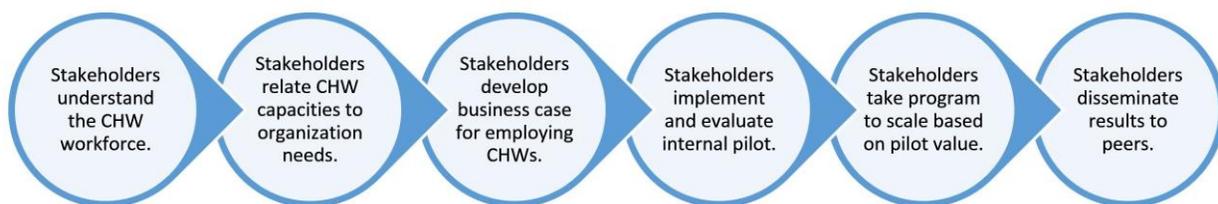
Initially, it is important to educate your audience about the nature, definition, and distinctiveness of the CHW workforce and roles. Many stakeholders need basic education about CHWs. Incomplete understanding or misconceptions can impede or undermine policy and systems change efforts. (See the "Introduction to Community Health Workers" section at the beginning of this document.)

Early discussions should also help identify key decisionmakers who will play a role in achieving desired policy or practice changes. Possible decisionmakers may include colleagues in state government, healthcare provider executives, commercial insurance and managed care executives, or industry and professional association representatives. Knowing your future audience will help build the business case

for CHW integration and financing. Stakeholders should therefore:

- Learn what has value and salience to decisionmakers. Identify areas of convergence between research demonstrating CHW effectiveness and decisionmakers' concerns and interests.
- Provide evidence that will help drive decisions about models, staffing, and financing.
- Provide timely information in formats and forums that are responsive to decisionmakers' needs.

Stakeholders should also convene appropriate partners and conduct an analysis of strengths, weaknesses, opportunities, and threats (a "SWOT" analysis) to inform goal-setting. It is critical to assess the state's own unique challenges and opportunities before deciding which financing strategies are most appropriate. Engage CHWs directly, drawing from state CHW association leadership, if possible. Stakeholders should also include state and territorial health agency staff representing programs that employ, fund, or could potentially fund CHWs. It may also be helpful to engage health providers, payers, academic stakeholders, and community health advocates.

During initial assessments and discussions, clarify priority areas for promoting CHW financing. There may be opportunities to pursue new financing mechanisms as the result of changes in state Medicaid policy, incentives or requirements in health system transformation design, or direct healthcare provider investments in CHW interventions. (Appendix B of this document provides a state self-assessment tool for planning sustainable CHW financing.)

It may be helpful to pay particular attention to ways to integrate CHWs into existing systems rather than to create dedicated funding streams built around the goal of employing CHWs. For example, highlight the value of unique CHW capabilities for emerging healthcare models and principles, and make the case for weaving the costs of CHWs into payment systems based on credible projections of net cost savings.

In addition, pay attention to existing flexibility in managed care, as health plans are already developing their own innovations. For instance, Medicaid managed care organizations have considerable flexibility in the use of their capitation revenues and the systems they employ to compensate providers. Multiple Medicaid managed care plans in various states currently hire or fund CHWs to provide services appropriate for identified members.

Conclusion

CHWs can help address some of the most pressing public health and healthcare needs, including improving service access, quality, and cost. CHWs' skills allow them to bridge the gaps between public health and healthcare by linking clinical and community resources, improving health outcomes, and reducing disparities among racially and ethnically diverse communities, as well as individuals with or at risk for high-cost, complex conditions. CHWs may bring particular value to multi-disciplinary teams by improving cultural competency, patient relationships, and patient communication.

Integrating CHWs into the healthcare system can help improve accountability for population health, as well as make service delivery more effective and efficient. Thoughtfully considering certification options and financing mechanisms, based on a true understanding of CHWs' skills, is a critical first step toward expanding this unique workforce.

Appendix A: Guiding Questions for Discussions on Certification

Assessment of Core Competencies and Requirements

As stakeholders seek to develop a responsive CHW certification system that does not create undue barriers to entry, they should address the following considerations:

___If stakeholders pursue a "grandparenting" approach based on a CHW's experience rather than training, will this option be available permanently (as in Texas) or for a limited introductory period (as in most other states)? Will there be a "look back" period for required experience? If so, how far back will be considered? (Experience suggests that the period should not be open-ended.)

___How will the certification process evaluate an individual's ability to use CHW core competencies?

___How will the process validate the "three C's" of community (connectedness, credibility, and commitment) as a certification qualification? (Experience suggests that this is difficult to specify in policy as a requirement.)

