ISSUE BRIEF

Community Health Workers in New Jersey: The Question of Certification

John V. Jacobi, J.D.
Tara Adams Ragone, J.D.

Seton Hall University School of Law
One Newark Center
Newark, NJ 07102
law.shu.edu

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ABOUT THE CENTER FOR HEALTH & PHARMACEUTICAL LAW & POLICY

Seton Hall Law School’s Center for Health & Pharmaceutical Law & Policy educates lawyers and health care industry professionals regarding the extraordinarily complex set of laws that govern patients, health care providers, manufacturers, and suppliers. Furthermore, Center faculty produce scholarship, white papers, and recommendations for policy on the varied and complex issues posed by health and pharmaceutical law, health care access, human subject research, mental health issues, and non-profit governance. Faculty members bring to the Center’s work nationally recognized expertise in health care finance, disability law, health insurance law, Medicare and Medicaid law, intellectual property law, and bioethics, among other areas. The Center fosters informed dialogue among policymakers, consumer advocates, the medical profession, and industry in the search for solutions to the ethical, legal, and social questions presented in the health and pharmaceutical arena.
EXECUTIVE SUMMARY

Community Health Workers (CHWs) form an emerging profession devoted to community-based problem-solving, health education, and bridge-building to needed resources and services. These tasks advance health goals by providing solutions to the health deficits caused by the effects of social determinants of health, and by squarely confronting disconnects between vulnerable populations and institutional caregivers.

This Issue Brief approaches the current status of CHWs in New Jersey from a regulatory lens. It asks what, if any, regulatory action the State of New Jersey should take with respect to the CHW profession. After review of the public health and policy literature on CHWs, a survey of the actions taken by other states with respect to CHW status, and consultation with a range of stakeholders in New Jersey, the authors provide analysis and recommendations. In summary, we found:

- CHWs are extremely valuable professionals assisting individuals and vulnerable populations to resolve their social and health care needs.
- CHW work, unlike that of many health professionals’ work, is not easily susceptible of licensing regulation, and it is impractical to delineate a professional scope of practice, which would place clear boundaries around CHWs’ professional activities.
- Descriptions in certification standards as to the appropriate skills, roles, types of training, and types of supervision for CHWs could provide a functional substitute for scope of practice regulation, while permitting CHWs as a profession to evolve and grow.
- Formal or informal regulatory recognition of the profession has benefits and disadvantages:
  - Recognition enhances CHW prestige and inter-professional recognition, enhances job mobility, and provides a step for CHWs on a professional employment ladder.
  - Regulatory oversight of CHWs’ activities helps to provide assurance to other helping professionals and patients as to the safety and regularity of CHW practice.
  - Regulatory recognition makes it more likely that public and private insurers will pay for CHW services, aiding in the sustainability of their important work.

Regulatory and legislative actors have long expressed interest in supporting CHWs in New Jersey. However, many complex issues should be addressed before New Jersey describes a regulatory structure for CHWs; the best vehicle for resolving these issues would be the creation of a broadly representative advisory body to work through the many issues described in this Issue Brief, and recommend to the Legislature the nature of the regulatory oversight most appropriate to support CHWs’ practice within a sound public health framework.

1 See infra Appendix A for the stakeholders consulted.
I. INTRODUCTION

The health care delivery system is changing. Health systems and public health research has established that the health status of individuals and populations is deeply affected by social determinants of health including housing and food security, public safety, access to education and recreation, and exposure to racism and poverty. The delivery of health care has shifted from an overwhelming focus on medical treatment of illness to a broader focus on the precursors and causes of poor health as well as curative interventions after the fact. The lens through which we consider health care has widened to encompass social services as well as medical care.

The American Public Health Association defines community health workers (CHWs) as, frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs 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. CHWs also build 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.2

CHWs play an important part in this evolving health care system. The roots of CHWs include the work of *promotoras de salud*, the cadre of caregivers rooted in the Mexican-origin and other Hispanic groups who provide health education and outreach as bridges to more formal social and medical care systems.3 The CHW model has spread to many communities and cultures, and its importance to advancing goals of wellness and whole-person health is now widely recognized.4 There has been a broad discussion of the importance of CHWs and their appropriate

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scope of practice among governments, health professionals, health systems and public health researchers, community-based organizations, and CHWs themselves. There is broad consensus as to the importance of CHWs, although that consensus weakens when questions of their training, supervision, eligibility for third-party payment, and relationship with the medical community are pressed.

This project addresses a small but important piece of the public policy discussion of the future of the CHW profession: whether and in what way the State of New Jersey should oversee the recognition and deployment of CHWs. We begin with an appreciation of the importance of CHWs’ work, particularly to vulnerable communities with sometimes fraught relationships with larger social service and health care providers. The broad interest in examining the legal status of CHWs has complex facets.

On one hand, CHWs are successful in large part due to their deeply ingrained ethos of caring engagement and their connection with their communities, and their local recruitment and informal formation seem key to the impact they have on their communities. On the other hand, the informality of CHWs’ professional existence causes concerns for them (lack of job mobility, impeded recognition of their professional acumen, and barriers to sustainability of CHW programs due to third-party payers’ preference for credentialed providers) and for consumer safety (as few formal rules define their scope of practice or educational/training requirements).

Seton Hall’s researchers performed legal, public policy, and public health literature searches, examined the activities of other states as they charted a way forward for CHW practice, and met with CHWs, organizations that employ and train them, and firms that manage payment for services that include CHWs. In this Issue Brief, we report on this research and outreach, and provide recommendations for New Jersey going forward. We strove to hit the sweet spot between over-bureaucratization that could stifle the development of the CHW profession, and an unregulated context in which CHWs are exposed to risks due to incomplete theorization of their relationships with others in the caregiving network.

Part II of this Issue Brief provides an overview of the current state of the field as to the functions, roles, and skills of CHWs, as well as an overview of the important issues of CHW training and supervision. We approach these issues from the context of regulatory lawyers; that is, we note that the usual means of state oversight of a helping profession – professional licensure – seem inapt in this setting. We review the literature on CHW roles, skills, training, and

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supervision both to provide a background on these important issues, and in part to describe how they may provide, in sum, a functional substitute for licensure, in the sense that they provide assurances of sound professional practice.

Part III addresses the question of certification of CHWs. We discuss the pragmatic reasons certification may be considered, the decisions made by sister states with respect to CHW certification, and the reactions provided through our consultation with many New Jersey stakeholders on these issues.

