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Research Article

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EMERGING & GLOBAL HEALTH POLICY

Pandemic era expansion of state laws governing the professionalization of community health workers

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Abstract

Introduction **Community Health Workers (CHWs) are trusted public health workers who strengthen healthcare access, quality, and cultural responsiveness by addressing social determinants of health. While CHW services show value, professionalization policies, including certification and training requirements, remain debated.**

Methods **To understand these policies, we conducted an empirical legal mapping study of CHW professionalism laws in 54 US jurisdictions (50 states, DC, Puerto Rico, US Virgin Islands, and Guam) in effect in 2019 and 2024 following consensus legal mapping guidelines for legal research, coding, and quality control.**

Results **We screened 2248 relevant laws, with 31 jurisdictions modifying CHW professionalization laws. Between 2019 and 2024, the number of jurisdictions with consistent terminology (16 to 21), defined CHW roles (15 to 21), laws concerning certification (14 to 22), and laws requiring training for practice or certification (21 to 23) increased. Jurisdictions with formal education requirements declined (12 to 8), while jurisdictions requiring training programs increased (12 to 20).**

Conclusion **CHW professionalization requires careful navigation. While increased professionalism might enhance workforce stability, it risks creating barriers to entry and undermining CHWs' community-rooted identity. Future research is needed to identify the balance between CHW professionalism and the preservation of CHW status as trusted members of the communities they serve.**

Keywords: Community Health Workers, legal epidemiology, allied health personnel, legislation, medical, government regulation, professional role, certification, social determinants of health, health education

Key Takeaways

- **Significant Legislative Activity:** Between 2019 and 2024, the number of US jurisdictions with laws regulating Community Health Workers increased from 37 to 44, with nearly 60% of jurisdictions modifying their professionalization policies during the pandemic era.
- **Balancing Professionalism and Identity:** Modern legislation reflects an ongoing effort to integrate Community Health Workers into formal healthcare teams while attempting to preserve their unique status as trusted, peer-level members of the communities they serve.

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Introduction

There is increasing evidence of the value that Community Health Workers (CHWs) provide in health promotion, especially in chronic disease management applications.[1,2] CHWs are frontline public health workers who are trusted by and often part of the community they serve.[3] This connectivity allows them to improve the access, quality, and cultural competency of the health or social services delivered to the community and directly address the health disparities in their communities.[3] CHWs serve in a variety of settings, including public health departments, community-based organizations, and healthcare teams.[4] As bridge figures, CHWs serve crucial and varied roles in vulnerable and rural communities, connecting individuals with health services and providing a wide range of culturally and linguistically specific health and social services such as education, counseling, and navigation.[1,5,6]

Given their value, it is unsurprising that the CHW profession is expanding, with an expected growth of 11% in the next decade, much faster than the rate of other professions.[4] As acknowledgment of the importance of CHW work increases in the healthcare field, there have been additional efforts to fully integrate CHWs into the healthcare workforce.[7,8] With this growth, there is increasing tension on the CHW professional identity between their historical identity as lay health workers whose value was derived from their lived experience and community-specific knowledge and one of being an increasingly regulated, trained, and credentialed health professional skilled in both general knowledge and specific competencies.

Indeed, ongoing debate exists about the value and means of professionalization of the CHW workforce. While formal regulations of other health professions, which may include licensing and certification requirements, have been justified as a way to increase safety and quality of care,[9] these metrics may not hold true to CHW professionalization. CHWs are commonly employed outside of formal healthcare settings, and even when CHWs are integrated into healthcare teams, they provide education, navigation, and other supportive care, not clinical healthcare.[4] Though extensive training of CHWs has been associated with positive interventional outcomes,[1,10] certification (licensing in Puerto Rico) requirements create financial, education, training, or language barriers for CHWs desiring to enter the field. As a result, such regulations can constrain the available labor pool of providers and result in increased healthcare costs and reduced service availability.[9] As CHW work is community-specific, the knowledge that makes one CHW effective in their community may be completely different from the skills necessary for another community.[9] Nevertheless, substantial progress has been made on assessing specific CHW competencies that can be applied across communities.[11]

