The Network for Public Health Law

Ideas. Experience. Practical answers.

COMMUNITY HEALTH WORKERS
Issue Brief

Legal Considerations for Community Health Workers and their Employers

Introduction

For decades, community health workers (CHWs) have improved access to health in underserved communities across the globe by helping to make health care, education, and prevention efforts more accessible and culturally relevant to their communities. CHWs have served U.S. communities for decades as well, and their distinctive role was officially recognized by the United States Department of Labor in 2010.[1] CHWs are not new to the health care or public health systems, but growing recognition of their unique ability to help address social determinants of health—especially as health care insurers and providers become increasingly responsible for patient outcomes—has given rise to an influx of opportunity for CHWs. Many public health departments and community-based organizations also rely on community health workers to conduct outreach, assess community needs, provide culturally relevant health education, and connect individuals to needed services.[2] Moreover, a mounting body of evidence demonstrates that community health workers play an important role not only in improving health outcomes, especially among vulnerable populations, but also in improving community-based public health research.[3] Accompanying this professional growth is an evolving area of legislation and regulation as well as legal considerations for employers as they integrate CHWs into their workforce.

There is no single definition of community health worker, but the Community Health Workers Section of the American Public Health Association (APHA) created the following definition, which has been adopted by the U.S. Department of Labor Community Health Worker Apprenticeship Program, and is widely seen as the national definition of the CHW workforce:

> A CHW is 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.[4]

The Community Health Worker Core Consensus (C3) Project which is comprised of leaders in the CHW community, academics, and others adopted this definition. Community health workers may use a variety of titles, such as promotores de salud, outreach educator, or outreach worker, and may perform a variety of roles depending on the needs of the

community they serve.[5] The C3 Project released a report in 2016 describing core roles and qualities of CHWs based on the results of robust community-based participatory research. The report emphasized that any definition of CHW must reflect that a defining CHW quality is membership in or close connection to the community served.[6]

This issue brief explores legal issues relating to the regulation and employment of community health workers. It outlines the authority for states to regulate CHWs, describes types of state legislation and activity currently affecting CHWs, and provides considerations for employers utilizing the services of CHWs.

Legal Background: Regulation of Health Care Professionals

In the United States, states possess broad power to regulate professions.[7] This power emanates from the states' police powers, defined as "the inherent authority of the state (and, through delegation, local government) to enact laws and promulgate regulations to protect, preserve, and promote the health, safety, morals, and general welfare of the people."[8] More than a century ago, the Supreme Court of the United States upheld state regulation of the practice of medicine and explained the purpose for such regulation as follows:

> [I]t has been the practice of different States, from time immemorial, to exact in many pursuits a certain degree of skill and learning upon which the community may confidently rely, their possession being generally ascertained upon an examination of parties by competent persons, or inferred from a certificate to them in the form of a diploma or license from an institution established for instruction on the subjects, scientific and otherwise, with which such pursuits have to deal.[9]

The Court also explained that states have wide latitude in prescribing the nature and extent of qualifications for a given profession, so long as the requirements are "appropriate to the calling or profession, and attainable by reasonable study or application."[10] However, a state may not exclude a person from a profession "in a manner or for reasons that contravene the Due Process or Equal Protection Clause of the Fourteenth Amendment."[11]

Today states regulate a great variety of health care professionals. Protecting the public from unqualified practitioners and promoting quality of care continue to be the primary purposes for state regulation, but the implications of professional regulation of health care professionals are much broader.[12] For example, professional regulation can provide a mechanism for an occupation to achieve legitimacy and respect in the health care field, and can help to increase public understanding of a particular role. In addition, regulation may make it easier for employers and payers to verify credentials, thus facilitating reimbursement for the professional's services. Eligibility for reimbursement may in turn increase demand for the profession.[13] Finally, each of these factors may ultimately lead to improved job security, increased pay, and better working conditions.[14]

Types of State Regulation

States use a variety of methods to regulate health care professionals depending on the nature of the occupation involved. Possible methods—listed below from most restrictive to least restrictive—include licensure, certification, and registration. Two key functions that may be considered in developing a regulatory framework include title regulation (i.e., defining who may use a particular title) and practice regulation (i.e., defining functions that a credentialed practitioner is deemed competent to perform and possibly limiting performance of those functions to credentialed practitioners). Regulation may also be accomplished by requiring members of an occupation to practice under the supervision of another licensed practitioner; this strategy may be coupled with one of the other regulatory frameworks or may stand alone.