Part IV provides analysis and recommendations. The central recommendation is that New Jersey – through the Legislature or otherwise – should convene a broadly representative advisory body to consider the complex and contested issues related to the status of CHWs. We recommend that the decisions reached support the vital contributions of CHWs in New Jersey and support the professional development of the men and women who serve our most vulnerable populations as professional community health workers.
II. **THE EMERGENCE OF THE CHW PROFESSION: ENSURING SOUND FORMATION, SUPPORT, AND CARE DELIVERY**

A. Functions: Scope of Practice, Roles, and Skills

1. Scope of practice

CHWs form an emerging profession of caregivers, responsive to the recognition that health status is related as much to access to safe housing, food, and education as to medical care. CHWs fit into this new conception of a health system by functioning as advocates, interpreters, and educators of members of their communities, acting as bridges between their clients and social services and the clinical health system.

CHWs play an increasingly important role in educating and advocating for community members, helping to connect them to appropriate social and health care services, and participating in public health research. From a regulatory perspective, the appropriate functions of CHWs in the larger social and health delivery systems must be assessed based on a determination of their appropriate roles and responsibilities in consideration of their professional training and supervision, and in relationship to other actors in those systems.

One approach to this definitional task is to consider the “scope of practice” of CHWs. Scope of practice is a term used to define the “type of services a member of a health profession can provide.” The legal use of the term is to define a relational range of activities for a profession — that is, the functions that a member of a profession may perform without impinging on the scope of another profession. Legal scope of practice rules, then, are intended to keep various helping professions “in their lanes,” and ensure that professional competencies of the various professions match the skills needed for a range of services and interventions, to protect the public from harm at the hands of unqualified providers of care. In New Jersey and other states, formal scope of practice rules have not been adopted for CHWs.

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8 Catherine Dower et al., *It Is Time To Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care*, 32 HEALTH AFFAIRS 1971, 1972 (2013).
9 *Id.*
10 Scope of practice rules do exist in New Jersey for many in caring professions. See, *e.g.*, N.J.A.C. § 13:35-6.4 (defining scope of practice and establishing training, education, and supervision requirements for Certified Medical Assistants before physicians are permitted to delegate administration of subcutaneous and intramuscular injections and performance of venipuncture to them).
More helpful at this stage of the development of the CHW profession is the *professional* scope of practice, which can be understood as,

[A] profession’s description of the services that its members are trained and competent to perform. Professional competence evolves over time as health professions integrate new developments into the clinical practice, expanding the body of knowledge and skills for that profession.11

In the absence of a regulatory scope of practice rule in New Jersey and elsewhere, this descriptive alternative takes on great importance. The CHW profession has focused on this descriptive sense of its scope of practice – the roles, skills, and competencies of CHWs without reference to formal comparisons to the scope of practice of other professions. This focus is sensible, as the profession is evolving along with its place in the range of professions serving communities’ and vulnerable individuals’ health needs.

The content of the professional scope of practice has been the subject of substantial analysis provided by state advisory committees and public health experts under the rubric of the proper roles and skills of CHWs, as described below. The imprecision of the boundaries of CHWs’ activities under a professionally-driven scope of practice definition should be noted. The next section describes the process by which the roles of and skills required of CHWs have come to something approaching consensus. These discussions describe in detail what CHWs can and should do; they tend to be silent on what they should not do, although this literature does address the boundaries of CHW practice indirectly through descriptions of recommended training regimens, also discussed below.

2. Roles

The literature tends to describe recommended roles for CHWs in lieu of a defined scope of practice. The focus on the tasks suitable for CHWs allows for a positive statement of the benefits CHWs have provided to their communities in the past, and suggestions for a defined slate of those tasks for the future. Some roles are central to CHWs in all settings:

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### CORE ROLES OF CHWs\(^{12}\)

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
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<tbody>
<tr>
<td>Health education</td>
<td>Provide culturally appropriate, relevant education and educational materials</td>
</tr>
<tr>
<td>Cultural bridge</td>
<td>Provide connections and mediation among community members, health and social service agencies, and government</td>
</tr>
<tr>
<td>Advocate</td>
<td>Speak on behalf of community members to surface deficits in available services and social supports; assist community members as they advocate for themselves and the community</td>
</tr>
<tr>
<td>Navigator</td>
<td>Assist community members to locate needed social and health services, and facilitate concrete connections of services to those in need of those services</td>
</tr>
<tr>
<td>Home visits</td>
<td>Come to community member where they are to ensure that health and social service needs are addressed and not neglected</td>
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</tbody>
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The literature describes a second category of roles for CHWs that are related to specialized tasks. Some of these tasks require specialized training:

### SPECIALIZED ROLES OF CHWs\(^{13}\)

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Outreach and enrollment/client retention</td>
<td>Contact community members to facilitate engagement with insurer or other institutional actor</td>
</tr>
<tr>
<td>Provide direct service/enhance adherence</td>
<td>Under the supervision of clinicians, deliver health services or monitor adherence to medications or other health interventions</td>
</tr>
<tr>
<td>Participate in research and evaluation</td>
<td>Gather quantitative or qualitative information to permit advancement of quality and access goals</td>
</tr>
<tr>
<td>Participate in development of community care capacity</td>
<td>With clinical and social services partners, facilitate the development/expansion of care provision</td>
</tr>
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\(^{12}\) See, e.g., Cara Whelan Smith et al., The 2018 Ohio Community Health Worker Statewide Assessment: Key Findings (Ohio Dep’t of Health and Ohio College of Medicine, Sept. 2018), available at [http://www.nursing.ohio.gov/PDFS/CHW/Assessment/1_CHW_Assessment_Key_Findings.pdf](http://www.nursing.ohio.gov/PDFS/CHW/Assessment/1_CHW_Assessment_Key_Findings.pdf); C3 Progress Report, supra note 7, at 9; Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability 8 (North Carolina Community Health Worker Initiative May 2018) [hereinafter CHWs in NC], available at [https://files.nc.gov/ncdhhs/DHHS-CWH-Report_Web%205-21-18.pdf](https://files.nc.gov/ncdhhs/DHHS-CWH-Report_Web%205-21-18.pdf); Findley et al., supra note 6, at 1983.

\(^{13}\) See Hannah Covert et al., Core Competencies and a Workforce Framework for Community Health Workers: A Model for Advancing the Profession, 109 AM. J. PUB. HEALTH 320, 322 (2019) (describing stratified categories of CHWs); C3 Progress Report, supra note 7, at 9; Findley et al., supra note 6, at 1983.
3. Skills

The literature describes skills central to the tasks that CHWs undertake. Some of these tasks are innate character or personality traits for which employers search when hiring CHWs (and that CHWs identify as integral to their practice). To say that these skills are “innate” has two implications. First, given the nature of the tasks CHWs undertake, there are certain qualities of personality that are fundamental to the enterprise of connecting with clients and making social and service connections for those clients. Second, although training programs can enhance aspects of these innate skills, they cannot teach them to someone without the right personality: one is either a “people person” or one is not.

Other skills identified in the literature can be acquired through didactic training or on-the-job experience. These skills can be further divided into two subcategories: those that are basic skills that all CHWs should acquire to practice as CHWs, and those that are specialized skills that are appropriate for CHWs engaged in particular tasks often in concert with clinical partners.

