VIRGINIA BOARD OF HEALTH PROFESSIONS

PUBLIC HEARING

IN RE: Regulation of
Community Health Workers

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 201
Richmond, Virginia

January 11, 2010
9:00 a.m.

APPEARANCES:

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| Damien T. Howell, | Board of Physical Therapy |
| Elizabeth Carter, Ph.D. | Executive Director for the Board |
| Justin Crow | Research Assistant, DHP |
| Laura Chapman | Operation Manager, DHP |

(The Public Hearing went on record at 9:05 a.m.)

CHAIRMAN: Good morning. I'm Damien Howell, Chairman of the Regulatory Research Committee. This is a public hearing to receive public comment on the Board's study of working professions, community health workers. The Code of Virginia authorizes the Board of Health Professions to advise the governor, the general assembly, the department director on matters related to the regulation of health care occupations and professions.

Accordingly, the Board is conducting this study and will provide recommendations on whether there is a need for regulation. So in terms of housekeeping if you haven't turned off your communication devices, do so. And do we

have any instructions on emergency.

(Emergency instructions were issued by Elizabeth Carter.)

CHAIRMAN: Thank you.

At this time I will call on persons who have signed up to comment. As I call your name please come forward to this table, tell us your name and your profession and what you wish to speak about and where you are from. First on our list is Chelsea Savage or Becky Bowers-Lanier.

MS. BOWERS-LANIER: I'm Becky Bowers-Lanier, and I am speaking on behalf of Chelsea Savage who is the chair of the Legislative Coalition of Virginia Nurses, and she was unable to be here today so I'm going to read her comments.

Thank you for this opportunity to provide public comment for the need to regulate community health workers. My name is Chelsea Savage and I chair the Legislative Coalition of Virginia Nurses which consists of 15 nursing and health related organizations and individual nurse members.

We have reviewed the material presented by

Catherine Bodkin and Dr. Garson appearing here in the November 2009 presentation before the Regulatory Research Committee of the Board of Health Professions. We believe that Bodkin and Dr. Garson's presentation speaks to the practice of community health workers now and possibly into the future with expansion of their roles that they presently perform. Due to the nature of these workers' practice in residents' homes we believe there are sufficient data to explore whether their practice poses a risk of harm to the public if they remain unregulated. We also believe that their practice appears to be autonomous or at least we are uncertain about the level of supervision by licensed individuals. At this point we are not convinced that all seven criteria have been met, but we all agree the November presentation suggests that there may be a need to regulate these individuals.

Therefore, The Legislative Coalition of Virginia Nurses recommends that the Board of Health Profession continue to study the current projected practice of the community health workers in order to determine whether these

individuals need to be regulated and if so at what level.

Would you like a copy of this?

CHAIRMAN: Yes, please. Thank you.

Next on the list is Christopher Nye.

MR. NYE: Thank you. My remarks are going to be a little more extensive with some background information if you don't mind.

Members of the Board, my name is Christopher Nye. I am the Executive Director of Harrisonburg Community Center and an Associate Director of James Madison University Institute for Innovation in Health and Human Services. Thank you for the opportunity to make and submit the following comments.

House Joint Resolution 195 of the 2004 Virginia General Assembly directed JMU to study the status impact and utilization of community health workers in Virginia. In January 2006 the final report was submitted to the general assembly. The report listed seven recommendations designed to maximize the unique value of community health workers within Virginia's health care work force.

Eliminating health disparities among the

racial, cultural and economically disadvantaged population has remained the priority of the U.S. Department of Health and Human Services since first expressed in the document helping people in 2000 and reaffirmed in subsequent updates.

Community health workers, or CHWs, are considered to be important members of the health care work force in reducing barriers in health community services among vulnerable populations. The integration of CHWs as members of health care teams within the context of roles where research has shown CHWs to be particularly effective is a promising strategy for improving health outcomes and efficiencies within health and human services delivery systems.

In 2006 the Virginia Department of Human Resource Management added "Community Health Worker" as a title to the direct service career group within three levels of Direct Service Associate 1, 2 and 3. Quoting the introduction this career group provides career tracks for health care support occupations that serves complimentary components as a comprehensive

health care or human services system by directly providing client services or assisting professionals in a residential clinic or community setting.