Nonetheless, some professional regulation may benefit the CHW field. For example, the lack of standardized certification processes can be a barrier to CHW compensation, making it difficult to adequately fund the CHW workforce.[8] State Medicaid programs and private health plans can more accurately make service reimbursements or coverage decisions when the roles of health professionals are clearly defined in law.[8] Additionally, certification and training requirements may benefit individual CHWs. Reports from previous surveys and interviews of CHWs have reflected support for additional training opportunities and a desire for professional advancement opportunities in the profession.[5,10,12] Certification programs have been associated with higher wages. A study by Jones et al. found that CHW hourly wages were $2.42 higher in states with certification programs compared to those without (although the wage effect was only statistically significant for white persons and men).[13] Governments can choose to support CHW professionalization through laws providing certification and training requirements.

Independent of the professionalization debate, there have been increasing calls for CHW roles and services that address the social determinants of health (SDOH). As trusted members of the communities they serve, CHWs can effectively target health concerns in vulnerable communities and promote health equity. Systematic reviews show many CHW services target client social needs, and this research broadly highlights the effectiveness of CHW-led interventions in chronic disease management such as cardiovascular risk reduction and cancer prevention.[1,2] Efforts to address social needs and improve population health also extend beyond traditional approaches to healthcare delivery. The medical-legal partnership (MLP) model, which embeds legal professionals onsite into the delivery of healthcare to address the root causes of poor health outcomes, and emerging community justice worker (CJW) initiatives demonstrate that community-based navigators increasingly operate across health, public health, and legal systems, raising shared questions about how certification and training requirements can broadly support SDOH work.

In addition to the existing evidence of their effectiveness, CHWs played a pivotal role in the COVID-19 response, particularly in reaching vulnerable populations.[14] CHWs were vital workers in vaccine outreach, contact tracing, and supporting vulnerable communities.[15,16] Additionally, the COVID-19 pandemic saw an influx of federal funding in support of the CHW workforce.[17] The Centers for Disease Control and Prevention reported investment of more than $340 million in the hiring, training, and deployment of CHWs for COVID-19 response.[18]

Comparing the national landscape of laws defining CHW certification or training requirements before and after the COVID-19 pandemic provides an opportunity to highlight how states adjusted CHW laws, policymaker understandings of how the role of CHWs in healthcare settings has changed, changes in CHW financing streams, or policy shifts acknowledging the role of the social determinants of health in health outcomes.

There is limited peer-reviewed and gray literature that has summarized the national scope of CHW professionalization-related policies. Most peer-reviewed literature covers policy changes in individual states and their impacts, while others have covered nationwide adoption of certain aspects of CHW professionalization.[19-21] Within the grey literature, 2 Centers for Disease Control and Prevention (CDC) state law fact sheets have provided evidence of increasing state-level CHW regulation. A 2013 CDC fact sheet provided information on 10 states with CHW professional identity or workforce development laws.[22] Responding to increasing interest in the need for CHW services from a variety of health and policy research organizations—including the National Governors Association, National Conference of State Legislatures, the Council of State Governments, the National Academy for State Health Policy, and the Association of State and Territorial Health Officials—the CDC conducted an expanded policy mapping study in 2016, and found that 23 states had laws regulating CHW professional identity or workforce development.[23] These 2 CDC factsheets

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revealed the dynamic and evolving nature of the CHW regulatory landscape in the pre-pandemic era. Given the dramatic impact of the COVID-19 pandemic on the US health system and the increasing reliance on and interest in CHWs for pandemic response and beyond, there is a critical need to understand how CHW professionalization legislation and regulation changed during the pandemic era.[24] This study addresses this gap by comprehensively reviewing United States state, territorial, and DC laws regulating the CHW profession, and analyzing and comparing the CHW laws in effect in these jurisdictions in 2019 with those in effect in 2024 to determine how the landscape has changed.