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<thead>
<tr>
<th>BASIC INNATE SKILLS</th>
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<tr>
<td><strong>Strong interpersonal skills</strong></td>
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<tr>
<td>Community connections</td>
</tr>
<tr>
<td>Commitment to community health</td>
</tr>
<tr>
<td>Advocacy bent</td>
</tr>
<tr>
<td>Professional presentation</td>
</tr>
<tr>
<td>Empathy</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Basic Acquired Skills</th>
<th></th>
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<tbody>
<tr>
<td>Time management</td>
<td>Ability to maintain caseload and respond to the needs of clients in timely fashion</td>
</tr>
<tr>
<td>Knowledge of social determinants of health</td>
<td>Basic understanding of relationship between contextual circumstances of clients and their health and health needs</td>
</tr>
<tr>
<td>Electronic communications</td>
<td>Facility with electronic devices including devices of accommodation</td>
</tr>
<tr>
<td>Charting</td>
<td>Understanding of the importance and process of charting client encounters</td>
</tr>
<tr>
<td>Interviewing</td>
<td>Knowledge of interviewing techniques</td>
</tr>
<tr>
<td>Legal standards</td>
<td>Familiarity with requirements of standards such as HIPAA, mandatory reporting laws, and the Americans with Disabilities Act (ADA)</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>Understanding of behavioral health conditions and the effects of these conditions on overall well-being</td>
</tr>
<tr>
<td>Navigation</td>
<td>Ability to assist clients in navigation of social service and health systems</td>
</tr>
<tr>
<td>Public health</td>
<td>Knowledge of basic public health principles</td>
</tr>
<tr>
<td>Language</td>
<td>Bilingual language skills</td>
</tr>
<tr>
<td>Safety/self-care</td>
<td>Knowledge of modes of safe conduct of professional functions; understanding of self-care</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialized Acquired Skills</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Research</td>
<td>Ability to participate in qualitative and quantitative research projects</td>
</tr>
<tr>
<td>Clinical</td>
<td>Knowledge of select health conditions, including symptoms, prognosis, and possible interventions</td>
</tr>
<tr>
<td>Education</td>
<td>Ability to lead or participate in community education programs; ability to participate in education of CHWs</td>
</tr>
<tr>
<td>Coordination/supervision</td>
<td>Ability to coordinate activities of CHWs and social services/clinical partners</td>
</tr>
<tr>
<td>Assessment</td>
<td>Ability to review community needs and resources and prepare community assessments</td>
</tr>
</tbody>
</table>
B. Acquiring CHW Skills: Training and Supervision

The profession of community health worker is adjacent to the already-crowded fields of social services and health care. As the above discussion indicates, a CHW with the requisite skills, filling the increasingly appreciated roles for which their skills are intended, can assist communities and individuals to overcome deficits caused by the effects of social determinants of health. In the absence of scope of practice regulations, CHWs and State regulators must rely on the emerging consensus as to CHWs’ requisite roles and skills to forge a coherent identity for this patient-facing profession.

Properly designed training and supervision can serve two quite different but equally important functions. First, they can ensure that CHWs acquire the basic and specialized skills important to their work, and that CHWs fulfill roles for which they are responsible. Second, thoughtful training and supervision can emerge as functional scope of practice guides, addressing concerns that CHWs may engage in activities that exceed their proper roles, thereby crossing “professional boundaries” to the possible dismay of other professions and potential harm to patients.

Thoughtfully designed training and supervision, then, can both support the advancement of CHW practice by ensuring professional conduct, and address any inter-professional hesitancy by training on and reinforcing knowledge of guardrails beyond which CHW practice ought not extend.

Training and supervision are important in all professions. They are emphasized here because, as described above, scope of practice regulation, a common method of delineating the metes and bounds of practice, is not appropriate at this stage in the development of the CHW profession. Training programs are, of course, primarily designed to support the knowledge and skill base of CHWs to permit them to serve clients effectively, and supervisory programs are primarily designed to assist CHWs to effectively deploy their skills for the benefit of their clients.

But training can also educate CHWs as to the boundaries of their proper roles by, for example, explaining that diagnosis and treatment of ailments are clinical skills properly left to licensed professionals. Similarly, well-designed supervisory methods can keep CHWs in frequent contact with managing professionals who can reinforce both the limits of CHWs’ roles and the availability of differently-trained professionals who can take up tasks at the limit of CHW practice.

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16 Sinai Urban Health report, supra note 6, at 81-81.
1. Training

As described above, the literature’s description of “skills” is heterogeneous. Some of the skills can be thought of as character traits, including being a “natural helper,” or being able to “communicate with empathy.” While sound training programs can reinforce these traits, they are more properly thought of as indications considered in the hiring process for CHWs, and not skills to be inculcated after hiring.

Other skills are not innate, and should be basic to the training of all CHWs. Other skills are similarly learned and not innate, but are more appropriately considered as supplemental or specialized skills for CHWs working on research or particular clinical projects. There are outstanding questions regarding training, which vary among areas of the country and places of employment. Outstanding issues include: when the training should occur; who should provide it and where; what the content of the training should be; and whether some aspect of the training should be subject to State oversight. We provide descriptions below of the major issues implicated by these questions; we recommend below that resolution of these issues be a subject for a broadly-inclusive advisory commission convened in advance of any definitive State decisions on training requirements.

- **When.** Training can be provided before CHWs are hired, after they are hired and before they are deployed, or at least in part on-the-job while the CHW is working in the field. There are advantages and disadvantages to each of these options, and a decision on timing could vary depending on the type of work undertaken. For example, some basic topics, such as knowledge of privacy principles and laws should be the subject of training before deployment. Others, such as good documentation and charting practices, might be more pedagogically appropriate while a CHW is practicing under supervision, so that the practical importance of good charting can be understood. Still others, such as knowledge of particular disease processes, could be delivered after an experienced CHW is selected for participation on particular clinical treatment or research programs.

- **By whom.** The subjects of training are various, and it may be appropriate that different aspects be provided by different persons or entities. For example, some of the fundamental knowledge base, such as personal training and navigation of local social service and clinical providers, could be provided in-house. More specialized training, as in the case of particular disease indications, could be provided by clinical partners in anticipation of specialized projects. On the other hand, there are several sources of

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17 See C3 Progress Report, supra note 7, at 24-27.
18 See id. at 23.
19 See id. at 9-10.
20 See id. at 10.
21 Findley et al, supra note 6, at 1984-85 (employers describe a “patchwork” of training opportunities).
22 Id.
comprehensive training that have been used by employers in New Jersey for a wide range of training. 23

- **State oversight.** Although further examination is required, it appears that there is a wide range of training provided to New Jersey’s CHWs. This variety could be problematic if deployed CHWs do not obtain training in centrally important aspects of their professional work. It is unobjectionable if the various forms of training include appropriate modules, arming CHWs with the knowledge they need to advance. State certification in the training area could focus on CHWs themselves, training entities, employers of CHWs, or training curricula. The possibility of certification – voluntary or mandated – of the training process is described below. 24

2. Supervision

Well-designed training of CHWs provides a professional grounding; in addition, it helps to provide a functional substitute for scope of practice regulation by helping CHWs appreciate their role vis-à-vis other social service and clinical professions. Similarly, well-designed supervisory programs do double duty: they assist CHWs as they maximize their contribution to the well-being of their clients and community, and they are role-reinforcing in that they assist CHWs to avoid exceeding their professional competence when addressing the needs of their clients.

