Workgroup on Workforce Development for Community Health Workers

HB 856 (2014)/Ch 259 – MSAR #10157
SB 592 (2014)/Ch 181 – MSAR #10135

Final Report to the Maryland General Assembly

by the

Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration

June 2015

Larry Hogan, Governor

Boyd K. Rutherford, Lieutenant Governor

Van T. Mitchell, Secretary, Maryland Department of Health and Mental Hygiene

Al Redmer, Jr., Commissioner, Maryland Insurance Administration

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HISTORY AND BACKGROUND

In response to House Bill 856/Senate Bill 592, Chapters 259 and 181 of the Acts of 2014, the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA) established the Workgroup on Workforce Development for Community Health Workers (Workgroup) to study and make recommendations regarding workforce development for community health workers (CHWs) in Maryland.

CHWs—also known as community health advocates, lay health educators, community health representatives, peer health promoters, community health outreach workers, and in Spanish, promotores de salud—are community members who work in community settings as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care.

The Workgroup was specifically tasked to make recommendations regarding:
1) Training and credentialing required for CHWs to be certified as non-clinical health care providers; and
2) Reimbursement and payment policies for CHWs through the Maryland Medicaid Assistance Program and private insurers.

The Workgroup was required to report its findings and recommendations to the Senate Education, Health and Environmental Affairs Committee, the Senate Finance Committee, and the House Health and Government Operations Committee by June 1, 2015.

The Workgroup carried out this review with a careful sensitivity to the contribution that CHWs can make to the whole health system. Ultimately, it is this demonstration of value that will justify workforce development for CHWs and allow them to benefit from sustainable funding streams. A Consumer Health Foundation discussion paper makes exactly this point, that "CHWs must successfully define their work in the context of the value it brings to communities and to the health care system…To expand the field, CHWs must be able to explain how their model offers additional value," (Erb, 2012).

WORKGROUP SELECTION AND MEMBERSHIP

A call for applications was held to solicit applications from the public to participate in the workgroup. Applicants were asked to submit resumes and other pertinent information via an online form. A panel of state officials then selected the members based on a set of evaluation criteria. Efforts were made to select members representing a wide range of backgrounds and perspectives on the CHW profession.

The workgroup was comprised of practicing CHWs and professionals with knowledge and experience of the provision of CHW services who supervise, coordinate, or work with CHWs in clinical and non-clinical settings. Local health departments, community colleges that have CHW training programs, 4 year colleges and universities, minority health, public health, hospitals that provide CHW training, nurses, physicians, social services and housing, and urban and rural jurisdictions were all represented. The membership and meeting schedule of the Workgroup are listed in Appendices 1 and 2.

OVERVIEW OF THE PROFESSION

The CHW is an occupation with a long history going back at least fifty years, forming a critical component of health systems, especially where highly trained physicians and nurses are in short supply. Their value to U.S. healthcare has been recognized more slowly, but they are increasingly being seen as an important resource for combating health disparities by promoting and supporting healthy behaviors in underserved communities (Institute of Medicine, 2002, and sections 5313, 10501(c) of the ACA, 2010a). Official Department of Labor figures estimate that there are 45,800 CHWs working in the U.S. in 2013 (Bureau of Labor Statistics, 2014), which is almost certainly a considerable underestimate when compared to data derived from surveys of CHW programs (e.g. HRSA, 2007).

CHWs are known by a variety of names, including 'community health advisors', 'outreach workers', 'lay health advisors', and 'promotoras/promotores', but regardless of the job title there is an overlapping commonality of role, activity and function as "workers who promote health or nutrition within the community in which an individual resides (Affordable Care Act, quoted in Brownstein, et al., 2011)." CHWs cannot work in isolation. They operate by building connections with community, state, and charitable resources which complement health interventions, but also in many cases by building strong connections with healthcare systems to accomplish direct health goals for the patient. In some models CHWs are lay members of communities where people live, work, or pray, building community capital and self-confidence in community members; other models place CHWs as core members of the healthcare delivery team, breaking down cultural and linguistic barriers between health teams and members of the community and providing practical support in engaging with health and community resources. There is no universal 'best' model for CHWs; the different approaches are not mutually exclusive and programs may select from and amalgamate between them.

Currently, CHW programs focus on particular populations, types of diseases, or health issues often in communities that experience health disparities. For example, programs may work with individuals with a chronic illness such as diabetes, cancer, or HIV, or a high risk group such as African Americans and teenage Latina pregnant women. CHWs can also target high utilizers of health services, chronically ill and at risk of becoming a high utilizer, chronically ill but under control, and healthy (aiming for prevention), depending on the design and purpose of the program.

When the target group is a minority population, CHWs' language skills, cultural awareness and/or trust from community members enable them to reach out to people who have previously been substantially or completely isolated from health services. When the target group is a vulnerable population whose self-efficacy and self-management is challenged through low health literacy, low socio-economic status, language barriers, limited education, migrant or immigration status, homelessness, urban or rural issues, race/ethnicity, disability, or cognitive impairment, the CHW provides the support necessary in order to access health services and/or self-manage the patient's health care.

