

DRAFT
DEPARTMENT OF HEALTH PROFESSIONS
BOARD OF HEALTH PROFESSIONS
REGULATORY RESEARCH COMMITTEE
FEBRUARY 9, 2010

TIME AND PLACE: The meeting was called to order at 11:05 a.m. on Tuesday, February 9, 2010, Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Board Room 2, Henrico, VA.

PRESIDING OFFICER: Damien Howell, P.T., Chair

MEMBERS PRESENT: David Boehm, L.C.S.W.

MEMBERS NOT PRESENT: Susan Chadwick, A.U.D.
Jennifer Edwards, Pharm.D.
Fernando J. Martinez
Vilma Seymour, Citizen Member

STAFF PRESENT: Elizabeth A. Carter, Ph.D., Executive Director for the Board
Justin Crow, Research Assistant
Laura Chapman, Operations Manager
Diane Powers, Communications Director
Elaine Yeatts, Senior Policy Analyst

OTHERS PRESENT: J. T. Magee, Jr.
David Jenette, CSA
Scott Sprouse, CSA
Lori Stuart
Michael Minor
Cornelius Cornell Scott
John Miller
Jerry Pumphrey
Henry Jackson
Steven Williams

QUORUM: With only two members present, a quorum was unable to be established.

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

PUBLIC COMMENT: Michael Minor, Kinesiotherapist
Mr. Minor stated that he has appeared in front of the board four times, having submitted all the information they have available in hopes that the board can take it and move forward. He stated that Kinesiotherapists are trying to create an open market for health care in the public and private sector.

Cornelius Scott, Surgical Tech at St. Mary's Hospital
He said that he is thankful for the opportunity to regulate Surgical Techs. Would like Scrub Techs who have military accreditation to be "grandfathered" in.

Laurie Short, American Kinesiotherapy Association

Ms. Short stated that she has been practicing Kinesiotherapy for 11 years in VA hospitals. She has done private work but finds it difficult to collect payment. She would be happy to provide any additional information that the Board may need.

Stephen Williams-Kinesiotherapy Patient

Mr. Williams stated that he is a USMC veteran, having served two tours in Iraq. He stated he feels that Kinesiotherapy is an amazing service that should be provided to the public. He said that he feels they are a necessary and vital part of our society and need to be available throughout the Commonwealth.

J.T. Magee, Jr. Kinesiotherapist, McGuire Medical Veterans Center. Mr. Magee said that the Virginia could use the services of Kinesiotherapy. He said that if licensure is granted, it does not guarantee jobs in the field.

John Miller, Physical Therapist

Mr. Miller stated that he opposes licensure of Kinesiotherapists. He stated that: 1) there are very few Kinesiotherapists in Virginia and the nation. 2) it will be costly to establish a Kinesiotherapy Board with the limited number of people in the profession. 3) they are not trained in clinical diagnosis. 4) they do not represent a unique body, but rather are a subset. 5) Senate Bill 573 states that it is unlawful to practice without a license, and 6) he agrees with exemption and certification.

Jerry Pumphrey, Physical Therapist

Mr. Pumphrey voiced opposition to Kinesiotherapist regulation.

Lisa Show, Virginia Physical Therapy Association

Ms. Show stated that there are currently 35 Kinesiotherapy positions in Virginia and is assuming that there are more graduates than that. She stated that VCU discontinued the Kinesiotherapy program because there were no jobs available. She further stated that there is a limited pool of Kinesiotherapists nationwide which appear to be like Physical Techs who may be certified and work in fitness and wellness center. She indicated that they are unable to set up their own practices.

APPROVAL OF MINUTES: Due to the lack of a quorum, the approval of the minutes was tabled to the next full Board meeting.

EMERGING PROFESSIONS UPDATE: Elaine Yeatts reviewed the bills currently up for review by the General Assembly: SJ80; HJ90H1; HB601.

Research Assistant Justin Crow provided an update on the research gathered, to date, on the efficacy of an Allied Health Board and on the Emerging Professions currently under review.

The slide presentation is incorporated into the minutes as Attachment 1.

