FINAL

DEPARTMENT OF HEALTH PROFESSIONS
BOARD OF HEALTH PROFESSIONS
REGULATORY RESEARCH COMMITTEE
SEPTEMBER 30, 2009

TIME AND PLACE:	The meeting was called to order at 9:10 a.m. on Wednesday, September 30, 2009, Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Room 2, Henrico, VA.
PRESIDING OFFICER:	Susan, Chadwick, Au.D., Chair
MEMBERS PRESENT:	David Boehm, L.C.S.W., Ex-officio Marty Martinez, Citizen Member
MEMBERS NOT PRESENT:	Damien Howell, P.T. Vilma Seymour, Citizen Member
STAFF PRESENT:	Elizabeth A. Carter, Ph.D., Executive Director for the Board Sandra Whitley Ryals, Director, DHP Justin Crow, Research Assistant Carol Stamey, Operations Manager Laura Chapman, Office Manager
OTHERS PRESENT:	Michael Jurgensen, Medical Society of Virginia Catherine Bodkin, VA Department of Health Arthur Garson, UVA, Executive VP and Provost Bonie P. Vencill, RN, CNOR, AORN/VCORN Richard Parisi, MD, VA Academy of Sleep Medicine Kathe Henke, VA Academy of Sleep Medicine Anna Rodriguez, VA Academy of Sleep Medicine Robin Wilson, JM Hospital, Abington, VA Wes Mullins, Norton Community Hospital Susan Ward, VHHA Michele Hughes, VCORN/AORN N. Napolitano, VSRC Karin Addison, VSO-HNS Sue Stallings, Sentara College of Health Science Lori Shuant, Kinesiotherapy J.T. Magee, Jr., Kinesiotherapy Henry E. Jackson, Kinesiotherapy Gary Bolden, Kinesiotherapy Charlie “Chuck” Smith, Kinesiotherapy Michael Minor, Kinesiotherapy Charlesay Bond, Kinesiotherapy Bennett G. Edwards, Kinesiotherapy Tyler Cox, MSV

QUORUM: With three members present, a quorum was established upon the arrival of Mr. Martinez.

AGENDA: No additions or changes were made to the agenda.

PUBLIC COMMENT: Catherine Bodkin, LCSW, MSHA, VA Department of Health, presented comment requesting a sunrise review on Community Health Workers (CHW). Dr. Bodkin reported that approximately 4,000 CHWs had been identified through a survey of state agencies who utilize them. Further, that the CHWs are known by a variety of titles and roles and serve as a bridge between diverse cultural and language communities promoting better health. Dr. Bodkin reported that the CHWs are not supervised and there was a need for scope of practice definitions.

Arthur Garson, Executive Vice President, Provost, UVA, presented comment regarding the need for certification of CHWs. The written comment of Dr. Garson is incorporated into the minutes as Attachment 1.

EMERGING PROFESSIONS UPDATE: Research Assistant Justin Crow provided an update on the Emerging Professions currently under review through slide presentation. The presentation is incorporated into the minutes as Attachment 2.

The ongoing Emerging Professions under current review are: Medical Interpreters, Polysomnography and Surgical Assistant/Surgical Technology. New requests for studies are for: Genetic Counseling, Kinesiotherapy and Community Health Workers.

With regard to Surgical Assistants and Surgical Technologists, Mr. Crow will be presenting further clarification of scopes of practice and role specific policy options at the November meeting.

Kinesiotherapy – Public Comment

Mr. Gary Bolden, Kinesiotherapist, presented comment stating the need for a certifying licensure board. He stated that the Educational Program is state accredited and funded by the Commonwealth of Virginia.

Mr. J.T. Magee, Kinesiotherapist, President American Kinesiotherapy Association, presented comment regarding the need for certification/licensure of Kinesiotherapists. He stated that there are reimbursement issues due to non-licensure.

Charles Smith, Patient, spoke regarding his multiple traumatic injuries and the benefits of the acquadic therapy he received.

Bennett G. Edwards, Kinesiotherapist, Norfolk State University, spoke regarding the need for certification/licensure of kinesiotherapists. He spoke of the need for an internship program, the subject matter of the educational program and clarified the scope of practice of kinesiotherapists.

Written comment submitted by Melissa Fuller, MA, RKT, Executive Director, AKA, is incorporated into the minutes as Attachment 3.

Community Health Workers
Written comment submitted by Karen Remley, M.D., MBA, FAAP, State Health Commissioner, is incorporated into the minutes as Attachment 4.

Ms. Ryals indicated that the Grand Aids program discussed by Ms. Bodkin and Dr. Garson has been projected to significantly reduce needless emergency room visits and their attendant costs. Triage services for minor illnesses and injuries would be provided by trained staffers available 24/7, with clearly defined protocols, telemetry devices, and constant supervision from a nurse or physician at the hospital.

DEVELOPMENT OF 2010 WORKPLAN:

Dr. Carter presented the proposed draft 2010 Workplan of the Regulatory Review Committee and it is incorporated into the minutes as Attachment 5.

With regard to the consideration of efficacy of a new allied health board, the Committee requested input from the Boards of Medicine, Nursing and Advisory Boards.

On properly seconded motion by Mr. Boehm, the Committee voted to adopt the 2010 Workplan of the Regulatory Research Committee as presented.

NEW BUSINESS:

No new business was presented.

ADJOURNMENT:

The meeting adjourned at 10:25 a.m.

_____ _____

Susan Chadwick, Au.D.
Vice-Chair

Elizabeth A. Carter, Ph.D.
Executive Director for the Board

Attachment 1

UNIVERSITY of VIRGINIA

EXECUTIVE VICE PRESIDENT AND PROVOST

September 25, 2009

Elizabeth Carter, PhD
Chair, Regulatory Research Committee
Board of Health Professions
Commonwealth of Virginia
9960 Mayland Drive
Richmond, Va 23233-1463

Re: Requested study to determine whether Community Health Workers should be certified

Dear Dr. Carter:

We believe that certification of Community Health Workers (CHW) would be beneficial for the citizens of the Commonwealth and also to the profession. We therefore request that the Regulatory Research Committee study the need for certification.

Background

The world's population is aging with high rates of chronic disease; health care utilization double over age 65. The supply of physicians and nurses is low and projected to decrease over the next 15 years, worsening the mismatch of supply and demand for access to care. This mismatch is, or shortly will be, manifested by longer waits to see physicians in emergency departments and clinics, lack of available timely follow-up for chronic diseases, as well as the current shortage of practitioners in underserved areas, both rural and urban. In the US, even if insurance coverage is made available to every citizen, access to care will continue to be of paramount importance. The state of Massachusetts reduced its population of uninsured by 75% and found that the time to see a primary care physician increased from 33 to 52 days. These trends will continue if we continue to deliver medicine the same way. We must identify new models of health care delivery. We propose to change the paradigm of care with the creation of a new model of the health care continuum. This model

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provides a conduit to proper care that efficiently allocates scarce professional resources. We further believe that this system will improve health, and health care, in currently underserved populations. We will establish teams beginning with the patient, progressing to Community Health Workers, to nurses, advanced practice nurses, primary care physicians, and specialists. Point of care devices linked to an interoperable electronic health record will tie the team together. The point of care devices will provide the community health worker with protocols and decision support tools created for these workers. Greater training and greater responsibility for other members of the health care team has been proposed by generalist physicians to deal with the shortages in primary care. These doctors recognize that they cannot provide, nor do they need to provide, all care.