Licensure

The most restrictive form of regulation is occupational licensure, which limits entry to a profession to individuals who meet established requirements (e.g. possessing academic credentials and/or passing an examination); defines a scope of practice and prohibits unlicensed individuals from engaging in activities within the defined scope of practice; and prohibits use of the title by unlicensed individuals.[15] A licensing scheme may also establish standards for practice and ethical

behavior; create disciplinary procedures and sanctions for failure to comply with such standards; and impose additional requirements on licensed practitioners, such as for continuing education.[16] All states require licensure for physicians, dentists, pharmacists, and a number of other health care professionals, but licensure requirements may be less consistent across states for emerging professions.[17]

Certification

Within a certification framework, a state generally requires members of an occupation to meet specified standards in order to use a particular title (e.g., certified community health worker), but does not exclude noncertified individuals from performing the functions of the occupation.[18] Under this framework, a state could establish certification standards and evaluate applicants for certification, or it could designate a private organization to perform these functions.[19] Though not a necessary part of a certification scheme, a state may also establish a scope of practice and/or develop practice standards for certified individuals.[20] The scope of practice would specify the range of functions that a certified practitioner is deemed competent to perform, but would not prohibit noncertified individuals from performing the designated functions.

Registration

Registration does not generally involve independent evaluation of an individual's aptitude to perform an occupation, but instead may require members of the occupation to provide certain information to the state in order to be included in the state registry.[21] The registration process may require registrants to provide documentation of training or other credentials so they may be verified by the registry, or the registration process could simply require registrants to submit enough information for a background check. Information about registered members of the occupation is then available for verification by prospective employers or others seeking to use the services of a CHW.

Alternatives to State Regulation

Although professional regulation is primarily a power of the states rather than the federal government, the federal government can exert substantial influence on occupational growth and regulation through financial incentives and funding conditions. For example, in 2010 the Affordable Care Act provided mechanisms for funding CHWs through three different programs: grants for use in medically underserved communities, opportunity for CHWs in Medicaid Health Homes, and State Innovation Model Grants.[22] In 2014 the federal Centers for Medicare & Medicaid Services (CMS) implemented a rule allowing state Medicaid programs to reimburse for prevention services recommended by physicians and provided by non-licensed providers.[23] These federal funding opportunities encouraged states to create programs employing CHWs.

The federal or state governments may also encourage CHWs to obtain certification or meet training standards by establishing baseline requirements for reimbursement by federally- or state-funded programs. Often the result of limiting Medicare or Medicaid reimbursement to services provided by licensed, certified, or registered staff is that most health care facilities will hire only individuals with the required credentials.[24] Reimbursement conditions could similarly be used to incentivize supervision of community health workers, such as by conditioning reimbursement for CHW services on supervision by a licensed professional. Though services could still be provided unsupervised, most health systems would choose to provide the supervision in order to receive the reimbursement.

In addition to state and federal fiscal pressures, private credentialing and accrediting bodies may provide additional mechanisms for encouraging use of particular types of community health workers.[25] For example, a state or national professional organization may establish a certification process for community health workers and then may limit use of its credential (e.g., "XYZ Association-Certified Community Health Worker") under trademark laws.[26] Alternatively, a professional organization could establish an accreditation process for CHW training programs as a mechanism for assuring the quality of training rather than evaluating the competence of individual practitioners.[27] Finally, organizations accrediting CHW employers (e.g., hospitals) may determine CHW credentials required for accreditation. For example, many hospitals seek accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO or the Joint Commission) in order to satisfy state regulatory requirements, qualify for insurance reimbursement (including private as well as federal insurance programs such as Medicare and Medicaid), and reduce liability insurance costs.[28]

The Joint Commission could, independent of any state or federal regulation, require that community health workers working for accredited hospitals be certified or registered in order to meet the accreditation standards.

Issues to Consider in State Regulation of CHWs

States have experience generally in licensing or certifying professionals[29], but there are unique considerations when creating a system for community health workers because they perform a variety of roles in a range of settings and come from diverse educational and experiential backgrounds. For instance, some community health workers are employees or contractors who provide services for pay while others are volunteers. All are chosen because of their connection with communities who tend to be underserved and underrepresented in the medical community. Indeed, CHWs and other stakeholders in the field have recognized that the primary source of a CHW's expertise—and therefore the most essential CHW quality—is the CHW's "connection to or close understanding of the community served."[30]

The same assets which make someone particularly well suited to be a community health worker may also create barriers to achieving certification or licensure. For example, cost—particularly for those volunteering—may make certification or licensure itself difficult, and equally importantly, any continuing education requirements may easily become cost prohibitive. Likewise, any application process must be accessible. While states often include citizenship or language requirements in licensing or certification systems, here these requirements may turn assets that make the CHW accessible to the community into barriers to certification and employment. Applications and education both need to be provided in formats which are easily available and understandable to all types of adult learners.

These considerations need not make core competency attainment unfeasible; rather, they demonstrate the need for states to include community health workers in the process of creating a training or certification system.

> Meaningful involvement of CHWs in creating policies that affect them is recognized in the field not only as a best and necessary practice, but also as a value core to the CHW profession.[31] .