Relying on sound supervision to provide assurance of fidelity to professional mission can be a sensible strategy. By connecting CHWs to, for example, highly-experienced CHWs, clinical social workers, nurses, and physicians, CHWs can operate within a team, with each team member contributing consistent with their professional training. Supervisory relationships can follow the same path, with CHWs following guidance from more experienced or differently-trained professionals. 25

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23 These training organizations include the Community Health Worker Training Program provided by the Rutgers School of Management and Labor Relations and funded by the New Jersey Department of Labor and Workforce Development through a partnership with the New Jersey Health Care Talent Network. See Rutgers School of Management and Labor Relations, available at https://smlr.rutgers.edu/content/community-health-worker-training-program; The Penn Center for Community Health Workers’ IMPaCT Model at the University of Pennsylvania School of Medicine and the Wharton School, see https://chw.upenn.edu/; and The Community Health Worker Institute of the Camden Area Health Education Center, see http://www.camden-ahec.org/chwinstitute.html.

24 See infra Section IV (Recommendations).

25 Such supervisory relationships have been built into New Jersey’s regulatory structure for health professionals. For example, certain practices by Certified Medical Assistants can be undertaken only under the supervision of a physician – a provision that both assures the deployment of suitable expertise and provides a predictable supervisory relationship to avoid practice beyond professional competence. See N.J. Admin. Code § 13:35-6.4 (performance of venipuncture by certified medical assistants).
The literature recognizes CHWs’ supervisory relationships with a wide variety of professionals including:

- a program coordinator; clinical psychologist or psychiatrist;
- physician; nurse or nurse practitioner; director (program/field/clinical);
- health administrator; health educator/certified health educator; primary study investigator;
- social worker; health priority specialist; or a more experienced CHW.\(^{26}\)

In addition, the structure of the supervisory relationship – periodicity, definition of roles, and intensity of supervision – is not clearly delineated in the literature, although thoughtful commentary is available.\(^{27}\) A few points stand out:

- **Mission compatibility.** The supervisors should be familiar and comfortable with the professional mission of CHWs. It is important that the supervisor “understands the unique role of the CHW on the service delivery team.”\(^{28}\) Supervisors who are knowledgeable about the roles of CHWs can assist in both maintaining morale and in ensuring that professional boundaries are respected.\(^{29}\)

- **Intensity of supervision.** Relatively frequent supervisory and team meetings can reinforce the training CHWs receive and ensure that referrals and consultation with other professionals occur in a timely and accurate fashion.\(^{30}\)

- **Supervision by clinicians.** The sometimes problematic relationship between CHWs and clinicians suggest that other professions have concerns about the place of CHWs in the health delivery system. These concerns can cause “role confusion,” leading other professionals to task CHWs in ways that are inconsistent with their proper roles, and that raise the possibility that CHWs may exceed the boundaries of those roles.\(^{31}\) For some tasks, one state requires that a CHW performing tasks “related to nursing care” must be performed “pursuant to the delegation of a registered nurse.”\(^{32}\) There are mixed views on the extent to which CHWs should be, or should be required to be, connected to clinicians as part of their practice. On one hand, consultation and cooperation with clinicians serve CHWs’ clients by ensuring team-based care and shared information. On the other, requiring supervision or delegation by clinicians can weaken the independence of CHWs, casting them in the role of clinical extender rather than as community advocate.

\(^{26}\) *Sinai Urban Health report*, supra note 6, at 64 (footnotes omitted).

\(^{27}\) See id. at 62-62; Wanda Jaskiewicz and Kate Tulenko, *Increasing community health worker productivity and effectiveness: a review of the influence of the work environment*, 10:38 HUMAN RESOURCES FOR HEALTH 1, 6-6 (2010).

\(^{28}\) See *Sinai Urban Health report*, supra note 6, at 62-63.

\(^{29}\) Id.

\(^{30}\) See id.; CHWs in NC, supra note 12, at 16.

\(^{31}\) See *Sinai Urban Health report*, supra note 6, at 81-82.

III. THE ROLE OF THE STATE: SUPPORTING PROFESSIONAL DEVELOPMENT, AVOIDING HARM

A. Certification: Vision and Pragmatism

The task at hand from a regulatory perspective is to assess the extent to which the State of New Jersey should set conditions on the practice of CHWs. This task has taken as its starting point that other disciplines have been and continue to work to advance the practice of this emerging profession; that CHWs add significantly to the value of health and social service delivery, particularly in vulnerable communities; and that the profession attracts and retains remarkably caring and creative community members to its ranks.

The success of CHWs in establishing their value does not weaken the argument that the State should consider its oversight role. To the contrary, the growing use of CHWs in a range of settings by a range of employers suggests that friction will arise in terms of the place of CHWs in the caregiving enterprise. To be clear, there is no evidence that CHWs currently present a risk either to other professionals’ practice prerogatives or to the safety of patients. The precautionary principle suggests, however, several reasons for asserting that the time for assessment is due.

First, the use of CHWs in New Jersey is largely championed by first adopters in the health and social services fields. These first adopters tend to be particularly conscientious in their relationships with employees and the public. The clear benefit presented by employing CHWs in many settings suggests that their use will spread more broadly, and that some consideration of formal oversight is appropriate.

Second, the clear value of the use of CHWs to this point has not been matched by a willingness of public and private insurers to pay for their value to patients. Medicaid is a major payer for care to the vulnerable communities to which much CHW work has been directed. Including CHWs in New Jersey’s Medicaid program could extend this valuable resource.\(^\text{33}\) While value-based payment and other bundled reimbursement strategies may at some point obviate the need to designate specific classes of caregivers for payment,\(^\text{34}\) that day has not come: fee-for-service payments remain important, and paying for CHWs’ services may be appropriate. Ensuring that public and private insurers can identify CHWs appropriate for payment seems a precondition to adding their services to the slate of those payable.