Community Health Workers

Community Health Workers (CHW) are defined as those who apply their unique understanding of the experience, language and culture of the populations they serve to promote healthy living and to help people take greater control over their health and their lives. CHW's are found in public and private social service and health care organizations across the Commonwealth. One study found 4,000-6,000 CHW's in 230 programs. There are four functions that CHW's serve: 1. Providing informal counseling on community services and family issues such as accessing needed health care, information about medical programs that could be available (e.g. Medicaid), and enrolling in job training; 2. Counseling for medical preventive care such as heart health or obtaining mammograms (this model has been well used in South Texas and New Mexico using the term "Promotoras."); 3. Counseling for chronic care, such as helping with outpatient diabetes management or attempting to avoid readmission for patients with congestive heart failure by, for example, counseling in medication adherence; 4. A relatively new function for CHW's is the provision of certain "acute care" services such as using a protocol working under the supervision of a nurse to deal with colds, sore throats, fever, etc.

This program is described in the accompanying document. This document describes a program of "Grand-Aids." In this model we propose to train and employ trusted members of the community to serve as the liaison between patient and health professionals. A Registered Nurse will train the professionals using a curriculum developed and supervised by a physician.

At a recent national meeting, a group of chairs of Family Medicine have said that a "significant proportion of their patients could be cared for by a good grandparent." We propose to employ grandparents or people with similar characteristics to grandparents, as Community Health Workers. These characteristics are: nurturing, caring, staying calm with a sick person, having taken care of others (e.g. retired teacher, nurse, physician), able to coach others, generating respect in patient and community. Grandparents have raised families, have helped to raise grandchildren and have had a wealth of challenging life experiences, many relating to medical care. Many grandparents are nearing retirement, or have retired, and may be searching for rewarding endeavors or for additional income. We believe that grandparents can become a new and valuable tool in a new paradigm for patient care. They can improve medical and social outcomes in their communities and derive personal benefit, learning and satisfaction.

We seek a study to determine the necessity of certification of CHW's. The Grand-Aid program is but one way in which CHW's could be used. Certainly, the realm of CHW's is broader than Grand-Aids. Curricula to train basic CHW's have been developed throughout the U.S. and will be used here. It is important to point out that Community Health Workers are certified in other states, such as Texas. The curriculum to train acute care CHW's as well as the testing and performance required are in progress and will be developed by nurses, physicians, professors of education, and professors of continuing and professional studies at UVA. At the end of the training, a certificate will be granted by the University of Virginia. This curriculum will serve as a model for the U.S., and the certificate-granting process should be replicated by community colleges.

CRITERIA FOR EVALUATING THE NEED FOR REGULATION

Criterion One: Risk for Harm to the Consumer

For every encounter of a CHW, the CHW is alone with the consumer. Therefore, decision-making even of what to advise in preventive strategies constitutes some risk for harm. However, it is in the "acute care" CHW's that risk may occur. While the CHW's will have protocols and backup at every step and be within telephone contact if they want, these CHW's will be assessing patients and making recommendations to

them. There is the need for malpractice coverage and this is one of the reasons that the acute care program is associated with Federally Qualified Health Centers, where they can be covered for malpractice.

Criterion Two: Specialized skills and training

The CHW's have a well-recognized and well-developed curriculum for teaching special skills such as those needed to approach any patient, including cultural awareness, confidentiality, etc. For the "acute care" CHW's there are 28 protocols that are being adapted from a nursing triage manual that require specialized skills and training.

Criterion Four: Scope of Practice

The scope of practice for CHW's generally ranges from informing families about the availability of services, providing screening child development using a standardized tool, developing a family plan to accomplish health goals, teaching patients with diabetes or HIV/AIDS about self care and nutrition. The designated role of a CHW depends upon the individual's educational level, the agency's mission, and the availability of adequate supervision. Experience and training support more independence in judgment and action. Specifically for acute care, the scope is limited to patients that fit within 26 CPT codes only, e.g. upper respiratory infection. The acute care CHW's will not provide care for those with chronic disease and acute superimposed symptoms. It is clear that these functions overlap what is currently handled by nurses and physicians in clinics and Emergency Departments. However, the purpose of the acute care CHW is to assist nurses and physicians and allow them to see the patients that they must see in a timely manner. This will also provide Virginia's citizens in rural and underserved areas with better access to quality medical care.

The characteristics of the acute care CHW's are: nurturing, caring, staying calm with a sick person, having taken care of others (e.g. retired teacher, nurse, physician), able to coach others, generating respect in patient and community. Criticality scaling will be used to define these characteristics such that it is clear who is being taken into the program, and kept into the program and the criteria used for that decision.

Criterion Five: Economic Impact

A preliminary analysis of the acute care CHW reveals that 8.3% of visits to the UVA Emergency Department (ED) last year could have potentially been handled by an acute care CHW. The savings were estimating at $500 per visit. For 119 million ED visits in the U.S., the saves 9.9 million; the net savings are approximately $4.4 Billion per year. This analysis does not include clinics as of yet. Savings have also been reported for case management of diabetes [Cathy].

Criterion Six: Alternatives to Regulation

In order to protect the public, State regulation of CHW's is necessary. CHW's will undergo competency-based training that should be regulated. They will be alone with the patient and should have their competency tested in a consistent manner. Testing should be ongoing, with logs of outcomes made available once per year.

An accompanying letter has been written by the Commonwealth Department of Health in support of the concept of certification of Community Health Workers.

I very much appreciate your consideration.

Sincerely,

Arthur Garson, Jr., MD, MPH
Executive Vice President and Provost

TOMORROW'S HEALTH CARE WORKFORCE:
New roles for practitioners and patients – the Grand-Aid program

BACKGROUND AND SIGNIFICANCE

The world's population is aging with high rates of chronic disease; health care utilization double over age 65. The supply of physicians and nurses is low and projected to decrease over the next 15 years, worsening the mismatch of supply and demand for access to care.[1] This mismatch is, or shortly will be, manifested by longer waits to see physicians in emergency departments and clinics, lack of available timely follow-up for chronic diseases, as well as the current shortage of practitioners in underserved areas, both rural and urban.

In the US, even if insurance coverage is made available to every citizen, access to care will continue to be of paramount importance. The state of Massachusetts reduced its population of uninsured by 75% and found that the time to see a primary care physician increased from 33 to 52 days.[2] These trends will continue if we continue to deliver medicine the same way.[3]

We must identify new models of health care delivery.

We propose to change the paradigm of care with the creation of a new model of the health care continuum. This model provides a conduit to proper care that efficiently allocates scarce professional resources. We further believe that this system will improve health, and health care, in currently underserved populations.

We will establish teams beginning with the patient, progressing to community health workers, to nurses, advanced practice nurses, primary care physicians, and specialists. Point of care devices linked to an interoperable electronic health record will tie the team together. The point of care devices will provide the community health worker with protocols and decision support tools created for these workers. Greater training and greater responsibility for other members of the health care team has been proposed by generalist physicians to deal with the shortages in primary care. These doctors recognize that they cannot provide, nor do they need to provide, all care.[4]

In this model we propose to train and employ trusted members of the community to serve as the liaison between patient and health professionals. At a recent national meeting, a group of chairs of Family Medicine have said that a "significant proportion of their patients could be cared for by a good grandparent." We propose to employ grandparents as community health workers.

Grandparents have raised families, have helped to raise grandchildren and have had a wealth of challenging life experiences, many relating to medical

care. Many grandparents are nearing retirement, or have retired, and may be searching for rewarding endeavors or for additional income. We believe that grandparents can become a new and valuable tool in a new paradigm for patient care. They can improve medical and social outcomes in their communities and derive personal benefit, learning and satisfaction. While being a grandparent is not required, the characteristics are: nurturing, caring, staying calm with a sick person, having taken care of others (e.g. retired teacher, nurse, physician), able to coach others, generating respect in patient and community. Hence the name, the Grand-Aid program.

