



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Lawrence J. Hogan, Jr., Governor – Boyd K. Rutherford, Lt. Governor – Van T. Mitchell, Secretary

February 6, 2015

The Honorable Shirley Nathan-Pulliam
304 James Senate Office Building
6 Bladen Street
Annapolis, MD 21401

RE: SB 592 and HB 856 (Ch. 118 and 259) of the Acts of 2014
Interim Report

Dear Senator Nathan-Pulliam:

Per your request the Department of Health and Mental Hygiene is submitting this interim report on the Workgroup on Workforce Development for Community Health Workers. The Workgroup was assembled pursuant to Senate Bill 592 and House Bill 856 (2014). The final report of this group is due June 1, 2015.

If you have any questions about this report, please contact Ms. Allison Taylor, Director of Governmental Affairs, at 410-767-6481.

Sincerely,

Van T. Mitchell
Secretary

Enclosure

cc: Allison Taylor, Director, Office of Governmental Affairs
Laura Herrera Scott, Deputy Secretary, Public Health Services
Michelle Spencer, Director, Prevention and Health Promotion Administration
Donald Shell, Director, Cancer and Chronic Disease Bureau

**INTERIM REPORT ON THE
WORKGROUP ON WORKFORCE DEVELOPMENT FOR COMMUNITY
HEALTH WORKERS**

Chapters 181 and 259 of the Acts of 2014

(SB 592 and HB 856)

**Maryland Department of Health and Mental Hygiene and
Maryland Insurance Administration**

January 2015

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HISTORY AND BACKGROUND

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

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

The Workgroup was specifically tasked to make recommendations regarding:

- 1) Training and credentialing required for CHWs to be certified as nonclinical health care providers; and
- 2) Reimbursement and payment policies for CHWs through the Maryland Medicaid Assistance Program and private insurers.

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

This interim report addresses training and credentialing issues; deliberation on the complex topic of payment policies will take place during the first half of 2015.

MEMBERSHIP

The membership and meeting schedule of the Workgroup are listed in Appendices 1 and 2 to this report.

COMMUNITY HEALTH WORKERS

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

CHWs are known by a variety of names, including ‘community health advisors’, ‘outreach workers’, ‘lay health advisors’, and ‘promotoras/promotores’, but regardless of the job title there is an overlapping commonality of role, activity and function as “workers who promote health or nutrition within the community in which an individual resides” (Affordable Care Act, quoted in Brownstein et al., 2011b).

CHWs cannot work in isolation. They operate by building connections with community, state and charitable resources which complement health interventions, but also in many cases by building strong connections with healthcare systems to accomplish direct health goals for the patient. In some models CHWs are lay members of communities where people live, work or worship, building community capital and self-confidence in community members; other models place CHWs as core members of the

healthcare delivery team, breaking down cultural and linguistic barriers between health teams and members of the community and providing practical support in engaging with health and community resources. There is no universal ‘best’ model for CHWs; the different approaches are not mutually exclusive and programs may select from and amalgamate between them.

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

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

COMMUNITY HEALTH WORKERS IN MARYLAND

Maryland already has many CHW programs in place with an estimated 1430 CHWs working in Maryland in 2013 in a wide variety of programs from community-based to hospital based to primary care team based (Dept. of Labor). It is critical to build on Maryland’s valuable experience of CHW programming so that organizations already engaged in CHW training and delivery will continue to develop and implement their programs.

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

In addition, Maryland developed a State Health Innovation Plan that outlines additional models to complement the All-Payer Hospital Model. The plan includes a concept for Community Integrated Medical Homes (CIMH), a modification of the PCMH model that would integrate primary care with evidence-based, intensive, non-clinical interventions for individuals with significant health needs and high costs, such as individuals with multiple chronic conditions. These so-called “super-utilizers” would receive assessments, intensive education and self-management training, and other interventions in home and community-based settings from CHWs. In addition, the State Health Innovation Plan calls for

establishing a Medicaid ACO, which would also provide increased incentives for prevention for some of Maryland' most vulnerable.

