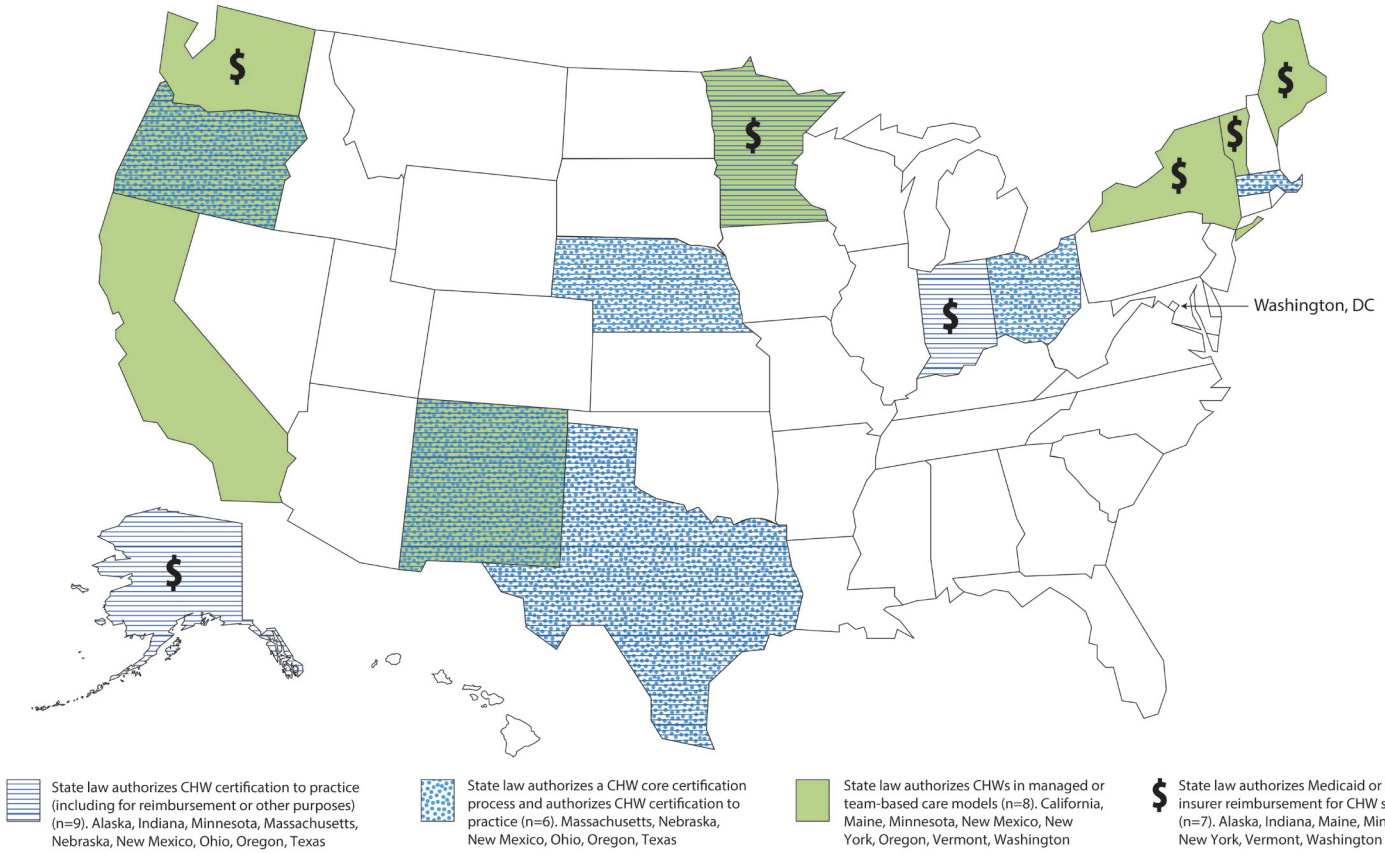
STATE LAW FACT SHEET: A SUMMARY OF STATE COMMUNITY HEALTH WORKER LAWS

States With Law Authorizing CHW Core Certification Process, CHW Certification to Practice, CHWs in Managed or Team-based Care, and Medicaid or Other Insurer CHW Reimbursement