Methods

We assessed CHW laws pertaining to CHW funding, sustainability, and professionalism as part of a broader policy surveillance project in 2019 that included laws pertaining to CHW funding and sustainability (including Medicaid).[8] These existing data provided a convenient pre-pandemic data point. By 2024, the frenetic legislative and regulatory response to the pandemic had slowed and sufficient time had elapsed for new laws to become codified and effective. Thus, we repeated our 2019 CHW professionalization protocol (described below) in 2024 to assess the changes in the legal landscape associated with the pandemic era.

Our analysis of CHW laws followed consensus policy surveillance research guidelines.[25-28] We used Westlaw to find CHW-related statutes and regulations in effect on February 11, 2019, and June 11, 2024, in 54 jurisdictions: 50 US states, Puerto Rico, Guam, US Virgin Islands, and the District of Columbia.

Data collection and scoping

We compiled a list of CHW titles and search terms identified through the National CHW Training Center, a broad search of CHW organizations, and cross-referenced this list against prior CHW policy reviews.[3,8] Our search terms were reviewed by CHW subject matter experts, including experts at the CDC, the Network for Public Health Law, and the National CHW Training Center (located at Texas A&M University) (Box 1).

We reviewed all collected laws for CHW relevance. In addition to looking for common CHW terms (eg, CHW, promotor[a]s), we included laws suggesting that the person or position (1) was involved in community engagement or outreach and (2) was involved in health education or access to health or social services.[8] However, to contain our focus to only state, territorial, and district-level CHW policies, we excluded laws solely about Certified Health Education Specialists who have an existing national credentialing framework.[29]

Coding

We developed our coding scheme after reviewing CHW literature and laws. Our draft coding criteria (Box 1) was reviewed by CHW experts, including CDC and Network for Public Health Law experts. The same coding scheme was used for both data sets. We used a custom MS Access database to code the laws in 2019. However, we used the CDC Public Health Law Information Portal to code in 2024 as it facilitated greater specificity in associating specific legal text to each code, which aided both quality control and data transparency. Each coding team, for both 2019 (CS, TC, ML) and 2024 (CS, RWF, TC, DM) data, included a licensed attorney to resolve coding disagreements.

Box 1. Westlaw Search Methodology and Coding Questions for Included Laws

Westlaw Search String:

adv: (Community lay/3 health outreach/3 rep! Promotor! Worker Advis! Navigat! Aide) CHW CHR "health advocate" "health Promoter" "enrollment counselor" "enrollment entity" "care navigator" "patient navigator" "health educator" "community health representative" "community care coordinator"

Coding Questions for Included Laws:

- Q1: Does the state have consistent terminology for CHWs in its laws?
- Q2: Does the state have a law describing competencies or clearly enumerating the different roles and responsibilities of a CHW?
- Q3.1: Does the state have a law relating to the certification of CHWs?
  - Q3.2: What type of entity (ie, state or non-state) issues certificates?
- Q4: Does the state have training requirements for CHW certification or practice?
  - Q4.1: Does the state have formal education requirements?
  - Q4.2: Does the state have training program requirements?
  - Q4.3: Does the state have hour-based training (ie, minimum training hours) requirements?
  - Q4.4: Does the state have experience/practice-based requirements (ie, field experience)?
- Q5: Does the state require continuing education for licensed or certified CHWs?
- Q6: Does the state have a licensing or certification exemption clause for experienced CHWs?
- Q7: Does the state have a law that requires CHWs obtain training from certified (or otherwise recognized) training programs?
- Q8: Does the state have a law establishing a mechanism for discipline or punishment relating to CHW activities?

Quality control

Given the complexity of empirical legal research, we adopted multiple quality control processes. We employed 100% redundant, independent coding with at least 2 researchers reviewing each law and a third researcher entering the validated codes.

