JOINT COMMISSION ON HEALTH CARE

STRATEGIES TO EXTEND HEALTH CARE ACCESS TO VULNERABLE POPULATIONS

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #887

COMMONWEALTH OF VIRGINIA
RICHMOND
2024

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Strategies to Extend Health Care Access to Vulnerable Populations

Contents

Extending Health Care Access: Mobile Health Clinics

POLICY OPTIONS IN BRIEF

Option: Direct the Board of Pharmacy to work with DBHDS to develop a process by which opioid treatment programs may be allowed to dispense OUD treatment medications from mobile units (Option 1, pg. 13).

Option: Direct DHCD to include broadband access services for mobile health clinics as a priority for broadband adoption programs (Option 2, pg. 17).

Option: Establish a grant program supporting mobile health clinics that provide services in rural and underserved areas (Option 3, pg. 19).

FINDINGS IN BRIEF

Mobile health clinics increase patient access to care by removing costs, distance, and administrative barriers

Mobile health clinics effectively fill gaps in the health care landscape, serving a wide range of vulnerable and underserved populations that lack access to regular health care services. As a flexible health care delivery model, mobile health clinics can tailor the services they provide in response to community needs. By removing cost, distance, and administrative barriers, they may capture patients who may not have sought care otherwise.

Mobile health clinics could be used to expand access to opioid treatment

Patients receiving Medication-Assisted Treatment for opioid use disorder require frequent clinic visits for medication management, therapy, and drug screenings. The treatment schedule can be difficult for patients without reliable transportation or accommodating work schedules. There is some evidence that patients who receive OUD treatment medication through mobile programs have similar or improved treatment retention compared to patients at fixed-site clinics. A few treatment centers in Virginia allow patients to get buprenorphine prescriptions at their mobile health clinics. DHBDS has received federal approval for mobile methadone clinics and plans to begin operations in the future.

Logistical challenges, staffing shortages, and lack of reliable funding make mobile health clinic operations difficult

The small, contained nature of mobile health clinics is a strength for taking health care where it is needed, but presents its own set of challenges. Staff must manage vehicle maintenance, weather, parking, and safety considerations that affect operations. Additionally, the kinds of services mobile health clinics can offer is highly dependent on vehicle size, staffing, funding, and the availability of broadband. Addressing internet deployment and adoption gaps would help mobile health clinics facilitate telehealth and expand access to services, particularly in rural areas.

JCHC Analyst: Kyu Kang

Extending Health Care Access: Community Paramedicine

POLICY OPTIONS IN BRIEF

Option: Direct OEMS to report updates on the status of draft regulations (Option 4, pg. 24).

Option: Establish or expand a grant program to provide funding to EMS agencies for community paramedicine and mobile integrated healthcare programs (Option 5, pg. 29).

Option: Reimburse treatment without transport for Medicaid patients who call 911 (Option 6, pg. 30).

Option: Direct DMAS to work with OEMS and other stakeholders to develop a plan for reimbursing community paramedicine and mobile integrated healthcare services (Option 7, pg. 32).

Option: Direct DMAS to seek approval for implementation of the Ground Emergency Medical Transportation Program (Option 8, pg. 33).

FINDINGS IN BRIEF

Community paramedicine and mobile integrated healthcare utilize emergency medical services (EMS) providers in new roles

EMS providers are increasingly being utilized in non-traditional roles and settings to provide public health, primary health care, and preventive services.

- **Community paramedicine** programs use paramedics
- **Mobile integrated healthcare** programs use multi-disciplinary care teams, which may include emergency medical technicians and paramedics

For brevity, this study will use the term "community paramedicine" to refer to both types of programs.

Community paramedicine extends patient access to care and relieve pressure from emergency systems

Community paramedicine programs usually serve high-risk or high-needs individuals who frequently call 911, have complex medical needs, or are at risk of hospitalization. Program participants may receive preventive care, primary care, and linkages to psychosocial supports. Community paramedicine programs effectively reduce unnecessary emergency call volume, ambulance transports, emergency department visits, readmission rates, and inpatient utilization. This leads to better outcomes for patients while also reducing medically unnecessary EMS calls and transports.

Funding and capacity are the largest program limiters

States have the flexibility to design how they will cover community paramedicine, and Medicaid is the most frequent payer for these services nationally. In Virginia, community paramedicine programs have few reimbursement opportunities. Programs do not charge participants and rarely can bill health insurance for their services. This makes it difficult for smaller or more rural EMS agencies who do not have the capacity to expand their services to community paramedicine. Reimbursing for community paramedicine would support sustainability, and tapping into additional federal funding may support general capacity building for EMS agencies.

Extending Health Care Access: Home Visiting

POLICY OPTIONS IN BRIEF

Option: Provide funding to Families Forward Virginia to collect necessary evidence to meet federal home visiting standards (Option 9, pg. 44).

Option: Direct DMAS to convene with stakeholders to develop a home visiting benefit (Option 10, pg. 45)

FINDINGS IN BRIEF

Home visiting programs are supported through a combination of funding streams

The capacity and sustainability of home visiting programs in Virginia is directly related to available funding and resources directed towards these efforts. In Virginia, as in other states, home visiting programs are supported by a mix of federal, state, local, and private funds. In FY 2024, overall investment in local home visiting services in Virginia totaled $36 million. The Maternal, Infant, and Early Childhood Home Visiting Program is the largest source of federal funding. There are certain requirements that need to be met to be eligible for federal funding. If more of Virginia's home visiting programs meet these requirements, it is possible more of this funding could be extended to other home visiting models.

Virginia could leverage Medicaid funding to enhance capacity of home visiting services

Since there is no single service under the Medicaid program defined as home visiting, federal guidance gives states the option to create state plan amendments under several other state plan benefit categories that cover services provided through home visiting programs. At least 28 states offered a home visiting benefit through their state Medicaid programs, most of which do through a Medicaid state plan amendment.

JCHC Analyst: Estella Obi-Tabot

Extending Health Care Access: Community Health Workers

POLICY OPTIONS IN BRIEF

Option: Provide additional funding to VDH for CHW services and to remove restrictions on use of such funds (Option 11, pg. 50).

Option: Direct VDH to report on current needs for and impact of CWHs at the state and local health departments (Option 12, pg. 51).

Option: Direct DMAS to convene a work group of stakeholders to design a state plan amendment for CHW services (Option 13, pg. 52).

Option: Direct DMAS to convene a workgroup to identify opportunities to expand use of CHWs by Medicaid MCOs (Option 14, pg. 54).

Option: Direct DMAS, DBHDS, and other relevant stakeholders to convene a workgroup to determine feasibility of flexible training standards to allow CHWs to obtain the same certifications as other lay health community-based providers (Option 15, pg. 56).

Option: Provide funding to support CHW workforce efforts through the Virginia CHW Association (Option 16, pg. 57).

FINDINGS IN BRIEF

Virginia has taken steps to expand access to services provided by CHWs, but insufficient funding continues to be a barrier
During the 2024 Session, the General Assembly appropriated $3.2 million per year in FY 2025 and FY 2026 to support CHW positions at local health districts but did not fund the full $5.2 million amount requested by VDH. Appropriating additional general funds to VDH to cover the full cost of supporting CHW positions at local health departments could ensure that CHWs remain available to provide necessary services in their communities. A more comprehensive review could allow VDH to determine the need for and capacity of state and local health departments to support CHWs and could help VDH better determine the funding needs of state and local health department CHW programs on an ongoing basis.

Access to CHW services could be expanded by leveraging Virginia's Medicaid program as a sustainable funding mechanism
At least 24 states offer Medicaid reimbursement for CHW services, either through a Medicaid state plan amendment or contracts with managed care organizations. Virginia could implement either option to leverage Medicaid reimbursement for the services CHWs provide. Virginia could also provide reimbursement for services provided by CHWs by developing opportunities for CHWs to become eligible for reimbursement for other services already reimbursed by the state's Medicaid program.

CHWs need ongoing workforce development opportunities to avoid burnout and support retention
Providing state support to a CHW professional organization can help ensure there is access to mentorship, advocacy, and training opportunities to engage the CHW workforce.

Extending Health Care Access: Telehealth

POLICY OPTIONS IN BRIEF

Option: Provide funding for a Telehealth Coordinator at VDH (Option 17, pg. 64).

Option: Direct DBHDS to develop and disseminate best practice educational training for providers on telehealth visits for patients with disabilities (Option 18, pg. 64).

Option: Provide funding to allow VTN to develop and implement a pilot Pharmacy Care Hubs program (Option 19, pg. 65).

Option: Direct DOE to require local boards of education to facilitate students' access to telehealth services (Option 20, pg. 66).

Option: Appropriate the funds for e-consults (Option 21, pg. 66).

Option: Direct DMAS to develop a plan for expanding eligibility criteria for Remote Patient Monitoring for chronic conditions (Option 22, pg. 67).

Option: Remove the exclusion of audio-only from the definition of telemedicine (Option 23, pg. 68).

Option: Increase funding for the Virginia Telemental Health Initiative (Option 24, pg. 69).

Option: Provide funding to Virginia Health Catalyst to plan and implement a teledentistry pilot program in SNFs (Option 25, pg. 71).

Option: Require the DOC to establish policies to accommodate inmates needing telehealth appointments (Option 26, pg. 71).

FINDINGS IN BRIEF

Telehealth improves access to health care for vulnerable and underserved populations
Telehealth can improve patient access to care by removing transportation-related barriers, increasing access to culturally appropriate care, improving efficiency of healthcare practices, and mitigating the effects of workforce shortage.

Inadequate coordination of telehealth initiatives, lack of training and guidance for providers creates challenges
Lack of dedicated staff at VDH has resulted in a failure to maintain progress on the Telehealth State Plan and lack of provider education on telehealth. Providers in Virginia require training around Medicaid coverage, telehealth best practices, and delivery of telehealth to individuals with disabilities.

Limited access to broadband and telehealth technology restricts patients' access to telehealth services
Telehealth Access Points (TAPs) are pre-existing community spaces that have the technology and internet infrastructure necessary to support telehealth services. TAPs could increase access to telehealth services for patients in areas where broadband access is an issue.

Gaps in coverage and insufficient reimbursement for telehealth are barriers to telehealth implementation
Low reimbursement rates and lack of coverage for some telehealth services disincentivize providers from offering telehealth services because they are receiving less compensation for what they view as the same amount of patient care.

Lack of resources to expand the capacity of programs that provide telehealth access limits access to services
Telehealth programs often lack adequate resources to meet demand for program services. Providing or increasing funding for telehealth programs would expand access to health care services for vulnerable and underserved patients.

JCHC Analyst: Emily Atkinson

Chapter 1: Strategies to Extend Health Care Access to Vulnerable Populations

Access to care is a critical marker of effective health care systems and is broadly defined as obtaining appropriate health care services when needed. Access to care considers opportunities and barriers to identifying health care needs, seeking health care services, using health care services, and having the need for those services fulfilled.

Access to care is influenced by social determinants of health (SDOH), defined as the non-medical factors, such as the conditions in which people are born, grow, work, live, and age, that influence health outcomes. Community variations in SDOH impact access to care, so that certain populations, nationally and in Virginia, have worse access to care than other populations. These gaps in access can lead to differences in health outcomes and, ultimately, life expectancy.

In 2020, the Joint Commission on Health Care (JCHC) identified accessibility as one of four strategic objectives to guide their work, in addition to affordability, quality, and equity. These strategic objectives reflect the JCHC's authorizing statute, which charges the JCHC to ensure "the availability of quality, affordable and accessible health services." The JCHC strives to achieve a system of health care in Virginia that meets its four strategic objectives.

To that end, for 2024, the JCHC asked staff to examine multiple strategies to extend health care access to vulnerable populations. Strategies examined in this study include mobile health clinics, community paramedicine, maternal home visiting, community health workers, and telehealth (see APPENDIX A for the study resolution). In conducting this study, staff was directed to:

- evaluate alternative models for extending health care access, including determining which populations benefit from these strategies, how these services are delivered, and how the costs of these services compare to their anticipated benefit;
- identify the ways in which peer states support similar alternative models; and
- develop policy options through which Virginia may support effective models to extend health care access to vulnerable populations.

Access to care is a multi-faceted construct

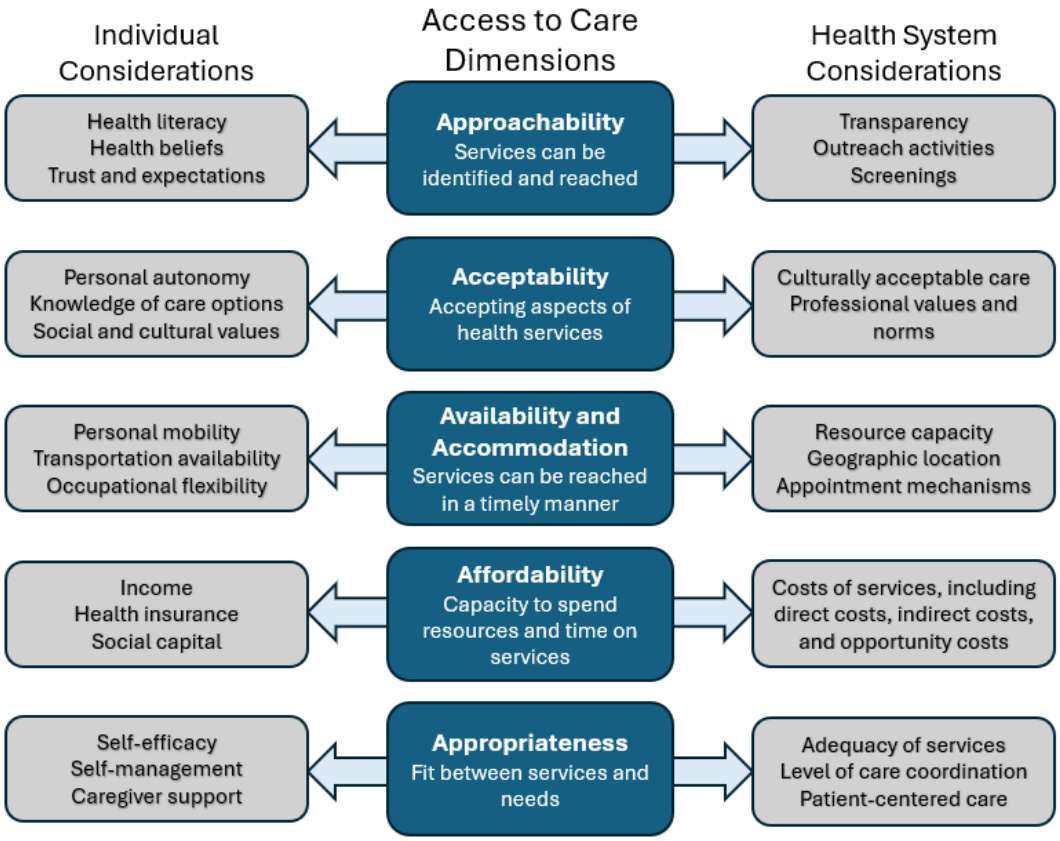
Access to care may be a commonly understood concept for health systems, but research on access suggests that it is a multi-dimensional concept that impacts populations differently. Measuring access to care, therefore, can be a challenge.

Dimensions of health care access include individual, community, and health system factors

Following a comprehensive review of the literature on access to care, Levesque and colleagues (2013) created a framework that organizes individual, community, and health system variables influencing health care access into five interdependent dimensions (FIGURE 1-1):

- **Approachability** reflects how well health care services can be identified and reached, and is influenced by health literacy and health beliefs at the individual level, as well as outreach activities, for example, at the health system level.
- **Acceptability** refers to the extent to which individuals accept aspects of health care services, and is dependent upon individuals' values, culture, gender, and autonomy. Health systems also contribute to acceptability by providing culturally appropriate care that meets the needs of the communities they serve.
- **Availability and accommodation** indicate whether health care services can be reached in a timely manner. Personal mobility and access to transportation are examples of individual considerations that may impact availability. From the health system perspective, the capacity of health care facilities, their location, and operating hours as well as the system's use of virtual health capabilities inform the availability dimension.
- **Affordability** is the extent to which people have resources and time to spend on health care services and is impacted by the health systems' costs of services and individual's access to health insurance and ability to pay.
- **Appropriateness** is a measure of the fit between the health care services provided and the patients' needs. This dimension can be impacted by individuals' self-efficacy and adherence to treatment plans as well as the quality of services and extent to which those services include patients in the decision-making process.

FIGURE 1-1. Access to care is defined through five dimensions



SOURCE: Adapted from Levesque, J. F., Harris, M. F., & Russel, G. (2013). Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. *International Journal for Equity in Health, (12),* 18, pp. 1-9.

Since its development, this framework has been used in 31 research studies to explore, assess, and measure access in various health care services and settings. For this study, it provides a structure to understand how the selected strategies described in this report impact different dimensions of access to care. For example, the use of telehealth primarily affects the availability of services from a health system perspective, while community health workers could impact multiple individual considerations within the domains of approachability, acceptability, and appropriateness. Notably, no single strategy described in this report addresses all dimensions of access. Wholistically addressing access to care requires multiple layers of intervention – at the individual, community, and health system level - to address barriers individuals face when identifying, seeking, and reaching health care.

Populations experience different barriers to health care access

The terms vulnerable populations and underserved populations are sometimes used interchangeably, but they describe different characteristics of populations who may

experience barriers to health care access. **Vulnerable populations** have a high risk for health care problems, face significant hardship, or have a limited ability to understand or communicate effectively (e.g., individuals with cognitive impairment or for which English is not a primary language). **Underserved populations** have been systematically denied opportunities to fully participate in health care based on a shared characteristics (e.g., people who live in rural areas or populations impacted by poverty). Underserved populations receive fewer health care services, face barriers to accessing primary care services, are not familiar with the health care delivery system, or face a shortage of readily available providers.

Populations often identified as vulnerable or underserved include older adults, individuals living in rural areas, children, individuals who are members of racial and ethnic minority groups, individuals with physical or intellectual disabilities, low income or homeless individuals, pregnant individuals, individuals with mental health or substance-related disorders, or individuals who identify as LGBTQI+. However, populations can be vulnerable without necessarily being underserved. For example, an individual with a disability may be considered vulnerable, but if they have access to high quality health care appropriate to their needs, they are not underserved.

Strategies featured in this report extend access to care to vulnerable populations, including older adults, individuals living in rural areas, and individuals who are members of racial and ethnic minority groups, that are also underserved. For example, both community paramedicine and mobile health clinics first emerged in Virginia as a model for providing health care to rural populations, while multiple home visiting programs primarily support pregnant women who are Black, Hispanic, or members of tribal communities.

Measuring access to care goes beyond service utilization

With multiple dimensions and multiple vulnerable populations, comprehensively measuring access to care becomes a complex task. While the utilization of services is often used as a marker for access, reviews of the literature suggest that several key metrics, in addition to utilization, can provide a fuller picture of access (TABLE 1-1).

TABLE 1-1. Key access to care metrics

Metric	Measures
Potential access	Health insurance coverage
Realized access	Service utilization including hospital admissions, physician visits, and dental visits
Equitable access	Differences in health insurance coverage and service utilization by vulnerable population groups
Effective access	Performance metrics such as adherence to clinical guidelines and quality initiatives
Efficient access	Relative cost of improving specific health outcomes

SOURCE: Adapted from Andersen, R. M., & Davidson, P. L. (2007). Improving Access to Care in America: Individual and Contextual Indicators. In R. M. Andersen, T. H. Rice, & G. F. Kominski (Eds.), *Changing the U.S. health care system: Key issues in health services policy and management* (3rd ed., pp. 3–31). Jossey-Bass

Compared to other states, Virginia's rankings on most access to care metrics falls in the lower half of states. Virginia ranks 21st in the nation in terms of the population of uninsured individuals, and 21st on the number of dental care providers per capita. However, Virginia ranks 36th and 35th in the US for access to mental health care and primary care, respectively. As of July 2024, all 133 localities in Virginia are federally designated as behavioral health shortage areas, 98 localities are federally designated as dental health shortage areas, and 96 localities are designated as primary care shortage areas.

Strategies to enhance health care access balance targeted and population approaches

Effective strategies to enhance access to care target barriers that are measurable and modifiable. Targeted strategies can provide short-term relief for specific populations, while population-based strategies may provide longer-term solutions for broader populations. A balance between the two approaches must be struck to fully address access. For example, following expansion during the COVID-19 pandemic, telehealth services are more widely available and used. However, as this report will describe, some populations – particularly individuals living in rural areas or individuals who struggle with technology use – still need additional support and resources to enhance access to care through telehealth.

Policy levers also exist within targeted and population approaches, aligned with the core functions of public health and the role of state government. The oversight or assurance function of public health provides the most direct means through which government agencies can influence disparities in health care access. In this role, agencies ensure that health care and a competent public health and personal health care workforce are available and evaluate the effectiveness, accessibility, and quality of health care. State government

can also affect health care access through their assessment role. Assessment functions of public health include monitoring the population's health status to identify community health problems and diagnosing and investigating health problems and health hazards in the community. Finally, through the policy development role, state government can improve access to health care by adopting policies that support a broad range of services intended to educate people about health issues and empower them to take action to improve their health, mobilize partnerships within the community to identify and solve health problems, and support efforts on the individual and community levels to improve health. This report will identify some policies that the General Assembly could adopt to address disparities in health care access.

Chapter 2: Mobile Health Clinics

Mobile health clinics, or "mobile health units," are vehicles such as large vans, recreational vehicles (RV), and trucks that have been modified to provide space for clinical services inside the vehicle. As self-contained units, mobile health clinics allow providers to deliver services in areas and to populations that may lack access to health care. Use of mobile health clinics can improve the approachability, acceptability, availability and accommodation, and affordability of health care for many vulnerable and underserved populations. For this study, Joint Commission on Health Care (JCHC) staff focused on clinic services provided by individual mobile health units and did not include coordinated mobile health events such as the Remote Area Medical clinics (SIDEBAR).

Remote Area Medical (RAM) clinics are pop-up clinics hosted by Remote Area Medical, a nonprofit organization that provides free medical, dental, and vision services. The events are hosted for one to three days in underserved areas around the United States. RAM held annual clinic events in Wise, VA for 20 years until 2019, at which point The Health Wagon stepped in to take over providing the services that had been available at the RAM clinic.

The Health Wagon, the oldest and one of the most well-known mobile health clinics in the United States, was established in Virginia in 1982 by Sister Bernadette Kenny. While serving in Dickenson County with the Medical Missionaries of Mary, Sister Bernadette grew concerned about transportation barriers and the lack of health care resources available to residents in Appalachia. She eventually purchased a retired RV from the Catholic Church for $1, and with support from St. Mary's Hospital, began providing services and distributing medications throughout southwest Virginia. While the mobile health clinic model has evolved since that time, the use of mobile health units as a flexible strategy for delivering care to communities and individuals in need of health care services has not changed.

Mobile health clinics effectively fill gaps in the health care landscape

Organizations across the health care ecosystem operate mobile health clinics, usually as extensions of their existing fixed-site operations. In Virginia, mobile health clinics are operated by community-based organizations/nonprofits, community services boards (CSBs), federally qualified health centers (FQHCs), free clinics, health plans, hospital systems, local health departments, and universities. Most mobile health clinics identified by JCHC staff for this study were operated by state entities (TABLE 2-1).

Mobile health clinics serve a wide range of vulnerable and underserved populations that lack access to regular health care services. Some mobile health clinics in Virginia specifically serve low-income students, uninsured individuals, unhoused people, agricultural workers, individuals with developmental disabilities, individuals with mental

health concerns, or residents in underserved communities. At other times, particularly during public events, mobile health clinics are available to the general public and serve anyone who requests care.

TABLE 2-1. Most mobile health clinics JCHC staff identified in Virginia are operated by state entities

Organization Type	Number of Organizations with Mobile Health Clinics
State entity (e.g., public school, local health department)	23
Free clinic/nonprofit	11
Hospital system	9
Federally qualified health center	7
Health care company	3
University	3
Health plan	2
Total	58

SOURCE: JCHC staff identification via snowball sampling and review of available program documentation, 2024.

NOTE: Table includes organizations that currently operate, plan to operate, or partner to operate mobile health clinics. Many organizations operate more than one mobile health unit.

Mobile health clinics provide a wide range of services in response to community needs

Mobile health clinics can be equipped and staffed to provide a wide range of services in both direct clinical care and public health. They are most often utilized to provide primary care, prevention services, and dental care, with a focus on screening, testing, and education. Some may offer limited services, providing only physicals or vaccinations in partnership with schools or other community organizations, while others provide a much larger array of services. For example, Mount Rogers Health District operates a mobile health clinic at Emory & Henry University where they provide students with family planning services like contraception, gynecological exams, counseling, sexually transmitted infection testing, immunizations, and referrals to community resources. This helps students, who do not have cars while on campus and are not familiar with providers in the community, access health care services, and supports a collaborative relationship with a local clinic that refers patients to the Mount Rogers mobile clinic when patients need to be seen faster. Mobile health clinics may also help patients address unmet social needs by facilitating connection to wider community resources or providing clothes, food, and baby supplies.