The Committee discussed the following issues:

Allied Health Professions Board – The Committee agreed that this issue is worthy of continued study. Mr. Crow was asked to provide additional information at the next meeting regarding the Ontario Model. The Committee indicated that given the complexity of the issues, the study's timetable may be lengthened in the future but should proceed as indicated in the study at this time.

Ms. Yeatts informed the committee that the General Assembly will be requesting an Allied Health Board Study.

Surgical Assistants and Surgical Technologists – Mr. Howell requested that the four versions of legislative language be put out for public comment.

Kinesiotherapists – This is still under review by the Committee and has been incorporated into the Allied Health study to determine if the risk of harm may be reviewed within the context of controlled acts.

ADDITIONAL PUBLIC COMMENT:

There was no additional public comment.

NEW BUSINESS:

No new business was presented.

ADJOURNMENT:

The meeting adjourned at 12:14 p.m.

Damien Howell, P.T.
Chair

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



Emerging Professions Review

Polysomnography
Kinesiotherapists
Surgical Assistant/Surgical
Technologists
Community Health Workers



Current Bills

- **HB 725**—VA Academy of Sleep Medicine Bill (Patron-Peace)
 - Creates separate advisory board
 - Explicit exemption for RC providers
 - 02/08/10—Passed in the House
 - **SB 573**—Kinesiotherapist Licensure Bill (Patrons-Ticer, Edwards, Locke, Lucas, McEachin, Miller, J.C. & Whipple)
 - Creates Board of Kinesiotherapy within DHP
 - 02/08/2010—in Health Licensing subcommittee, Committee on Education and Health
 - DPB Impact Statement
 - Cost \$200,000
 - Approximately \$1,000 annual fee per licensee
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Surgical Assistant/Surgical Technologist

Version	Advisory Board	Scrub Role Certified	Advanced Surgical Tech Certified	LPNs perform advanced surgical tech?
1	SA/ST	Yes	--	Yes
2	SA/ST	No	Yes	No
3	PA	No	Yes	No
4	PA	Yes	--	Yes

Scrub Role	Advanced Surgical Technology
<ul style="list-style-type: none"> · Clean and prep room and equipment · Set up operating room and instrument trays · Assemble medications or solutions · Transport Patient · With circulator, verify chart, patient identity, procedure and site of surgery · Shave and drape patient · Maintain Sterile Field · Perform counts with circulator · Assist surgeon with gown and gloves · Pass instruments · Prepare sterile dressing 	<ul style="list-style-type: none"> · Hold retractors, instruments or sponges · Sponge, suction or irrigate surgical site · Apply electrocautery to clamps · Cut suture material · Connect drains to suction apparatus · Apply dressing to closed wounds · Venipuncture (Inserting IV) · Manipulation of endoscopes within the patient · Skin stapling

Proposed statutes vary on:

1. Advisory Board Structure
2. Scrub Role/Advanced Surgical Technology
 1. LPNs and advanced surgical tech?
 2. Type of training programs approved
 1. For Scrub Role Certified, includes hospital-based training programs
 3. Board maintains list of Advanced Surgical Technology Tasks



Other Key Provisions

- Gives the advisory board the duty to recommend regulations that facilitate appropriate practice of military-trained personnel,
- Allows practice by surgical techs from a Board-approved military training program
- Allows the Board to approve individual Surgical Assistant training programs (i.e. does not accept CAAHEP accredited programs carte blanche)

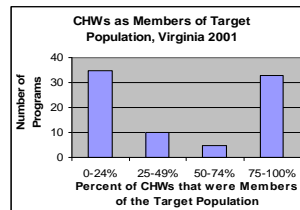
Next Steps

- Recommendation
- Public Comment on Proposed Statute
- Submit for 2011 GA Session



Community Health Workers

- Seven Core Roles
 - Cultural mediation
 - Informal counseling/Social support
 - Culturally appropriate health education
 - Individual and community advocates
 - Assuring people get needed services
 - Building individual and community capacity
 - Providing direct services
- Two Conceptual Frameworks
 - CHW's as community members supporting their neighbors
 - CHWs as health workers on the periphery of the health delivery system



CHW Framework

- Goals of the Community
 - Individual and community access to health services & resources
 - Make services culturally appropriate/acceptable
 - Strengthen community relations and individual capacity
- Goals of the Health Delivery System
 - Efficient delivery of health services
 - Reimbursement/funding for health services
 - Extension of services to more people to support public health

Communities focus on individuals and individuals aggregated into specific groups. The health delivery system focuses on populations and public health. The goals of each overlap but are not identical.



