



COMMUNITY HEALTH WORKERS

EXPANDING THE SCOPE OF THE HEALTH CARE DELIVERY SYSTEM

NATIONAL
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STATE
LEGISLATURES

By Kristine Goodwin and Laura Tobler

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INTRODUCTION

Ensuring that underserved populations receive needed health care services is a challenge for policymakers. The changing landscape of the U.S. population, which is growing older and more diverse, coupled with other challenges—the increasing complexity of the health care system, rising health care costs, growing numbers of uninsured, more people with chronic diseases, and provider shortages—have policymakers looking for ways to extend the already strained health care system and more effectively reach underserved communities.

In response, states are examining how community health workers (CHWs) can connect underserved populations with health and human service providers. Although the CHW concept is not new, states and other health care providers are partnering more often with these workers to help individuals navigate a complex health care system, receive primary and preventive care, maintain healthy behaviors, and manage chronic conditions in culturally and linguistically relevant ways. CHWs do not provide clinical care or replace other health care providers. Instead, they complement services delivered through the more formal health care network “to provide more comprehensive and supportive care.”¹ In addition to helping improve health care quality for underserved communities, some programs are finding they can save money by focusing on prevention and chronic care management. In many cases, they can help patients avoid costly hospitalization and emergency department visits. CHWs services make it possible to deliver more appropriate primary and preventive services that can prevent use of some inpatient and emergency room services.

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COMMUNITY HEALTH WORKER DEFINED

“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 health educators. CHWs 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 individuals and community health needs, and provide some direct services such as first aid and blood pressure screening.”

As of July 1, 2007, the Provider Taxonomy of the National Uniform Claims Committee has a provider code for CHWs which can be used in fee-for-service claims systems using the above definition.

Source: HRSA, Bureau of Health Professions, *Community Health Worker National Workforce Study*, March 2007.

SNAPSHOT OF THE CHW WORKFORCE

Recent studies help to describe the CHW workforce in terms of its size, credentials and core services performed. Table 1 summarizes workforce characteristics.

Characteristic	Description
Size	The CHW National Workforce Study estimates that 120,000 community health workers were active in American communities in 2005. They are more heavily concentrated in certain states, including California and New York—with 8,000 or more workers per state—and Florida, Pennsylvania and Texas, with more than 3,500 workers per state.
Setting	Clinic-based workers typically work in hospitals, community health centers and health departments, performing tasks such as patient registration, translation, health education and basic health assessments. ² Community-based workers perform a range of duties outside the health care system, depending on community needs.
Credentials and Training	Educational backgrounds vary among workers, ranging from some on-the-job training to formal community college-based programs that grant certification or an associate's degree. ³ Approximately 35 percent of workers who participated in a national study had completed high school, 30 percent had received a four-year degree, and 20 percent had completed some college requirements. About 7 percent reported they had less than a high school diploma, and another 7 percent reported they received a two-year degree. Some states mandate specific credentials for community health workers, a move that some believe will help integrate them into the health care system, raise the visibility of their roles, and obtain higher pay and reimbursement from insurers. Others fear this standardization will force out CHWs who do not have the resources to obtain the required credentials.
Funding	A variety of federal, state and local government, private and nonprofit organizations fund community health workers positions, often on a short-term basis, according to the study. Maintaining stable, ongoing funds for community health worker positions is a challenge for employers and hinders efforts to develop the workforce. ⁴
Wages	Approximately two-thirds of community health workers are wage earners, according to the study, and 33 percent are volunteers. The national study reports that most experienced workers earn more than \$13 per hour. Approximately two-thirds of new workers, on the other hand, earn less than that.

Although the job description for health workers varies by setting, employer and community needs, seven core roles exist for them, according to the National Community Health Advisor Study.⁵ They include:

- Proving cultural mediation between communities and health and human services systems,
- Providing informal counseling and social support,
- Providing culturally appropriate health education,
- Advocating for individual and community needs,
- Ensuring that people obtain necessary services,
- Building individual and community capacity, and
- Providing basic screening services.

HOW CHWs AFFECT ACCESS, QUALITY AND COST

In its 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine recommended community health workers as part of a “... comprehensive, multi-level strategy to address racial and ethnic disparities in health care.”⁶ Similarly, the Pew Health Professions Commission wrote that health workers “... offer unparalleled opportunities to improve the delivery of preventive and primary care to America’s diverse communities.”⁷ Experiences reported by several existing U.S. and international programs support these claims. “The use of CHWs in health intervention programs has been associated with improved health care access, prenatal care, pregnancy and birth outcomes, client health status, health- and screening-related behaviors, as well as reduced health care costs.”