Models for training caring community members have worked well serving Native American populations, in Alaska and New Jersey[5] through the community health aide program. These programs have provided outstanding care to those who lack it.[6]

The eventual goal is to have patient-Grand-Aid-nurse-physician teams delivering care served linked by an electronic medical record.[7] Grand-aides will be paid. The funding will be ultimately self-sustaining as the payment for "grand-aides" will clearly be less than unneeded visits to emergency departments and clinics. Grand-aides will serve one or more of the following functions:

1. The "Acute Care" Grand-aide provides first-line information to patients in the community – e.g. how to treat a fever, making home visits – teamed with a nurse and generalist physician.
2. The "Health Promotion – Social Work" Grand-aide provides basic patient education, improves health literacy, carries out first-line preventive care and screening, counsels people on availability of health insurance coverage programs, counsels on job placement.
3. A nurse-physician-Grand-aide "Chronic Care" team provides specialty care; one member of the team (with one back-up) is the main contact person who is seen by the patient as a trusted advisor. The Community Health Center serves as the "medical home."

We will begin with "Acute care Grand-aides" as there is an acute need for primary care, grand-aides can be trained to deliver care in one year, and the outcomes are the most straightforward to measure. We will begin the training for the acute care s with material that will be applicable to the "Health Promotion-Social Work" grand-aide as this training will be an important addition to their skill set.

We have initiated pilots in rural Virginia, and urban Houston, and are considering Mississippi, Detroit, and New York. Pilots are also in early stages in Shanghai, Hohhot and Lesotho with consideration in Sydney, Limpopo and Delhi.

SPECIFIC AIMS

To pilot a health care team model approach involving specifically trained grand-aides as community health workers to improve access

- To improve the health of a defined population
- To achieve appropriate access to health care providers
- To reduce costs involved in the population's health care

METHODS

Acute Care Community Healthcare Workers Pilot Study:

The initial pilot will be developed around the "Acute Care" Grand-aide model to demonstrate that increased access using trained community health workers for the underserved can improve health, achieve appropriate access to health care providers, and reduce costs. They will also receive training on health promotion and social work with the goal of demonstrating improved knowledge of the health system, available programs and preventive care.

Patient-community health worker-nurse-physician teams will be created and linked by an electronic health record and point of care devices which implement protocol and decision support tools.

A four month training program designed to address the appropriate evaluation and intervention approach for the model will be developed by the community health center. Each community health worker will be provided with and trained to use a device to communicate with his or her supervisor regarding each patient, and to acquire digital photos and videos. Community health workers will be paid a small stipend for participation in the training program.

The pilot will last 2 years. This is a "proof of concept" study and this is the minimum amount of time that can be spent – the first year to train and the second year to demonstrate the concept for a period of time working in the community and providing outcomes.

The first year of the pilot will be devoted to protocol development, training, and testing of the training of grand-aides at a Federally Qualified Health Center.

1. The conditions chosen in Virginia will be reviewed by clinic physicians and nurses and changed if necessary. The protocols will be also be adopted from Virginia and changed as necessary to conform to the practices in Houston. The protocols will be developed with clear instructions as to when the grand-aide is to recommend the patient stay home, go to the clinic or to the emergency room. The protocols will be revised to indicate when "call the Grand-aide" might be indicated.

2. Protocol testing – Physicians and nurses. The protocols will be tested by physicians and Nurses at the clinic to determine if these protocols match their style of practice for >80% of patients (10 patients each diagnosis; total 200 patients.) Depending upon results, the protocols would be changed. [Note: by virtue of being employed by a Federally Qualified Health Center, the grand-aides are covered for malpractice by the Federal Tort Claims Act.]
3. Electronic Medical Record and mini-laptop. The protocols will be developed into algorithms that can be easily understood by grand-aides with drop-down menus. These algorithms will then be loaded into a mini-laptop that has a simple electronic medical record that records the results of the visit (including video if applicable) and has web access to permit downloading to the clinic. The mini-laptop will also have telephone and video so that the worker can be directly supervised.
4. Training. Grand-aides will be recruited from the population of the clinic. A community health center nurse will train and supervise 4 healthcare workers for 3 months in the classroom and then for 1 month in the clinic addressing the health system and components of the system available to help individuals and families with social or medical services (e.g. Medicaid), preventive care and basic health care issues, patient encounter discipline, the use of protocols and when the protocols do not apply. At the end of the 1 month in the clinic, each grand-aide will be tested for ability with actual patients and evaluated by the teaching nurse with results of the testing reviewed by the supervising physician.
5. Each grand-aide group of two (grand-aides would alternate days for taking calls) will be assigned to 50 families as close as possible to their home. The families would be recruited from the clinic rolls. The 50 families are expected to generate less than 1 call per day. The grand-aides would be assigned to teach preventive "patient guidelines" to every family for "when to call" in each of the conditions.
6. For the first three months, the grand-aide will be in contact with a nurse for every patient. After three months, if a review of the decisions reveals outstanding performance, then for certain conditions, the grand-aide may be permitted not to call; every encounter will be documented by an electronic medical record and reviewed the next day.
7. The records of these house calls will be kept as part of the permanent record of the clinic.
8. At the end of the year, grand-aides will be tested with a written and practical case-based test. A passing grade will result in a

certificate of completion of training issued by the University of Virginia.

At the end of the first year, the expected outcomes are that each grand-aide will pass the test and receive a certificate from the University of Virginia.

The second year of the pilot, the grand-aides care for their families and outcomes are measured. While grand-aides are likely to be in constant contact with supervising nurses constantly, all cases will be reviewed by the nurse weekly. Grand-aides will be paid $10 per hour (approximately $20,000 per year). This not only provides income, but also is an incentive to performance. This amount does not affect Social Security for those <62 or >67 years old. For those 62-67, a $3,000 penalty is assessed by Social Security, netting $17,000.

Outcome measures

i. Number of calls to grand-aides and reasons for calls (intervention group only)
ii. Number of visits by grand-aides and reasons for visits (intervention group only)
iii. Number of calls to nurses and reasons for calls
iv. Number of calls to physicians and reasons for calls
v. Estimated reduction in visits to primary care physicians
vi. Number of visits to emergency departments and reasons for visits
vii. Estimated reduction in emergency department visits
viii. Number of hospital admissions, admission duration and reason for admission
ix. Estimated reduction in number of hospital admissions
x. Number of work days missed by family members due to illness in adult or child
xi. Number of school days missed by school age children
xii. Satisfaction of families and practitioners
xiii. Deaths and reason
xiv. Costs associated with i-xi
xv. Pre-test and post-test for families about availability of services and preventive care.
xvi. Pre-test and post test for grand-aides about their own self image as well as knowledge and actions regarding their own health (e.g. medication adherence)

Future Directions

1. In the future, the model will be applied to larger groups of grand-aides and comparisons made of care with grand-aides vs. usual care.

2. A community model will be applied in which children and adults not currently clinic patients will be recruited. Methods of recruiting families will be tested. We recognize that a grand-aide cannot go door-to-door. Therefore, we will test the following general methods.
   - Flyers saying that a community health worker will call placed in newspapers, on bulletin boards, in grocery check-outs
   - Meetings held in community centers, churches and schools as well as health fairs.

3. The program will be expanded to include training in primary prevention and social work ("Health Promotion-Social Work Grand-aide") and in chronic care, ("Chronic Care Grand-aide.") Training for each of these would involve three additional months. These functions could eventually all be taken on by a single person or different people.