Grandfathering is an issue under consideration in most states which have or are developing certification processes. Grandfathering is a process by which a community health worker's work or volunteer experience is "grandfathered' in to fulfill some or all of the criteria for certification. This is a method by which states can attempt to limit both the time and monetary cost of certification for experienced community health workers.[32]

An additional issue to consider in developing certification processes is that some of the most qualified CHWs may have nontraditional backgrounds. For example, one population who may be assisted by community health workers is those who are re-entering their communities following incarceration. Community health workers with experiences similar to the community are desirable. If state regulation precludes all who have a criminal conviction from certification or licensure, this important group of CHW candidates may be excluded from the certification or licensure process. One way to navigate this challenge is to allow employers to develop background check policies rather than implementing blanket requirements or policies at the state level; at the employer level, there may be more room for flexibility and individuation based on the needs of the population served. Employer considerations are discussed in more detail below.

Community Health Worker Regulation

Regulation of community health workers has been a subject of considerable debate for well over two decades. Community health workers are uniquely situated as members of the communities with which they work. There have been concerns that overly professionalizing the field could either create barriers to some of the best situated persons becoming CHWs or alter a CHW's relationship with his or her community. Currently, voluntary certification is the most common framework employed in states that regulate CHWs. While this creates some leeway for those who face barriers (e.g. financial, language) to obtaining training and certification, once certification is available, many employers or funders begin to employ and pay only for services delivered by those who are certified. The chart below outlines some of the most commonly cited pros and cons of increased community health worker regulation.

Pros and Cons of Regulation

With stakeholder input, the Association of State & Territorial Health Officials has identified a number of anticipated pros and cons associated with regulation of community health workers. Some of these key benefits and concerns are identified in the table below.

Pros

- Increase recognition of unique role among health care professionals
- Clarify appropriate roles for CHWs
- Improve understanding of CHW role / decrease confusion and perceptions of competition from medical assistants, nurses, case managers, etc.
- Increase job mobility and opportunities for career advancement
- Increase confidence for funders and payers
- Improve data collection and evidence base

Cons

- Potential loss of key CHW attributes: over medicalization, over professionalization
- More restrictions on activities / less flexibility
- Increase barriers to entry (e.g., criminal background check)
- Negative impact on those who do not seek voluntary credential[33]

Current State Laws

There is wide variability in state laws regarding community health workers. For example, states can use legislation or administrative rulemaking to: define community health workers, provide funding mechanisms for CHWs, create CHW certification or training requirements, and identify CHW oversight bodies. Here we will specifically describe examples of laws which provide financial mechanisms and laws creating certification or other training requirements. Though states vary in the use of law regarding community health workers, as of July 2018 only three states have no policies regarding CHWs either in place or under consideration.[34]

Examples of State Laws

Laws Providing Financing Mechanisms

Many states have developed mechanisms for funding community health workers through Medicaid. For example, Minnesota law enables Medicaid coverage of care coordination and patient education services provided by a community health worker who has received a certificate from an approved CHW curriculum and is supervised by a licensed professional.[35] The state Medicaid manual provides that covered services include “diagnosis-related patient education services” ordered by specified licensed professionals, among other requirements.[36] In contrast to Minnesota’s legislative approach, Michigan has created funding mechanisms for CHWs through administrative actions. For example, Michigan included in its contract with Medicaid Managed Care Organizations (MCOs) a requirement that MCOs “provide or arrange for” CHW or peer support services for enrollees with specified behavioral and physical health challenges and requires MCOs to maintain a specified CHW to enrollee ratio.[37] In addition, as part of the State Plan Amendment for its Medicaid Health Homes program, Michigan requires inclusion of community health workers on the health care team.[38] Other states employ a variety of administrative strategies to pay for CHW services, such as including CHWs in Medicaid waiver or demonstration projects.[39] According to the National Academy for State Health Policy, nearly a quarter of states have some funding mechanism through Medicaid for community health workers.[40]

Laws Creating Certification or Training Programs

As mentioned above, states can choose to encourage certification or training for community health workers. Some states have not chosen to do so, but the number of states moving towards establishing a regulatory scheme for CHWs is

increasing. The C3 Project's July 2016 report, which had the stated goal of building a national consensus on the roles, skills, and qualities of CHWs, pointed to the current patchwork of laws and regulations throughout the country, leading to different training and requirements in each state.[41] As of 2018, the patchwork remains, but more states are providing training and/or certification.

One example of a state law establishing CHW certification is New Mexico's 2014 Community Health Workers Act. The Act provides a mechanism for voluntary certification through the state department of health and allows for grandfathering of individuals previously serving in the role of community health workers. The Act outlines the scope of practice (including a prohibition on delivering services provided by licensed health care providers), establishes title protection for "certified community health worker", and creates a Board of Community Health Workers including CHW representatives.[42]

In comparison, Indiana does not provide certification through the state, but the Indiana State Department of Health commissioned the Indiana Community Health Workers Association, a state-level professional association, to approve certified training vendors who can provide certification in the state.[43] Certification is not required to work as a CHW in Indiana, but once certification is available, some employers may choose to hire those with certification over others that are not certified.

States may use a combination of funding, training, and certification mechanisms to encourage hiring of and standardized competencies among CHWs. It is important to keep in mind that even in states that do not require training or certification outright, many employers will prefer those with whatever credentials are required to receive reimbursement. For more information on relevant state laws for your state, please see the following hyperlinked resources from the National Academy for State Health Policy and ASTHO Community Health Worker Resources.

