Promoting Policy and Systems Change to Expand Employment of Community Workers (CHWs)

Session 4: Occupational Regulation: Research and Evaluation

Session Overview

The objectives for this session include:

- Identify the motivation behind the drive for credentialing CHWs
- Recall oppositions to the credentialing argument
- Describe certification programs currently in place for CHWs across the United States
- Identify the impact of credentialing CHWs

Audio Transcript

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Public Policy Arenas 2 and 3

Arenas of public policy affecting CHWs include:

- Workforce development
- Occupational regulation
- Standards for research and evaluation
- Sustainable funding for CHW positions

Audio Transcript

Welcome to Session 4. We will be looking at the second and third public policy arenas: occupational regulation and standards for research and evaluation of CHW programs and services.

Any conversation about recognizing the CHW as a regular occupation is likely to turn eventually to setting occupational standards. We begin this session by looking at key issues within this policy arena:

- What influences are behind the drive for credentialing?
- What influences oppose credentialing?
- Where is credentialing in place? Where is it being considered?
- What are the mechanics of credentialing for CHWs?
- What are some features of systems currently in place?

- What is the impact of credentialing?

What Is Behind the Drive for Credentialing?

So what is behind the drive for credentialing?

- Need to be recognized as providers for funding sources such as Medicaid
- Desire for credibility and respect from other professions
- Defense against community members who challenge CHW qualifications
- Need for baseline, transferable qualifications to create functioning job market
- Concerns over quality of care and liability

Audio Transcript

For CHWs to be recognized as reimbursable providers under Medicaid and other major payer programs, their qualifications may need to be defined. This need is likely to be the driving force behind discussions of occupational regulation for CHWs in most states.

Another motivation for credentialing is the desire for credibility and respect. CHWs operate in an environment in which most professionals carry sets of letters after their names signifying their qualifications. Having a similar distinction can help CHWs in their quest for recognition and credibility, not only with other professionals, but also with community members who may question their authority to deliver broad-based services.

We have noted in earlier sessions that CHW employment is often temporary and treated as casual. Many CHWs want a meaningful job market in which their qualifications are portable from one position to another.

Lastly, various stakeholders have expressed the need to assure the quality of services provided by CHWs. In an environment in which program administrators sometimes insist on having registered nurses deliver health education to ensure clinical accuracy, CHWs need an accepted mechanism for proving their capability.

What Is the Opposition to Credentialing?

So what is the opposition to credentialing?

- Employer concern about rising wage expectations
- Other professions fear encroachment
- Credentialing process may be a barrier to entry for some community members
- Concern about loss of authenticity and effectiveness in the community
- Fear of creating a wedge between volunteer and paid CHWs

Audio Transcript

At the same time, not all stakeholders support regulating the CHW occupation. Some employers fear that raising standards for the occupation may raise expectations about salaries and working conditions. Experience in states that have credentialing for CHWs suggests that those in other professions may fear that CHWs will encroach on their scope of practice.

Some CHWs oppose credentialing because they believe it may create a barrier to entry for community members who cannot meet academic requirements. Others link credentialing with professionalizing their occupation and fear that it may further distance them from the community. Some CHWs also fear that credentialing will create a wedge between volunteer and paid CHWs,. They believe volunteers will lose respect and paid CHWs will lose their authenticity.

Where Is Certification in Place?

The following provide CHW certification:

- Texas and Ohio—for all paid CHWs
- Alaska and Indiana—for CHWs in specific programs
- Minnesota—for CHWs reimbursed by Medicaid (not described as certification)

Audio Transcript

The only universal certification for CHWs is in Texas and Ohio, which require all CHWs who are compensated for their work to be certified. These programs were put in place in the mid 1990s. Alaska and Indiana actually initiated the first certification programs for CHWs in the early 1990s, but these programs were limited to CHWs participating in specific programs.

Minnesota established a CHW regulation program in 2008, but it does not technically constitute certification because it applies only to CHWs who want their services to be billable to Medicaid.