4. Certification will be sought by the Commonwealth of Virginia

5. On the basis of the results obtained, application will be made for a Medicaid waiver to pay for grand-aides through Medicaid. Eventually Medicare and private coverage will be sought.

6. International pilots are in various stages of planning in: Shanghai; Hohhut, Inner Mongolia; Seoul; Delhi; Lesotho; Limpopo

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[1] Colwill, J.M. et al. (2008) Will Generalist Physician Supply Meet Demands of an Increasing and Aging Population? Health Affairs Web Exclusive 29 April 2008:w232-241.

[2] Sack, K. (2008) In Massachusetts, Universal Coverage Strains Care http://www.nytimes.com/2008/04/05/us/05doctors.html

[3] Bureau of Health Professions (2006). Physician supply and demand: projections in 2020. Washington, DC: Health Resources and Services Administration, October 2006.

[4] Bodenheimer, T (2008). Transforming practice. N Engl J Med 359: 2086-9.

[5] Campbell, C. (2009) New Jersey Program Finds Alternatives for ER 'Super Users' http://www.kaiserhealthnews.org/Stories/2009/March/09/ER-Super-Users.aspx

[6] Maternity Care Coalition. (2009) Community health worker effectiveness. http://www.momobile.org/programs/effective.html

[7] Health Resources and Services Administration (2006) Training Community Health Workers: Using technology and distance education. http://ruralhealth.hrsa.gov/pub/TrainingFrontier.asp

Emerging Professions Review

Ongoing:

Medical Interpreters

Polysomnography

Surgical Assistant/ Surgical Technology

Requests:

Genetic Counseling

Kinesiotherapy

Community Health Workers

And:

Allied Health Board

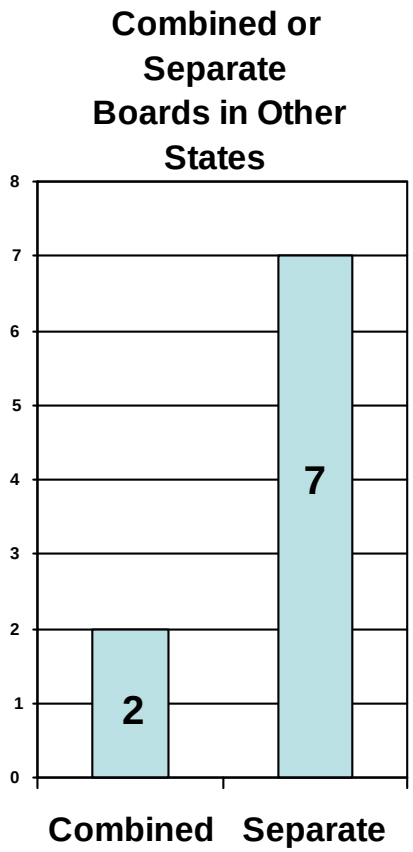
Medical Interpreters

- No New Information from DoH/DMAS
- FY 2010 Budget Cuts
  - $70,000 Reduction in grants to local health departments.

Polysomnography

- Numbers
  - 979 persons performing polysomnograms?
    - Many are likely nurses or respiratory therapists
  - 293 Registered Polysomnographic Technologists
    - Some are likely nurses or respiratory therapists
  - 132 sleep centers?
    - 48 attached to hospitals (nurses and respiratory therapists)
  - The number of non-RTs seeking polysomnography licensure may be less than the number of RPSGTs.

Advisory Board Structure



Licensees needed to break even:

Combined Advisory Board: 27

Independent Advisory Board: 64

Issues:

Distinctiveness of Profession?

Separate advisory boards/standards for same task—need for coordination?

Number of licensees?

Surgical Technologist/Surgical Assistant

Scope of Practice

- Scrub Role and Assistant at Surgery Role:
  - Licensed Practical Nurse, Registered Nurse and Advanced Practice Nurse
  - Physician Assistant
- “Specialist Assistants”
  - Orthopedic Technician/Orthopedic Physician Assistant
  - Cardiovascular Technologist
  - Podiatrist Assistant
  - Ophthamalic Assistant
- Lack of a Scope of Practice

Autonomous Practice

Surgical Team

- Web of credentialing/delegation/supervisory authority
  - Nevertheless, authority may not always be clear
  - Circulator/surgeon may not be present at all times
- Employment arrangements vary
  - Independent Contractor or Employee
  - Facility or Surgeon or Agency
- Specialist v/s Generalist backgrounds
- Surgical Assistant as “Co-Pilot”

Requests for Sunrise Review

- Genetic Counselors
  - Request expected within six months

Kinesiotherapy

- Kinesiotherapy is the application of scientifically based exercise principles adapted to enhance the strength, endurance, and mobility of individuals with functional limitations or those requiring extended physical conditioning
- Direct therapeutic exercise to recondition and rehabilitate a person following injury or illness
  - Directed at whole person, not specific injury or illness
  - Originally addressed the *physical and psychological* effects of being bed-ridden
  - By contrast, PTs often focus on rehabilitating a specific injury or condition

Community Health Workers

- Models of Care (DHHS)
  - Member of care delivery team
  - Health system navigator
  - Screening and health education provider
  - Outreach-enrolling-informing agent
  - Organizer
- Services (DHHS)
  - Interpretation & Translation
  - Culturally appropriate health education & Information
  - Assist people in receiving care
  - Informal counseling & guidance on health behaviors
  - Advocate for individual and community health needs
  - Provide some direct services
    - First Aid
    - Blood Pressure Screening

Source: Department of Health & Human Services, Bureau of the Professions. *Community Health Worker National Workforce Study*. March, 2007. pg. 2

Community Health Workers

- Seeking voluntary certification
- “Grand-aids” will provide certain primary care-related duties as part of a delivery team
- Related to 26 CPT codes for upper respiratory infection

Allied Health Board

Attachment 3

American Kinesiotherapy Association
118 College Drive #5142
Hattiesburg, MS 39406

September 25, 2009

Mr. Damien Howell, Chairman
Regulatory Research Committee
Virginia Board of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233

Dear Mr. Howell,

Thank you and the committee for considering a study for the need to license Kinesiotherapy in the Commonwealth of Virginia. Since it's inception in 1946 as the Academy of Physical and Mental Rehabilitation the American Kinesiotherapy Association has worked to promote the profession of Kinesiotherapy and act on behalf of its membership. Kinesiotherapy is recognized within the healthcare infrastructure through a listing in the Healthcare Provider Taxonomy (code #226300000X), and through the revenue code assigned by the National Uniform Billing Committee. It is also a vital component of the Department of Veterans Affairs' physical medicine and rehabilitation programs. The United States Department of Labor has also recognized Kinesiotherapy as a service within it's Workers Compensation programs.

Kinesiotherapists are the original exercise specialists, and have a long history of serving throughout the physical medicine and rehabilitation service of the Department of Veterans Affairs. Professionals entitled to use the certification mark Registered Kinesiotherapist, or RKT, are graduates of educational programs that are accredited by the Committee on Accreditation of Allied Health Education Programs (CAAHEP), have successfully completed a national certification exam, and meet annual continuing education requirements. They are eligible for, and in many instances have obtained, a National Provider Identifier number.