Mobile health clinics are a flexible health care delivery model

Mobile health clinics are able to adjust the services they deliver to fit the changing needs of the communities they serve much more flexibly than traditional facility settings. Some mobile health clinics follow a set schedule, providing regularly available health care services at scheduled times and locations. Others may be more ad hoc, acting like pop-up clinics during community events.

Additionally, as contained units with limited scope, mobile health clinics have the ability to quickly adapt to public health crises, meeting patients where they are to provide services that fill gaps in care. For example, during the COVID-19 pandemic, many mobile health clinics pivoted to respond to pandemic concerns and provide testing and vaccinations, targeting their services to address disparities in health care. In Virginia, the Richmond-Henrico Health District used their mobile health unit (FIGURE 2-1) to bring vaccinations and care to small group homes, small assisted living facilities, and homebound populations who could not travel to mass vaccination sites and did not have access to the same resources and staff as larger facilities.

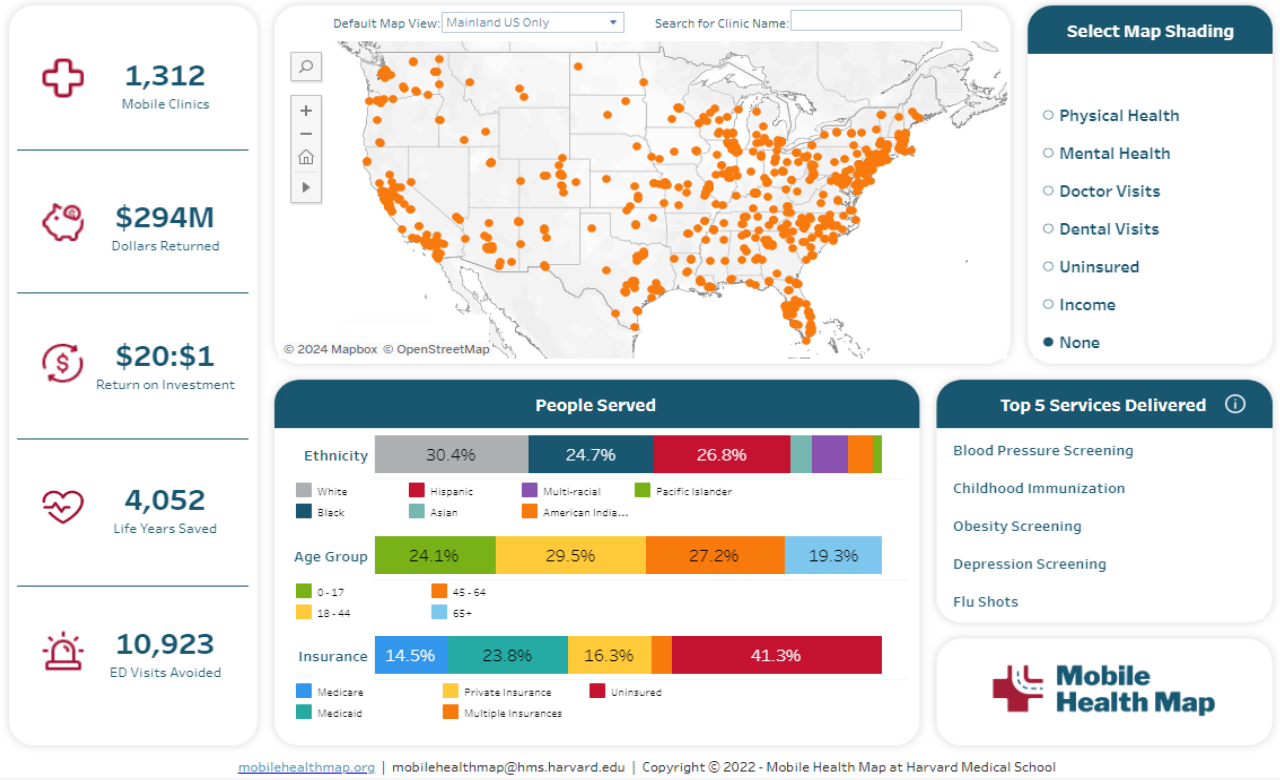
FIGURE 2-1. Richmond-Henrico Health District's mobile van has an extendable awning to create more space

SOURCE: Richmond-Henrico Health District, 2024

It is unclear how many mobile health clinics are in operation in Virginia

While the flexibility of mobile health clinics allows them to be responsive to changing community needs, it also means it is difficult to know if and when mobile clinics are operating. There is no central oversight body that keeps track of when, where, and how many mobile health clinics are in operation. Mobile Health Map is a national network of mobile health clinics that tracks and reports mobile health clinic data nationally (FIGURE 2-2). However, it relies on members submitting and updating information about their clinics, leading to significant gaps in the available data and an undercount of operating mobile health clinics. For example, as of September 2024, Mobile Health Map reports 21 mobile health clinics in Virginia, but JCHC staff identified 58 organizations that currently operate, plan to operate, or partner to operate one or more mobile health clinics in the state (see APPENDIX B for a full list). The actual number is likely larger, as JCHC staff were told of additional organizations that also operate mobile health clinics but could not obtain enough information to include them in this study (see APPENDIX J for methodology).

FIGURE 2-2. Mobile Health Map is a national network of mobile health clinics that tracks clinic locations, services, and impact based on self-reported data



SOURCE: Screenshot of Mobile Health Map's Mobile Clinic Impact Tracker dashboard, https://www.mobilehealthmap.org/tableau-public-data/, August 2024.

Mobile health clinics generally operate as extensions of their fixed-site clinics and are regulated by various state professional boards

Most states do not have specific regulations regarding management of mobile health clinics. Rather, mobile health clinics must follow state regulations governing provider scope of practice and clinic operations generally. Mobile health units in Virginia tend to operate as extensions of fixed-site clinics, so providers and staff follow the same organizational protocols regardless of setting. For example, mobile health clinics owned and operated by local health departments in Virginia are staffed by Virginia Department of Health (VDH) employees who are subject to the same scope of practice requirements and operational policies and procedures as regular on-site local health department employees.

Under certain circumstances, regulations provide flexibility to accommodate the nature of services being provided by mobile health clinics. For example, in Virginia, dental hygienists generally may only practice when a supervising dentist is available during the delivery of services; however, dental regulations allow dental hygienists in the Department of Behavioral Health and Developmental Services (DBHDS) mobile dentistry program and certain dental hygienists employed by VDH to practice under remote supervision. Authority to practice under remote supervision allows public health dental hygienists employed by

VDH or DBHDS to practice more independently, as long as they have "regular, periodic communications" with a supervising dentist. This flexibility allows mobile dental clinics to expand access to health care services.

Regulations adopted by the Board of Pharmacy provide additional flexibilities for mobile health clinics that provide access to medications. Mobile health units generally do not meet requirements related to storage and security of drugs that apply to brick-and-mortar pharmacies – e.g., the prescription department shall not be less than 240 square feet; the pharmacy shall be constructed of permanent and secure materials. To provide flexibility for mobile health units, the Board of Pharmacy has adopted Guidance Document 110-10, which addresses the waiving of certain regulations under specific circumstances, e.g., how drugs carried by mobile units must be stored for security. For instance, mobile units may only store and dispense Schedule VI drugs (prescription-only drugs with very low potential for abuse) and must have an alarm system that fully protects the drug storage area.

Mobile health clinics increase patient access to care by removing cost, distance, and administrative barriers

Mobile health clinics tend to target vulnerable and underserved populations, focusing on individuals without insurance or with limited access to health care. Many mobile health clinics design their service delivery to remove as many barriers as possible for patients. They travel to communities with the greatest need to close geographic distances, offer services at low or no cost to patients, and often do not require appointments.

Improved access to care provided by mobile health clinics improves both outcomes for vulnerable and underserved populations and community health outcomes. For example, one study of mothers in Florida found that those who visited a mobile health clinic van for prenatal care began receiving prenatal care earlier in their pregnancies and had significantly lower rates of preterm birth and low birthweight babies than mothers with the same sociodemographic characteristics who did not. Mobile health clinics that operate on regular schedules and can see patients consistently can also be an effective delivery method for helping patients manage chronic diseases and see improvements in their hypertension, cholesterol status, and diabetes, leading to fewer unnecessary emergency department visits, shorter hospital stays, and increased quality of life and symptom-free days.

Mobile clinics may capture patients who may not have sought care otherwise

By removing barriers to care, mobile health clinics are able to serve people who may not have otherwise sought care due to lack of time or financial resources, making them an attractive service delivery method for reaching marginalized individuals who would have forgone care otherwise. One rural mobile health clinic in Tennessee surveyed their patients and found that one in five patients had not been to a primary care provider in at least five years or had never been, and almost one-third (31 percent) of patients said they would not

have received any care if the mobile health clinic was not available. In addition, one stakeholder JCHC staff spoke with noted that mobile health clinics often capture people who have never been served before – this may lead to them becoming more permanent patients of the clinic and potentially going to receive care at the fixed-site clinic, as well.

There is an opportunity to use mobile health clinics to expand access to opioid treatment

Patients in treatment for opioid use disorder (OUD) may receive Medication-Assisted Treatment (MAT), or opioid agonist therapy, as part of their recovery. This requires frequent and even daily visits to the clinic to meet with medical staff for medication management, individual or group therapy, and drug screenings. The treatment schedule can be challenging for patients who live far from the clinic, have schedules that don't align with clinic hours, lack transportation, don't have health coverage, or are simply not aware of their options.

Drug Enforcement Agency (DEA) regulations related to mobile narcotic treatment programs outline that:

- Narcotics treatment providers may operate mobile units under their existing DEA registration.
- Mobile units must operate in the same state in which their treatment program is registered – they may not cross state lines.
- Mobile units must return to their registered fixed-site location at the end of each day, or programs must apply for exception and propose alternate security measures.
- Controlled substances must be removed from the mobile unit at the end of each day and secured inside the registered fixed-site location.

Beginning in 2021, the federal Drug Enforcement Administration lifted restrictions on opioid treatment programs (OTPs) deploying mobile medication units to dispense OUD treatment medication. There is some limited evidence that patients who receive OUD treatment medications through mobile programs have similar or improved treatment retention compared to traditional fixed-site OTP patients. In interviews at one mobile unit, patients said they preferred receiving their OUD treatment medications from the mobile unit rather than at the regular OTP because it was efficient, convenient, faster, and felt more like a positive environment with less anxiety and crowding. Though the federal restriction on new OTP mobile medication units has been lifted, there are still strict requirements related to proper medication storage and security that lead to significant operating costs (SIDEBAR).

While there are currently no OTP mobile medication units in use in Virginia, DBHDS has received federal approval to add OTP mobile medication units and plans to begin operations in the future. The process is currently underway, and as a first step, the DBHDS Office of Licensure and Certification is making changes to OTP licenses to allow programs to add on mobile units providing methadone, an OUD treatment medication. In order to move forward, the Board of Pharmacy will need to identify a pathway for OTP mobile medication units to apply for permission to waive Virginia's traditional pharmacy requirements, either by amending current pharmacy regulations or individually approving each OTP mobile medication unit through their Innovative Pilot

Program. Regulations allowing the Board of Pharmacy to waive existing requirements applicable to traditional pharmacies to allow OTPs to operate mobile units may differ from existing allowances for mobile health clinics that provide access to medications (SIDEBAR). DBHDS must collaborate with the Board of Pharmacy on this process, as opioid/narcotic treatment programs are regulated by both DBHDS and the Board of Pharmacy.

➔ **Option 1:** The Joint Commission on Health Care could introduce legislation directing the Board of Pharmacy to work with the Department of Behavioral Health and Developmental Services to develop a process by which opioid treatment programs can apply for and receive necessary permissions and waivers to allow dispensing of opioid use disorder treatment medications from mobile units. The Board would report on the status of the process and any barriers to developing and implementing such process to the Joint Commission on Health Care by November 1, 2025.

In the meantime, there are several CSBs that received federal State Opioid Response funding to serve individuals with substance use disorder through mobile health clinics. Though none are dispensing medication, CSBs can still use their mobile units to provide support services, therapy, drug screening, and prescriptions for buprenorphine/naloxone (or Suboxone), which patients must go to the pharmacy to fill.

Mobile pharmacy is not explicitly authorized in Virginia, but the Board of Pharmacy has created multiple pathways for mobile health clinics that want to carry and dispense medications.

For Schedule VI drugs:

- **Permitted physician licenses** allow physicians to dispense drugs from a mobile unit serving medically underserved and low-income populations with limited access to pharmacy services
- **Special or limited-use pharmacy permits** allow dispensing medications under "special, limited or unusual" circumstances

For non-Schedule VI drugs:

- The option with the greatest flexibility is the Board of Pharmacy's **Innovative Pilot Program**, which reviews and approves processes or procedures related to the dispensing of drugs that are not specifically authorized by the Code of Virginia; proposals that expand pharmacists' scope of practice are not allowed

Case Study: Piedmont Community Services Board (CSB)

Piedmont CSB serves individuals with intellectual disability, development disability, mental health, and substance use disorder challenges in Franklin, Martinsville, Henry, and Patrick counties. Their largest office-based addiction treatment (OBAT) clinic is in Franklin County, where patients receive case management, care coordination, peer recovery services, and therapy. Some patients drive up to an hour to reach the clinic for their appointments. In 2021, Piedmont CSB applied for federal State Opioid Response grant funding to launch their mobile OBAT unit. Their goal was to better support patients who were having difficulty coming into their fixed-site OBAT clinic multiple times a week for services. The mobile unit launched in June 2023.

Piedmont CSB's mobile OBAT unit operates four days a week, rotating through different locations in their service region. To determine the best service locations, they looked at their current patient population, mapped how far patients were traveling for services, and identified locations within 10 miles of areas with the highest density of patients coming for OBAT services. Sometimes the mobile OBAT care coordinator will go pick up patients who have no form of transportation to bring them to the mobile unit to receive their services. No patients who come to the clinic are turned away, and staff see patients from both walk-ins and appointments.

Staff check patients' vitals and perform basic medical evaluations, distribute naloxone, educate patients, process urine drug tests, provide therapy, and refill prescriptions for patients receiving Medication-Assisted Treatment. When patients cannot go to the pharmacy themselves to pick up their prescriptions, sometimes the peer recovery specialist or care coordinator on board the mobile unit will drive them to the nearest pharmacy. The mobile clinic operations total approximately $450,000 a year, including all staff salaries, which the CSB covers with a combination of insurance reimbursements, state funding, and grant funding.

Mobile health clinics also support providers and health systems

In addition to bringing care closer to patients and communities, mobile health clinics can be valuable in both supporting providers and reducing overall health care costs. For larger organizations, like hospital systems or health plans, mobile health clinics can be an opportunity to provide charity care, increase provider satisfaction, and generate cost savings by providing preventive care and improving patient outcomes.

Providers working and training on mobile health clinics report high satisfaction

Mobile health clinics are staffed by physicians, advanced practice providers, paraprofessionals, mental health providers, peer support specialists, outreach workers, and administrative support staff. Students sometimes get the opportunity to do clinical rotations through mobile health clinics as part of their training. Old Dominion University, Virginia Tech, and the Virginia Commonwealth University (VCU) School of Nursing all

operate mobile health clinics through which students receive clinical training and provide community services under guidance and supervision. Providers who work in a mobile health clinic as part of their clinical training report greater understanding of culturally competent care and the broader health and social care systems in which they treat patients. This can in turn help foster safe environments for patients, who feel mobile health clinic staff are "easy to talk to" and that their providers care about their well-being.

Additionally, mobile health care providers report high professional satisfaction and appreciate being able to work in patients' communities, help patients get the care they need, and build trust and better patient relationships. As such, health care leaders see mobile programs as an effective strategy for recruiting, training, and retaining staff, as well as for building community trust in their health system.

Greater efficiency and preventive care can lead to cost savings

Studies of mobile health clinics have found they can reduce overall health care costs. When patients delay care and their health care needs are not managed, they are more likely to have avoidable emergency department visits and hospitalizations. By increasing access to care, mobile health clinics can prevent negative patient outcomes and protect health systems from unnecessary costs. One study of a broad-service mobile health clinic calculated that the projected emergency department costs that their patients avoided, along with the value of potential life years saved by the preventive services patients received, created a return-on-investment (ROI) of $36 for every $1 invested. A follow-up study of the same clinic, which conservatively looked only at the potential benefits of providing blood pressure education and hypertension screenings, found a significant decrease in patients' relative risk of myocardial infarction and stroke, translating to an ROI of $1.30 for every $1 invested due to avoided emergency department visits. And current calculations by Mobile Health Map, based on self-reported clinic data, estimate a national ROI of $20 for every $1 invested across all mobile health clinics for which reported data are available.

Logistical challenges, staffing shortages, and lack of reliable funding make mobile health clinic operations difficult

Despite their strengths, mobile health clinics frequently start and stop their work due to the difficulty of sustaining operations. The ease with which they can start means it is equally as easy to shut down. Not only must they manage existing staffing and funding difficulties – common barriers to delivering health care services – but they must also manage the unique logistical challenges that come with mobile operations.

Logistics and vehicle constraints are a unique challenge for mobile health clinics

Commercial Driver's Licenses (CDL) are required for drivers of commercial motor vehicles, with some exclusions (e.g., firefighters operating emergency vehicles). Commercial motor vehicles are classified by their gross combination weight rating and size:

- Class A. Includes tractor-trailers, truck and trailer combinations, and tractor-trailer buses
- Class B. Includes straight trucks, large buses, segmented buses, school buses
- Class C. Any vehicle that is not class A or B that carries hazardous materials requiring placards OR is designed to carry 16+ occupants, including the driver

The small, contained nature of mobile health clinics is a strength for taking health care where it is needed, but presents its own set of challenges. Space constraints and lack of consistent power can limit the kinds of equipment mobile health clinics carry (e.g., portable mammography machines have lower quality imaging, some vaccinations require consistent refrigeration) or the services they can provide. Vehicles require ongoing maintenance, and costs increase as vehicles age. It can be difficult to find suitable locations to safely park for extended periods of time while addressing security concerns related to potential theft or violence as well as community concerns about patient privacy and stigma. Inclement weather can also interfere with routes and schedules.

Larger mobile health units have the space to provide more robust services – some have multiple exam rooms, imaging equipment, bathrooms, and lab space. However, larger mobile health units may require drivers with a commercial driver's license (SIDEBAR), adding another logistical challenge for the clinic to manage. Half of the mobile health clinics JCHC staff spoke with mentioned either the difficulty of finding drivers or the tradeoffs of selecting a vehicle that would not require a dedicated, professional driver. Mobile health clinics must decide between using smaller vehicles that are easier to maneuver and that staff may be more willing to drive, finding health care professionals who also have a commercial driver's license in order to operate larger vehicles, or taking on the expense of a dedicated driver who may not have much to do when the unit is parked for services.

Addressing internet deployment and adoption gaps would help facilitate telehealth-enabled mobile health clinics

Reliable internet access is important for mobile health clinic operations – one clinic JCHC staff interviewed mentioned it is one of the factors they consider when choosing sites to set up their mobile health clinic. Unreliable internet access can prevent mobile health clinics from utilizing certain types of equipment and providing some health care services. At the same time, reliable internet access can allow mobile health clinics to provide a broader array of health care services. For example, mobile health clinics can be equipped with telehealth capabilities to facilitate patient connections with primary care, advanced care, and specialty care remotely. Facilitating patient access to primary care providers and specialists through telemedicine helps patients receive appropriate care earlier, before

illnesses become exacerbated, preventing unnecessary emergency department visits, hospitalizations, and costs. Many individuals in health care deserts who would benefit from telemedicine lack the technology, digital literacy, and internet infrastructure needed to access telemedicine services, particularly in rural areas where there are gaps in broadband. Telehealth-enabled mobile health clinics can fill these gaps, expanding access to telehealth services for patients from surrounding areas. One pilot of telehealth-enabled mobile health clinics at four rural sites found that the mobile health clinics not only served patients who lived in the town, but almost half of the clinics' appointments served patients from surrounding communities as well. Several mobile health clinics JCHC staff interviewed have or plan to add telehealth capabilities to their mobile health unit.

In rural localities, it can be harder to find spaces where mobile health clinics can set up and connect to broadband. In some areas, even regular cellphone service is unreliable, creating safety concerns if the mobile unit breaks down or staff need assistance. These logistical challenges mean that while the potential benefits of mobile health clinics to rural residents can be very high, particularly to facilitate telemedicine visits with providers, mobile clinics often have greater difficulty operating in remote areas.

The Virginia Department of Housing and Community Development (DHCD)'s Office of Broadband works to expand access to broadband infrastructure to unserved areas. DHCD is the state's designee to administer and implement broadband programs under the federal Infrastructure, Investments, and Jobs Act. As part of this work, they manage Virginia's allocation of federal Broadband Equity, Access, and Deployment (BEAD) Program funding to invest in broadband affordability and adoption. While DHCD's current priority for disbursing BEAD funds is developing broadband infrastructure to ensure every household, business, and community anchor institution has reliable high speed internet access, a portion of remaining funds will be devoted to state agencies and other high-capacity partner organizations for broadband adoption programs. In preparation, DHCD is currently identifying state needs and priorities – such as telehealth, smart farming, and digital literacy, as well as other innovative broadband adoptions programs.

➔ **Option 2:** The Joint Commission on Health Care could introduce legislation directing the Department of Housing and Community Development to include broadband access services for mobile health clinics as a priority for broadband adoption programs using Broadband Equity, Access, and Deployment Program funding, as part of the Department's broader initiative to support other telehealth adoption programs.

Staffing can be a challenge for mobile health clinics

Almost half (six of thirteen) of the mobile health clinic providers that JCHC contacted cited staffing and workforce difficulties as one of the largest barriers to operating a mobile health unit. This is not only because of current health care workforce shortages, but also because it is important to find staff who are drawn to mobile health clinic work and interested in going into communities to serve patients. One FQHC mobile health clinic JCHC staff spoke

with noted that it can be difficult to find staff who want to be on the move all the time, particularly as sometimes they need to make trips that take up to four hours, such as when they are traveling from Franklin County to Grayson County. One national survey of mobile health clinic providers found that one-third of respondents reported difficulties with staffing, whether related to recruitment and retention or balancing the right mix of staff. Mobile health clinics need to recruit providers who are culturally competent, willing to go into underserved neighborhoods, experienced, and comfortable working in a small space on a vehicle. And with limited available space, mobile clinics must prioritize which staff to have on board the unit, which can limit their operations. For example, Richmond-Henrico Health District noted that while their fixed-site clinics have Office Support Specialists to help process patient eligibility and paperwork, they aren't available on their mobile health clinics, making it difficult to manage billing.

Labor costs are the largest expense for mobile health clinics. Advanced practice providers and doctors are more expensive to keep staffed on mobile health clinics, which often have lean finances. Staff with less training are more affordable but may not be qualified or credentialed to provide all services that patients need (e.g., mobile clinics cannot run blood lab work if there are no staff who can draw blood). One mobile health clinic JCHC staff interviewed noted that their prescriber is often at capacity, but that they lack the funding to cover the costs of bringing in another provider who can prescribe. Another organization whose mobile health clinic is currently dormant challenged that mobile health clinics and outreach models that entail putting highly paid providers into vehicles and sending them out into the community are not sustainable.

State-funded mobile health clinics provide services to vulnerable populations throughout the state, both through specific contracts and through general funding that supports agency operations of mobile health clinics. General Assembly actions include:

- Annual appropriations to The Health Wagon (from 2006 through 2024) to provide services and summer outreach to low-income and uninsured individuals living in southwest Virginia
- In 2022, DMAS was required to revise contracts with Medicaid managed care organizations to include mobile vision clinics to provide services to eligible children in Virginia schools
- General funding to local health departments and community services boards, which operate mobile health clinics
- General funding to DBHDS, which operates a mobile dental clinic for individuals with developmental disabilities who are unable to receive treatment in regular dentist offices

Revenue generation is not reliable with mobile health clinics

While mobile health clinic services have been found to create cost savings through preventive care, patient education, and management of patients' chronic conditions, the savings can be difficult to quantify and often are not realized by the mobile health clinic but instead are long-term reductions in health care utilization and costs. Many organizations JCHC staff spoke with purchased their mobile health units with one-time grant funding. This is very common, but the lack of ongoing funding sometimes leaves mobile health clinics struggling to sustain operations after their one-time funding is spent and may eventually force them to discontinue services when they are unable to find a

reliable revenue stream. Mobile health clinics generally rely on a mix of funding sources in order to sustain operating costs: charity/philanthropic funding, state or federal funding (SIDEBAR previous page), insurance reimbursement, and patient payments. Providers may want to try to bill insurance if patients have coverage; however, mobile health clinics often serve uninsured or underinsured patients, and don't serve enough patients with commercial insurance to fully subsidize costs. As a result, they are reliant upon grants and government funding to help bridge the gap. JCHC staff frequently heard of mobile health clinics starting with one-time grant funding, but quickly realizing they did not have enough sustained funding to manage ongoing operational costs. One stakeholder mentioned they knew there were clinics that had mobile health units that were left "sitting" and not being used.

Even if patients have insurance or are willing to pay out of pocket, depending on the area and service type, patient volume can be too low for mobile health clinics to see any profits. Clinics require a certain service/patient volume to recoup their infrastructure costs and particularly in rural areas, mobile health clinics often will not see the kinds of volume they would need to be profitable. One mobile health clinic provider felt low patient volumes also made it challenging to secure grant funding because, compared to more densely populated areas, they were serving a smaller number of individuals in their rural localities.

