NORTH Dakota | Health & Human Services
Be Legendary.

Community Health Worker Task Force
Public Comment – Written
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1. Only LCSWs are listed as referring providers, while LMSW (Licensed Masters in Social Work) and LBSW (Licensed Bachelors in Social Work) are not. I know in the last meeting, it was outlined that this is due to a LMSW and LBSW usually working below or under the supervision of a "higher ranked" professional, such as a LCSW (or similar profession such as a psychiatrist). Many smaller sites (even larger sites) do not employ a LCSW, but employ LMSW/LBSW. The social work and CHW role go hand in hand in many settings, especially the healthcare setting. The collaboration between the two roles creates great continuity of care for patients. Therefore, I see this as being a gap in many of our more rural settings where an LCSW being employed is not the norm.
    a. This brings me to a question regarding LMSWs who are practicing LCSW duties under the supervision of a LCSW:
        i. "The practice of masters social work, which includes, in addition to the practice of baccalaureate social work, the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation, intervention, evaluation, social work case management information and referral, counseling, supervision, consultation, education, research, advocacy, community organization, and the development, implementation, and administration of policies, programs, and activities. Under the supervision of a licensed clinical social worker, the practice of masters social work may include the practices reserved to licensed clinical social workers." - ND State Law Chapter 43-41.
    b. Since some LMSWs can practice LCSW duties if the correct supervision is in place, are those LMSWs able to act as a referring provider in relation to CHWs, or would the LCSW, who is supervising them, need to be brought into the referral process? Or would a LMSW appropriately providing LCSW services not be eligible for CHW referral with Medicaid reimbursement at all?
2. Dieticians should be included in the list of referring and supervising entities. Dieticians play a big role in Diabetes Center and overall diabetes patient care. Thus the need for the inclusion of Dieticians.

3. Internship supervision. During the November 27 meeting, it was discussed that only a licensed CHW could supervise an Intern CHW. This will greatly hinder our expansion of CHWs in the state. Only a few health care facilities have individuals practicing as CHWs, and this number will not increase, without expanding who can supervise interns. It is the recommendation that nurses, social workers, etc, be added .
4. Change the ROI bullet under Workforce TA to:
    a. Impact Assessments (e.g., using data to identify CHW focus areas and target populations, developing evaluation metrics, demonstrating measurable impact, and cost savings, etc.).
5. Revise "Sustainability and Return on Investment" to:
    a. Sustainability: Increase public and private payer and employer coverage of services provided by CHWs. Advance financing options that prioritize broad CHW competencies, roles, and skills, including work addressing the social determinants of health (SDOH).
    b. Since ROI is typically interpreted as a strictly financial evaluation of outcomes, broader language would be more effective in demonstrating value.
6. Referral requirement – this is going to hinder the uptake of billing.
7. Non-covered services – this is has been a big concern. Definition of non-covered services would help.
8. Inclusion of Community Based Organizations should be considered. Homeless shelters and domestic violence organizations, along with public health, are great candidates for CHWs.