___When assessing work experience, who may serve as a qualified reference to attest to the applicant's proficiency in core competencies?

Provision of Training

Most states regulate the provision of CHW training in some fashion, and stakeholders may consider the following discussion questions on this topic:

___How will you regulate or certify training services? Will you certify training organizations, individual trainers or facilitators, or curricula, or all of the above?

___Will you require that training providers employ current or former CHWs to serve as instructors or co-trainers?

___Will you impose fiscal, management, or legal integrity standards for CHW training organizations?

___Will training organization be required to show prior connection to community and familiarity with CHWs?

___How will you assess the quality of CHW curriculum and program design?

___How will you assess the qualifications, background, and capacities of CHW program faculty and program administrators?

___What methods will you use to evaluate the quality and effectiveness of CHW training programs in operation?

___What accountability (including reporting) will you require from approved training programs?

Administration

The following questions address the design of the administrative structure for a certification program:

___Which entity will serve as the CHW certification issuing authority? Will the state government administer individual certifications, or will a non-governmental body do this?

___What will be CHWs' role(s) and level of authority in CHW certification program ongoing operation or monitoring?

___How will other stakeholders participate in CHW certification? Which stakeholders need to be included on an ongoing basis (e.g., employers, payers, trainers, or other professions)?

___If the state government (particularly the health department) is involved administratively in CHW certification, how will it communicate between operational program units employing CHWs (e.g., Medicaid offices and chronic disease programs) and the unit responsible for certification?

___What resources will be required to actually administer the CHW certification program? Does the certifying body have the capacity to assess individual and training program qualifications?

___What resources will be required to promote and assure participation in CHW continuing education? What will be required to process certification renewals and to remind and encourage CHWs to renew?

___How can the program streamline the application process, balancing the need for quality assurance and accountability with the need to handle applications in a timely manner?

Appendix B: State Self-Assessment Tool for Planning Sustainable Community Health Worker Financing

State Medicaid and State Health Reform Design
The following questions explore current state resources for CHW financing:
___Has your state expanded eligibility for Medicaid under the Affordable Care Act? ___Has your state government pursued and attained a State Innovation Model grant from the Center for Medicare and Medicaid Innovation to design and test state government-led delivery or payment changes in healthcare? If so, does the grant include explicit or implicit opportunity for CHWs? ___What is the current status in your state of any 1115 Waiver proposal to CMS, and are there possibilities to include CHWs? ___To what extent have health systems in your state moved to include alternative payment systems beyond fee-for-service (e.g. bundled, global, or value-based payment)?

Status of CHW Integration into Health Systems
The following questions explore how CHWs already function in your state:
___How widespread is awareness and employment of CHWs among healthcare and public health systems in your state? ___Is there existing research on who and where CHWs are employed, and in what roles?

Level of CHW Program Development
The following question discusses CHW training, credentialing, definition and scope of practice, and core competencies:
___Have authoritative organizations in your state (e.g. the state health department or CHW association) established and promoted a definition, core competencies, training, and possibly credentialing standards for CHWs? (Financing opportunities through healthcare payers and providers can be increased when such standards are in place.)

Features of Stakeholder Networks, Engagement, and Leadership
The following questions discuss stakeholders involved in CHW certification and support, including **the** state health department, CHW associations, and coalitions:
___Who is currently at the table to discuss CHWs? What allies are missing? ___How committed are CHW stakeholders in your state? ___Is there dedicated staff time to support the CHW campaign or promotion? (Depending on the goals and timeline, gathering the information, data, and organizing for such an effort can be time-consuming, and dedicated staff time can enhance efficiency and effectiveness.) ___Is the state health department actively promoting CHWs as a workforce, and their financing options in particular?

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[1] American Public Health Association (APHA). "Community Health Workers." Available at https://www.apha.org/apha-communities/member-sections/community-health-workers. Accessed 10-27-16.

[2] CHW Core Consensus (C3) Project. Available at: http://www.chrllc.net/id12.html. Accessed 10-24-2016.

[3] CHW Core Consensus (C3) Project. "Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field." Available at: http://c3report.chwsurvey.com. Accessed 10-24-2016.

[4] Rosenthal EL, Brownstein JN, Rush CH, et al. "Community Health Workers, Part of the Solution." *Health Affairs*, July 2010. [PLEASE ADD LINK TO THIS ARTICLE ONLINE, ALSO.]

[5] APHA. "Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities." Available at: http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities. Accessed 10-24-2016.