The profession also has a long history of recognition within the Commonwealth of Virginia. Many Kinesiotherapists in the Commonwealth are graduates of either Virginia Commonwealth University or Norfolk State University. Conservative estimates suggest that, since 1989, 250 or more individuals were conferred degrees after completing a program of study in Kinesiotherapy. The Virginia Division of Workers Compensation has recognized Kinesiotherapists as providers of, and reimbursed Kinesiotherapists for the delivery of, physical medicine and rehabilitation services. With permission from the Commonwealth Educational board, in cooperation with the Virginia Medical Board, a for-profit Kinesiotherapy clinic was created at Norfolk State University, to serve as a functioning rehabilitation clinic and clinical training site for the university's Kinesiotherapy students. In the mid-1990s some Kinesiotherapists were able to obtain licensure as Rehabilitation Providers under the Board of Professional Counselors and Marriage and Family Therapists. Yet despite this acknowledgement from different agencies and institutions of the Commonwealth, there is no statutory recognition of Kinesiotherapy within the Commonwealth.

With the growing utilization of physical medicine and rehabilitation in the private sector the need for qualified professionals goes unmet. The increasing trend toward preventative services coupled with the increasing awareness of the role of exercise in controlling many medical conditions, including the top five causes of preventable death in the United States, is certain to hit a critical mass in the near future. It is essential that the public have access to qualified

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exercise professionals to provide those services. In addition to providing for the public, the statutory recognition of a profession is a default criteria many healthcare organizations, most notably the Centers for Medicare and Medicaid Services, utilize in recognizing service providers and making reimbursement determinations. The lack of such regulation for Kinesiotherapy serves only to deny the public access to a very valuable service.

Enclosed with this letter please find responses to questions from Appendix A of the Virginia Board of Health Professions Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions. The Association believes that this information should be sufficient to initiate a sunrise study of the profession of Kinesiotherapy, and intends to provide assistance in any matters which may arise in the course of such study.

Thank you for considering this request to study the need for licensure of Kinesiotherapy in the Commonwealth of Virginia.

Sincerely,

Melissa Fuller, MA, RKT
Executive Director, American Kinesiotherapy Association
118 College Drive #5142
Hattiesburg, MS 39406
info@akta.org

QUESTIONS TO BE CONSIDERED FOR THE EVALUATION OF THE NEED FOR REGULATION OF A HEALTH OCCUPATION OR PROFESSION

A. GENERAL INFORMATION

1. What occupational or professional group is seeking regulation?
   Registered Kinesiotherapists, or RKT's.

2. What is the level or degree of regulation sought?
   Licensure.

3. Identify by title the association, organization, or other group representing Virginia-based practitioners. (If more than one organization, provide the information requested below for each organization.)
   The American Kinesiotherapy Association (AKTA) and the Council on Professional Standards for Kinesiotherapy (COPS-KT), on behalf of the (re-)emerging Virginia Kinesiotherapy Association.

4. Estimate the number of practitioners (members and nonmembers) in the Commonwealth.
   There are at least 250 kinesiotherapists in the Commonwealth. Virginia Commonwealth University conferred 95 degrees in Kinesiotherapy between Spring Semester 1991 and Fall Semester 2004. Contacts with Norfolk State University, including interviews with current and former directors of the Kinesiotherapy program, suggest (conservatively) that there is an average of 8 or 9 degrees conferred in Kinesiotherapy annually, which would yield at least 160 alumni of that program over the past 20 years. [Exact numbers and graduation rosters were requested from both institutions, but had not been received as of the submission deadline.]

5. How many of these practitioners are members of the group preparing the proposal? (If several levels or types of membership are relevant to this proposal, explain these level and provide the number of members, by type).
   There are currently 37 Registered Kinesiotherapists in the Commonwealth, all of whom are members of the AKTA.

6. Do other organizations also represent practitioners of this occupation/profession in Virginia? If yes, provide contact information for these organizations.
   NO.

7. Provide the name, title, organizational name, mailing address, and telephone number of the responsible contact person(s) for the organization preparing this proposal.

   American Kinesiotherapy Association
   118 College Drive #5142
   Hattiesburg, MS 39406

   James T Magee, President
   804-690-1651

   Jon M. VonderHaar, Past-President
   661-747-6827

   Council on Professional Standards of Kinesiotherapy
   PO Box 1390
   Hines, IL, 60141-1390

8. How was this organization and individual selected to prepare this proposal?
   The American Kinesiotherapy Association (AKTA) is the only national professional association for Kinesiotherapy. The Council on Professional Standards for Kinesiotherapy (COPS-KT) maintains the scope of practice, educational, certification, and continuing competency standards for the profession of Kinesiotherapy. Both organizations have a vested interest in representing their constituents in any regulatory action, but also desire assurances that regulations are consistent with the education, training and scope of practice for kinesiotherapists, and consistently applied across all jurisdictions. James Magee and Jon VonderHaar were delegated to coordinate this project by the Executive Board of the AKTA.

9. Are there other occupations/professions within the broad occupational grouping? What organization(s) represent these entities? (List those in existence and any that are emerging).**No.**

10. For each association or organization listed above, provide the name and contact information of the *national* organizations with which the state associations are affiliated.
    The American Kinesiotherapy Association and the Council on Professional Standards for Kinesiotherapy (see contact information above).

B. QUESTIONS WHICH ADDRESS THE CRITERIA

Criterion One: Risk for Harm to the Consumer. *The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.*

1. Provide a description of the typical functions performed and services provided by members of this occupational group.
   The Kinesiotherapist is a health care professional competent in the administration of musculoskeletal, neurological, ergonomic, biomechanical, psychosocial, and task specific functional tests and measures. The Kinesiotherapist determines the appropriate evaluation tools and interventions necessary to establish, in collaboration with the client and physician, a goal specific treatment plan. The intervention process includes the development and implementation of a treatment plan, assessment of progress toward goals, modification as necessary to achieve goals and outcomes, and client education. The foundation of clinician-client rapport is based on education, instruction, demonstration and mentoring of therapeutic techniques and behaviors to restore, maintain and improve overall functional abilities. See Appendix B for complete Scope of Practice

2. Has the public actually been harmed by unregulated providers or by providers who are regulated in other states? If so, how is the evidence of harm documented (i.e., court case or disciplinary or other administrative action)? Was it physical, emotional, mental, social, or financial?
   No. We are not aware of any reports of harm to the public by an RKT.

3. If no evidence of actual harm is available, what aspects of the provider group's practice constitute a potential for harm?
   The Kinesiotherapist uses only exercise and education when delivering therapeutic interventions. While the benefits of exercise are well documented, and form the basis of kinesiotherapist practice, the risks of exercise are equally well known, as evidenced by the universal disclaimer to consult a physician before beginning an exercise program. There are inherent risks for adverse cardiovascular events with any exertion, and more critically in patient populations is the potential for causing further damage to injured and recovering tissues.
   The Kinesiotherapy programs in the Commonwealth of Virginia emphasize Drivers' Education, as part of their didactic and clinical curricula. These services carry greater than average risks especially when one is supervising the elderly, stroke patients, visually impaired, brain injured, and spinal cord injury patients while driving on public roadways.

4. To what can the harm be attributed? Elaborate as necessary.
   - lack of skills
   - lack of knowledge
   - lack of ethics
   - lack of supervision
   - practices inherent in the occupation
   - characteristics of the client/patients being served
   - characteristics of the practice setting
   - other (specify)

   <u>Lack of skills/knowledge</u> – inability to correctly interpret a referral diagnosis and recognize the limitations and contraindications associated with that diagnosis. Inability to understand how co-morbid conditions can impact treatment plans.
   <u>Lack of supervision</u> – kinesiotherapists are autonomous practitioners, and assume sole responsibility for creating and delivering exercise based interventions on referral.
   <u>Characteristics of the clients/patients being served</u> – all patients referred for Kinesiotherapy services are medically stable, but are referred to address the effects of disease, injury, or congenital disorder. The presence of a medical diagnosis, with the potential for multiple co-morbidities, requires a practitioner who recognizes the limitations and contraindications that they may impose.
   <u>Characteristics of the practice setting</u> – services are delivered in a variety of practice settings, including outpatient therapy departments, outpatient clinics, or community facilities.

