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Meeting Minutes

Community Health Worker Task Force
Public Comment Special Meeting
Monday December 2, 2024

Quick recap

The meeting focused on obtaining public feedback on three drafts produced by the Task Force, with a particular emphasis on the Medicaid draft and the requirements for referrals from physicians or licensed practitioners for Medicaid preventative services. The discussion also covered the roles and responsibilities of a Community Health Worker (CHW), the certification and recertification process for CHWs in North Dakota, and the progress and future steps of the CHW certification and regulation process in North Dakota. Lastly, the meeting touched on refining a draft document related to the CHW Collaborative. Funding and operational aspects of a stakeholder group were discussed.

Meeting was called to order at 1:01 p.m.

Members of the Task Force and the public were in attendance. Brian Barrett invited public comment starting with the Medicaid draft recommendations.

Medicaid Draft Recommendations

Members of the public asked several questions about the draft:

- Eligibility Criteria
    - Chronic Conditions: Will these be further identified such as identification via diagnosis codes?
    - Is the list of Chronic conditions exhaustive? HIV and hepatitis B are lifelong, and the populations would meet many of the other requirements.
    - Should indicators state the following: “These indicators include but are not limited to elevated blood pressure or glucose levels”.
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- Referring Providers
    - Would it be appropriate to include local public health nurses/administrators as CHW supervisors?
    - Are LMSWs able to act as a referring provider in relation to CHW’s for Medicaid requirements since LMSWs can practice LCSW duties in some situations?

    - Would a statewide standing order or protocol be beneficial to help handle the referring barriers mentioned?
    - How do community-based organizations fit into this? In other states, CBOs play a role in connecting patients to CHWs.

- CHW Supervisors
    - Do the professions listed under supervision carry malpractice insurance that would be appropriate for supervision or is it going to be covered under the state? Does the physical assume liability for the visit or assessment?

- Service Plan Requirement
    - Regarding the sentence “finalized prior to CHW services being rendered” does this mean the service plan has to be developed before a community health worker can start services?

- Non-covered Services
    - How is it handled when all these other services are not available, such as in the case with rural North Dakota?
    - Is the service duplicative if not available to the person in their community?
    - Can these services be billed under different codes?

<u>Public Comment/Recommendations:</u>

- Eligibility Criteria
    - List “transportation limitation” as a barrier.
    - List “food insecurity” as a barrier.
    - Under documented barrier, include language “through a health-related social needs” so it’s inclusive of other barriers.
    - Eligibility should be associated with all the Z social determinants of health codes for billing.
    - Add time periods to the eligibility criteria (e.g., hospital admissions within 1 year).

- Referring Providers
    - Requiring referrals may be a bottleneck for the program because providers tend to “under refer”. It would be better to reach out to some of the patients directly, especially those who meet these eligibility criteria. Maybe something can be done around standing orders?
    - Referral might also be a barrier because there are situations where family members request CHW services. This is why local public health nurses or administrators as supervisors would be useful.
    - Licensed dietitians should be included in the list of referring and supervising practitioners.
    - LPH Nurses/administrators should be able to refer and to supervise.

        - Clarification is needed for “under supervision”. Does this refer to “general supervision” as in Medicare, where the CHW doesn’t need to be in the physical office? Maybe the state should follow Medicare’s lead?
        - The requirement for ongoing assessment of acuity should be a part of a measure on when the services could possibly cease.
        - Add certified asthma educators to the list of referring and supervising people.
        - It will be very challenging to have the referring person identify how long the program will need to be prior to an initial assessment.

    - CHW Supervisors
        - Create a clear definition of a supervisor.