In Effect On June 30, 2016



Background

About half of adults in the United States had one or more chronic health condition in 2012, not including mental health conditions.[1] In 2014, approximately 4.1% of US adults had a serious mental illness[2] and 14.8% of the population lived in poverty.[3] Disparities in health outcomes are associated with county of residence, poverty, race, ethnicity, mental illness, and other social and environmental factors.[4] As part of a national strategy to address racial, ethnic and socioeconomic disparities in health conditions and associated risk factors, the Office of Minority Health, Department of Health and Human Services, promotes the use of Community Health Workers[5] (CHWs), frontline public health workers who are trusted members or have a particularly good understanding of the culture and language of the community served. Also known as promotoras and various other terms, CHWs are effective at connecting the community to needed health and social services and improving the quality and cultural competence of health service delivery.[6]

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Table 1: Table of CHW Interventions by Evidence Rating (Best, Emerging, Promising and NA†)

Intervention	Evidence Rating
Infrastructure	
Commission, task force, or advisory body established to study or to make recommendations for the development and implementation of a sustainable CHW program.	NA
Professional Identity	
Provision of chronic disease care services (i.e., blood pressure self-management, education, and measurement)	Best
Inclusion of CHWs in multidisciplinary health care teams (i.e., Medicaid or private insurance models)	Best
CHW health care service provision under supervision of a health care professional.	Best
Defines CHW scope of practice (i.e., provides a definition of CHW or defines CHW roles, responsibilities, or functions).	Best
Educational campaign to raise awareness of CHW health care role.	Emerging
Workforce Development	
CHW core competency certification process.	Best
CHWs included in the core certification development process.*	Best
CHWs included in the standardized curriculum development process.*	Promising Impact
Multiple levels of CHW certification.	NA
CHW certification to practice.	NA
Develop standardized core competency curriculum.	Best
Specialty area or disease-specific certification (e.g., certification in blood pressure measurement).	Best
Standardized specialty area or disease-specific CHW curriculum (e.g., to promote heart health).	Promising Quality
Financing	
Medicaid coverage or reimbursement for CHW services.	Best
Grant funding and other financial incentives to support CHW workforce development.	Emerging
Private insurer reimbursement for CHW services.	Emerging

† NA= No Evidence Assessed

* The evidence base for including CHWs in the core certification development process fell in the best category and the evidence base for including CHWs in the standardized curriculum development process fell in the promising impact category. For the law assessment these interventions are combined because state laws either addressed the role of CHWs in the certification and curriculum development process more broadly or it was difficult to find a distinction.

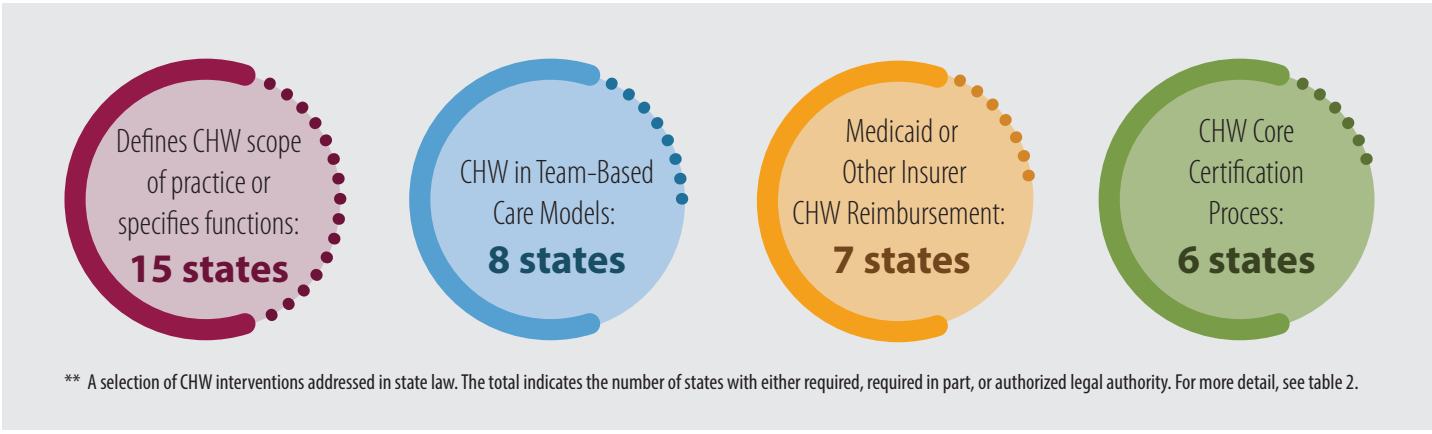
There is an expansive body of evidence supporting the use of CHWs in health care delivery models to prevent and control chronic diseases and other health conditions.[6,7] For example, a systematic review conducted in 2015 by the Community Preventive Services Task Force recommends, on the basis of strong evidence of effectiveness, team-based care interventions that engage CHWs to control hypertension and high cholesterol among people at risk for cardiovascular disease (CVD).[8] CHWs providing health education and related services also improved patient health behaviors. In addition, in 2016 the Community Preventive Services Task Force found providing CHW services, such as health education, informal counseling, and extended support, to individuals or groups at risk of developing diabetes type 2 are effective interventions for weight management and improved glycemic control.[9]

