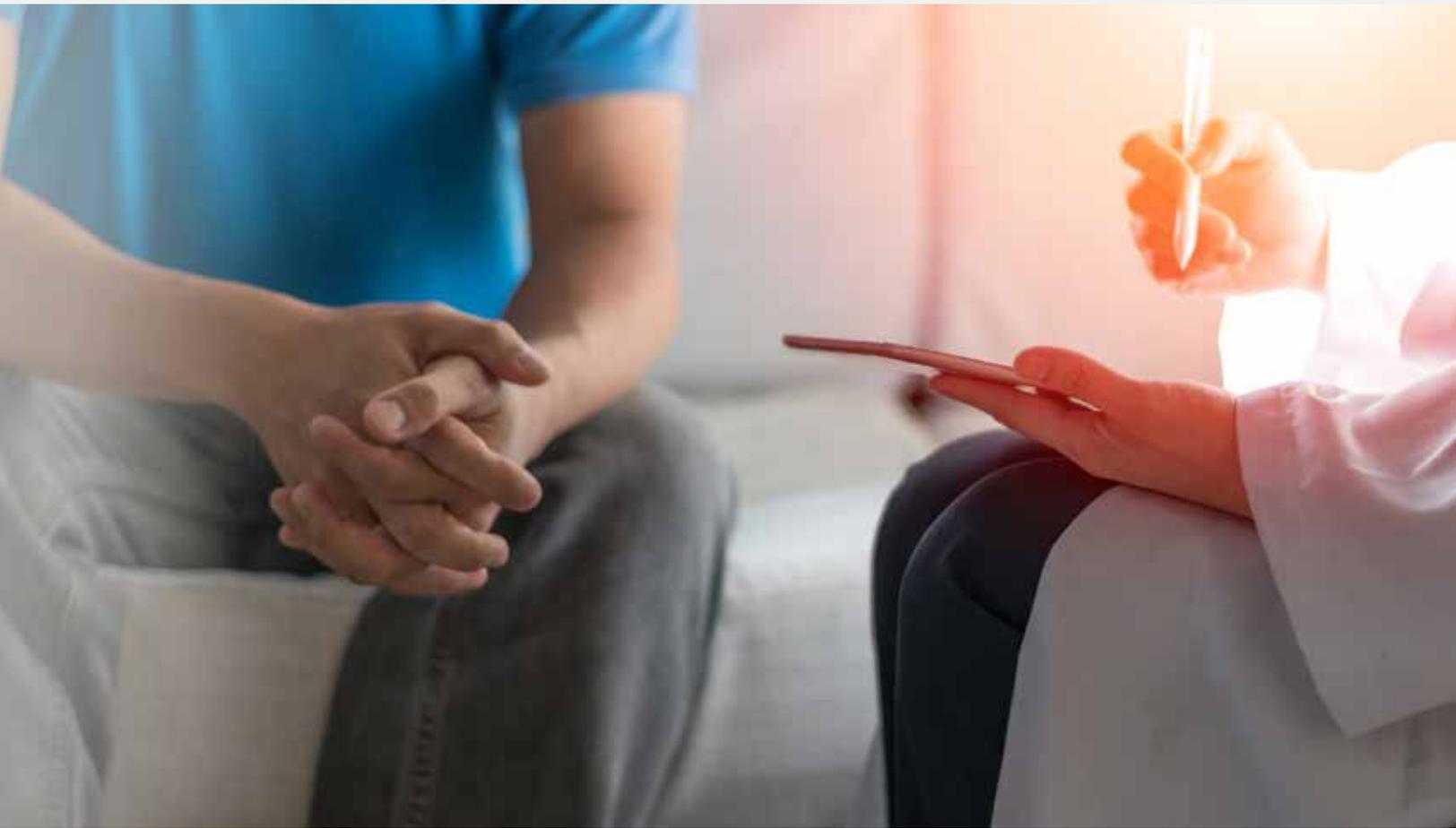


HEALTH

# Meeting Health Care Needs with an Emerging Workforce



NATIONAL CONFERENCE OF STATE LEGISLATURES

APRIL | 2020



# Meeting Health Care Needs with an Emerging Workforce

BY SYDNE ENLUND

---

The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories.

NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues, and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are:

- Improve the quality and effectiveness of state legislatures.
- Promote policy innovation and communication among state legislatures.
- Ensure state legislatures a strong, cohesive voice in the federal system.

The conference operates from offices in Denver, Colorado and Washington, D.C.

---

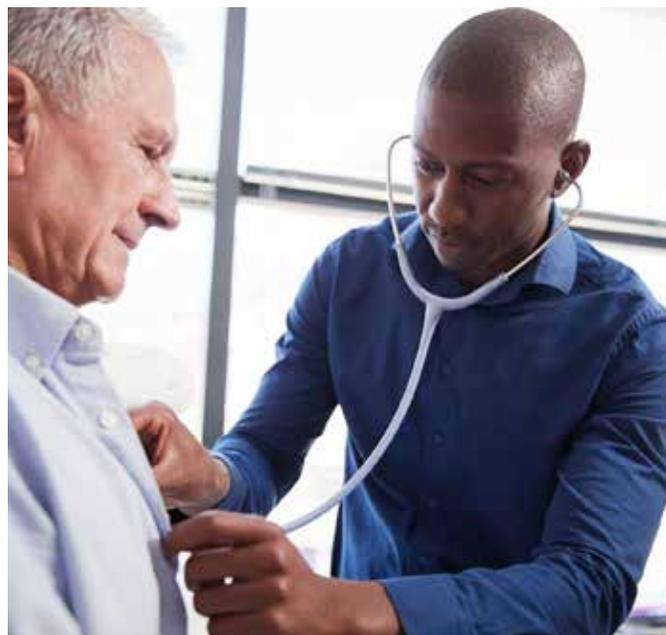


Receiving health care services can improve a person's physical, mental and social health, quality of life and life expectancy. Barriers to accessing health care, on the other hand, can lead to unmet health needs, a lack of preventive services, and preventable, costly hospitalizations. But in many parts of the country, especially in rural and other underserved areas, the supply of health care providers cannot keep up with the demand for services. This is leading lawmakers to consider supporting other kinds of health care workers, besides doctors and nurses, to help fill in the gaps.

The federal government uses Health Professional Shortage Areas (HPSA) to identify areas, population groups or facilities in the United States that are experiencing a shortage of health care professionals. HPSA data, as of Dec. 31, 2019, indicate that [only 45%](#) of the national need for primary care professionals is met. Furthermore, the [data estimates](#) that it would take nearly 14,400 primary care providers to address these shortages.

Moreover, provider shortages are expected to worsen over the next several years. The [Association of American Medical Colleges](#) projects a nationwide shortfall of between 46,900 and 121,900 physicians (across all specialties) by 2032. The Health Resources and Services Administration (HRSA) anticipates shortages of [primary care](#), [specialty](#) and [critical care](#) practitioners, as well as a wide variety of other [health workforce practitioners](#). HRSA also projects that the national need for nurses [will rise 28%](#) by 2030.

Rural communities are disproportionately affected by provider shortages and other barriers to health care for patients. Rural Americans [live an average of 10.5 miles from the nearest hospital](#) compared to 4.4 miles for urban Americans and 5.6 miles for suburban Americans. Rural hospital closures further threaten communities' access to emergency care and other health services. More than [150 rural hospitals have closed](#) across the country in the last 15 years, with many more at risk of closure.



States use a variety of strategies to increase access to health care services, including incentives to enhance provider [recruitment and retention](#), [telehealth](#) and [scope of practice](#), among others. This report provides information about one strategy policymakers have pursued to improve access to care—developing new health care professional types and supporting emerging health professions across primary care, behavioral health and other health care areas.