Best Practice Components of Evidence-Based Community Health Worker Policies

As states continue to integrate community health workers into complex health care systems, there is a growing body of research documenting best practices. A seminal work from the Centers for Disease Control and Prevention (CDC) outlines fourteen components of evidence-informed community health worker policies.[44] The components are assessed based on evidence and divided into four categories: "best," "promising quality," "promising impact," and "emerging." Policy components with the best evidence include, among others, integrating CHWs into multidisciplinary health care teams, establishing core competency-based training curricula and certification programs, requiring supervision by other health care professionals, establishing pathways for Medicaid reimbursement, and involving CHWs in developing certification requirements. Promising policy components warranting further study include defining a CHW scope of practice and developing specialty area training curricula. And finally, newly emerging policy components include, among others, establishing private insurer reimbursement pathways, promoting CHW integration into health care systems through educational campaigns, and providing grants or other financial support for CHW workforce development.[45]

Each of these elements can be codified through state laws in whole or in part.[46] State regulatory structures may incorporate components such as specifying services which CHWs may provide, outlining supervision and/or training requirements, and including community health workers in policy development. State laws may support financing of CHWs by explicitly including them as members of the multidisciplinary health care team, providing for Medicaid coverage of CHW services, and/or establishing grant incentives for hiring CHWs. As states continue to develop CHW regulatory policies, research on best practices offers an important tool for developing policies likely to have the greatest impact.

Legal Considerations for CHW Employers

Community health workers can be hired in a variety of settings. Hospitals, clinics, health departments, community-based programs, Medicaid managed care entities, and others can all benefit from the services of community health workers. Community health workers can be employed, contracted, or volunteers. Each of these settings and employment arrangements have attendant challenges and liability risks to be considered, some of which are explored below.

Hiring Community Health Workers

A common question associated with the hiring process pertains to one of the core CHW qualities: membership in the community served. This quality can be difficult to ascertain through hiring processes. But developing recruitment criteria that are specific to each CHW role and the community served; advertising job opportunities in a manner that reaches qualified applicants (e.g., sharing job announcements with appropriate community partners); communicating clear expectations about the role, requirements, and salary; including all appropriate staff (and possibly community representatives) in the hiring process; and probing a candidate's motivation for applying for the position may aid in attracting and selecting qualified candidates.[47]

From a legal standpoint, it is essential that employers are cognizant of discrimination laws throughout the hiring process. In general, employers may not discriminate on the basis of age, disability, race, religion, national origin, or sex, among other characteristics which may be protected by state laws. Exceptions are permitted only for "bona fide occupational qualifications" (BFOQs) (or, in the context of age, "reasonable factors other than age" (RFOA[48])). BFOQs are defined under Title VII of the Civil Rights Act as a qualification "reasonably necessary to the normal operation of that particular business or enterprise…"[49] BFOQs are fact specific and the burden to show a BFOQ falls on the employer. Employers may find it helpful to consult with legal counsel to develop organizational policies designed to assure that bona fide job requirements are satisfied without engaging in discriminatory practices.

Another hiring challenge pertains to conducting criminal background checks. Background checks are generally performed in the field of health care, either as a part of the licensing or certification process or the employment process. As discussed briefly above, unique issue arises in the context of hiring CHWs to serve populations who have been involved in the criminal justice system. For organizations dedicated to reaching this underserved population, it may be beneficial to employ CHWs who have successfully re-entered the community following incarceration; thus, these CHWs may have a criminal record. A number of health care systems, including Johns Hopkins Health and Hospital System and Kaiser Permanente, have participated in hiring those with past convictions. Moreover, studies have demonstrated a higher retention rate for individuals hired post-conviction as compared to similarly-situated employees without criminal records.[50] When hiring CHWs to work with formerly incarcerated populations, employers will need to determine if and how to make exceptions to any organizational policies restricting hiring of individuals with criminal records. CHW supervisors and managers may find it helpful to work with organizational risk management to develop hiring, supervision, and other policies.

Billing for Community Health Worker Services

Community health workers may be volunteer or paid staff members. For those who are paid, grants are a common though generally short-term source of funding. Some states have sought approval from CMS to use Medicaid funds to pay for CHW services; Medicaid payment can take a variety of forms.