COMMUNITY HEALTH WORKERS IN MARYLAND

Maryland already has many CHW programs in place with an estimated 1430 CHWs working in the state in 2013 in a wide variety of programs from community-based to hospital-based to primary care team-based (Dept. of Labor). CHW programs in Maryland are already making an important contribution to the healthcare of underserved populations. They provide an invaluable platform of experience and expertise from which to move forward. It is critical to build on Maryland's valuable experience of CHW programming so that organizations already engaged in CHW training and delivery will continue to

develop and implement their programs. These organizations include the Health Enterprise Zones (HEZ) grantees, universities/community colleges, Area Health Education Centers (AHECs), Minority Outreach and Technical Assistance (MOTA) grantees, and some Local Health Departments. However, to date, there has been a lack of standardization for training requirements, curricula, and other professional requirements across various programs in the state.

The use of CHWs in Maryland is likely to increase in the coming years as the state's health system continues to transform. As part of the new All-Payer Hospital Model, Maryland hospitals are being financed via global budgets that establish a strong financial incentive to reduce utilization and improve population health. Hospitals are investing new resources into care management and prevention activities in order to meet their financial tests under the new model, and many of these approaches utilize CHWs. Moreover, delivery models such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs) are already widespread, and their proliferation will continue as other parts of the delivery system transform to align with the All-Payer Model. These models also incentivize prevention and team-based care that may include CHWs. This transformation comes ahead of Phase 2 of the All-Payer Hospital Model, which establishes a total cost of care test for all health care delivery settings – not just acute care. With these changes, for the first time, the basic financial incentives in health care delivery are aligned with population health improvement and, in turn, the roles and capacities of CHWs.

With their roots in community development, CHWs have the potential to assist the transformation of our fragmented health care system towards a more holistic type of care, centered on the total needs of the individual patient and embedded in the community and culture in which the patient lives. CHWs can support individual and population health because, as culturally competent mediators between health providers and the members of diverse communities, they are uniquely well placed for promoting the use of primary and follow-up care for preventing and managing disease (Brownstein et al., 2011b).

STATUS OF CHWS IN OTHER STATES AND BARRIERS TO PROGRESS

The potential of the CHW concept cannot be realized unless payers and purchasers of health care recognize their value and potential contribution for improving health care quality and outcomes. Any organization asked to commit funding for CHWs will expect clear articulation of what it is that CHWs do and what standards their practice can be expected to meet. Lack of standardization is therefore a barrier to progress on workforce development for CHWs.

States have typically addressed standardization through the introduction of a CHW definition and required qualifications (Massachusetts, Minnesota, Ohio and Texas), and/or state-level certification programs (Massachusetts, New Mexico, Ohio and Texas). State standards have also been developed for the training of CHWs (North Carolina and Nevada)(HRSA, 2011). Some states have defined a CHW scope of practice (e.g. Minnesota), and some require that CHWs be supervised by a state-regulated professional (e.g. Alaska, Ohio) (HRSA, 2007). Two states (Massachusetts and New Mexico) have legislated to establish CHW Boards of Certification, while Ohio uses its Board of Nursing to certify CHWs and other states delegate certification to training programs.

Variation in state approaches to legislation has resulted in important differences between states as to who certification is required for, what kind of governance is needed (including who advises the state on CHW policies), whether there is a defined scope of practice for CHWs, and the extent and location of training. As well as varying in their credentialing processes, states vary in the standards they require,

with some more stringent than others. States have argued that higher training and education standards not only contribute to higher quality of practice but also lead to improved recruitment and retention through increased status and satisfaction for the CHW workforce (Kash, et al, 2007).

States that have not introduced formal certification have generally not pursued a standard curriculum for CHWs, with the result that CHW training in those states is largely delivered 'on-the-job' rather than in separate training programs. A survey of CHW training in 17 states found that states with strong community college training programs, like Massachusetts, Arizona, California and Virginia, saw training and education as opening a pathway to higher career goals for CHWs; other states, like Oregon, Mississippi and West Virginia, utilized CHWs as members of care coordination and outreach teams, with training typically on-the-job and tailored to the needs of each community served (Kash, et al, 2007).

In addition, some states such as Ohio have explicitly recognized the need for training of CHW supervisors. However, the particular route chosen to navigate through CHW training and credentialing has profound implications for the character of the CHW workforce. On the one hand, some CHWs who live in the community, are trained on-the-job for the specific program for which they are recruited, are paid little (if at all), and operate as part of independent community-based programs which are accountable only to their grant funders; on the other hand, other CHWs who have been awarded certification after an arduous college course and practicum, function as integrated members of health teams which are reimbursed for their work, and are ascending a CHW career ladder which demands continuing education but offers increasing status and remuneration. Standards that are too high or too inflexible risk excluding many of those with strong credentials as traditional 'community connectors' -- but who lack strong educational credentials - from serving as CHWs (CHW-NEC, 2008). Based on an examination of state approaches to CHW development, the critical areas of decision-making and development identified and needing further exploration were identified by the Workgroup as:

1. Development of statewide scope of practice, core competencies, and curriculum for CHWs.
2. Decisions about who/m certification will be required for (all CHWs in the state or only those operating in teams where reimbursement is agreed).
3. Decisions about educational prerequisites for entry into certification training, including how experience may substitute for education.
4. Development of educational training opportunities for delivery of the curriculum.
5. Development of oversight mechanisms for certification.
6. Decisions about the supervision and oversight of CHWs.
7. Decisions about how the developing infrastructure will be resourced.
8. Decisions about best to provide for a CHW career ladder, and in particular whether this is to be built into the structure of the curriculum (as in tiers of optional competencies to supplement the core competencies) or the structure of the health delivery system (as in tiers of job levels).

