North Dakota Legislative Council

Prepared for the Health Care Committee
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COMMUNITY HEALTH WORKER STUDY - BACKGROUND MEMORANDUM

INTRODUCTION

House Concurrent Resolution No. 3015 (2021) directs the Legislative Management to study the feasibility and desirability of implementing a community health worker program, including:

- Recommendations regarding a definition of a community health worker;
- The scope of work of a community health worker;
- The infrastructure for training of community health workers;
- The development of a community health worker certification process and related training curriculum and continuing education requirements;
- A strategy for community health worker services being Medicaid-reimbursed services; and
- Private insurers' use of community health workers.

BACKGROUND

The cost of health care has been increasing steadily. The Centers for Disease Control and Prevention (CDC) states "[c]ontributing factors include poor management of chronic diseases, reliance on fee for services provided by clinicians in clinical or emergency hospital settings, lack of preventive care, and poor health status as result of lifestyle choices, such as smoking."[1]

Community health workers (CHWs) have been practicing since the 1950s; often serving in areas in which health care services may not be readily available or easily accessible. The federal Bureau of Labor Statistics estimates as of May 2019, more than 117,000 CHWs and health educators were employed across almost every state.[2]

The CDC reports CHWs can help to reduce the demand on the health care system by conducting outreach and prevention education, coordinating care, improving patient communication and compliance, and facilitating early diagnosis in underserved communities. Communities can support preventive services in clinical settings with community-based prevention programs. Community-based clinical services connect health providers, such as physicians, to other available services, such as a community education program that teaches how to manage health problems. The involvement of CHWs in preventive health services can benefit communities by overcoming and reducing cultural and other barriers to services. Community health workers also promote the use of health services, encourage people to adopt healthier lifestyles, add services for a more diverse health care workforce, and serve as a link between clinical services and social services. Community health workers also can provide services outside traditional clinical settings and improve understanding of services for patients.[3]

Community Health Worker Definition

North Dakota state law does not define the term "community health worker"; however, the United States Department of Health and Human Services Health Resources and Services Administration (HRSA) provides:

> Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as)," outreach educators, community health representatives, peer health promoters, and peer

[1]Centers for Disease Control and Prevention, Issue Brief: Collaborating with Community Health Workers to Enhance the Coordination of Care and Advance Health Equity, https://www.cdc.gov/nccdphp/dch/pdfs/dch-chw-issue-brief.pdf.
[2]Sydne Enlund, National Conference of State Legislatures, Meeting Health Care Needs with an Emerging Workforce (2020).
[3]Supra, note 1.

health educators. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.[4]

Scope of Practice

Although the scope of practice of a CHW likely is related directly to how the term "community health worker" is defined in the jurisdiction of practice, there are some traditional roles CHWs fill. Community health workers typically work in the communities in which they live, working in community health facilities providing case management, client education, and follow-up care.[5] Services provided by CHWs often include:

- Creating connections between vulnerable populations and health care systems.
- Providing health education on topics related to chronic disease prevention, physical activity, and nutrition.
- Performing health screenings, informal counseling, and referrals.
- Facilitating health care and social service system navigation.[6]

A CHW national employer inventory of all 50 states was conducted as part of a HRSA study conducted in 2007. This survey provided the most frequently reported health issues for which employers chose interventions that included CHWs were:

- Women's health (46 percent of respondents);
- Nutrition (48 percent);
- Child health (41 percent);
- Pregnancy/prenatal care (41 percent);
- Immunizations (37 percent); and
- Sexual behavior (34 percent).[7]

Regulation and Training

Occupational regulation typically is addressed at the state level as a police power to protect public health and safety. Regulatory strategies include registration, certification, and licensure.

