2018

REPORT TO THE LEGISLATURE ON COMMUNITY HEALTH WORKER CERTIFICATION

A Report of the State Innovation Model Community Health Worker Advisory Committee

DRAFT

SIM CHW Initiative

8/31/2018

This Report is a product of the Community Health Worker Advisory Committee, prepared by:
Dashni Sathasivam, Yale School of Public Health
Jenna Lupi, Connecticut Office of Health Strategy
Katharine London, UMass Medical School
The SIM CHW Team at UConn and Southwestern AHEC

This project was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

CT SIM Community Health Worker Advisory Committee

Migdalia Belliveau
Generations Family Health Center

Ashika Brinkley, MPH
Goodwin College

Thomas Buckley, MPH, RPh
UConn School of Pharmacy

Juan Carmona (CHW)
Project Access New Haven

Darcey Cobbs-Lomax, MBA, MPH
Project Access New Haven

Michael Corjulo, APRN, CPNO
Children's Medical Group

Grace Damio, MS, CD/N
Hispanic Health Council

Tiffany Donelson, MPH
Connecticut Health Foundation

Loretta Ebron (CHW)
Housatonic Community College

Peter Ellis, MD, MPH
Project Access New Haven

Liza Estevez (CHW)
Northeast Medical Group

Linda Guzzo, EdD, RD
Capitol Community College

Terry Nowakowski, LCSW
Partnership for Strong Communities

Chioma Ogazi, DVM, MS, RN
CT Department of Public Health

Nicholas Peralta
ProHealth Physicians

Lauren Rosato
Planned Parenthood of Southern New England

Milagrosa Seguinot, AS (CHW)
CHW Association of Connecticut

Mayce Torres (CHW)
Planned Parenthood of Southern New England

Robert Zavoski, MD
CT Department of Social Services

Contents

Deleted: 6
Deleted: 9
Deleted: 10
Deleted: 11
Deleted: 20
Deleted: 24
Deleted: 29
Deleted: 29
Deleted: 29
Deleted: 30
Deleted: 31
Deleted: 33
Deleted: 34
Deleted: 36
Deleted: 41
Deleted: 42
Deleted: 43
Deleted: 44
Deleted: 46

A. Executive Summary

In 2017, Connecticut passed Public Act 17-74, An Act Concerning Community Health Workers. The law, which ultimately became part of Public Act 18-91, Section 63, tasked State Innovation Model (SIM) leadership, in consultation with the Department of Public Health (DPH) and the SIM CHW Advisory Committee to examine the fiscal impact of creating a statewide CHW certification program and develop recommendations for such a program. It also established a statewide definition for Community Health Workers (CHWs).

The CHW Advisory Committee noted in its 2017 Report that it views CHW certification as voluntary. That is, the State of Connecticut should not require an individual to obtain CHW certification in order to perform certain roles or tasks; however, an employer could require its employees to obtain certification, and a payer could choose to restrict reimbursement to services provided by certified CHWs.

The SIM Program Management Office partnered with the UConn Area Health Education Center/Southwestern Area Health Education Center (AHEC), and Katharine London of UMass Medical School to lead a design process with the CHW Advisory Committee to develop recommendations in support of a Certification Program in Connecticut.

The CHW Advisory Committee's recommendations are as follows:

(1) Requirements for certification and renewal of certification of community health workers, including any training, experience or continuing education requirements:

Recommendation 1: Connecticut should establish two ongoing paths to certification: one path with training and one without training. The two paths will serve individuals currently working in a CHW capacity and those that are interested in starting their careers as CHWs.

Recommendation 2: To be eligible to apply for CHW Certification, applicants should be at least 16 years of age. There should be no additional eligibility requirements.

Recommendation 3: A Supervisory reference and a Community reference should be required for all prospective CHWs seeking certification.

Recommendation 4: Reciprocity should not be established with other states; applicants from other states could apply through one of the two paths to certification.

Recommendation 5: Certification should be issued for two years and for renewal, applicants should be required to attest to the completion of 20 hours of continuing education requirements (CERs) including two hours focused on cultural competency and two hours focused on social determinants of health. The Certifying Entity should not routinely require applicants to produce evidence of completion but could request such documentation.

Recommendation 6: Conferences, webinars, workshops, seminars, trainings, presentations and self-studies should count toward continuing education hours and be tracked on a designated tracking sheet.

Recommendation 7: Applicants for CHW certification should commit to abide by a CHW Code of Ethics. The following infrastructure should be established to implement this recommendation:

- The Advisory Body should adopt the nationally-utilized Code of Ethics as previously adopted by the CHW Association
- In response to an alleged Code of Ethics violation, DPH should follow its established investigation, adjudication, and disciplinary proceedings. The Advisory Body should be informed of such complaints

Deleted: (AHEC),

Deleted: ,

Formatted: Font color: Auto

Deleted: Applicants should complete these hours outside of employment or volunteer positions.

Deleted: Either DPH as the Certifying Entity or its Advisory Body should establish a Code of Ethics

and remediation efforts.

(2) *Methods for administering a certification program, including a certification application, a standardized assessment of experience, knowledge and skills, and an electronic registry:*

Recommendation 8: The Department of Public Health (DPH) should serve as the CHW Certifying Entity. The Department of Public Health should be responsible for the administrative tasks related to certification including reviewing applications, verifying that requirements have been met, issuing certificates, and maintaining a CHW registry like those maintained for other professionals that are searchable by name and region.

Recommendation 9: A separate Advisory Body should be established to inform the full development of Certification Standards. The Advisory Body should have a more prominent role in the initial development of the Certification Program, and should meet less often thereafter to assess the need to adjust the Certification Standards and to weigh in on critical questions as identified by the Certifying Entity.

Recommendation 10: The Advisory Body should include: 6 CHWS; 1 CHW Association of CT representative; 1 Community-Based CHW training organization representative; 1 Community College representative; 1 Community-Based CHW employer; 1 Healthcare organization CHW employer; and 1 Health Care Provider with direct CHW experience.

Recommendation 11: The application process for Certification should not create unnecessary barriers. Unless otherwise required by Agency policy, DPH should accept copies of application materials and should not require notarization. To the extent possible, applications should be accepted via email, online, or regular mail.

(3) *Requirements for recognizing training program curricula that are sufficient to satisfy the requirements of certification:*

Recommendation 12: The content of training CHWs should consist of the core skills and services utilizing the Community Health Worker Consensus Project (C3) Core Competencies.

Recommendation 13: Training programs should include 90 hours of training and an internship with a minimum of 50 hours.

Recommendation 14: Training modality and methodology should follow Adult Learning Principles, include role-playing, and be interactive.

Recommendation 15: Training should be delivered in-person or utilize a hybrid approach that includes in-person sessions and distance learning in "real-time." Online training alone should not meet the requirements of certification. At least 40% of the hours of instruction should be taught or co-taught by faculty who are Community Health Workers.

Recommendation 16: Instructors for CHW training should be inclusive of CHWs with experience in the field, as well as non-CHWs who meet the requirements of the training vendor. Instructors should demonstrate past experience training individuals who provide community health work services, including, but not limited to: Promotores, CHWs, or other health care professionals and paraprofessionals in the previous six years. They should have the knowledge, skills and competence to effectively teach a CHW Core Competency curriculum.

- Instructors who are not CHWs should provide a resume to demonstrate their experience training in the past six years. Other requirements may additionally be defined by the training vendor (i.e. educational background).
- Instructors who are CHWs should have at least three years of experience working full-time as a CHW, proof of completion of a CHW Core Competency Training, and knowledge of the community and community resources.

Formatted: Font color: Auto

Formatted: Indent: Left: 0.32", Right: 0.15", Space Before: 6 pt

Deleted: The Advisory Body should include: 6 CHWS; 1 CHW Association of CT representative; 1 Community-Based CHW training organization representative; 1 Community College representative; 1 CHW employer; 1 Health Care Provider with direct CHW experience; and 1 Health Educator.

Formatted: Condensed by 0.05 pt

Formatted: Font color: Auto

Formatted: Indent: Left: 0.32", Space Before: 6 pt

Formatted: Indent: Left: 0.57", Right: 0.42", Space Before: 0 pt

Formatted: Font color: Auto

Formatted: Font color: Auto

Deleted: **Recommendation 16:** CHW training instructors, both Non-CHW and CHW, should have at least 1,000 hours of experience training individuals who provide community health work services including promotores, CHWs, and other health care paraprofessionals and professionals in the previous six years. They should have the knowledge, skills and competence to effectively teach a curriculum. In addition, CHW Instructors should have:¶ 3-5 years of experience working fulltime as a CHW¶ Proof of completion of a CHW Core Competency Training¶ Knowledge of the community and community resources, and preferably reside in the community¶

Recommendation 17: Assessments of successful training completion should utilize (1) pre- and post-tests, (2) skills assessment, and (3) include a capstone project or portfolio, or a combination of the two.

Recommendation 18: The CHW Certification Advisory Body should review and approve CHW training vendors.

The CHW Advisory Committee urges the Connecticut State Legislature to pass legislation establishing CHW Certification in Connecticut that reflects the recommendations contained in this Report. Such legislation will lead to more sustainable funding options for CHWs, increase the profession's visibility and recognition, and expand the utilization of CHWs across the state. Increasing utilization and funding for CHWs will improve health outcomes, reduce health inequities, and ultimately reduce healthcare costs in Connecticut.

B. Purpose of this Report

In 2017, Connecticut passed Public Act 17-74, An Act Concerning Community Health Workers. The law, which ultimately became part of Public Act 18-91, Section 63, established a statewide definition for Community Health Workers and tasked State Innovation Model leadership, in consultation with the Department of Public Health and the SIM CHW Advisory Committee to examine the fiscal impact of creating a statewide CHW certification program and develop recommendations for such a program. The text of the law is as follows.

> Sec. 63. Section 20-195sss of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):
>
> (a) As used in this section, "community health worker" means a public health outreach professional with an in-depth understanding of the experience, language, culture and socioeconomic needs of the community who
>
> (1) serves as a liaison between individuals within the community and health care and social services providers to facilitate access to such services and health-related resources, improve the quality and cultural competence of the delivery of such services and address social determinants of health with a goal toward reducing racial, ethnic, gender and socioeconomic health disparities, and
> (2) increases health knowledge and self-sufficiency through a range of services including outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, research related to social determinants of health and basic screenings and assessments of any risks associated with social determinants of health.
>
> (b) The Executive Director of the Office of Health Strategy, established under section 19a-754a, as amended by this act, shall, within available resources and in consultation with the Community Health Worker Advisory Committee established by said office and the Commissioner of Public Health, study the feasibility of creating a certification program for community health workers. Such study shall examine the fiscal impact of implementing such a certification program and include recommendations for
> (1) requirements for certification and renewal of certification of community health workers, including any training, experience or continuing education requirements
> (2) methods for administering a certification program, including a certification application, a standardized assessment of experience, knowledge and skills, and an electronic registry, and
> (3) requirements for recognizing training program curricula that are sufficient to satisfy the requirements of certification.
>
> (c) Not later than October 1, 2018, the Executive Director of the Office of Health Strategy shall report, in accordance with the provisions of section 11-4a, on the results of such study and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services.