THE WORKGROUP PROCESS

The Workgroup worked towards a common understanding of the impact of different recommendations on existing CHW programs and on the capabilities of a future Maryland CHW workforce. Through structured, inclusive discussions with varied viewpoints, the Workgroup embraced the Maryland-wide expertise available by virtue of its membership which encompasses a variety of jurisdictions. The Workgroup successfully functioned as a collective learning community that built on shared inquiry and dialogue, was open to new ideas, and sought out the viewpoints of CHWs in the community. One of the main tasks of the Workgroup was to review and discuss well-established training and certification

models from several states, in particular Massachusetts, Michigan, Minnesota, New Mexico, New York, Ohio, South Carolina, and Texas.

At its first meeting, the Workgroup received presentations on the history and current state of CHW workforce development, nationally and in other states, details of which can be found on the CHW website. The majority of the discussion was around the critical issues of the definition of a CHW, what roles a CHW should undertake, and what competencies will be required in order to ensure CHWs are trained to practice to a satisfactory standard.

Work on the definition of a CHW began in meeting two, based on definitions from the American Public Health Association (APHA), the Bureau of Labor, the Affordable Care Act, HRSA and the states of Massachusetts, Minnesota, Texas and Oregon (New Mexico and Michigan use the APHA definition). Discussion in breakout groups was followed by plenary feedback. Differences of opinion were noted and further feedback was sought through a survey of members between meetings and through further comment during meetings three and four. Final agreement was reached at the fifth meeting to use the American Public Health Association (APHA) definition with a minor modification.

CHW roles were initially approached in a similar way, with breakout groups in meetings two, three, and four to discuss roles published by APHA, the Affordable Care Act, Massachusetts and Oregon as the starting point for discussion, leading to nine roles being identified. The Workgroup requested further discussion in the large group which led to considerable revision of detail and the addition of a tenth role. As with the definition, final agreement on roles was reached at the fifth meeting of the Workgroup.

CHW core competencies were also discussed in small and large groups in meetings 2, 3, and 4. Additionally, meeting five incorporated a panel discussion comprised of Workgroup members on the key training processes required for certification, including curriculum requirements and the number of classroom hours needed to deliver the curriculum adequately. The panel discussion led to debate about the core competencies that should be included in a Maryland CHW curriculum. A crosswalk of competencies (the most important competencies as determined by the CDC) from seven other states (Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina and Texas) shared with the Workgroup by state officials demonstrated that other states do not differ greatly in the competencies they use. This crosswalk is presented in Appendix 4.

Roles as they relate to competencies, with the goal of making sure that each role relates to at least one competency that would be required of Maryland CHWs were discussed. Many of the apparent differences in competencies between states are largely the result of changes in ordering or in the way roles are grouped together to form individual competencies. As part of the competency discussion, CHW programs in Maryland were asked to submit curricula in use for CHW training. This exercise showed that Maryland's existing programs align well with the competencies in use in other states. There was also a presentation on curriculum comparisons by state: whether certification is required, what is the education prerequisite, and training requirements (South Carolina, Michigan, Massachusetts, Texas, Ohio, New York, and Minnesota).

In meeting six, the list of Maryland competencies was reviewed and there was a discussion about which competencies were added as a reflection of discussion at the last meeting. There was also a presentation on CHW Competency Curriculum/Course Content Crosswalk. The presentation compared the competencies and number of hours as required by South Carolina, Michigan, Massachusetts, Texas, Ohio, New York and Minnesota. Lastly, there was a discussion around the landscape of where Maryland

programs are in relation to the competencies that the Workgroup has selected. Specific programs reviewed include: Project Heal, the Eastern Shore Area Health Education Center, Western Maryland Area Health Education Center, Institute for Public Health Innovation, Healthy Start Baltimore, Sisters Together and Reaching, Inc., and Prince Georges' Health Enterprise Zone. This crosswalk is presented in Appendix 4.

During meeting seven, there was a discussion about CHW training, grandfathering, and certification requirements. There was a crosswalk presentation on these requirements, comparing South Carolina, Massachusetts, Texas, Ohio, New York, Minnesota and New Mexico. This crosswalk is presented in Appendix 5. It was noted that the average number of training hours in existing Maryland programs is somewhat less than other states. The workgroup came to an agreement on several matters: Maryland needs to offer certification for CHWs; certification should be of programs, not individuals, therefore those completing a certified training program would be eligible to be certified as CHWs; and a combination of hours and competencies would be required for grandfathering eligibility (80 hours of training and 4,000 hours of work experience). In the discussion of a certification body, a majority of Workgroup members felt that this body should not be the Board of Nursing, although this point was not put to a vote. Workgroup members also presented a proposed alternative set of competencies and roles, presented in Appendix 6. These were discussed but a vote on approving them was not held.

At the eighth and final meeting, DHMH staff led a review and summarized the recommendations. Following this, the Workgroup was asked to vote on how to describe these recommendations in the final report. Lastly, comments were facilitated from public attendees.

A draft of this report was released for public comment on April 30, 2015. The draft report was sent to a mailing list of CHW stakeholders and posted to the CHW Workgroup page on the DHMH website. A version of the report translated into Spanish was also released via email and the website on May 12, 2015. The public was given until May 22, 2015 to provide written comment via email to DHMH. A total of 8 comments were received before the deadline, and they were considered in developing the final version of this report. Appendix 7 summarizes and provides responses from DHMH to the comments received.