CHW Workforce

State	Paid CHWs	Volunteer CHWs	Total CHWs
Virginia	1,515	210	1,725
Maryland	1,310	544	1,853
West Virginia	417	210	631
Kentucky	733	197	930
Tennessee	884	349	1,233
North Carolina	1,410	557	1,967
District of Columbia	410	162	572
United States	57,571	28,308	85,879

Table 7: DHHS estimates of the CHW Workforce for the year 2000. Numbers may not sum due to rounding.
Source: DHHS 2007, 14

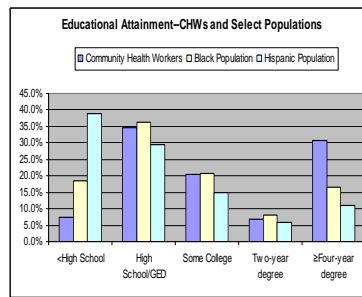
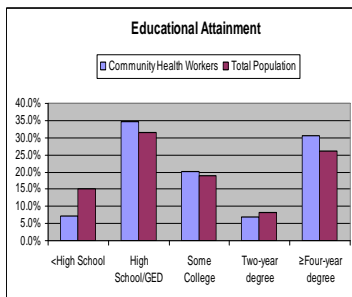
Race or Ethnicity	% of CHW Workforce	% of US Population 2007
American Indian/Alaskan Native	0.5%	0.8%
Asian/Pacific Islander	1.8%	4.5%
Black/African American	16.8%	12.3%
Hispanic/Latino	30.8%	15.1%
Non-Hispanic White	48.3%	66.0%
Other/Multiracial	1.4%	1.4%

African Americans and Latinos make up a disproportionate share of the CHW workforce.

Sources: DHHS 2007, 16; US Census Bureau 2007 Population Estimates, accessed through American FactFinder: <http://factfinder.census.gov>



CHW Workforce





Financing of CHW Programs

- Short-term/unstable financing
 - Government & Foundation Grants
 - Medicaid
 - Capitation Payments (62% of DMAS enrollees)
 - Administrative Costs
 - Government agency funding
 - Hospitals, MCOs, Large Employers
 - Certification is often seen as a means of obtaining third party, fee-for-service funding
- No regulation shall be imposed upon any profession or occupation except for the exclusive purpose of protecting the public interest when:
1. The unregulated practice of the profession or occupation can harm or endanger the health, safety or welfare of the public, and the potential for harm is recognizable and not remote or dependent upon tenuous argument;
 2. The practice of the profession or occupation has inherent qualities peculiar to it that distinguish it from ordinary work and labor;
 3. The practice of the profession or occupation requires specialized skill or training and the public needs, and will benefit by, assurances of initial and continuing professional and occupational ability; and
 4. The public is not effectively protected by other means.



Expanded Roles for CHWs

- Grand-Aide Pilot Program
- Three roles
 - Health promotion/social care role
 - Chronic care role
 - *Acute care role*
- Acute Care Grand-Aide (ACGA)—first response primary care
 - Patient assessment
 - The ACGA assess the patient for 28 common complaints
 - Diagnosis
 - Using standardized protocols, determine if the complaint is minor or requires professional care
 - Treatment
 - For minor ailments, the ACGA may suggest basic treatments
 - Gatekeeping*
 - Coach/advise families on when to seek professional care