To assess the fiscal impact and fully develop recommendations for a CHW Certification Program in Connecticut, SIM leadership in partnership with the SIM CHW team and the Department of Public Health led an intensive design process with the SIM CHW Advisory Committee. This Report summarizes the Recommendations of the Advisory Committee.

C. Making the Case for Community Health Workers

Substantial evidence confirms that intervention models involving CHWs produce improved health outcomes.[1] Rooted in the communities they serve, CHWs possess a unique understanding of how those communities function and how the local resources, environment, and culture affect health, enabling them to bridge ethnic and racial inequities in healthcare. In addition, CHWs are on the frontlines of addressing the social determinants of health[2] and are particularly well-positioned and equipped to connect what happens inside the clinic to what happens in neighborhoods, homes, and workplaces. By working in homes, on the street, in communities, and in clinics, they complement clinically trained healthcare teams by carrying out a broad range of responsibilities that facilitate access to services and supports and help patients achieve the goals of their care plans. By providing these services and supports, CHWs allow all members of the care team to work at the top of their licenses, increasing the efficiency and effectiveness of the care team. In short, they link the healthcare system to the community, enabling each to feedback positively on the other.[3]

Deleted: address

Deleted: disparities

"The Business Case for Community Health Workers in Connecticut," published by Southwestern AHEC in 2014, identified a CHW movement in Connecticut with a unique opportunity to improve population-based health outcomes. Extensive evidence demonstrates that intervention models that utilize CHWs result in better health outcomes across a variety of health issues by enhancing the services already offered and create cost savings and revenue enhancements. The report also confirmed that existing CHW program models[4] in Connecticut improve access to care, increase knowledge, prevent disease, and improve select health outcomes for target populations. The report identified a substantial need to educate stakeholders, inventory the existing CHW workforce, support the CHW Association of Connecticut, establish an infrastructure for CHW education and training, develop sustainable funding opportunities created through the Affordable Care Act, and establish collaborative efforts among partners to study CHW cost effectiveness.[5]

In 2012, Connecticut's Southwestern AHEC conducted a survey on CHWs and their employers to improve understanding and propel the CHW workforce in Connecticut forward. The survey report (Community Health Workers: Connecticut) was created by students at the Yale School of Public Health in collaboration with SWAHEC and was supported by the CT-RI Public Health Training Center with funding from the Health Resources Services Administration (HRSA). This survey found that CHWs in Connecticut are predominantly middle-aged minority women, which is comparable to CHWs nationwide. Both CHWs and their employers expressed a desire for more training, and CHWs also indicated a need for a standardized training program. Credentialing was considered as a formal mechanism to assist CHWs in meeting their training needs while also providing a record of their qualifications. The survey confirmed that CHWs in Connecticut are known by many job titles, which presents a barrier to their recognition as a professional workforce and seems to affect the level of payment for the work they do. Ultimately, lack of understanding of the benefit of CHWs, low pay, and unstable funding were identified as

[1] CDC, "Addressing Chronic Disease Through Community Health Workers: A Policy and Systems-Level Approach," 2nd Ed., April 2015, http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

[2] Phalen, J and Paradis, Rebecca. "How Community Health Workers Can Reinvent Health Care Delivery in the US," Health Affairs Blog, January 16, 2015. http://healthaffairs.org/blog/2015/01/16/how-community-health-workers-can-reinvent-health-care-delivery-in-the-us/

[3] CT AHEC et al., "The Business Case for Community Health Workers in Connecticut," Fall 2014 http://swctahec.org/wp-content/uploads/2010/08/CHW-Business-Case-2014-with-Task-Force-Final.pdf

[4] Community health workers evidence-based models toolbox. HRSA Office of Rural Health Policy. U.S. Department of Health and Human Services. Health Resources Services Administration. August 2011.

[5] CT AHEC et al., "The Business Case for Community Health Workers in Connecticut," Fall 2014 http://swctahec.org/wp-content/uploads/2010/08/CHW-Business-Case-2014-with-Task-Force-Final.pdf

barriers to the CHW workforce in Connecticut that in turn affect job satisfaction and job security.

With the CHW workforce growing and recognition of its effectiveness at reducing health disparities by using health information to change health seeking-behaviors among underserved populations increasing, it is critical to provide robust, competency-based CHW training. Adequate and consistent training and statewide recognition of such can lead to certification, which can boost the recognition and sustainability of what this workforce is already doing to improve health.[6]

To help achieve this goal and support integration of CHWs into the state's healthcare delivery model, the SIM CHW Initiative is focused on developing infrastructure to support the CHW workforce, including through certification and sustainable funding.

D. Background on the State Innovation Model CHW Initiative

The SIM CHW Initiative launched in 2015 when the State of Connecticut received the CMMI State Innovation Model Test grant award, a 4-year, $45 million grant. The SIM is committed to statewide healthcare reform that achieves the triple aim: Better Care, Smarter Spending, and Healthier People and Communities. Across these three aims, the SIM is also dedicated to improving health equity and empowering consumers.

An important component of the overall SIM strategy is to promote CHWs as critical members of primary care teams, in addition to promoting the continuation of community-based CHW initiatives. SIM emphasizes the importance of incorporating CHWs directly into clinical care teams, as well as establishing formal partnerships between clinical care teams and community-based CHW-led interventions in order to:

- Address the **social determinants of health** that prevent improved health outcomes
- Provide **navigation services** to both clinical and community resources
- Provide **chronic illness self-management** education and support

SIM initiatives promote the use of CHWs through:

- Care coordination add-on payments for FQHCs participating in the Medicaid Shared Savings program, Person-Centered Medical Home Plus (PCMH+)
- Up-front funding for CHWs in primary care settings for healthcare organizations participating in PCMH+
- Technical assistance to support the integration of CHWs into primary care teams
- Funding and technical assistance to community based organizations and accountable healthcare organizations to establish formal partnerships for CHW-led diabetes self-management and education programs

SIM leadership has worked concurrently with the CHW Advisory Committee to develop policies and practices that promote the CHW workforce, with a special focus on CHW certification. The increased demand for CHWs through PCMH+ has been an important driver of this work. The majority of participating organizations have hired CHWs to help improve the quality of care for patients with complex needs, to reduce health inequities, and to help reduce overall healthcare costs. Value-based payment models like shared savings programs increase the demand for such improvements, therefore increasing the demand for CHWs. As the demand for CHWs grows, the need for standardized training and recognition grows as well.

SIM leadership works closely with UConn Area Health Education Center (UConn AHEC) and Southwestern Area Health Education Center (SWAHEC) to support efforts. Additionally, Katharine London, principal at the University of Massachusetts Medical School's Center for Health Law and Economics, provides facilitation support and expert

Deleted: .

Deleted: by providing

Deleted: those

Deleted: accountable payment

Deleted: models

Deleted: ¶

guidance to the CHW Advisory Committee. Together, this "CHW team" worked with the CHW Advisory Committee to develop the recommendations included in this Report.

[6] American Public Health Association, "Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities," November 10, 2009, https://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

E. The Role of the SIM CHW Advisory Committee

Under SIM, the CHW Advisory Committee was established to provide multi-stakeholder guidance on the SIM CHW efforts. The CHW Advisory Committee's Charter describes their full charge and was approved by the Health Care Innovation Steering Committee (HISC), the SIM's oversight committee, on February 11, 2016. In 2017, the Committee produced a Report that provided recommendations on a CHW definition and scope of practice, a process for CHW certification, and mechanisms for sustainably financing CHW services. This Report influenced the passing of Public Act 17-74.

Members of the Committee represent a broad range of CHW-stakeholder groups, including CHWs, health care providers, consumer advocates, academics, state agencies, and employers of CHWs. The names and affiliations of Committee members are detailed at the beginning of this report. The SIM PMO issued a solicitation for membership applications in late January 2016, and the HISC approved the 21 members nominated by the Personnel Subcommittee and the Consumer Advisory Board on March 10, 2016. Because two members have since resigned, there are currently 19 Committee members.

Certification Recommendations: Committee and Design Group Process

To develop the recommendations contained in this Report, the CHW Advisory Committee met twice as a full group between November 2017 and February 2018. During those meetings, they determined that a Design Group Process was needed to fully develop all recommendations needed to establish a CHW Certification Program. The Committee worked with the CHW team to identify key individuals that should be part of the Design Group Process.

Three Design Groups were established to discuss and develop recommendations aligned with the expectations of Public Act 17-74. The Design Groups were charged with issuing recommendations on the following Decision Points:

Table 1. Design Group Decision Points

Group 1 Certification Requirements	Group 2 Methods & Administration of Certification Program	Group 3 Training Curricula
Required Work Experience	Certifying Entity	Core Competencies
Background Check Requirements	Certification Board structure	Training Components
Professional/Personal Recommendations	Responsible Entity for Reviewing Applications	Required Number of Training Hours
Process for Grandfathering/Grandparenting	Application Process	Internship Criteria
Length of Certification before renewal	Eligibility for Certification	Assessment Type needed to assess proficiency
Required Continuing Education for Renewal	Registry Requirements	Training Vendor Criteria
Additional requirements for Renewal	Fiscal Implications of Establishing Certification	Instructor Qualifications
Reciprocity based on Certification in other states		Preferred training modality/ standards for instructional methods

The Design Groups met as a full group in March 2018 to review the goals of the process, and came back together in May and June to review and provide feedback on key recommendations developed within each group. Between March and June, each design group separately met between 4-6 times either in person or via webinar to deliberate and come to consensus on recommendations. Design group membership is included in Table 2.