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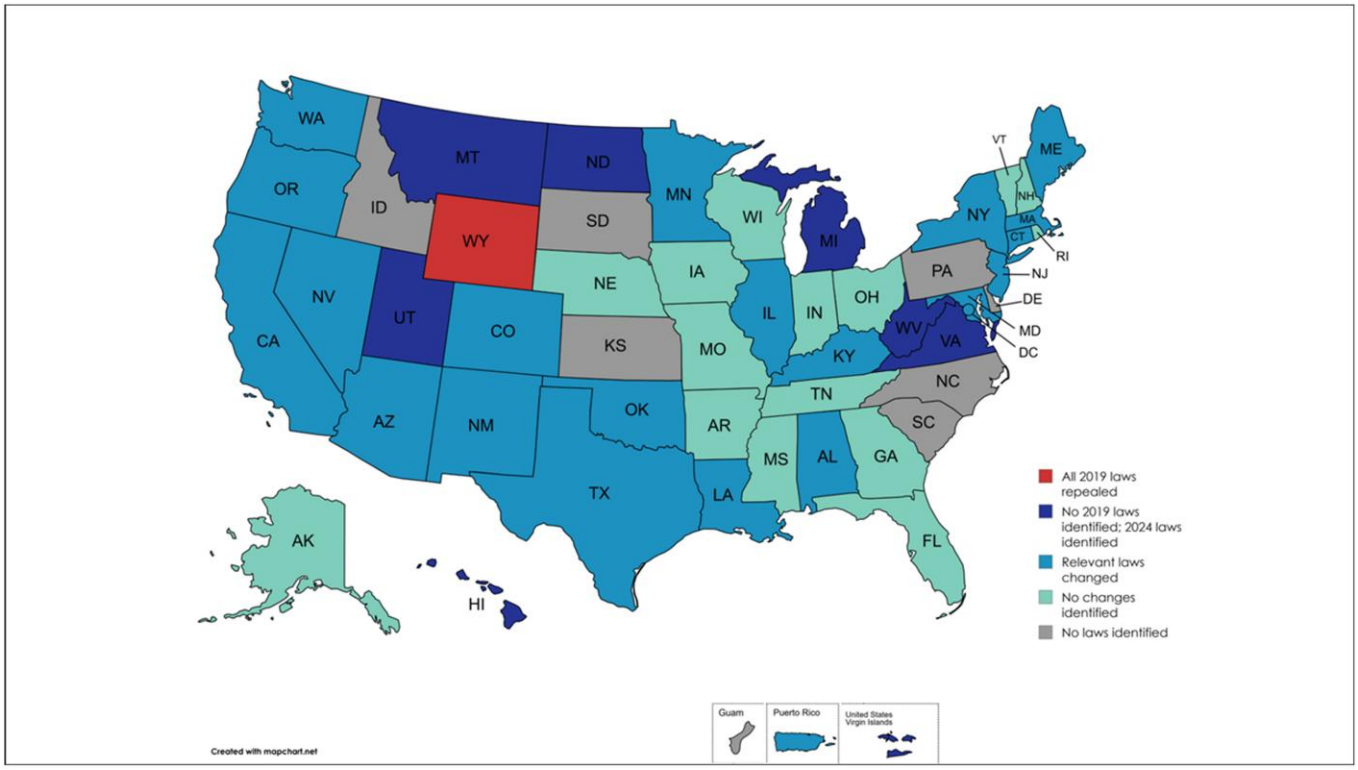


Figure 1. Jurisdictions with observed changes in CHW professionalization laws between 2019 and 2024.