➔ **Option 3:** The Joint Commission on Health Care could introduce a budget amendment to establish a grant program administered by the Virginia Department of Health supporting mobile health clinics operated by local health departments and community-based organizations that provide services in rural and underserved areas.

Chapter 3: Community Paramedicine

Emergency medical services (EMS) providers are increasingly being utilized in non-traditional roles and settings to assist with providing public health, primary health care, and preventive services through community paramedicine programs. Implementation of community paramedicine programs can expand access to health care by improving the acceptability, availability and accommodation, and affordability of health care. The idea of community paramedicine is not new, originally emerging in the United States in the 1990s as a strategy to use EMS providers to improve access to care for underserved rural populations. However, the model's popularity has grown in recent years, both nationally and in Virginia. As of 2023, community paramedicine programs have been reported in over 40 states.

In 2015, the Virginia Department of Health (VDH) convened a workgroup of stakeholders interested in exploring community paramedicine models within Virginia. The workgroup met periodically between 2015 and 2020 and issued guidance for EMS agencies that wished to begin providing community paramedicine services. The guidance recognized the existence of two similar models of providing health care services that utilize EMS providers in non-traditional roles:

- **Community paramedicine (CP)** programs use paramedic-level EMS providers operating in expanded roles to assist with public health and primary health care.
- **Mobile integrated healthcare (MIH)** programs use multi-disciplinary care teams, which may include many levels of EMS providers including emergency medical technicians and paramedics, as well as other health care professionals.

While the two models differ, the terms are often used interchangeably or referred to collectively as mobile integrated healthcare-community paramedicine (MIH-CP). For brevity, this report will use the term "community paramedicine" as an umbrella term to refer to the use of EMS providers in non-traditional roles, with the caveat that the two models do have distinct differences.

Community paramedicine programs are an increasingly popular model for utilizing EMS providers in new roles

EMS providers are first responders trained in emergency medical care. They are certified by the Commissioner of Health and often affiliated with an EMS agency, which must be licensed by the Commissioner. EMS agencies are typically combined or work in coordination with a fire company or fire department. Traditionally, EMS providers' role is to stabilize seriously injured or ill patients before transporting them to the hospital. When EMS providers arrive at the scene, they assess individuals, identify patients' emergent needs, and provide pre-hospital emergency care. Community paramedicine programs have

grown with increased recognition that EMS providers are well suited to operate in expanded roles given their skill sets, status as trusted community first responders, and the patients they serve.

Community paramedicine provides an alternative to traditional EMS services

Community paramedicine programs use EMS providers to increase community members' access to primary care, facilitate linkages to services that address patients' health-related social needs, and reduce inappropriate use of emergency care resources. Program participants are connected to community paramedicine programs in different ways. In some models, potential participants are identified by EMS personnel or health care providers and selected for participation because they meet certain criteria, e.g., unhoused individuals, older adults with fall risk. In other program models, 911 dispatchers triage calls to the emergency line and refer low-acuity calls to a community paramedicine response team rather than to traditional EMS. In Virginia, most community paramedicine programs use the first approach, scheduling non-emergent home visits with participants that agree to enroll in the program. Only one community paramedicine program in Virginia, operated by the Arlington County Fire Department, responds directly to low-acuity 911 calls and requests non-emergent resources in real-time.

Community paramedicine programs do not replace traditional EMS services available to residents – they are an expansion of services on top of existing EMS responsibilities. EMS agencies are expected to be able to respond to 100 percent of all emergent calls in their primary service region before expanding their services to community paramedicine.

Virginia has at least 26 community paramedicine programs

Joint Commission on Health Care (JCHC) staff identified 26 community paramedicine programs across the state (TABLE 3-1). The majority are operated by a city or county EMS agency, although three are operated by EMS agencies owned by a hospital system – Centra Health, the University of Virginia Medical Transport Network, and Valley Medical Transport.

TABLE 3-1: JCHC staff documented 26 MIH-CP programs across the state

EMS Agency	Locality
Alexandria Fire Department	Alexandria
Arlington County Fire Department	Arlington County
Centra Health	Lynchburg
Chesapeake Fire Department	Chesapeake
Chesterfield Fire and EMS	Chesterfield County
City of Harrisonburg Fire Department	Harrisonburg
City of Williamsburg Fire Department	Williamsburg
Danville Life Saving Crew	Danville
Emergility	Alexandria
Fairfax County Fire and Rescue	Fairfax County
Franklin County Department of Public Safety	Franklin County
Gloucester Volunteer Fire and Rescue Squad	Gloucester County
Hampton Division of Fire and Rescue	Hampton
Henrico County Division of Fire	Henrico County
Loudoun County Fire and Rescue	Loudoun County
Madison County Emergency Medical Services	Madison County
Martinsville Fire and EMS	Martinsville
Portsmouth Fire, Rescue, and Emergency Services	Portsmouth
Suffolk Fire and Rescue	Suffolk
University of Virginia Medical Transport Network	Charlottesville
Valley Medical Transport	Winchester
Virginia Beach Emergency Medical Services	Virginia Beach
Westmoreland County Department of Emergency Services	Westmoreland County
Winchester Fire-Rescue Department	Winchester
Wintergreen Rescue Squad	Nelson County
York County Fire and Life Safety	York County

SOURCE: JCHC analysis of OEMS program documents, EMS provider websites, and local news, 2024.

NOTE: Other localities may have operated community paramedicine programs in the past which were discontinued. There may also be additional programs that JCHC staff were unable to identify.

Virginia's community paramedicine programs most frequently serve individuals who have been identified as frequent 911 callers by the EMS agency, or individuals with chronic diseases or complex medical needs at high risk for hospitalization (TABLE 3-2). They are focused on reducing the burden of low-acuity calls to 911, decreasing unnecessary emergency department transports and reducing hospitalizations and readmissions.

TABLE 3-2: Community paramedicine programs in Virginia most frequently target individuals with complex medical needs

Target Populations/Areas of Focus	Number of Community Paramedicine Programs
High-need/high-risk/chronic disease	12
Frequent utilizers of 911 system	10
Fall risk/older adults	9
Mental health/substance use disorder	7
Social determinants of health	7

SOURCE: JCHC analysis of available community paramedicine program documents, EMS provider websites, and local news, 2024.

NOTE: Target population information was only available for 22 community paramedicine programs. Categorizations are not mutually exclusive as many programs had multiple focus areas and target populations.

Efforts to strengthen oversight of community paramedicine programs in Virginia are underway

Currently, Virginia does not regulate community paramedicine programs. EMS agencies operating a community paramedicine program may submit Notice of Intent paperwork to the VDH Office of Emergency Medical Services (OEMS). OEMS program leadership review the program details and coordinate with the VDH Office of Licensure and Certification (OLC), which reviews the proposal to ensure the community paramedicine program operations stay within EMS scope and do not encroach on home health agency services. However, this submission of Notice of Intent and review by OEMS and OLC is voluntary for community paramedicine programs. As of July 2024, OEMS had reviewed paperwork for 18 of the 26 community paramedicine programs JCHC staff identified (see APPENDIX C for each program's status with OEMS). Because the Notice of Intent process is voluntary, and community paramedicine programs are not subject to reporting requirements, it is difficult to get a clear picture of how many community paramedicine programs are in operation throughout the state.

OEMS has prepared draft regulations that could address some of the gaps in oversight of community paramedicine programs in Virginia. The draft regulations are currently under review by the Governor. If the draft regulations are approved, all community paramedicine programs will be required to submit Notice of Intent paperwork to OEMS, with details on program implementation, patient interaction, staffing, training, protocols, and data, so that there is greater oversight. Additionally, the regulations will clarify that:

- Only licensed EMS agencies may operate mobile integrated health care or community paramedicine programs,

- Community paramedicine programs must have a state-certified paramedic staffing the EMS vehicle at all times, and
- Mobile integrated health care EMS vehicles may not be used for patient transportation except for major medical emergencies.

In the meantime, under current regulations, reporting will remain a voluntary process and EMS agencies will not need to seek approval from OEMS or undergo additional review by OLC for their community paramedicine programs.

➔ **Option 4:** The Joint Commission on Health Care could introduce legislation directing the Virginia Department of Health's Office of Emergency Medical Services to report to the Joint Commission on Health Care by October 1, 2025, regarding the status of draft regulations related to community paramedicine and mobile integrated healthcare.

Community paramedicine programs can be tailored to support specific vulnerable and underserved populations

Community paramedicine programs offer a wide variety of services. They may provide primary and preventive care, home safety checks and fall prevention services, resource referrals, patient education, or post-hospital follow-up care. Some community paramedicine programs facilitate patient telehealth visits with their healthcare provider. Similar to traditional EMS, community paramedicine programs often coordinate with law enforcement and local health systems. However, in addition to these traditional partnerships, they may also work closely with social services, local health departments, and other community-based organizations.

Community paramedics extend patient access to primary and preventive care

EMS providers working with community paramedicine programs can serve as physician extenders and public health professionals, bringing care directly into patients' homes. They can collaborate with physicians, nurses, physician assistants, pharmacists, and social workers to provide disease management, care coordination, health assessments, medication management, and health education. They can provide clinical care directed by physicians or other advanced care practitioners. During the COVID-19 pandemic, community paramedicine programs were able to provide disease surveillance and testing to patients in congregate living facilities, as well as serve people experiencing homelessness.

Patients enrolled in community paramedicine programs report better mobility and self-care, reduced pain, depression, and anxiety, increased engagement in their own health care, better management of chronic health diseases, and improved quality of life. They value the interpersonal nature of the care they receive in community paramedicine programs and report high satisfaction. Some patients perceive the care they receive from community paramedicine providers to be higher-quality and have reported that they would prefer

future urgent care in the home with community paramedics rather than in the emergency department. Patients who lived in health districts with high health disparities who participated in one community paramedicine program in which EMS providers brought technology to patients' homes to enable telehealth consultations with emergency physicians appreciated that the program eliminated transportation barriers, felt more engaged with the health system, and demonstrated improved health literacy.

Case Study: Chesterfield Fire and EMS Community Paramedicine

Chesterfield Fire and EMS established its community paramedicine program in 2014, making it one of the longest-running programs in the state. With the goal of alleviating strains on both the 911 system and emergency departments, they target older adults and individuals in poverty who utilize 911 for non-emergent calls. The community paramedicine team, comprised of paramedic firefighters and a peer recovery specialist from the Chesterfield County Community Services Board (CSB), works with participants to facilitate resource referrals and connection to psychosocial supports. Through participant tracking and data collection, they have seen a reduction in call volume from frequent utilizers of the 911 system as measured by participant calls before, during, and after enrollment in the community paramedicine program.

EMS crews also refer individuals with substance use disorder to the program if they respond to an overdose call or administer Naloxone (a medicine that reverses opioid overdose) to someone in the field. The community paramedicine team follows up and offers a Suboxone bridge program for patients that want a pathway to long-term opioid addiction recovery services. They evaluate patients' medical needs and withdrawal possibilities, refer them to area treatment centers, and facilitate telemedicine appointments with the agency's medical director, who will write short-term prescriptions for Suboxone to help bridge patients until they can receive a long-standing Suboxone prescription at their treatment center appointment. The team works with the Chesterfield County CSB to help patients receive their medications, even if they do not have insurance or if cost is a barrier.

Beginning in February 2024, Molina Healthcare began contracting with Chesterfield Fire and EMS' community paramedicine program to serve a target list of Molina plan members who may benefit from additional support. Molina reimburses the agency for each home visit made by the community paramedicine team.

Community paramedicine programs effectively facilitate patient access to psychosocial supports

Community paramedicine programs can ensure patients who are eligible for health insurance or affordability programs are enrolled, helping to expand patients' access to providers. They may also link patients to other community resources and social supports to assist with nutrition, housing, utilities, and transportation. Community paramedicine programs may also provide case management or care coordination services for program participants to facilitate care and improve outcomes. For example, patients with substance use disorder who have a history of overdose may receive case management, referral to

additional medical care and social supports, or transport to treatment facilities. An evaluation of one community paramedicine program that provided care coordination services found that fully addressing patients' care coordination needs was significantly associated with reduced 30-day readmissions of high-risk patients.

While community paramedicine programs may provide mental health supports, or target patients with mental health needs or substance use disorder, community paramedicine programs in Virginia are distinct from mobile crisis response and alternative transport (see APPENDIX D for more detail on differences).

Community paramedicine programs help relieve pressure on emergency departments and 911 systems

EMS agencies are facing growing resource constraints as they try to manage workforce shortages and increased call volume from community members. Emergency calls to 911 in Virginia have been steadily increasing and grew by 40 percent between 2021 and 2023. Studies have shown that up to one-third of EMS calls may be medically unnecessary and do not lead to patient transport to the emergency department – even among those who are transported, a significant portion could have been effectively treated outside of the emergency department. One study of Medicare beneficiaries who called 911 estimated up to 16 percent of EMS transports involved conditions that were likely non-emergent or could be treated by primary care. Another study of pediatric patients transported to the area pediatric emergency department found one-third of transports were for low-acuity complaints.

Community paramedicine programs have been proven to significantly reduce unnecessary emergency call volume and immediate ambulance transports to the emergency department. One program that targeted individuals who had called 911 three or more times in the past 90 days found an overall average decrease in 911 utilization of 25 percent, with most participants significantly reducing their call rate. Another program targeting high-risk patients referred by clinicians and individuals who had called 911 five or more times in the past six months saw that within the first 30 days of participation in the program, participants' 911 calls reduced by 74 percent and requested transports dropped by 77 percent. In both programs, the results were not universal or permanent, potentially due to the complexity of some patients' conditions and their need for sustained multi-disciplinary care.

Community paramedicine programs can also reduce subsequent emergency department visits, readmission rates, and inpatient utilization. One analysis found that community paramedicine programs result in a 44 percent reduction in emergency department visits, and 54 percent reduced risk of hospital admission. Studies also suggest that while patients enrolled in community paramedicine programs have decreased health care utilization, with fewer 911 calls and fewer transports to the emergency department, the effects decrease or

disappear once patients are no longer part of the program. This is understandable as these programs usually target patients with complex medical, behavioral, and social needs that are unlikely to be resolved by short-term participation in a community paramedicine program.

Participant use of health care resources may shift but not decline

While community paramedicine programs can reduce unnecessary emergency department utilization, they do not necessarily mean that patients are using less health care resources generally. One study found that patients with a history of high utilization who enrolled in medical management with a community paramedicine team had significantly decreased primary care clinic utilization and emergency department visits. However, when visits from community paramedicine providers were counted, those patients had more touch points with the health care system than before the program. Additionally, community paramedicine programs may facilitate increased access to health care for patients who may not have sought care in the past. This can result in increased doctor visits, screenings, and non-emergent utilization as patients seek care. Finally, several community paramedicine programs have found some participants may sometimes make more calls to EMS when they are enrolled in the program, perhaps due to increased comfort with and reliance on their EMS providers.

Funding and capacity are the largest limiters for community paramedicine programs

Most community paramedicine programs cite funding as a significant obstacle to their operations. A 2023 national survey of EMS agencies found that among those who were not operating a community paramedicine program, almost half reported they never initiated a program due to funding challenges. More than one-third of those who had operated a program but discontinued it reported it was due to loss of funding, staffing, or resources. A 2017 national survey of community paramedicine programs found that while some EMS agencies were able to generate revenue to support their program, most brought in very little to no revenue.

The cost-effectiveness of community paramedicine is unclear

The wide variability of community paramedicine programs makes it difficult to determine their cost-effectiveness. A few assessments have found that community paramedicine programs costs are "equivalent to or less than usual paramedic care." However, studies of program costs have been inconsistent and most studies of community paramedicine programs do not quantify savings at all. While savings from reduced emergency department visits and EMS utilization can be expected in successful community paramedicine programs, additional data and evaluation are needed to determine the scope of those savings. Studies have demonstrated that community paramedicine providers

spend less time on scene at the patient's home than traditional EMS providers and community paramedicine program ambulances have shorter return-to-service times than traditional ambulances, allowing them to improve program efficiency and respond to additional EMS calls. One study of return on investment (ROI) for a community paramedicine program operated by a statewide insurance group calculated an ROI of nearly $3 for every $1 invested in the program. However, analysis of another community paramedicine program concluded that their program was not cost-effective at all.

Additionally, effective community paramedicine programs that reduce emergency department utilization and readmissions ultimately generate the greatest cost savings for the patient, health plan, and hospital system, rather than for the EMS agency. Because savings accrue to entities other than the EMS agency, it is difficult to determine whether community paramedicine programs offer any cost-benefit for EMS agencies that operate community paramedicine programs.

Case Study: Centra Health Community Paramedicine

Centra Health's community paramedicine program targets community members that have been diagnosed with one of four chronic diseases – chronic obstructive pulmonary disease, congestive heart failure, hypertension, or diabetes – as well as those who have had multiple admissions to the hospital in the past year. Patients who are enrolled in the program receive home visits, where paramedics check patient vital signs, review medications, assess home safety, and address other barriers patients may face (e.g., difficulty getting to the grocery store, need for nutritional planning). Program staff make weekly visits over a four to six-week period. In 2023, the program enrolled 589 patients.

The community paramedicine program was funded by Centra Health and the Centra Foundation, with start-up costs of approximately $350,000. Analysis of 2023 data compared participants' health care utilization in the 180 days before and 180 days after enrolling in the community paramedicine program. In a sample of 335 patients, there was a 76 percent decrease in inpatient admissions, 44 percent decrease in emergency department visits, and 75 percent decrease in readmissions.

Program staff estimate that based on penalties Centra Health would have had to pay for individuals who were readmitted, as well as write-offs the hospital likely would have had to make for care provided to patients with public insurance or no insurance, the community paramedicine program has saved Centra Health four to five million dollars since its inception in 2015.

Current EMS reimbursement models do not support community paramedicine

Community paramedicine programs usually rely on some combination of grants, local funding, and health system funding to sustain operations. Traditionally, EMS agencies only receive reimbursement from health insurance when patients request 911 emergency services and are transported to the emergency department. This creates a strong disincentive for providers to manage non-emergent and lower acuity needs on scene, rather than transporting the patient.

In 2021, the Centers for Medicare and Medicaid Services (CMS) tested a pilot community paramedicine reimbursement program for Medicare enrollees – the Emergency Triage, Treat, and Transport (ET3) Model. The ET3 Model reimbursed participating EMS agencies for transporting Medicare patients to alternative destinations or initiating treatment in place with a qualified health care provider. Unfortunately, the pilot ended early, in December 2023, due to lackluster participation and traction.

The lack of opportunity to seek reimbursement from third-party payers for services provided hinders community paramedicine programs. Programs generally do not charge individuals for services provided, either. In cases in which community paramedicine programs do charge individuals for ambulance response to calls that do not result in a transfer to the emergency department, the charge is much lower than the actual cost of responding to a call. Two programs JCHC staff spoke with charged between $125-150, although one program noted that if the patient's insurance does not cover the bill, then they do not pass the cost on to the individual. This means that in many cases, EMS agencies absorb the cost of their community paramedicine programs, community paramedicine programs are self-funded, or funding comes from a health care system.

Additionally, community paramedicine programs must operate in addition to regular EMS services. Guidance from OEMS clearly states that EMS agencies are expected to be able to respond to all regular EMS calls before expending additional resources to operate community paramedicine programs. Therefore, only EMS agencies with extra resources and capacity are able to start and sustain community paramedicine programs. In areas where EMS capacity is low and agencies are challenged to meet demand for traditional EMS services, EMS agencies are unlikely to operate community paramedicine programs. EMS agencies that face financial barriers to establishing community paramedicine programs may benefit from start-up funding to help launch their programs. Grant funding could help bridge the gap until community paramedicine programs are able to build their systems and capacity to cover the cost of providing services or find reliable reimbursement opportunities.

➔ **Option 5:** The Joint Commission on Health Care could introduce a budget amendment to establish a grant program or expand an existing grant program administered by the Virginia Department of Health's Office of Emergency Medical Services to provide funding to emergency medical services agencies for community paramedicine and mobile integrated healthcare programs.

Medicaid is the most frequent payer of community paramedicine programs nationally

While some commercial health plans allow EMS agencies to bill for community paramedicine programs serving plan members, Medicaid is still the most frequent payer for community paramedicine programs. When CMS announced the ET3 model, it also released guidance to encourage states to take advantage of flexibilities that would allow them to

structure Medicaid reimbursements in alignment with the Medicare ET3 Model. CMS has created a billing code – Healthcare Common Procedure Coding System (HCPCS) Code A0998, for treatment without transport – that can be applied when EMS providers arrive on scene and address patient needs without transporting individuals to the emergency department. Some state Medicaid programs reimburse EMS agencies for services billed under HCPCS Code A0998 for treatment without transport to the emergency department or for other community paramedicine services.

Medicaid covers treatment without transport in more than half of states

A 2019 Medicaid rate survey conducted by the American Ambulance Association reported reimbursement for treatment without transport – HCPCS Code A0998 – in at least 19 states. JCHC staff identified an additional seven states that allow Medicaid reimbursement for ambulance treatment and response without transport. Reported Medicaid reimbursement rates ranged from $420.62 in Oregon to $30.00 in Georgia. In 2023, Georgia submitted intent to increase their reimbursement rate for treatment without transport from $30.00 to $753.35 effective January 1, 2024, pending CMS approval. In Virginia, Medicaid does not reimburse for EMS treatment without transport.

States also have the flexibility to design their own reimbursement models for EMS services provided to Medicaid enrollees. **Arizona** established a Treat and Refer (T&R) Recognition program for Medicaid enrollees who call 911 but do not have an illness or injury that requires ambulance transport. EMS agencies accepted to participate in T&R can receive reimbursement to provide an appropriate clinical or social evaluation; refer patients to a primary care physician or specialist, crisis response, behavioral health provider, or urgent care; and follow up with the patient to check on adherence with the treatment plan. The state fiscal year (FY) 2025 rate was set at $268.72. **Washington** modeled their Treat and Refer program after Arizona's program. Eligible agencies participating in the Washington model receive $115 for treating and referring Medicaid clients who call 911 to a licensed health care provider, crisis response, urgent care, or other appropriate care.

➔ **Option 6:** The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to cover HCPCS Code A0998 treatment without transport when Medicaid patients call 911.

Community paramedicine programs may bill for services that are ordered by patients' physicians in some states

Some states provide reimbursement for non-emergent community paramedicine services that are not triggered by a 911 call. These models focus on services for participants who have been identified as needing additional supports and enrolled in a community paramedicine program.

Minnesota covers community paramedicine services for Medicaid enrollees who have either received emergency department services three or more times in a four-month period

within the past year or been identified as eligible by their primary care provider, with the goal of preventing admission or readmission to a hospital or nursing facility. Covered services must be part of a care plan ordered by the patient's primary care provider, and delivered in coordination with other agencies to ensure there is no duplication of services. **Nevada** also covers medically necessary community paramedicine services that are part of a care plan ordered by a patient's primary care provider. Services may include health assessments, chronic disease monitoring and education, medication compliance, vaccinations, discharge follow-up care, minor medical procedures within scope of practice, home safety assessments, and acting as a telehealth originating site. Reimbursement does not cover travel time, mileage, personal care services, duplicated services, or ambulance transport for medical emergencies.

Eight states allow EMS agencies to provide transportation to alternative destinations

While no community paramedicine programs in Virginia currently provide transportation to alternative destinations, it is a popular model in programs nationally and was encouraged by CMS during the COVID-19 pandemic, as well as through the ET3 Model. **Maryland** provides Medicaid reimbursement for transport of patients to alternative destinations, such as an urgent care center or Federally Qualified Health Center. At least seven other states – Arizona, California, Delaware, Illinois, Louisiana, New Mexico, and Ohio – also provide Medicaid reimbursement for EMS agencies that transport patients to alternate destinations.

Community paramedicine providers may be allowed to bill for individual services provided as part of non-emergent care at home

States may design their reimbursement of community paramedicine services as broadly or granularly as they like. In some states, like **Maryland**, community paramedicine providers use the HCPCS Code A0427 for treatment in place for all non-emergent community paramedicine services they provide to program participants in their home or other community-based setting. Others, like **Nevada**, allow community paramedicine providers to bill a variety of specific codes, depending on the services provided. For instance, Nevada allows community paramedicine programs to bill for administering immunizations (HCPCS Code 90471), 60-minute home visits for new patients (HCPCS Code 99344), and a telehealth originating site facility fee for facilitating telemedicine visits (HCPCS Code Q3014), among others.

The General Assembly has considered legislation to allow community paramedicine providers to bill for services

Two Virginia programs JCHC staff spoke with expressed desire for EMS providers to be able to bill more granularly for medical services provided as part of community paramedicine

programs. Senate Bill 1226 (Chase), introduced during the 2019 Session of the General Assembly, would have allowed community paramedicine programs to bill for home health services provided by EMS providers under direction from a patient's physician, nurse practitioner, or physician assistant. The Department of Planning and Budget's fiscal impact statement for SB 1226 noted that the Department of Medical Assistance Services expected the additional costs to cover these expanded services would be offset by decreases in emergency department costs; however, the legislation was not adopted.