Table 2. Design Group Membership

Group 1 Certification Requirements	Group 2 Methods & Administration of Certification Program	Group 3 Training Curricula
Lead Facilitator: **Katharine London** UMass Medical School	**Lead Facilitator:** **Jenna Lupi** Office of Health Strategy-SIM	**Lead Facilitators:** **Meredith Ferraro and Maggie Litwin** SWAHEC
Thomas Buckley UConn School of Pharmacy	**Chris Andresen** Department of Public Health	**Ashika Brinkley** Goodwin College
Juan Carmona (CHW) Project Access New Haven	**Migdalia Belliveau** Health Educator	**Michael Corjulo** Children's Medical Group
Darcey Cobbs-Lomax Project Access New Haven	**Giselle Carlotta-McDonald** Project Access New Haven	**Grace Damio** Hispanic Health Council
Randy Domina Department of Public Health	**Tiffany Donelson** Connecticut Health Foundation	**Liza Estevez** (CHW) Northeast Medical Group
Maria Millan (CHW) CHW Association of CT	**Loretta Lloyd-Ebron** (CHW) Housatonic Community College, CHW Association of CT	**Linda Guzzo** Capitol Community College
Terry Nowakowski Partnership for Strong Communities	**Dr. Bruce Gould** UConn AHEC	**Erika Lynch** Gateway Community College
Lori Pasqualini Ability Beyond	**Nina Holmes** Department of Social Services	**Fernando Morales** SWAHEC
Elena Padin (CHW) CHW Association of CT	**Keturah Kinch** Wheeler Clinic	**Chioma Ogazi** Department of Public Health
Milagrosa Seguinot (CHW) CHW Association of CT	**Dana Robinson-Rush** Department of Social Services	**Milagrosa Seguinot** (CHW) CHW Association of CT
Mayce Torres (CHW)	**Lauren Rosato** Planned Parenthood of Southern New England	**Cecil Tengatenga** City of Hartford

The lead facilitators, with additional support from the SIM CHW team, provided design group members with resources on other states' CHW certification programs, meeting presentations, and meeting summaries to guide discussion and decision making. In addition to meetings, in some cases members were surveyed about their views on particular CHW issues to help gain consensus. As a large group, the Committee elected to focus on Massachusetts, Rhode Island, Texas, and Florida as model states to help in the development of recommendations. All meetings were open to the public and time was allotted for public comment. Meeting minutes, slides, and materials are available on the SIM website.

F. Recommendations for a CHW Certification Program in Connecticut

The following recommendations were developed through the CHW Advisory Committee Design Group Process described above. Each Design Group was assigned **Key Decision Points** on which to issue recommendations, and each group developed **Guiding Principles** to help guide the decision-making process. Each **Recommendation** is supported by accompanying **Key Considerations**. The CHW Advisory Committee reviewed, discussed, amended and ultimately approved the recommendations of the individual Design Groups for inclusion in this Report.

F.1 Certification Requirements

This section discusses "requirements for certification and renewal of certification of community health workers, including any training, experience or continuing education requirements." These recommendations were developed primarily by Design Group 1, with some contributions from Design Groups 2 and 3.

Key Decision Points

Design Group 1 developed recommendations to address Certification Requirements in the following five areas:

Deleted: that

1. Paths for certification
2. Methods to verify CHW experience
3. Alternative pathways to certification, such as reciprocity with other states
4. Requirements for certification renewal
5. Standard Code of Ethics for CT CHWs

Guiding Principles

Design Group 1 identified the following goals in the development of their recommendations. Much of the group's discussion focused on how to balance these two goals:

1. Include requirements that make certification **meaningful** to employers and payers
2. Make the certification process easy to access for **new CHWs** and **experienced CHWs,** using the following strategies:
    a. Do not create barriers
    b. Simplify the application process for applicants
    c. Simplify the recommendation process for CHW references/supervisors
    d. Simplify the review process for the entity that has to review submitted applications
    e. Keep forms to one page
    f. Use check boxes instead of free text, where feasible
    g. Use clear language that does not require a high level of literacy and that is easy to translate into other languages
    h. Keep the cost down

Recommendations and Key Considerations

Recommendation 1:

Connecticut should establish two ongoing pathways to certification: one path with training and one without training. The two path will serve individuals currently working in a CHW capacity and those that are interested in starting their careers as CHWs.

Recommendation 1a.

To be considered for one of the two CHW Certification paths, applicants should meet the following requirements:

Table 3. Requirements for CHW Certification

Requirements	Path 1	Path 2
Training	90 hour training & 50 hour internship (minimum)	None
Experience*	1,000 hours in past 3 years	2,000 hours as paid/unpaid CHW in past 5 years
Portfolio	Optional: *A portfolio including 3 of the 8 items on Rhode Island's list*	Required: A resume documenting years of experience, and A portfolio including 3 of the 7 other items on Rhode Island's list

*Experience does not need to occur in Connecticut.

Key Considerations:

- The Committee reviewed others states' certification requirements, and found that they vary widely. Many states "grandparented" in experienced CHWs when they first started their certification programs while some states, such as New Mexico, South Carolina, and Texas, require a training certificate OR experience.
- The Committee assessed other states certification requirements by distinguishing between Certificate States and Certification States:
  - **Certificate states**: approve training programs that are authorized to award a CHW certificate, but the state does not certify individual CHWs
  - **Certification states:** have a process for certifying individual CHWs and renewing certification
- **Table 4** outlines some of the key differences between the states that were assessed.

Deleted: New CHW

Deleted: Experienced CHW

Formatted Table

Formatted: Font: 11 pt, Not Bold, Font color: Blue

Formatted: Indent: First line: 0.21"

Formatted: Font: 11 pt, Not Bold

Table 4. Certification Requirements in Certificate and Certification States

Requirements	CHW Certification States				
	CT Proposed	FL	MA	RI	TX
Path 1					
Hours of experience	1000	500	2000	1000	
in the previous x years	3	5	10	5	
Classroom hours	90	30	80	70	160
Field hours (internship)	50	-	-	50	-
Written exam	No	Yes	No	No	No
Portfolio	No	No	No	Yes	No
Path 2					
Hours of experience	2000	NA	4000	NA	1000
in the previous x years	5		10		6
Classroom hours	-		-		-
Field hours (internship)	-		-		-
Written exam	No		No		No
Portfolio	Yes		No		No

Deleted: ¶

- The Committee considered the findings in **Table 4** and developed recommendations for the number of training hours, internship hours, and hours of experience.
- The Committee considered different methods to assess applicant capabilities beyond training and hours of experience, including Rhode Island's portfolio model. The Committee determined that this model, which offers a menu of application material options from which the applicant can select, allows applicants to demonstrate the depth and breadth of their experience and show the value of their actions (RI Portfolio Requirements can be found in Appendix A). The Committee determined that the portfolio approach can also demonstrate roles and skills and is helpful documentation to share with prospective employers. There was some discussion as to whether the portfolio should be mandatory or optional which led to the decision to make it optional for newly trained CHWs and required for experienced CHWs seeking certification.
- The Committee recommended AGAINST a written exam because it determined that an exam would not assess key CHW skills, which are largely practice-based and experiential. Instead, a written exam would impose a barrier for many potential applicants.

Recommendation 2:

To be eligible to apply for CHW Certification, applicants should be at least 16 years of age. There should be no additional eligibility requirements.

Key Considerations:

- The Committee concluded that applicants should be at least 16 years of age to apply for CHW certification based on the following:
  - Applicants 16 years of age or older have the level of maturity required to perform CHW functions

- Excluding applicants aged 16-17 could negatively impact successful youth CHW programs that utilize peer support models

- The Committee discussed other possible eligibility requirements based on those enforced in other states, including education level, residency, personality traits, and criminal background checks. Ultimately, the Committee determined that such requirements should be left to individual employers to establish if they choose. The Committee identified cases for each of the above considerations for which establishing a baseline eligibility requirement could exclude an important member of the community, as described below:
  - Establishing a minimum education requirement could exclude a well-qualified and respected member of the community who lacks his or her high school or college degree;
  - Establishing a residency requirement could exclude a member of an immigrant community who lacks proper documentation;
  - Establishing personality trait requirements is largely subjective and could unfairly exclude an applicant;
  - Establishing criminal background check requirements could exclude an applicant with a felony who could be an ideal CHW to work with community members with similar background.

Recommendation 3:

A Supervisory reference and a Community reference should be required for all prospective CHWs seeking certification:

- **Supervisory reference:** At least one supervisor, who has experience supervising Community Health Workers (or other staff titles who perform CHW Roles), must attest that the applicant has the required paid or volunteer hours performing at least five CHW Roles and demonstrated proficiency in at least four CHW skills (not including Skill #11 knowledge base). This reference can be made by a supervisor from an internship, volunteer, or paid work experience. See Appendix B for full list of CHW Roles and Skills.
- **Community reference:** At least one member of the community, who has known the applicant for at least one year, must attest that the applicant has "an in-depth understanding of the experience, language, culture and socioeconomic needs of the community." Community references are often provided by staff of partner organizations, fellow volunteers for a charity, community leaders, clients, friends or neighbors.
- A Supervisory or Community reference may not be provided by an immediate family member (including parents, spouses, children, or siblings), any person sharing the same household, or any person who is now or ever has been in a romantic or domestic relationship with the applicant.
- See Appendix C for Draft Supervisor and Appendix D for Draft Community Reference Forms.

Deleted: not including

Deleted:)

Key Considerations:

- The Committee determined that two types of references were needed for individuals seeking certification. The Design Group felt that two distinct categories of references were necessary to verify that an individual has the breadth of experience and proficiency of skills required to be a Certified CHW. The Supervisory reference provides evidence that the individual has the requisite number of hours performing CHW roles with proficiency in CHW skills. The Community reference verifies the individual's understanding of and connection to the community served.
- The Committee considered what requirements would be meaningful and yet not impose barriers, given the variations in personal circumstances among applicants. The Committee noted that training programs should cover all CHW roles and skills, but a specific job may not. The Committee felt that requiring CHWs to demonstrate five roles and four skills proficiently was enough to demonstrate competence, but not so many as to become a barrier. The CHW skill, "knowledge base", was excluded from the list of potential CHW skills because it is different for each job.

Recommendation 4:
Reciprocity should not be established with other states; applicants from other states could apply through one of the two paths to certification.

Key Considerations:

- The Committee determined that states vary widely in their requirements, as is demonstrated in **Table 4: Certification Requirements in Certificate and Certification States**, above.
- The Committee found that many states approve training curricula but do not have a certification or registry process.
- The Committee found no practical way to implement reciprocity at this point because there is no national entity that administers reciprocal certifications, as there is for other professions. For example, the International Certification & Reciprocity Consortium administers reciprocity for Alcohol & Drug Counselors, Certified Criminal Justice Addictions Professionals, and Peer Recovery specialists. Furthermore, DPH has not established reciprocity with other states for any other profession it certifies, although DPH does endorse certain credentials from other states.
- The Committee agreed that individuals moving to Connecticut can be certified through one of the two paths to certification.
- After reviewing the variability in other states' certification requirements, the Committee recommended against offering state reciprocity.