FINAL RECOMMENDATIONS

The Workgroup reached agreement on final recommendations in key areas necessary for a certification process for Maryland. These final recommendations were voted for by the majority of Workgroup members as they are most likely to ensure seamless, continuous, and patient-centered care. These recommendations will allow patients' needs to be considered first and foremost, CHWs will be readily accessible, and comprehensive and coordinated care will be provided. See Appendix 6 for CHW roles and core competencies developed by two workgroup members as an alternative, though not formally approved, to those recommended by the workgroup as a whole.

CHW Definition
A Community Health Worker (CHW) is defined as 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 cultural competence of service delivery. 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.

Roles
1. Serving as a liaison between communities, individuals and coordinated health care organizations.
2. Provide evidence based health guidance and social assistance to community residents.
3. Enhancing community residents' ability to effectively communicate with health care providers.
4. Providing culturally and linguistically appropriate health education.
5. Advocating for individual and community health equity.
6. Providing care, support, follow-up, and education in community settings such as homes and neighborhoods.
7. Identifying and addressing issues that create barriers to care for specific individuals.
8. Providing referral and follow-up services or otherwise coordination of human services options.
9. Proactively identifying and referring individuals in federal, state, private or non-profit health and human services programs.
10. Integrating with patient's care team to support progress in care plan and overall patient wellness.

Core Competencies
1. Effective oral and written communication skills
2. Cultural competency
3. Knowledge of local resources and system navigation
4. Advocacy and community capacity building skills
5. Care coordination skills
6. Teaching skills to promote healthy behavior change
7. Outreach methods and strategies
8. Ability to bridge needs and identify resources
9. Understanding of public health concepts and health literacy
10. Understanding of ethics and confidentiality issues
11. Ability to use and understand health information technology

Certification
The Workgroup recommends that certification be considered to meet future professional validation and that certification should have two tiers. CHWs may be trained via tier I, termed "pre-certified Community Health Worker," which should be made up of 80 hours of training curriculum and will lay the framework for providing CHW services in the community, may be paid or unpaid, and may lead to tier II training. Tier II (Certified Community Health Worker) will be rendered via a 160 training curriculum that can be a flexible combination of classroom and practicum (experience).

Oversight Body
The Workgroup recommends that an oversight body be created to provide input to the legislature and oversee CHWs. Membership of the oversight body should be made up of at least 50 percent CHWs. The oversight body should house a certification board that would approve the CHW curriculum and CHW training programs.

Grandfathering

Grandfathering should be permitted for individuals with 80 hours of training and 4,000 hours of CHW experience, which must have been accumulated prior to the establishment of the certification program. The experience be recent (within 2-4 years), and the grandfathered CHW must meet current competency standards. The opportunity for grandfathering should end two years after the establishment of a state certification program.

Reimbursement

The law asked for consideration of reimbursement for CHWs. After discussion, the workgroup determined that it would be premature to issue recommendations related to reimbursement at this time. The recommendations above are key to establishing the value of CHWs and a framework for the profession, which can then be used to advocate for reimbursement at a later date. Instead, the workgroup discussed the importance of considering and promoting multiple sources of payment for CHWs in the future, not just reimbursement by public and private payers. This should include promoting direct hiring of and/or contractual payment to CHWs by providers operating in risk-based payment structures, such as hospitals under the All-Payer Model, ACOs, and PCMHs. The workgroup recommended that a group of CHW stakeholders continue to discuss and develop more detailed guidelines and/or recommendations for reimbursement from multiple public and private payment sources.

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APPENDIX 1: WORKGROUP MEMBERS

Following an open call for membership in July 2014, the following representatives were selected to serve on the Workgroup:

Deborah Agus	Mar-Lynn Mickens
Pamela Bohrer Brown	Dwyan Y. Monroe
Kim Burton	Sonia Mora
Perry Chan	Dr. Bettye Muwwakkil
Elizabeth Chung	Ruth Ann Norton
Dr. Kimberly M. Coleman	Rosalie Pack
Jennifer Dahl	Marcos Pesquera
Shirley Devaris	Maxine Reed-Vance
Ashyrra C. Dotson	Tricia Roddy
Wendy Friar	Michael Rogers
Dr. Chris Gibbons	Dr. Maura Rossman
Rev. Debra Hickman	Kate Scott
Dr. Cheryl L. Holt	Laura Spada
Ann Horton	Dr. Yvette Snowden
Terri Hughes	Novella Tascoe
Dr. Michelle LaRue	Dr. Richard K. Tharp
Beth Little-Terry	Lesley Wallace
Ruth Lucas	Lori Werrell
Susan L. Markley	Lisa Widmaier
Dr. Pat McLaine	Joe Winn

APPENDIX 2: MEETING SCHEDULE

The Workgroup met on eight occasions in 2014 and 2015 on the dates and at the venues below.
- Meeting 1: September 22, 2014, DHMH
- Meeting 2: October 6, 2014, DHMH
- Meeting 3: October 20, 2014, DHMH
- Meeting 4: November 14, 2014, DHMH
- Meeting 5: December 1, 2014, Maryland Department of Transportation
- Meeting 6: December 15, 2014,Maryland Hospital Association
- Meeting 7: February 23, 2015, Maryland Hospital Association
- Meeting 8: March 23, 2015, Maryland Hospital Association

The first four meetings were led by external facilitators from The Grant Group; the remaining four were facilitated by DHMH staff and led by Deputy Secretary of Public Health Services, Dr. Laura Herrera Scott. All meetings were recorded. Minutes were posted on the HSIA DHMH website (CHW tab) after formal review and approval by the workgroup.