➔ **Option 7:** The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to work with the Virginia Department of Health's Office of Emergency Medical Services to develop a plan for reimbursing community paramedicine and mobile integrated healthcare services in Virginia, in consultation with community paramedicine programs and other stakeholders including hospital systems and health plans. The plan should specify the circumstances under which services would be covered; eligible patient populations; eligible providers; whether the model would require a State Plan Amendment or modification of MCO contracts; and whether reimbursement would be a flat fee or allow billing for individual services. The Department of Medical Assistance Services would report to the Joint Commission on Health Care by October 1, 2025, regarding the content of the plan.

Participation in the federal Ground Emergency Medical Transportation program may support general capacity building for EMS agencies

OEMS guidance makes clear that EMS agencies should be able to effectively respond to 100 percent of the 911 calls in their region before establishing community paramedicine programs. However, many rural localities face significant funding and resource constraints that limit their capacity to expand EMS services to accommodate community paramedicine programs. As a result, residents in many rural localities of Virginia do not have access to community paramedicine.

EMS agencies' financial challenges and financial barriers to implementation of community paramedicine programs are exacerbated in many rural areas by the patient mix. Rural EMS agencies are more likely to serve and transport individuals with Medicaid insurance than in urban or suburban areas. An analysis of 2020-2021 county-level Medicaid coverage estimates found that of Virginia adults aged 19-64 years, 11 percent of those living in metro counties had Medicaid coverage compared to 18 percent of those in small towns/rural areas (counties with populations of less than 50,000 people). Children's Medicaid/CHIP coverage also varied, covering 29 percent of children in Virginia's metro areas compared to 45 percent of children in small towns/rural areas. Medicaid reimbursement for EMS is not always sufficient to offset the cost of providing those services. The Ground Emergency Medical Transportation (GEMT) program is a federally funded EMS supplemental payment program intended to cover unreimbursed costs when EMS providers transport Medicaid patients (SIDEBAR next page).

Virginia's participation in GEMT could provide additional support to all EMS agencies, but may be especially beneficial for rural localities, who are serving a disproportionate share of Medicaid enrollees. The GEMT program may provide an additional funding stream that could help build EMS agency capacity generally, as well as support their ability to launch or sustain community paramedicine programs.

Ground Emergency Medical Transportation (GEMT) program provides federal supplemental payments to EMS agencies to cover a portion of the gap between the amount Medicaid reimburses for transport of a Medicaid patient and the actual costs to the EMS agency of the transport, which are usually much higher. The voluntary program is only available to publicly owned/operated EMS agencies. Costs related to general fire and rescue activities are not eligible. States must submit a State Plan Amendment for the GEMT program.

➔ **Option 8:** The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to seek approval from the Centers for Medicare and Medicaid Services for implementation of the Ground Emergency Medical Transportation (GEMT) program in Virginia, to allow emergency medical services providers in Virginia to receive supplemental reimbursement for uncompensated costs related to the transfer of Medicaid patients.

Chapter 4: Home Visiting

Home visiting focuses on promoting positive parenting and child development, preventing child maltreatment, and improving family health. Home visiting programs aim to support expectant and new parents who live in communities at risk for poor maternal and child health outcomes by connecting them to a trained family support professional who provides customized coaching and guidance during pregnancy, the postpartum period, and the early stages of a child's development. The home visitor engages the family to develop a care plan, provide education to the parent or caregiver, identify the appropriate service referrals, provide necessary screening and monitoring for developmental benchmarks, and provide appropriate follow-up as needed. Home visiting programs can improve the approachability, acceptability, and appropriateness of health care services, expanding access to health care for program participants.

Mandatory home visiting programs operated through local departments of social services are excluded from this study. Local departments of social services conduct certain required home visiting with families to ensure safety, health, and well-being through child protective services when there are reports of suspected child abuse or neglect, to support agency placement adoption, and for certain foster care programs.

All home visiting programs are voluntary and usually offered through local non-profit organizations, health systems, and public agencies. These voluntary maternal and early childhood home visiting programs are distinct from home visiting activities that occur within the child welfare system (SIDEBAR). Virginia's Medicaid managed care organizations currently offer their own high-risk maternity and infant programs that may include home visiting services to beneficiaries. While these may be similar to the programs described in this chapter, Joint Commission on Health Care (JCHC) staff focused this report on programs that receive state general funds and have a primary focus on home visiting.

Eight home visiting models have been implemented in Virginia

Eight home visiting models have been implemented in Virginia (TABLE 4-1) under the oversight of Early Impact Virginia (EIV) (SIDEBAR). Though there are similarities across home visiting models, they may vary with regard to their purpose, enrollment length, provider delivering home visiting services, intended target population, and the available evidence that supports its effectiveness. Local organizations determine which home visiting model to implemented as part of a home visiting program by considering their own community's needs, characteristics, and available resources.

Early Impact Virginia (EIV) is a public-private partnership created in 2007 to support all of Virginia's voluntary home visiting programs by coordinating efforts across programs to ensure that families are connected to appropriate services. Since 2019, EIV has been required to annually report to the General Assembly on key outcomes across Virginia's home visiting program; support continuous quality improvement, training, and coordination across programs; and conduct statewide needs assessments at least once every three years.

TABLE 4-1: Early Impact Virginia oversees the eight home visiting models operating in Virginia

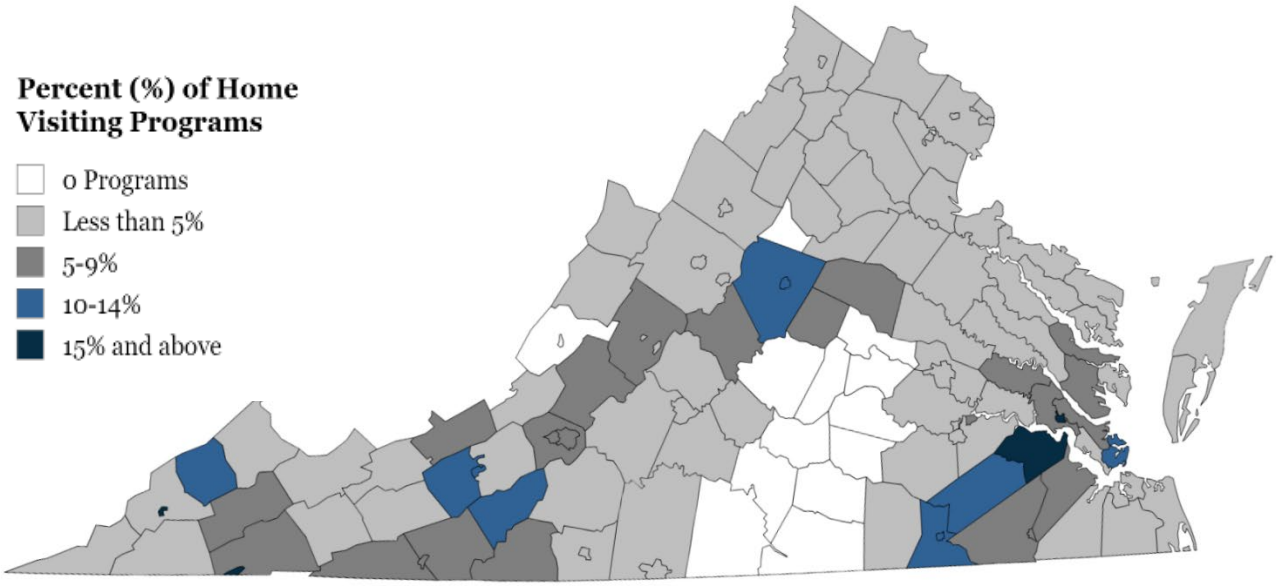
Model	Goal	Eligibility	Visit Frequency
CHIP of Virginia	Promotes healthy pregnancy and positive child development by pairing families with integrated teams of registered nurses and parent educators	Prenatal to age 6	Twice monthly, depending on location
Family Spirit	Combines community-based health educators and home visitors to deliver a culturally focused, strengths-based curriculum to support caregivers during pregnancy and early childhood	Prenatal to age 3	Weekly until 90 days post-partum, then bi-weekly
Healthy Families Virginia	Reduces risks and builds resiliency so families can raise healthy children who are ready to learn	Prenatal to age 5	Weekly initially, then depending on needs
Healthy Start/Loving Steps	Reduces infant mortality and perinatal health disparities by delivering high-quality, effective prevention strategies primarily to African American and Hispanic families	Prenatal to age 18 months	Weekly for high-risk clients
Nurse-Family Partnerships	Pairs nurse home visitors with first-time mothers who face major barriers to accessing resources and supports	Prenatal to age 2, first-time mothers	Flexible depending on needs
Parents as Teachers	Promotes optimal early development, learning, and health of young children by supporting and engaging their parents as caregivers	Prenatal to age 5	Monthly to twice monthly, depending on needs
Virginia Head Start Association	Nurtures healthy attachments between parent and child and child and caregiver	Prenatal to age 3	Weekly
Virginia Resource Mothers	Aims to lower infant mortality and low birth weight rates among Virginia's pregnant and parenting teens. Community health workers serve as a mentor to support transition to parenthood.	Prenatal to 12 months, teens age 19 years or younger	Twice Monthly

SOURCE: Early Impact Virginia and JCHC staff review of program documentation, 2024.

Home visiting programs served fewer children in fiscal year 2024 than in fiscal year 2023 due to limited organizational capacity and workforce challenges

According to EIV, 68 local early childhood home visiting programs serve 120 (92 percent) Virginia localities. Despite service availability in most localities, home visiting programs meet less than 5 percent of the need for services in most localities due to limited organizational capacity (FIGURE 4-1). In state fiscal year (FY) 2024, approximately 6,744 children were served by seven of the eight home visiting programs overseen by EIV. The total number of children served by an eighth program, Family Spirit, was not available. The number of children served in FY 2024 represents a 9 percent decrease in the total number of children served from FY 2023, when 7,245 children were served by the same programs. Service disruptions, site closures, and loss of home visiting staff may explain the decrease in the number of children served through home visiting programs during this period. EIV reports home visiting programs in Virginia lost five percent (n=27) of staff in the last year, consistent with an overall trend of reduction of staff in the last five years.

FIGURE 4-1. Home visiting providers meet less than 5 percent of community need in most localities



SOURCE: Early Impact Virginia and JCHC staff review of program documentation, 2024.

Two state programs provide home visiting services as part of a broader focus on high-risk populations but are not considered home visiting models

Project LINK is a state program run by the Department of Behavioral Health and Developmental Services and locally administered by 14 community services boards across the state. The program is funded through a federal substance use and mental health services block grant. Project LINK is an intensive case management program that provides

gender-specific services to pregnant and parenting women, particularly those who have given birth to a substance-exposed infant. Individuals are referred to the program through child protective services, hospitals, community services boards, and other community providers. The goal of the program is to reduce substance use and co-occurring behavioral health needs among pregnant, postpartum, parenting, and at-risk women by coordinating substance use, mental health, medical, and social services. The program provides community referrals, case management, linkages to prenatal care, a cadre of substance use disorder and mental health services, linkages to childcare, and transportation services to attend treatment. Project LINK offers home visiting services for program participants, but these services are not the primary focus of the program. Project LINK served 1,024 total individuals in federal fiscal year (FFY) 2023.

Virginia BabyCare is a Medicaid program that offers services for pregnant persons enrolled in fee-for-service (FFS) Medicaid, the Family Access to Medical Insurance security (FAMIS), FAMIS Plus, or the FAMIS MOMS program who are considered high-risk. Services are delivered through local health departments, which bill Medicaid for the service provided. The program aims to reduce infant mortality and morbidity, ensure access to comprehensive services to eligible pregnant persons and infants up to age two, and provide wrap-around services that improve their well-being. Services available through the BabyCare program include behavioral risk screening, case management services, client education classes, homemaker services, nutritional services, and substance use disorder services. Home visiting services are also available through the BabyCare program; however, similar to Project LINK, home visiting is not the primary focus of the BabyCare program.

Home visiting improves maternal and child outcomes and benefits of home visiting programs outweigh program costs

Home visiting programs target social determinants of health and support families outside of the clinical setting. At a national level, 92 percent of families that participate in home vising programs had a household income at or below 200 percent of the federal poverty level. Most adults (58 percent) that participated had a high school education or less. Children born into low-income families are more likely to have poor social, emotional, cognitive, behavioral and health outcomes. Joint Commission on Health Care (JCHC) staff analysis of peer-reviewed literature suggests that one of the greatest benefits home visiting can present is improving socioeconomic status of children and families. Participation in home visiting programs facilitated increased individual earnings and reduced reliance on government programs, supporting family economic self-sufficiency.

Families that participate in home visiting programs demonstrate improved maternal and infant health, positive parenting practices, reduced health disparities, healthier relationships, increased school readiness, and increased social and emotional development. Home visiting programs are especially effective for families who experience poverty or mental health challenges as home visiting programs increase access to resources such as

food, transportation, housing, and employment services which are essential for healthy outcomes. National data shows that children that participated in home visiting programs implementing the Nurse Family Partnership model had less involvement in the criminal justice system, reduced prevalence of child maltreatment and neglect, and reduction in substance use among adolescents.

Home visiting programs are particularly effective in reducing pre-term births and improving maternal and infant health outcomes. Babies born to mothers who participated in the two Virginia-based home visiting programs, Healthy Families Virginia and CHIP of Virginia, were 40 percent more likely to reach full term compared to babies from mothers who did not participate in these programs. Babies born full term are associated with positive developmental outcomes.

EIV, in partnership with the Alliance for Early Childhood Home Visiting, has developed a set of uniform indicators to standardize outcome measures across Virginia's eight home visiting models (APPENDIX E). Uniform indicators and respective outcome measures fall under five domains: maternal health, child health, school readiness, relational health, and family functioning. Positive selected outcomes of home visiting service delivery are shown in the table below (TABLE 4-2).

TABLE 4-2. Virginia's home visiting programs demonstrate positive outcomes

Program	Indicator	Outcome
Nurse Family Partnership	Pregnancy Outcomes	5.4% of babies were born pre-term compared to the Virginia pre-term birth rate of 9.9%
Healthy Families	Risky Parental Behavior	98.2% monitoring and connection to services after positive substance abuse screening
Parents as Teachers	Early Identification of Developmental Delays	90% of children qualified for follow-up services after screening for health and developmental delays
CHIP of Virginia	Employment	13% increase in one or both parents employed after one year
Healthy Start/Loving Steps	Perinatal Depression	100% referral to services after positive depression screening

SOURCE: JCHC analysis of Early Impact Virginia program data.

National research suggests the benefits of home visiting programs outweigh costs

Since home visiting models vary with regard to the type of provider offering home visiting services, program length, and total number of visits, it is not possible to identify cost-effectiveness across all home visiting programs. However, available literature suggests that participation in home visiting programs can benefit individuals, families, and communities, which in turn benefit the state. The cost benefit of home visiting programs is not realized in the short term but may accrue over time. This is likely due to upfront programmatic costs for program implementation and the time needed for measurable benefits to develop. Studies that reviewed two home visiting models, Nurse Family Partnership and Healthy Families America, did not find programs benefits to exceed costs within 4 years or 7 years. However, at 15 years, the benefits of the Nurse Family Partnership program exceeded the costs of the program four times over. The return on investment was the most apparent for families with the lowest socioeconomic status within the Nurse Family Partnership program.

Home visiting programs are supported through a combination of funding streams

The capacity and sustainability of home visiting programs in Virginia is directly related to available funding and resources directed towards these efforts. In Virginia, as in other states, home visiting programs are supported by a mix of federal, state, local, and private funds. In FY 2024, overall investment in local home visiting services in Virginia totaled $36 million. Federal funding was the greatest funding source, accounting for $19.0 million (53 percent). Localities contributed an additional $9.1 million (25 percent), and private funding accounted for $7.0 million (19 percent). State general funds accounted for approximately $1.01 million (3 percent) of the total amount spent to deliver home visiting services.

Since home visiting funding comes through multiple funding streams, it can be beneficial to combine federal, state, and local funds to enhance the capacity of home visiting programs. Several states have identified opportunities to leverage existing federal funding streams, including Medicaid, to expand access to home visiting services. Home visiting programs can often include services that do not meet Medicaid requirements; therefore, these services need to be paid for through other options.

Recent state support to Virginia's home visiting programs may only maintain service levels

In FY 2024, federal funds from the Temporary Assistance for Needy Families (TANF) block grant accounted for 53 percent of total funding available for home visiting programs in Virginia. For FY 2025, appropriations of TANF block grant funds for home visiting programs were significantly reduced due to shifting costs within the TANF program and the

need to reallocate federal TANF block grant funds away from discretionary programs to satisfy core program requirements (APPENDIX F). To fill the gap, the General Assembly increased state funding for home visiting programs beginning in FY 2025. Increased state general fund appropriations have resulted in a 2.4 percent increase in the total amount of state funding for home visiting program funding between FY 2024 and FY 2025 (TABLE 4-3) However, recent increases in state funding are unlikely to translate to increased home visiting service delivery as the overall cost of delivering home visiting services has increased due to inflation.

TABLE 4-3. State investment in home visiting services increased by 2.4 percent in FY 2025

Program	Source	FY2024	FY2025
Healthy Families Virginia	TANF	$9,035,501	$9,035,501
CHIP of Virginia	TANF	$2,400,000	$0
Resource Mothers	TANF	$1,000,000	$0
Early Impact Virginia	TANF	$600,000	$0
Total TANF Funding		**$13,035,501**	**$9,035,501**
Resource Mothers (state)	VDH	$0	$1,000,000
Early Impact Virginia (state)	VDSS	$0	$600,000
MIECHV (state match)	VDH	$0	$333,333
CHIP of Virginia (state)	VDH	$832,946	$3,232,000
Total State Funding		**$832,946**	**$5,165,333**
Total TANF and State Funding		**$13,867,501**	**$14,200,834 (+2.4%)**

SOURCE: JCHC analysis of Virginia State Budget. Federal discretionary TANF funds are administered by VDSS. Federal MIECHV program provides funding for home visiting programs in Virginia.

The Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program, administered by the federal Health Resources and Services Administration (HRSA), is the source of the largest share of federal funding for home visiting services that Virginia receives. The program was established in 2010 to provide funding to states to support voluntary, evidence-based home visiting services for pregnant people, families, and at-risk parents of children up to kindergarten entry to help them access resources and develop the skills needed to raise children who are physically, socially, and emotionally healthy and ready to learn. Each state approved for participation in the MIECHV program receives an amount of base funding that is based on the state's share of children under the age of five. For FFY

2024, Virginia received $10,208,699, which will be distributed to home visiting programs in the state for FY 2026.

The American Rescue Plan Act of 2021 (ARPA) appropriated additional federal funding for the MIECHV program to address the needs of expectant parents and families with young children during the COVID-19 public health emergency. States were given flexibility to use the funds received for a variety of purposes including training, service delivery, and purchase of supplies for participating families. Virginia was awarded two rounds of ARPA funding to support MIECHV programs, including $879,347 for the period between May 1, 2021, and September 30, 2021, and $1,779,495 for the period between December 1, 2021, and September 30, 2024.

Following reauthorization of the MIECHV program in 2022, HRSA began offering states the opportunity to apply for additional MIECHV grant funding beginning in FY 2024. States approved for MIECHV program grants are required to contribute one dollar for every three dollars of federal funding received. The maximum amount of the federal contribution available through the MIECHV grant program is based on the share of children under 5 in the state whose families have incomes below the federal poverty level. States have the opportunity to apply for any amount of federal funds available through the grant program, up to the maximum amount established by HRSA. To take advantage of this opportunity, Virginia appropriated an additional $333,000 in state matching funds, allowing the state to secure the full amount available to the state through the new grant program in FFY 2024 and increase federal funding for home visiting programs in the state by $725,892. As with federal MIECHV base funding, these amounts will be distributed to home visiting programs in the state for FY 2026.

Starting in FFY 2025, HRSA will allow states to apply for additional MIECHV grant program matching funds beyond the maximum amount of grants calculated using the formula implemented in FFY 2024. Additional available funds will include any amounts that were not distributed to or used by states in previous years.

Three home visiting models receive federal MIECHV funding, and one model needs more evidence to be eligible for federal funding

States that participate in the MIECHV program distribute funds to local implementing agencies such as public health departments or community non-profits to implement home visiting services consistent with an eligible home visiting model.

To be eligible for MIECHV funding, a home visiting model must conform to a clear and consistent home visitation model that has been in existence for at least three years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, and associated with a national organization or institute of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement. Programs must also meet evidence-based standards established by the Department of Health and Human Services' (DHHS) Home Visiting Evidence of Effectiveness (HomVEE) review process (SIDEBAR). Currently, 24 home visiting models meet HomVEE and other eligibility criteria for MIECHV funding. Three home visiting models implemented in Virginia are eligible for and receive MIECHV funding - Nurse-Family Partnership, Parents as Teachers, and Healthy Families Virginia. Two additional models - Early Head Start Home-based Option and Family Spirit – meet HomVEE standards but receive funding through other federal funding sources. One model, Resources Mothers, previously attempted to meet HomVEE standards as a first step toward qualifying for MIECHV funding but was unable to do so. Another model, Healthy Start/Loving Steps, is not eligible for HomVEE review because it is a federal grant program.

Home Visiting Evidence of Effectiveness (HomVEE) is an evaluation tool developed in 2009 by the Department of Health and Human Services (HHS) to assess maternal and early childhood home visiting models that serve families with pregnant people and children birth through age 5. The HomVEE review identifies which home visiting models meet evidence-based guidelines defined by HHS, summarizes research from available literature, and provides implementation guidelines for each home visiting model. Any home visiting model that receives federal MIECHV funding is required to meet HomVEE criteria.

One home visiting model currently implemented in Virginia – CHIP of Virginia – could be eligible for HomVEE certification and MIECHV program funding but has not yet been reviewed. CHIP of Virginia began in 1988, prior to initiation of federal home visiting funding and prior to creation of federal HomVEE standards. Stakeholders report that CHIP of Virginia has documented positive outcomes, but that additional evidence is necessary to support HomVEE criteria. During the 2023 and 2024 Sessions, the General Assembly considered budget amendments that would have provided funding to allow Families Forward Virginia, the organization that administers the CHIP of Virginia, to conduct the randomized control trial to collect evidence the organization would need to submit to DHHS to begin the HomVEE evaluation process. However, these amendments were not approved by the General Assembly.

Obtaining HomVEE certification would not guarantee eligibility for MIECHV funding, but obtaining HomVEE certification is a necessary step in determining whether CHIP of Virginia could be eligible for federal MIECHV program funds, which could allow the program to expand access to home visiting programs for vulnerable and underserved populations.

➔ **Option 9:** The Joint Commission on Health Care could introduce a budget amendment to provide funding to Families Forward Virginia to serve a new cohort of parents that will be part of a randomized control trial required to collect evidence to be submitted to the federal Department of Health and Human Services to determine whether CHIP of Virginia meets criteria for certification as an evidence-based home visiting model consistent with the Department's Home Visiting Evidence of Effectiveness criteria.

Virginia could leverage Medicaid funding to enhance capacity of home visiting services

While the Centers for Medicare and Medicaid Services (CMS) has not established a distinct Medicaid benefit for home visiting, states can choose to cover individual services provided by home visiting programs that align with existing Medicaid coverage authorities and benefit categories. As of 2023, at least 28 states offered a home visiting benefit through their state Medicaid programs. Twenty-two states covered home visiting services through their Medicaid state plan, and eight states had implemented a Medicaid waiver to support home visiting services.

Most states that cover home visiting services do so through a Medicaid state plan amendment

Federal Medicaid regulations require any potential state plan amendment to fit within the definition of a statutorily defined service. Since there is no single service under the Medicaid program defined as home visiting, federal guidance gives states the option to create state plan amendments under several other state plan benefit categories that cover services provided through home visiting programs.

Prior to the COVID-19 pandemic, there was momentum in Virginia to create a Medicaid home visiting benefit. The 2020 Appropriation Act included $1 million in FY 2021 and $11 million in FY 2022 for the development of a home visiting benefit for pregnant and postpartum women at risk for adverse health outcomes. The goal of this benefit was to allow Medicaid managed care organizations to contract with local providers for home visiting services. However, this funding was unallotted in 2020 due to competing priorities to mitigate the impact of the COVID-19 pandemic.

Language included in the 2021 Appropriation Act directed the Department of Medical Assistance Services (DMAS) to convene a workgroup to study the feasibility of a Medicaid home visiting benefit, including assessing which home visiting models would be recommended under the benefit. The workgroup submitted a report summarizing a potential home visiting benefit that includes four HomVEE-approved models (Nurse Family Partnership, Parents as Teachers, Early Head Start Home-Based Option, Family Spirit, or Healthy Families Virginia) operating in Virginia and provided a five-year forecast of costs if every eligible family received home visiting services. Given these conditions, DMAS estimated a total cost of $131.5 million over a 5-year period for home visiting in Virginia.

However, DMAS recognized that the cost of a home visiting benefit could vary substantially depending on which home visiting models were eligible for reimbursement and how the target population was defined. No additional action has been taken to implement a Medicaid home visiting benefit since the final report was submitted in December 2021.