Health and policy research organizations such as the National Conference of State Legislatures,[10] The Council of State Governments,[11,12] the National Governors Association,[13] The Association of State and Territorial Health Officials,[14] the National Academy for State Health Policy,[15] the Milbank Memorial Fund,[16] and other national and state level organizations also have addressed the role of and need for CHW services for specific populations, health conditions, or statewide health systems reform to reflect the growing momentum for policy solutions to address social determinants of health (e.g., housing and food access, transportation, legal aid, etc.) of health while ensuring access to quality health care service delivery, particularly among populations with high rates of chronic disease.

This state law document builds on the CDC's 2013 state law fact sheet, A Summary of State Community Health Worker Laws[17] that describes the landscape of state laws addressing four attributes of a sustainable CHW program: infrastructure, professional identity, workforce development, and financing. To assist the breadth of interested stakeholders in scaling up CHW interventions through law, this report incorporates the results of CDC's Quality and Impact of Component[18] (QuIC) early evidence assessment analyzing the evidence basis of CHW interventions and programs that have been recommended or studied to show the quality and state of the evidence for potential public health impact associated with enacted state CHW law.

Data Collection and Methods

We updated the state law analysis of legal features addressing infrastructure, professional identity, workforce development, and financing and examined the extent state law included 17 types of interventions: 14 evidence-informed interventions and 3 interventions for which no evidence assessment was conducted (CHW



** A selection of CHW interventions addressed in state law. The total indicates the number of states with either required, required in part, or authorized legal authority. For more detail, see table 2.

task force; tiered certification; certification requirement to practice) that provide context for state law implementation. The evidence informed interventions are described in two CDC reports: the 2014 CHW Policy Evidence Assessment Report[19] (PEAR) and the 2016 Policy Evidence Assessment Report[20]: What Evidence Supports State Laws to Establish Community Health Worker Scope of Practice and Certification? These two reports combined provide an assessment of the evidence basis for 14 types of interventions that could comprise an evidence-informed state CHW law. Evidence ratings for 12 interventions addressing professional identity, workforce development, and financing are based on the 2014 PEAR findings. Evidence ratings for two interventions addressing professional identity (scope of practice) and workforce development (certification) are based on the updated 2016 PEAR findings. These two interventions are of increasing salience to stakeholders interested in expanding the use of CHWs. Of the 14 CHW evidence-informed interventions identified; 9 had best, 2 had promising (one had promising quality and one had promising impact), and 3 had emerging evidence bases (Table 1).

One legal analyst collected and reviewed historic (from 1977) and current enacted laws (statutes, legislation, and regulations) in the 50 states and DC (hereafter collectively referred to as states) using the legal search engine, Westlaw (Thomson Reuters, Eagan, Minnesota). Search terms included "community health worker" and 21 alternate terms identified by subject matter experts. The body of law as a whole for each state is coded according to the level of authority (e.g., required, required in part, authorized, or prohibited) specified. If state law was relevant to the intervention but not on point, it is categorized as "other." For quality assurance, a second legal analyst independently reviewed and coded the law for 12 of 51 (24%) states. The analysts resolved coding discrepancies through discussion and consensus. Laws effective on June 30, 2016, are described below with some reference to historic laws for context.