Coding disagreements were resolved at coding meetings with a licensed attorney or CHW subject-matter expert deciding the outcome of ambiguous cases.[8]

Additionally, we employed several data validation processes on our final dataset. We focused these additional validation processes on observed differences between the 2019 and 2024 measurements because those provided the greatest likelihood of identifying coding errors in either the 2019 or 2024 measurements (ie, assuming it was statistically unlikely for 2 sets of redundant coders and validators to code laws erroneously and identically in 2019 and 2024). We performed this validation 2 ways: (1) a randomly selected 25% of jurisdictions (14 of 54 total) were verified to determine whether coding differences in the study period were concurrent with new, amended, or repealed laws that could explain coding changes between 2019 and 2024, and (2) an additional random 15% of jurisdictions (9 of 54 total) were verified to determine whether changes in coding results were due to specific language changes in law to rule out coding errors. We further checked all jurisdictions with data indicating differences in CHW terminology (Box 1, question 1) to verify that there were no scoping discrepancies between the data collections in 2019 and 2024. None of these probabilistic quality control checks revealed systematic issues that would have necessitated broader quality control efforts.

Limitations

The varied terminology used to describe CHWs created interpretive and scoping challenges for this study. To be inclusive of most CHW positions, we used a broad search string that included common CHW roles (ie, "community health aide" and "promotor") and CHW-related activities (ie, "enrollment counselor" or "health educator"). As the scope of our analysis was limited by including only laws that clearly applied to CHWs performing specified CHW-related activities (such as those involving the community), laws that implied CHW involvement but failed to specifically discuss CHW roles or related activity may not have been captured.

Results

We screened 2248 relevant laws (1216 in 2019 and 1032 in 2024), of which 835 (371 and 464) were within scope. Overall, the number of jurisdictions with laws related to the regulation of the CHW profession increased from 37 to 44, and nearly 60% of jurisdictions in our sample (31 of 54) created or modified their laws on CHW professionalization between 2019 and 2024. Only one state (Wyoming) repealed all its CHW-related laws (although we note that Iowa rescinded many of its CHW laws in 2025, outside of our observational cross-section) (Figure 1).

The number of jurisdictions using consistent terminology in their laws, ie, those which used the same words to refer to CHWs across all laws, increased from 16 to 21 between 2019 and 2024 (Table 1; Box 2; Table S1). We observed a 40.0% increase in the number of jurisdictions with laws clearly enumerating CHW competencies, roles, or responsibilities (15 to 21). Jurisdictions took different approaches for enumerating competencies, roles, and responsibilities, including listing competencies or skill-attainment tied to training and certification requirements (eg, California, Connecticut, Nevada), using enumerated services to legally define CHW practice (eg, New Jersey, New Mexico, Texas), or enumerating CHW services tied to specific government programs or reimbursement requirements (eg,

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Table 1. Total number of US states, territories, and DC with laws related to CHW professionalization (2019 and 2024).

Legal provisions	2019	2024
Q1: Consistent terminology		
Yes	16	20
No	21	23
Q2: CHW roles and responsibilities		
Yes	15	21
No	31	25
Q3: Certification for practice or reimbursement		
No	31	23
Offered	7	8
Required	8	15
Q3.1: What entity offers certificates		
N/A	32	24
State	10	17
Non-State	4	5
Q4: Training requirements for certification or practice		
No	25	23
Practice	8	6
Both	13	17
Q4.1: Formal education		
Yes (High school or equivalent)	4	5
Yes (Bachelor's or 4-year degree)	6	2
Yes (Master's or equivalent)	2	1
No	34	38
Q4.2: Training program		
Yes	12	20
No	34	26
Q4.3: Experience or practice-based		
Yes	14	12
No	32	34
Q4.4: Hour-based training		
Yes	2	10
No	44	36
Q5: Continuing education		
Yes	9	13
No	37	33
Q6: Grandfather clause		
Yes	7	9
No	39	37
Q7: Training through certified programs		
Yes	13	21
No	33	25
Q8: Discipline mechanism		
Yes	9	13
No	37	33

Indiana, Kentucky, Oregon). Additionally, we observed a 57.1% increase in the number of jurisdictions with laws on CHW certification (14 to 22), a 70.0% increase in the number of jurisdictions offering state certifications (10 to 17), a 75.0% increase in the number of jurisdictions requiring certification for practice or reimbursement (8 to 14), and a 44.4% increase in the number of jurisdictions with laws establishing mechanisms for CHW disciplinary actions (9 to 13).