Attendance and Public Comment
The average workgroup member attendance at meetings was 28 out of a full complement of 40 members (35, 32, 30, 27, 31 23, 27, and 20 attended the meetings, respectively).

The average number of public attendees who signed in was 10 for a total of 80 sign-ins altogether, with a maximum sign-in of 18 at the first meeting and with 10, 14, 7, 9, 13, 4, and 5 attending the subsequent meetings). Note: Some public attendees did not sign in, and others signed in at more than one meeting.

Opportunity for public comment was provided at meetings 4, 5, 6, 7, and 8. Appendix 3 summarizes public comment received.

Further Information
For meeting minutes and further information about the workgroup meetings and membership, please visit the CHW Workgroup web page:
http://hsia.dhmh.maryland.gov/SitePages/CHW%20ADVISORY%20WORKGROUP.aspx.

APPENDIX 3: PUBLIC COMMENT RECEIVED

Meeting 4: November 14ᵗʰ 2014

Leslie Demus, Community Health Worker
- Concerned regarding the ratio of CHWs to total number of the CHW Workgroup, as well as the smaller proportion of men on the Workgroup.
- Decisions are going to be made as they relate to the population of the workforce. Definition is very important, certain wording needs to be categorized or enlightened, especially as you are speaking about community as related to CHWs.
- CHWs need to have a clear understanding of the community they serve.
- Leslie initially began as a non-clinical CHW – with additional training (housing, case management, phlebotomy). Further training, counseling and specifics may be dependent on the agency that the CHW works for.
- In structuring the core competencies, you especially want to pay attention to the fact that the CHW has an unusual and very close understanding of the community that they serve – and also that outreach, community education, social support advocacy and informal counseling is part of the work so you don't want to be too technical.

Terrie O. Dashiell, LifeBridge Health
- It is important to discuss the different settings in which CHWs practice. It is critical to not only train the CHWs but also the people that they will be working with, i.e. clinicians. All parties should have a mutual and clear understanding of what impact the CHW will have on the care of a patient and what their role on the care team is going to be. Once trained, practitioners that are not accustomed to working with CHWs will realize the importance of the CHW role, and therefore respect and appreciate them as a member of the care team.

Marsha Green, LifeBridge Health
- Proudly represents CHWs and has been carrying out this work for about 15 years – before the term CHW was "coined." Began career as an outreach worker for the HIV/AIDS community with HIV pregnant women.
- CHWs are public health workers who are trusted members and/or have an unusually close understanding of the community they serve The CHW has a real stake in defining who the community is by increasing the health knowledge and self-sufficiency of members through a range of activities
- CHWs demand respect for who they are and the work that is done.
- The CHW definition is too narrow. CHWs have various titles including but not limited to outreach workers, case managers, etc. We should not use the word "adhere" in the definition because ultimately we don't want to just help the patient adhere to long term engagement, we want to help our patient and community gain independence. We want to give them the strength and the power to take of their own health, thus empowering them to become advocates for their own health.

Robyn Elliot, Maryland Nurses Association
- Some persons represent themselves, other persons represent organizations.
- Materials sent out further in advance will provide time for discussion with the organizations that they represent so that representatives can bring back organized responses.

Meeting 5, December 1ˢᵗ 2014

Adrienne Ellis, Mental Health Association of Maryland
- Works with consumers who are trying to get insurance cover mental health services.
- Consider talking to private payers to find out how they will consider reimbursing for CHWs.
- State's certification must allow for reimbursement.

Katy Battani, Maryland Dental Action Coalition
> Mission of the Maryland Dental Action Coalition is to increase access to dental care. Oral health training should be considered for CHWs as tooth decay is still the number one chronic condition for children in the U.S. It is important for CHWs to create linkages tto services, teach oral health and prevention, etc.

Robyn Elliot, Public Policy Partners, representing Maryland Dental Action Coalition DHMH
- Oral health coverage is part of the essential health benefits package for children, but not for adults. Most MCOs do offer some kind of coverage for Medicaid population.

Meeting 6, December 15ᵗʰ 2014

Robyn Elliott, representing Maryland Nurses Association
- Mentioned that many of the disease specific educational components are already built into the CNA scope of practice.

Patty Archuleta, Parents' Place of Maryland
- Commented that maternal and child health issues should be added as part of competencies.

  NOTE: Dr. Herrera Scott responded that the disease specific components may be optional and/or supplemental. A list of optional topic modules is also possible. These can be based on categorical funding or the priorities of the Local Health Improvement Coalitions, which have done community health needs assessments and are defining the needs of the communities. There is an effort to link hospitals (must identify community needs in order to keep non-profit status) and their initiatives with work that is already being done in the community.

A'lise Williams, Maryland Board of Nursing
- Would like to have flexibility with specific health modules to select ones that may not be identified priorities.

Margie Donohue, Maryland Dental Action Coalition
- Importance of oral health needs to be included into training and health literacy for Marylanders. Lack of oral health resources for adults is a problem in Maryland.

Chris Rogers, Bon Secours
- Stated that paraprofessionals like CHWs are usually a stepping stone to other careers such as social work, nursing, etc.
- If there are competencies that should be included so that CHWs can be effective, we must make sure we are training them for their vital roles.

Shantia Collins, Charles County Department of Health
- Expressed concern about the career path for CHWs i.e., if CHWs get higher level degrees, will their salary just cap out? Will there be no place for CHWs to go?
- Continuing education is important for CHW maintenance.