State Laws

To understand how states are using law as a tool to develop sustainable CHW programs, this document summarizes how states have enacted laws addressing CHW infrastructure, professional identity, workforce development and financing, and the evidence rating associated (i.e., best, promising quality, promising impact, or emerging) with 14 evidence-informed interventions.

Infrastructure

On June 30, 2016, 25 states (including DC) had laws in effect addressing the CHW workforce (Table 2 [For a compliant version of this table, please visit https://www.cdc.gov/dhdsp/pubs/docs/State_Law_FS_CHW_table2.xls]). Six states had a law in effect authorizing or requiring an advisory or similar body to study and make recommendations regarding the CHW workforce. Texas was the first state to authorize a committee to consider a framework for developing the CHW workforce in 1999 and after several legislative amendments, including authorizing a pilot project in 2003, established a Promotor(a) or Community Health Worker Training and Certification Advisory Committee in 2015 that advises on the implementation of standards, guidelines, and requirements related to CHW training and regulation, as well as employment, funding and program sustainability. Two states, Virginia and Utah, commissioned studies through resolutions in 2004 and 2013 respectively. Two states with the most recent legislative directives (enacted in 2014) to conduct CHW studies include Maryland and Illinois. Maryland established a workgroup to study and make recommendations on CHW training and credentialing, reimbursement, and payment; however, the workgroup was sunset on June 30, 2015. Illinois enacted the Community Health Worker Advisory Board Act that creates an Advisory Board composed in part of CHWs. The Board is tasked with drafting a report summarizing best practices, curriculum, and training programs for designing a certification program and recommendations for reimbursement and securing funding.

Professional Identity

Six states explicitly specify a role for CHWs in chronic disease prevention and care and eight states authorize or require the inclusion of CHWs in multidisciplinary health care teams for some payors or health care delivery systems (i.e., Medicaid or private insurance models) (Table 2). Both of these interventions are classified as best and are recommended by the Guide to Community Preventive Services.[8] There are provisions in eight states authorizing health care professionals to supervise some or all health delivery services provided by CHWs (best). Fifteen states either define a CHW scope of practice (13 states) or specify CHW roles, responsibilities and functions (12 states) for specific health conditions (best). For example, Massachusetts, New Mexico, Oregon, Rhode Island, and Texas have adopted a similar definition as that set forth by the American Public Health Association CHW Section that supports a breadth of CHW services. Some states, such as Louisiana, have adopted laws to use CHWs for specific purposes, such as using patient navigators to serve as outreach coordinators for sickle cell patients served by its Sickle Cell Patient Navigator Program.

Workforce Development

CHW workforce development interventions addressing certification and training are supported by best and promising evidence. Six states have enacted workforce development laws that authorize a certification process (best); five of these states authorize the creation of standardized curricula on the basis of core competencies and skills (best) and four of the six states require the inclusion of CHWs in establishing the certification process (best) or curriculum development (Table 2). However, nine states either authorize or require for reimbursement purposes that certain health services be provided by certified CHWs (Table 2). With respect to specialized certification (best) and training (promising quality), two states authorize specialty certification for CHWs and four states provide for specialized CHW training. Indiana requires Division of Mental Health and Addiction certification for CHWs who assist individuals with serious mental illness through a Medicaid state plan. New Mexico allows CHWs to be certified at a generalist level or one of three specialist levels with training and education in one, two, three, or more specialty areas including basic clinical support skills, heart health, chronic disease, behavioral health, maternal and child health and developmental disabilities.

Financing

To finance the CHW workforce, seven states have laws authorizing Medicaid reimbursement (best) for CHW services (Table 2). However, states may also incorporate CHW services through Medicaid waivers and state plan amendments and managed care organizations, which does not always involve legislative or regulatory action. Five states authorize the use of financial incentives, grants, or other resources (emerging) to fund CHW training or services. For example Minnesota authorizes grant funds for clinical medical education programs meeting certain criteria to train an array of health providers, including community paramedics or community health workers. Vermont is the only state identified that explicitly requires CHW coverage by private insurers (emerging).