The most straightforward payment method is direct reimbursement for services. In Minnesota, for example, as described above, if a community health worker is supervised by a licensed professional and is providing diagnosis-related patient education services, the services may be reimbursed by the state Medicaid program within specified limits.[51] More commonly, Medicaid Managed Care Organizations may pay for CHW services through their administrative budget or, if permitted by state policy, as part of their service budget.[52] Alternative payment models, such as per-member, per-month payments, give health care providers and health plans more flexibility over how they spend Medicaid dollars and may provide another mechanism for covering the costs of CHW services.[53]

In addition to these strategies, many states have developed creative ways to pay for CHW services using Medicaid section 1115 demonstration waivers. For example, Washington has incentivized their Accountable Communities of Health to create delivery reform projects which pay community health workers.[54] In Los Angeles County, community health workers play a central role in the county's waiver-funded Whole Person Care program that targets six high-risk populations including people experiencing homelessness, individuals recently released from incarceration, persons with mental health issues, substances use disorders, or multiple medical conditions, and women facing barriers to a healthy pregnancy.[55]

There are some challenges to consider as states strive to support the CHW workforce. First, states that reimburse CHW activities may put constraints on the CHW, such as certification requirements which are cost prohibitive or difficult to obtain. In other instances, the states may provide a set fee for services which are not informed by the time required to contact difficult-to-reach patients and to address other social impediments to health. Second, some of the current funding mechanisms are time limited. Some are demonstration projects and others are grants. It is important to continue gathering data on the efficacy and return on investment associated with CHWs so that more permanent reimbursement structures can be instituted and maintained as time-limited funding options expire.

Exposure to Liability and Risk Management

In general, organizations strive to be aware of and mitigate potential liability risks. Liability can be incurred as a result of injury or harm to a patient or to CHWs themselves. Depending on the state and the specific circumstances, employers may held liable for employees' actions performed within the scope of their employment under the legal concept of *respondeat superior* or for acts occurring outside of an employee's defined scope of employment under theories of negligent hiring, supervision, training, or retention. Additionally, employers can be held liable for harm to employees under certain circumstances if that harm comes while on the job. Given the variety of duties performed by community health workers, the nature of an employer's liability risk may vary depending on the scope of the specific position. CHW supervisors and hiring managers may find it helpful to talk through these considerations with their legal counsel.

Transportation Considerations & Community Based Settings

Many community health workers provide services in a community setting. These workers often drive vehicles and may work in non-controlled settings like patients' homes. In a survey of employers using CHWs in a rural setting, the employers listed transportation as one of their top liability concerns.[56] Some programs do not allow CHWs to transport patients in their personal cars in order to mitigate risks.[57] Other programs may decide that this service is critical to programming. In the latter case, employers may need to explore insurance coverage options specific to transportation issues.

Community safety is another important consideration. Community health workers are often working in communities without other professionals present. Some employers provide their employees with "safety kits" including items such as "pepper spray, insect spray, sunscreen, phone cards, and other resources" in an effort to mitigate potential risks.[58] While these items may be helpful, of course they do not fully eliminate the risk of injury to a CHW nor do they eliminate the associated liability risks. However, these issues are not unique to the CHW profession; social workers similarly work across multiple settings, including remote and community settings. Thus, CHW employers may wish to look to other professions as they determine how to best deal with these and other emerging issues for community health workers. For example, the National Association of Social Workers has created Guidelines for Social Work Safety in the Workplace for employers and workers. Suggestions such as provision of mobile phones for those out in the field and annual safety training may be useful to CHW employers.

Injury to Community Health Workers: Protecting Volunteers

In general, state workers' compensation laws require employers operating in the state to maintain workers' compensation insurance; this assures that employees who are injured as a direct result of their job are able to obtain cash benefits and/or medical care. However, volunteers are generally not eligible for workers' compensation. To assure that volunteer CHWs are eligible for the protections provided by workers compensation programs, states could define an employee to include some volunteers. For example, Minnesota defines certain state or local agency volunteers—including certain local health department volunteers— as employees for purposes of workers' compensation.[59]

Injury to Patients: CHWs Performing Limited Direct Health Services

Though the core of the CHW profession is not clinical in nature, there are circumstances in which certain health care providers may delegate limited clinical tasks to CHWs. For example, Ohio law allows registered nurses or other health professionals to delegate tasks within their scope of practice to certified CHWs.[60] These clinical tasks must be performed under the direction and supervision of the delegating health professional, and the Ohio Board of Nursing (which certifies

community health workers) has established specific criteria and standards for registered nurses delegating tasks to CHWs.[61] The law also protects registered nurses from liability for a CHW's performance of delegated activities as long as the activities were delegated and supervised in accordance with the applicable statute and rules.[62]

In general, if a CHW is negligent in some way in providing delegated clinical services, both the CHW and the employer may be exposed to liability. Thus, it is important for the protection of both CHWs and employers that appropriate supervision is in place and that supervisors and CHWs both understand the scope of services which CHWs are permitted to provide. Employers may consider whether malpractice insurance is appropriate in light of the specific activities performed by their CHWs.

Many states have Good Samaritan statutes which protect CHWs and/or other health care professionals from civil liability in emergency situations if the professional acts without gross negligence and in accordance with their training.[63] Good Samaritan statutes vary by state, but they often do not apply to ordinary, non-emergency situations, do not protect individuals employed specifically to provide emergency services, and may require that a person receive first aid or other trainings in order to qualify for the statute's protection.