5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?
   Yes. There are countless health and fitness organizations that purport to certify exercise professionals. The educational and training requirements can vary from online study/exam programs to home study or correspondence courses to one- or two-day seminars. Very few require a Bachelors' level education, fewer still require an accredited didactic program, and none include the supervised clinical training required to attain credentialing as a Registered Kinesiotherapist. There is currently no mechanism for the public to easily make informed choices when selecting an exercise professional.

6. Does a potential for fraud exist because of the inability for third party payors to determine competency?
   Yes. There are many qualified health care professionals skilled in the delivery of physical medicine and rehabilitation services, several of whom are commonly recognized by third party payors (and by statute in many jurisdictions). Many third party payors recognize licensure as the default standard for ensuring competency, which places the onus for protecting patients on state regulatory agencies.
   More specifically, several occupational groups utilize titles similar to that of Registered Kinesiotherapist (e.g. Kinesiologist, Applied Kinesiologist) which are descriptive terms that imply, but do not represent, a unique, well-defined scope of practice.

7. Is the public seeking regulation or greater accountability of this group?
   Yes, Human Resource Departments now require credentialing and annual competency verifications for all health professionals, including Kinesiotherapists, and typically defer to state credentialing agencies to ensure competency for those profeesionals.
   The hundreds of individuals who received degrees from Virginia institutions of higher education in Kinesiotherapy and were unable to obtain careers - or even credentialing - in their chosen profession are also seeking regulation.

<u>Criterion Two:</u> Specialized Skills and Training. *The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.*

1. What are the educational or training requirements for entry into this occupation?
   1. **Possess a bachelor's degree from a college or university Kinesiotherapy program accredited by the Committee on Accreditation of Allied Health Education Programs (CAAHEP).**
   2. **Complete a minimum of 1,000 contact hours providing rehabilitation exercise and education to various patient populations.**

   Are these programs accredited? By whom?
   Yes, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits these programs.

   Are sample curricula available?
   Yes, please see Appendix A for degree requirements from Norfolk State University.
   Are there training programs in Virginia?
   Yes. Norfolk State University currently offers Kinesiotherapy as a major course of study. Virginia Commonwealth University conferred degrees in Kinesiotherapy from Spring Semester 1991 through Fall Semester 2004.

2. If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived? **N/A**

3. Are there national, regional, and/or state examinations available to assess entry-level competency?

Yes, the National Certification Examination for Kinesiotherapists.

- Who develops and administers the examination?
- What content domains are tested?
- Are the examinations psychometrically sound -- in keeping with *The Standards for Educational and Psychological Testing*?

The National Certification Examination for Kinesiotherapists was developed and is scored in conjunction with Professional Examination Services (PES), 475 Riverside Drive, New York, according to currently accepted psychometric standards. The content of the exam is based on core competencies developed by The Council on Professional Standards for Kinesiotherapy (COPS-KT) in collaboration with The American Kinesiotherapy Association (AKTA).

Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?

The Continuing Competency Board for Kinesiotherapy (CCBKT) requires that 1.2 continuing education units (CEU) be submitted annually. One CEU represents ten contact hours of participation in an organized educational experience under accountable sponsorship, capable direction, and qualified instruction. A copy of the course completion certificate or CEU award certificate prepared and authenticated by the sponsoring agency is required to verify the pertinence and value of the activity.

5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?

The public requires state assurances of initial and continuing competency so as to not be misled or subject to treatment which is ineffective and possibly harmful. Practitioners who lack sufficient education, training, and experience to deliver medically prescribed services risk doing greater harm. Numerous private entities offer certifications, but the sheer volume of these credentialed "exercise professionals" confounds the public's ability to make informed choices. And even though many of these credentialing bodies require continuing competency, the responsibility largely falls to the ethos of the practitioner. It is very difficult to mandate private credentialing without state assurance of consequential oversight.

6. Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so:

No. The Council on Professional Standards for Kinesiotherapy has established the minimum competencies for an entry-level practitioner. COPS-KT recognizes that Registered Kinesiotherapists may practice in specialized areas such as Driver Education, Aquatic Therapy, Cardiac Rehabilitation, among others. These services are beyond the Scope of Practice for Kinesiotherapy, and COPS-KT only recognizes the ability of a Registered Kinesiotherapist to practice in those areas if he/she has received appropriate training and credentialing.

- What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other

organization)?

- What are the various levels of specialties in terms of the functions or services performed by each?
- How can the public differentiate among these levels or specialties for classification of practitioners?
- Is a "generic" regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?

Criterion Three: *The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.*

1. What is the nature of the judgments and decisions which the practitioner must make in practice?
   - Is the practitioner responsible for making diagnoses?
     No.
   - Does the practitioner design or approve treatment plans?
     Yes. The Registered Kinesiotherapist creates therapeutic interventions based on assessment findings.
   - Does the practitioner direct or supervise patient care?
     Yes. Registered Kinesiotherapists are autonomous practitioners who develop and deliver exercise based interventions.
   - Does the practitioner use dangerous equipment or substance in performing his functions? **No.**

   If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?
   The referral source (physician or other privileged provider) is responsible for diagnosing the client's condition.
2. Which functions typically performed by this practitioner group are unsupervised, i.e., neither directly monitored or routinely checked?
   - What proportion of the practitioner's time is spent in unsupervised activity?
   - Who is legally accountable/liable for acts performed with no supervision?

   Up to 100% of the practitioner's time is spent in unsupervised activity. The Registered Kinesiotherapist is accountable for all services rendered under a Kinesiotherapy plan of care.

3. Which functions are performed only under supervision?
   - Is the supervision *direct* (i.e., the supervisor is on the premises and responsible) or *general* (i.e., supervisor is responsible but not necessarily on the premises)?
   - Who provides the supervision? How frequently? Where? For what purpose?
   - Who is legally accountable/liable for acts performed under supervision?
   - Is the supervisor a member of a regulated profession (please elaborate)?
   - What is contained in a typical supervisory or collaborative arrangement protocol?

   Kinesiotherapy services are only provided under the supervision of another qualified healthcare provider (e.g. "incident to" physician services) to fulfill requirements for reimbursement of services. In these settings the supervision standard defaults to requirements of the provider responsible for the treatment (in the eye of the payor).

3. Does the practitioner of this occupation supervise others? Describe the nature of this supervision (as in #3 above).
   While a Kinesiotherapist may function in a supervisory capacity, there is no formal training for other than an entry level Kinesiotherapist position.

4. What is a typical work setting like, including supervisory arrangements and interaction of the practitioner with other regulated/unregulated occupations and professions?
   The specifics of the work setting will vary depending on the practice situation. Like other providers of Physical Medicine and Rehabilitation Services, Kinesiotherapists may function independently, or may serve as part of an interdisciplinary team.

5. Does this occupational group treat or serve a specific consumer/client/patient population?
   Kinesiotherapists treat the effects of disease, injury, or congenital disorder by utilizing the modalities of exercise and education. Kinesiotherapy training is more "wholistic" in that practitioners consider not just the affected systems, but the client as a whole, when creating and delivering interventions. As such, kinesiotherapists can treat any individual with a condition where exercise could be beneficial. Kinesiotherapists can be found in a variety of settings client populations as found in general medicine, extended care, poly-trauma and spinal cord injury clinics within the Department of Veterans Affairs.