Other states are also considering the question of CHW credentialing. In 2010, a Virginia regulatory board found that licensure was not necessary for CHWs, because there was no evidence that unlicensed CHWs posed any harm to the public. CHW advocates in Virginia are pursuing other avenues to establish standards for the occupation. Most recently, the Massachusetts Legislature passed a bill establishing a CHW certification board. Leaders in California, Florida, Illinois, New Mexico, and New York, among other states, are currently discussing the need for CHW certification.

Mechanics of Credentialing for CHWs

Elements common to other professions:

- Attainment of skill standards
- Application
- Continuing education
- Regular renewal

Distinctive elements for CHWs:

- Performance-based assessment
- Grandfathering provisions

Audio Transcript

Many elements of occupational regulation are common to most professions, including Documenting the attainment of skills standards, an application process, maintenance of skills through continuing education, and a regular renewal process.

Because of the unique nature of the practice of CHWs and the expertise they gain from personal experience, their skills are often assessed through actual performance, commonly within the educational environment. Also, in part because many CHWs develop their skills as volunteers, their performance record is usually accepted as documentation of their skills. A provision for “grandfathering” for experienced practitioners is not unusual, but in the case of CHWs, the ending date for eligible experience may not be fixed.

Other State CHW Certification Systems

Other state CHW certification systems include:

- Alaska—standard training and exam
  - Certification limited to Community Health Aide Program
  - Includes limited clinical care duties
- Indiana—standard training and exam
  - Limited to prenatal care coordination program (Medicaid)

Audio Transcript

In Alaska, certification applies only to workers in the Community Health Aide Program. Aides perform some clinical care duties, including dispensing prescription drugs and administering injections, because they serve in remote frontier communities where physicians and nurses may be available only once or twice a year. Indiana certifies CHWs participating in its prenatal care coordination program, which is funded under a Medicaid waiver.

Certification in both states is tied to completion of standard training and of a certification exam. Indiana does not regulate the general preparation of CHWs, but CHWs must complete a one-day workshop provided by the state before they may take the exam.

Discussions are under way in Indiana to expand CHW certification beyond the prenatal care coordination program.

Certification in Minnesota, Ohio, and Texas relies on the completion of standard training and submission of an application. In Minnesota, the application is only for registration as a Medicaid provider and is not technically considered certification. In other words, CHWs in Minnesota who are not paid out of Medicaid are not required to complete the standard training.

Texas Certification System

In Texas, certification is called a "Certified Community Health Worker" credential. The Texas certification system:

- Uses eight recognized core competency areas
- Is administered by the state health department
- Is based on completion of approved training or six years' previous experience
- Includes no fees and no SSN or reporting of citizenship status

Audio Transcript

In Texas, certification is called a "Certified Community Health Worker" credential. Initially, legislation provided for voluntary certification, but subsequent bills made certification mandatory for all CHWs who receive compensation and directed the state to employ certified CHWs in public insurance programs such as Medicaid "to the extent possible".

The Texas program for certifying CHWs is based on the eight areas of core competency described in Session 3. Rather than requiring a certification exam, the Texas system is based on completion of an approved training program that includes at least 20 hours of instruction in each of the core competency areas. Experienced CHWs may become certified by grandfathering, or documenting past experience, during the six years before the application date. Initially, the Texas program imposed a predefined deadline date on grandfathering, but because volunteer CHWs may continue to accumulate work experience without being certified, a fixed closing date for grandfathering was considered unfair.

It is also notable that Texas has no application fee for certification, and the applicant is not required to provide a Social Security number or to report citizenship or immigration status. The state considered revising the regulations to limit participation on the basis of criminal background only if convictions were relevant to the applicant's potential duties as a CHW, but as noted earlier, this change was not implemented.

In addition to CHWs, Texas certifies instructors and sponsoring institutions. Although the state does not prescribe a specific curriculum for CHW training, it does specify standards for such curricula. As a result, the approximately 20 approved training programs in the state have independently developed 20 different CHW curricula meeting state standards.