Managing Risks: Certification, Scope of Practice, and Hiring Processes

When determining legal liability, four elements must be met: duty, breach, harm, and causation.[64] One way a person can defend against liability is to show that they did not breach the duty of care owed to the person who was harmed. When professionals defend against liability, one way to demonstrate that they fulfilled their duty is to show that they acted within the standard of care exercised by other professionals in similar situations. For this reason, states that delineate a scope of practice for CHWs may simultaneously help to provide clear and consistent guidelines for courts to use in determining whether a CHW was acting within established and recognized standards.

Again, it is important to keep in mind that CHWs are distinct from other health workers because they do not generally provide clinical services. Employers can manage their risk of exposure to liability by ensuring that employees and volunteers understand their scope of practice and are asked and expected to perform only those responsibilities which fall within their scope of practice. Hiring certified CHWs may further protect an employer from liability in two ways: first, the CHW's certification provides assurance to the employer that the CHW is trained and prepared to perform core duties; and second, the certification may help an employer to demonstrate that they exercised reasonable care in hiring the CHW.

Conclusion

Community Health Workers are important and unique members of the public health community. They are non-clinical workers whose expertise lies in their understanding of and relationship with their communities. CHWs' close connections to the populations they serve enable them to address social determinants of poor health through culturally appropriate education, outreach, and support. In addition, CHWs can be tremendously insightful and powerful advocates for the needs of their communities. Legal tools promoting certification, training, and financing have great potential to promote the sustainability and growth of this important profession, but must be employed thoughtfully to assure that positive outcomes (e.g., increased understanding of the CHW role) are maximized and negative impacts (e.g., barriers to entry) are minimized. As policymakers consider how to approach CHW regulation and financing, it is crucial that they involve, listen to and prioritize CHWs' diverse perspectives. Employers should also be cognizant of CHWs' distinctive skill sets and varied roles and consider how to best support their professional growth and on-the-job success.

SUPPORTERS

The Network for Public Health Law is a national initiative of the Robert Wood Johnson Foundation with direction and technical assistance by the Public Health Law Center at William Mitchell College of Law.

This document was developed by Heather McCabe, JD, MSW, Associate Professor, Indiana University School of Social Work and Colleen Healy Boufides, J.D., Senior Attorney, Mid-States Region of the Network for Public Health Law at the University of Michigan School of Public Health. Thanks to the following for providing their expert feedback and review: Colleen Barbero, MPPA, PhD, Siobhan M. Gilchrist, JD, MPH, Carl Rush, MRP, and Durrell J. Fox, Community Health Worker, Health Equity Consultant, JSI – Atlanta,GA . The Network for Public Health

Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.

[1] U.S. Office of Management and Budget, 2010 Standard Occupational Classification (SOC)—OMB's Final Decisions; Notice, 74 Fed. Reg. 3920 (Jan. 21, 2009), available at http://www.bls.gov/soc/soc2010final.pdf.

[2] *See, e.g.*, *Health Equity Zones*, Rhode Island Dept. of Health (Aug. 2018), http://www.health.ri.gov/publications/brochures/HealthEquityZones.pdf (describing state health equity zones that employed CHWs to "conduct needs assessments, identify safe routes to schools to improve attendance, promote recovery services, and build community-clinical linkages."); Los Angeles County Department of Health Services, *Whole Person Care – Los Angeles* (Pilot Application) (revised May 18, 2017), available at http://www.dhcs.ca.gov/provgovpart/Documents/Whole%20Perons%20Care/WPC%20Updates_Apps%20and%20Memos/LosAngelesWPCApplicationFINAL(2).pdf.

[3] *See* Stewart Landers and Mira Levinson, *Mounting Evidence of the Effectiveness and Versatility of Community Health Workers*, 106 Amer. J. Pub. Health 591 (2016); Kyounghae Kim et al., *Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review*, 106 Amer. J. Pub. Health e3 (2016); Sarah D. Hohl et al., *Characterizing Community Health Workers on Research Teams: Results from the Centers for Population Health and Health Disparities*, 106 Amer. J. Pub. Health 664 (2016).

[4] Amer. Public Health Ass'n., Policy Statement: Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities (2009), available at 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.

[5] U.S. Dept. of Health & Human Servs., Community Health Worker National Workforce Study (2007), available at https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/communityhealthworkforce.pdf

[6] E. Lee Rosenthal, Carl H. Rush, and Caitlin G. Allen, *Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field (Progress Report of the Community Health Worker (CHW) Core Consensus (C3) Project: Building National Consensus on CHW Core Roles, Skills, and Qualities)* (2016), http://www.chwcentral.org/sites/default/files/CHW%20C3%20Project.pdf.

[7] KENNETH R. WING, THE LAW AND THE PUBLIC'S HEALTH 125-27, 163 (6th ed. 2003).

[8] LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT, 92 (2d ed. 2008).

[9] Dent v. West Virginia, 129 U.S. 114, 122 (1889).

[10] *Id*.

[11] Schware v. Bd. of Bar Examiners of New Mexico, 353 U.S. 232, 238-39 (1957).