Improving the Bottom Line

Current research concerning cost savings and health workers shows promising results. CHWs are cost-effective, often resulting in improved health, more visits for preventive and primary care (and less for costly urgent care) and fewer hospitalizations, all of which translate into cost savings. Some examples of cost-effectiveness findings are summarized below.

- Denver Health analyzed the return on investment for its CHW program and found that community health workers saved \$2.28 for every \$1 invested in the program. Moreover, primary and specialty care visits increased after patients met with a health worker, and costly urgent and inpatient care dropped.
- A Baltimore program that matched community health workers with diabetes patients in the Medicaid program demonstrated cost savings and improved patient health. Emergency room visits dropped by 38 percent, and hospitalizations dropped by 30 percent.

Improving Health

The Amigos en Salud (Friends in Health) Research Project is a partnership between Pfizer Health Solutions and multiple health care facilities, including the Charles R. Drew University School of Medicine and Science (located in southern Los Angeles). The program uses community health workers to help Hispanic patients with diabetes and co-occurring depression understand and manage their conditions by pairing them with a community health worker. The need for medical intervention is clear: Patients with both diseases tend to

COMMUNITY HEALTH WORKERS' EFFECT ON COST AND USE

A growing body of evidence suggests that CHWs reduce health care costs for people with chronic diseases. A Baltimore program that matched community health workers with diabetes patients in the Medicaid program achieved significant drops in emergency room visits and hospitalization (38 percent and 30 percent, respectively). This drop translated into a 27 percent reduction in Medicaid costs for the patient group. According to the 2003 study, the program achieved savings of \$80,000 to \$90,000 per year for each community health worker. A study measuring the return on investment for a CHW program at Denver Health found that health worker interventions decreased urgent care and inpatient and outpatient behavioral health visits. As a result, primary and specialty visits increased, and reduced costs by program costs totaled approximately \$6,000 per month. Still, improved use reduced costs by more than \$14,000 per month. Although the CHW model requires investments in prevention and primary care, these health services are less costly than treating serious and avoidable conditions.

KENTUCKY HOMEPLACE: PROFILE OF A SUCCESSFUL COMMUNITY HEALTH WORKER PROGRAM

Since it was created by the legislature 14 years ago, Kentucky Homeplace, a community health worker initiative, has linked thousands Kentuckians with medical, social and environmental services they otherwise might not have received. The community health workers are trained to help medically underserved residents access appropriate health services, emphasizing preventive care, health education and disease self-management.

The program employs 39 community health worker, called family health care advisors, who visit families in 58 predominately rural counties. These workers evaluate family health care needs, deliver health education, and help participants gain access to free or discounted medical and prescription drug services. There are no eligibility guidelines, but many participating families have family incomes at or below 100 percent of the federal poverty level.

In 2007, Homeplace workers provided more than 403,000 services to nearly 13,000 clients. By networking with hospitals, health departments, pharmacists, physicians and other providers, Homeplace workers often are able to acquire free or reduced cost medications, medical supplies or equipment, and medical services for their clients. Workers accessed more than \$24.1 million in medications at no cost and other items worth more than \$1.6 million (eyeglasses, hearing aids, wheelchairs, etc.) for many of the families they served last year. Since 2001, the program has assisted more than 74,000 rural residents, provided more than 1.5 million services for them, and accessed nearly \$106 million worth of medications and medical supplies.

Homeplace has been funded by state general revenues since its inception—funding for 2007 was approximately \$2 million. According to the program's director, Fran Feltner, "... the continued state funding is a testament to the program's importance as part of Kentucky's health care safety net."

The program provides some encouraging return on investment data for policymakers in other states. According to Feltner, for \$1 the state spends on the program, Homeplace generates \$15 to \$20 in free or discounted services for its clients.

The Homeplace program also participates in a variety of research, initiatives and partnerships to promote disease prevention, encourage wellness, and encourage healthy choices with the goal of creating a healthier Kentucky.

Homeplace recently partnered with the Southeast Kentucky Area Health Education Center, the American Cancer Society, the Kentucky Cancer Program, and two district health departments on a colorectal cancer awareness project. Workers met with more than 1,200 clients to discuss the risks of colorectal cancer and the available resources for medical information, screenings and care, which led to improved screening rates.