In particular, community health workers, community paramedics and peer support specialists are among the professions being tapped to help address health workforce shortages and improve access to care in underserved areas. These [health care “extenders”](#) connect patients with services and offer support, education and disease management in between other health care provider visits. As members of a health care team, these professionals can help increase the reach and capacity of existing health care providers. These extenders are often existing members of the communities they serve, with established relationships, and sometimes draw on their personal experiences and knowledge when providing services.

## Community Health Workers

[Community health workers \(CHWs\)](#) have been practicing since the 1950s and states continue to examine the role these professionals can play in rural and underserved areas. CHWs often serve in areas where health care services may not be readily available or easily accessible. CHWs help people navigate a complex health care system by connecting them to preventive and other health care services in culturally and linguistically relevant ways.



CHWs traditionally work in the communities where they live and understand the community they serve. They often work in community health facilities providing case management, client education and follow-up care. Others may be employed by government agencies and nonprofit groups to assist with community organizing, health education, Medicaid enrollment and preventive care services. Building relationships with both patients and providers allow CHWs to effectively function as a liaison between providers and patients. CHWs also help connect patients with additional support, such as reducing social isolation, outside of a specific health care practice.

The [Bureau of Labor Statistics](#) (BLS) estimates that as of May 2019, more than 117,000 community health workers and health educators were employed across almost all states. The estimated size of the CHW workforce tends to vary, as BLS and other groups (e.g., community health worker coalitions) define this workforce and its roles and responsibilities differently.

### **What Services do Community Health Workers Provide?**

Community health worker services often include:

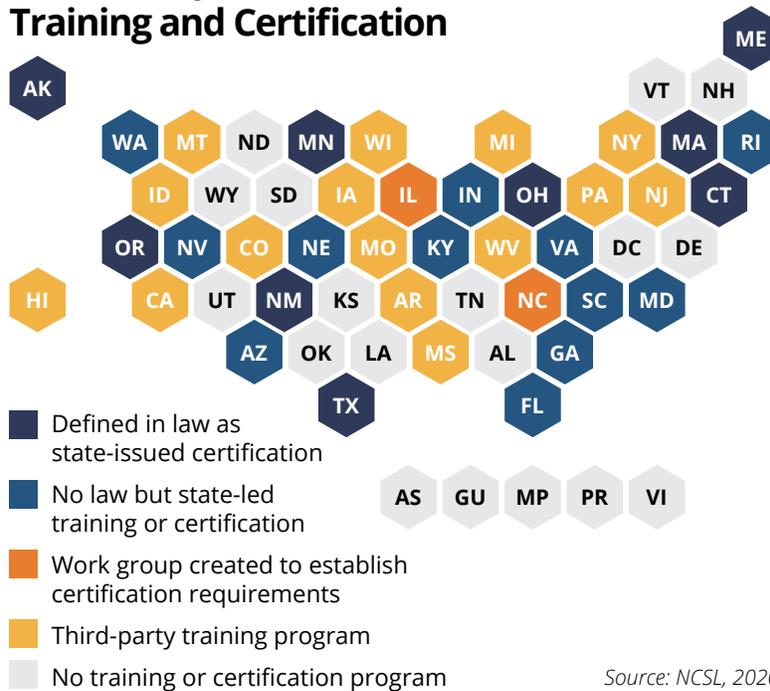
- Creating connections between vulnerable populations and health care systems.
- Providing health education on topics related to chronic disease prevention, physical activity and nutrition.
- Performing health screenings, informal counseling and referrals.
- Facilitating health care and social service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

### **TRAINING AND CERTIFICATION**

Occupational regulation, which involves certification, licensing or other credentials for community health workers, falls under the purview of state legislatures. States may consider occupational regulation to create standards for the CHW profession, which has typically been very broadly defined. Credentialing requirements can include training, skills, competencies and a standardized scope of practice, which would delineate CHWs' practice abilities and limitations.

As of 2019, at least [nine states](#) have laws or regulations for CHW certification. In addition, **Illinois** and **North Carolina** passed laws to establish a work group or task force charged with determining requirements. Many states have established, or are working toward, establishing certification processes through state agencies (e.g. departments of health) or other nonlegislative directives (e.g., third-party organizations).