➔ **Option 10:** The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services, in conjunction with relevant stakeholders, to convene a workgroup to develop a plan for home visiting benefit for pregnant and postpartum individuals and their families. The workgroup shall develop consensus with stakeholders and make recommendations in the plan regarding the design of various program elements including service definitions, administrative structure, eligibility criteria, provider participation requirements, population prevalence, service setting options, and federal evaluation requirements, to guide any future cost impact analysis for the proposed home visiting benefit that may be required. The Department would report to the Joint Commission on Health Care and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1st, 2025, regarding the plan for the design of a home visiting benefit and any next steps which shall be necessary for federal approval and implementation of the home visiting benefit.

Chapter 5: Community Health Workers

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member and has a close understanding of the community they serve. This trusting relationship enables CHWs to serve as a link between community members and helping services to improve the quality and cultural competence of service delivery.

CHWs apply their unique understanding of the experience, language, and culture of the populations they serve. They increase patient health literacy by providing culturally appropriate health education and information, advocate for individual and community needs by identifying gaps and strengths to build capacity, and link individuals to direct health and social service providers. Use of CHWs can improve the approachability, acceptability, and appropriateness of health care services, expanding access to health care for program participants. CHWs are non-licensed providers; they do not provide clinical diagnosis or treatment, but they can strengthen health care teams.

Virginia joined 23 other states in implementing a CHW certification process

House Bill 688, passed during the 2020 Session of the General Assembly, directed the Virginia Department of Health (VDH) to create requirements for CHW certification. Consistent with the American Public Health Association's recommendation that CHW leadership be involved in efforts to establish standards for the CHW workforce, VDH partnered with the Virginia Community Health Worker Advisory Group and the Virgnia Community Health Worker Association to develop requirements for CHW certification in Virginia.

Certified Community Health Worker Requirements:

- One (1) year of full-time or 2000 hours of part-time volunteer or paid employment
- Copy of current community health worker volunteer/job description, obtained from current organization and signed by both the applicant and their immediate supervisor
- 50 hours of qualifying supervised work experience in the community health worker domains
- 60 total hours of experiencing, including experience in each of the seven the learning domains, within the last three years. All 60 hours must be provided by a Virginia Certification Board accredited CHW training provider
- $100.00 Certification Fee (one half of fee is refundable if application is denied)

Applicants for certification as a CHW are required to meet all the listed criteria before seeking certification (SIDEBAR). Applicants are also required to be currently working or volunteering as a CHW at the time of application. In addition, only experience within the last 3 years is counted towards the total experience requirement. VDH has a contract with the Virginia Certification Board, a private entity located in Harrisburg, Pennsylvania, to review and track all CHW certifications.

The Certified Community Health Worker (CCHW) credential is optional in Virginia; however, some employers do require staff to seek certification as a requirement of employment. Certification may help an individual grow their career or pursue future career opportunities. As of June 2024, approximately 21 percent (290 total) of CHWs in Virginia have sought CCHW certification. Some organizations offer training for Spanish speakers and for individuals who are deaf or hard of hearing to ensure program accessibility. Training to become a CCHW may be self-funded, funded by an employer, or funded in whole or in part by scholarships or grants. To be certified in Virginia CCHWs must be trained and have experience in the following seven learning domains: (1) community health concepts and approaches; (2) service coordination and system navigation; (3) health promotion and prevention; (4) advocacy, outreach, and engagement; (5) communication; (6) cultural humility and responsiveness; and (7) ethical responsibility and professionalism.

CHWs work in a variety of settings to improve health outcomes among vulnerable and underserved populations

CHW is an umbrella term to describe an individual's scope and approach to their work. CHWs may be identified by several job titles including community health advisors, lay health advocates, promotoras, case managers, community health representatives, peer health promoters, peer health educators, and outreach specialists. For this reason, CHW presence in Virginia, currently estimated at 1,380 individuals, may be underestimated.

CHWs provide services in a variety of settings. In the past, many CHWs worked with health departments and community-based organizations. In a recent shift, however, CHWs are more often employed by hospitals, health systems, and insurers to address unmet social needs, support access to preventative services, and reduce use of costly and unnecessary services among vulnerable populations. In these settings, CHWs may focus their practice on a variety health care issues including infectious disease control and prevention, oral health, maternal and infant health, chronic disease management, and social determinants of health. Nationally, less than 10 percent of CHWs are employed by health departments.

CHWs can support care teams by filling gaps in chronic disease management and mental health services

Within clinical settings, CHWs help patients manage chronic conditions under the guidance of or in partnership with providers to improve health outcomes and reduce the total cost of providing care. In a study of patients with cardiovascular disease, patients receiving an intervention with a health care provider and CHW had better systolic blood pressure, LDL-cholesterol, hemoglobin A1C, and improved self-perception of chronic illness, compared to patients who were offered the intervention solely with a health care provider. An evaluation of a CHW home visiting program for children with uncontrolled asthma enrolled in Medicaid, participants saw an increase in the number of symptom-free days, reduced health

care utilization, and reduced costs at urgent care. The program also resulted in increased quality of life for the parent or caregiver.

CHWs can also support mental health interventions, conducting outreach, facilitating connections with providers, and providing ancillary support of mental health treatment by encouraging patient adherence to treatment or case management. Within a tiered-care model, CHWs can provide lower levels of care to patients while mental health professionals provide a higher level of care. CHWs who possess the appropriate credentials may also deliver mental health services as the sole treatment provider.

CHWs can reduce health disparities in communities of color and promote health equity

Many groups benefit from CHW-led intervention because CHWs build trust within their communities and facilitate access to resources and services. CHWs are most effective among those with limited English proficiency, rural groups, and minority groups that have trouble navigating the health care system. CHWs played a critical role in encouraging widespread adoption of testing and vaccinations to improve health outcomes among Black and Hispanic groups during the COVID-19 pandemic. One study in which CHW coaching was paired with training for physicians on patient-centered communication saw the greatest reduction in systolic blood pressure among Black individuals with uncontrolled hypertension.

Case Study: Eastern Virginia Care Transitions Partnership

The Eastern Virginia Care Transitions Partnership was a pilot program by Bay Aging and Riverside that brought health care coaches or CHWs affiliated with the Partnership's Care Transitions Intervention program from the Area Agencies on Aging into the Riverside Walter Reed Hospital in Gloucester, the Riverside Tappahannock Hospital, and the Rappahannock General Hospital to work directly with patients and families preparing to transition home. One hundred and forty Medicare patients participated in the pilot. Only 2 percent of program participants were readmitted to the hospital within one month of discharge, as compared to the average of 20 percent of Medicare recipients who are readmitted to the hospital within 30 days of discharge. The Partnership estimated that the program produced a cost savings of approximately $1 million.

Bilingual CHWs can effectively assist immigrant groups with limited English proficiency access health care. A study of bilingual CHW interventions found that participation of bilingual CHWs led to increased breast and cervical cancer screenings among Hispanic women and showed positive changes in screening, knowledge of screening guidelines, and general beliefs in early detection.

Virginia has taken steps to expand access to services provided by CHWs, but insufficient funding continues to be a barrier

VDH began investing in CHWs prior to the COVID-19 pandemic; however, in recent years, the CHW workforce has been supported by large one-time federal grants. Despite documented success of the CHWs, long-term sustainability of the workforce is hampered by limited funding streams. Virginia, like many states, has adopted CHW certification standards to professionalize the workforce and facilitate reimbursement for CHW services by Medicaid and commercial insurance, but Virginia has not yet acted to provide reimbursement through the state's Medicaid program. Virginia could consider reimbursing CHW services through a Medicaid state plan amendment or requiring managed care organizations to use CHWs within their managed care contracts. Virginia already provides reimbursement for other community-based lay health providers, such as doulas and peer recovery specialists, through its Medicaid program. Virginia could expand the CHW workforce by identifying and aligning CHW services with the services these community-based providers provide.

Virginia has received time-limited federal funding for CHWs but sustainability of CHW workforce is uncertain without long-term funding

The federal government made significant one-time investments during the COVID-19 pandemic to support CHW hiring and training, but most of these funds have been exhausted or will expire by early state fiscal year (FY) 2026 (TABLE 5-1). In September 2022, the federal American Rescue Plan Act (ARPA) awarded $225.5 million in funding to train 13,000 CHWs nationally. VDH received approximately $3 million in one-time ARPA funds to expand access to CHW services in Virginia. VDH used the funding to support about 112 CHW positions across Virginia's 25 health districts, either through direct employment at local health departments or through contracts between local health departments and nonprofit and other organizations that employed CHWs to provide services. In addition, the Centers for Disease Control and Prevention awarded the Virginia-based Institute for Public Health Innovation approximately $13 million over three years to expand the roles and capacity of CHWs in supporting COVID-19 response and recovery. Full-time and contract CHWs in local health districts have been instrumental in supporting COVID-19 vaccination efforts, sexually transmitted infection prevention, perinatal health, and other key initiatives.

TABLE 5-1. Virginia has received $17 million in federal funds to support CHWs since FY 2022.

Program	*Program Length*	*Source*	*Total Award*
*Local Community-Based Workforce to Increase COVID-19 Access**	7/2021	HRSA	$1,000,000
*Community Health Workers for a Healthy Virginia***	8/2021-8/2024	CDC	$13,019,685
Community Health Worker Training Awards	9/2022-9/2025	HRSA	$2,999,487
Total Funding			**$17,019,172**

NOTE: *Awarded to Boat People S.O.S. Inc. **Awarded to Institute for Public Health Innovation. HRSA = Health Resources and Services Administration; CDC = Centers for Disease Control and Prevention

A dedicated and consistent stream of state general funds would allow local health districts to continue to support CHWs in their localities. In 2023, VDH determined that approximately $5.7 million each year of the next biennial budget would be needed to continue funding existing CHW positions. During the 2024 Session, the General Assembly appropriated $3.2 million per year in FY 2025 and FY 2026 to support CHW positions at local health districts but did not fund the full amount requested by VDH. Appropriating additional general funds to VDH to cover the full cost of supporting CHW positions at local health departments could ensure that CHWs remain available to provide necessary services in their communities. Language accompanying the appropriation in the 2024 Appropriation Act directed VDH to prioritize funding for CHW positions in localities with the highest rates of maternal mortality. Removing that language could provide flexibility in how funds appropriated by the General Assembly to support CHWs working at local health departments are deployed to address priority heath disparities as they arise.

➔ **Option 11:** The Joint Commission on Health Care could introduce a budget amendment to provide an additional $2.5 million to the Virginia Department of Health (VDH) in fiscal year 2026 to support all remaining community health worker (CHW) positions initially supported by federal funding and remove language requiring VDH to prioritize CHW positions in high maternal mortality areas to allow flexibility of localities to develop and implement CHW-led programs that address community needs.

VDH has made efforts to conduct an internal evaluation of the CHW workforce employed in state and local health departments to identify the total number of CHWs employed in these settings, which provides some insight into the funding necessary to maintain the current CHW workforce. As of September 2024, VDH has a total of 130 CHW staff. There are 8 vacancies, and 3 positions are in recruitment. Regular review of state and local health

departments to determine the need for and capacity to support CHWs could help VDH better determine the funding needs of state and local health department CHW programs on an ongoing basis. Such review could also include analysis of performance and outcome measures for services provided by CHWs to understand the impact of CHWs.

➔ **Option 12:** The Joint Commission on Health Care could introduce a budget amendment directing the Virginia Department of Health to report annually, by November 1, to the chairs of the Senate Finance and Appropriations and House Appropriations Committees and the Director of Department of Planning and Budget regarding the numbers of community health workers employed within state and local health departments, the type of services provided by CHWs and performance and outcome measures for such services, the need for additional CHWs to meet demand for services provided by state and local health departments, any success in attracting non-state resources, and descriptions of the contracts entered by localities.

Access to CHW services could be expanded by leveraging Virginia's Medicaid program as a sustainable funding mechanism

At least 24 states offer Medicaid reimbursement for CHW services, either through a Medicaid state plan amendment (SPA) or contracts with managed care organizations (MCOs). Virginia could implement either option to leverage Medicaid reimbursement for the services CHWs provide. Virginia could also provide reimbursement for services provided by CHWs by developing opportunities for CHWs to become eligible for reimbursement for other services already reimbursed by the state's Medicaid program.

A Medicaid state plan amendment could provide reimbursement for a narrow set of CHW services in Virginia

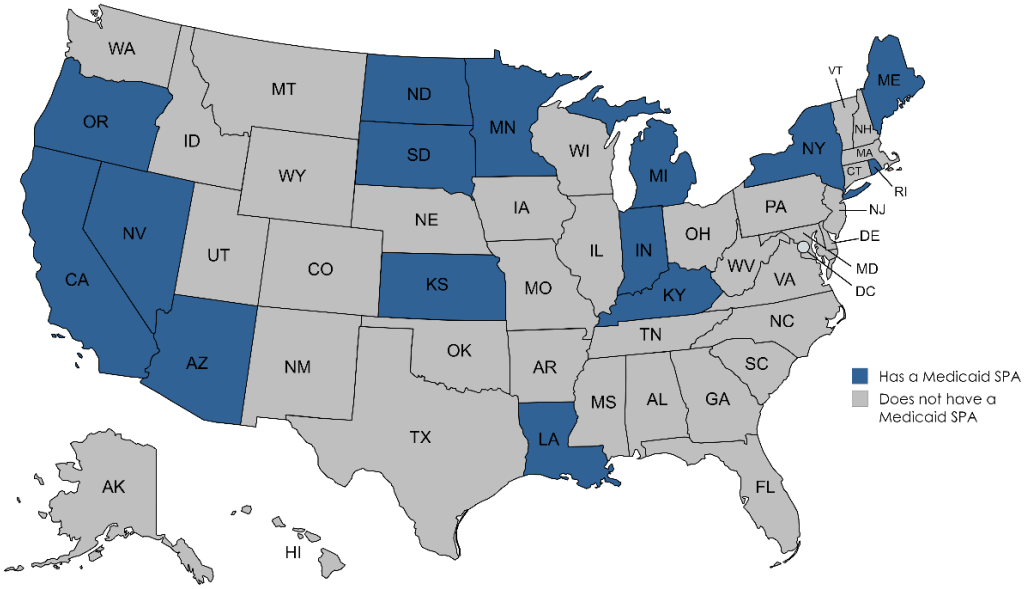
Fifteen states have authorized coverage of CHW services through a SPA (FIGURE 5-1). States have used SPAs to authorize payment of CHWs under different state plan benefits including the preventive services benefit and outpatient hospital service benefit. While the specific types of CHW services covered under Medicaid SPAs varies by state, services generally fall into three categories: health education and training, health promotion and coaching, and care coordination or resource referral. Some state Medicaid SPAs cover additional services provided by CHWs. For example, Kansas covers screening and assessment of health-related social needs and barriers to accessing health care. State Medicaid SPAs generally require that services be recommended by a licensed provider to be eligible for reimbursement.

To provide coverage for CHW services through a SPA, the Department of Medical Assistance Services (DMAS) would need to submit the SPA to the Centers for Medicare and Medicaid Services (CMS) for review and approval. Generally, SPAs must describe the groups of individuals to be covered, specific services to be delivered, and the reimbursement payment methodology to be employed. Because services covered through a Medicaid SPA must fit

within the scope of the benefit under which they are authorized, it is possible that any Medicaid SPA would cover only a narrow subset of services provided CHWs and may not encompass all the services a CHW could provide. However, crafting a CHW benefit with a narrow scope of services could be a reasonable starting point to begin reimbursing CHW services.

In 2024, the General Assembly considered House Bill 594 (Sickles) and Senate Bill 615 (Pillion), which would have required the Department of Medical Assistance Services to convene a workgroup of stakeholders to design a CHW benefit for Virginia's Medicaid program. The bills directed the workgroup to identify the types of services to be covered, the educational and training standards that CHWs would be required to meet to be eligible for reimbursement, and the reimbursement methodology to be employed. The bills were ultimately not approved by the General Assembly. An approach similar to the approach described in House Bill 594 and Senate Bill 615 could be employed to design a SPA to authorize Medicaid reimbursement for services provided by CHWs in Virginia.

FIGURE 5-1. Fifteen states authorize coverage of CHW services through Medicaid state plan amendments



SOURCE: JCHC staff analysis of the Association for State and Territorial Health Officials and National Academy of State Health Policy data.

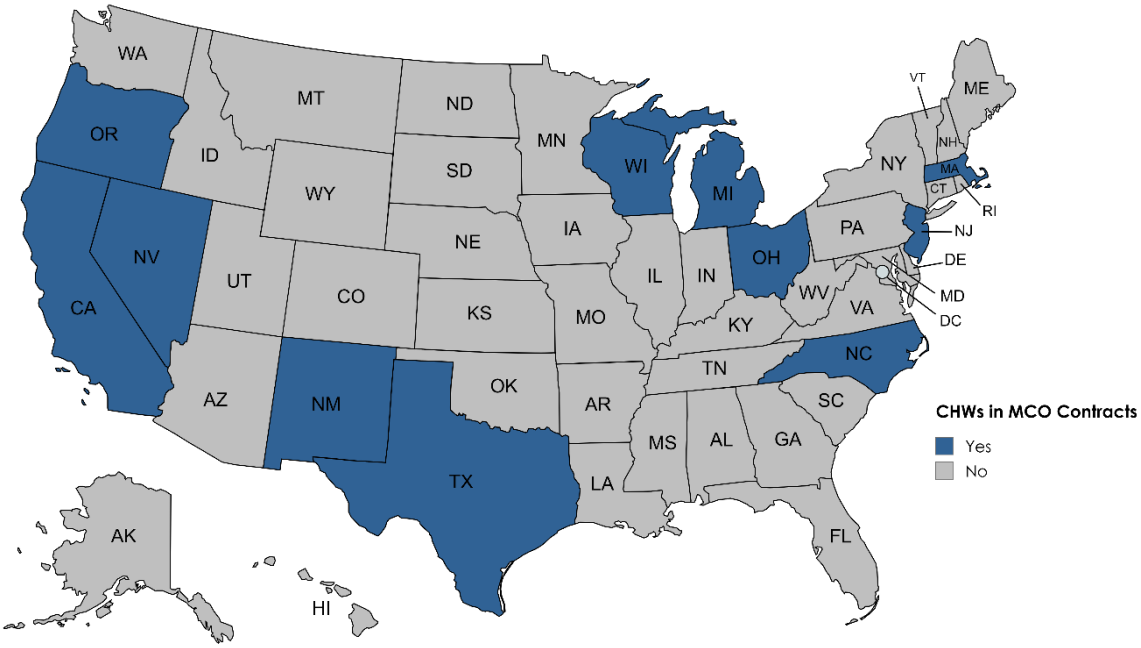
➔**Option 13:** The Joint Commission on Health Care could introduce a budget amendment directing the Department of Medical Assistance Services (DMAS) to convene a work group of stakeholders to design a state plan amendment (SPA) to provide reimbursement for services provided by Certified Community Health Workers (CCHWs). The plan shall include service definitions, administrative structure, eligibility criteria, provider participation requirements, population prevalence, service setting options, and federal evaluation

requirements. The Department shall report to the Joint Commission on Health Care and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees regarding the plan for a SPA to provide reimbursement for services provided by CCHWs and any next steps necessary for federal approval and implementation of the SPA by October 1, 2025.

Virginia could require use of CHWs within existing managed care contracts

Virginia, like many other states, contracts with MCOs to deliver services to Medicaid beneficiaries. States have the option to encourage or require certain services through contracts with MCOs. Eleven states use MCO contracts to encourage or require payment of CHW services (FIGURE 5-2). For example, New Mexico requires MCOs to provide CHW services to 3 percent of their beneficiaries to avoid a penalty in their capitation rate. Michigan requires MCOs to facilitate the design and implementation of CHW intervention that address social determinants of health, promote prevention, and education. MCOs are also required to maintain specific CHW-to-enrollee ratios. This approach gives states flexibility to define the scope of a CHW benefit and how the service can be delivered, whether contracted with a community-based organization, network provider, or directly by the MCO. When states chose to require MCOs to use CHWs to deliver services, the cost of CHW services is accounted for in capitation rates.

FIGURE 5-2. Eleven states encourage or require MCOs to use CHW services



SOURCE: JCHC staff analysis of the Association for State and Territorial Health Officials and National Academy of State Health Policy data.

Virginia's Medicaid MCOs utilize CHWs to deliver certain services. DMAS requires MCOs to establish and implement ongoing comprehensive quality assessment and performance improvement (QAPI) programs. Within these QAPIs, DMAS has required MCOs to complete CHW-interventions as part of their performance improvement projects. For example, one MCO developed a program to address tobacco use cessation in pregnant women. The MCO trained an outreach team as CHWs to provide case management and education to pregnant members.

MCOs also report using CHWs to implement intervention strategies designed to reduce tobacco use among pregnant women, required by DMAS as part of the agency's Quality Strategy initiative to improve outcomes for maternal and infant members. Each MCO reported using trained certified CHWs within their proposed intervention strategy. Another two MCOs mentioned other roles that CHWs may fall under such as care coordinators or case managers within their targeted proposed intervention strategy.

Virginia's Medicaid MCOs offer CHW services as value-added services. JCHC staff surveyed each Medicaid MCO to determine CHW services offered to their members. Each Medicaid MCO reported using CHWs across various programs focusing on equity, identifying health related social needs, member outreach and education, administrative supports, medication adherence, and disease self-management. Medicaid MCOs also reported that CHWs may conduct home visits to deliver supplies, assess environment and safety, or at member request for additional support. One Medicaid MCO cited using certified CHWs to work with pregnant and postpartum women to provide education, screening and detection services and make connections to community resources to improve outcomes. Another Medicaid MCO reported implementing the National Health Care Equity Community Health Worker toolkit to build and maintain positive working relationships with their members and interdisciplinary care team to reduce cultural and socioeconomic barriers between their members and the institutions they interact with for their care. These services are generally offered as value-added benefits not included in capitation rates paid to the Medicaid MCO.

➔ **Option 14:** The Joint Commission on Health Care could introduce a budget amendment directing the Department of Medical Assistance Services to convene a workgroup to identify opportunities to expand use of community health workers by Medicaid managed care organizations.

Flexible certification programs could allow CHWs to receive Medicaid reimbursement for some services

CHWs are generalists in their field, which allows them to provide an array of services to support their communities and to tailor their services to identified community needs. However, some stakeholders stated that the breadth and general nature of services

provided by CHWs makes it difficult to develop a Medicaid benefit that encompasses all of the services CHWs may provide.

Some of the services CHWs provide overlap with services provided by other lay health professionals such as state-certified doulas and registered peer recovery specialists (SIDEBARS). State-certified doulas and registered peer recovery specialists can receive Medicaid reimbursement for the services they provide while CHWs cannot. Some CHWs who choose to focus their practice in areas where there are significant overlaps in the services they provide and the services provided by state-certified doulas or registered peer recovery specialists, may be interested in obtaining the certifications necessary to receive reimbursement for those services under existing Medicaid benefits. However, some stakeholders reported that the financial, temporal, and administrative burdens of obtaining additional certifications required to be eligible for Medicaid reimbursement are a barrier to doing so. Flexible training and certification programs that allow CHWs to use education and experience they already possess to satisfy some of the requirements for state certification as a doula or registration as a peer recovery specialist could enable CHWs who wish to pursue certification or registration to do so more easily. Qualification as a state-certified doula or registered peer recovery specialist would allow CHWs to receive Medicaid reimbursement for services provided without sacrificing their professional identity of CHW and could expand access to CHW services in Virginia. The Virginia Association of Community Health Workers is currently developing a blended training program for state-certified doulas and certified community health workers that could provide a pathway to certification as a state-certified doula for CHWs who wish to practice in this area. This program could serve as a model for similar programs; however, it would be important to gather stakeholder consensus on opportunities to blend training to avoid the risk of conflating the scope of these providers.

State-Certified Doulas are trained, community-based, non-medical professional who offer a broad set of non-clinical, continuous support services to pregnant women throughout pregnancy, at labor and delivery, and during the postpartum period. Community doulas provide support to pregnant and postpartum women through their grounding within the community, languages, and value systems of the populations they serve. The emotional, physical, and informational support provided by doulas include childbirth education, lactation support, and referrals for health or social services. A state-certified community doula is certified by the Virginia Certification Board and is a trusted source of support for birthing families.

Registered Peer Recovery Specialists (RPRS) provide non-clinical, person-centered, strengths based, wellness focused, and trauma-informed support while helping to ensure the person's wellness-recovery plan reveals the needs and preferences of the person being served to complete their measurable and personalized goals. RPRS serve adults with behavioral health challenges, parent peers, and family members who provide support to parents and children who experience behavioral health challenges. RPRSs are required to be registered with the Board of Counseling to be reimbursed for their services through Virginia's Medicaid program.

➔ **Option 15:** The Joint Commission on Health Care could introduce legislation directing the Virginia Department of Health (VDH) to convene a work group composed of representatives of the Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), and other relevant stakeholders to determine the feasibility of developing flexible training and certification standards that allow community health workers (CHWs) to use their education and experience to satisfy some of the requirements for qualification as a state-certified doula or registered peer recovery specialist. The workgroup would report on activities to the Joint Commission on Health Care and the chairs of the Senate Committee on Education and Health and House Committee on Health and Human Services by October 1, 2025.