Direct client services including medical and mental health care, case management, client training in education, health and social service activities, mentoring, environmental health monitoring, patient preparation and observation, therapeutic treatment and dental care. Support services include laboratory testing, behavioral screening, pharmaceutical preparation and distribution, diagnostic procedures, nutrition assessment and administrative services. Certification or specialized training to meet local, state or federal requirements may be required. Employees perform duties ranging from entry level assistance to fully trained professionals and supervisors.

And that is the introduction.

The three levels of direct service associate and their corresponding description of complexity resulting in accountability suggest the need for certification at the

highest or expert level while I believe they also recognize and serve a non-certification level within traditional roles and functions of community health workers.

The 2006 study indicated that community health workers in Virginia, and nationally, received training through a variation of methods. The National Community Health Adviser study in 1998 found that 83 percent of the CHWs responded through the survey received formal on-the-job training. Second to this, on-the-job training was experienced while performing the job at 79 percent. And 21 percent of respondents indicated school base training. With greater emphasis now placed on certification of the CHWs since 1998 these numbers may no longer be accurate. However, it is important to consider that there are many CHWs in Virginia that are very successful within their roles because of their natural ability as care givers and their connection to their clients. This connection is often due to the fact that a CHW belongs to the same community as their client, and this bridges the disconnect that we often see between health

1 care professionals and patients.
2 It is my opinion that certification of
3 CHWs should not discount these skills and
4 displace workers who for one reason or another
5 would not pursue or achieve certification.
6 According to the American Academy of
7 Family Practitioners primary care among other
8 descriptions provides health promotion, disease
9 and prevention, health maintenance, counseling,
10 patient education and diagnosis and treatment
11 of acute and chronic illnesses in a variety of
12 health care settings. The shortage of primary
13 health care professionals is a critical issue
14 facing Virginia and our country on the eve of
15 health insurance reform and aims to improve
16 access to primary health care professionals for
17 millions of uninsured individuals.
18 As the executive director of a federally
19 qualified health center our primary care
20 physicians and nurse practitioners
21 unfortunately do not have the time to provide
22 their patients with a level of health promotion
23 and disease prevention information they would
24 like. The reality of today's medical economics
25 is focused on pro-activity. These CHWs such as

1 the Grand Aid project -- that's a name you're
2 about to hear through these submitted
3 comments -- we see this project as serving as a
4 foundation for our outreach efforts in
5 providing important health and promotion in
6 disease prevention information.
7 And this is the last page.
8 I would like to highlight several of the
9 JMU Board's recommendations. Recommendation 4
10 suggests collaboration with Virginia's college
11 system and other institutions of higher
12 learning and that these institutions that
13 explore and develop ways to provide CHWs with
14 educational opportunities and academic credit
15 and identify career pathways.
16 Historically, many CHW programs across the
17 country have worked with community colleges to
18 establish academic credit for CHW training.
19 According to the 1998 CHW study, partnerships
20 between CHW programs and community colleges
21 have gone through periods of demand where there
22 were large numbers of CHWs seeking academic
23 credit. These programs dissolve due to demand
24 or resources whether personal or program fade.
25 While resources may be scarce, demand should be

high as many people are without work today, and the health services spectrum is projected to grow.

Recommendation 5 suggests that health professions training program should identify opportunities within existing curricula to educate students through practicing professionals regarding the role of community health care workers in an efficient and effective health community delivery system. This recommendation seeks to capitalize on the unique skills of community health workers to build multidisciplinary health care communities and achieve the promise of health promotion and disease prevention.

Recommendation 6 suggests that the Commonwealth in collaboration with public and private agencies should seek opportunities to support demonstration projects that integrate community health workers within existing health community service delivery systems that care for vulnerable populations.

Lastly, Recommendation 7 suggests collaboration with the Virginia Department of Medical Assist Services to examine

opportunities for additional Medicaid reimbursement to utilize CHWs. Reimbursement for CHW services is necessary to develop and sustain community health worker programs.

Most health profession certifications and standards, these all precede reimbursement. As the Board continues to examine the roles of CHWs I hope that its actions will ensure the recognition and growth of this segment of our health care work force, its important contributions and the problems of CHWs to reach vulnerable populations of Virginia.

Thank you.

CHAIRMAN: Thank you. Any questions?

JUSTIN CROW: The 2006 final report, one of the recommendations was that the VCHO track the KSAs of CHWs. Has that advanced anywhere and if so, how much?