Recommendation 5:
Certification should be issued for two years and for renewal, applicants should be required to attest to the completion of 20 hours of continuing education requirements (CERs), including two hours focused on cultural competency and two hours focused on social determinants of health. Applicants may be required by the certifying entity to produce evidence of completion of CERs, but it should not be a routine requirement.

Key Considerations:

- The Committee considered the need for continuing education requirements, and was especially cautious of placing an unnecessary burden on CHWs to maintain their credential. The Committee assessed other states, and found that most have similar continuing education requirements, which can be seen in **Table 5: State CHW Certification Continuing Education Requirements**, below.

Table 5. State CHW Certification Continuing Education Requirements

State	Certification Length of Time	Continuing Education Requirements	Other Requirements
Florida	2 years	10 hours/year	$100
Massachusetts	2 years	15 hours	Fee, CORI* check
New Mexico	2 years	30 hours	$45, CORI check
Oregon	3 years	20 hours	CORI check
Rhode Island	2 years	20 hours	Fee
Texas	2 years	20 hours	

**CORI: Criminal Offender Record Information.*

- The Committee noted that continuing education requirements (CERs) help CHWs stay current with rapidly changing practices. Continuing education requirements also provide the State with a vehicle to recommend or require specific training needed to address current circumstances, for example, the use

of Narcan to prevent overdoses.

- The Committee reviewed renewal processes in other states, some of which required the submission of CER verification documents. To reduce the burden on applicants and to align with current State practices, the Committee recommends requiring applicants to attest to completion of CERs and authorizing the certifying entity to request documentation as needed.

Recommendation 6: Conferences, webinars, workshops, seminars, trainings, presentations and self-studies should count toward continuing education hours and be tracked on a designated tracking sheet.

Key Considerations:

- The Committee recognized the breadth of learning opportunities available to CHWs that could fulfill continuing education requirements. The Committee sought to ensure that CHWs are recognized for the time they commit to these learning opportunities and was cautious to develop narrow CER specifications.
- The Committee considered requiring specific content areas from which CHWs should complete CERs. However, after assessing other state requirements, the Committee concluded that content-specific CERs are not typically required.
- A sample tracking sheet for documenting CERs is included in Appendix E.
- Organizations employing CHWs should consider supporting the completion of CERs through paid continuing education time.

Recommendation 7:

Applicants for CHW certification should commit to abide by a CHW Code of Ethics. The following infrastructure should be established to implement this recommendation:

- The Advisory Body should adopt the nationally-utilized Code of Ethics as previously adopted by the CHW Association.
- In response to an alleged Code of Ethics violation, DPH should follow its established investigation, adjudication, and disciplinary proceedings. The Advisory Body should be informed of such complaints and remediation efforts.

Key Considerations:

- The Committee discussed the Code of Ethics that was established by a national group 10 years ago and adopted by the CHW Association of CT. Several states (MA, RI, OR) adopted a similar Code of Ethics and require applicants for certification to agree to abide by this Code. Other states require applicants to agree to abide by a set of laws or a general code of ethics for all professions certified by the certifying entity.
- A number of state and private certification boards have established a process for investigating potential ethics violations and taking disciplinary action. DPH has an established process for investigating complaints and adjudicating them through hearing officers, who can take disciplinary action.
- The Committee discussed at length the various options for responding to alleged violations of the Code of Ethics.
    - Some Committee members felt that the Advisory Body should play a role in responding to and remediating allegations against CHWs as advocates. It was noted that, as members of vulnerable communities, CHWs need support in order to support their communities. It was recommended by some that the Advisory Body serve as the disciplinary body or assign advocates to navigate disciplinary processes established by the Certifying Entity.
    - Other Committee members felt that it was important to keep the Advisory Body separate from

Deleted: U

Deleted:

Deleted: Applicants should complete these hours outside of employment or volunteer positions.

Formatted: Font color: Blue

Formatted: Indent: Left: 0.25", Bulleted + Level: 1 + Aligned at: 0.57" + Indent at: 0.82"

Formatted: Font color: Blue

Deleted: <#>Either DPH as the Certifying Entity or its Advisory Board should establish a Code of Ethics¶

the disciplinary actions of the Certifying Entity. They felt that because there are already numerous systems in place to protect workers, the role of the Advisory Body should remain focused on the Certification Standards.

- The Committee came to a compromise, recommending that DPH, as the Certifying Entity, utilize its established disciplinary process to handle alleged violations of the Code of Ethics, and that the Advisory Body be informed of such allegations and remediation efforts.

F.1. Methods and Administration of Certification Program

This section discusses "methods for administering a certification program, including a certification application, a standardized assessment of experience, knowledge and skills, and an electronic registry." Design Group 2 was responsible for developing these recommendations.

Key Decision Points

The Design Group developed recommendations to address the following components of administering a CHW Certification Program:

1. Certifying Entity and Certification Board (Advisory Body) Structure, Roles, and Responsibilities
2. Application Process
3. Eligibility for Certification
4. Registry Requirements
5. Fiscal Implications of a Certification Program

Guiding Principles

To guide the development of recommendations, the Design Group considered the following principles:

1. Recommendations should consider successful processes in other states, especially Massachusetts, Florida, Texas, and Rhode Island.
2. Recommendations should build on the CHW Advisory Committee's prior decisions
3. Recommendations should be:
    a. Truly supportive of Community Health Workers
    b. Realistic to implement

Recommendations and Considerations

Recommendation 8:

The Department of Public Health (DPH) should serve as the CHW Certifying Entity. The Department of Public Health should be responsible for the administrative tasks related to certification including reviewing applications, verifying that requirements have been met, issuing certificates, and maintaining a CHW registry like those maintained for other professionals that are searchable by name and region. Outside

Recommendation 8a.

To the extent possible, the Committee recommends that the certification and recertification fees be as nominal as possible in order to reduce barriers for the CHW workforce. Additionally, if there are opportunities to waive fees due to financial burden, the Committee recommends doing so. To help offset these costs, outside funding should be allowed to support the start-up costs for CHW Certification.

Key Considerations:

- The Committee considered three possible certifying entities: the Department of Public Health (DPH), the CHW Association of CT, and a third party certification organization. Based on the assessment of the four key states, the Committee concluded the following:
    - The certifying entity would need credibility, capacity, and infrastructure
    - Strong support from State leaders would help establish the State as the certifying entity
    - Funds would likely be needed to help subsidize the cost of certification, regardless of the certifying entity
    - Funding to support certification could come from multiple sources
- The Committee assessed the overall cost, timeline for approval, timeline for implementation, infrastructure

Deleted: the

Formatted: Font: Bold

Formatted: Indent: Left: 0.06", Hanging: 0.06"

Formatted: Font color: Blue

Formatted: Indent: Left: 0.06"

Formatted: Indent: Left: 0"

for implementation, equity with other healthcare providers, and flexibility to change certification requirements if needed across the three certifying entity options. **Table 6** below outlines the various considerations. **Table 7** below outlines the pros and cons of each option, as identified by the Committee.

- The Committee ultimately recommended DPH based on the following:
  - Infrastructure: DPH has the needed infrastructure to serve in this capacity, as it already provides certification for 65 other health care providers
  - Sustainability: DPH represents a more sustainable option for certification once it is named as such in statute. A third party would rely on raising funds on an annual basis, which may negatively impact the longevity of a CHW Certification program.
  - Cost: Certification fees will be more easily controlled through DPH than through a third party.
  - Length of Implementation: Although the process for establishing certification through DPH may take longer, it is important to consider the long-term sustainability of the program.

Formatted: Body Text, Right: 0.36", Space Before: 0.25 pt, Line spacing: Multiple 0.98 li, Bulleted + Level: 2 + Aligned at: 0.58" + Indent at: 0.83", Tab stops: 0.83", Left

Deleted: s¶
¶

Table 6. Implications of CHW Certifying Entity Options

	Department of Public Health	CHW Association	Third Party
Overall Cost	~$25,000 annually for staff salary	Likely substantial upfront investment	~10,000 first year, $7,500 annually
Timeline for Approval	Earliest: June 2019	Could be 2018	2018
Timeline for Implementation	Earliest: January 1, 2020	At least mid 2019	Could be late 2018 or early 2019
Infrastructure for Implementation	Existing	None	Existing
Equity w/ Other HC Providers	65+ Providers	None	~10 Providers
Flexibility to change Requirements	Low	High	Medium

Table 7. Pros and Cons of CHW Certifying Entity Options

	Department of Public Health	CHW Association	Third Party
Pros	• Same certifying entity as most health care providers (~65) • Infrastructure already established	• No legislation needed • CHW Association would have the authority to adjust requirements without legislation	• May have existing infrastructure- faster implementation • May be more cost effective
Cons	• Fees • Difficult to change requirements once set • Requires legislation- may take longer to implement	• No existing infrastructure- may take longer to establish • Costs could be high to develop infrastructure- Fees would likely be needed • Not the same certifying entity as most other providers • May be challenging for the Association to manage (legal issues, etc.)	• Usually computer-based assessment • Fees • Not the same certifying entity as most other providers • Would require some regular funding from State or other source

Recommendation 9:

A separate Advisory Body should be established to inform the full development of Certification Standards. The Advisory Body should have a more prominent role in the initial development of the Certification Program, and should meet less often thereafter to assess the need to adjust the Certification Standards and to weigh in on critical questions as identified by the Certifying Entity.

The **four key objectives** of the Advisory Body should be to:

- Review certification criteria, processes and policies developed by the Certifying Entity
- Respond to questions from the Certifying Entity on individual certification requests, as needed via a standard process for assessing and responding to such questions
- Issue annual recommendations for needed adjustments to the certification criteria based on national trends
- Review and approve CHW training vendors

Key Considerations:

- The Committee was tasked with recommending a Certification Board structure, however, the term "Certification Board" has different meanings in different states. The Committee instead developed recommendations for an "Advisory Body" to provide guidance to the Certifying Entity on certification requirements. To do so, the Committee considered the following questions:
  - What are the benefits/challenges of establishing an Advisory Body that exists separately from the Certifying Entity?
  - If Connecticut were to establish an Advisory Body, what would be the preferred model and roles? (Application review vs. general Advisory Capacity)
  - Based on responses to the above, who would need to be included in the Advisory Body?
- In identifying the primary objectives of the Advisory Body, the Committee considered including an objective focused on sustainable payment for CHWs. It was concluded, however, that a narrower focus on certification requirements and criteria would be most appropriate.
- The Advisory Body would be responsible for determining how best to verify the quality of training programs. This may include, for example, randomly selecting an approved training vendor for curriculum review.