CHWs need ongoing workforce development opportunities to avoid burnout and support retention

While state general funds support CHW positions within the state and local health departments, this funding does not convey to health care systems, insurers, and community-based organizations that may have also received time-limited funding during the COVID-19 pandemic. CHWs show trends of leaving their position due to lack of job security created by the short-term or grant funded nature of these positions. Grant-funded positions tend to have limited opportunity for salary growth and professional advancement opportunities. This can leave organizations at risk of losing CHWs with the most experience, which negatively impacts access to care and the quality of services provided.

Lack of career development and advancement opportunities, challenges related to social determinants of health may negatively impact CHW retention

Some CHWs join the field as a step to another health professional career; however, most CHWs want to retain their identity as a CHW. CHWs may face limited opportunities for advancement within their field or to move into supervisory positions. Larger organizations that employ CHWs may place a premium on higher education or formal degrees rather than lived experience, excluding the marginalized populations intended to serve in these roles. Additionally, CHWs have cited they are usually reporting to someone who has never been a CHW themselves and may not have experience in the field, so their role can be easily misunderstood on a care team.

CHWs are usually part of the community they serve, often sharing the same ethnicity, language, socioeconomic status, and life experiences as the people to whom they provide services. They are often affected by the same social determinants of health they aim to address in their work. Challenges related to social determinates of health affecting the well-being of both the community and individual CHWs may create stresses that contribute to CHW burnout. CHWs' emotional investment in their work with the community can heighten the risk. In a national sample, CHWs identified the importance of staying connected and receiving support from other CHWs in their field. Supporting CHWs to engage with their

network through ongoing job support, training, or joining professional organizations can enhance CHW contributions to patients, members of the care team, and the community. A professional network and identity can promote a sense of belonging, opportunity to influence their work on a larger scale, and resilience within their work.

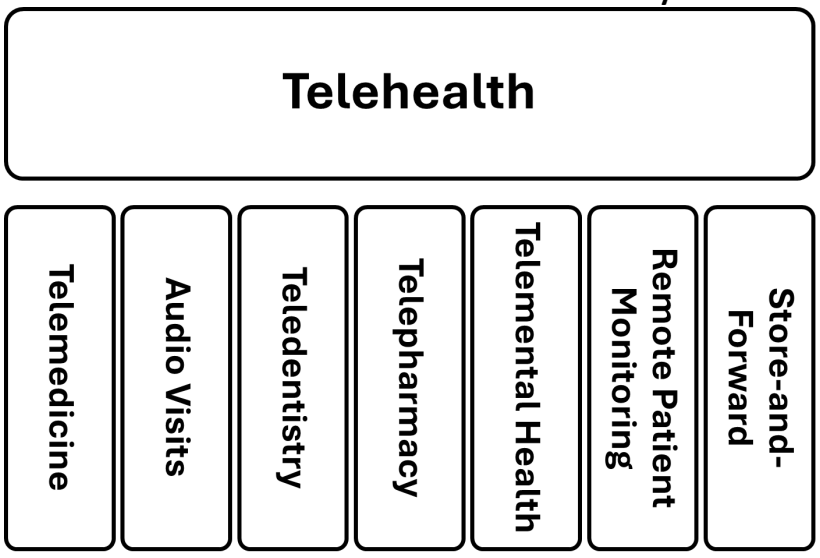
In Rhode Island, the health department directly funds their state CHW association, which provides mentorship, advocacy, networking, and professional development. The CHW association provides the core CHW competency training as well as training in targeted areas including social justice, healthy aging, and racial equity. The Virginia Community Health Worker Association is a trusted resource to CHWs in Virginia and already conducts similar activities. Providing funding to this organization would help to provide additional training, professional development, and connections for CHWs to support retention efforts; support necessary data collection of the workforce; and ensure CHWs are included in health equity strategic planning efforts across the state.

➔ **Option 16:** The Joint Commission on Health Care could introduce a budget amendment to provide funding to the Virginia Community Health Worker Association (VACHWA) to, in partnership with relevant stakeholders, expand workforce development efforts for community health workers. The VCHWA would report to the Joint Commission on Health Care and the chairs of the Senate Committee Education and Health, and House Committee on Health and Human Services by October 1, 2025, regarding plans for the use of such funding.

Chapter 6: Telehealth

Telehealth is the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. It is a tool that facilitates virtual patient-provider interactions. Telehealth can improve availability and accommodation of health care, improving access for both vulnerable and underserved populations as well as others who utilize health care services. The term "telehealth" is often used as an umbrella term to refer to various services and modalities, such as telemedicine, teledentistry, telepharmacy, telemental health, remote patient monitoring, store-and-forward devices, and audio-only communications (FIGURE 6-1) (see APPENDIX G for descriptions of each of these activities).

FIGURE 6-1. Telehealth is an umbrella term that describes an array of services and modalities



SOURCE: JCHC staff analysis of peer-reviewed literature, 2024

Virginia has consistently supported telehealth development and expansion

Stakeholders interviewed for this study reported that Virginia has been a leader in the telehealth space for several decades. Beginning in the mid-1990's, the University of Virginia (UVA) pursued programs and projects to expand telehealth to meet the healthcare needs of rural populations. Other early efforts to expand access to telehealth services, identified in the Joint Commission on Health Care's (JCHC) 1996 report on telemedicine in the Virginia, included efforts by Virgnia Commonwealth University's Medical College of Virginia (MCV) to provide telehealth in underserved areas of the state and to inmates in the custody of the

Department of Corrections, and the Southwest Virginia Telepsychiatry Project, which established telemental health services at three rural community services board sites. By 1998, the JCHC reported that Virginia's Medicaid program had initiated limited coverage for provider consults and telepsychiatry services. Five years later, Governor Mark Warner's administration oversaw efforts to expand Virginia's Medicaid program to cover telemedicine without geographic restrictions.

The General Assembly has expanded access to telehealth services in the Commonwealth

In 2010, the General Assembly enacted legislation requiring commercial health insurance plans to cover services provided via telemedicine and to reimburse a provider for services delivered through telemedicine at the same rate as services provided in person. In the years that followed, the General Assembly passed laws that regulate how telehealth is conducted, funded telehealth initiatives, and expanded scope of practice for providers delivering services via telehealth. In 2020, the General Assembly directed the Board of Health to create and maintain a Statewide Telehealth Plan to promote an integrated approach to the introduction and use of telehealth services.

The General Assembly rapidly expanded access to telehealth in response to the COVID-19 pandemic

The COVID-19 pandemic forced rapid expansion of telehealth services to ensure individuals continued to receive adequate medical care. During the pandemic, the federal Centers for Medicare and Medicaid Services (CMS) provided flexibility to states to expand coverage for telehealth services in ways that were not previously permissible (see APPENDIX H for a list of federal telehealth flexibilities). The General Assembly leveraged telehealth advancements during the COVID-19 public health emergency to further expand access to telehealth services, enacting legislation over the next several legislative sessions to permanently codify telehealth-related flexibilities offered during the pandemic (See APPENDIX I). For example, in 2022 the General Assembly enacted legislation allowing a health care provider licensed in another state to use telehealth to practice across state lines to provide health care services to a current patient located in Virginia for the purpose of ensuring continuity of care. In 2023, the General Assembly added further flexibility, allowing another provider in the same practice group to provide telemedicine across state lines to a patient in Virginia when the provider with whom the patient had already established a relationship was not available.

The General Assembly funds the Virginia Telehealth Network to expand telehealth services

The Virginia Telehealth Network (VTN) formed in 2006 to promote telehealth in Virginia, striving "to provide education, resources, and best practices to telehealth stakeholders

while advocating for safe and effective delivery of telehealth services." In 2016, the General Assembly began providing funding to VTN to pursue several strategic initiatives related to telehealth. For example, each year VTN conducts a telehealth benchmarking survey which provides a summary of current telehealth usage in Virginia and opportunities for telehealth expansion. In 2022, the General Assembly recognized VTN's role in promoting introduction and integration of telehealth services in Virginia, directing the Board of Health to contract with VTN regularly to update and track compliance with the Virginia State Telehealth Plan.

In 2018, VTN established the Virginia Telemental Health Initiative (VTMHI). VTMHI utilizes telehealth to expand access to mental health services while also working to address workforce issues by helping mental health providers who are in the process of becoming licensed meet their licensure requirements. Through this mutually beneficial program, individuals who are patients of Virginia's free clinics receive free mental health services online from pre-licensed mental health providers seeking to obtain patient contact hours necessary for licensure.

Virginia offers comprehensive telehealth services with few restrictions

Compared to other states, Virginia is less restrictive than other states, in defining uses and parameters for telehealth, giving Virginians significant access to telehealth services (see TABLE 6-1). Virginia's Medicaid program covers a wide array of health care services provided via telehealth, though some services are subject to restrictions that may limit access. Virginia's Medicaid program reimburses both a facility fee and a transmission fee for telemedicine, remote patient monitoring, store-and-forward, virtual check-in, and audio-only telehealth services. Virginia is also in the majority of states that have established private payer laws prohibiting commercial health plans from excluding a service from coverage solely because the service is provided via telehealth and not provided in person. Virginia also requires that insurers reimburse a treating provider or consulting provider for the diagnosis, consultation, or treatment of an insured person delivered via telemedicine on the same basis as the provision of the same service through face-to-face consultation or contact.

TABLE 6-1. Telehealth limitations and allowances in Virginia compared to other states

Type of Limitation/Allowance	Allowed in Virginia?	Number of States with Limitations/Allowances similar to Virginia
Live Video Reimbursement	Yes	50
Store-and-Forward	Yes	33
Remote Patient Monitoring	Yes	37
Audio-Only	Yes	43
Informed Consent Requirement in statues, administrative code, or Medicaid Policy	Yes	45
Reimbursement for transmission, facility fee, or both	Yes, Both	35
Originating Site List or Restrictions	No	33
Private Payer Laws	Yes	43
Explicit Payment Parity	Yes	26

SOURCE: JCHC staff analysis of The National Telehealth Policy Resource Center Policy Trends Maps

Telehealth improves access to health care for vulnerable and underserved populations

Telehealth increases access to health care for many people; however, there are specific populations that can particularly benefit from telehealth services. Typically, these populations are vulnerable, underserved, or both. Telehealth can help vulnerable and underserved populations overcome barriers to health care created by lack of access to transportation and lack of access to culturally competent care. Telehealth can also improve efficiency of health care practices and help mitigate effects of health care provider workforce shortages, improving the ability of providers to offer health care services. Ultimately, telehealth can be a tool to enhance vulnerable and underserved Virginians' access to health care services to which they would otherwise not have access.

Telehealth can increase patient access to care by removing transportation related barriers

Transportation-related issues are frequently reported as barriers to accessing health care services. Patients may lack access to vehicles or transit services to travel to health care appointments. In areas where providers are not readily available, patients may have to travel long distances to reach health care services. For patients that require more frequent health care services, such as patients with chronic conditions that require regular appointments to monitoring their conditions, the burden created by regular travel to and from appointments can be significant. And for certain populations, such as older adults and

institutionalized individuals, the need to travel to access health care services can pose additional challenges that negatively impact access to care. Telehealth can help overcome transportation-related barriers to care, eliminating the need to travel to connect with providers, better facilitating access to care and maintaining continuity of care when transportation is unreliable or unavailable or travel is difficult.

Telehealth can improve patients' access to care by increasing access to culturally appropriate care

Lack of culturally appropriate care can be a barrier to healthcare utilization for individuals who are members of racial and ethnic minority groups. Using telehealth can bridge the gap created by lack of culturally appropriate care by allowing patients the opportunity to connect with interpreters or with culturally competent providers who may be able to more appropriately serve their specific needs. Research indicates that improvements in health outcomes from the use to telehealth are evident among patients who are members of racial minority groups, when telehealth services are delivered in a culturally appropriate manner that considers groups' digital and health literacy. For example, one study found that digital health interventions improved cardiovascular related health outcomes for patients who are members of racial minority groups as well as patients of lower socioeconomic status in both rural and urban settings.

Telehealth can improve access to care by improving efficiency of healthcare practices

Telehealth is efficient and can help providers reduce wait times for in-office visits and streamline healthcare services. In a 2024 VTN benchmarking survey, 88.2 percent of providers reported that telehealth allows them to have more schedule flexibility and 84.1 percent of providers reported that telehealth allows them to see more patients. Stakeholders report using telehealth to triage patients before they come into the office, making the office visit more efficient. Telehealth can also reduce opportunity costs for patients, such as lost wages and costs associated with travel, resulting in fewer no shows for appointments. Providers also reported that telehealth allows them to more easily connect patients with other specialty providers outside of their local area, who may be able to more accurately diagnose or treat a patient.

Telehealth can improve access to health care by mitigating the effects of workforce shortages

Telehealth can also assist with filling workforce shortage gaps. The health care workforce has contracted, especially following the COVID-19 pandemic, and stakeholders stated that telehealth has assisted with filling gaps for maternity and obstetrics care, behavioral health care, rural healthcare, pharmacy services, and primary care services. According to stakeholders, access to telehealth services has proved to be an important solution to meet

the healthcare needs of patients, especially during a time when finding an adequate number of providers is a challenge.

Lack of coordination and support, limited access to technology, and lack of reliable funding are barriers to telehealth

Telehealth increases access to care and has been shown to improve health outcomes for patients; however, many factors influence a patient's ability to use telehealth services. Systemic and individual barriers to accessing telehealth can hinder a patient's uptake of telehealth services. Certain populations may experience additional barriers beyond those faced by a typical patient due to their unique needs not being adequately met.

Inadequate coordination of telehealth initiatives, lack of training and guidance for providers creates challenges to expansion of telehealth services

Stakeholders in Virginia have undertaken numerous initiatives to expand access to telehealth services, but insufficient monitoring and coordination may limit the effectiveness of these efforts. The Virginia Department of Health (VDH) is tasked with developing and implementing the Virginia Telehealth State Plan to promote an integrated approach to the introduction and use of telehealth services; however, it does not have a full-time position dedicated to supporting telehealth initiatives in the state. Stakeholders attributed several issues to this lack of dedicated staff, including failure to maintain progress on the Telehealth State Plan and lack of provider education on telehealth. Stakeholders report that progress toward implementation of the current State Telehealth Plan is not being monitored, resulting in a lack of clarity regarding the status of current telehealth initiatives, and efforts to update the plan consistent with statutory requirements have been sporadic due to agency delays in contracting and payments.

Stakeholders also report that a lack of awareness regarding Medicaid coverage for telehealth services and a lack of guidance about telehealth best practices are barriers to providing telehealth services. This is an issue particularly in Virginia where telehealth services are rapidly expanding and changing each year. In the absence of clear guidance for the use of telehealth, providers may be disinclined to use telehealth services or to use telehealth inappropriately. While resources for providers exist through entities such as VTN and the Mid-Atlantic Telehealth Resource Center, providers appear to be unaware of these resources, suggesting the need for state-level coordination of provider education on telehealth.

Creating a position within VDH dedicated to coordinating and supporting telehealth efforts in Virginia could help address barriers to telehealth. Full-time staff could develop and disseminate materials for providers and improve efficiency of contracting and payment of

outside organizations to facilitate better monitoring of implementation of and more regular updates to the State Telehealth Plan.

➔ **Option 17:** The Joint Commission on Health Care could introduce a budget amendment to provide funding for a Telehealth Coordinator position at the Virginia Department of Health.

One specific area in which telehealth providers may require additional training and guidance is the delivery of telehealth services to individuals with disabilities. Some stakeholders reported that providers can feel uncomfortable providing care to patients with disabilities via telehealth due to a lack of experience with and understanding of the unique needs of the patient. With increased training in this area providers may become more comfortable providing telehealth services to patients with disabilities, which would increase access to telehealth services for this population. The Department of Behavioral Health and Developmental Services (DBHDS) is adequately equipped to develop and disseminate training materials for providers to educate and support providers on providing health care services to patients with disabilities via telehealth.

➔ **Option 18:** The Joint Commission on Health Care could introduce legislation directing the Department of Behavioral Health and Developmental Services to work with relevant state agencies and stakeholders to develop and disseminate best practice educational training for providers on how to conduct telehealth visits for patients with disabilities, including individuals with intellectual and developmental disabilities.

Limited access to broadband and telehealth technology restricts patients' access to telehealth services

Limited access to broadband service and telehealth technology were frequently mentioned barriers in interviews JCHC staff conducted with stakeholders. In VTN's 2024 benchmarking survey, 72.9 percent of providers reported that internet connectivity for patients was a top area for improving telehealth services in Virginia and 53.3 percent of providers reporting that patients' access to devices was another top area for improvement. Patients' lack of access to broadband and the necessary telehealth technology can be attributed to a variety of reasons including the cost of the technology and broadband, poor usability of the telehealth technology, or the patient's lack of digital literacy.

The Department for Housing and Community Development (DHCD) operates the Broadband Equity, Access, and Deployment (BEAD) Program, which aims to expand broadband access to remaining unserved locations that do not have a funded solution for connectivity. However, there are still areas of the Commonwealth – particularly rural areas - with limited access to broadband. This lack of access to adequate broadband creates a gap between intended reach and actual implementation of telehealth services.

Stakeholders interviewed by JCHC staff also reported that patients may face barriers to utilizing telehealth technology. Some patients lack digital literacy and do not feel

comfortable using telehealth technology. Patients with disabilities may struggle with using telehealth technology that was not designed with their unique needs in mind. Some patients report issues with platform interoperability and lack of system uniformity, which makes accessing telehealth services difficult. In a 2024 VTN benchmarking survey, 51.4 percent of providers reported that technical assistance for patients was a top area needed to improve telehealth services in Virginia.

Telehealth Access Points could increase access to telehealth services for patients in areas where broadband access is an issue

Telehealth Access Points (TAPs) are pre-existing community spaces that have the technology and internet infrastructure necessary to support telehealth services. They can be established in various settings, such as pharmacies, schools, libraries, and community centers. Many locations at which TAPs are established also have staff who can assist patients with telehealth technology, helping to overcome barriers to telehealth created by lack of digital literacy, lack of comfort with telehealth, and other individual barriers to accessing telehealth services.

Pharmacy Care Hubs are TAPs located in pharmacies. Pharmacy staff are available during telehealth visits to help patients utilize telehealth technology. Pharmacy staff may also perform various tests as directed by the physician, administer vaccines, or provide therapeutic injections during the telehealth visit. If medication is prescribed during the visit, the pharmacist may dispense the medication prior to the end of the appointment. Currently, United Health Care operates 11 Pharmacy Care Hubs in Virginia. VTN is appropriately positioned through their experience with other TAP programs to expand the Pharmacy Care Hub model in Virginia over a multi-year period. VTN could first lead a feasibility study to identify actionable models and prospective partners, then develop a plan for deployment of Pharmacy Care Hubs across the Commonwealth.

➔ **Option 19:** The Joint Commission on Health Care could introduce a budget amendment to provide funding to allow the Virginia Telehealth Network to conduct a feasibility study and develop a plan to implement a pilot program to provide funding for Pharmacy Care Hubs, particularly for Medicaid patients. The VTN would report to the Joint Commission on Health Care by November 1, 2025, regarding the results of the feasibility study and the plan to implement additional Pharmacy Care Hubs in Virginia.

Schools can also be TAPs. Several school divisions in Virginia have established programs to provide students with access to telehealth services. For example, Washington County Public Schools in Southwest Virginia has developed a partnership with Ballad Health that allows students and staff to connect to urgent care physicians or nurse practitioners via telehealth for evaluations, testing, diagnosis, and treatment. Creating additional TAPs in schools could expand access to health care services for vulnerable and underserved populations in Virginia. As a first step, local boards of education would need to adopt policies to set

parameters for school-based TAPs and facilitate students' access to telehealth services in schools during the school day.

➔ **Option 20.** The Joint Commission on Health Care could introduce legislation directing the Virginia Board of Education to require local boards of education to establish policies to facilitate students' access to telehealth services during the school day, including designating private spaces for appointments to occur.

Gaps in coverage and insufficient reimbursement for telehealth are barriers to telehealth implementation

Coverage Parity requires the same services be covered via telehealth as would be covered if delivered in-person.

Payment Parity is a requirement for the same payment rate or amount to be reimbursed for services provided via telehealth as would be available if the service had been delivered in-person.

Stakeholders frequently described lack of coverage and insufficient reimbursement as factors limiting the uptake of telehealth in Virginia. In a 2024 VTN benchmarking survey only 47.3 percent of respondents agreed that reimbursement for telehealth is adequate and 66.2 percent of respondents identified reimbursement as a top area for improvement of telehealth in Virginia. Low reimbursement rates and lack of coverage for some telehealth services disincentivize providers from offering telehealth services because they are receiving less compensation for what they view as the same amount of patient care.

Providing funds to reimburse providers for e-consults could alleviate some financial barriers to telehealth services.

E-consults are communications between health care providers via telehealth. Providers can use e-consults in the emergency department to get recommendations for complicated conditions from providers in other locations with additional expertise, for example in specialty areas like acute care for stroke, trauma, ICU, or behavioral health.

E-consults (SIDEBAR) were approved for reimbursement through Medicaid during the 2022 legislative session, but the General Assembly did not appropriate funds for this purpose. In the 2024 VTN survey, 56.5 percent of providers reported that synchronous provider-to-provider consultations was the modality of telehealth that they used most frequently. Appropriating funds to provide reimbursement for e-consults allow providers to be compensated for time spent consulting on patient care.

➔ **Option 21:** The Joint Commission on Health Care could introduce a budget amendment to appropriate the funds for e-consults.

Restrictions on Medicaid coverage for remote patient monitoring limit access to this service

Virginia's Medicaid program provides coverage for remote patient monitoring (see APPENDIX G for full definition); however, restrictions on the use of this service create a barrier to access. Currently, only high-risk pregnant patients, medically complex infants and children, transplant patients, patients who have undergone surgery within the past three months, and certain patients with chronic conditions are eligible for remote patient monitoring. A patient with a chronic condition is eligible for remote patient monitoring if he or she has been hospitalized two or more times or visited the emergency department two or more times within the last year for reasons related to his or her chronic condition. Limitations on the use of remote patient monitoring, particularly with regard to patients with chronic conditions, may not be the most effective way to utilize the service as it is reactive rather than proactive and requires the patient to experience a medical emergency before remote patient monitoring can be initiated. Expanded, proactive use of remote patient monitoring could improve health outcomes for patients by allowing health care providers to identify changes in a patient's health status before the patient's condition deteriorates or detect the onset of a medical emergency earlier, thus reducing the need for higher-intensity or emergent health care services.

Other states have expanded Medicaid coverage of remote patient monitoring to make the service available to individuals with diabetes without requiring that the individual first experience a medical emergency. For example, in both Kentucky and Texas patients with diabetes can receive remote patient monitoring services for many different reasons including a documented history of poor adherence to medication regimens, limited informal support systems, or because the patient lives alone or is alone for extended periods of time. Minnesota provides Medicaid coverage for remote patient monitoring for patients with diabetes as long as the prescribing provider has identified and documented how telemonitoring services would likely prevent the member's admission or readmission to a hospital, emergency room or nursing facility. This preventative approach allows patients who are at risk of a medical emergency to receive remote patient monitoring before an emergency occurs, potentially providing improved health outcomes for the patient and cost savings for the state.

➔ **Option 22:** The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to develop a plan and estimate costs for expanding eligibility criteria under Medicaid for remote patient monitoring for individuals with chronic conditions and to report to the Joint Commission on Health Care by October 1, 2025, regarding such plan and estimated costs.

Inconsistent coverage for audio-only visits may dissuade providers from providing telehealth services

The *Code of Virginia* prohibits an insurer from refusing to cover a health care service solely because the service is provided through telemedicine rather than face-to-face consultation or contact between a health care provider and a patient, provided the insurer has determined that the health care service is appropriate to be delivered via telemedicine. However, language included the *Code of Virginia* explicitly excludes health care services provided by "audio-only telephone" from the definition of "telemedicine," so that the prohibition on excluding services provided by telemedicine does not apply to telemedicine services provided by audio-only telephone. While some insurers may choose to reimburse for some audio-only telehealth services, stakeholders reported that some insurers refuse to cover audio-only telephone visits, leaving a gap in coverage.

Despite gaps in coverage for telehealth services provided by audio-only telephonic communication, stakeholders report frequently using the modality to provide services to patients who are unable to access other forms of telehealth due to a lack of access to broadband or telehealth technology. In a 2024 VTN survey, 50.5 percent of providers reported that audio-only patient encounters were one of the most frequently used telehealth modalities. Due to gaps in insurance coverage, providers are often unable to receive reimbursement for these services when the patient is covered by a commercial health insurance policy. Virginia's Medicaid program does cover telehealth services provided by audio-only telephonic communication when the provider determines that delivery of the health care service via audio-only telephonic communication is appropriate and in-person services are not medically or clinically necessary and the service is delivered consistent with the same standard of care as is required when the service is provided in-person.

Requiring insurers to reimburse telehealth services provided via audio-only telephonic communication to the same extent that they reimburse other services provided by telehealth would compensate providers for time spent providing these services and could increase access to telehealth services for individuals who are unable to access other forms of telehealth, expanding access to health care for vulnerable and underserved populations. Requiring that telehealth services be clinically appropriate for audio-only telephonic communication, audio-only telephone telehealth services be provided consistent with the same standard of care as is applicable to in-person services, and that audio-only telephone telehealth only be covered when other forms of telehealth are not available or cannot be accessed by the patient could ensure that providers are utilizing audio-only telephone telehealth services in an appropriate manner, reduce opportunities for fraud, and ensure that patients are receiving appropriate care.