6. Are clients/consumers/patients referred to this occupational group for care or services? If so, by whom? Describe a typical referral mechanism.
   Yes. Kinesiotherapists deliver services only on referral from an appropriate source (MD, DO and privileged PA or NP). The referral source will write an order for Kinesiotherapy, including referral diagnosis, frequency/duration of treatment, and any specific contraindications or treatment goals.

7. Are clients/consumers/patients referred from this occupational group for care or services? If so, to what practitioners are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made?
   Yes, to the extent allowed by the practice acts in the jurisdiction. Typical recommendations for referral outside the profession are sent back to the original consultative source with suggestions for other, more appropriate interventions based on initial evaluation findings or the client's response to treatment.

Criterion Four: *The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.*

1. Which functions of this occupation are similar to those performed by other health occupational groups?
   - Which group(s)?

   Physical Therapist, Occupational Therapist, Athletic Trainers, Exercise Physiologists, Exercise Specialists, Kinesiologists, Health Educators
   - Are the other groups regulated by the state?

   Yes, Physical Therapists, Occupational Therapists, and Athletic Trainers
   - If so, why might the applicant group be considered different?

   The knowledge, skills, and abilities of the kinesiotherapist are uniquely suited for application in sub-acute settings. Registered Kinesiotherapists work with medically stable clients, and utilize only exercise/activity interventions and

education to remediate the effects of injury, disease, or congenital disorders. Evidence continues to grow illustrating the benefits of exercise in alleviating or correcting numerous diseases and medical conditions, including the top causes of preventable death in the United States.

2. Which functions of this occupation are distinct from other similar health occupational groups?
   - Which group(s)?
   - Are the other groups regulated by the state?

   Kinesiotherapy is distinguished by its foundation in exercise science, with didactic and clinical training in applying those principles in a clinical setting. Kinesiotherapists possess a skill set that recognizes the precautions and contraindications for exercise in different patient populations when delivering exercise-based interventions, making them uniquely qualified for work in this capacity. The curriculum for Kinesiotherapy, both the didactic requirements and the clinical experiences, includes more training in psychology than other allied health disciplines. This curriculum allows a Kinesiotherapist assess not only the tissue and muscular systems but also the psychological parameters of each patient or client.
   Other exercise professionals speak of a similar skill set, yet lack the educational background, clinical experience, and/or requirements for maintaining competency.

3. How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?
   Among the unregulated occupational groups, the regulation of Kinesiotherapy will establish a precedent for the level of education and training that the Commonwealth of Virginia demands to ensure the safety of its citizens. There should be little effect on the other regulated groups, as all are currently licensed in the Commonwealth, and thus possess the status conferred by statutory protection of their scope of practice.

   We are not requesting recognition of a new profession, rather we are asking for enhanced regulation of a profession that has been in existence for over 60 years. As exercise services are increasingly sought, both for prevention/management and for therapeutic benefit, it is critical that competent professionals be involved in providing such treatment.

<u>Criterion Five:</u> *The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.*

1. What are the range and average incomes of members of this occupational group in the Commonwealth? In adjoining states? Nationally? Average Nationally:**$60,000-$75,000** Range Nationally: **$29,000-$150,000**

2. What are the typical current fees for services provided by this group in the Commonwealth? In adjoining states? Nationally?

   Registered Kinesiotherapists provide Physical Medicine and Rehabilitation services, which are well defined within current coding and documentation standards (CPT),

and for which a standard fee schedule exists. Local, regional, and national reimbursement rates for services are consistent with the Centers for Medicare and Medicaid Fee Schedules. (Reference Appendix C)

3. Is there any evidence that cost for services provided by this occupational group will increase if the group becomes state regulated? In other states, have there been any effects on fees/salaries attributable to state regulation?
   No evidence exists to suggest an increase in the cost of services provided by kinesiotherapists. No such regulation exists in other states.

4. Would state regulation of this occupation restrict other groups from providing care given by this group?
   - Are any of the other groups able to provide similar care at lower costs?
   - How is it that this lower cost is possible?

   No. Regulation of Kinesiotherapy would not restrict other groups from providing these services, provided that said services fell within that occupational group's scope of practice.

   The costs of services are based on established standards (as noted above). The cost to a health care organization or institution may be lower than with other providers, due to the lower degree requirement for certification (e.g. Bachelors level for entry level Kinesiotherapists vs. the emerging Doctoral level standard for Physical Therapy.

5. Are there current shortages/oversupplies of practitioners in Virginia? In the region? Nationally?
   Yes. The lack of statutory recognition of Kinesiotherapy in the Commonwealth has resulted in less than 20% of qualified, degreed professionals obtaining professional credentials and pursing employment in the field. Exercise is medicine, and as this concept is increasingly embraced by the medical field there is a growing demand for competent professionals to deliver these services.

6. Are third-party payers in Virginia currently reimbursing services of the occupational group? By whom? For what?
   - If not in Virginia, elsewhere in the country?
   - Are similar services provided by another occupational group reimbursed by third-party payers in Virginia? Elsewhere? Elaborate.
     Not to our knowledge.

7. If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation?
   Yes. For many third party payors (including Medicare) the default standard for practitioners is state regulation. It is the absence of such regulation which is the greatest barrier to third-party payment presently.

   Kinesiotherapy is recognized throughout the reimbursement infrastructure, having been assigned both a unique code in the Health Care Provider Taxonomy [a provider classification system established by the Health Care Finance Administration (Centers for Medicare/Medicaid)] and a distinct revenue code by the National Uniform Billing Committee. Registered Kinesiotherapists have been assigned National Provider Identifier numbers.

Criterion Six: *There are no alternatives to State regulation of the occupation which adequately protect the public. [Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.]*

1. What laws or regulations currently exist to govern:
    - Facilities in which practitioners practice or are employed?
    - Devices and substances used in the practice?
    - Standards or practice?

Currently, Kinesiotherapy educational programs are accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). Registration in the field of Kinesiotherapy is granted upon completion of all educational requirements and with the passing of a competency exam administered nationally by the Council on Professional Standards for Kinesiotherapy (COPS-KT). Once registered, an annual continuing education requirement is mandated.

Standards of Practice for Registered Kinesiotherapists

These standards have been established by the Council on Professional Standards for Kinesiotherapy and are endorsed by the American Kinesiotherapy Association. The intent of these standards is to serve as guidelines for Registered Kinesiotherapists and to provide a basis for assessment of Kinesiotherapy practice. A registered Kinesiotherapist has attained that status upon passing the registration examination of the Council on Professional Standards for Kinesiotherapy. Herein after in this document a registered Kinesio therapist will be referred to as an RKT.

Standard 1: Only individuals who qualify by virtue of their education and clinical experience can practice Kinesiotherapy.
Standard 2: Referrals shall contain appropriate information before treatment can be administered by an RKT.
Standard 3: An RKT shall develop an individual treatment plan for each client.
Standard 4: An RKT shall perform assessments on the first visit and on subsequent visits as change in status dictates.
Standard 5: An RKT shall administer therapeutic exercise or activity to accomplish the stated goals of the treatment plan.
Standard 6: An RKT shall educate the client and family/caregiver as appropriate to accomplish the stated goals of the treatment plan.
Standard 7: An RKT shall document patient treatment information.
Standard 8: An RKT shall actively participate in the activities congruent with health care delivery.
Standard 9: An RKT shall follow established quality assurance guidelines to assure quality and appropriateness of treatment provided.

For complete Standards see Appendix D

2. Does the institution or organization where the practitioners practice set and enforce standards of care? How?
   Yes. The Department of Veterans Affairs is the largest employer of Registered Kinesiotherapists, in both the Commonwealth of Virginia and nationwide. Within the VA there are global standards of care promoted the Central Office for Physical Medicine and Rehabilitation Services. Each medical facility must meet JCHAO standards, and many have sought additional accreditation through CARF.