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\(^\text{33}\) *See ASSOC. OF STATE AND TERRITORIAL HEALTH OFFICIALS, supra note 14, at 9-11.*

\(^\text{34}\) *Id. at 13.*
Third, a major strength of the movement to CHWs is the somewhat informal nature of their qualifications. That is, they are valuable in large part because they come from the community, because they have innate skills and leadership qualities, and because they can step into the role of CHWs without significant bureaucratic or credential-driven barriers. Should the State be faced with the need to address the credentialing of CHWs on a short timeline, driven by crisis or other pressure, barriers to entry may be interposed by default. It is not a criticism of state governments to say that in creating new regulatory structures they tend to borrow from previous efforts. The place of CHWs is sufficiently distinct and unusual to suggest the benefit of starting the process before pressure grows for quick results. The issues to be addressed are complex, the stakeholders are many, and CHWs should be involved at every step of the way. As a leading report on these issues advised,

Future efforts will be most fruitful when implemented in alliance with existing CHW-led efforts in the field. New efforts must be dedicated to fostering strong CHW leadership especially in areas that have been overlooked, under-resourced or otherwise left out.  

The following sections discuss the steps sister states have taken to grapple with these issues, and the perspectives of stakeholders with whom we’ve discussed these issues.

B. Activity in Other States

Our sister states have experimented with different CHW regulatory regimes. Indeed, according to a compilation maintained by the National Academy for State Health Policy (NASHP), only three states (Alabama, Tennessee, and Wyoming) have no identified state activity on CHWs.  

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35 See C3 Progress Report, supra note 7, at 33.
36 Those stakeholders are identified infra at Appendix A.
37 See NAT’L ACADEMY FOR STATE HEALTH POLICY, “State Community Health Worker Models,” https://nashp.org/state-community-health-worker-models/ (last accessed Aug. 31, 2019) [hereinafter NASHP CHW Compendium]. This compendium offers a rich collection of materials regarding state regulation of CHWs. It is important to note, however, that it may not have been updated since May-July 2017 (depending on the state), when it surveyed the states to update the resource. See generally NAT’L ACADEMY FOR STATE HEALTH POLICY, “Responses to a 2017 Survey on State Policies Regarding Community Health Workers: Home Visiting to Improve the Home Environment,” https://nashp.org/wp-content/uploads/2015/05/Home-visiting-PDF-final-approval-NCHH-3.2.18.pdf (noting that survey on state CHW policies to update NASHP’s State Community Health Worker Models Map “were conducted between May and July 2017, and responses may not reflect the current landscape in each state”). Connecticut’s recently enacted CHW legislation, for example, is not reflected in this resource. See State of CT, H.B. 7424, “An Act Concerning the State Budget for the Biennium Ending June Thirtieth, 2021, and Making Appropriations Therefor, and Implementing Provisions of the Budget” [hereinafter CT H.B. 7427], https://www.cga.ct.gov/2019/TOB/h/pdf/2019HB-07424-R00-HB.PDF.
This number, however, can be a bit misleading. A relatively small fraction has passed comprehensive legislation concerning CHWs; even fewer have mandated certification to serve as a CHW within the state; and none to date have required licensing of CHWs, although Nevada requires licensure of “CHW Pools, which are organizations or agencies that hire CHWs.”\(^\text{38}\)

A minority of states have linked certification to funding. In Minnesota, for example, certification is not required to work as a CHW, but it is required to receive “Medical Assistance reimbursement for services provided to MN Health Care Program enrollees.”\(^\text{39}\) This reimbursement covers care coordination and patient education services provided by a certified CHW who works under the supervision of specified medical assistance-enrolled health care providers.\(^\text{40}\) Oregon has similar requirements for CHWs to receive Medicaid reimbursement.\(^\text{41}\)

Texas similarly does not mandate certification for CHWs or *promotoras* who provide services without compensation. But certification, and its requisite training and education, is mandatory if a CHW or *promotora* receives payment or reimbursement for expenses.\(^\text{42}\)

Rather than requiring certification, a substantial number of states, including Connecticut,\(^\text{43}\) Florida, Indiana, Maryland, Massachusetts, New Mexico, Ohio, Oregon, and Rhode Island, among others, have created a voluntary certification process, such that the state recognizes particular training and credentials that may be used to identify oneself as a CHW.\(^\text{44}\)

There is some variation among states regarding the entity that oversees the certification process. The state Department of Health implements the voluntary certification program in New Mexico.\(^\text{45}\) In Texas, the Department of State Health Services is the responsible entity.\(^\text{46}\) In 2003, Ohio delegated certification responsibility to its existing Board of Nursing.\(^\text{47}\) In Florida and Rhode Island, the Florida Certification Board and Rhode Island Certification Board, respectively, administer voluntary certification.\(^\text{48}\) Massachusetts similarly established a board of Certification of CHWs in the Department of Public Health to certify CHWs.\(^\text{49}\) Indiana identified the Indiana

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\(^{39}\) NASHP CHW Compendium, *supra* note 37.

\(^{40}\) See Minn. Stat. § 256B.0625 subdiv. 49(a)-(b).

\(^{41}\) NASHP CHW Compendium, *supra* note 37.


\(^{43}\) See CT H.B. 7424, *supra* note 37.

\(^{44}\) NASHP CHW Compendium, *supra* note 37. Note that, although certification is voluntary in Oregon, only certified CHWs may participate in health homes. *See id.*

\(^{45}\) Id.

\(^{46}\) Id.

\(^{47}\) Id.

\(^{48}\) Id.

\(^{49}\) Id.
Community Health Workers Association (INCHWA) as the state’s certifying body, which is developing a state certification exam.\(^{50}\)

Several states have neither a voluntary nor mandatory state-sanctioned certification process for CHWs, but they nonetheless have created a role for the state with respect to CHW training and education. Thus, many states are involved in designing or approving CHW training programs even if those states do not have a CHW certification process in place.

Some states have charged state entities with responsibility for developing CHW training and educational programs. The Nevada System of Higher Education offers CHW trainings at two local community colleges, and the Nevada Division of Public and Behavioral Health (DPBH) offers a quarterly CHW training course, both of which programs are approved by the state.\(^{51}\) The New York “Department of Health’s CHW Program in maternal and child health trains CHWs to provide health education, referrals, and support for individuals navigating the health system.”\(^{52}\)

Other states approve training programs developed by other entities and/or approve entities to deliver the training and education. In New Mexico and Oregon, for example, responsible state entities approve CHW training programs.\(^{53}\) Texas’s Department of State Health Services must develop the training and education program, but community colleges, other academic institutions, Area Health Education Centers (AHECs), Federally Qualified Health Centers (FQHCs), a CHW network, and community-based organizations deliver the approved training to CHWs.\(^{54}\) Wisconsin has approved a CHW Registered Apprenticeship that was developed through a collaboration between the State Department of Workforce Development and the State Department of Health Services. The training programs then are offered by entities such as the Milwaukee AHEC and UniteMKE Pathways Community HUB.\(^{55}\) The Florida Certification Board approves curricula for CHWs. The Indiana Community Health Workers Association reviews and approves curricula from training vendors.\(^{56}\) In Oregon, the Traditional Health Worker Commission certifies CHW training centers.\(^{57}\)

Not all states, however, have adopted an approval process for CHW trainings. Idaho and Kentucky, for example, do not approve CHW educational programs or curricula.\(^{58}\) Although Rhode Island does not have a standardized curriculum for CHWs, “certification requires education in specified domains.”\(^{59}\)

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50 Id.
51 Id.
52 Id.
53 Id.
54 Id.
55 Id.
56 Id.
57 Id.
58 Id.
59 Id.
Several states have included grandparenting provisions in their CHW statutes and regulations, given the number of CHWs who were practicing prior to enactment. Massachusetts, for example, designated a grandparenting period for the first three years of its voluntary certification program, which began in 2017. Arizona, Texas, and Ohio’s plans also included some degree of grandparenting.