[12] *See* INST. OF MEDICINE (US) COMMITTEE TO STUDY THE ROLE OF ALLIED HEALTH PERSONNEL, *Licensure and Other Mechanisms for Regulating Allied Health Personnel*, in ALLIED HEALTH SERVICES: AVOIDING CRISES (Nat'l Academy of Sciences, 1989) [hereinafter IOM, *Licensure and Other Mechanisms for Regulating Allied Health Personnel*].

[13] *Id*.

[14] Carl H. Rush, *Basics of Community Health Worker Credentialing* (revised 2015), on file with the authors.

[15] IOM, *Licensure and Other Mechanisms for Regulating Allied Health Personnel*, *supra* note 11, at 237-40.

[16] *Id. See also* WING, *supra* note 6, at 126.

[17] *See* IOM, *Licensure and Other Mechanisms for Regulating Allied Health Personnel*, *supra* note 11.

[18] *Id.* at 239-40.

[19] *Id. See also, e.g.*, *Certification*, INDIANA COMMUNITY HEALTH WORKERS ASS'N, available at http://www.inchwa.org/certification (last visited July 11, 2018).

[20] *See* IOM, *Licensure and Other Mechanisms for Regulating Allied Health Personnel*, *supra* note 11, at 239-40.

[21] *Id.* at 239.

[22] *See* 42 U.S.C. § 280g-11 (authorizing CDC to award grants to promote use of CHWs in medically underserved communities); 42 U.S.C. § 1396w-4 (authorizing the Medicaid Health Homes program to provide team-based care, which may include services provided by CHWs); 42 U.S.C. § 1315a (creating the CMS Center for Medicare & Medicaid Innovation to test innovative payment and delivery models).

[23] Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule, 78 Fed. Reg. 42160, 42226 (July 15, 2013) (codified at 42 C.F.R. § 440.130).

[24] *See* IOM, *Licensure and Other Mechanisms for Regulating Allied Health Personnel*, *supra* note 11, at 252.

[25] *Id.* at 235.

[26] *See* Gina Green and James M. Johnston, *A Primer on Professional Credentialing: Introduction to Invited Commentaries on Licensing Behavior Analysts*, 2 Behavioral Analysis in Practice 51 (2009).

[27] *See* J. Moore and G.L. Shook, *Certification, Accreditation, and Quality Control in Behavior Analysis*, 24 The Behavior Analyst 45, 46-49 (2001).

[28] *See What is Accreditation,* THE JOINT COMMISSION, available at https://www.jointcommission.org/accreditation/accreditation_main.aspx (last visited July 11, 2018); *State Recognition*, THE JOINT COMMISSION, available at https://www.jointcommission.org/state_recognition/state_recognition.aspx (last visited July 11, 2018).

[29] The Minnesota Department of Health, Department of Health Workforce Planning and Analysis Unit created A Guide for Emerging Professions: Tips For Stakeholders and Advocates of Emerging Professions to Professionalize and Integrate With The Health Care System. This guide provides detailed information regarding considerations for emerging health professions like community health workers and also includes many useful links to outside resources.

[30] Rosenthal et al., *supra* note 5, at 25.

[31] *Id.* at 15.

[32] Katharine London, Margaret Carey, and Kate Russell. Tomorrow's Health Care System Needs Community Health Workers: A Policy Agenda for Connecticut. Connecticut Health Foundation, July 2015. https://www.cthealth.org/wp-content/uploads/2016/02/CHW-Certificaiton-by-State-Final-Final.pdf

[33] *See Community Health Worker Certification and Financing*, ASSOC. OF STATE & TERRITORIAL HEALTH OFFICIALS (2016), available at http://www.astho.org/Community-Health-Workers/CHW-Certification-Financing/.

[34] *See State Community Health Worker Models,* NAT'L ACAD. STATE HEALTH POL'Y, (updated Aug. 2017), https://nashp.org/state-community-health-worker-models/ (last visited Sep. 5, 2018) (the three states without CHW laws under consideration are Wyoming, Tennessee, and Alabama).

[35] Minn. Stat. § 256B.0625 subd. 49.

[36] Minn. Dept. of Human Servs. Minnesota Health Care Programs Provider Manual, available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_140357 (last visited Sep. 5, 2018).

[37] State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services (Effective Jan. 1, 2016), available at https://www.michigan.gov/ documents/contract_7696_7.pdf (last visited Sep. 5, 2018).

[38] Michigan State Plan Amendment #15-2000 (approved Mar. 4, 2016), available at https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-15-2000.pdf. *See also* Raven Gomez, Ellen Albritton, and Sinsi Hernández-Cancio, *How States Can Use Medicaid Managed Care Contracts to Support Community Health Workers*, FAMILIESUSA (June 2018), http://familiesusa.org/sites/default/files/product_documents/How-States-Can-Use-Medicaid-Managed-Care-Contracts-to-Support-CHWs_0.pdf.

[39] *See, e.g.,* Ellen Albritton, *How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities,* FAMILIESUSA (July 2016), http://familiesusa.org/sites/default/files/product_documents/HE_HST_Community_Health_Workers_Brief_v4.pdf.

[40] *State Community Health Worker Models,* NAT'L ACAD. STATE HEALTH POL'Y, *supra* note 34.