Registration is the least restrictive regulatory strategy. This form of regulation typically is considered when there is a low probability the practitioner will inflict serious harm on the public. In its purest form, regulation does not require the practitioner to demonstrate any particular qualifications. The most basic form of registration does not carry a warranty of competence or any assurance the practitioner has met any predetermined standards, such as education or experience.[8]

Statutory certification is more restrictive than registration. In its purest form, statutory certification provides title protection rather than practice protection; noncertified individuals legally may perform the same function as those who are certified but are not permitted to use a designated title.[9]

Licensure is the most restrictive form of occupational and professional regulation. Restriction of practice is the hallmark of licensure. An occupation can be licensed only through a formal action of a legislative body.[10] "Once a professional has achieved licensure status, it is illegal for non-licensed individuals, or individuals licensed in other professions, to engage in any of the activities set forth in the profession's 'scope of practice' unless there is an overlap in the various professions' scopes of practice."[11]

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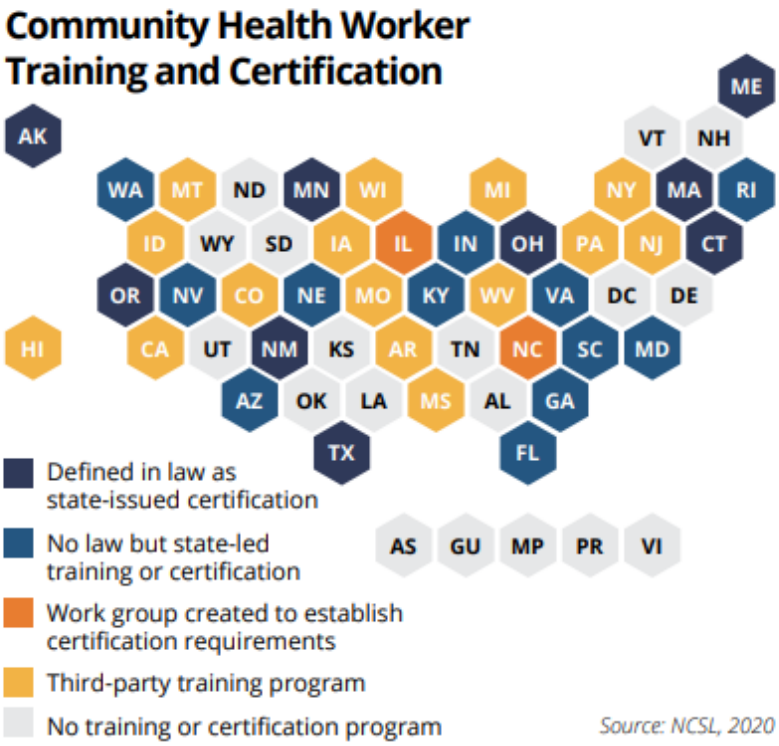
[4]U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professionals, Community Health Worker National Workforce Study (2007).
[5]Supra, note 2.
[6]Supra, note 2.
[7]Supra, note 4.
[8]Kara Schmitt and Benjamin Shimberg, Council on Licensure, Enforcement and Regulation, Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask (1996).
[9]Id.
[10]Id.
[11]Id.

As of 2019, at least 9 states had enacted laws or passed regulations for CHW certification.[12] Training requirements for CHWs vary widely from state to state, ranging from formal education to on-the-job experience. Almost half the states have CHW training programs, some of which are connected to certification and were established by state agencies.[13] North Dakota does not have a state CHW training or certification program.



The three main trends in CHW workforce development are:

- Certificates or degrees at the community college level which provide career advancement opportunities;
- On-the-job training to improve standards of care, CHW income, and retention; and
- Certification at the state level which recognizes the work of CHWs and facilitates Medicaid reimbursement for CHW services.[14]

The Minnesota Department of Health reports "Minnesota is the first state to create and offer a statewide CHW curriculum based in post-secondary education. The Minnesota standardized curriculum is a competency-based, 14-credit certificate program that creates a pathway for students interested in a wide range of health and social services careers." However, Minnesota does not regulate the occupation of CHWs and does not define the CHW scope of practice in statute or rule.