3. Does the occupational group participate in a nongovernmental credentialing program, either thorough a national certifying agency or professional association (e.g., National Organization for Competency Assurance)?
   - How are the standards set and enforced in the program?
   - What is the extent of participation of practitioners in the program?

   Yes. Educational programs for Kinesiotherapy are accredited by the Committee on Accreditation of Allied Health Educational Programs, and undergo periodic review by the Committee on Accreditation of Kinesiotherapy (CoA-KT) guidelines and standards.

   Having passed the Kinesiotherapy certification exam, the Registered Kinesiotherapist must meet mandatory continuing education requirements subject to oversight by The Council on Professional Standards for Kinesiotherapy. Failure to maintain one's Registration can result in probationary status and/or revocation.

   Kinesiotherapy is an associate member of CARF – The Accreditation Commission, and participates in reviews of CARF standards as they apply to Kinesiotherapy practice settings.

4. Does a Code of Ethics exist for this profession?
   - What is it?
   - Who established the Code?
   - How is it enforced?
   - Is adherence mandatory?

   Yes (see attached). The Code of Ethics was developed jointly by the American Kinesiotherapy Association and the Council on Professional Standards for Kinesiotherapy. Any misuse/abuse is reported to COPS-KT, and an ad hoc committee is formed to investigate each complaint.

4. Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.
   [See COPS-KT Bylaws Appendix E regarding due process]

5. How is a practitioner disciplined and for what causes? Violation of standards of care? Unprofessional conduct? Other causes?
   [See COPS-KT Bylaws Appendix E regarding due process]

6. Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?
   The Council on Professional Standards for Kinesiotherapy reviews practitioner code of conduct complaints and makes decisions regarding the right to practice based on the current law and in accordance with the Bylaws established by the Council.

7. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)? How are challenges to a practitioner's competency handled?
Liability/malpractice insurance is available to all practitioners, but is commonly provided by the employer. Every institution (university, hospital) has its own processes in place for ensuring consumer protection. The Council on Professional Standards for Kinesiotherapy reviews all formal complaints in accordance with the Bylaws established by such.

8. What is the most appropriate level of regulation?
Licensure. Registered Kinesiotherapists are autonomous practitioners who possess a minimum of a bachelor's degree, have demonstrated competency in a specific skill set, and complete continuing education annually to maintain their credentials.

Attachment 4

COMMONWEALTH of VIRGINIA

Karen Remley, MD, MBA, FAAP
State Health Commissioner

Department of Health
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RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

September 25, 2009

Elizabeth Carter, PhD
Chair, Regulatory Research Committee
Board of Health Professions
9960 Mayland Drive
Richmond, Virginia 23233-1463

Dear Dr. Carter:

The Virginia Department of Health (VDH) joins Dr. Arthur Garson, Provost of the University of Virginia, in his request that the Board of Health Professions initiate a study to determine whether Community Health Workers should be certified in the Commonwealth of Virginia.

Community health worker (CHW) roles were defined in *Weaving the Web*, the 1996 national study funded by the Annie E. Casey Foundation, as providing a bridge between communities and health/social service systems, providing culturally appropriate health education, assuring people get services needed, providing informal counseling and social support, advocating for individuals and community, providing direct service, and building individual and community capacity. The CHW has been an area of focus for the Centers of Disease Control for over 20 years. In 2001, the American Public Health Association designated CHWs as one of its Special Primary Interest Groups in an effort to integrate the knowledge and skills of these health workers into the health care system, provider education and research agendas. One of the recommendations was to include CHWs in a credentialing process.

CHWs are known by various titles depending on the funding source: peer counselor, lay health outreach worker, resource mothers, family support worker, patient navigators, and promatores. Some definitions distinguish CHWs from other health professionals as primarily hired for their understanding of the population to be served and by the fact that 50% or more of their time is spent in the community as opposed to the office. In Virginia, CHWs work in a variety of private and public programs ranging from maternal and child health to HIV/AIDS, geriatrics, injury prevention, breast and cervical cancer and nutrition; settings include health departments, free clinics, community health care centers, managed care organizations and hospitals. The largest identified group of CHWs in the Commonwealth works in programs serving pregnant women and families with young children.

In 2005, the Virginia Department of Human Resource Management reviewed the Direct Service Career Group Description and amended the descriptions to include Community Health Workers

under the Health and Human Services Occupational Family. Included in this same occupation are emergency medical technicians. The "Final Report on the Status, Impact and Utilization of Community Health Workers" (House Document # 9, 2006) identified advantages to the government/health system, the community and the CHWs of standards for training and certification and recommended the identification of establishing educational and career pathways.

Some states, such as Texas, Alaska and Indiana, have adopted credentialing while others have been actively considering certification (Nevada, New Mexico, Arizona, Ohio, California, Massachusetts and Kentucky). Training curricula have been established in a few states' higher education systems.

The use of CHWs is increasing with the changes in our society and health care system. As families live long distances apart and the health care system grows increasingly complex, citizens need assistance navigating the various clinics to carry out a health care plan. The increase in outpatient treatment and short hospital stays means that the patient's follow-through on medical recommendation becomes critical to improving health care outcomes and containing costs. CHWs serve as a bridge between diverse cultural and language communities. The CHW roles of educating the community and promoting positive health behaviors are congruent with the increasing national and state focus on health promotion and prevention.

Given the various tasks assigned to CHWs, the independent decisions made by CHWs while working alone in the home and community, and the knowledge that the CHW must have to provide effective services, it seems advisable to consider state standards to protect the consumer and to guide organizations employing CHWs. We would urge the Board to consider credentialing for three different levels of expertise: entry, experienced, and advanced/specialized.

Under the Governor's Working Group on Early Childhood Initiatives, ten statewide programs have formed the Virginia Home Visiting Consortium to improve the quality of services through training and evaluation. The state coordinators of these programs have expressed interest in participating in this study. The CHWs in their programs would be at all three levels while the Grand-Aid program would employ advanced/specialized CHWs.

Thank you for your attention. We look forward to working with you in the future. If you have further questions, please contact Catherine Bodkin, LCSW, MSHA at 804-864-7768 in the Division of Women's and Infants' Health of the Office of Family Health Services at VDH.

Sincerely,

Karen Remley, MD, MBA, FAAP
State Health Commissioner

III. REGULATORY RESEARCH COMMITTEE — Attachment 5

Mission: T o evaluate regulated and unregulated health care professions to consider whether the professions should be regulated and the degree of regulation to be imposed. To examine scope of practice conflicts involving regulated and unregulated professions and advise the boards and the General Assembly regarding the nature and extent of these conflicts.

A. Monitor the introduction of all legislation substantially affecting regulation of health providers and provide comment to the Secretary, Governor, and relevant General Assembly Members through the Director. **Status: Future work pending legislation introduced for 2010.**

B. Remain abreast of emerging health occupations and professions and the need for required regulation.

The Emerging Professions Review - **Status - Completed:**

Central Services/Sterile Processing Technicians - published December 17, 2008
Orthopedic Technologysts and Orthopedic Physician's Assistants - published December 17, 2008
Orthotists, Prosthetists and Pedorthists - published May 12, 2009

The Emerging Professions Review - **Status - Pending:**

Polysomnographers - update on impact today
Surgical Assistants and Surgical Technologists - consideration of comment
Medical Interpreters - response from VDH

Requests for new studies:

Kinesiotherapist (response to Criteria)
Genetic Counselors (expected in 6 months)
Community Health Workers (requested today)

C. Consider efficacy of a new allied health board.