Box 2. Terms for community health workers in US state and territorial statutes and regulations, 2019 and 2024 (# of jurisdictions using term).

Community health workers (36); health educator (21); patient navigator (8); public health educator (5); community health aide (4); care navigator (3); promotadora (3); community health representatives (2); community outreach workers (2); community care coordinator (1); community health care workers (1); community health educators (1); community health promoters (1); community outreach peer workers (1); community volunteers and outreach workers (1); enrollment counsellors (1); lay health worker (1); outreach workers or community health personnel (1); peer navigator (1); personal health navigators (1); public health advocates (1); representatives of community mental health centers (1); tuberculosis community health worker (1).

We also observed notable changes in laws pertaining to CHW training that included 19 states adding or removing various types of training requirements (Table S2). In all, we observed a 9.5% increase in states with requirements for training for CHW practice or certification (21 to 23), with each requiring some combination of formal education (12 to 8), training programs (12 to 20), experience-based training (14 to 12), or hours-based training (2 to 10). In 2019, 33.3% of jurisdictions with training requirements ($n = 7$) had exemption clauses allowing for certification based on experience that provide a pathway for certification for those with sufficient practice experience.. In 2024, 39.1% of jurisdictions with training requirements ($n = 9$) had exemption clauses allowing for certification based on experience We also observed a 44.4% increase in jurisdictions with laws on continuing education for certified ("licensed" in Puerto Rico) CHWs (9 to 13), and a 28.5% increase in jurisdictions with exemption clauses allowing for certification based on experience (7 to 9) that provide a pathway for certification for those with sufficient practice experience.

Discussion

Between 2019 and 2024, there was considerable legislative and regulatory activity regarding CHW professionalization. There are many possible explanations for the extensive legislative and regulatory activity related to CHWs. For example, CHWs are increasingly being integrated into interprofessional healthcare teams,[4,7] which may have an impact on the level of CHW professionalism desired by different jurisdictions as CHWs are being hired directly by hospitals and health systems that are more likely to have educational and training requirements for CHW applicants.[30]

Additionally, 2019 and 2024 bookend the COVID-19 pandemic and its immense influence on the healthcare system. CHWs made a vital contribution to the COVID-19 pandemic response in vulnerable communities through public health interventions such as vaccine outreach and contact tracing.[17] During the pandemic, CDC provided funds for CHW programs to 67 health departments to aid the public health response.[31] The subsequent increase in

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regulatory and legislative activity in jurisdictions following the COVID-19 pandemic may be a recognition of the critical role that CHWs played in addressing healthcare delivery inequalities that was highlighted by the COVID-19 pandemic. As COVID-era funding mechanisms ended, stakeholders (including CHWs) sought additional ways to continue funding the revitalized CHW workforce. States increasingly allowed Medicaid reimbursement for CHW services or allowed Medicaid managed care organizations to reimburse these services.[8,32,33] The observed increase in CHW professional regulation might reflect the recognition of many jurisdictions that training and certification requirements are useful in determining which providers qualify for Medicaid reimbursement.[13]

Further, as policymakers seek to control expensive healthcare costs, CHWs are both effective and efficient in addressing health behaviors and the social determinants of health that affect an important portion of the overall health of the population.[5,34] With an increasing focus on risk sharing in alternative payment models, health system reimbursement is becoming more dependent upon how well systems keep their patients healthy, rather than just cure them when they are sick.[35]

CHWs can provide cost-effective public health interventions. One systematic review found that studies measuring CHW-based intervention-related return on investment reported positive returns on investment (from $1.36 per dollar spent to $27.51 net return per dollar spent), while a systematic economic review of CHW participation in cancer screenings found that CHWs are cost-effective.[2,6,36] These findings present an even more convincing case that a strong CHW workforce may be critical to improving health and lowering costs going forward. States and jurisdictions can support additional CHW integration into existing healthcare systems by enacting policies that improve CHW working conditions, expand CHW roles, and ensure the quality and consistency of CHW work through establishment of clear training, certification, and disciplinary standards.