➔ **Option 23:** The Joint Commission on Health Care could introduce legislation removing the exclusion of audio-only telephonic communication from the definition of telemedicine and requiring insurers to cover audio-only telephone telehealth visits to the same extent

that they cover other types of telemedicine services in cases in which audio-only telephone telehealth services are clinically appropriate, provided consistent with the same standard of care as is applicable to comparable in-person services, and utilized only in cases in which other forms of telehealth are not available or cannot be accessed by the patient.

Lack of resources to expand capacity of programs that provide telehealth access limits access to services for some vulnerable and underserved populations

Telehealth can expand access to healthcare for vulnerable and underserved populations. However, existing telehealth programs focusing on specific patient populations often lack adequate resources to meet demand for program services while lack of resources often prohibit implementation of new programs to serve specific vulnerable or underserved populations. Providing or increasing funding for telehealth programs would expand access to health care services for vulnerable and underserved patients.

Additional funding for the Virginia Telemental Health Initiative could increase access to mental health services for underserved individuals

Telehealth is a useful tool for providing mental health services to patients. Research demonstrates that efficacy rates for telemental health are similar to rates for in-person mental health services. Telemental health has been shown to improve mental health symptoms, patient satisfaction, quality of life, cost-effectiveness of treatment, and reliable diagnoses. Stakeholders interviewed by JCHC staff indicate that mental health care is ideally suited for telehealth as there is less need for in-person physical interactions. They also suggested that using telehealth for mental health treatment increased access to mental health services by mitigating some of the challenges created by the severe workforce shortage for mental health providers. Stakeholders felt that telemental health expanded the number of potential providers from whom a patient could receive care from because the provider and the patient do not need to be physically located in the same city or even region for treatment to occur.

The General Assembly provides funding to VTN to implement the VTMHI, focused on expanding access to telemental health services and addressing workforce barriers. During their pilot year, VTMHI scheduled nearly 1,000 patient visits and provided clinical hours for 43 pre-licensed mental health professionals. VTMHI plans to continue to increase training and implementation opportunities, with the goal of serving 45 free and charitable clinics, providing over 10,000 telemental health visits, and support a network of more than 100 pre-licensed mental health professionals through 2026. VTMHI also aims to increase its patient services by 50 percent with an emphasis on serving a more complex patient population with culturally and linguistically appropriate services. They estimate that with increased funding they could provide clinical hour opportunities to an additional 36 pre-licensed mental health professionals and serve 160 additional patients. Overall, they anticipate 2,390 new patient visits if they are awarded additional funding from the General

Assembly. VTMHI is a state-funded and established program which already has the infrastructure in place to expand access to telemental health services for patients, while also helping with workforce development, making this program a viable opportunity to increase telemental health capacity in Virginia.

➔ **Option 24:** The Joint Commission on Health Care could introduce a budget amendment to increase funding for the Virginia Telemental Health Initiative by $482,000 to support increasing patients served by 50 percent.

Funding for teledentistry programs in nursing homes could expand access to oral health services for older adults

Teledentistry involves the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. It is the method of delivering oral health care and education via a virtual platform, enabling clinicians to communicate with patients for advice, consultation, and triage. It facilitates the creation of a comprehensive record that includes images, forms, consent, and payment, functioning as both an electronic dental record (EDR) and an administrative system. Importantly, teledentistry is not a specific service and does not alter a provider's scope of practice; healthcare professionals may not perform procedures virtually that they would not be authorized to perform in person.

Older adults in nursing homes have frequent oral health needs; however, these individuals often face numerous transportation-related barriers to receiving services in a dental office. Through expanded use of teledentistry (SIDEBAR), older adults in nursing homes can receive virtual oral screenings with a distant site dentist supported by an on-site dental or medical care provider (i.e., dental hygienist, dental assistant, nurse, or medical assistant) present at the facility. These virtual appointments can identify any emergent or urgent needs as well as any opportunities for preventive or palliative care necessary to maintaining good oral health for the patient. At the end of the appointment, the on-site provider can assist with coordination of follow-up care and assist the patient with navigating transportation to the dental clinic to address any emergent, urgent, or preventive oral health care needs that require in-person care. This model provides the potential to address barriers residents of nursing facilities often face when seeking oral health care as well as promote medical-dental integration to enhance whole-person health.

Virginia Health Catalyst is an organization which focuses on improving oral health care for Virginians. More recently, they have been working on initiatives focused on teledentistry and assisting dental offices with incorporating teledentistry into their practices, as well as promoting teledentistry adoption in schools. They have successfully implemented school-based teledentistry programs by leveraging relationships with local FQHC's and community health centers to provide oral healthcare to students at Title I schools. This same model could be implemented in nursing homes as a way to provide teledentistry to the older adult population.

➔ **Option 25:** The Joint Commission on Health Care could introduce a budget amendment to provide funding to Virginia Health Catalyst to, in collaboration with the Oral Health Task Force, plan and implement a pilot program, through Federal Qualified Health Centers and local community health centers, in which dental hygienists deliver teledentistry services in nursing homes.

Policies to accommodate telehealth visits could expand access to health care for incarcerated individuals

Incarcerated individuals are another vulnerable population that could be better served through telehealth. The Virginia Department of Corrections (VADOC) is responsible for providing healthcare to inmates including nurse and doctor sick calls, chronic care visits, dental visits, and other specialty appointments. In a 2018 report on VADOC spending on healthcare, JLARC found that, VADOC "transported inmates for offsite care and back more than 25,000 times at an estimated cost of between $1.3 and $1.6 million for fuel and vehicle maintenance." More fully incorporating telehealth services within VADOC, could reduce unnecessary and expensive transport of inmates.

The Mid-Atlantic Telehealth Resource Center (SIDEBAR) established a tele-corrections workgroup in March 2020 with the goals of reducing the healthcare transport of offenders by staff and establishing a more robust and secure telemedicine capability for VADOC inmates. One month later, VADOC began a pilot program in several correctional centers, allowing on-site clinical staff to use a secure tablet loaded with the necessary applications and connected to wireless peripheral devices, such as blood pressure monitors or stethoscopes, to connect to providers. The pilot continued throughout the pandemic and had the goal of eventually expanding to all 43 VADOC sites. Based on the momentum of this pilot program it appears the VADOC has the infrastructure and tools in place to continue expanding telehealth services for inmates.

Telehealth Resource Centers are federally funded to assist with the development of sustainable telehealth programs as a way to increase access to quality care, with a focus on rural and other traditionally underserved and/or vulnerable populations.

➔ **Option 26:** The Joint Commission on Health Care could introduce legislation requiring the Department of Corrections and the Virginia Board of Local and Regional Jails to establish policies to accommodate inmates needing to participate in telehealth appointments, including designating a private space for such appointments to occur.

Chapter 7: Summary

The strategies presented in this report – mobile health clinics, community paramedicine, home visiting, community health workers, and telehealth – approach extending access to care for vulnerable populations through different means. As illustrated in Table 7-1, the strategies target domains of access to care; however, the number of domains targeted, and the scope of their impact vary. For example, mobile health clinics address multiple barriers to care, including approachability, acceptability, availability, and affordability, for targeted populations in Virginia. In contrast, telehealth improves the availability of health care, addressing one significant barrier for whole populations.

TABLE 7-1: Strategies address multiple domains of health care access

Access to Care Domains	Mobile Health Clinics	Community Paramedicine	Home Visiting	Community Health Workers	Telehealth
Approachability	X		X	X	
Acceptability	X	X	X	X	
Availability and Accommodation	X	X			X
Affordability	X	X			
Appropriateness			X	X	

SOURCE: JCHC staff analysis, 2024.

Notably, no strategy addressed in this report impacts all domains. As such, wholistically addressing access to care requires weaving together multiple strategies that address discrete access issues within a broader strategy of addressing other institutional access issues not covered in this report, such as workforce shortages, access to insurance coverage, and the costs of health care. Policy options JCHC members could consider to further extend access using the strategies addressed in this report are summarized in Table 7-2.

TABLE 7-2: Policy options reflect multiple strategies to extend health care access

Mobile Health Clinic Policy Options
Option 1: The Joint Commission on Health Care could introduce legislation directing the Board of Pharmacy to work with the Department of Behavioral Health and Developmental Services to develop a process by which opioid treatment programs can apply for and receive necessary permissions and waivers to allow dispensing of opioid use disorder treatment medications from mobile units. The Board would report on the status of the process and any barriers to developing and implementing such process to the Joint Commission on Health Care by November 1, 2025. (pg. 13)
Option 2: The Joint Commission on Health Care could introduce legislation directing the Department of Housing and Community Development to include broadband access services for mobile health clinics as a priority for broadband adoption programs using Broadband Equity, Access, and Deployment Program funding, as part of the Department's broader initiative to support other telehealth adoption programs. (pg. 17)
Option 3: The Joint Commission on Health Care could introduce a budget amendment to establish a grant program administered by the Virginia Department of Health supporting mobile health clinics operated by local health departments and community-based organizations that provide services in rural and underserved areas. (pg. 19)

Community Paramedicine Policy Options
Option 4: The Joint Commission on Health Care could introduce legislation directing the Virginia Department of Health's Office of Emergency Medical Services to report to the Joint Commission on Health Care by October 1, 2025, regarding the status of draft regulations related to community paramedicine and mobile integrated healthcare. (pg. 24)
Option 5: The Joint Commission on Health Care could introduce a budget amendment to establish a grant program or expand an existing grant program administered by the Virginia Department of Health's Office of Emergency Medical Services to provide funding to emergency medical services agencies for community paramedicine and mobile integrated healthcare programs. (pg. 29)
Option 6: The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to cover HCPCS Code A0998 treatment without transport when Medicaid patients call 911. (pg. 30)
Option 7: The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to work with the Virginia Department of Health's Office of Emergency Medical Services to develop a plan for reimbursing community paramedicine and mobile integrated healthcare services in Virginia, in consultation with community paramedicine programs and other stakeholders including hospital systems and health plans. The plan should specify the circumstances under which services would be covered; eligible patient populations; eligible providers; whether the model would require a State Plan Amendment or modification of MCO contracts; and whether reimbursement would be a flat fee or allow billing for individual services. The Department of Medical Assistance Services would report to the Joint Commission on Health Care by October 1, 2025, regarding the content of the plan. (pg. 32)
Option 8: The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to seek approval from the Centers for Medicare and Medicaid Services for implementation of the Ground Emergency Medical Transportation (GEMT) program in Virginia, to allow emergency medical services providers in Virginia to receive supplemental reimbursement for uncompensated costs related to the transfer of Medicaid patients. (pg. 33)

Home Visiting Policy Options
Option 9: The Joint Commission on Health Care could introduce a budget amendment to provide funding to Families Forward Virginia to serve a new cohort of parents that will be part of a randomized control trial required to collect evidence to be submitted to the federal Department of Health and Human Services to determine whether CHIP of Virginia meets criteria for certification as an evidence-based home visiting model consistent with the Department's Home Visiting Evidence of Effectiveness criteria. (pg. 44)
Option 10: The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services, in conjunction with relevant stakeholders, to convene a workgroup to develop a plan for home visiting benefit for pregnant and postpartum individuals and their families. The workgroup shall develop consensus with stakeholders and make recommendations in the plan regarding the design of various program elements including service definitions, administrative structure, eligibility criteria, provider participation requirements, population prevalence, service setting options, and federal evaluation requirements, to guide any future cost impact analysis for the proposed home visiting benefit that may be required. The Department would report to the Joint Commission on Health Care and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1st, 2025, regarding the plan for the design of a home visiting benefit and any next steps which shall be necessary for federal approval and implementation of the home visiting benefit. (pg. 45)

Community Health Workers Policy Options
Option 11: The Joint Commission on Health Care could introduce a budget amendment to provide an additional $2.5 million to the Virginia Department of Health (VDH) in fiscal year 2026 to support all remaining community health worker (CHW) positions initially supported by federal funding and remove language requiring VDH to prioritize CHW positions in high maternal mortality areas to allow flexibility of localities to develop and implement CHW-led programs that address community needs. (pg. 50)
Option 12: The Joint Commission on Health Care could introduce a budget amendment directing the Virginia Department of Health to report annually, by November 1, to the chairs of the Senate Finance and Appropriations and House Appropriations Committees and the Director of Department of Planning and Budget regarding the numbers of community health workers employed within state and local health departments, the type of services provided by CHWs and performance and outcome measures for such services, the need for additional CHWs to meet demand for services provided by state and local health departments, any success in attracting non-state resources, and descriptions of the contracts entered by localities. (pg. 51)
Option 13: The Joint Commission on Health Care could introduce a budget amendment directing the Department of Medical Assistance Services (DMAS) to convene a work group of stakeholders to design a state plan amendment (SPA) to provide reimbursement for services provided by Certified Community Health Workers (CCHWs). The plan shall include service definitions, administrative structure, eligibility criteria, provider participation requirements, population prevalence, service setting options, and federal evaluation requirements. The Department shall report to the Joint Commission on Health Care and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees regarding the plan for a SPA to provide reimbursement for services provided by CCHWs and any next steps necessary for federal approval and implementation of the SPA by October 1, 2025. (pg. 52)
Option 14 The Joint Commission on Health Care could introduce a budget amendment directing the Department of Medical Assistance Services to convene a workgroup to identify opportunities to expand use of community health workers by Medicaid managed care organizations. (pg. 54)

Option 15: The Joint Commission on Health Care could introduce legislation directing the Virginia Department of Health (VDH) to convene a work group composed of representatives of the Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), and other relevant stakeholders to determine the feasibility of developing flexible training and certification standards that allow community health workers (CHWs) to use their education and experience to satisfy some of the requirements for qualification as a state-certified doula or registered peer recovery specialist. The workgroup would report on activities to the Joint Commission on Health Care and the chairs of the Senate Committee on Education and Health and House Committee on Health and Human Services by October 1, 2025. (pg. 56)

Option 16: The Joint Commission on Health Care could introduce a budget amendment to provide funding to the Virginia Community Health Worker Association (VACHWA) to, in partnership with relevant stakeholders, expand workforce development efforts for community health workers. The VCHWA would report to the Joint Commission on Health Care and the chairs of the Senate Committee Education and Health, and House Committee on Health and Human Services by October 1, 2025, regarding plans for the use of such funding. (pg. 57)

Telehealth Policy Options

Option 17: The Joint Commission on Health Care could introduce a budget amendment to provide funding for a Telehealth Coordinator position at the Virginia Department of Health. (pg. 64)

Option 18: The Joint Commission on Health Care could introduce legislation directing the Department of Behavioral Health and Developmental Services to work with relevant state agencies and stakeholders to develop and disseminate best practice educational training for providers on how to conduct telehealth visits for patients with disabilities, including individuals with intellectual and developmental disabilities. (pg. 64)

Option 19: The Joint Commission on Health Care could introduce a budget amendment to provide funding to allow the Virginia Telehealth Network to conduct a feasibility study and develop a plan to implement a pilot program to provide funding for Pharmacy Care Hubs, particularly for Medicaid patients. The VTN would report to the Joint Commission on Health Care by November 1, 2025, regarding the results of the feasibility study and the plan to implement additional Pharmacy Care Hubs in Virginia. (pg. 65)

Option 20. The Joint Commission on Health Care could introduce legislation directing the Virginia Board of Education to require local boards of education to establish policies to facilitate students' access to telehealth services during the school day, including designating private spaces for appointments to occur. (pg. 66)

Option 21: The Joint Commission on Health Care could introduce a budget amendment to appropriate the funds for e-consults. (pg. 66)

Option 22: The Joint Commission on Health Care could introduce legislation directing the Department of Medical Assistance Services to develop a plan and estimate costs for expanding eligibility criteria under Medicaid for remote patient monitoring for individuals with chronic conditions and to report to the Joint Commission on Health Care by October 1, 2025, regarding such plan and estimated costs. (pg. 67)

Option 23: The Joint Commission on Health Care could introduce legislation removing the exclusion of audio-only telephonic communication from the definition of telemedicine and requiring insurers to cover audio-only telephone telehealth visits to the same extent that they cover other types of telemedicine services in cases in which audio-only telephone telehealth services are clinically appropriate, provided consistent with the same standard of care as is applicable to comparable in-person services, and utilized only in cases in which other forms of telehealth are not available or cannot be accessed by the patient. (pg. 68)

Option 24: The Joint Commission on Health Care could introduce a budget amendment to increase funding for the Virginia Telemental Health Initiative by $482,000 to support increasing patients served by 50 percent. (pg. 70)
Option 25: The Joint Commission on Health Care could introduce a budget amendment to provide funding to Virginia Health Catalyst to, in collaboration with the Oral Health Task Force, plan and implement a pilot program, through Federal Qualified Health Centers and local community health centers, in which dental hygienists deliver teledentistry services in nursing homes. (pg. 71)
Option 26: The Joint Commission on Health Care could introduce legislation requiring the Department of Corrections and the Virginia Board of Local and Regional Jails to establish policies to accommodate inmates needing to participate in telehealth appointments, including designating a private space for such appointments to occur. (pg. 71)

Appendix A: Study Resolution

Strategies to Extend Health Care Access to Vulnerable Populations

Authorized by the Joint Commission on Health Care on December 6, 2023

WHEREAS, more than three-quarters of Virginia's localities lack sufficient access to health care services and are federally designated as medically underserved; and

WHEREAS, individuals with limited access to quality health care due to age, geographic location, language spoken, health literacy, chronic illness or disabilities, race or ethnicity, poverty, or gender are vulnerable to poor health outcomes; and

WHEREAS, local health departments and health systems have consistently identified a need to extend health care access directly to the communities where vulnerable populations live to ensure timely care is received before a condition becomes emergent; and

WHEREAS, alternative models for extending health care access to vulnerable populations, including community paramedicine, home visiting, mobile health clinics, telehealth, and use of community health workers, are becoming increasingly common; now, therefore be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to study the impact of models to extend health care access to vulnerable populations in Virginia.

In conducting its study, staff shall (i) evaluate alternative models for extending health care access, including determining which populations benefit from these strategies, how these services are delivered, and how the costs of these services compare to their anticipated benefit; (ii) identify the ways in which peer states support similar alternative models; and (iii) develop policy options through which Virginia may support effective models to extend health care access to vulnerable populations.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Department of Health, the Virginia Department of Social Services, the Virginia Department for Aging and Rehabilitative Services, the Virginia Department of Behavioral Health and Developmental Services, and the Virginia Department of Medical Assistance Services, shall provide assistance, information, and data to the Joint Commission on Health Care for this study upon request.

Appendix B. Organizations with mobile health clinic operations

Joint Commission on Health Care staff identified 58 organizations that currently operate, plan to operate, or partner to operate one or more mobile health clinics in the state (TABLE B-1).

TABLE B-1. JCHC staff identified 58 organizations across the health care ecosystem with mobile health clinic operations

Organization Type	Organization Name
Federally Qualified Health Center	Capital Area Health Network
Federally Qualified Health Center	Johnson Health Center
Federally Qualified Health Center	Clinch River Health Services
Federally Qualified Health Center	Neighborhood Health
Federally Qualified Health Center	Tri-Area Community Health
Federally Qualified Health Center	Hampton Roads Community Health Center
Federally Qualified Health Center	Connect Health + Wellness
Free Clinic	Augusta Regional Dental Clinic
Free Clinic	Fralin Free Clinic
Free Clinic	Health Brigade
Free Clinic	Mel Leaman Free Clinic
Free Clinic	Crossroads Medical Mission
Free Clinic	Purpose Medical Outreach
Health Care Company	Optum
Health Care Company	Sentara Health
Health Care Company	Kaiser Permanente
Health Plan - Medicaid	Aetna
Health Plan - Medicaid	Molina Healthcare
Hospital System	Ballad Health
Hospital System	Augusta Health
Hospital System	Bon Secours
Hospital System	Centra Health
Hospital System	Chesapeake Regional Healthcare
Hospital System	Riverside Health

Organization Type	Organization Name
Hospital System	UVA Health
Hospital System	Valley Health
Hospital System	Inova Health System
Nonprofit	The Health Wagon
Nonprofit	Rockbridge Area Health Center
Nonprofit	Daily Planet
Nonprofit	Conexus Vision
Nonprofit	New Hope Housing
State - Agency	Virginia Department of Behavioral Health and Developmental Services
State - CSB	Chesapeake Integrated Behavioral Healthcare
State - CSB	Eastern Shore Community Services Board
State - CSB	Hampton-Newport News Community Services Board
State - CSB	Piedmont Community Services Board
State - CSB	Valley Community Services Board
State - Health Department	Blue Ridge Health District
State - Health Department	Chesapeake Health District
State - Health Department	Cumberland Plateau/Lenowisco Health District
State - Health Department	Eastern Shore Health District
State - Health Department	Hampton/Peninsula Health District
State - Health Department	Mount Rogers Health District
State - Health Department	New River Health District
State - Health Department	Prince William Health District
State - Health Department	Rappahannock Health District
State - Health Department	Richmond/Henrico Health District
State - Health Department	Roanoke/Allegheny Health District
State - Health Department	Chesterfield HD
State - Health Department	Loudoun HD
State - Health Department	Fairfax HD
State - Health Department	Western Tidewater HD
State - Health Department	Central Shenandoah HD
State - Public Schools	Loudoun County Public Schools
University	Virginia Tech

Organization Type	Organization Name
University	Old Dominion University
University	VCU School of Nursing

SOURCE: JCHC staff identification via snowball sampling and review of available program documentation, 2024.

NOTE: Table includes organizations that currently operate, plan to operate, or partner to operate mobile health clinics. Many organizations operate more than one mobile health unit.

Appendix C: OEMS has reviewed Notice of Intent paperwork for most community paramedicine programs operating in Virginia

Currently, the Virginia Department of Health's Office of Emergency Medical Services (OEMS) has received and reviewed Notice of Intent paperwork for 18 of the 26 community paramedicine programs Joint Commission on Health Care staff identified across the state (TABLE C-1). Most have received approval from OEMS – three programs are still awaiting OEMS approval.

TABLE C-1. OEMS has reviewed and approved 15 of the 26 community paramedicine programs

OEMS Review Status	EMS Agency	Locality
Approved by OEMS	Chesapeake Fire Department	Chesapeake
	Chesterfield Fire and EMS	Chesterfield County
	City of Harrisonburg Fire Department	Harrisonburg
	City of Williamsburg Fire Department	Williamsburg
	Emergility	Alexandria
	Franklin County Department of Public Safety	Franklin County
	Hampton Division of Fire and Rescue	Hampton
	Martinsville Fire and EMS	Martinsville
	Portsmouth Fire, Rescue, and Emergency Services	Portsmouth
	University of Virginia Medical Transport Network	Charlottesville
	Valley Medical Transport	Winchester
	Westmoreland County Department of Emergency Services	Westmoreland County
	Winchester Fire-Rescue Department	Winchester
	Wintergreen Rescue Squad	Nelson County
	York County Fire and Life Safety	York County
Awaiting approval by OEMS	Arlington County Fire Department	Arlington County
	Gloucester Volunteer Fire and Rescue Squad	Gloucester County
	Madison County Emergency Medical Services	Madison County
No paperwork filed with OEMS	Alexandria Fire Department	Alexandria
	Centra Health	Lynchburg

OEMS Review Status	EMS Agency	Locality
	Danville Life Saving Crew	Danville
	Fairfax County Fire and Rescue	Fairfax County
	Henrico County Division of Fire	Henrico County
	Loudoun County Fire and Rescue	Loudoun County
	Suffolk Fire and Rescue	Suffolk
	Virginia Beach Emergency Medical Services	Virginia Beach

SOURCE: JCHC review of OEMS program documents, 2024.

Appendix D: Community paramedicine programs are similar to but distinct from mobile crisis response and alternative transport for mental health

While emergency medical services (EMS) providers are increasingly being utilized in new roles and functions, community paramedicine programs in Virginia that serve individuals with mental health and substance use disorders are distinct from state and local efforts related to mobile crisis response and alternative transport.

Community paramedicine teams operate separately from mobile crisis response in Virginia

While the crisis care continuum is very similar to the EMS response model, mobile crisis response efforts are managed by the Department of Behavioral Health and Developmental Services (DBHDS) rather than by the Virginia Department of Health's Office of Emergency Medical Services (OEMS) or local EMS agencies. Individuals who call 911 or 988 are triaged, and if mobile crisis response is indicated, a team of providers is dispatched to address the behavioral health crisis. Mobile crisis response teams must be licensed by DBHDS as providers of Outpatient Crisis Stabilization services and pass specific training. Teams include licensed mental health providers and peer support specialists. If it is clear the patient has an emergent medical need, then EMS may be co-dispatched, or may be separately called by the mobile crisis response team.

There are community paramedicine models in other states in which EMS providers respond to behavioral health emergencies. There are also EMS agencies in Virginia that participate in both community paramedicine and in mobile crisis response. However, generally, mobile crisis response is triggered by a call to 911 or 988 for an emergent behavioral health need, whereas community paramedicine in Virginia is primarily focused on non-emergent needs.