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

TRAINING AND CREDENTIALING OF COMMUNITY HEALTH WORKERS AND BARRIERS TO PROGRESS

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

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

Variation in state approaches to legislation has resulted in important differences between states as to who certification is required for, what kind of governance is needed (including who advises the state on CHW policies), whether there is a defined scope of practice for CHWs, and the extent and location of training. As well as varying in their credentialing processes, states vary in the standards they require, with some more stringent than others. States have argued that higher training and education standards not only contribute to higher quality of practice but also lead to improved recruitment and retention through increased status and satisfaction for the CHW workforce (Kash et al., 2007).

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

However, the particular route chosen to navigate through CHW training and credentialing has profound implications for the character of the CHW workforce. On the one hand, some CHWs who live in the community, are trained on-the-job for the specific program for which they are recruited, are paid little (if at all), and operate as part of independent community-based programs which are accountable only to their grant funders; on the other hand, other CHWs who have been awarded certification after an

arduous college course and practicum, function as integrated members of health teams which are reimbursed for their work, and are ascending a CHW career ladder which demands continuing education but offers increasing status and remuneration. Too high or too inflexible a standard risks excluding many of those with strong credentials as traditional 'community connectors' - but who lack strong educational credentials - from serving as CHWs (CHW-NEC, 2008).

Based on an examination of state approaches to CHW development, the critical areas of decision-making and development identified and needing further exploration were identified by DHMH early in 2014 as:

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

THE WORKGROUP PROCESS OF LEARNING

The Workgroup has been working towards a common understanding of the impact of different recommendations on existing CHW programs and on the capabilities of a future Maryland CHW workforce. Through structured discussions, the Workgroup has embraced the Maryland-wide expertise available by virtue of its membership which encompasses a variety of jurisdictions. The Workgroup has also reviewed and discussed well-established training and certification models from several states, in particular Massachusetts, Michigan, Minnesota, New Mexico, New York, Ohio, South Carolina and Texas.

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

Work on the definition of a CHW began in meeting 2, based on definitions from the American Public Health Association (APHA), the U.S. Bureau of Labor Statistics, the Affordable Care Act, HRSA and the states of Massachusetts, Minnesota, Texas and Oregon (New Mexico and Michigan use the APHA definition). Discussion in breakout groups was followed by plenary feedback. Differences of opinion were noted and further feedback was sought through a survey of members between meetings and through further comment during subsequent meetings. Final agreement was reached at the 5th meeting to use the American Public Health Association (APHA) definition with a minor modification.

CHW roles were initially approached in a similar way, with breakout groups discussing roles published by APHA, the Affordable Care Act, Massachusetts and Oregon as the starting point for discussion, leading to nine roles being identified. The Workgroup requested further discussion in the large group which led to considerable revision of detail and the addition of a tenth role. As with the definition, final agreement on roles was reached at the 5th meeting of the Workgroup.

Meeting five also incorporated a panel discussion, using panel members from among the Workgroup membership, on the key training processes required for certification, including curriculum requirements and the number of classroom hours needed to deliver the curriculum adequately. The panel discussion led to debate about the core competencies that should be included in a Maryland CHW curriculum.

In meeting six, a cross-walk of competencies from seven other states (Massachusetts, Michigan, Minnesota, New York, Ohio, S. Carolina and Texas) shared with the Workgroup by state officials demonstrated that other states do not differ greatly in the competencies they use. Many of the apparent differences in competencies between states are largely the result of changes in ordering or in the way roles are grouped together to form individual competencies. As part of the competency discussion, CHW programs in Maryland were asked to submit curricula in use for CHW training. This exercise showed that Maryland's existing programs align well with the competencies in use in other states. Based on these materials, the Workgroup ended meeting six with an expression of views about the draft competencies set out in the recommendations section below.

Subsequent to meeting six, volunteers from the Workgroup have been engaged in refining the core competencies outside of the Workgroup meeting. This may lead to further refinement of the competencies before final recommendations are determined.

INTERIM RECOMMENDATIONS AND FINDINGS

The workgroup reached agreement on the following interim recommendations on the following key areas necessary for a certification process for Maryland.