Finally, and importantly, the CHW professionalism movement is being bolstered within the CHW workforce. A 2014 policy brief by the American Public Health Association discussing CHW training and credentialing emphasized the importance of CHW leadership's collaborative input in these potential developments with policymakers.[37] Supporting professionalization efforts at the national level is the formation of the National Association of Community Health Workers in 2019, which marked a key milestone in the broader professionalization movement, established a unified national body to promote workforce cohesion, advanced consistent terminology, and advocated for policies that support the long-term sustainability of the profession.[38-40] Similarly, the National Council on Community Health Worker Core Consensus Standards developed a uniform set of CHW roles and competencies that has promoted the visibility and understanding of CHW practice.[41] More recently, Envision, the CHW-led technical assistance and training center, has been invaluable in improving and sustaining CHW programs—supporting a workforce that is a critical part of the public health system.[31]

The significance of consistent terminology

The lack of consistent CHW terminology in legislation and regulatory provisions is a persistent and substantial barrier towards increased professionalization. Consistent terminology and, similarly, well-defined CHW roles and responsibilities can help policymakers, healthcare systems, and other decision-makers understand the role that CHWs play in promoting health equity in the community.[17,41] Jurisdictions that lack consistent terminology (38 in 2019 and 33 in 2024) can be limited in their understanding of how CHWs contribute to and complement allied health professionals. Established healthcare teams in hospitals and clinics that already struggle with understanding CHW roles and responsibilities are further limited by a lack of consistent terminology that imposes additional barriers toward professionalization.[42] As we have noted in our past work mapping CHW laws pertaining to funding and sustainability (including Medicaid), inconsistent terminology and legal definitions make it difficult to link CHWs in the field with legal funding mechanisms that are critical to long-term CHW funding and sustainability.[8]

Despite these challenges, we observed a trend toward consistent terminology within jurisdictional laws. While consistent terminology may imply that CHW roles within the state are uniform, some CHW stakeholders argue that role uniformity creates cohesion within the CHW workforce and increases understanding of the profession.[11,40]

The significance of increasing CHW professional regulation

Professionalization of the CHW workforce is a key issue among stakeholders whose goal is to integrate or sustain CHWs in their enterprises (eg, existing teams, public health initiatives).[43] We have observed significant legal trends toward CHW professionalization that include the introduction of certification mechanisms, the clarification of CHW roles and competencies, and the establishment of optional or mandatory training for CHW workers and the disciplinary mechanisms required to support quality services.

There are several anticipated benefits to increased CHW professionalization. Certification validates skills, sets competency standards, enhances healthcare integration by increasing role acceptance by other healthcare providers, and can lead to higher pay without significant sociodemographic shifts in the workforce.[44] The absence of clear roles and responsibilities outlined in state laws may be one reason for the friction between CHWs and other allied health professionals when integrating CHWs into existing healthcare systems.[7] Interprofessional competition seems to wane considerably once expectations are established and teams understand the role of CHWs in the healthcare process.[5,7,8,45]

Yet, CHW professionalization remains a complex issue. While professionalization and certification offer strategies that will formally recognize CHW expertise and training, they also present challenges for CHWs seeking to volunteer or work in informal roles within their community.[46] Foundationally, CHWs arise from the community they serve to address specific community issues with a unique skillset derived from experience in that community. Requiring credentialing could create barriers that hinder the ability of new or existing CHWs to respond to the needs of their communities.

The effectiveness of CHWs is derived from their status as lay, or peer, community members, and, arguably, professionalization efforts have the potential to create a wedge between the CHWs

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and the communities they serve. For example, while training requirements can provide beneficial skills and knowledge to CHWs, legally codified requirements may not accurately reflect community needs. Moreover, laws requiring formal education may prevent CHWs with irreplaceable knowledge of their community from practicing if they lack the education or degree required by law. Some jurisdictions mitigate the consequences of CHW certification with exemption-based experience clauses that exempt existing CHWs from new training requirements.