Meeting 7: February 23rd 2014

Landas Lockett, Charles County Department of Health
- Keep certification simple. CHWs have families, lives, etc. and if we make training too involved and lengthy, we inhibit entry into the field.

Chantia Collins, Charles County Department of Health
- CHWs are trying to get time out in the community, training should be structured so as not to interfere.

Leslie Demus, Community Health Worker
- Feels the group is doing a good job.
- Standards for CHWs are very important, as is ongoing training.

Jerry Wade, Outreach Worker, Charles County Department of Health
- Believes that grandfathering should only be in place for a limited time. At some point in the future, it should no longer exist.

Meeting 8: March 23rd 2014

Marsha Green, LifeBridge Health
- Believes that all CHWs on both tiers will want to be certified and that all CHWs should be certified
- CHWs wear a lot of "hats" such as serving as the voice of the patient/client
- It takes a while to show documentation for grandfathering, so the deadline should reflect this.

Shantia Collins, Charles County Department of Health
- Emphasized that no grandfathering is perfect, but training is continuous and refresher training should be an option
- CHWs wear two "hats," one for the client and one for the organization
- You will gain a variety of experiences depending on the job

Landas Lockett, Charles County Department of Health
- Suggested that we use wording in certification that requires continuing education of a certain number of hours to maintain certification
- Suggested that we distribute final report through MOTAs, hospitals with CHW programs

Jerry Wade, Outreach Worker, Charles County Department of Health
- Feels that certifying body should be made up of at least 50 percent CHWs because they do the work
- CHWs should be overseen by those who have shared experiences
- Need everyone to work as a unit, as communities are active 24/7.

Perry Chan (member of Workgroup)
- Suggested that CEUs should be tailored to function and that many CHWs are part-time, so this should be considered when setting time limit for work hour experience

APPENDIX 4: CORE COMPETENCY CROSSWALK

State Core Competency/ Curriculum Crosswalk

The following table crosswalks similar Community Health Worker competencies from other states:

South Carolina	Michigan	Massachusetts	Texas	Ohio	New York	Minnesota
Effective Communication	Communication Skills and Cultural Competence	Effective Communication Cultural Responsiveness and Mediation	Communication Skills Interpersonal Skills	Communication Skills	Communication and Interpersonal Skills	Communication and Cultural Competence
Outreach Methods and Strategies	Advocacy and Outreach	Outreach Methods and Strategies	Advocacy Skills	Individual and Community Advocacy	Advocacy Skills	Role, Advocacy, and Outreach
	Community and Personal Strategies	Individual and Community Assessment	Org Skills		Org Skills	Organization and Resources: Community and Personal Strategies
Support, Advocate and Coordinate Care for Clients	Coordination, Documentation and Reporting	Care Coordination and System Navigation Documentation	Service Coordination Skills	Service Skills and Responsibility	Service Coordination	Coordination, Documentation and Reporting
Community Capacity Building	Teaching and Capacity Building	Education to Promote Healthy Behavior Change	Teaching Skills Capacity Building Skills	Community Resources	Technical Skills	Teaching and Capacity Building
Health Education for Behavior Change	Health Promotion	Educate to Promote Healthy Behavior Change	Knowledge Base on Specific Health Issues	Health Care Health Education	Informal Counseling	Health Promotion Competencies

Apply Public Health Concepts and Approaches		Use of Public Health Concepts and Approaches				Healthy Lifestyles
Ethics	Legal and Ethical Responsibility	Professional Skills and Conduct				Legal and Ethical Responsibility

Maryland Program Core Competency Crosswalk

Crosswalk of existing programs and their use or incorporation of recommended core competencies:

Training Program	Oral & Written Comm	Cultural Comp	Know Local Resources System Navigation	Advocacy & Comm Capacity Building	Care Coor Skills	Teaching Skills & Promote Healthy Behavior	Outreach Methods & Strategies	Ability to Bridge Needs & Identify Resources	Understand PH Concepts and Health Literacy	Understand Ethics & Confident-iality	Ability to Use and Understand Health Info Tech
Project HEAL	X	X	X	X					X	X	
Eastern Shore AHEC	X	X	X	X	X	X	X	X	X	X	
Western MD AHEC	X	X	X	X	X	X	X	X	X	X	
IPHI	X	X	X	X	X	X	X	X	X	X	X
Healthy Start Baltimore	X	X	X	X	X	X	X	X	X		
Sisters Together & Reaching	X	X	X	X	X	X	X	X	X	X	
Prince George's HEZ	X	X	X	X	X	X	X	X	X	X	

APPENDIX 5: CROSSWALK OF STATE CERTIFICATION, TRAINING, AND GRANDFATHERING RQUIREMENTS

State Certification, Training, and Grandfathering Crosswalk

	South Carolina	Massachusetts (Boston Initiative)	Texas	Ohio	New York	Minnesota	New Mexico
Certification	No decision at this time	Yes	Yes	Yes – To Be Able to Perform Tasks Delegated By a Nurse (Though Not Required to Perform Other CHW Duties)	No; Certification deemed to be possible deterrent to entering field	Yes – To Participate in Medicaid	Yes
Training Requirement	Six week, full time training program includes classroom and in office and/or community	80 hours minimum; Still in process for final determination	100 hours, 60 practicum	Variety of training programs (governed by Board of Nursing)	70 Hours Classroom, 35 Hours practicum; 35 Hours additional for specific disease	17 College Credit; 80 hour Internship	100 Classroom; 100 Experience (Practicum)
Grandfathering (Incumbent)	Served for at least 3 Years	4,000 Hours	At Least 1,000 Cumulative Hours Within The Most Recent 6 Years	Those Hired Before 2005			2,000 Hours of Documented Experience
Continuing Education for Certification		15 Hours Every 2 Years	Yes – Required for Certification Renewal (20 hours every two years)	15 Hours Every 2 Years			
Certification Duration		2 Years	2 Years				2 Years
Certification Test Costs			No cost for initial certification or renewal	$35.85			