Implications

State policies vary widely in their level of support for or regulation of the CHW field. There is high quality, strong evidence of potential public health impact for CHW interventions that have been translated into laws addressing professional identity, workforce development and financing. A handful of states have adopted multiple interrelated provisions that are instrumental in developing and sustaining the CHW workforce (Table 2). For example, Oregon authorizes certified CHWs to perform an array of health services including chronic disease related services in coordinated care settings; the state is also implementing a core certification process. While Oregon law does not explicitly define payment mechanisms for CHW services, the Oregon Health Authority is engaged in payment reform initiatives with public and private payers that focus on value based payment design, which includes CHW services.[21]

Given this emerging area of interest for state policy makers as one strategy to address health care costs, disparities and adverse health outcomes, studies are needed to better understand the impact of state approaches, such as CHW certification. CDC commissioned a comparative case study in 2016 to explore state health department and other stakeholder perspectives across diverse state CHW policy environments with respect to the role of CHW certification, scope of practice and sustainable funding. Results of this study are expected to help inform other state's deliberations in regulating the CHW profession or supporting its expansion through alternate methods.

Table 2. CHW Interventions Addressed in State Law, Effective June 30, 2016

	Infrastructure	Professional Identity					Workforce Development						Financing		
State	Establish a CHW commission or advisory body	Provide chronic disease care services	Managed or team-based care models	Supervision by other health care professionals	Defined scope of practice	Educational campaign	CHW core certification process	CHW certification to practice	Creation of standardized core curriculum	Include CHWs incertification or curriculum development	Specialty area or disease-specific certification	Standardized specialty area or disease-specific curriculum	Medicaid reimbursement	Incentives or grants for CHW workforce	Private insurer reimbursement
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TOTALS															
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❖	2	6	5	0	2	2	6	1	5	1	1	4	5	5	2
—	17	13	12	17	8	20	13	15	15	20	22	17	13	14	22

Legal Authority: ○ Authorized ◗ Required in part ● Required ❖ Other law — No law identified

Evidence Assessment Result: Best; Promising Quality or Impact; Emerging; No Evidence Assessment

*** Table does not include Multiple Levels of CHW Certification data.**

Table 3. Relevant State CHW Related Statutory and Regulatory Sections As of June 30, 2016