Homeplace coordinated client walking programs in multiple south-central Kentucky counties. In 2003, Homeplace participated in a research project to better understand the diabetes epidemic sweeping the state. Community health workers distributed self-test surveys to more than 3,000 clients. The results showed that nearly 75 percent of respondents were at moderate to significant risk of having or developing diabetes. This participation led to foundation funding to develop a diabetes case management program in Leslie County, Ky., where 20 percent of the population is uninsured.

Homeplace collaborates with a rural hospital where a community health worker is stationed in the hospital's emergency department to help patients in non-life-threatening situations find a "medical home"—a consistent setting for primary care—and obtain appropriate cancer screening or smoking cessation assistance.

In conjunction with the University of Kentucky's College of Public Health, Homeplace is participating in a tobacco cessation program where smoking status is monitored and reinforced via the Internet.

have higher primary care costs, and fewer Hispanics receive care for depression than whites. The nurse-directed diabetes management program has the following objectives:⁸

- Increase Hispanic awareness of diabetes and depression,
- Achieve American Diabetes Association clinical practice standards,
- Improve patient behavior and self-management skills, and
- Demonstrate participant satisfaction working with community health workers.

The program noted favorable and statistically significant results for each objective. Compared to patients who were not enrolled in the program, patients reported improved health status—they were five times more likely to rate their overall health as “good” or “excellent”—and improved health behaviors. For example, participants were more likely to report eating fresh fruit and vegetables daily, less likely to eat fatty foods, and more likely to report exercising three or more times each week. Participants also demonstrated improved depression severity scores, as measured through patient surveys. Finally, participants in the CHW group experienced statistically significant clinical results, as measured by lipid profiles including LDL cholesterol levels, resulting in an overall reduction in cardiovascular risk.

STATE LEGISLATIVE ACTION

Although health workers have a long history of working within their communities, state legislation concerning the profession is relatively new. States are increasingly considering legislation to define community health workers, study the workforce, establish training and certification programs, integrate health workers into state Medicaid programs, and create community health worker programs.

According to a 2005 17-state survey of community health worker certification and training programs,⁹ all respondents have some form of training or certification for these workers, most often delivered at community colleges or service agencies. Although some states sponsor the training or certification programs, few have passed legislation to require workers to obtain specific training or certification. As health workers assume a more prominent role in the health care system, however, states are considering the need for standardized training and certification for the community health worker workforce.

Training and certification standards can help to enhance recognition of health worker roles and provide greater opportunities for reimbursement through state Medicaid programs and third-party insurers and also can increase workers' skills and ensure a high quality of care. On the other hand, there is concern about the effect of these requirements on the workforce. Some advocacy groups argue that requiring certification will significantly reduce the number of community health workers especially for programs that rely on volunteers and the help of undocumented aliens.

Examples of State Legislation

Kentucky. The Kentucky General Assembly authorized the Kentucky Homeplace Program in 1994 and has been authorizing general fund support since then—state funding for the program was close to \$2 million in 2007.

Massachusetts. In its landmark universal health reform bill of 2006, the Massachusetts legislature required community health worker representation on the Massachusetts Public Health Council and required the Department of Public Health to convene a statewide advisory group to make recommendations for a sustainable community health worker program.¹⁰

New Mexico. In 2003, the New Mexico Legislature passed Senate Joint Memorial 76 to require the Department of Health to lead a study on the development of a community health worker advocacy program, examine the value of health workers to the health care delivery system, and determine how they affect patient health. The data, analysis and findings of this report show that access to community health workers has the potential to improve public health outcomes, increase access to care, and reduce costs for health services. The Department of Health made recommendations aimed at providing sustainability for community health workers.

Ohio. In 2003, the Ohio legislature established a credentialing program for community health workers. The certification program, launched in 2003 and authorized through the Nursing Practices Act, awards a “certificate to practice” credential after applicants complete an approved training program. The training programs—three were accredited in 2006—consist of at least 100 hours of classroom instruction and 130 hours of clinical instruction.¹¹

Texas. In 2001, the Texas Legislature required certification for paid community health workers and directed health and human service agencies to use certified workers when possible. Texas health and human service agencies are required to use certified CHWs for outreach and education programs for medical assistance recipients. To obtain the required credentials, applicants must complete an approved training program or prove equivalent experience.