## Community Health Worker Training and Certification



Training requirements for CHWs vary widely, ranging from formal educational institutions to on-the-job learning. Requirements commonly focus on skills and competencies rather than achieving specific education levels. Almost half of the states have training programs, some of which are connected to certifications and were established by state agencies.

### FINANCING

Many community health workers traditionally served as volunteers but are increasingly being employed by hospitals and health systems. CHWs can be deployed to reach Medicaid beneficiaries, especially as state programs increasingly move toward a comprehensive approach that addresses patients’ barriers and needs (e.g., transportation, health literacy, social stigma, etc.) and emphasizes preventive and coordinated care.

In 2007, **Minnesota** passed legislation to become the first state to reimburse for CHW services under Medicaid. The Centers for Medicare and Medicaid Services (CMS) [issued a regulation](#) in 2014 that expanded reimbursement for preventive services and helped facilitate reimbursement for CHW services through state Medicaid programs.

Medicaid is not the only mechanism for financing CHWs. CHWs are also [funded through](#) a variety of federal, state, local and private dollars. These include funds from federal, state and private grants, state and local health departments, hospitals and clinics, private insurers, community-based organizations, and university and college research projects.

## Community Paramedics

As Emergency Medical Services (EMS) see an increase in responses to nonemergency situations, the role of EMS providers is being reconsidered. With their strong ties to local communities, community paramedics can play a unique role by extending the primary care provider’s reach into the patient’s home or community setting.

While the definition of a community paramedic varies slightly across states, the Joint Committee on Rural Emergency Care (JREC) defines a [community paramedic](#) as “a state-licensed EMS professional that has

completed an appropriate educational program and has demonstrated competence in the provision of health education, monitoring and services beyond the roles of traditional emergency care and transport and in conjunction with medical direction. The specific roles and service are determined by community health needs and in collaboration with public health and medical direction.”

**Community paramedicine** programs are typically implemented within EMS departments or health systems and provide training to community paramedics to perform procedures within their scope of practice. Programs have been implemented in both rural and urban areas. In particular, community paramedicine programs may focus services on frequent users of emergency department services who may need access to more consistent and less costly primary care services.

### **What Services do Community Paramedics Provide?**

Community paramedic services often include:

- **Assessment** (e.g., checking vital signs, blood pressure screening and monitoring, medication compliance monitoring).
- **Treatment/Intervention** (e.g., providing wound care and changing dressings, patient education).
- **Referrals** (e.g., mental health and substance use disorder referrals, social service referrals).
- **Prevention and Public Health** (e.g., immunizations, well baby checks).

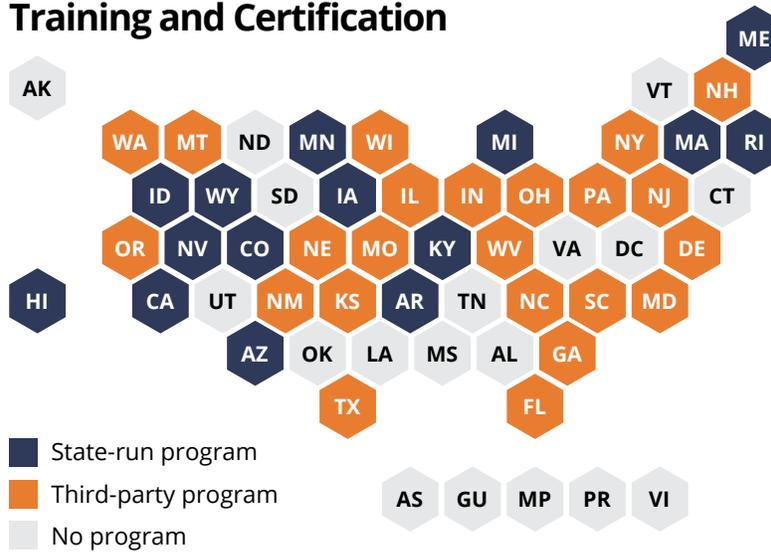
### **STATE-RUN PROGRAMS**

Community paramedicine programs can be implemented at the state level or by third-party organizations. There are typically two models of care for community paramedicine: the primary health care model and the community coordination model. The primary care model focuses on preventing hospital readmissions and targeting specific high-risk patients. The community model connects patients to primary care providers and other social and medical services. Community paramedicine programs can offer one or both models, depending on the needs of the community.