Recommendation 10:

The Advisory Body should include: 6 CHWS; 1 CHW Association of CT representative; 1 Community-Based CHW training organization representative; 1 Community College representative; 1 Community-Based CHW employer; 1 Healthcare organization CHW employer; and 1 Health Care Provider with direct CHW experience.

Recommendation 10a. The Advisory Body representatives should be selected through a neutral appointment process, such as the process used to select SIM advisory committee members.

The CHW Association of CT should serve as the administrative lead for the Advisory Body, including such activities as scheduling meetings and coordinating recommendations.*

**The Office of Health Strategy may consider providing support to the CHW Association of CT to serve in this capacity.*

Recommendation 10b. The Advisory Body should include non-voting members in the Advisory Body process for special engagements, including DSS, DMHAS, and commercial payers.

Formatted: Line spacing: single

Deleted: three

Formatted: Indent: Left: 0.32"

Formatted: Indent: Left: 0.32", Line spacing: single

Formatted: Font color: Auto, Not Expanded by / Condensed by

Formatted: Bulleted + Level: 1 + Aligned at: 0.32" + Indent at: 0.57"

Formatted: Bulleted + Level: 2 + Aligned at: 0.82" + Indent at: 1.07"

Formatted: Bulleted + Level: 1 + Aligned at: 0.32" + Indent at: 0.57"

Formatted: Not Expanded by / Condensed by

Formatted: Not Expanded by / Condensed by

Deleted: <#>¶

Formatted: Indent: Left: 0.32"

Deleted: ; and 1 Health Educator.

Recommendation 10c. To promote a fair process, the Community-Based CHW training organization and Community College representatives should not participate in the assessment of training programs.

Key Considerations:

- The following conclusions were made by the Committee in determining the composition of the Advisory Body:
    - Half of the Advisory Body should be represented by CHWs, including a representative of the Association
    - CHW training entities- both community college and community-based- should be represented
    - State agencies should not be represented as voting members there is no precedent on similar advisory groups for other health care professions.
    - Commercial and public payers need not be represented since there are no objectives related to payment.
- The Committee determined that the CHW Association of Connecticut has an important role to play in the promotion of CHWs in the State, and therefore should have a leadership role in Certification. As Administrative Lead, the Association will have a prominent role on the Advisory Body, and may be able to build on the momentum of certification to expand its CHW promotion efforts.
- The Committee raised concerns about the CHW Association of Connecticut's available resources to serve as Administrative Lead to the Advisory Body. For this reason, the Committee recommends that the Office of Health Strategy or other State Agencies/Private Funders with special interest in CHWs consider supporting the Association for this purpose.
- The Committee recommended a transparent selection process for selecting Advisory Body members in order to help ensure CHWs are selected from different geographies around the state.
- The Committee recommends the CHW Association serve as the lead administrative role in addition to having a seat on the Advisory Body in order to ensure that CHWs have a strong voice and leadership role in the complete development of the Certification Program. Further, the Committee recognizes the critical importance of a strong CHW Association in Connecticut to promote and support the CHW workforce. The Committee believes this leadership role will provide the Association a needed platform from which to continue their work.
- The authority of the Advisory Body should be established through legislation.

Recommendation 11:

The application and renewal process for Certification should not create unnecessary barriers. Unless otherwise required by Agency policy, DPH should accept copies of application materials and should not require notarization. To the extent possible applications should be accepted via email, online, or regular mail.

Key Considerations:

- The Committee reviewed application processes in other states, some of which required notarization of documents, primary source verification, and other processes that could prove burdensome to a potential applicant. To the extent possible, the Committee felt that the application process should aim to reduce barriers for CHW applicants.

Formatted: Font: Bold, Font color: Blue

Formatted: Font color: Blue

Formatted: Bulleted + Level: 1 + Aligned at: 0.32" + Indent at: 0.57"

Formatted: Bulleted + Level: 2 + Aligned at: 0.82" + Indent at: 1.07"

Formatted: Bulleted + Level: 1 + Aligned at: 0.32" + Indent at: 0.57"

Formatted: Not Expanded by / Condensed by

Formatted: Bulleted + Level: 1 + Aligned at: 0.32" + Indent at: 0.57"

Formatted: Not Expanded by / Condensed by

Deleted: ¶

Formatted: Body Text, Indent: Left: 0.32", Right: 0.25", Space Before: 2.05 pt, Line spacing: Multiple 1 li, Tab stops: 0.57", Left

F.2. Training Standards and Curricula

This section discusses "requirements for recognizing training program curricula that are sufficient to satisfy the requirements of certification." Design Group 3 was responsible for developing these recommendations.

Key Decision Points

The Design Group developed recommendations to address the following components of a Training Curricula in the following 9 areas:

Deleted: the

1) Content – Identify Core Competencies
2) Number of Training Hours
3) Internship
4) Training Modality/Methodology and Delivery
5) Type of Assessment
6) Instructor Qualifications
7) Vendor Criteria
8) Continuing Education

Guiding Principles

To guide the development of recommendations, the Design Group considered the following:

1. Training recommendations should consider the recommendations and processes in other states, especially Arizona, California, Massachusetts, Michigan, Minnesota, New Mexico, Florida, Oregon, Texas, Indiana, and Rhode Island.
2. Training recommendations should take into consideration the current state of CHW training in CT.
3. Recommendations should build on the CHW Advisory Committee's prior decisions.
4. Training recommendations should be:
    a. Truly supportive of Community Health Workers
    b. Realistic to implement
    c. Inclusive of the needs of community-based CHWs and CHW employers
    d. Should be meaningful to CHWs
    e. Should be provided in a way that best supports learning CHW roles and skills
    f. Requirements should not conflict with requirements of colleges and other entities that provide this training

Recommendations and Considerations

Recommendation 12: The content of training CHWs should consist of the core skills and services utilizing the Community Health Worker Consensus Project (C3) Core Competencies.

Key Considerations:

- The Committee accepted a modified version of the C3 Core Competencies (See Appendix B), which were previously discussed and accepted as the key CHW roles and skills by the CHW Advisory Committee in the 2017 Report (pg. 12, para. 1-2, Table 1). The C3 Core Competencies were developed as part of the CHW Core Consensus Project which, in 2014, brought together national experts to establish core elements of CHW Scope of Practice and Competencies.

Recommendation 13: Training programs should include 90 hours of training and an internship with a minimum of 50 hours.

Key Considerations:

- The Committee assessed the number of training hours required in other states, as outlined in **Table 8. Training Hours Required by State.** Other states' number of training hours ranged from 30 hours to 160 hours. The Committee also discussed current training programs in Connecticut, including those offered through Community Colleges and Community Based Organizations. Based on this review, the Committee narrowed the number of training hours down to 80 or 90 hours, but finally decided on 90 hours because of the opportunity for the training program to apply for collegiate credits if they wished to do so.

Table 8. Training Hours Required by State

State	Number of Training Hours	Number of Core Competencies
Florida	30	5+ elective
Massachusetts	80 *(48-hr training to be phased out)	10
Rhode Island	70	9
Texas	160	8

- The Committee discussed what an internship is and whether or not it should be a part of CHW training programs. The Committee gathered input from national CHW expert Carl Rush who highly recommended that an internship be included and advised that most are 40-80 hours in length.
- The Committee reviewed internship requirements in other states, outlined in **Table 9. Internship Requirements by State**, and concluded that a 50-hour (minimum) internship would be sufficient practical experience as part of the overall training. The Committee did not want an internship that was too onerous that it would deter CHWs.
- Internships, paid or unpaid, from both non-credit and credit bearing training programs were reviewed. The Committee discussed an internship description from City College of San Francisco and felt this was the most appropriate description for Connecticut with some modifications. The Internship Description decided upon is as follows: *An internship should be an opportunity for the CHW to observe and practice core CHW skills and services in the field, and to receive additional training, supervision and feedback from professionals working in the public health, health care, non-profit and community settings.*

Table 9. Internship Requirements by State

State	Internship Hours	Training Provider(s)	Credits
Florida	N/A	-	-
Massachusetts	125	Holyoke Community College	Certificate Program, 26 credits
Rhode Island	Not required, but offer some trainings	-	-
Texas	80-160	Variety of organizations provide training	-
Minnesota	72-80, 80-90	Minnesota West Community & Technical College, Normandale Community College	17 credits, 16 credits

California	128	City College of San Francisco	Certificate Program, 20 Units of Study

Deleted: ¶

- There was discussion about the training time being 90 hours, and the internship time being 50 hours, as being burdensome for some CHWs. In the 2017 report (pg. 13, para. 5 and pg. 14, para. 1), the CHW Advisory Committee collected and reviewed the potential benefits of certification for CHWs in CT and decided that it was necessary for recognition of the profession and for sustainable payment.

Recommendation 14: Training modality and methodology should follow Adult Learning Principles, include role-playing, and be interactive.

Key Considerations:

- The Committee discussed different types of training modalities and methodologies. They took into consideration guidance from national CHW expert Carl Rush that CHW education be based on adult learning principles.
- The Committee felt it was critical that training programs be participatory in nature, focus on empowerment, popular education, and IBEST (integrated basic education skills training). They further recommended against lecture and quiz formats.

Recommendation 15: Training should be delivered in-person or utilize a hybrid approach that includes in-person sessions and distance learning in "real-time." Online training alone, should not be considered sufficient to meet the requirements of certification. At least 40% of the hours of instruction should be taught or co-taught by faculty who are Community Health Workers.

Key Considerations:

- With so many options for online education and training now available, the Committee discussed whether online training modalities would be sufficient for CHW training programs. They considered online, in-person, and hybrid training programs. The Committee took into consideration guidance from national CHW expert Carl Rush who indicated that in-person training for CHWs is always best, independent online learning is not recommended, and hybrid and interactive TV modes can work well, especially to meet the needs of smaller states and rural areas.
- The Committee favored in-person training programs that offer interactive, person-centered activities like role-play and role modeling. However, they determined that hybrid models offer opportunities for potential CHWs who may not be able to commit to a fulltime in person curriculum. Such options may be especially important in rural areas. Furthermore, online education has transformed in recent years to provide more "real-time" interactive components that could be beneficial to potential CHWs.
- The Committee reviewed the requirement from Massachusetts requiring that at least 40% of the hours of instruction shall be taught or co-taught by faculty who are CHWs or Community Health Worker Trainers. They chose to adapt this requirement by removing "or Community Health Worker Trainers."