Jurisdiction	Statutory Citation Sections	Regulatory Citation Sections
Alaska	ALASKA STAT. §§ 18.28.010 TO .050 & 18.28.100 (2013)	ALASKA ADMIN. CODE tit. 7 §§ 125.160, 155.020, 145.140 (2013); See also ALASKA ADMIN. CODE tit. 7 §§12.450 to 12.490, §100.124; 7 §§ 27.600 to 27.629 (2016)
California	CAL. HEALTH & SAFETY CODE §§ 106000 & 106005 (WEST 2014); CAL.WELF. & INST.CODE §§ 16002.5 & 14127 (WEST 2014)	None identified
DC	D.C. CODE §§ 7–1631 TO 1633 (2013)	None identified
Georgia	GA. CODE ANN. §§ 33-23-201 (2016)	None identified
Illinois	20 ILL. COMP. STAT. ANN. 2335/1, 2335/5, 2335/10, 2335/15 & 2335/99 (WEST 2015)	None identified
Indiana	NONE IDENTIFIED	405 IND. ADMIN. CODE §§5-21.8-1 TO 5-21.8-11 (2015)
Iowa	IOWA CODE ANN. § 135.106 (WEST 2014)	IOWA ADMIN. CODE R. 641 §§10.1(135) - 10.9(135) (2015)
Kansas	KAN. STAT. ANN. §65-1,158 (2015)	None identified
Louisiana	LA. REV. STAT. ANN. §§ 46:161 – 165, 40:1081.8 & 40:2018.3 (2015)	None identified
Maine	ME. REV. STAT. ANN. TIT. 32 §§13821 - 13825 (2013)	MD. CODE REGS. §§ 10.61.01.03, 05, 06 (2015)
Massachusetts	10-144-101 ME. CODE R. CH. II § 91 (WEIL 2015): SEE ALSO 10-144-101 ME. CODE R. CH. III § 91	None identified
Maryland	MD. CODE ANN., HEALTH-GEN. §§ 20-1401 TO 1407 & MD. CODE ANN., TAX - GEN. § 10-731 (WEST 2013)	MD. CODE REGS. §§ 10.61.01.03, 05, 06 (2015)
Massachusetts	MASS. GEN. LAWS ANN. 17 § 3 (WEST 2013); MASS. GEN. LAWS ANN. 112 §§ 259 TO 262 (WEST 2013); MASS. GEN. LAWS ANN. 13 §106 TO 108 (WEST 2013); SEE ALSO MASS. GEN. LAWS ANN. 13 § 9; MASS. GEN. LAWS ANN. 6D § 15 (WEST 2013); MASS. GEN. LAWS ANN. 111 § 2H (WEST 2013)	None identified
Minnesota	MINN. STAT. ANN. §§ 256B.0625, 256B.79 & 256B.0755 (WEST 2014); MINN. STAT. ANN. § 145A.17 (WEST 2014); MINN. STAT. ANN. § 62J.692 (WEST 2015)	None identified
Nebraska	NEB. REV. STAT. § 81–3140 (2016)	None identified
Nevada	NEV. REV. STAT. §§ 449.001; 449.0027, 449.0028, 449.0045, 449.030, 449.0302, 449.089, 449.119, ETC (2015)	None identified
New Mexico	N.M. STAT. ANN §§ 24-30-1 TO 24-30-7, 27-2-12.13 & 27-2-12.15 (WEST 2014)	N.M. CODE R. §§ 7.29.5.1 TO 7.29.5.14 (2015)
New York	N.Y. PUBLIC HEALTH LAW § 2959-A (MCKINNEY 2013)	None identified
North Carolina	10A N.C. ADMIN. CODE 48B.0803 (WEST 2013)	None identified
Ohio	OHIO REV. CODE ANN. §§ 4723.01, 4723.06, 4723.07 & 4723.81 TO 4723.88 (WEST 2016); OHIO REV. CODE ANN. § 4723.33 TO 35 (WEST 2014)	OHIO ADMIN. CODE § 5122-29-33 (2014); OHIO ADMIN. CODE §§ 4723-2-01 TO 2-04, 4723-26-01 TO 4723-26-14 (2015)
Oregon	OR. REV. STAT. ANN. §§ 413.260 & 413.600 (WEST 2015); OR. REV. STAT. ANN. § 410.604 (WEST 2015); OR. REV. STAT. ANN. §§ 414.018, 414.025 & 414.625, 414.635 & 414.665 (WEST 2016)	OR. ADMIN. R. 410-120-0000 (2013); OR. ADMIN. R. 410-138-0060 (2013); OR. ADMIN. R. §§ 410-141-0300, 410-141-3015, 410-141-3180, 410-141-3260 & 410-141-3320 (2016); OR. ADMIN. R. 410-146-0120 (2013); OR. ADMIN. R.410-180-0300 TO 410-180-0380 (2013); OR. ADMIN. R. 418-010-0010 & 418-020-0010 (2015)
Pennsylvania	4 PA. CODE § 6.402 (2015)	None identified
Rhode Island	R.I. GEN. LAWS 1956, § 40-19.1-1 (2016); R.I. GEN. LAWS 1956, §§ 23-64.1-1 TO 23-64.1-8 (2013)	None identified
Texas	TEX. HEALTH & SAFETY CODE ANN. §§ 48.001, 48.051, 48.052, 48.053 & 48.101; SEE ALSO TEX. HEALTH & SAFETY CODE ANN. § 1001.035; TEX. HUMAN RES. CODE ANN. § 32.071 (WEST 2013); TEX. INS. CODE ANN. § 845.155 (WEST 2013)	TEX. ADMIN CODE 25 §§ 146.1 THROUGH 146.8 (146.9 TO 146.12 REPEALED AS OF 6/24/15) (2015); TEX. ADMIN CODE 1 § 351.20 (2014)
Vermont	3 VT. CODE R. § 12-3-217:5370 (2015)	None identified
Washington	WASH. REV. CODE ANN. § 43.70.725 (WEST 2015)	WASH. ADMIN. CODE §§ 182-501-0065, 182-533-0315, 0320, 0325, 0327, 0328, 0330, 0340, 0345, 0360, 0365, 0370, 0375, 0378, 0380, 0385, 0386 (WEST 2016); WASH. ADMIN. CODE §§ 246-170-011 & 246-170-035 (WEST 2016)

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This document presents a summary of laws in effect as of June 30, 2016, and is not intended to promote any particular legislative, regulatory, or other action. Learn more about State Law Fact Sheets at www.cdc.gov/dhdsp/pubs/policy_resources.htm.

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