ELIZABETH CARTER: And for clarification for the audience, KSA is knowledge, skills and abilities.

MR. NYE: Part of that study was a survey of community health worker programs across Virginia. We actually gave community health workers and community health worker supervisors

the opportunity to select from a list of knowledge, skills and abilities that we had collected from research. I don't have the study with me. Unfortunately, I don't have that list with me. But I know that one of the outcomes of that was the home visiting consortion that you may be aware of -- and other people here may be able to address more accurately than I could. But there are efforts at developing a core or standard curriculum or what I would like to call a foundational curriculum for all community health workers regardless of what particular arena or topic they may be addressing including things like communication skills, boundary settings, the appropriate roles of a community health worker, issues of confidentiality. Those types of things.

CHAIRMAN: Thank you.

Next on the list is Julie -- and unfortunately, I cannot read your handwriting. Can you come forward and tell us your name.

MS. BILODIAM: Can I bring someone else up with me. She'll be able to help with my case.

CHAIRMAN: Yes.

MS. BILODIAM: My name is Julie Bilodiam, Director of CrossOver Ministry. We are a free clinic located here in Richmond. And we provide health education and medical services to low income uninsured. And Marilyn Metzler is with me. Marilyn is the director of patient education. Marilyn created and has built the program in our community, and I'm going to read comments related to that program.

Janice McMillan is a mother of four who had a life-long dream of being a nurse. Living in Mosby Court housing community with a 10th grade education she didn't expect her dream of being able to care for the health and welfare of others to ever come true. Twelve years ago Ms. McMillan received the opportunity to be trained as a Lay Health Promoter through CrossOver Ministry, and she has been voluntarily providing health information and services to her community ever since.

Ms. McMillan states: My life has gained new purpose and meaning since becoming a Lay Health Promoter, and I love helping people, and I now have the tools and the knowledge and the title to be able to help people who need me.

My neighbors know they can call me even at 3:00 a.m. and I'm ready to help and guide them with health questions. By giving back to the community I'm helping other lives to be changed like mine. Sometime people ask me if I get paid for what I do. But I tell them that God pays me. Receiving money would take the heart and the soul out of my gift. LHP stands for Lay Health Promoter, but to me it also stand for Love Helping People. I love helping people, and that is what I do.

CrossOver Ministry is a member of the Virginia Association of free clinics and has managed 24,000 patient visits last year through our network or three free clinics in the Richmond area. One of the ways that low income and uninsured individuals are informed about accessing our services is through our community base pool of volunteers.

CrossOver has trained over 1,000 Lay Health Promoters; some in English and some in Spanish over the last 15 years. And these individuals have made over 87,000 health education contact visits in the community. Our volunteers go through a 20-hour curriculum of

classroom instruction led by Marilyn, who is with me. Marilyn is an RN who helped develop this program. The peer educators use their training to voluntarily provide culturally appropriate health education and they guide those in need to access the appropriate services.

CrossOver Lay Health Promoters are deeply embedded in our communities, and they help to bridge the gap between the medical community and those who are living in our most adverse communities. Lay Health Promoters volunteer their time because they believe in the mission of promoting wellness, and they feel valued by CrossOver in those communities.

The risk of credentialing all community health workers is that it would create barriers for individuals willing to serve in our adverse communities. Requiring credentialling of all community health workers also raises the risk of undermining the true spirit of volunteerism that we believe our society needs.

Thank you.

CHAIRMAN: Questions?

(No questions from the Board.)

CHAIRMAN: Thank you.

Next on the list is Karen Rhenham.

MS. RHENHAM: Good morning, Chairman. My name is Dr. Karen Rhenham, and I am the pediatrician and Senior Associate Dean for Continuing Medical Education and External Affairs and Medical Director of Howard Medical at the University of Virginia. I'm here to represent Dr. Arthur Garson who unfortunately is out of the country and could not be here today.

In follow up to the comments submitted by Dr. Garson, provost at the University of Virginia, we wish to provide further clarification to the Board. We believe a study as to feasibility regarding the certification of community health workers in the Commonwealth of Virginia is both timely and important. Our nation faces a critical shortage of health care professionals just as we face ever increasing rates of chronic disease and its aging population.

