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].

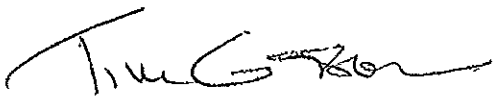
Criterion Six: Alternatives to Regulation

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.