Community paramedicine efforts to redirect individuals to more appropriate care settings is not the same thing as alternative transport for mental health needs

While some community paramedicine programs nationally offer transport to alternative destinations, redirecting patients to an urgent care facility or clinic instead of the emergency department, Virginia has a contracted vendor to provide alternative transportation specifically for individuals placed under a medical Temporary Detention Order (TDO). Instead of law enforcement, Allied Universal transports patients to acute psychiatric facilities for care.

Appendix E: Early Impact Virginia Uniform Indicators for Home Visiting

Early Impact Virginia (EIV) is a public-private partnership that brings together Virginia's home visiting and early childhood leaders to advance the delivery of high quality, efficient services. EIV is housed within Families Forward Virginia, a non-profit organization dedicated to building healthier, stronger, more self-sufficient families by partnering with families and communities. EIV works across Virginia's eight early childhood home visiting models (CHIP of Virginia, Early Head Start, Family Spirit, Healthy Families Virginia, Healthy Start Loving Steps, Nurse Family Partnership, Parents As Teachers, Resource Mothers) to demonstrate impact and return on investment, while leading the effort to alleviate fiscal and workforce burdens by streamlining data collection and reporting.

In 2018, the General Assembly granted EIV the authority and responsibility to determine, systematically track, and report annually on the key activities and outcomes of Virginia's home visiting programs; conduct systematic and statewide needs assessments for Virginia's home visiting programs at least once every three years; and support continuous quality improvement, training, and coordination across Virginia's home visiting programs on an ongoing basis.

In 2019, EIV and the Alliance for Early Childhood Home Visiting worked together with key stakeholders to develop a set of uniform indicators to yield actionable information for maximizing the positive impact of Virginia's home visiting system. The resulting list of uniform indicators was informed by data elements currently collected and tracked by each home visiting model in Virginia, as well as other states and national metrics.

These uniform indicators, when analyzed with demographic and other descriptive variables, will enable Virginia to:

- Identify emergent service delivery needs to increase the precision of services and upskill the home visiting workforce;
- Strategically target resources to families and communities with the greatest need;
- Ensure accountability;
- Prompt quality improvements across programs and;
- Drive innovation and sustainability.

Most importantly, Virginia's Uniform Indicators for Home Visiting will enable EIV to tell the story of how children, families, and communities benefit from home visiting services delivered by qualified professionals across the Commonwealth.

Only selected domains are shown. For more information please visit: https://www.earlyimpactva.org/virginia-outcomes

Domain	Indicator	Outcome Measure	Benchmark	Numerator	Denominator
Maternal Health	*Pregnancy Outcomes*	Preterm Birth	Percent of mothers who had a preterm birth	Number of mothers of singletons enrolled prenatally with at least 8 home visits prior to 35 weeks who gave birth prior to 37 weeks while still enrolled in home visiting	Number of mothers of singletons enrolled prenatally with at least 8 visits prior to 35 weeks who were still enrolled in home visiting when they gave birth
	Maternal Mental Health	Depression Referral/ Resource Connections	Percent of mothers for whom resource connections were made based on a positive depression screen	Number of mothers not already receiving treatment for depression who received a maternal depression screening using a validated tool within 3 months of enrollment or within 3 months of delivery (if enrolled prenatally) who screened positive AND who were connected to resources within 6 months of enrollment or of the birth of target child	Number of mothers not already receiving treatment for depression who received a maternal depression screening using a validated tool within 3 months of enrollment or within 3 months from delivery (if enrolled prenatally) who screened positive
	Maternal Health	Postpartum Care	Percent of mothers who received a postpartum visit with a health care provider	Number of mothers who enrolled in home visiting prenatally or within 2 weeks after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery	Number of mothers who enrolled in home visiting prenatally or within 2 weeks after delivery

Domain	Indicator	Outcome Measure	Benchmark	Numerator	Denominator
Child Health	*Child Health*	Well Child Visits	Percent of well child visits completed	Number of well child visits recommended by the Academy of Pediatrics (AAP) that were received over the course of children's entire home visiting enrollment by children with at least 7 months of home visiting services	Number of well child visits recommended by the Academy of Pediatrics (AAP) over the course of children's entire home visiting enrollment by children with at least 7 months of home visiting services
	Child Safety	Substantiated Child Abuse and Neglect	Prevalence of primary caregivers with investigated referrals – and within investigated referrals, prevalence of substantiation – of child abuse and neglect	Number of primary caregivers enrolled in home visiting with completed VDSS parental consent forms with 1 or more investigated referrals – and within the investigated referrals, the number of substantiated cases – of child abuse	Number of primary caregivers enrolled in home visiting with up to date, completed VDSS parental consent forms
Family Functioning	*Family Stability*	Food Security Resource Connections	Percent of primary caregivers screening positive for food insecurity for whom resource connections were made	Number of primary caregivers enrolled in home visiting who had a positive screening for food insecurity for whom resource connections were made	Number of primary caregivers enrolled in home visiting who had a positive screening for food insecurity
		Housing Stability Resource Connections	Percent of primary caregivers without stable housing for whom resource connections were made	Number of primary caregivers with at least 12 months of enrollment who screen positive for housing instability for whom resource connections were made within 12 months	Number of primary caregivers with at least 12 months of enrollment who screen positive for housing instability

Domain	Indicator	Outcome Measure	Benchmark	Numerator	Denominator
Relational Health	*Parental Practices and Capacity*	Family Self-Assessment	Percent of primary caregivers who reported an improvement in their parenting practices	Number of primary caregivers with one or more children of the age of at least one year old who completed a Survey of Parent Practice within 11-14 months of enrollment who reported an improvement in their parenting practices	Number of primary caregivers with one or more children of the age of at least one year old who completed a Survey of Parent Practice within 11-14 months of enrollment
	Risky Parental Behavior	Tobacco Cessation Resource Connections	Percent of primary caregivers who screened positive for tobacco use for whom tobacco cessation resource connections were made	Number of primary caregivers enrolled in home visiting who screened positive for tobacco use for whom tobacco cessation resource connections were made	Number of primary caregivers enrolled in home visiting who screened positive for tobacco use
		Substance Use Resource Connections	Percent of primary caregivers who screened positive for substance use for whom substance use treatment resource connections were made	Number of primary caregivers with at least 6 months of home visiting services who screened positive for substance use and for whom substance use cessation resource connections were made	Number of primary caregivers with at least 6 months of home visiting services who screened positive for substance use

Appendix F: Shifting costs within the Temporary Assistance for Needy Families program has impacted funding for home visiting programs in Virginia

Temporary Assistance for Needy Families (TANF) is a federal block grant program that provides short-term, cash assistance to families in poverty to help them achieve self-sufficiency. The federal government allows states to establish their own eligibility criteria and amount of benefit payments. States are not required to spend the entire TANF allotment each year, and unused funds, also known as TANF discretionary funds, can be used to fund future programming that aligns with overall TANF program objectives. In past years, Virginia has used TANF discretionary funds to support a range of programs, including home visiting programs.

Availability of TANF discretionary funds in Virginia has declined, reducing funds available for home visiting programs

Historically, Virginia has not adjusted the amount of TANF benefit payments paid to eligible families, nor the income eligibility threshold used to determine financial eligibility for the TANF program, known as the Standard of Assistance, to keep pace with inflation or the federal poverty level. As a result, both caseloads and overall program spending remained low, and the TANF program built a substantial reserve of unspent funds from previous fiscal years. However, in recent years, Virginia has taken steps to increase both the amount of benefit payments for eligible families and the Standards of Assistance. Between 2019 and 2022, the General Assembly directed the Department of Social Services (DSS), the agency charged with administering the TANF program, to increase the amount of cash benefits four times. During the same period, the General Assembly directed DSS to increase the Standard of Assistance twice. In the 2021 Appropriation Act, the General Assembly directed DSS to create a plan to increase the Standards of Assistance by 10 percent annually until they equal 50 percent of the federal poverty level.

Recent changes to the Standard of Assistance have increased the number of families eligible to receive TANF payments. This, coupled with increase in the amount of cash benefits paid to eligible families, has increased overall expenditures in the TANF program and depleted available funding for expanded TANF programming. In 2023, DSS reported that the TANF block grant would be fully obligated in FY2025.

Appropriations of state general funds have filled funding gaps for home visiting programs

Loss of TANF discretionary funding would have resulted in a funding cliff for home visiting programs across Virginia, which would have had to drastically reduce capacity or risk closure absent some other source of funding. To fill the gap created by the loss of TANF

discretionary funding, the General Assembly directed funds to Early Impact Virginia, Resource Mothers, and CHIP of Virginia in the 2024 Appropriations Act, transitioning these programs from discretionary TANF funds to state general funds starting in fiscal year 2025.

Appendix G: Definitions of telehealth services and modalities

The term "telehealth" is often used as an umbrella term to refer to various services and modalities, such as telemedicine, teledentistry, telepharmacy, telemental health, remote patient monitoring, store-and-forward devices, and audio-only communications.

Form of Telehealth	**Definition**
Telemedicine	Use of two-way, real time interactive electronic communication between a patient and a provider located at a site distant from the patient. The electronic communication must include, at a minimum, the use of audio and video equipment.
Audio Visits	Use of real-time telephonic communication between a patient and a provider that does not include use of video.
Teledentistry	Use of electronic information to provide and support dental care delivery, diagnosis, consultation, treatment, transfer of dental information, and education.
Telepharmacy	Use of telecommunication technology by a pharmacist to oversee aspects of pharmacy operations or provide patient care services.
Telemental health	Use of telecommunications or videoconferencing technology to provide mental health services. Telemental health is sometimes referred to as telepsychiatry or telepsychology.
Remote Patient Monitoring	Collection and transmission of personal health information from a patient in one location to a provider in a different location for the purposes of monitoring and management. Remote patient monitoring includes monitoring of both patient physiologic and therapeutic data.
Store-and-Forward	Asynchronous transmission of a patient's medical information from an originating site to a provider located at a distant site. Medical information transmitted via store-and-forward technology may include video clips, still images, x-rays, laboratory results, audio clips, and text. The information is reviewed at the Distant Site without the patient present with interpretation or results relayed by the distant site provider via synchronous or asynchronous communications.
Virtual Check-In	Brief, patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed.

Appendix H: CMS flexibilities following COVID-19

The U.S. Department of Health and Human Services took a range of administrative steps to expedite the adoption and awareness of telehealth during the COVID-19 public health emergency. Some of these telehealth flexibilities have been made permanent while others are temporary.

Permanent Medicare changes

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as a distant site provider for behavioral/mental telehealth services
- Medicare patients can receive telehealth services for behavioral/mental health care in their home
- There are no geographic restrictions for originating site for behavioral/mental telehealth services
- Behavioral/mental telehealth services can be delivered using audio-only communication platforms
- Rural Emergency Hospitals (REHs) are eligible originating sites for telehealth

Temporary Medicare changes through December 31, 2024

- FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services
- Medicare patients can receive telehealth services in their home
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services
- Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms
- An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required
- Telehealth services can be provided by all eligible Medicare providers

Appendix I: Legislative history of efforts to expand access to telehealth services in Virginia

The General Assembly has adopted legislation expanding access to telehealth services in Virginia, including legislation to permanently codify telehealth-related flexibilities offered during the COVID-19 pandemic (TABLE I-1).

TABLE I-1: Legislative history of efforts to expand access to telehealth services in Virginia

Legislative Session	Legislation	Legislative Action
2010	SB 675	Requires health insurers, health care subscription plans, and health maintenance organizations to provide coverage for the cost of health care services provided via telemedicine.
2015	HB 2063/ SB 1227	Amends the definition of telemedicine services to encompass the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment.
2016	SB 369	Directs the Virginia Telehealth Network (VTN) and the Center for Telehealth of the University of Virginia to establish a telehealth pilot program to expand access to and improve coordination and quality of health care services in rural and medically underserved areas of the state.
2017	HB 1767/ SB 1009	Allows health care practitioners to prescribe Schedule II through VI controlled substances to the patient via telehealth.
2019	HB 1970/ SB 1221	Requires insurers, corporations, or health maintenance organizations to cover medically necessary remote patient monitoring services.
2020	HB 1332	Directs the Board of Health to develop and implement the Statewide Telehealth Plan
2020, Special Session I	HB 5046/ SB 5080	Clarifies that DMAS shall provide reimbursement for telemedicine services regardless of originating site.
2021, Special Session I	HB 1987/ SB 1338	Requires DMAS to cover remote patient monitoring services provided via telemedicine for certain high-risk patients.

Legislative Session	Legislation	Legislative Action
2022	HB 264/ SB 369	Allows a practitioner licensed in another state to practice in the Commonwealth with a patient located in the Commonwealth for continuity of care through the use of telemedicine services if the patient is a current patient and the practitioner has performed an in-person examination of the patient within the previous 12 months.
2022	HB 537	Allows a behavioral health practitioner licensed in another state to treat a patient located in the Commonwealth through use of telemedicine services for a period of no more than one year from the date on which the practitioner began providing such services to such patient.
2022	SB 426	Directs DMAS to expand coverage for (1) remote patient monitoring to patients who have experienced a chronic or acute health condition who have had two or more hospitalizations in the previous 12 months and (2) provider-to-provider consultations.
2022	SB 663	Allows payment of the originating site fee to EMS agencies for facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member.
2022	HB 81/ SB 436	Requires the Board of Health to consult with the Virginia Telehealth Network in amending and maintaining the Statewide Telehealth Plan.
2023	HB 2374	Prohibits pharmacists from refusing to fill prescriptions solely on the basis of a prescriber's use of a telemedicine platform to provide services.
2023	HB 1602/ SB 1418	Provides that health care providers are not required to maintain a physical presence in the Commonwealth to maintain eligibility to enroll as a Medicaid provider.
2023	HB 1754/ SB 1119	Allows another practitioner of the same subspecialty at the same practice group as a practitioner who has established a practitioner-patient relationship with a patient in Virginia who has access to the patient's treatment history to provide health care services via telemedicine for the purpose of providing continuity of care until the practitioner with whom the patient has a previously established practitioner-patient relationship becomes available.

Appendix J. Methodology

Joint Commission on Health Care (JCHC) staff used multiple data sources for this study, including comprehensive literature reviews, stakeholder interviews, and other methods of data collection.

Literature Review

Mobile Health Clinics

JCHC staff conducted a narrative review of peer-reviewed literature to address two study questions: (1) what do mobile health clinics do, and (2) which populations benefit from mobile health clinics and what are their health outcomes, and (3) how does the cost of these services compare to their anticipated benefit.

JCHC staff identified common words and phrases associated with mobile health clinics based on existing literature. Using these key terms, a Boolean search phrase was created:

(mobile health clinic OR mobile medical clinic)

JCHC staff used this phrase to conduct an advanced literature search, identifying articles in which these terms were used in either the title or the abstract. This search was conducted in one database, PubMed, and staff identified 65 articles that fit the inclusion criteria and were applicable to the study questions of interest. The inclusion criteria required that studies be: (1) written in English, (2) published in or after 2014, and (3) describe mobile health clinic operations in the United States.

JCHC staff used snowball sampling to identify additional relevant peer-reviewed literature and grey literature. JCHC staff reviewed a subset of the literature in detail, using content analysis techniques to identify significant themes across studies addressing each study question.

Community Paramedicine

JCHC staff conducted a narrative review of peer-reviewed literature to address two study questions: (1) what do community paramedicine and mobile integrated healthcare programs do, and (2) which populations benefit from community paramedicine and mobile integrated healthcare programs and what are their health outcomes, and (3) how does the cost of these services compare to their anticipated benefit.

A Boolean search phrase was created:

(community paramedic* OR mobile integrated health*)

JCHC staff used this phrase to conduct an advanced literature search, identifying articles in which these terms were used in either the title or the abstract. This search was conducted in one database, PubMed, and staff identified 74 articles that fit the inclusion criteria and were applicable to the study questions of interest. The inclusion criteria required that studies be: (1) written in English, (2) published in or after 2014, and (3) describe community paramedicine or mobile integrated health care programs in the United States.

JCHC staff used snowball sampling to identify additional relevant peer-reviewed literature and grey literature. JCHC staff reviewed a subset of the literature in detail, using content analysis techniques to identify significant themes across studies addressing each study question.

Home Visiting Programs

JCHC staff conducted a narrative review of peer-reviewed literature to address three study questions: (1) what home visiting programs support positive perinatal outcomes, (2) which populations benefit from home visiting programs, and (3) how does the cost of these services compare to their anticipated benefit.

A Boolean search phrase was created:

(home visiting* OR perinatal home visiting* OR maternal home visiting)

JCHC staff used this phrase to conduct an advanced literature search, identifying articles in which these terms were used in either the title or the abstract. This search was conducted in Virginia Commonwealth University libraries catalog that grants access to over 600 databases, including PubMed/Medline, Web of Science, JSTOR, and Google Scholar. JCHC staff identified 77 articles that fit the inclusion criteria and were applicable to the study questions of interest. The inclusion criteria required that studies be: (1) written in English, (2) published in or after 2014, and (3) describe or evaluate home visiting programs in the United States.

JCHC staff used snowball sampling to identify additional relevant peer-reviewed literature and grey literature. JCHC staff reviewed a subset of the literature in detail, using content analysis techniques to identify significant themes across studies addressing each study question.

Community Health Workers

JCHC staff conducted a narrative review of peer-reviewed literature to address three study questions: (1) what services do community health workers provide; (2) which populations benefit from community health workers; and (3) how does the cost of community health worker services compare to their anticipated benefit.

A Boolean search phrase was created:

> (Community health worker* OR promotores* OR promotoras OR patient navigator OR case manager OR care coordinator* OR lay health worker)

JCHC staff used this phrase to conduct an advanced literature search, identifying articles in which these terms were used in either the title or the abstract. This search was conducted in Virginia Commonwealth University libraries catalog that grants access to over 600 databases, including PubMed/Medline, Web of Science, JSTOR, and Google Scholar. JCHC staff identified 136 articles that fit the inclusion criteria and were applicable to the study questions of interest. The inclusion criteria required that studies be: (1) written in English,

(2) published in or after 2014, and (3) describe or evaluate community health worker programs in the United States.

JCHC staff used snowball sampling to identify additional relevant peer-reviewed literature and grey literature. JCHC staff reviewed a subset of the literature in detail, using content analysis techniques to identify significant themes across studies addressing each study question.

Telehealth

JCHC staff conducted a literature review to address three study questions: (1) which populations most benefit from telehealth and is there a gap between intended reach and actual implementation of telehealth services; (2) what are the cost benefits of telehealth; and (3) what barriers exist related to telehealth delivery in Virginia.

Staff identified common words and phrases associated with telehealth based on existing literature. Using these key terms, a Boolean search phrase was created:

> (Telehealth OR Telemedicine OR Remote Patient Monitoring OR Telepharmacy OR Teledentistry) AND (Benefits OR Access OR Enhance OR Improve OR Barriers OR Limitations OR Gap OR Costs OR Cost Benefits OR Cost Savings) AND (Population OR Age OR Rural OR language OR Equity)

JCHC staff used this phrase to conduct an advanced literature search, identifying articles in which these terms were used in either the title or the abstract. This search was conducted in one database, PubMed, and staff identified 362 articles which fit the search criteria. JCHC staff independently reviewed articles for relevancy to the inclusion criteria. The inclusion criteria required that studies be: (1) written in English, (2) published between 2019 and 2024, (3) a systematic review, (4) published in a credible peer-reviewed journal, (5) implicitly or explicitly mentions a form of telehealth, and (6) implicitly or explicitly focused on a particular population or equity. Exclusion criteria required that studies not be: (1) conference briefs and presentations, or (2) outside the scope of the original study.

JCHC staff then reviewed articles for applicability to the three study questions of interest. Articles could be relevant to more than one category, which resulted in some article overlap between study questions. One hundred and twenty-five articles were removed for lack of relevance, 78 articles were removed due to article type, leaving 171 articles for content analysis. JCHC staff reviewed the remaining articles in detail, using content analysis techniques to identify significant themes across studies addressing each study question.

Interviews

Mobile Health Clinics

JCHC staff conducted stakeholder interviews to understand program operations in Virginia, including populations served, program benefits, provider experience, funding, and barriers. Individual interviews were conducted with ten stakeholders and a focus group with three stakeholders. Participants represented the perspectives of mobile health clinics operated

by community services boards, federally qualified health centers (FQHCs), free clinics, hospital systems, local health departments, payers, and state agencies.

JCHC staff transcribed interview notes and performed qualitative analysis to identify overarching categories and themes. Any categories and themes that emerged were used to derive a deeper understanding of mobile health clinics in Virginia.

Community Paramedicine

JCHC staff conducted supplemental stakeholder interviews to understand program operations in Virginia, including populations served, program benefits, provider experience, funding, and barriers. Interviews were conducted with five stakeholders, representing community paramedicine, mobile integrated health care, and a payer.

JCHC staff transcribed interview notes and performed qualitative analysis in order to verify findings from the narrative review and document review and inform program case studies.

Home Visiting Programs

JCHC staff conducted stakeholder interview to understand home visiting program operations in Virginia including populations served, program benefits, provider experience, funding, and barriers to widespread implementation. Individual interviews were conducted with eight stakeholders and follow-up meetings were scheduled as necessary throughout the study period. Participants represented state and local agencies, professional associations, and health care organizations.

JCHC staff transcribed interview notes and performed qualitative data analysis to identify overarching categories and themes. Any categories and themes that emerged were used to derive a deeper understanding of home visiting services in Virginia.

Community Health Workers

JCHC staff conducted stakeholder interview to understand community health worker participation and program operations in Virginia including populations served, program benefits, provider experience, funding, and barriers to widespread implementation. Individual interviews were conducted with ten stakeholders and follow-up meetings were scheduled as necessary throughout the study period. Participants represented state and local agencies, professional associations, and health care organizations.

JCHC staff transcribed interview notes and performed qualitative data analysis to identify overarching categories and themes. Any categories and themes that emerged were used to derive a deeper understanding of community health workers in Virginia.

Telehealth

JCHC staff conducted stakeholder interviews to address five study questions: (1) what is the history of telehealth in Virginia and nationally; (2) how are telehealth services being

delivered in Virginia; (3) which populations most benefit from telehealth and is there a gap between intended reach and actual implementation of telehealth services; (4) what are the cost benefits of telehealth; and (5) what barriers exist related to telehealth delivery in Virginia.

Interviews were conducted with numerous providers, provider associations, and telehealth organizations JCHC staff transcribed interview notes and performed qualitative analysis to identify overarching categories and themes. Any categories and themes that emerged were used to derive a deeper understanding of telehealth implementation in Virginia.

Other Methods

Mobile Health Clinics – Program Identification

JCHC staff relied on three main sources to identify mobile health clinics in Virginia – a review of the Mobile Health Map database; referrals by state agencies and industry associations; and focused Internet searches for news articles and press clippings mentioning mobile health clinics.

JCHC staff started with the list of 14 mobile health clinics identified in Virginia by the Mobile Health Map database. While these numbers were an undercount, staff were able to use the listed clinics to get a sense of the types of organizations operating mobile health clinics.

Staff then asked the following state agencies to identify any mobile health clinics in operation across Virginia under their management:

- Department of Behavioral Health and Developmental Services (DBHDS)
- Department of Health (VDH)
- Department of Health Professions (DHP)
- Department of Medical Assistance Services (DMAS)

Staff also asked the following industry associations to help identify mobile health clinics in operation among their members:

- Virginia Association of Free and Charitable Clinics (VAFCC)
- Virginia Association of Health Plans (VAHP)
- Virginia Community Healthcare Association (VCHA)
- Virginia Hospital and Healthcare Association (VHHA)

Lastly, staff conducted Internet searches with the keywords “mobile health” AND “Virginia” in order to identify news articles that mentioned mobile health clinics and press releases from providers and health plans about their mobile clinic operations. For any mobile clinics identified, staff reviewed each organization’s website to confirm the mobile unit was still in operation and to gather additional information about clinic operations.

JCHC staff identified 58 organizations in total that currently operate, plan to operate, or partner to operate one or more mobile health clinics in the state. Many organizations operate more than one mobile unit.

Mobile Health Clinics – Program Survey

JCHC staff conducted a survey of mobile health clinics operated by federally qualified health FQHCs to understand program operations in Virginia, including populations served, program benefits, provider experience, funding, and barriers. Staff of the Virginia Community Healthcare Association (VCHA), the primary membership association for FQHCs, distributed the survey link to their members. Three FQHCs submitted information about their mobile health clinic operations.

JCHC staff included the survey findings as part of their qualitative analysis to identify overarching categories and themes. Any categories and themes that emerged were used to derive a deeper understanding of mobile health clinics in Virginia.

Community Paramedicine – Program Identification

JCHC staff relied on the Virginia Department of Health's Office of Emergency Medical Services' program documentation, Notice of Intent paperwork submitted by emergency medical services (EMS) agencies, and referrals from stakeholders to identify current community paramedicine and mobile integrated healthcare programs across Virginia. JCHC staff also conducted Internet searches with the keywords "community paramed*" OR "mobile integrated health*" AND "Virginia" in order to identify news articles and other EMS agency materials that mentioned community paramedicine or mobile integrated healthcare programs.

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