Legislative and regulatory activity, however, seems to be charting a middle ground between the 2 views on CHW professionalization, recognizing both the benefits and the tradeoffs. For example, we observed that 8 jurisdictions removed formal education or experience-based requirements (4 removed both) while 14 jurisdictions added training programs and hours-based requirements (4 added both) (Table S2). This may suggest that, as formal education, particularly baccalaureate or graduate-level requirements, pose a more substantial entry barrier to CHW practice than training programs, jurisdictions are attempting to balance the benefits and penalties of formalized CHW professionalism. These results demonstrate a middle ground approach to CHW professional regulation that attempts to respect the importance of CHWs being trusted community members, while acknowledging the value of professional regulations and training that might enhance CHW skills and knowledge.

CHWs and Cross-Sector Navigation Efforts to regulate and professionalize community-based workforces raise empirical questions about how legal and policy design shapes workforce growth, role clarity, and access to services. For CHWs, this includes work that extends beyond clinical teams into public health departments, community-based organizations, and medical-legal partnerships (MLPs), where they help individuals address health-harming social and legal needs related to housing, income, and family stability. In many MLPs, CHWs are integrated as key members of interprofessional teams that identify and respond to social determinants of health (SDOH), while other collaborative care settings rely on different configurations of lay navigators and legal specialists.[47] For example, in Rhode Island, the Legal Key Partnership for Health and Justice is an innovative MLP that partners with the state to provide CHWs with legal training and problem-solving consultation to help them detect and meet families' health-related social needs in areas such as housing, benefits, utilities, education, child welfare, and family law.[48] By providing CHWs with legal education on SDOH, this partnership illustrates one model of how CHW practice can be supported at the intersection of clinical care and community-based work.

Similarly implicated are emerging MLP and health-system models that rely on community justice workers (CJWs) as a category of lay, community-embedded providers who are specifically trained to help people understand and navigate the same legal processes that drive SDOH.[49] CJWs are inspired by CHW models in that they recruit trusted community members as lay navigators, and they extend the underlying logic directly to legal and administrative systems rather than solely focusing on clinical and public health services.[50] A core point of contact between CHWs and CJWs is their shared role as community-rooted navigators of complex systems whose effectiveness at improving lives and health depends on community trust and incorporation with larger institutional frameworks.[51]

Seen from the vantage point of CHW regulation, both MLP-based CHW models and independent CJW initiatives—including in Utah,[52] Alaska,[53] and Washington, D.C.,[54] and a similar role proposed in Texas[55]—underscore that choices around certification, training, and supervision will increasingly shape how lay navigators across sectors can equitably expand access to services and address SDOH. Our finding that some jurisdictions are moving away from formal education requirements toward more flexible training and hours-based pathways for CHWs suggests one concrete model for how regulation might simultaneously preserve low barriers to entry and support quality in similar health-promoting navigation workforces like CJWs.

Conclusion

The increasing trend toward CHW professionalization across the United States holds transformative potential for healthcare delivery and team integration. We cannot conclude from this descriptive study whether these legal changes will have positive effects on health and public health systems. These are empirical questions, and the legal data here can provide an important antecedent to answering those questions. We expect that formalizing CHW roles through certification and competency standards will provide several benefits, including fostering higher levels of integration of CHWs into healthcare teams, enhancing access to culturally competent services, and improving the health outcomes of underserved communities. These efforts could reduce interprofessional friction, expand the CHW workforce, and provide a foundation for more cohesive and effective healthcare delivery. However, careful implementation that includes CHW input is crucial to ensuring equitable participation in the CHW workforce. Further research might be needed to identify the optimal balance between preserving the traditional lay health worker identity of CHWs and the push toward increasing professionalization.

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Supplementary material

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

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Data availability

Data are provided in the supplemental materials.

Notes

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