The definition of a community health worker:

“A Community Health Worker (CHW) is defined as a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”

Community Health Worker Roles for Maryland:

1. Serving as a liaison between communities, individuals and coordinated health care organizations.
2. Provide evidence based health guidance and social assistance to community residents.
3. Enhancing community residents' ability to effectively communicate with health care providers.
4. Providing culturally and linguistically appropriate health education.
5. Advocating for individual and community health equity.
6. Providing care, support, follow up, and education in community settings such as homes and neighborhoods.

7. Identifying and addressing issues that create barriers to care for specific individuals.
8. Providing referral and follow-up services or otherwise coordination of human services options.
9. Proactively identifying and referring individuals in federal, state, private or nonprofit health and human services programs.
10. Integrating with patient's care team to support progress in care plan and overall patient wellness

Draft Core Competencies for Community Health Workers in Maryland:

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

FUTURE WORK PLANS

The Workgroup has begun work on translating the definition, roles and competencies into a recommended curriculum for CHW training. As its work progresses it will seek to make further recommendations on minimum training hours, grandfathering of existing CHWs and programs, state certification arrangements and reimbursement policies.

One challenging area the group has been considering is whether a state-wide examination should be part of the certification process. Some members are concerned that due to low-literacy or low-English proficiency that this could exclude traditional CHWs from becoming certified. Other members felt that we should not underestimate what we can expect of people given an appropriate level of educational support. Still other members argued that a certification test can be a combination of written, oral, and observations which will show knowledge in practical settings. This discussion will be continued into 2015.

One subgroup of the Workgroup wished to include reference to integration with the primary care team but the Workgroup could not reach a consensus on including this. The Workgroup also considered the question of clinical vs. non-clinical CHW roles but agreed that the legislation which established the Workgroup dictated that the present Workgroup focus only on non-clinical roles (as recorded in the minutes of 11/14). The legislature should consider whether a future workgroup will be needed to look at clinical CHW roles.

APPENDIX 1: WORKGROUP MEMBERSHIP

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

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

Biographical details of workgroup members are available on the Workgroup website at:
<http://hsia.dhmh.maryland.gov/SitePages/CHW%20ADVISORY%20WORKGROUP.aspx>

APPENDIX 2: MEETING SCHEDULE

The Workgroup met on six occasions in 2014 on the dates and at the venues below.

- Meeting 1: September 22, 2014; DHMH, 201 West Preston Street, Baltimore, MD 21201
- Meeting 2: October 6, 2014; DHMH, 201 West Preston Street, Baltimore, MD 21201
- Meeting 3: October 20, 2014; DHMH, 201 West Preston Street, Baltimore, MD 21201
- Meeting 4: November 14, 2014; DHMH, 201 West Preston Street, Baltimore, MD 21201
- Meeting 5: December 1, 2014, Dept. of Transportation, 7201 Corporate Center Drive, Hanover, MD 21076
- Meeting 6: December 15, 2014; Maryland Hospital Association, 6820 Deerpath Road, Elkridge, MD 21075

The first four meetings were led by external facilitators from The Grant Group; the remaining two were facilitated by DHMH staff led by Deputy Secretary of Public Health Services Dr. Laura Herrera Scott.

All meetings were recorded. Minutes were posted on the CHW website after approval by the workgroup.

Attendance and Public Comment

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

The average number of public attendees who actually signed in was 12 for a total of 71 sign-ins altogether, with a maximum sign-in of 18 at the first meeting (and with 10, 14, 7, 9 and 13 attending the succeeding meetings). Note however that some public attenders did not sign in, and others signed in at more than one meeting.

Opportunity for public comment was provided at meetings 4 to 6; Appendix 3 summarizes public comment received.