CHW instructor training programs were not approved in Texas until 2009, and at this writing only two approved instructor programs exist, both in the Houston-Galveston

area. Before the approval of these two programs, the only way CHW instructors could become certified was through acquiring 1,000 hours of experience. The supply of qualified CHW instructors is still an open question, but the currently approved instructor training programs have both begun to offer certification training online.

Ohio Certification System

CHW certification in Ohio is referred to as a "Certificate to Practice." The Ohio certification system:

- Was established in 2003
- Is administered by the Ohio Board of Nursing
- Allows transfer from other states' certification programs by endorsement
- Requires citizenship or resident status, and a criminal background check
- Includes a $35 application fee

Audio Transcript

Ohio's CHW certification program, established in 2003, was placed under the control of the Ohio Board of Nursing. CHW certification in Ohio is referred to as a "Certificate to Practice." The Ohio system is similar to that of Texas, using completion of approved training as the basic qualification. At this writing, the state has only three approved training programs. Ohio also provides for "reciprocity," or transferability of CHW credentials from other states. Unlike the Texas system, the Ohio application for certification requires proof of citizenship or resident status. It also requires a criminal background check and a $35 application fee.

Ohio Certification System (cont.)

The Ohio certification program differs in the following ways from the Texas program:

- Grandfathering ended after first year; only required work as a CHW "at some point"
- RNs are allowed to delegate some nursing tasks
- Includes a standard curriculum heavy in medical content
- Does not include separate credentialing for instructors
- Sets standards for quality of care by CHWs

Audio Transcript

The Ohio certification program differs in other ways from the Texas program. Although Ohio initially had a grandfathering provision, it lasted for only one year and required only that a person had worked as a CHW "at some point."

The Ohio system closely relates CHW practice to nursing practice. Registered nurses are allowed to delegate certain nursing tasks to CHWs. There is more medical content in the Ohio standard CHW curriculum than in the Texas curriculum. Instructors do not have separate credentialing, and certain professionals, such as registered nurses, are automatically considered qualified to teach CHWs.

Perhaps most significantly, Ohio is the only state to have established standards for quality of care for CHWs. This is a feature that all states considering CHW credentialing may want to review.

Texas and Ohio—Key Points

The Texas and Ohio certification system share the same key points:

- Neither relies on direct assessment of skills
- In Texas, certification is mandatory for all paid CHWs, but not enforced
- In Ohio, the status of uncertified and volunteer workers is unclear
- Approved training programs are not required to grant academic credit (most in Texas do not)

Audio Transcript

What can we say about the broadly based CHW certification systems in Texas and Ohio?

First, unlike the regulatory systems that govern most other professions, these systems do not rely on direct assessment of an applicant's skills, but rather on assessment by instructors in approved training programs. They do not use standardized exams. This strategy places the cost of skills assessment on the training institutions, relieving the state government of that burden. Other options certainly exist, including workplace-based assessment by peer evaluation teams.

In Texas, certification is mandatory for all paid CHWs but neither the law nor regulations impose any penalty for failure to comply. Whether practice by an uncertified CHW places legal liability on the CHW, the employer, or both remains uncertain. The regulatory system in Ohio is silent on the status of uncertified and volunteer CHWs. Neither state requires approved training programs to grant academic credit, and most approved programs in Texas do not.

Minnesota Occupational Regulations

The regulatory system in Minnesota has some fundamentally different features including:

- 2007 legislation authorized Medicaid to reimburse for CHW services
- CHWs must complete standardized curriculum to enroll as provider
- Must work under clinical supervision
- Employers bill at $25/hour under CPT® code “patient self-management and education”

Audio Transcript

The regulatory system in Minnesota has some fundamentally different features. CHW advocates in Minnesota explicitly chose not to create a certification system, fearing that it would cause divisions within the workforce if some CHWs achieved certification and others did not. Instead, they focused on a single goal: qualifying CHWs for Medicaid reimbursement.

Authorizing legislation for this policy was introduced in early 2007 and incorporated into an omnibus appropriations bill in May of that year. After the bill was passed, the state Medicaid agency submitted a proposed Medicaid State Plan Amendment authorizing reimbursement for CHW services.