[41] Rosenthal et al., *supra* note 5.

[42] N.M. Stat. § 24-30-1 et seq. *See also* Dawn M. Hunter, *Community Health Worker Credentialing*, Network Pub. Health L. (Dec. 5, 2014), https://www.networkforphl.org/the_network_blog/2014/12/05/524/community_health_worker_credentialing_new_mexicos_approach.

[43] *Certification*, Ind. Cmty. Health Workers Ass'n, http://www.inchwa.org/certification (last visited Sep. 5, 2018).

[44] Ctrs. for Disease Control and Prevention, *Policy Evidence Assessment Report: Community Health Worker Policy Components,* U.S. Dept. of Health & Human Servs., Ctrs. For Disease Control and Prevention (2014), https://www.cdc.gov/dhdsp/pubs/docs/chw_evidence_assessment_report.pdf.

[45] Colleen Barbero et al., *Do State Community Health Worker Laws Align with Best Available Evidence?*, 41 J. CMTY. HEALTH 315-325 (Apr. 2016).

[46] Ctrs. for Disease Control and Prevention, *State Law Fact Sheet: A Summary of State Community Health Worker Laws*, U.S. Dept. of Health & Human Servs., Ctrs. For Disease Control and Prevention (2016), https://www.cdc.gov/dhdsp/pubs/docs/SLFS-Summary-State-CHW-Laws.pdf.

[47] *See* Wanda Jaskiewicz and Rachel Deussom, *Recruitment of Community Health Workers*, in Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policymakers ch. 8 (Henry Perry and Lauren Crigler, Eds., USAID Maternal and Child Health Integrated Program, 2014), available at https://www.mchip.net/sites/default/files/MCHIP_CHW%20Ref%20Guide.pdf.

[48] See 29 C.F.R. §1625.7(e)(1) (" A reasonable factor other than age is a non-age factor that is objectively reasonable when viewed from the position of a prudent employer mindful of its responsibilities under the ADEA under like circumstances.").

[49] 29 C.F.R. §1625.6.

[50] Sodiqa Williams et al., *A Healthcare Employer Guide to Hiring People with Arrest and Conviction Records: Seizing the Opportunity to Tap a Large, Diverse Workforce*, NAT'L EMPLOYMENT LAW PROJECT and SAFER FOUNDATION (Sep. 2016), https://www.nelp.org/wp-content/uploads/NELP-Safer-Toolkit-Healthcare-Employer-Guide-Hiring-People-with-Arrest-Conviction-Records.pdf.

[51] Minn. Stat. § 256B.0625 subd. 49; Minn. Dept. of Human Servs. Minnesota Health Care Programs Provider Manual, available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_140357 (last visited Sep. 5, 2018).

[52] *See* Jeremy Lapedis, Edith C. Kieffer, Carrie Rheingans, and Marianne Udow-Phillips, *Advancing the Profession and Sustainability of Community Health Workers*, CENTER FOR HEALTHCARE RESEARCH AND TRANSFORMATION (March 19, 2018), https://www.chrt.org/publication/advancing-profession-sustainability-community-health-workers/.

[53] *Id.*

[54] Department of Health and Human Services, *Approval letter for Washington State Demonstration Program for DSRIP*, (June 2017). https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/medicaid-transformation/wa-medicaid-transformation-dsrip-plan-prtcl-062817.pdf; Tina Kartika, *Innovative Community Health Worker Strategies: Medicaid Payment Models for Community Health Worker Home Visits,* NATIONAL ACADEMY FOR STATE HEATLH POLICY (Dec. 2017) https://nashp.org/wp-content/uploads/2017/11/CHW-Home-Improvement1.pdf.

[55] Los Angeles County Department of Health Services, *Whole Person Care – Los Angeles* (Pilot Application) (revised May 18, 2017), available at http://www.dhcs.ca.gov/provgovpart/Documents/Whole%20Perons%20Care/WPC%20Updates_Apps%20and%20Memos/LosAngelesWPCApplicationFINAL(2).pdf.

[56] Alycia Infante, Alana Knudson, & Alexa Brown, *Promising Practices for Rural Community Health Worker Programs,* WALSH CENTER FOR RURAL HEALTH ANALYSIS (March 2011) http://www.norc.org/PDFs/Walsh%20Center/Rural%20Evaluation%20Briefs/Rural%20Evaluation%20Brief_March2011_Yseries_1.pdf

[57] *Id.*

[58] *Id.*

[59] Minn. Stat. § 176.011 available at:https://www.revisor.mn.gov/statutes/?id=176.011

[60] Ohio Rev. Code § 4723.82(B)(1).

[61] Ohio Admin. Code 4723-26-06 through 4723-26-10.

[62] Ohio Rev. Code § 4723.82(B)(2).

[63] *See, e.g.*, Nev. Rev. Stat. Ann. § 449.194

[64] Cornell University Law School, Legal Information Institute, Definition of Tort, https://www.law.cornell.edu/wex/tort (last visited August 2018).