With anticipated greater numbers of uninsured Americans as a result of health reform we expect a significant increase in

demand for services as has been demonstrated in states such as Massachusetts. Community health workers offer one solution to this anticipated regional need for health providers by extending the reach of our nurses and physicians into the communities they serve.

A recent comprehensive report prepared by the Commonwealth of Massachusetts Department of Public Health December 2009 has validated the impact of community health workers on increasing access to health care, the quality of care, health outcomes, costs and elimination of disparities in vulnerable populations.

Massachusetts reports no statewide infrastructures to support standardized training although individualized programs exist in the state and are fully subscribed. The Massachusetts Department of Public Health reported that community health workers reported that training opportunities for higher education are important to their effectiveness and advancements in the field. They also report that certification of community health workers is critical to advancement of the work force, and that other states have passed

1 legislation formalizing certification of that
2 work force.
3 Community health worker training programs
4 can be tailored to prepare workers to provide a
5 host of services ranging from health promotion
6 and disease prevention, enhanced access to
7 social services, chronic disease management to
8 coronary care models.
9 The Grand Aid program proposed by
10 Dr. Garson includes a primary care community
11 health outreach worker model in which carefully
12 vetted and trained outreach workers serve as an
13 extension of the health professional work force
14 of our federally qualified health centers.
15 Following completion of an extensive training
16 program and supported by tele-medicine
17 technology the primary care grand aid will
18 gather information about their patient and
19 communicate with their mentor, partner, health
20 professionals which includes RNs, advanced
21 practice nurses and physicians employed by
22 federally qualified health centers.
23 We have engaged and secured the
24 (inaudible) afforded the Virginia Community
25 College system to develop a standardized

curriculum and to provide testing and evaluation of the grand aid.

The Virginia Community College System is uniquely qualified to build upon its existing curriculum in nursing and the allied health profession. In particular, the VCCS can respond to work force needs in all regions of the Commonwealth.

I have attached here a letter from the Chancellor as well.

Certification of community health workers will serve to ensure a sustainable high quality community health worker infrastructure with requisite continuing education. Equally importantly, certification will ensure employment opportunities in models designed to enhance access to quality health care and improve the health of the citizens of the Commonwealth.

We encourage the Board to support this request to study certification of the community health workers.

Thank you for the opportunity to speak to you today.

CHAIRMAN: Questions.

ELIZABETH CARTER: The certification that you're speaking of, would you be adverse to allowing people who currently hold the title of community health worker who are not doing direct patient engagement, where you talked about with grand aids here, is there going to be a problem with them retaining them as far as you all are concerned?

MS. RHENHAM: I don't have any problem with it. The issue is going to be, we believe payment of grand aids and community health workers would be important to sustain this work force model. And in so far as certification is required for payment by payers then that would be the reason to go ahead and provide that.

ELIZABETH CARTER: Thank you.

MS. RHENHAM: There's a wonderful model in Alaska that you probably are familiar with.

CHAIRMAN: Anymore questions?

(No further questions from the Board.)

CHAIRMAN: Does anyone else wish to speak?

Come forward and tell us your name and a little bit about yourself.

MS. SPECTER-DUNAWAY: My name is Lisa

1 Specter-Dunaway. I'm CEO of CHIP of Virginia,
2 Comprehensive Health Investment Project. And
3 we pair an RN with the community health workers
4 and work with low-income pregnant women or
5 at-risk when the child is under the age of six.
6 So depending on the family's needs they get
7 visits from, both, the community health worker
8 and the RN. Some get more nursing. Some get
9 more community health worker. Again, depending
10 on the health issues that are specific to that
11 family. We do believe that it is important to
12 study the certification of community health
13 workers in looking at the risks of harm that
14 could be posed by unregulated practice. In
15 seven age-appropriate core roles as described
16 by the National Community Health Adviser Survey
17 of 1998 included providing culturally
18 appropriate health education as well as
19 cultural mediation between communities and
20 health and social service providers. CHWs are
21 playing increasingly important roles in the
22 health and human service delivery system, and
23 their use is multiplying. Their role in the
24 system place them in a position to abide by
25 certain legal requirements such as HIPAA and

FERPA laws. Without formal regulation violation of HIPAA or FERPA laws may occur more frequently resulting in harm to the public and liability to the organizations who utilize CHWs in their work with the public. This includes public and private entities, including student liabilities for the activities of CHWs used in their services delivered. In addition, within the roles of health care delivery they face certain ethical obligations that are not well defined within the profession and are not connected to any professional association. The unregulated provision of health education to the public could result in over stepping of boundaries providing clinical medical advice or recommendations as opposed to simply health education.