A common approach among states that are regulating CHWs has been to appoint a study commission or advisory committee to assist them with CHW policy making decisions. Typically, these entities include a variety of stakeholders with different perspectives and expertise, including CHWs, health care professionals, community health centers, health plans, CHW training entities, and other public health agencies and/or experts, which can help surface issues as well as build community buy-in. Texas, for example, established a “statewide advisory committee to provide recommendations on CHW training, funding and employment.” The Illinois Community Health Worker Advisory Board developed core competencies for training and certification. Maryland’s Workgroup on Workforce Development for Community Health Workers developed recommendations on CHW training, credentialing, and financing. Connecticut’s CHW Advisory Committee consulted with the state’s Director of the State Innovation Model and Commissioner of Public Health “to study the feasibility of creating a CHW certification program, including the fiscal impact of implementing the program.”

Many advisory entities seem to have been appointed for relatively short durations to help create a roadmap for the state. Some states, however, have a longer view in mind for their commissions. When Arizona enacted legislation in 2018 to instantiate a voluntary certification process for CHWs, it delayed the repeal of its Community Health Workers Advisory Council until 2022. Similarly, Connecticut, which appointed an advisory board in 2017, when it was studying whether to adopt a certification program, continued this board when it enacted a voluntary certification program this year so that the body will continue to give it advice and approve training programs.

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60 Id.
62 NASHP CHW Compendium, supra note 37.
63 Id.
64 Id.
65 Id.
66 See AZ. H.B. 2324, supra note 61.
67 See CT H.B. 7424, supra note 37.
C. The New Jersey Landscape

As part of our research for this Issue Brief, we interviewed a number of individuals in New Jersey whose work involves or at least intersects with CHWs, including community-based health care providers, health insurers, employers, entities that provide training for CHWs, nonprofits, advocates, and, of course, CHWs themselves. While there were shades of variation in some aspects of the perspectives, opinions, and recommendations they shared, there was considerable agreement on a number of issues.

We consistently and repeatedly heard that it is essential that CHWs display personal skills related to interpersonal communication and connection, empathy, social graces, reading social cues, resourcefulness, determination, and flexibility. CHWs should have a natural problem-solving bent and enjoy making a difference in their communities. A common refrain was the reminder that unlike technical skills that may be taught or learned on the job, no amount of training or education can adequately teach or instill these critical personal skills.

We also overwhelmingly -- though not unanimously -- heard the view that direct community connection is centrally important. The vast majority of individuals interviewed emphasized how valuable it is to have CHWs who come from and are familiar with the community they are serving. One CHW referred to this as a “street bachelor’s” degree. A few individuals tempered their opinion on this issue, however, noting that while it certainly can be beneficial to have this personal, lived experience, it is not essential. CHWs with the right mix of personal skills are able to relate to individuals from different backgrounds and learn how to navigate and connect with new communities. The innate personal skills, again, are the key factor.

Input split into two main camps regarding requisite educational credentials for CHW applicants. Most interviewees were of the view that a high school diploma or its equivalent is sufficient, reminding that a key attribute of CHWs is that they are a demographic mirror of the community being served. Some, however, opined that an Associate Degree or other higher education should be required or at least preferred, and several specifically look for individuals who majored in a public health-related field. Although interviewees sometimes expressed a preference for applicants with backgrounds in community service, social services, or public health, most did not want to erect barriers to employment for fear of losing strong candidates from the community.

Several individuals interviewed who hire CHWs mentioned that it could be helpful for applicants to possess other skills or experience, depending on the specific program with which the CHW would be working. For example, bilingual skills may be required based on the demographics of a community being served. In addition, experience with the jail system may be

68 See Appendix A to this Issue Brief for a compendium of individuals interviewed as part of this project.
at least helpful, if not necessary, for programs that serve incarcerated or recently incarcerated individuals.

Given this, interviewees generally expressed hesitance to impose many outright disqualifiers from employment, including smoking and non-violent criminal histories. We consistently heard that programs fear such barriers would frustrate the goal of employing CHWs who are representatives of their community and with whom patients will relate and connect.

We heard of a range of roles for CHWs, with the variations seemingly aligning with the particular setting in which the CHW works. For example, some health care providers focus on CHWs as physician-extenders and therefore members of the clinical care team who are appropriately supervised by clinicians. Non-profits that are not engaging in care provision, some community-based providers with grant funding for CHWs, and CHWs themselves, however, more commonly described CHWs as representatives of the community, who serve the vital role of a bridge from clients to medical care and social services, and who should not be supervised by clinicians. While a number recognized that many CHWs fill both roles to some extent, individuals generally had strong opinions regarding the primary role each CHW filled. Insurers tend to have a narrow view of the role of CHWs that centers on fulfilling case management and coordination functions.

Programs also shared that the particular roles that CHWs have to perform sometimes are dictated by the particular funding source. For example, one grant could specify that the CHW will be knocking on doors in the community, while another could forbid this field work in favor of requiring that the CHW primarily serves a role in a clinical setting. Other grants may require CHWs to serve functions specific to the particular disease or condition that is the focus of the grant.

Given the emphasis on personal skills over substantive medical knowledge, and the variation in opinions with respect to education and roles, it is not surprising that those interviewed have somewhat varying views on how to train and supervise CHWs. There is general consensus that some form of training is appropriate, although several individuals expressed concern that the completion of such training should not be a prerequisite to employment as a CHW. Rather, hiring should focus on identifying applicants with the essential innate personal skills that cannot be taught; once hired, individuals then can receive training in the learnable skills and knowledge that can be taught.

A number of individuals expressed concern that training not be over-standardized, given the varying roles that CHWs may fulfill in different organizations, which likely require different training. As one interviewee phrased it, “build this as flexibly as CHW job descriptions are.”

Despite this concern, there still was general consensus that it is possible to devise a baseline training program that all CHWs should take that would cover core competencies of CHWs, such as patient engagement, motivational interviewing, patient activation measures,
respecting scope of practice boundaries, patient privacy, ethical boundaries, and trauma informed care.

