August 25, 2016

The Arizona Public Health Association (AzPHA) supports the adoption of the following APHA Policy Statement 201414 - Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing and its action step requirements.

Policy Statement: 201414

Abstract
Community health workers (CHWs) are frontline public health professionals who are known by many job titles, but they share the characteristics of being trusted and culturally responsive within the communities they serve. CHWs are included in the Patient Protection and Affordable Care Act as health professionals who serve as members of health care teams, and a recent change to Medicaid rules allows for the possibility of reimbursement for preventive services offered by CHWs. These developments may prompt further movement toward developing training and credentialing standards for the CHW workforce. Numerous stakeholders may be interested in addressing these issues, but there is significant evidence that CHWs are both capable of and best suited for leading collaborative efforts to determine their scope of practice, developing standards for training, and advocating for policies regarding credentialing. As individual states make decisions about whether and how to regulate the CHW workforce, policies are needed to support CHW leadership in determining, in collaboration with other public health colleagues, whether standards for training and credentialing are appropriate and what these standards should be.

Relationship to Existing APHA Policy Statements
In 2009, APHA adopted Policy Statement 20091, Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities. The policy addressed numerous issues related to the community health worker (CHW) workforce. Importantly, the statement included a definition of CHWs developed within the APHA Community Health Workers Section, with national representation of CHWs and their advocates. The definition is as follows:

“Community Health Workers (CHWs) are frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build 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.”

Policy Statement 20091 encouraged employers and academic institutions to support initial and continuing education for CHWs. However, the policy did not specifically address the issue of CHWs' participation in determining standards for CHW training and credentialing. This statement complements and supplements Policy Statement 20091 by providing recommendations regarding CHW involvement in the development and oversight of training and credentialing standards. This resolution does not replace any existing policies.

Problem Statement

"Community health worker" is an umbrella term for dozens of paid and volunteer job titles that constitute a vital part of the public health workforce.[1] Some examples of commonly used job titles are community health representatives, health outreach workers, lay health workers, community health advisors, peer health educators, and promotores.[1] CHWs' defining feature is their trusted relationships with the communities they serve.[2] Their roles include, but are not limited to, health coaching, connecting underserved communities to health and human service systems, advocating for individual and community needs, providing social support, increasing the cultural competence of service delivery, service coordination,[1] and participating in research.[3]

Since the advent of CHW programs in the United States in the 1950s,[4] the field has evolved in a piecemeal fashion, with CHW initiatives waxing and waning depending on community needs and on funding streams from local, state, federal, and private sources.[5] CHWs have worked on a variety of programs in numerous settings, and they have filled a wide range of roles.[1] Nonetheless, there is evidence that the workforce is becoming more professionalized. Recent research demonstrates that activities of CHWs in the United States have become more standardized over time, and experts have argued for conceptualizing CHWs as a workforce.[6] CHWs have organized themselves into professional groups in at least 20 states and the District of Columbia.[7] In 2009, the United States Department of Labor (DOL) recognized CHWs as a distinct occupation by creating a standard occupational classification for the field,[8] and in 2010 DOL added CHWs to its list of apprenticeable occupations.[9] The Patient Protection and Affordable Care Act specifically lists CHWs as health professionals who function as members of health care teams.[10] Another key development for the workforce is a 2013 change to federal Medicaid rules that opened the door for potential reimbursement for preventive services offered by CHWs.[11] This rule change may spur the hiring of new CHWs, and DOL estimates that there will be a 25% increase in demand for these workers by 2022.[12]

Increased demand for CHW services raises the issue of how to ensure that members of the paid workforce are adequately prepared. The Centers for Medicare and Medicaid Services and other federal agencies, along with state and local governments, academic institutions, CHWs, or other stakeholders, may seek to standardize training for CHW practices or advocate for the requirement of CHW credentialing. Such decisions require

careful consideration for several reasons. For example, the CHW role requires a fundamentally different skill set than other health professions. Training for other health professions focuses primarily on development of advanced clinical skills and knowledge. Preparing CHWs, in contrast, requires first carefully selecting people with essential qualities that employers seek (e.g., community trust and shared life experiences) and then offering them training in various nonclinical skills through widely recommended popular education techniques.[13,14] In addition, CHWs work in a variety of settings. Training must be appropriate for those who function as members of health care teams as well as those who work in a myriad of other community-based settings.

Practices regarding CHW training and credentialing vary widely throughout the United States.[15] As with the licensing of clinical professions, governmental recognition of standards for the CHW workforce has been established on a state-by-state basis. In some areas, CHWs may receive informal, on-the-job training, while in other places CHW courses are offered by community colleges, area health education centers, proprietary training institutions, or community-based agencies.[15] Only a few states require CHWs to attend a state-certified training program, and CHWs receive an associated credential upon successful program completion.[16–19] As of July 2014, only Texas and Ohio had adopted statewide certification for CHWs, but CHW policy initiatives were under way in other states. State legislation calling for the development of state standards for CHWs has been passed in Illinois,[20] Maryland,[21] Massachusetts,[22] New Mexico,[23] and Oregon.[24]

The establishment of education and credentialing programs for CHWs also requires responsiveness to the circumstances of individuals who are best suited for this work. While the commonality in background between CHWs and the communities they serve is essential to their effectiveness, this also means that education and credentialing programs must avoid creating barriers to entry related to financial resources, educational attainment, language preference/proficiency, race/ethnicity, culture, or immigration status.