Virginia. In 2004, the Virginia General Assembly passed Joint Resolution No. 195, directing James Madison University to study the status, effect and use of community health workers in the Commonwealth. The final report, published in 2006, included seven recommendations related to development of a statewide core curriculum for community health workers, developing educational pathways beyond a core curriculum, maximizing the role of these workers through support of pilot programs and projects that include them, and financing issues. The full report is available at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD92006/\\$file/HD9.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD92006/$file/HD9.pdf).

Washington. The Washington Legislature recently appropriated close to \$1 million for a cost-effectiveness study of community health workers in asthma management under the State Medicaid Office.

MEDICAID PARTICIPATION AND REIMBURSEMENT

Integrating health workers into the health care system may help states meet the needs of underserved communities. States recognize that the role of community health workers may be especially important within Medicaid programs because health workers connect underserved populations with health resources. These groups may be isolated from the health system at large due to geography, language or other barriers. As states integrate community health workers into their Medicaid programs, they also examine opportunities for reimbursing them. For example, Texas health and human service agencies are required to use certified community health workers for outreach and education programs for medical assistance

recipients. In September of 2007, Minnesota filed a Medicaid state plan amendment that would authorize reimbursement for community health worker services, allowing a much broader range of services than other states.

State policymakers and Medicaid administrators view partnerships between state Medicaid agencies and health workers as a strategic alliance. As Medicaid program administrators expand access to primary and preventive care, help enrollees manage chronic conditions and control costs, the role of the community health worker emerges as a promising part of the solution.

Community Health Workers in the Medicaid Program

Community health worker roles vary considerably from job to job and program to program. Within state Medicaid programs, they focus primarily on increasing access to care through outreach and enrollment, improving health through education and support, and appropriate use of health care services.

Improving Access to Health Care Services and Resources. Denver Health employs two community health workers in the Free Pregnancy Testing Program to conduct pregnancy tests, help women schedule appointments and identify a medical home. In addition to increasing access to services for underserved pregnant women, Denver Health realized a positive return on investment of almost \$7 for every \$1 spent on these services.¹²

Improving Health. To date, evidence is promising that community health worker participation in the state Medicaid program has a positive effect on health, supporting a team approach to care and helping patients manage their disease. St. Louis diabetes patients who allowed a community health worker to help them with their self-care for 18 months improved glycemic control. The group that accepted a home health aide showed a significant decline in fasting blood sugar (13.9 mg/dl). These patients also were more likely to attend clinic visits for diabetes care and were less likely to go to the emergency room (compared to a control group that did not see community health workers).¹³

Improving Appropriate Use of the Health Care System. Community health workers play an important role by helping enrollees understand how to navigate the health care system. They also provide patients with information about staying healthy and managing diseases, emphasizing prevention and primary care. This results in more appropriate use of the health care system, leading to lower overall costs of care. For example, a 2003 study of West Baltimore City Medicaid patients with diabetes found that trained community health workers connected patients with providers, helped them set and keep appointments, and monitored patient self-care, which resulted in 38 percent fewer emergency room visits, 30 percent fewer hospitalizations, and a 27 percent reduction in Medicaid costs among participants.

Medicaid Funding and Reimbursement for CHW Services

States sustain community health worker roles within Medicaid programs by using Medicaid funds to pay for their services. Although federal rules do not recognize community health workers as a billable provider, the rules do not prohibit these workers from being employed within the Medicaid program. “States are permitted within federal parameters to explore and

implement their own programs,” according to a 2006 report by the University of California, San Francisco’s Center for Health Professions. According to the UCSF report, states use four methods to fund community health worker services: Medicaid managed care, Section 1115 waivers, federal support for administrative costs and direct reimbursement.

Medicaid Managed Care. Managed care organizations that participate in state Medicaid programs and the State Children’s Health Insurance Program (SCHIP) must comply with various mandated requirements; if these requirements are met, the health plans have latitude in how they use the capitated funds they receive from the state. Some managed care organizations directly employ community health workers while others contract with an organization that provides the services. The Health Plus managed care organization in New York City, for example, employs 35 community health workers to deliver outreach and education.

Section 1115 Waiver. States can obtain a waiver to expand services statewide through community health worker programs, and the waiver enables reimbursement for certain of these services. California, for example, used a Section 1115 waiver to expand family planning services to low-income women and adolescents. The waiver allows the state to reimburse per-unit community health worker counseling and technical services. Under waiver authority, New York created a successful maternal and child health community health worker program.