    - Service Plan Requirement

        - Regarding the sentence “finalized prior to CHW services being rendered” many patients are “picked up” from the provider knowing the patient needs help and they have not been able to develop the service plan. This will take away a significant population of patients with that “warm handoff”.
        - Having physicians involved with the service plan is not ideal. Requesting that they approve a service plan will be challenging because physicians are overwhelmed with paperwork and taking care of their own patients.
        - Can there be a clearer description pertaining to “Rate set by ND Medicaid”? What does “considering payment outside the encounter rate for encounter-based providers” mean?
        - The daily limit of 2 hours could easily be exceeded.
        - Recommended that service limits are not lower than 2 hours/day or 12 hours/month. This is based on evidence-based CHW interventions for individuals with multiple medical, behavioral and social needs include up to 90 minutes per week of direct time with a client, as well as time coordinating services or identifying resources on behalf of that client.

    - Covered Services
        - Coordination of translation services, helping patients enroll in insurance programs, including Medicaid and expansion and transportation are barriers to patients being seen by a physician.
        - An on-going assessment of a client’s immunization status and recommendations according to their forecast in the NDIIS and other recommendations should be a core service.
        - It was recommended that the Task Force review Medicare’s service description, which is broader than what is included in this draft.
        - Resource Coordination is stated but not scoped out in the bullets.

    - Non-covered Services
        - There are numerous services on the list that represent a large portion of what a CHW performs (e.g., delivery of food, medication, medical equipment or medical

supplies, counseling, screening brief interventions, transporting and referral to treatment). It is recommended that this be re-evaluated.
    - It was suggested that the Task Force review Medicare and "mirror some of the broad language" because it could address a lot of the concerns.
    - There is a concern that services on this list will translate into services a CHW cannot provide.
    - CHW's should be able to provide care coordination, translation services, helping patients enroll in insurance programs including Medicaid Expansion and transportation.
    - The 1915(i) language is confusing and should be clarified.
    - Excluding aiding in member Medicaid enrollment conflicts with aiding in resource acquirement.
    - It was suggested that these services be funded by another source if they are not in the Medicaid budget.
    - It was recommended to re-evaluate this list because CHW's are often the only resources available in the more rural areas.
    - Is there an opportunity where a CHW could be billing time when they are not with the patient? There are times when the patient is not present but remains the focus of the CHW's work.

- Telehealth
    - No comments.

- Settings
    - Not allowing services to be performed in a facility-based setting will limit what CHW's can perform. It was mentioned that 50% of services are performed in a clinical setting.
    - It was advised that this could limit how many people CHWs can help.
    - Consider how CHW services can be primarily community-based when CBO's cannot supervise.
    - Suggested language: "services may be delivered in person in the clinic, in-person, in the home or community, telephonically, or via telehealth, service time billed must be for either direct contact (in person, telephonically, or via telehealth) with a beneficiary or for services performed as part of an individual's care plan even if the individual is not present" There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

Draft Certification and Regulation Administrative Rules

There were several questions about the draft rules:

- Scope of Practice
    - If a CHW has multiple certifications, how does this relate to subsection 2 of Scope of Practice?

- Competencies
  - If you have taken a course to be a CHW, would this satisfy the requirements?
  - Will CHW's need to show proof of evidence of these competencies?

Public Comment/Recommendations:

- Definitions
  - Recommended to that the definition of abuse includes all members of the household. Sometimes there are multiple generations in the household.

- Competencies
  - Change subsection 4 to be broader (e.g., "ethical conduct). Also, change subsection 5 to be broader (e.g., "service coordination and navigation").
  - It was recommended that the Task Force add language stating how an individual can provide proof of the listed competencies.
  - Recommended subsection 5 be listed without the sub-bullets.

- Community Health worker Certification
  - No comment

- Reciprocity
  - No comment

- Recertification
  - No comment

- Denial of certification or recertification
  - No comment

- Disciplinary actions
  - No comment

Community Health Worker Collaborative

Public Comment/Recommendations:

- It was mentioned that additional funding will be necessary besides what is being reimbursed by Medicaid.
- It was mentioned that the "health promotion and chronic disease prevention team" was listed to get this started because there are federal grant dollars that can be utilized to support the Collaborative. This funding will be short term until the ND Legislature can make an appropriation.
- It was recommended that the Task Force hold another Focus Group meeting with CHW's prior to submitting the drafts to the Department of Health and Human Services.

Adjourn 2:35pm CST
Date Posted: 12/5/2024