Recommendation 16: Instructors for CHW training should be inclusive of CHWs with experience in the field, as well as non-CHWs who meet the requirements of the training vendor. Instructors should demonstrate past experience training individuals who provide community health work services, including, but not limited to: Promotores, CHWs, or other health care professionals and paraprofessionals in the previous six years. They should have the knowledge, skills and competence to effectively teach a CHW Core Competency curriculum.

Formatted: Font: Bold, Font color: Blue

Formatted: Font color: Blue

Formatted: Font color: Blue

- Instructors who are not CHWs should provide a resume to demonstrate their experience training in the past six years. Other requirements may additionally be defined by the training vendor (i.e. educational background).
- Instructors who are CHWs should have at least three years of experience working full-time as a CHW, proof of completion of a CHW Core Competency Training, and knowledge of the community and community resources.

Key Considerations:

- Instructor qualifications varied from state to state. The Committee looked at instructor qualifications in-depth for Massachusetts, Michigan, and Texas. Michigan's CHW Training and Instructor training is done by MiCHWA, which is a stakeholder coalition that serves as the hub for CHW information for the state. Since CT does not use this model, the committee decided to focus on Texas and Massachusetts.
- Texas requires that instructors be certified by the Department of State Health Services in one of two ways. An instructor must be a Texas resident who is at least 18 years old and demonstrate either:
  - Completion of an approved 160-hour competency-based Community Health Worker Instructor training or
  - At least 1000 cumulative hours of experience training individuals who provide community health work services including promotores, community health workers, and other health care paraprofessionals and professionals in the previous six (6) years.
- Massachusetts instructor qualifications require that curriculum be delivered by faculty who possess the knowledge, skills and competence to effectively teach a curriculum which covers the 10 core competencies, and at least 40% of the hours of instruction shall be taught or co-taught by faculty who are Community Health Workers or Community Health Worker Trainers.

Recommendation 17: Assessments of successful training completion should utilize (1) pre- and post-tests, (2) skills assessment, and (3) include a capstone project or portfolio, or a combination of the two.

Key Considerations:

- In its 2017 Report (pg. 13, para. 2) the Advisory Committee recommended that an assessment of skills should be required as part of the overall assessment for CHW Certification. For experienced CHWs, an assessment of skills should be completed through the submission of portfolio requirements (Appendix A). For new CHWs, the Committee determined that an assessment should be conducted following completion of a training program.
- The Committee agreed that a single written test is insufficient to assess CHWs' skills.
- The Committee reviewed different types of assessments and reviewed how CHW training programs in Connecticut are currently assessing CHWs in their training programs. The Committee agreed pre- and post-tests were effective and that there should some assessment of skills, but did not define a specific type of assessment method, feeling that each training program provides ongoing assessments throughout the training.

Recommendation 18: The CHW Certification Advisory Body should review and approve CHW training vendors.

Key Considerations:

- The Committee determined that programs should be required to obtain approval to provide CHW training that is recognized for CHW certification. A Draft Training Vendor Application is included in Appendix F.
- The Committee assessed who reviews and approves training vendors in other states and found that the Advisory Body often serves that role (See **Table 10**).

Formatted: Font color: Blue

Formatted: Font color: Blue

Formatted: Font color: Blue

Formatted: Font color: Blue

Formatted: Font color: Blue

Formatted: Font color: Blue

Formatted: Font color: Blue

Deleted: **Recommendation 16:** CHW training instructors, both Non-CHW and CHW, should have at least 1,000 hours of experience training individuals who provide community health work services including promotores, CHWs, and other health care paraprofessionals and professionals in the previous six years. They should have the knowledge, skills and competence to effectively teach a curriculum. In addition, CHW Instructors should have:¶
3-5 years of experience working fulltime as a CHW¶
Proof of completion of a CHW Core Competency Training¶
Knowledge of the community and community resources, and preferably reside in the community¶

- Training vendors should not be limited to any particular type of organization, but should identify themselves, have a plan to screen and recruit participants, state the cost of training, and specify training frequency.
- The Committee recognizes that current training providers in CT are Community Colleges and community based agencies.

Table 10. Training Vendor Details by State

State	Organizations Providing Training	Entity Approving Training Programs/Curriculum	Advisory Body
Florida		FL Certification Board	FL CHW Coalition
Texas	AHECs, Health Centers, Community Colleges, DSHS, Training Centers	DSHS	State Advisory Body
Michigan	MiCHWA, other community agencies	Using MiCHWA approved training curriculum, MiCHWA trains CHWs and the trainers	NA
Rhode Island	DOH, Community Colleges, other community agencies	Rhode Island Certification Board follows CHW Subject Matter Experts recommendations	CHW Subject Matter Experts
Arizona	Community Colleges	AZCHWA and CHW Workforce Coalition	NA
Indiana	HealthVisions Midwest, other training vendors to be approved	INCHWA	NA
Massachusetts	Community Health Education Center (CHEC), Center Health Impact, Community Colleges, UMass School of Public Health, DPH	Board of Certification of CHWs (under MA Dept of Public Health)	NA

G. Fiscal Implications of a CHW Certification Program

In addition to developing recommendations for the development of a CHW Certification Program, the CHW Advisory Committee was tasked with assessing the fiscal implications of implementing such a program. To conduct this assessment, the Committee considered the following:

1. Projected upfront and ongoing direct costs associated with establishing a Certification Program in Connecticut, based on experience with other health professional Certification Programs
2. A comparison of financial support provided for CHW Certification Programs in other states, including sources and types of funding
3. Projected costs associated with establishing a Certification Program in Connecticut, based on cost and demand for CHW Certification in other states
4. Potential economic value of CHW Certification

G.1 Projected Costs Based on Connecticut Health Professional Certification Programs

The Committee began its analyses by assessing the likely certification cost for each of the three potential certifying entities considered throughout this process, including both the cost to the state and the cost to the individual applicant. As previously described in this Report, the Committee concluded that the Department of Public Health would be the most reliable option in terms of funding. **Table 11** summarizes the Committee's analysis.

Table 11. Projected Costs of CHW Certification in Connecticut Based on other Health Care Professionals

	Department of Public Health	CHW Association	Third Party
Projected Cost to the State	~$25,000 annually for half time staff member within DPH	Substantial upfront investments to develop entire infrastructure- likely higher than other options	~$10,000 first year, $7,500 annually
Estimated Applicant Fees	~$100	As determined by the Association to cover setup costs	~$100-$200
Committee Perspective on Cost	Most reliable source of funding once established in statute	Costs are largely unknown due to lack of existing infrastructure	Relies on unreliable sources of funding (fundraising, etc.)

Deleted: *<object>*

Deleted:

	Department of Public H
Projected Cost to the State	~$25,000 annually for h staff member within DP
Applicant Fees	~$100
Committee Perspective on Cost	Most reliable source of once established in stat

G.2 State Comparison: Financial Support for CHW Certification Programs

The Committee then assessed the sources and types of funding provided in support of CHW Certification Programs in other states, initially focusing on Massachusetts, Texas, Florida, and Rhode Island. Each state adopted a unique approach to funding CHW Certification. **Table 12** summarizes the type of organization selected as the certifying entity and the initial Certification Applicant fee.

Table 12. State Comparison: CHW Certification Program Application Fees and Certifying Entity Type

	Massachusetts	Texas	Florida	Rhode Island
Initial Applicant Fees	$35	No Fee	$50	$125
Certifying Entity	State Health Dept.	State Health Dept.	Third Party	Third Party

The Committee consulted with each of the states identified in **Table 12** to gain a better understanding of the types of support allocated to the CHW Certification Programs. The Committee identified the following critical points:

- **Rhode Island**
  - The RI Department of Health paid the application fee for the first 100 applicants. They also provided a scholarship for those in need.
  - The Department of Labor and Training subsidized the application fee through a grant as an investment in workforce development.
- **Florida**
  - No state funding was directly allocated to the CHW Certification Program.
  - Certification and recertification fees and Training provider fees ($200/year) support the Program.
  - In the first year, 660 CHWs were certified, mainly through the grandfathering process. It is becoming difficult for CHWs to afford recertification ($100 every two years) which has resulted in a decreased number of certified CHWs in the state. Some Managed Care Organizations subsidize the fees, but the Department of Health does not.
- **Massachusetts**
  - The Office of CHWs includes two full-time staff funded through CDC chronic disease funding.
  - The Office of CHW staff, the Certification Board Chair, and the staff from the Bureau of Health Professions Licensure spend the equivalent of at least one full-time position on certification implementation.
- **Texas**
  - One-two full time staff are assigned to oversee the program.
  - Approximately 600 CHWs were certified during the first year.
  - All costs are subsidized by the State.

Based on the above considerations, the Committee determined the following key points which contributed to the Certifying Entity recommendation, but are also important considerations for the implementation of a CHW Certification Program:

- The certifying entity would need credibility, capacity, and infrastructure
- Strong support from State leaders would help establish the State as the certifying entity
- Funds would likely be needed to help subsidize the cost of certification, regardless of the certifying entity
- Funding to support certification could come from multiple sources

G.3 Projected Costs Based on Other State Experience

To further understand the potential cost implications of a CHW Certification Program in Connecticut, the Committee requested data on the number of CHWs certified and the associated fee collection in other states. **Table 13** summarizes the findings, which include the total number of certified CHWs, Certification fees, total amount collected through fees, and the state population. Using this data, Table 12 also projects the number of CHWs likely to be certified in Connecticut and the associated fees that could be collected. These projections can be

used to further clarify the needed State investment in the Certification Program, and how the collection of fees could offset some of the cost.

Table 13. Projected Cost Implications for CHW Certification in Connecticut

Example state	Total number certified	Certification Fee	Est. total collected for initial certifications	State pop. (millions)	Equivalent number certified for CT pop. size	Equivalent collections for CT population size
CT				3.59		
MA	-	$35	-	6.86	-	$0
FL	588	$115	$67,620	20.98	101	$11,564
TX	4500	$0	$0	28.30	571	$0
NM	206	$45	$9,270	2.09	354	$15,929
RI	217	$125	$27,125	1.06	735	$91,816
Average across states	1,378	$64	$26,004	10.48	440	$29,827

G.4 Potential Economic Value of CHW Certification

Community Health Workers have a unique role to play in the healthcare system, and CHW initiatives have consistently demonstrated improved health outcomes and reduced costs. However, the CHW workforce is not sustainably funded, and CHWs are currently paid low salaries relative to their value within the healthcare system. Certification may provide an economic benefit to the CHW workforce, as research has demonstrated increased wages associated with professional certification. The U.S. Department of Labor, Bureau of Labor Statistics currently estimates CHW wages in Connecticut as summarized in **Table 14**, with a median hourly wage of $20.94 and annual mean wage as $47,100. Without a professional certification, Community Health Workers are hired under many titles which are often paid much lower salaries.