Federal Support for Administrative Costs. The federal government matches state administrative costs for certain expenses, such as translation services and operating costs for state Medicaid offices. Community-based community health worker programs also can receive federal matching funds for outreach and coordination.

Direct Reimbursement. Some states define community health workers as billable providers who can bill the Medicaid program directly for their services. States define certain eligibility requirements for workers, such as training and, in some cases, certification. In Alaska, for example, community health workers must be supervised by a physician who certifies that the services are medically necessary.

POLICY CONSIDERATIONS FOR LEGISLATORS

Existing community health worker programs provide important insights and lessons for policymakers who are integrating them into state public health strategy. Key considerations for integrating health workers into the formal health system include the following.

Raising Requirements, not Barriers. As the health worker role in the health care system grows so, too, does interest in formalizing and standardizing workforce training requirements. Although raising standards for community health workers may help to improve quality of care, increase visibility of the workforce, and enhance opportunities for reimbursement, it also raises concern about their effect on the workforce. States have allowed experience to substitute for educational and training requirements and to offer assistance or scholarships to offset application fees and tuition. Achieving consistency and standardization among the workforce and preserving culturally relevant support, without changing the nature of the profession, is a sensitive issue for states and other stakeholders.

According to a report on health workers in California, "... membership in the community, fluency in the native language, and a desire to serve have been the only qualifications required of many community health workers. Formal training programs will add prerequisites which could make entry into the field more difficult." In many underserved communities where there are provider shortages, formal educational requirements may prevent community health workers who have relevant experience from providing services.

Partnering for Results. Convening the stakeholders involved and encouraging private-public partnerships can help states achieve desired results. Key stakeholders include community health workers, community and state colleges, and industry and health system representatives. Ensuring that community health workers have input in the process is important, according to a 2006 report by the Brookings Institution. "Involving CHWs in designing the credentialing process is critical to minimize negative effects."¹⁴ Perhaps more important, these workers have important insight to contribute in both their work with patients and integrating their responsibilities into the existing health care system.

Using Resources Effectively. Policymakers need information about cost savings and health outcomes for specific community health worker programs to know where the workforce will be most effective and to provide for reimbursement. In many cases, states require evaluations to analyze the effect of the program on quality, access to care, health status and cost. Policymakers also want to identify the greatest unmet need and understand how community health workers can address it. The Alaska Community Health Aide Program, for example, addresses the oral health needs of Alaska Natives in rural settings with a Dental Health Aide Program. Other states and localities may identify prenatal care or chronic disease management as a priority.

Scope of Practice. As the role of community health workers grows, other health professions may question these increasing roles and responsibilities, particularly if they perceive that the workforce is encroaching on their scope of practice. Some states place health workers under the authority of their nursing practice act and require oversight by a registered nurse. States also may consider developing a standard scope of practice for community health workers, because "... public agencies may resist direct reimbursement for CHW services until a standardized scope of practice is established."¹⁵

Sustainable Funding. Because community health workers rely upon short-term, project-specific funding, states are examining use of Medicaid reimbursement to make community health worker programs more sustainable. Expanding the programs will require public and private stakeholders to enhance reimbursement for the services or identify longer-term streams of funding.

POLICYMAKERS ARE EXAMINING THE IMPORTANCE OF:

- Defining the workforce through legislation.
- Developing a statewide, core curriculum for the workforce.
- Requiring credentials for all community health workers or a sub-set, such as those who receive compensation.
- Substituting experience for formal training.
- Requiring state agencies and contractors to use community health workers.
- Encouraging community health workers to be members of the communities they serve.

CONCLUSION

Recent state experience suggests that states and Medicaid programs are increasingly using community health workers to expand the health care safety net to reach underserved populations. As community health workers become integrated into the health care system—and specifically into state Medicaid programs—policymakers are examining how they can preserve the qualities of this informal workforce and standardize qualifications.

Community health workers, representatives of 22 college-based educational programs, and other stakeholders form the Community Health Worker National Education Collaborative. The collaborative developed educational resources, services, curricula, and promising practice delivery strategies for the community health worker field. For additional information, visit <http://www.chw-nec.org>.

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National Conference of State Legislatures
William T. Pound, Executive Director

7700 East First Place
Denver, Colorado 80230
(303) 364-7700

444 North Capitol Street, N.W., #515
Washington, D.C. 20001
(202) 624-5400

www.ncsl.org

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