Therefore, it is vital that the estimated 120,000 CHWs in the United States[1] lead discussions about how and whether CHW workforce standards should be developed, as they and future CHWs will be affected by these decisions. CHWs have special insight into the training and professional development needs of the workforce. Furthermore, as the CHW field becomes increasingly recognized as a profession, self-determination of training standards is a logical next step, consistent with theory on emergence of professions[25] and current practices in other health professions.[26] Given that many stakeholders may be interested in setting CHW workforce standards, policies are necessary to ensure that CHWs lead the development of such standards when and if they are created.

Evidence-Based Strategies to Address the Problem

There is strong evidence that CHWs are well suited to lead conversations about workforce definitions and standards. CHWs have contributed to developing culturally appropriate training protocols at the community level.[27–33] A CHW-led national initiative funded by the US Department of Education made recommendations for establishing CHW capacity-building programs at community colleges. However, this initiative stopped short of recommending any specific curriculum, advocating instead that such issues be resolved at the state and local levels with the leadership and participation of CHWs.[34] While other occupational groups such as medical interpreters[35] and health educators[36] have chosen to create professional standards and credentialing at a national level, the breadth of CHWs' scope of practice and the many local variations in titles and job duties suggest that a state-level CHW workforce may be more appropriate.

CHWs have also organized themselves to make recommendations (and, in some cases, pass laws) regarding workforce standards in their respective states according to local needs. In New York, for example, CHWs conducted research that established a professional scope of practice and provided guidance for CHW training content and methodology.[37] Ultimately, as a result of considerations related to potential effects on the local CHW workforce, they opted not to require or offer a credential.[13,37] In Minnesota, CHWs participated in developing a CHW certificate curriculum that is offered for credit in community colleges.[38] CHWs in Massachusetts drafted a bill and were successful in advocacy efforts to pass legislation on voluntary CHW certification.[22,39] This legislation created a CHW board of certification that is required to include, among its 11 members, "no fewer than four community health workers selected from recommendations offered by the Massachusetts Association of Community Health Workers."[22] A recently enacted law in New Mexico requires that three of the nine members of the state's newly created Board of Certification of Community Health Workers be CHWs.[23] Similarly, legislation in Oregon established a commission to recommend CHW education and training requirements and mandated that at least 50% of members be traditional health workers, including CHWs.[24] In addition, CHWs in Michigan are developing an optional credentialing process,[40] as are CHWs in several other states. Texas requires CHW representation on the statewide advisory committee related to CHW training and certification.[41] CHWs in other states have recommended that CHWs participate in any board that develops policies regarding certification.[16,17,34]

It is common practice for workforce standards for a given occupation to be overseen by boards composed primarily of members of that profession. Among 60 boards of nursing in the United States, more than 90% report that at least half of their members are from the nursing profession.[42] Similarly, in more than 90% of the 70 medical boards in the United States and its territories, physicians account for more than half of the members.[43] Social workers make up the majority of the membership of the Association of Social Work Boards, which oversees upwards of 60 US and Canadian

regulatory bodies for the profession.[44]

Opposing Arguments

Some may argue that policies regarding CHW participation in the development of workforce standards are not necessary. However, in at least one state, Ohio, CHW standards are already determined by the state board of nursing rather than CHWs themselves.[19] This situation could be replicated in other states, particularly those in which CHWs are not yet organized into professional groups. In addition, CHWs are generally members of underserved and underrepresented groups.[1] Without codification of their participation, members of this workforce could face cultural, linguistic, and other barriers that would limit their ability to participate in conversations about their own workforce standards.

In addition, CHWs' participation in workforce decisions could address some of the larger issues that have caused opposition to formalized training and credentialing. For example, some experts have noted concern that participation in required courses or credentialing could create barriers to workforce entry or cause CHWs to lose their trusted status among the communities they serve.[45] People who do not identify themselves as CHWs, even if they fill similar roles, may resist being considered part of the workforce and potentially being subject to training and credentialing requirements.[46] These challenges can be overcome if CHWs of various backgrounds participate in discussions about whether formalized training and credentialing are appropriate and for whom. When such programs are deemed to be fitting, CHW input could help develop guidelines to ensure that incumbent workers receive recognition for prior learning and practice-based experience. CHWs can also advise on training and credentialing costs, continuing education, cultural appropriateness, and linguistic accessibility among CHWs with limited English proficiency.

Finally, it is important to note that CHW leadership in addressing issues related to training and credentialing does not preclude equitable collaboration with outside entities or experts who may contribute a wealth of knowledge on relevant topics such as health service delivery models, public health competencies, training curriculum development, and public health policy. Previous collaborations among CHWs, researchers, government agencies, and other stakeholders demonstrate that such groups can create effective CHW capacity-building programs[28–33] and generate policy change regarding credentialing.[37]

Action Steps

Therefore, APHA:

- Encourages local and state CHW professional associations to organize CHWs in developing a consensus about the desirability of training standards and credentialing, including decisions about the most appropriate organizational location for the administration of a credentialing program, if established.

- Calls on local and state CHW professional groups to consider creating policies regarding CHW training standards and credentialing, if appropriate for local conditions, in collaboration with CHW advocates and other stakeholders.
- Urges state governments and other entities considering creating policies regarding CHW training standards and credentialing to engage in collaborative CHW-led efforts with local CHWs and/or CHW professional groups. If CHWs and other entities partner in pursuing policy development on these topics, a working group composed of at least 50% self-identified CHWs should be established.
- Encourages state governments and any other entities drafting new policies regarding CHW training standards and credentialing to include in the policies the creation of a governing board in which at least half of the members are CHWs. This board should, to the extent possible, minimize barriers to participation and ensure a representation of CHWs that is diverse in terms of language preference, disability status, volunteer versus paid status, source of training, and CHW roles.

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