The language of this policy change was relatively simple, requiring that a CHW complete a standard curriculum leading to a certificate and practice under certain guidelines. The Minnesota State Colleges and Universities System published the curriculum for use by community colleges and other post- secondary institutions. The standard curriculum follows skill requirements similar to those in use in Texas and Ohio.

The CHW must work under the supervision of a doctor, dentist, advanced practice nurse, mental health professional, public health nurse or other approved health professional. Although CHWs must apply for and receive a Medicaid provider number, they may not bill directly or independently. Their employer may bill for their services in half-hour increments at an hourly rate of $37 for a maximum of four hours per patient per month. All billing is under the procedure code for “patient self-management and education.” You may be familiar with the term “CPT Codes,” referring to the Current Procedural Terminology system, which are numbers assigned to every task and service a medical practitioner may provide to a patient. The Minnesota billing policy also provides for sub-codes for patient education in group settings. We will return to the details of the Minnesota system in Session 6, as part of the Minnesota case study.

Impact of Credentialing

The following are impacts of credentialing CHWs:

- Too soon to assess impact or value of credentialing
- Limited impact in Texas and Ohio due to failure to link regulations to other areas of state policy

Audio Transcript

Occupational regulation for CHWs has only been in place for a few years, and no systematic studies of the impact of credentialing have been conducted. However, interviews with stakeholders in Texas and Ohio suggest that credentialing has had limited impact, primarily because it was implemented more or less in a vacuum. In other words, related policies were not coordinated with the occupational regulation of CHWs.

In both states, relatively few CHWs have been certified. The maximum number in Ohio hovers around 100. In Texas, which has more aggressive training programs, just over 1,000 of an estimated 3,000 to 4,000 CHWs are certified, but the renewal rate has been relatively low. No more than 40% of CHWs due for renewal in a given year have renewed on time. However, these rates are increasing, largely because continuing education is now more available and new provisions allow for renewal within a year after certification expires.

The Case for CHWs: What Evidence Exists?

The following evidence exists supporting the use of CHWs in the health care industry:

- Professional literature contains:
  - Summaries of data on CHWs
  - Systematic reviews of literature on CHW effectiveness
- Shortcomings of existing evidence:
  - Many evaluations go unpublished
  - Wide-ranging CHW roles make drawing overarching conclusions difficult

Audio Transcript

Seeing research and evaluation in a list of important areas of policy might be surprising, but policymakers and others are looking for evidence-based policy initiatives. A frequent theme in this training series has been the diversity of roles and activities performed by CHWs. Evidence is generally associated with one specific role, function, or intervention, making it extremely challenging to paint an overall picture of the impact of CHWs.

In this portion of Session 4, we will look at some key points about research and evaluation: What evidence is now available? How good is it? How can we use unpublished data from employers to bolster this evidence base?

Many commentators have focused on a small number of compelling studies describing the impact of CHW services, and over the last 10 to 15 years, a number of systematic reviews of formal studies of CHW effectiveness have been published. These reviews, however, have highlighted the challenges in drawing broad conclusions from published data.

Also, the published studies cover only a limited range of programs, most of which were created by researchers for the purpose of testing the efficacy of a particular intervention. Funders of pilot or demonstration projects typically require formal evaluations, but the results of these evaluations do not always find their way into professional journals. Again, these studies and unpublished reports cover a wide range of interventions

involving dozens of different health issues and conditions, making it difficult to draw overarching conclusions.

Summaries of Compelling Data

The following evidence exists supporting the use of CHWs in the health care industry:

- Case for Minnesota Medicaid legislation based on three studies showing return on investment
- A total of 12 studies were used as evidence in Massachusetts report to the legislature
- CDC used several studies for March 2011 Translation Brief, “Addressing Chronic Disease through Community Health Workers: a Policy and Systems-Level Approach”

Audio Transcript

Advocates for policy change concerning CHWs have frequently produced summaries of evidence that they consider compelling as a tool for communicating with policymakers. In the case of the Minnesota Medicaid legislation, CHW advocates, including supporters of the legislation within state government, most frequently presented a one-page summary of three diverse studies showing a positive return on investment from employing CHWs on specific health issues. We will review these on the next several slides.