Delegation & Supervision--Grand Aides

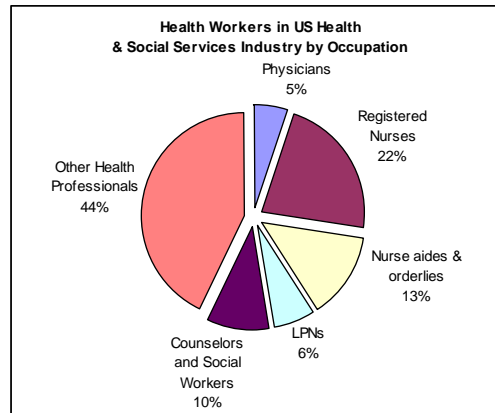
- General Supervision
 - Housed in Federally Qualified Health Clinic
 - One nurse per four ACGAs during training
 - 1st three months, ACGA required to call/videolink with nurse for each visit
 - Physician supervises teams
 - Clinical Protocols
 - Create decision matrix for ACGAs
 - Mini-laptop with drop-down menus
 - Electronic Medical Record
 - Drop-down menus create an EMR
 - May also include video
 - Clinic staff have access to EMR
 - Training and Assessment
 - Three months of classroom/one month clinical training
 - Clinical assessment, reviewed by physician
 - After one year—written and case based test & certificate of completion
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Allied Health Professions

Allied Health Workers

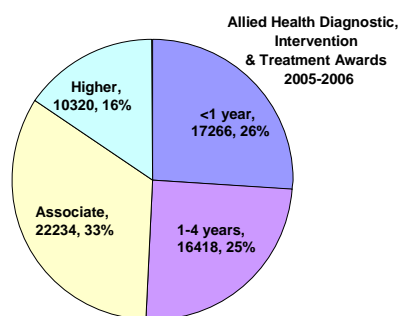
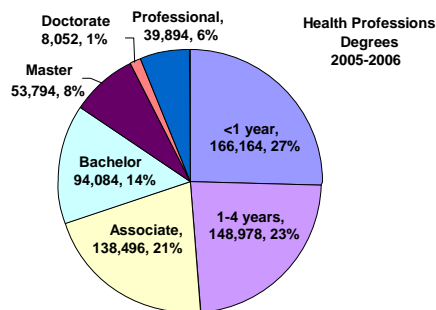
- 26 % of Health and Social Services Industry Workforce
- 44 % of Care-oriented health workers
- Up to 60 % of the health care workforce
- 200 Professions/Occupations



Allied Health Professions

71% - Less than Four-Year Degree or Certificate

84% - Less than Four-Year Degree or Certificate





Preliminary list of allied health professions w/o an independent regulatory board

	Total Licensees	Allied Health Licensees	Percentage
Counseling	6191	329	5.31%
Rehabilitation Provider		329	
Medicine	53090	14343	27.02%
Podiatry		476	
Chiropractic		1644	
Athletic Trainer		955	
Licensed Acupuncturist		403	
Limited Radiologic Technologist		806	
Occupational Therapist		2726	
Occupational Therapist Assistant		631	
Radiologic Technologist		3179	
Respiratory Care Therapist		3484	
Licensed Midwife		39	
<i>Polysomnographers</i>		NA	
<i>Surgical Assistants</i>		NA	
<i>Surgical Technologists</i>		NA	
Nursing	186306	5302	2.85%
Certified Massage Therapist		5302	
Board of Health Professions	--		
Dialysis Patient Care Technicians		NA	
Dieticians & Nutritionists		NA	
All DHP Boards	315724	19974	6.33%



Preliminary Policy Options

- Ontario Model
 - Controlled acts regulated (not professions)
- Limited Ontario Model
 - Controlled Delegable Tasks
 - Prohibits licensed professionals from delegating specific dangerous tasks to unqualified personnel
 - May protect the public while allowing workforce flexibility
- Mandatory Certification
 - Require private sector certification (or other credentials) w/o a state run program
- Title protection only
 - Provides statutory title protection to persons holding protected private credentials
- Composite Board
 - Use existing regulatory framework, but create a composite Board of Allied Health Professions



Allied Health Board Workplan

- February-March 2010: Identify stakeholders, solicit comment and hold public hearings
 - April 2010: Complete Interim Report of Summary of Research
 - **May 4, 2010:** Present Interim Report to the Regulatory Research Committee, the Board of Health Professions, Stakeholders and the General Public
 - May-June 2010: Solicit Comment and discussion, including public hearings, on the Interim Report
 - July –August 2010: Prepare draft final report and draft recommendations
 - **August 17 2010:** Present draft report and recommendations to Regulatory Research Committee and the Board of Health Professions for approval
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