Several interviewees had very positive things to say about particular training curricula, although some pressed concern about the cost of some training programs, particularly in the absence of grant funding dedicated to training. Some also expressed their interest in customizing or tailoring a training curriculum to their specific program needs.

We spoke with a number of “early adopters” of CHW programs, who are breaking a path for New Jersey in terms of standing up CHW programs. They were somewhat concerned that constructing State requirements might be difficult, as they would need to apply both to sophisticated entities pioneering innovative community-based care as well as newcomers with less programmatic experience. Some suggested that State requirements establish minimum standards that more ambitious programs could exceed. Alternatively, some asked that the State approve or accredit existing programs that have established track records.

That said, we also heard a contrary note from some, calling for a standardized training that establishes a consistent baseline of knowledge. While some entities seemed worried that State regulation would resort to a lowest common denominator method of training in the process of standardizing it, others seemed to appreciate the prospect of having certainty that a training curriculum has passed muster, allowing it to be implemented without much fuss, given resource constraints.

Interviewees also expressed support for offering layers of training – a baseline for all CHWs, supplemented as needed based on the skills and knowledge required for the specific role being fulfilled. We repeatedly heard the need for plentiful and frequently-available training opportunities to reflect the dynamic nature of professional hiring and practice.

There was a strong preference for post-hire training, rather than a regimen in which a CHW must acquire training pre-hire. This would permit hiring to focus on identifying the right kind of person with the necessary, unteachable innate traits that make them good candidates to serve as CHWs. Some interviewees recognized, however, that training in advance of hiring may help grow the workforce and improve employability for citizens, which is a valuable goal on its own. A few interviewees suggested that perhaps both options could be available to increase options for all, as long as the State does not require pre-employment training. One individual warned, however, that if the State adopts a pre-employment training option, satisfaction of such a program should not create an automatic pathway to CHW employment; rather, employers must retain the ability to screen individuals, even if they have completed this standard training, to ensure that applicants possess the innate skills necessary to be an effective CHW. In the words of one interviewee, “Who [the CHW is] is more important than the training received.”

There were varying opinions with respect to supervision. Not surprisingly, health care providers tended to express the need for a clinician to supervise CHWs who are part of a care
team and/or providing health services. Their concern lessened if CHWs’ roles focused more on connecting patients to care and serving as a patient navigator.

CHWs, their supervisors, and entities that train CHWs generally believed these concerns are misplaced. They maintain that existing training already makes plain that CHWs are not to engage in practices that require a professional license. Quality training reinforces these guardrails, and CHWs uniformly expressed a strong disinclination to cross into other health care professionals’ lanes. Strong communication between health care providers and CHWs, with appropriate supervision of CHWs by non-clinical staff, reinforces this training and serves patient needs and interests.

No one interviewed advocated for or supported State licensure of CHWs. Employers generally favor some form of certification, be it voluntary or involuntary. CHWs, however, are of two minds regarding certification. Some appreciate the professionalism-advancing features and reimbursement benefits that could come with certification; others, however, are more leery of certification because of the danger of over-bureaucratization and the risk that certification might make it harder for them to help their communities and might even impinge on their community identities. A few interviewees shared their fear that certification would be a way for the State to make money. One also predicted that certification would have the perverse effect of lowering standards: people would do the bare minimum necessary to satisfy certification standards when CHWs, for years, have been far exceeding these minimums simply because they love and want to help their communities.

It is not surprising that the individuals interviewed would enthusiastically accept reimbursement for CHW services. The service providers uniformly signaled that they would hire more CHWs if they had more resources, which is in line with their strongly expressed views that CHWs add great value to New Jersey’s health care system. One interviewee wondered whether NJ FamilyCare’s newly announced policy to reimburse for services provided by certified peer recovery specialists might serve as a model for CHW reimbursement as well.69

CHWs were united and clear on the position of “nothing about us without us” – that is, that any decisions about certification or other formalization may proceed only with CHWs’ robust input. No one we interviewed disagreed with this strongly held view.

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IV. **RECOMMENDATIONS: INCLUSIVE PROCESS, CONFRONTING TENSIONS, FOSTERING CONTINUED COMMUNITY SERVICE**

A. Overview

The work of CHWs fits comfortably within the current understanding of health care as whole-person based and aware that the wellness of individuals and communities is contingent on addressing the effects of social determinants of health. CHWs are central to incorporating this broad vision into our health care system. They are natural helpers, they are of the community, and they are committed problem-solvers. The problems they are equipped to address are those that keep communities – particularly those made vulnerable by the effects of socioeconomic and racial disparities – from achieving wellness and flourishing for their residents.

That some things about the profession are unsettled is a criticism neither of CHWs nor the health system in which they practice. Rather, it is a consequence of the regulatory imperative that the State consider the proper degree of oversight, if any, it should exercise over CHWs. The need for a regulatory interrogation is simply a reflection of the fact that the profession and its relationship with other social and health care professionals are maturing. CHWs are fulfilling many of the goals they and others set for the profession. The expansion of the profession as more CHWs are hired by more health care and social service providers calls for the resolution of some of the vestigial blurriness in practice that raises regulatory concerns.

Who can hold herself out as a CHW? Under what circumstances will public and private insurers pay for CHWs’ services? Where are the borders of CHWs’ roles, delineating the line between conduct that advances patient health and conduct that puts patients at risk? How can this vital profession, peopled with caring and community-rooted helpers, be nurtured? Inquiry into these questions must find their way onto New Jersey’s health regulatory agenda.

The legal research, literature search, and stakeholder consultation undertaken to produce this Issue Brief supports the recommendations contained in this part. The recommendations come with several caveats:

- This Issue Brief is not intended to provide a complete review of the CHW profession, a topic that is the subject of extensive literature. Rather, it outlined that literature above, and in this Part provides legal/regulatory recommendations.
- The issues surrounding the State’s regulation of CHWs are complex, and further consultation is necessary for all affected stakeholders to come to consensus; these recommendations are intended to set the stage for such further inquiry.
It is critical that CHWs be fully engaged in the discussion of State regulation. CHWs take great (and justified) pride in their emerging professional status, and they adhere to the maxim, “nothing about us without us.”