At least **15 states** have a community paramedicine program at the state or local level. In 2019, at least two states passed laws related to community paramedicine programs or certification. **Hawaii** established a community paramedicine program within the state’s department of health. The law instructs the department to develop guidelines for community paramedicine; explore and develop partnerships with public and private health care entities, insurers and community organizations; and employ telehealth to enhance access and improve the patient experience.

**Kentucky** enacted a bill in 2019 directing the Board of Emergency Medical Services to establish educational, testing, credentialing and licensure requirements for advanced practice paramedics, which includes certified community paramedics.

## Community Paramedicine Training and Certification



### FINANCING

Many community paramedicine programs have been implemented as pilot programs and funded through state and grant funds. Historically, Medicaid reimbursement for emergency medical services has been tied to patient transport, posing a challenge to the field of community paramedicine, which aims to provide care for patients in their homes.

In February 2019, the federal Department of Health and Human Services (HHS) launched a new Center for Medicare and Medicaid Innovation (CMMI) payment model called Emergency Treat, Triage and Transport (ET3), allowing Medicare reimbursement for community paramedics for care delivered on-site or through telehealth. In August 2019, CMS issued guidance for states outlining the flexibilities they have to structure Medicaid transportation services to align with the ET3 model. For example, a state may seek a state plan amendment recognizing licensed community paramedics as providers of services furnished on-site without having to transport a patient to an emergency department. Currently, at least six states require Medicaid reimbursement for community paramedic services. In 2018, Anthem Blue Cross Blue Shield became the first private insurer to pay for treatment without transport for patients in 14 states.

## Peer Support Specialists

Peer support specialists, another type of health care extender, draw on their personal knowledge and experience to provide mental health or substance abuse services, such as education and connection to other services. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer support specialist (also called a “peer provider”) as someone who “uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency.”

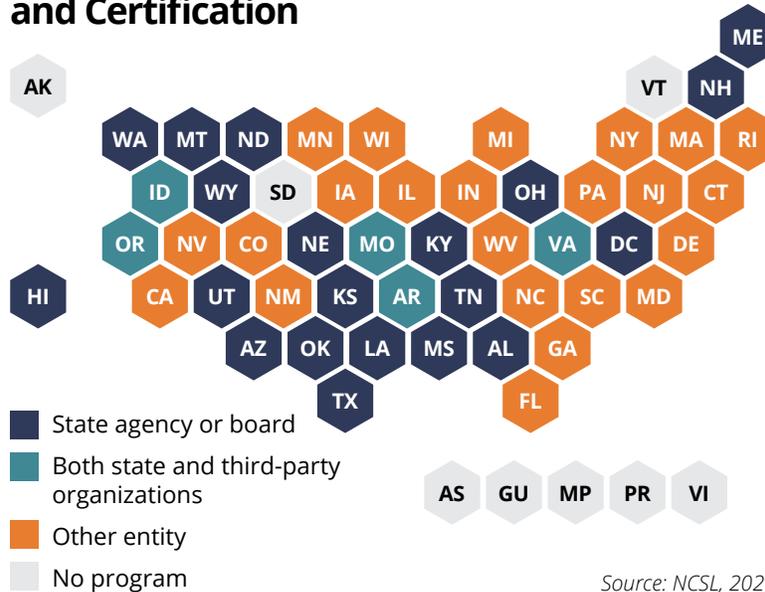
Peer support specialists can enhance states’ ability to address unmet behavioral health care needs for many communities. In 2019, HRSA reported more than 116 million Americans resided in a mental health HPSA.

## What Services do Peer Support Specialists Provide?

Peer support specialist services often include:

- Building community and relationships for those in recovery.
- Leading recovery groups.
- Providing mentoring and goal setting opportunities.