Medicaid and Other Funding Sources

Medicaid

Despite their popularity, CHWs tend to rely on unpredictable and often insufficient financial support.[15] However, a new pathway of reimbursement for CHW services through Medicaid emerged in 2014 through the "preventative services rule change."[16] This rule change gave states the option to reimburse nonlicensed practitioners, including CHWs, for preventative services recommended by a licensed practitioner. In effect, the rule change allows states to include CHWs as qualified providers of certain preventative services under Medicaid.[17]

[12]Supra, note 2.
[13]Supra, note 2.
[14]Supra, note 4.
[15]National Center for Healthy Housing, Milken Institute School of Public Health, The George Washington University, Advancing the Role of Community Health Workers: Engaging State Medicaid Offices to Develop State Plan Amendments Regarding the Preventative Services Rule Change (2018).
[16]Id.
[17]Id.

To invoke the rule change, states must seek from the Centers for Medicare and Medicaid Services (CMS) a state plan amendment (SPA). In general, an SPA must propose a change that is statewide, is comparable, and offers a choice of providers.

In addition to the Medicaid preventative services rule changes, "states have multiple options available to them to provide reimbursement for CHWs through Medicaid and expand the scope of coverage as necessary to support this workforce. Other approaches, including Section 1115 waivers, Medicaid health homes, and Medicaid managed care contract requirements, can be used to support funding for CHWs; each has its own advantages and limitations. Medicaid managed care organization (MCO) program costs can also be classified as a medical service or administrative expense."[18]

North Dakota Senate Bill No. 2321 (2015) would have provided for medical assistance reimbursement of certified CHWs, but failed to pass in the House. Currently, North Dakota's Medicaid program does not reimburse CHWs. In 2019 South Dakota did an SPA to provide for Medicaid reimbursement of CHW services.

Other Funding Sources

The American Hospital Association and National Urban League identified the following four funding models for CHWs:

1. Charitable foundations and government agencies are the most common arrangement within the U.S., usually involving a community-based organization (CBO). Typically, strict requirements must be met for the program to receive ongoing funding. Sources for these grants include the National Institutes of Health (NIH), HRSA, and temporary assistance for needy families (TANF). State and locally administered programs are often disease specific.
2. Medicaid presents multiple avenues for funding, including direct reimbursement and managed care contracts. Under direct Medicaid reimbursement, CHWs are recognized as "billable providers." However, federal codes and regulations do not allow for direct billing by CHWs; services billed for must be part of a recognized program. The Medicaid §1115 waiver permits states to use federal funds in ways that do not conform to federal standards, so in this case Medicaid funds can be used to support CHW programs. In either case, mainstream health care providers must explore billing and reimbursement rules in their respective state (Dower, Knox, Lindler, & O'Neill, 2006). The second Medicaid option is under the auspices of a managed care contract. Here, a capitated amount from the state is allotted per the number of Medicaid enrollees within the CHW program.
3. Federal, state, or local government general funds, supported by taxes, are often seen in budgets as dedicated line items within an existing program that provides CHW services. This model is frequently found in county hospitals and/or health departments.
4. The fourth funding model is from private organizations such as mainstream health care providers (e.g., hospitals, health systems), managed care organizations, insurance companies, and employers. Typically, mainstream health care providers, health plans, and other businesses either employ or contract for CHW services. Mainstream health care providers' goal is to save money by reducing inappropriate emergency department visits and/or readmissions--a cost-avoidance approach. On the other hand, employers retain CHW services to maintain a healthy workforce.[19]

STUDY APPROACH

In conducting the study, the committee may wish to consult with:

- The Department of Human Services;
- The State Department of Health;
- The Indian Affairs Commission;
- The University of North Dakota School of Medicine and Health Sciences and the Center for Rural Health;
- The North Dakota University System;
- The North Dakota Hospital Association;

[18]Id.

[19]American Hospital Association and National Urban League, Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs (2018).

- Local public health units;
- Health insurance carriers;
- Health care providers, such as hospitals, physicians, nurses, and dentists; and CHWs in the state.