B. Choices

1. Recommended regulatory approach – three categories of options

- **Professional licensure**: requirement to meet State-imposed and supervised standards such as education, training, and scope of practice
- **Certification**: requirement to meet standards set by private certifying organization as to training, roles, and skills
  - **Mandatory**: required for person to hold self out as CHW
  - **Voluntary**: optional, but required if one holds self out as “certified CHW”
  - **Voluntary but required for Medicaid payment**
- **Unregulated**: State does not impose or recognize any process

Recommendation: Voluntary but required for Medicaid payment

*Allows flexibility but some standardization; permits movement to sustainability through Medicaid payments*

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2. Process for review – three modes of moving forward with status issues

- Direct legislative action: Legislature resolves outstanding issues and creates process of CHW oversight
- Private consultation among stakeholders
- Legislatively-created study commission to consider outstanding issues and file proposals with Legislature

Recommendation: Legislatively-created study commission

Allows Legislature to identify key stakeholders; permits stakeholders to consider outstanding issues in depth, permitting the Legislature to act after full airing of issues

3. Outstanding issues for resolution by process chosen above

Once the process for proceeding in New Jersey has been determined, may important issues will present themselves for resolution. The authors describe them below as “punch lists” of items to be addressed. We do not offer recommendations on these issues, which we believe are best left to a fuller process involving deliberation by stakeholders including CHWs.

a. What personal qualifications for CHWs?

- Educational level required:
  - High school or equivalent
  - Higher education (e.g., Associate’s Degree)
- Background check
- Residency/community connection
- Language facility
b. What CHW training would be required?

- Approval by advisory board created by Legislature
  - Approval of course provider
  - Approval of curriculum
- Approval by State agency
  - Created by State agency
  - Approval of course provider
  - Approval of curriculum
- Levels of training
  - Only base level training
  - Base level supplemented by advanced training
- Timing of training
  - After hire, before deployment
  - After hire, during deployment (“on-the-job”)
  - Before hire

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d. What supervision of CHWs should be required?

- **Content of supervision**
  - Direct supervision
    - Qualifications of direct supervisor
    - Periodicity of supervision – e.g., weekly
    - Intensity of supervision – e.g., one-on-one; team; both
  - Management (supervisor’s supervisor)
    - Qualifications of manager
    - Periodicity of supervision of direct supervisor
    - Intensity of supervision
    - Team supervision – e.g., CHW, supervisor, manager
  - Clinical supervisor/consultant
    - Supervisor or consultant?
    - Periodicity of consultation – regular or on-call?
    - Intensity of consultation
    - Team consultation – e.g., CHW, supervisor, manager, clinician

- **Enforcement of supervision requirement**
  - Professional practices – fault-based review
  - Periodic reporting to State agency
  - Periodic inspection by State agency

C. Conclusion

CHWs are an increasingly important, and therefore an increasingly common and effective, helping profession in New Jersey. Regulatory and legislative actors have expressed interest in supporting CHWs in New Jersey. As we describe in Part III(B) above, many states have considered forms of regulatory oversight of CHWs. The time for consideration of some form of regulatory oversight in New Jersey has come. The work of CHWs is too important, their growth as a professional cohort is too rapid, and the chance for friction with public safety or the work of other helping professions is too great to forego or delay consideration of their status under New Jersey law.

Further, regulatory recognition of CHWs under a certification program or otherwise will help CHWs to mature as a profession. Recognition by the State will lend credence to CHWs’ and
others’ assertions that CHWs are valuable actors in a quest to improve care in New Jersey, particularly in vulnerable communities. Such recognition will afford CHWs greater job mobility, as they would obtain a credential that will allow employers to recognize their professional qualifications. It will assist them, by providing them with skills and training, to move up an employment ladder if they wish (although many CHWs articulate a strong sense that they wish to remain CHWs; others describe a desire for more training and education). And it will increase the likelihood that public and private insurers will recognize the contributions of CHWs by paying for their services. This predictable and enduring source of financial support would aid in the sustainability of CHW programs and allow the regularization and enhancement of CHW salaries.

This Issue Brief does not attempt to comprehensively describe the process for reaching a regulatory recognition of CHWs in New Jersey law. Decisions about that process should include a broader discussion including CHWs and other stakeholders, preferably after the convening of an advisory committee by a State agency or the Legislature. The issues described above are complex and contain layers of areas fraught with the potential for conflict and confusion. A decision as to the resolution of one issue often threatens the optimal resolution of others. Inclusive deliberation is called for. CHWs add too much to the health of New Jersey’s communities for the State to delay starting the process for ensuring the future of their profession, the support for their activities, and the recognition of the need for programmatic sustainability.
APPENDIX A: INDIVIDUALS CONSULTED AND INTERVIEWED FOR THIS ISSUE BRIEF\textsuperscript{71}

The following individuals graciously shared their perspectives, experience, research, and expertise regarding Community Health Worker certification, training, and supervision. While each of these individuals informed our analysis and enhanced the substance of the Issue Brief, its evaluations, recommendations, and any errors remain the responsibility of the authors and should not be ascribed to any of the below individuals.

Dr. Kemi Alli, Henry J. Austin Health Care Center
Jessica Alpert, Harvard Medical School Center for Primary Care
Dr. Daren Anderson, Weitzman Institute
Raichelle Arthur, Central Jersey Family Health Consortium
Padma Arvind, Ph.D., Rutgers University School of Management and Labor Relations
Teresa Berumen, Rush University Medical Center
Jose R. Caraballo, Henry J. Austin Health Care Center
Martha Chavis, Camden Area Health Education Center
Kelly Craig, Camden Coalition of Healthcare Providers
Robyn D’Oria, Central Jersey Family Health Consortium
Jill Feldstein, Penn Center for Community Health Workers
Markia Francis, Central Jersey Family Health Consortium
Robyn Golden, Rush University Medical Center
Amaryllis Gonzalez, Henry J. Austin Health Care Center
Ashley Gonzalez, Henry J. Austin Health Care Center
Valerie Harr, Horizon Blue Cross Blue Shield of New Jersey
Annette Hastings, University Hospital
Nemiah R. Johnson, Henry J. Austin Health Care Center
John Koehn, Amerigroup
Shakira Linzey, Central Jersey Family Health Consortium

\textsuperscript{71} All affiliations reflect status at the time of interviews.
Deborah Lorán, Henry J. Austin Health Care Center
Jenna Lupi, NYC Health + Hospitals
Martha Marquez, Central Jersey Family Health Consortium
Dr. Kristine McCoy, VNA Health Group, Children and Family Health Institute
Billy Millwee, Sellers Dorsey
Maria Monteagudo, Central Jersey Family Health Consortium
Ernie Morganstern, Trenton Health Team
Christopher Nolan, Rush University Medical Center
Kathleen Noonan, Camden Coalition of Healthcare Providers
Tracy Parris-Benjamin, Horizon Blue Cross Blue Shield of New Jersey
Marcea Patterson, Henry J. Austin Health Care Center
Gregory Paulson, Trenton Health Team
Dr. Denise Rogers, Rutgers Biomedical and Health Sciences
Adriana Rojas, Weitzman Institute
Connie Samuel, Central Jersey Family Health Consortium
Mia Sapp, Central Jersey Family Health Consortium
Erin Sullivan, Ph.D., Harvard Medical School Center for Primary Care
Laura Taylor, Central Jersey Family Health Consortium
Michael Yuhas, Integra ServiceConnect