Table 14. State Occupational Employment and Wage Estimates in Connecticut

Occupation code	Occupation title	Employment	Employment RSE	Median hourly wage	Mean hourly wage	Annual mean wage	Mean wage RSE
21-1094	Community Health Workers	470	25.5%	$20.94	$22.64	$47,100	3.2%

(RSE = Relative Standard Error)

Source: https://www.bls.gov/oes/current/oes_ct.htm. Accessed 7/18/18

In 2015, the CDC released a Technical Assistance Guide entitled "States Implementing Community Health Worker Strategies."[1] In discussing the potential benefits of CHW Certification, the Guide indicates that Certification can

[1]Centers for Disease Control and Prevention (2015) States Implementing Community Health Worker Strategies. https://www.cdc.gov/dhdsp/programs/spha/docs/1305_ta_guide_chws.pdf

improve CHWs' income, stating, "A national survey of CHW training and certification programs found…that training and certification improve CHWs' income and retention levels while also facilitating Medicaid reimbursement for their services."[2] Overall, occupational licensing, defined as a mandatory regulation required to practice an occupation, was statistically significant and associated with an 18% increase in wages while certification, the analogous voluntary form of labor regulation, was found to have a smaller positive impact (8%) on increased wages."[3] Another study demonstrated a 5-8% increase in wages for licensed workers, with an even higher impact in bridging the wage gap for women (6-11% increase) and Hispanic workers (11% increase). Licensed workers have also been found to have lower unemployment and a longer work tenure[4]. The positive effects of licensure on wages and employment has been found more prevalent in health care professions.[5] The Obama White House Report on licensing found that "Licensing may also help practitioners to professionalize, encouraging individuals to invest in occupational skills and creating career paths for licensed workers. For example, accountants in States requiring more experience (three or more years) are 26 to 36 percent more likely to have acquired training since starting their current job."[6]

Deleted: ¶
¶
¶

Formatted: Font: (Default) +Body (Calibri)

Deleted: ¶

[2] Kash, B. A., May, M. L., & Tai-Seale, M. (2007). Community health worker training and certification programs in the United States: findings from a national survey. *Health Policy*, *80*(1), 32-42.

[3] Kleiner, Morris and Alan Krueger (2013) "Analyzing the Extent and Influence of Occupational Licensing on the Labor Market," Journal of Labor Economics, 31, 2, S173-S202.

[4] Nunn, Ryan (2018) "How Occupational Licensing Matters for Wages and Careers." *Brookings, The Hamilton Project.* https://www.brookings.edu/research/how-occupational-licensing-matters-for-wages-and-careers/

[5] Nunn, Ryan (2016). "Occupational Licensing and American Workers." *The Hamilton Project.* http://www.hamiltonproject.org/papers/occupational_licensing_and_the_american_worker.

[6] Department of the Treasury Office of Economic Policy, Council of Economic Advisers, Department of Labor (2015). "Occupational Licensing: A Framework for PolicyMakers." https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf

Formatted: Font: Italic

Formatted: Font: Not Italic

Formatted: Font: Italic

H. Next Steps

This Report is intended to support legislative or policy changes within the State that will allow for the development of a CHW Certification Program in Connecticut. It is the hope of the CHW Advisory Committee and its partners that upon release of this Report, action will be taken to implement CHW Certification.

The CHW Advisory Committee urges the Connecticut State Legislature to pass legislation establishing CHW Certification in Connecticut in accordance with the above recommendations. Certification is a preliminary step for Connecticut to achieve sustainable funding options for CHWs, increase the profession's visibility and recognition, and expand the utilization of CHWs across the state. As noted by experts speaking on the Association of State and Territorial Health Officials' CHW Call Series on Certification and Licensure, certification by itself does not ensure increased wages and recognition[7]. It is essential to continue advancing collective efforts to bolster the evidence-base of demonstrable CHW impact and highlighting the value CHWs bring to communities among stakeholders[8]. Overall, increasing utilization and funding for CHWs will improve health outcomes, reduce health inequities, and ultimately reduce healthcare costs in Connecticut.

[7] Association of State and Territorial Health Officials. (2016). CHW Call Series: Certification and Licensure [PowerPoint slides]. Retrieved from http://www.astho.org/Community-Health-Workers/

[8] Association of State and Territorial Health Officials. (2016). CHW Call Series: Certification and Licensure - Q&A Summary handout]. Association of State and Territorial Health Officials Arlington, VA. Retrieved from http://www.astho.org/Community-Health-Workers/Call-Series/Certification-and-Licensure-Q-and-A/

Appendix A. Rhode Island Portfolio Requirements

PORTFOLIO

A portfolio is a collection of personal and professional activities and achievements. This part of the requirement for the CCHW is highly personalized and no two applicants will submit the same documentation.

An applicant will fulfill this requirement by submitting documentation and requirements of at least three (3) of the seven (7) categories listed below. Applicants must choose three unique categories. Multiple submissions in one category will only count as fulfilling one (1) of the three (3) required. Supporting documentation can include reports, letters, PowerPoint presentations, transcripts, etc. The applicant should submit what they feel best supports and describes their experiences under their chosen categories. When selecting a category and submitting the documentation, the CHW should use the opportunity to highlight the value and commitment to not only the profession, but the community served.

1. Community Experience & Involvement: CHW's are usually involved in community activities. To fulfill this category, the applicant must submit three (3) letters from an organization(s) that the applicant has worked or volunteered with in one or more of the areas listed. The letters should clearly describe the applicant's impact as a CHW and the value added to the community served. When possible, letters should be on the organization's letterhead.
    a. Leadership experience
    b. Board participation
    c. Social support and advocacy
    d. Education
    e. Policy development and promotion
    f. Needs assessments

2. Research Activities: CHW's can be involved in a variety of research activities. To fulfill this category, the applicant must submit a summary of how they participated in the research activity and supporting documentation. Examples of research activities include:
    a. Data collection – qualitative and quantitative
    b. Focus groups – either facilitating or participating
    c. Panels – either facilitating or participating
    d. Surveys – developing, conducting and interpreting data
    e. Community mapping/Community resources – activities that center around finding resources for the population served
    f. Dissemination of research – publication and how it was disseminated is required

3. <u>College Level Courses/Advanced or Specialized Training:</u> Applicants that complete coursework relevant to the CHW domains, in addition to the 70 hours, must submit documentation and a summary of the coursework. Coursework in this category must be completed within the last 10 years prior to the date of application. Acceptable forms of coursework include:
    a. College course – a degree does not need to be completed for the course to count
    b. Advanced or specialized training - trainings can be in multiple topic areas, but must total at least 6 hours

4. Community Publications, Presentations & Projects: Applicants who have completed one or more of the following should submit documentation (i.e.: copy of completed brochure, event announcement, promotion materials) and a summary of their participation.

a. Newsletters to the community
b. Abstracts
c. Poster Presentations
d. Brochure development
e. Curriculum and training development
f. Facilitating trainings
g. Resource guide development
h. Community programming/workshops
i. Promotion: TV, radio, social media, website management, etc.
j. Community event organization and participation

5. Statement of Professional Experience: Respond to one of the following questions. Answers should be 500 – 1000 words (2-4 paragraphs).

a. Describe a success story you have had in your role as a CHW.
b. What resources (systems, agencies, etc.) have you helped people connect to?
c. Describe your areas of expertise related to community health.
d. Describe how you have applied training as a CHW to your professional life.
e. Briefly describe your strengths and opportunities for improvement in your professional life.
f. Describe your motivation to work in community health.

6. Achievements/Awards: Provide documentation and a summary of the award or achievement received – either locally or nationally. Examples that would fulfill this category include:

a. Recognition from agency, community, advocacy, professional association, etc.
b. Featured in or on TV, radio, print or social media for advancing community health

7. Performance Evaluation: Applicants can choose one or more of the areas listed below. Evaluations should highlight the applicant's abilities as a CHW, and must be completed within two years prior to the application date.

a. Copy of an agency or participant evaluation
b. Statement from supervisor or colleague evaluating the CHW's performance
c. Documentation of feedback received from the participant or community
d. Capacity building

Appendix B. Connecticut Modifications to C3 Roles and Skills

The C3 Roles and Skills were adapted as follows and recommended by the CHW Advisory Committee as part of the 2017 Committee Report, accepted by the Healthcare Innovation Steering Committee on February 8, 2018.

Table 1. Roles and Sub-Roles

	Role	Sub-Roles
1	**Cultural Mediation among Individuals, Communities, and Health and Social Service Systems**	a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate) b. Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication
2	**Providing Culturally Appropriate Health Education and Information**	a. Conducting health promotion and disease prevention education in a manner that matches linguistic, ~~and~~ cultural, and developmental needs of participants or community b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)
3	**Care Coordination, Case Management, and System Navigation**	a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping to address other barriers to services d. Documenting and tracking individual and population level data e. Informing people and systems about community assets and challenges f. Facilitating the participant-provider relationship and effective communication
4	**Providing Coaching and Social Support**	a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (including chronic disease) d. Planning and/or leading support groups
5	**Advocating for Individuals and Communities**	a. Advocating for the needs and perspectives of communities b. Connecting to resources and advocating for basic needs (e.g. food and housing) c. Conducting policy advocacy

Formatted: Font: 11 pt, Bold

6	**Building Individual and Community Capacity**	a. Building individual capacity b. Building community capacity c. Training and building individual capacity with CHW peers and among groups of CHWs
		d. Identifying gaps in available resources and recommending improvements
7	Providing Direct Service	a. Providing basic screening ~~tests~~ (e.g., heights & weights, blood pressure) b. Providing basic services (e.g., first aid, diabetic foot checks) c. Meeting basic needs (e.g., direct provision of food and other resources) d. Conducting psychosocial screening
8	**Implementing Individual and Community Assessments**	a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environmental assessment) b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)
9	**Conducting Outreach**	a. Case-finding/recruitment of individuals, families, and community groups to services and systems b. Follow-up on health and social service encounters with individuals, families, and community groups c. Home visiting to provide education, assessment, and social support d. Presenting at local agencies and community events
10	**Participating in Evaluation and Research**	a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community consent processes c. Participating in evaluation and research: i) Identification of priority issues and evaluation/research questions ii) Development of evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings

Table 2. Skills and Sub-Skills

	Skill	a. Sub-Skills
1	**Communication Skills**	b. Ability to use language confidently c. Ability to use language in ways that engage and motivate d. Ability to communicate using plain and clear language e. Ability to communicate with empathy f. Ability to listen actively g. Ability to prepare written communication including electronic communication (e.g., email, telecommunication device for the deaf) h. Ability to document work i. Ability to communicate with the community served (may not be fluent in language of all communities served) j. Ability to negotiate and advocate on behalf of participants a.
2	**Interpersonal and Relationship-Building Skills**	b. Ability to provide coaching and social support c. Ability to conduct self-management coaching d. Ability to use interviewing techniques (e.g. motivational interviewing) e. Ability to work as a team member f. Ability to manage conflict g. Ability to practice cultural humility
3	**Service Coordination and Navigation Skills**	a. Ability to coordinate care (including identifying and accessing ~~resources and overcoming barriers)~~ in a way that is personcentered b. Ability to identify and access resources and overcome barriers c. Ability to make appropriate referrals d. Ability to facilitate development of an individual and/or group action plan and goal attainment e. Ability to coordinate CHW activities with clinical and other community services f. Ability to follow-up and track care and referral outcomes
4	**Capacity Building Skills**	a. Ability to help others identify goals and develop to their fullest potential b. Ability to work in ways that increase individual and community empowerment c. Ability to network, build community connections, and build coalitions d. Ability to teach self-advocacy skills e. Ability to conduct community organizing
5	**Advocacy Skills**	a. Ability to contribute to policy development b. Ability to advocate for policy change c. Ability to speak up for individuals and communities

6	**Education and Facilitation Skills**	a. Ability to use empowering and learner-centered teaching strategies b. Ability to use a range of appropriate and effective educational techniques c. Ability to facilitate group discussions and decision-making d. Ability to plan and conduct classes and presentations for a variety of groups e. Ability to seek out appropriate information and respond to questions about pertinent topics f. Ability to find and share requested information g. Ability to collaborate with other educators h. Ability to collect and use information from and with community members
7	**Individual and Community Assessment Skills**	a. Ability to participate in individual assessment through observation and active inquiry b. Ability to participate in community assessment through observation and active inquiry
8	**Outreach Skills**	a. Ability to conduct case-finding, recruitment and follow-up b. Ability to prepare and disseminate materials c. Ability to build and maintain a current resources inventory
9	**Professional Skills and Conduct**	a. Ability to set goals and to develop and follow a work plan b. Ability to balance priorities and to manage time c. Ability to apply critical thinking techniques and problem solving d. Ability to use pertinent technology e. Ability to pursue continuing education and life-long learning opportunities f. Ability to maximize personal safety while working in community and/or clinical settings g. Ability to observe ethical and legal standards (e.g. CHW Code of Ethics, Americans with Disabilities Act [ADA], Health Insurance Portability and Accountability Act [HIPAA]) h. Ability to identify situations calling for mandatory reporting and ~~carry out mandatory reporting requirements~~ follow mandatory reporting protocols i. Ability to participate in professional development of peer CHWs and in networking among CHW groups j. Ability to set boundaries and practice self-care k. Ability to work in teams

10	**Evaluation and Research Skills**	a. Ability to identify important concerns and conduct evaluation and research to better understand root causes b. Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) c. Ability to participate in evaluation and research processes including: i) Identifying priority issues and evaluation/research questions ii) Developing evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings
11	**Knowledge Base**	a. Knowledge about social determinants of health and related disparities b. Knowledge about pertinent health issues c. Knowledge about healthy lifestyles and self-care d. Knowledge about mental/behavioral health issues and their connection to physical health e. Knowledge about health behavior theories f. Knowledge of basic public health principles g. Knowledge about the community served h. Knowledge about United States health and social service systems

Appendix C: Draft Supervisory Reference Form

DRAFT 6/29/18

[*Applicant Name*] has applied for Certification as a Community Health Worker in the State of Connecticut and has submitted your name as a supervisory reference. Please complete the following information.

Name: _____ Title: _____

Employer: _____
Address: _____
Email: _____ Phone: _____

A. How long have you known the applicant? Years:_____Months: _____

B. Community Health Worker Roles. Please check each role that the applicant performed satisfactorily while under your supervision. A list of tasks included in each role is attached to this form.

Satisfactory Performance of Community Health Worker Roles			
1. Cultural Mediation among Individuals, Communities & Health Social Service Systems		6. Building Individual and Community Capacity	
2. Providing Culturally Appropriate Health Education and Information		7. Providing Direct Service	
3. Care Coordination, Case Management, and System Navigation		8. Implementing Individual and Community Assessments	
4. Providing Coaching and Social Support		9. Conducting Outreach	
5. Advocating for Individuals and Communities		10. Participating in Evaluation and Research	

C. Please verify that the applicant completed [*number of hours listed by applicant on application form*] hours performing the roles checked above since [*date 3 or 5 years prior to application date*].
Yes, the applicant completed at least this number of hours ____
No, the applicant completed fewer hours

D. For how many years have you supervised individuals performing the roles checked above? _____

E. Community Health Worker Skills. Please check each skill in which the applicant demonstrated proficiency while under your supervision. Proficiency is defined as having the subskills listed with each skill on the list attached to this form.

Proficiency in Community Health Worker Skills			
1. Communication Skills		6. Education and Facilitation Skills	
2. Interpersonal and Relationship-building Skills		7. Individual and Community Assessment Skills	
3. Service Coordination and Navigation Skills		8. Outreach Skills	
4. Capacity Building Skills		9. Professional Skills and Conduct	
5. Advocacy Skills		10. Evaluation and Research Skills	

F. I certify that the information I provided on this form is true to the best of my knowledge. I further certify that I am not related to the applicant, I do not share the same household as the applicant, and I am not and never have been in a romantic, domestic or familial relationship with the applicant.

_____ _____
Signature Date

Appendix D. Draft Community Reference Form

DRAFT 6/29/18

[Applicant name] has applied for Certification as a Community Health Worker in the State of Connecticut and has submitted your name as a community reference. Please complete the following information.

Name: _____ Title (if any): _____

Address: _____

Email: _____ Phone: _____

G. How long have you known the applicant? Years:_____Months: _____

H. Please describe the nature of your relationship with the applicant, including how you are qualified to provide the applicant with a character/personal reference for Certification as a Community Health Worker.

I. Describe why you believe the applicant would be successful as a Certified Community Health Worker. How has the applicant demonstrated an in-depth understanding of the experience, language, culture and socioeconomic needs of the community?

J. I certify that the information I provided on this form is true to the best of my knowledge. I further certify that I am not in the immediate family of the applicant, I do not share the same household as the applicant, and I am not and never have been in a romantic or domestic relationship with the applicant.

_____ _____

Signature Date

Appendix E. Indiana Continuing Education Unit Tracker

CONTINUING EDUCATION (CEU) RECORD

Training Date	Provider/ Agency	Instructor/ Presenter	Training Title	Training Topic(s)	CEU Hours

Total: _____ Please complete and submit this form to MHANI by May 31st, 2018, with the CRS Renewal Application.

Appendix F. Draft Training Vendor Application

Training vendors should provide the following information, and in some cases meet specific criteria on the following:

Organization Information	General information (name, address, contact, etc.)	
Organization Type	☐ *College/University* ☐ *Community College* ☐ *Community-Based Organization (CBO)* ☐ *Clinic/Hospital* ☐ *Faith-based Organization*	☐ *Local Health Department* ☐ *Non-Profit Organization* ☐ *State Agency* ☐ *Other (please specify)*
Accreditation	*Are you accredited by The Council for Higher Education Accreditation or similar accreditation body? If so, please provider this information.* **Note: This is not required.*	
Recruitment & Screening	*Please describe how you plan to recruit and screen participants for training.*	
Frequency	*Please state how many trainings you anticipate to provide per year.* **Note: It is recommended that you at least host one training per year.*	
Cost	*How much will you charge participants for this training?*	
Training Method(s)	*Please describe what training methods you plan to use?* **Note: Training methods should at least be based on Adult Learning Principles, and should include role-play and be interactive.*	
Training Delivery	*Please describe how you plan to deliver this training.* **Note: This training should be conducted in-person or as a hybrid training to include in-person sessions with distance learning in "real-time". Online training will not be allowed.* **Note: At least 40% of the hours of instruction should be taught or co-taught by faculty who are Community Health Workers.*	
Instructors	*CHW Instructor:* ☐ *3-5 years experience working as a CHW (fulltime)* ☐ *Proof of completion of a CHW Core Competency Training* ☐ *Preferred resident with knowledge of the community and community resources* ☐ *Has the knowledge, skills and competence to effectively teach a curriculum* *Non-CHW Instructor: Has the knowledge, skills and competence to effectively teach a curriculum* **Note: The CHW instructor and/or the non-CHW instructor should have at least 1000 hours of experience training individuals who provide community health work services including promotores, community health workers, and other health care paraprofessionals and professional in the previous six years.*	
Hours of Training	*How many hours of training will be provided?* **Note: This training should be a minimum of 90 hours.*	

Core Competencies	*Explain how you plan to train CHWs on each of the Core Competencies.* *Link: C3 Core Competencies recommended by SIM CHW Advisory Committee* **Note: This training should cover all of the accepted C3 Core Competencies previously decided on by the SIM CHW Advisory Committee.*
Internship	*Please describe the CHW internship experience and how many hours the internship will be.* **Note: This internship is required as part of the training and should be a minimum of 50 hours.* **Note: This should be an opportunity for the CHW to observe and practice core CHW skills and services in the field, and to receive additional training, supervision and feedback from professionals working in the public health, health care, non-profit and community setting.*
Evaluation	*Please describe how you plan to evaluate participants.* **Note: This should NOT just be a test. Should utilize pre and post tests, utilize a skills assessment, and include either a Capstone Project or Portfolio (or a combination of both).*

Appendix G. Additional Resources

2017 Report of the CHW Advisory Committee

CHW Advisory Committee Meeting Materials, Summaries and Presentations

Design Group Meeting Materials, Summaries and Presentations

Community and Clinical Integration Program Core Standards

C3 Project Report

CHW Certification by State (CT Health Foundation 2016)

CHW Policy Brief (CT Health Foundation, 2015)

CHWs in Connecticut -Survey (Southwestern AHEC)

CHWs in Connecticut - White Paper (Heinrich Consulting for Southwestern AHEC)

Business Case for CHWs in Connecticut (2014)