Certification of Instructors			Yes	Yes	Minnesota State Universities in Partnership with Stakeholders		
CHW Training and Certification Advisory Committee (Approval of Training Program)		Board of Certification for CHWs	Yes – Advises DSHS and the Texas Health and Human Services Commission (State Health Services Commissioner)				Board of Certification of Community Health Workers
Credentialing		Massachusetts Department of Public Health	Texas Department of State Health Services	Ohio Board of Nursing		State of Minnesota; Medicaid Program, state, universities, and colleges	Secretary of Health

APPENDIX 6: ALTERNATIVE ROLES AND COMPETENCIES

Role #1: Community Mobilization and Outreach:

- Assess community strengths, needs and environment.
- Prepare and disseminate educational materials.
- Increase awareness and encourage action on community health issues.
- Perform home visits and conduct outreach to individuals and groups in community settings.
- Serve as an information source on community needs and perspectives

Role #2: Health Promotion and Coaching:

- Promote health literacy by explaining the process of obtaining care, and educating on wellness and/or disease prevention and management.
- Build motivation and self-confidence of individuals to care for their own health and achieve wellness.
- Provide informal and supportive counseling.
- Supporting individuals with problem solving.
- Organize and/or facilitate support groups.
- Promote harm reduction models and treatment adherence.
- Provide basic health screenings that lay individuals could be trained to perform for themselves.

Role #3: Service System Navigation:

- Educate and provide information on available resources and services.
- Help individuals to access and stay connected to health or social services through education, skills building, and peer support.
- Accompany individuals on health or social service appointments to assist with access and build skills for self-reliance.

Role #4: Care Coordination/Management

- Perform individual strengths/needs assessments.
- Engage family members, friends, caregivers, and social networks.
- Address basic needs and barriers that may be obstacles to engaging in health or social services.
- Coordinate and follow-up on referrals to ensure effective linkage to and retention in care.
- Promote treatment adherence.
- Document all findings and interactions with clients

Core Competencies:

1. **Effective Communication**
   - Be respectful and culturally aware during interactions with clients
   - Speak and write to clients in their preferred language at an appropriate comprehension level *(apply understanding of health literacy concepts)*

- Speak honestly and clearly
- Communicate with individuals in a non-judgmental and appropriate manner
- Practice active and reflexive listening and attend to client concerns
- Identify and respond to non-verbal behavior
- Ask open-ended questions to solicit client information and give positive reinforcement
- Utilize affirming statements to provide positive reinforcement
- Use written and visual materials that convey information clearly and accurately
- Speak and present information effectively to small and large groups of clients and/or colleagues
- Assist clients in understanding technical/medical/legal processes, documents and information
- Report relevant information to others succinctly, accurately and in appropriate format
- Document information in an effective, efficient and timely manner
- Address conflicts that may arise in a professional and safe manner
- Seek assistance from supervisors as necessary to address language barriers, personal relationships or other challenges

2. **Cultural Responsiveness and Mediation**
   - Identify and respect cultural and linguistic differences in communities
   - Understand how one's own culture and life experience influence one's work with clients, community members and professional colleagues from diverse backgrounds
   - Recognize and understand different aspects of culture and how these can influence people's thinking and behavior (family unity, religious beliefs, health-related beliefs and practices, generational differences, traditions, histories, socioeconomic system, refugee and immigration status and government systems)
   - Employ techniques for interacting sensitively and effectively with people from cultures or communities that differ from one's own and seek assistance from supervisors if there are communication difficulties
   - Advocate for and promote the use of culturally and linguistically appropriate services and resources within organizations and with diverse colleagues and community partners

3. **Care Coordination and System Navigation**
   - Serve as a liaison between organizations, groups and clients
   - Facilitate client enrollment into appropriate programs
   - Refer clients to appropriate services and follow-up to confirm
   - Obtain and share knowledge of community resources for health care, social services and additional support services
   - Provide information and support for people in using agency and institutional services
   - Advocate effectively with others so that clients receive the needed care in timely manner
   - Help improve access to resources by identifying barriers, documenting details and developing strategies to remove them
   - Record and maintain information on clients, referrals and appointments

4. **Use of Public Health Concepts and Approaches**
   - Recognize and understand how individual health is shaped by family, community, neighborhood and wider social conditions (such as education, poverty, housing, safety, transportation and environmental quality)
   - Understand differences as well as connections between public health and health care
   - Understand the relationship between public health and social justice
   - Understand public health's emphasis on prevention and the role of policy change in preventing injury and disease, and CHW roles in prevention strategies and reducing health inequities