In terms of specialized skills and training. In the community health advisory study they indicate that community health workers are able to achieve results in health promotion because they have the specialized training, experience, language and culture of the communities that they serve. Training included covering ethical and professional

1 roles of boundaries, HIPPA and FERPA laws and
2 topics within the training such as prenatal
3 health can be used to ensure that the community
4 health worker can effectively fill their roles.
5 Without this training they cannot safely and
6 effectively do them.
7 In terms of autonomous practice of those
8 things which require independent judgement and
9 functioning, meaning health workers by their
10 very nature are functioning in communities
11 where their clients live and work. This
12 includes homes, neighborhood centers and
13 clients' workplaces. In community settings
14 such as clients' homes, community health
15 workers work independently without the need for
16 supervision or collaboration with other
17 professionals. Working in an uncontrolled and
18 informal setting we can help workers who often
19 must make decisions quickly and independently
20 which will impact the state of people and well
21 being of their clients health. Examples
22 include whether or not to report child abuse
23 and neglect that would provide the victim of
24 violence on options to protect their safety or
25 whether or not to advise communications with

1 their health care provider.
2 In terms of scope of practice being
3 singled from other regulated professions. In
4 (inaudible) established here in Professional
5 Health Nurses in a 2005 study indicates the
6 goals associated with community health workers
7 are threefold: One, establishment of ongoing
8 therapeutic alliance which is provided in a
9 community setting; two, improving appropriate
10 health care utilization; and three, reduction
11 of risks. With those goals community health
12 workers are trained and highly skilled to build
13 relationships with clients in ways that are not
14 efficient or cost effective for clinical health
15 professionals such as nurses and physicians.
16 Unlike the health care work force CHWs are not
17 federally restricted to formal health care
18 settings and can provide these services as a
19 compliment for these services while operating
20 in the patient's natural environment of home
21 and community.
22 In terms of the economic costs to the
23 public and restricting the supply of
24 practitioners. As the use of community health
25 workers grows within the health care work force

more of the public will come into contact with persons in this role as part of their health care team. However, consideration must be made of the burden of fees placed on the small organizations that use CHWs as their primary strategy to promote health and prevention to the private physician. These organizations have little resources with which to pay annual fees. And the CHWs often fall in the lowest sphere of the pay scale making it very unlikely that they themselves could bear the financial burden of fees.

Because community health workers are utilized in such a broad array of organizations they are not regulated under one body. Independent regulation of the role may be the most effective method of ensuring appropriate protection from the public and from both public and private entities which utilize them.

Our biggest concern is the cost to the organizations and the community health workers themselves. Again, these are programs that are working sometimes in the toughest communities. And they working very hard to raise the funding, and state funding we need, we would

like to have Medicaid reimbursement, and this would support that. But we have to be careful that it does not put a burden on the agencies that are already struggling for survival.

CHAIRMAN: Questions.

(No questions from the Board.)

CHAIRMAN: Would anyone else like to speak?

(No response.)

CHAIRMAN: We want to thank you who took the time to come today and offer comments on the study. We will consider all comments prior to the development of recommendations concerning further study.

Written comment will be accepted until 5:00 p.m. on January 31st.

Again, thank you for your time and participation. This concludes this hearing. Thank you.

(Proceedings concluded at 9:35 a.m.)

C E R T I F I C A T E

State of Virginia )
) Ss:
Chesterfield County )

I, Mary E. Aliff, a Notary Public within and for the State of Virginia, at Large, duly commissioned and qualified, do hereby certify that that the testimony then given was reduced by me to stenotype, subsequently transcribed into English text under my direction, and that the foregoing is a true and accurate transcript of the testimony so given.

I do hereby certify that this hearing was taken at the time and place as specified in the foregoing caption and was completed without adjournment.

I do hereby further certify that I am not a relative, counsel or attorney of any party or otherwise interested in the outcome of this action.

In witness whereof, I have hereunto set my hand this 13th day of Jan

---------- Mary E. Aliff
Mary Elizabeth

Virginia Notary Registration No. 270874

My commission expires
May 31, 2010.