The Massachusetts Department of Public Health highlighted 12 published studies in its 2009 report to the legislature on the CHW workforce. And CDC’s Division for Heart Disease and Stroke Prevention selected a small number of representative studies for inclusion in its translation brief published in March 2011; the link for this brief is on the Resources page of this course. If you have not already reviewed this brief, we recommend that you do so.

Studies Used in Minnesota

The following evidence came from studies used in Minnesota:

- Baltimore Medicaid patients with diabetes, average annual savings of $2,245 per patient
- Denver Health 2.28:1 return on investment from reduced use of urgent, inpatient care
- Hawaii program reduced asthma-related per capita charges by 75% mainly from decline in ER visits

Audio Transcript

The first of the three studies used before the Minnesota legislature was conducted in Baltimore among Medicaid patients with diabetes. Although this published study did not meet the standards of a randomized controlled trial, the average annual savings of $2,245 per patient was sufficiently dramatic to convince legislators that investing in CHWs was cost-effective. The study also found improved quality of life among patients.

The second study was conducted by Denver Health, the public safety net system for the greater Denver area, which serves 25% of the region's population. Conservatively estimating Minnesota's rate of return at half that found in the Denver study, the Minnesota Department of Human Services predicted a net savings to the state of 14 percent above the cost of providing CHW services. This is a 1.14:1 return on investment. The Denver study also found increased use of primary and specialty care and reduced use of urgent, inpatient, and outpatient behavioral health care.

Finally, advocates in Minnesota used a study of asthma management in Hawaii as evidence that employing CHWs could reduce the state's asthma-related costs and improve quality of life for people with asthma. The Hawaii program reduced emergency room visits related to asthma and reduced overall costs of care for participating patients by 75 percent.

Studies Used in Massachusetts

The following evidence came from studies used in Massachusetts:

- A total of 14 studies were conducted indicating improved:
  - Access to care (one study)
  - Chronic disease management (five studies)
- The studies also indicated increased:
  - Use of primary care (three studies)
  - Use of prevention services (five studies)

Audio Transcript

The Massachusetts state health department selected 14 studies covering a wide range of services by CHWs. These studies generally did not address cost or cost-effectiveness, but rather focused on improved access to care, improved chronic disease management, and increased use of primary care and preventive services. The full report can be downloaded at the web address shown on the slide.

Citations in the CHW Policy Brief

The following evidence came from the CHW Policy Brief:

- Improved HTN control with teams including CHWs
- Improved cancer screening knowledge and cervical and mammography screening outcomes
- Improved appointment keeping, compliance, risk reduction, BP control, and related mortality
- Better diabetes clinical measures when cared for by a CHW and nurse case-manager group compared to CHW or nurse alone

Audio Transcript

This slide summarizes the topics of the selected research studies in the CHW policy brief produced by CDC's Division for Heart Disease and Stroke Prevention. For specifics topics addressed in the brief, please refer to it directly. The brief emphasizes heart disease, but also includes studies on diabetes and cancer.

Other Reviews of Published Data

The following literature reviews have some patterns in their findings:

- HRSA's CHW National Workforce Study—summarizes six systematic reviews
- Brownstein et al.—2005, 2007
- Cochrane Reviews series—2005, 2010
- Agency for Healthcare Research and Quality—review by RTI International (Viswanathan, 2009)

Audio Transcript

The CHW National Workforce Study for HRSA summarizes the findings of six systematic reviews published before 2007. Dr. Nell Brownstein of CDC has published a series of literature reviews, some of which have appeared in CDC's online journal Preventing Chronic Disease.

A series of systematic reviews led by Dr. Simon Lewin was published in the highly respected Cochrane Reviews series. These reviews, however, are international in scope, and most of the studies they consider are from outside the U.S.

The Agency for Healthcare Research and Quality released another review in 2009, and it has highlighted a number of CHW initiatives in its online Health Care Innovations Exchange in recent years.

Taken together, these literature reviews have some patterns in their findings, as we will see.