5. **Education/Teaching Skills to Promote Healthy Behavior Change**
   - Apply information from client and community assessments to health education strategies
   - Develop health improvement plans in cooperation with clients and colleagues that recognize and build upon client goals, strengths and current stage of commitment and ability to act upon health behavior goals
   - Understand how to use multiple techniques for helping people understand and address health risks for themselves, their family members or their communities (informal counseling, motivational interviewing, active listening, group work or other strategies)
   - Learn and convey information accurately, using culturally and linguistically accessible methods and materials
   - Coordinate education and behavior change activities with the care that is provided by professional colleagues and team members
   - Provide on-going support and follow-up as necessary to support health behavior change
   - Communicate with providers and service organizations to help them understand community and individual conditions, culture and behavior to improve the effectiveness of services they provide
   - Document information in an effective, efficient and timely manner

6. **Outreach Methods and Strategies**
   - Define communities or populations to be served by outreach
   - Engage in and utilize appropriate outreach methods (home visiting, agency outreach, street outreach, social marketing, etc.)
   - Implement outreach plans based on individual and community strengths, needs and resources and developed in collaboration with others in order to accomplish assigned work or objectives
   - Identify and share appropriate information, referrals, and other resources to help individuals, families, groups and organizations meet their needs
   - Communicate effectively with diverse individuals and groups in a variety of community and service provider settings
   - Adapt and employ effective, culturally responsive strategies to address targeted issues and behaviors

- Initiate and sustain trusting relationships with individuals, families and social networks
- Establish and maintain cooperative relationships with community-based organizations and other resources to promote client services, care, education and advocacy
- Conduct outreach with attention to possible safety risks for self, clients and colleagues

7. **Advocacy and Community Capacity Building**
   - Encourage clients to identify and prioritize their personal, family, and community needs
   - Encourage clients to identify and use available resources to meet their needs and goals
   - Provide information and support for people to advocate for themselves over time and to participate in the provision of improved services
   - Advocate on behalf of clients and communities, as appropriate, to assist people to attain needed care or resources in a reasonable and timely fashion
   - Apply principles and skills needed for identifying and developing community leadership
   - Build and maintain networks, and collaborate with appropriate community partners in capacity building activities
   - Use a variety of strategies, such as role-modeling, to support clients in meeting objectives, depending on challenges and changing conditions

8. **Professionals Skills and Conduct**
   - Practice in compliance with the Code of Ethics for Community Health Workers.
   - Observe the scope and boundaries of the CHW role in the context of the agency team and agency policy.
   - Respect client rights under HIPAA and applicable agency rules.
   - Understand issues related to abuse, neglect, and criminal activity that may be reportable under law and regulation.
   - Maintain appropriate boundaries that balance professional and personal relationships, recognizing dual roles as both CHW and community member.
   - Seek assistance from supervisors as necessary to address challenges related to work responsibilities.
   - Establish priorities and organize one's time, resources, and activities to achieve them.
   - Work proactively and creatively to identify and address client, community, and agency needs.
   - Utilize and advocate as necessary for supervision, training, continuing education, networking, and other resources for professional development and lifelong learning for self and colleagues.
   - Use health information technology appropriately to support health and wellness

9. **The CHW Profession**
   - Describe the history, role and impact of CHWs in improving individual and community health
   - Describe the MD CHW Scope of Practice
   - Define the CHW Code of Ethics and demonstrate performance of ethical behavior as a CHW

- Identify and explain the boundaries of the CHW role, how to establish boundaries with clients, and the role of a CHW on healthcare teams
- Describe and utilize self-awareness and self-care practices
- Describe the determinants of health and recognize how they impact health needs and priorities
- Describe a client-centered approach
- Recognize and appropriately respond to the beliefs, values, culture, and languages of the individuals and communities being served
- Prioritize activities and effectively manage time
- Describe and access national and state CHW professional organizations and training resources
- Explain the MD CHW certification policy and process for obtaining certification
- Identify and utilize tools and resources for CHW professional development

APPENDIX 7: PUBLIC COMMENTS

DHMH held a public comment period from April 30, 2015 to May 22, 2015. A draft of this report was released in English and Spanish via email and on the DHMH website. A total of eight comments were received before the deadline. Factual errors identified by commenters were corrected in this final report. Below is a list of suggestions related to the workgroup recommendations that were made by multiple commenters, with responses from DHMH.

1. **Reimbursement.** Five commenters felt that the workgroup should have provided a concrete recommendation on reimbursement.

   ➢ The workgroup determined that the other recommendations are a prerequisite to reimbursement and that a group of stakeholders should continue discussing the issue. However, language was added to the final report to make it clearer that the workgroup strongly felt that reimbursement is vital for the profession and that a group of CHW stakeholders should continue defining reimbursement and make more detailed recommendations in the future.

2. **Grandfathering**. Three commenters felt that the requirement for 4,000 hour work experience within the last 2-4 years for grandfathering is excessive and may preclude part-time CHWs from receiving certification.

   ➢ This recommendation was approved by majority vote and will not be changed at this time. However, future considerations of grandfathering may want to revisit these requirements.

3. **Clinical focus.** Two commenters felt that the recommendations for roles and competencies were too focused on clinical functions.

   ➢ These recommendations were approved by majority vote and will not be changed at this time. The clinical functions are consistent with roles and competencies used for CHWs in other states and reflect the ways that CHWs are currently being used in Maryland. Given the increasing focus on prevention and population health within the health care delivery system, use of CHWs for these functions will only increase, and some basic knowledge in these areas was determined by the workgroup to be appropriate. It is understood that not all CHWs perform clinical functions, and these recommendations are not intended to suggest that all CHWs should or must perform clinical functions.