## Peer Support Specialist Training and Certification



### TRAINING AND CERTIFICATION

Training programs and certification standards vary widely across states in terms of curriculum, requirements and continuing education standards. As of December 2019, 48 states and the District of Columbia had established training and certification programs for peer support specialists, either through state-run programs or third-party organizations. A report from the [University of Michigan Behavioral Health Workforce Research Center](#) found that certification for peer support specialists requires an average of about 50 hours of specialized training and 550 hours of volunteer experience.

In addition to state programs and standards, several organizations offer peer support specialist certification or guidelines for states. For example, the [Association for Addiction Professionals](#) and [Mental Health America](#) both offer national peer support specialist certifications.

### FINANCING

Medicaid has become the largest funding source for peer support services. This follows [2007 guidance](#) from CMS authorizing Medicaid billing for peer services based on research identifying peer support as an evidence-based model of care. As of 2019, [at least 39 states require](#) Medicaid reimbursement for mental health peer services. Medicaid reimbursement for mental health and/or substance abuse services can be provided through mechanisms such as a state plan amendment, the rehabilitation services option or a Medicaid waiver.

Medicaid is not the only mechanism through which states have supported funding for peer support services. According to the [University of California](#), most states use a combination of general funds, federal funds and foundation grants to implement and sustain peer support programs.

In 2018, **Maryland** enacted legislation requiring the health secretary to convene a work group to make recommendations for reimbursing peer recovery specialists. The work group was directed to look at whether statutory or regulatory changes are required and whether a state plan amendment or waiver is required. The work group consists of health department staff, behavioral health providers, certified peer recovery specialists, advocacy organizations and other interested stakeholders.

Recent examples of state action in 2019 to support peer support specialists include:

- The **Arkansas** General Assembly enacted legislation authorizing individuals with prior drug-related offenses to work as peer support specialists. They must obtain certification in peer recovery by the Arkansas Substance Abuse Certification Board.
- **Florida** also enacted legislation allowing for certification of peer specialists if they have been in recovery from a substance use disorder or mental illness for at least two years.
- **Montana** enacted legislation allowing certified behavioral health peer support services to qualify as medical assistants under the state Medicaid program.

## Emerging Health Professions Policy Options

Below are a few policy options for state policymakers to consider when examining the use of these emerging health professions.

- Determine whether, and where, emerging health professionals are practicing in your state. Consult with hospitals, payers or others who use these professionals to determine communities being served, gaps and needed services, and potential policy changes.
- Examine existing requirements for emerging health professionals and consider developing state standards, certifications or training programs that focus on needed skills and competencies. Consider developing certification programs or requirements that are based on a set of core competencies needed for these professionals across the state and consider specialized certification standards for professionals in specific programs.
- Consider developing new Medicaid reimbursement policies to support financing for emerging health professionals working in your state. Consult with your state's Medicaid program about payment mechanisms, whether through managed care or fee-for-service environments.

## Conclusion

A number of strategies exist for state policymakers seeking to address health workforce issues, including supporting emerging health professionals such as community health workers, community paramedics and peer support specialists. Legislators have adopted training, certification and reimbursement policies for these professionals to remove barriers and enhance access to health care in rural and underserved communities. As challenges persist in these areas, legislators will surely continue to grapple with these issues and consider innovative strategies to improve individual, community and population health.

*This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UD3OA22893, National Organizations for State and Local Officials.*

*This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.*

NCSL Contact:

**Sydne Enlund**

Policy Specialist, Health Program

303-856-1401

[sydne.enlund@ncsl.org](mailto:sydne.enlund@ncsl.org)



**Tim Storey, Executive Director**

7700 East First Place, Denver, Colorado 80230, 303-364-7700 | 444 North Capitol Street, N.W., Suite 515, Washington, D.C. 20001, 202-624-5400

[www.ncsl.org](http://www.ncsl.org)

© 2020 by the National Conference of State Legislatures. All rights reserved.