Common Themes in Systematic Reviews

Common themes in systematic reviews include:

- Results are promising but more study needed
- Very few studies include costs
- Key points often unspecified (e.g., specific CHW intervention, selection, training)
- Wide range of activities and health issues means lack of common metrics, difficulty in generalizing, comparing, or replicating

Audio Transcript

Systematic reviews of the CHW literature all conclude that CHW interventions show promising results, but more study is needed. Out of 1,000 or more studies examined, reviewers commonly end up with only 40 or 50 studies meeting their rigorous criteria for inclusion.

The lack of cost data in most CHW studies creates a serious hurdle for policy change, but it is understandable considering that most of the studies were funded as short-term research projects.

Most reviews criticize the majority of published studies for failing to specify key points such as the details of the CHW intervention, the qualifications and selection process for the CHWs themselves, and the extent and content of the training provided to CHWs.

Another pattern evident from these reviews is that published studies cover a wide range of activities and health issues and use many different measures, making it difficult to come to overarching conclusions. Most of the studies reported changes in individual self-reported knowledge, attitudes, and behaviors, and a significant number reported changes in clinical measures such as blood pressure or blood glucose, but very few reported conclusions based on clinical outcomes.

Documenting Unpublished Employer Data

A number of benefits may derive from persuading employers to release previously unpublished data on employment of CHWs.

- Employers lack incentive to publish
  - Data may be proprietary
  - Studies may not meet highest research standards
- Real-world data reflect diverse CHW activity
- Employers will share data with their peers
- Data can be compelling to policymakers and other stakeholders

Audio Transcript

A number of benefits may derive from persuading employers to release previously unpublished data on employment of CHWs. Unlike academic researchers, employers may have little incentive to publish their data. It takes a lot of work, and the CHW occupation is not universally recognized. The corporate culture of many organizations is not supportive of individuals who venture into such a new and untried field.

Many decision makers, including public officials, tend to rely on common standards for evidence: To be valid, findings must come from a scientifically designed study, preferably a randomized controlled trial, and must be presented in a peer- reviewed journal. Many evaluation studies and internal employer reports do not meet these standards, often because they are the result of regular internal operations and are not subject to experimental comparisons. Data also may be proprietary. Furthermore, the data collected from ongoing services and established organizations often reflect the reality of the wide range of activities performed by CHWs, and linking results to specific actions by the CHW can be difficult.

However, employers may be willing to share data with their peers in a collegial atmosphere, and this exchange can help to build momentum in reaching common conclusions about the effectiveness of CHWs. By the same token, if the employers themselves present results to policymakers and other stakeholders, the effect can be very different from that of testimony by academic researchers or even CHWs. A key to getting attention for systems change is for stakeholders such as employers to communicate that employing CHWs advances their organizational self-interest.

Research on CHWs has varied greatly in terms of quality and topics. No global strategy is in place for the systematic assembly of evidence about this workforce. Researchers and funders of research have tended to pursue specific topics in which they have an interest, and no unifying strategy or research agenda guides the selection of future studies.

To address this situation, an invitational conference was held in Dallas in 2007. The goal was to draft an initial research agenda for the CHW field. The conference produced a prioritized list of research questions that needed to be addressed and recommended some common principles for future research studies involving CHW interventions. Participants expressed interest in creating a standard set of research metrics and an online clearinghouse for published and unpublished research documents. A summary of the proceedings of the conference can be downloaded from the address shown on the Resources page.

Session Summary

The takeaways for this session include:

- Some influences favor and some oppose credentialing of CHWs
- So far, regulation efforts have had limited success
- Published data suggest broad benefits, but
    - Quality of studies is mixed
    - Standards are needed

Audio Transcript

What do you take away from this session? In reflecting on what we have discussed, you might consider:

- Some influences favor and some oppose credentialing CHWs
- So far, regulation efforts have had limited impact
- Published data on CHW effectiveness suggest broad benefits, but the quality of studies is mixed—standards are needed

In the next session, we will address what some consider the biggest policy arena concerning CHWs: sustainable funding for employment.

Thanks for participating!