Further Information

For meeting minutes and further information about the workgroup meetings and membership, please visit the CHW Workgroup web page:

<http://hsia.dhmh.maryland.gov/SitePages/CHW%20ADVISORY%20WORKGROUP.aspx>

APPENDIX 3: PUBLIC COMMENT RECEIVED

Meeting 4: November 14th 2014

Leslie Demus

- Discussion re: ratio of CHWs to total number of the CHW Work-Group and proportion of men on the CHW Work-Group
- Decisions are going to be made as it relates to the population of the workforce
- Definition is very important, certain wording needs to be categorized or enlightened especially as you are speaking about community as related to community health workers
- A CHW needs to be “out of” that community, needs to be familiar with that community
- As you speak about clinical and non-clinical, initially began as a non-clinical CHW – with additional training (housing, case management, phlebotomy) – additional training and counseling and specifics may be dependent on the agency that the CHW works for
- In structuring the core competencies, you especially want to pay attention to the fact that the CHW has an unusual and very close understanding of the community that they serve – and also that outreach, community education, social support advocacy and informal counseling is part of the work so you don’t want to be to technical

Terrie O. Dashiell

- Works for LifeBridge Health
- Main concerns from inception to now, is that as we speak about titles and salaries, that we also talk about the different settings in which CHWs will be practicing
- Important not only to train the CHWs but also the people that they are going to be working with as to what the impact of what their role is going to have
- This is important for the clinicians i.e. this was learned from personal experience
- Role is to take all facets of what patient is going to have to go through i.e. not just go out and do what the physician says but how to form a health and wellness regimen even if you are still in treatment for an illness
- Important for practitioners that are not used to working with CHW to be able to understand the CHW role so that they can give the CHW the respect that they deserve, a lot of the language indicates that the CHW will enhance the community residents ability to communicate with the provider, it needs to go the other way around also i.e. especially in the private setting - the practitioner shouldn’t just pull the CHW in and say “Go in that room and talk with Mr. Jones to make sure that they take their medication” – the practitioner still hasn’t addressed the problem (that needs to be understood) as the healthcare provider
- There needs to be some training of the healthcare provider of their role and exactly what the impact will be

Marsha Green

- Proudly represents CHWs, has been carrying out this work for about 15 years
- Before CHW was “coined” – this is a new phrase for CHWs
- Started out as an outreach worker for HIV/AIDS community with HIV pregnant mothers
- Started on the ground with the community
- The community trusts the CHW
- The CHW has a real stake in defining “who we are”
- CHWs demand respect for who they are and the work that is done
- The work is not properly represented
- Represents many, many outreach workers, case managers and the various other titles that CHWs have

- Some of the language bothers her i.e. adherence bothers her because the definition is narrow – ultimately don't want to just help the patient adhere to long term engagement, we want to help our patient and community gain independence
- Want to give them the strength and the power to take care of their own health, thus empowering patients
- Advocates for their own health

Robyn Elliott

- Maryland Nurses Association
- Materials sent out earlier will help us pick up speed
- Some persons represent themselves, other persons represent organizations
- Materials further in advance which will provide time to be able to discuss materials with the organizations that they represent so that representatives can bring back organized responses

Meeting 5, December 1st 2014

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

- **Katy Battani, Maryland Dental Action Coalition**—Her organization's mission is to increase access to dental care. Please consider oral health training for CHWs. Tooth decay is still #1 chronic condition for children in U.S. Links to services, prevention, etc. are so important.

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

Meeting 6, December 15th 2014

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

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

NOTE: Dr. Herrera Scott responded that the disease specific components are optional/supplemental. We can put together a list of optional topic modules. These can be based on categorical funding or the priorities of the Local Health Improvement coalitions, which have done community health needs assessments and are defining the needs of the communities. There is work to link hospitals (must identify community needs in order to keep non-profit status) and their work with efforts already underway in the community.#

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

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

Chris Rogers, Bon Secours—Paraprofessionals like CHWs are usually stepping-stone to social worker, nurse, etc. If there are competencies that should be included so that CHWs can be effective, we must make sure we are training them for their vital roles.

Shantia Collins, Charles Co. Health Dept. —Expressed concern about the career path for CHWs. If CHWs get higher level degrees, will their salary just cap out? Will there be no place for CHWs to go? Continuing education is important for CHW maintenance.