Decision Matrix

Policy Options for 2019 General Assembly Session

TABLE OF CONTENTS

STAFF REPORTS

ADDITIONAL REPORTS

PURPOSE OF DOCUMENT

A. To review and discuss findings, public comments, and policy options regarding staff reports and other issues that came before the Commission in 2018.
B. To develop legislative recommendations for the 2019 General Assembly Session.

Medical Aid-in-Dying in Virginia

Michele Chesser
Executive Director

Study Mandate

Delegate Kaye Kory requested via letter that the JCHC study the issue of Medical Aid-in-Dying (MAID) including a review of states that currently authorize MAID and addressing the following questions:

- What has been the impact of informing patients about end-of-life options such as hospice care and palliative care?
- In current MAID states, how have health care systems, institutions and providers acted to implement the law?
- In current MAID states, have people been coerced to ingest end-of-life medication?
- Have any of the states enacted protections to discourage or prevent coercion?
- Has the implementation of the law impacted any state's health care costs?
- Using data from states that allow MAID, how many people would likely utilize MAID if it became law in Virginia?

JCHC members approved the study during the Commission's May 23, 2017 work plan meeting.

Background

Medical Aid-in-Dying is the ability of a patient to obtain, from a physician, a medication that the patient may use to end their life if they are competent, terminally ill, and over 18 years of age.

Current Virginia Statute § 8.01-622.1 provides an injunction against assisted suicide, allows for the recovery of compensatory and punitive damages, and indicates that a health care provider who assists/attempts to assist a suicide shall have his/her certificate or license to provide health care services in the Commonwealth suspended or revoked by the licensing authority.

Existing Medical Aid-in-Dying Statutes:

- Oregon (1998)
- Washington (2008)
- Vermont (2013)
- California (2016) May 24, 2018: Judge overturns law; June 15, 2018: Judgement is stayed in appeals court. Currently legal, pending further litigation.
- Colorado (2016)
- Washington, D.C. (2017)
- Hawaii (2018)
- **By Judicial Review:**
- Montana (2009)

Generally, existing MAID statutes include:

Eligibility Criteria:

- Adult, 18 years of age and older
- Resident of the state
- Suffer from a terminal illness
- Able to self-administer the medication

Requires physician provide the following to the patient:

1. Diagnosis with prognosis
2. Range of options including palliative care and hospice care
3. Risks and probable death from prescription

Process:

- Attending and consulting physicians determine and agree that the patient suffers from a terminal disease with less than six months to live.
- Patient must provide 2 voluntary oral requests no less than 15 days apart.
- Patient must provide a signed written request (form provided) for the medication, co-signed by 2 witnesses
- Physician to provide prescription at least 15 days after the initial oral request and at least 48 hours after the signed request.
- Before providing the prescription, the physician must confirm the patient has not rescinded the request and remind the patient that the patient is not required to ingest the medication.
- If either physician believe the patient is suffering from depression or any behavioral health condition that may be impacting their choice, they are to refer the patient to a psychiatrist before proceeding.
- For prescription: After obtaining patient approval, attending physician calls pharmacy to alert pharmacist of the prescription to be filled and sends the written prescription through specified means.
- When ingesting, patient must self-administer the medication.

MAID Work Group:

- A work group was created to discuss Medical Aid-in-Dying. Six meetings were held with approximately 20-30 participants per meeting.
- Discussions focused primarily on the reasons to support/oppose MAID, the preferred name of the practice (e.g. MAID vs. Physician Assisted Suicide) and, using Oregon statute as a blueprint, the many components that should be included or removed from the language of any potential Virginia statute. Ultimately, the work group decided to use California's language with additions listed in policy option two (see below). It was established that, for members who oppose MAID, working on language for a potential Virginia statute does not indicate support for MAID.

Areas of Work Group Member Disagreement:

- Term used in statute (e.g. MAID vs Physician Assisted Suicide)
- Accuracy of "terminal illness (likely death in ≤ 6 months)" language
- Overall, balance in language between safeguards and access to MAID
- Requirements necessary to recognize and prevent individuals from using MAID whose judgment is impaired by depression
- Potential for discrimination against the disabled and other vulnerable groups
- Need for additional language to further decrease the likelihood of coercion
- Definition of informed decision
- Voluntarily expressing wish to die (relating to forms of communication)

(*Please see in PowerPoint presentation appendix 4 Compassion and Choices slides and the 4 "10 Reasons to Oppose Physician Assisted Suicide" slides for examples of arguments in support of and in opposition to MAID.)

Information addressing study request questions:

- All MAID statutes require that both the attending and consulting physician inform the patient about end-of-life options, including hospice and palliative care.
- The last 20 years of research show a wide variation in implementation policies/practices among health care systems, hospitals, hospice and palliative care programs and physicians.
- The majority of researchers conducting studies in MAID states have found that physicians, nurses, social workers, clergy and others in health care systems, institutions or private practice want and need education and guidance on MAID.
- In 2012, Compassion and Choices convened the Physician Aid-in-Dying Clinical Criteria Committee to create guidance for physicians willing to provide MAID to eligible patients.
- To decrease the likelihood of implementation challenges, participating institutions should create a plan to review, evaluate, and provide real-time guidance to help address any problems that may occur.
- A significant number of hospice programs set limits regarding "(a) providing information to the patient, (b) notifying the primary physician of the patient's request, (c) providing or assisting with the medications necessary to hasten a patient's death, and (d) permitting the presence of staff members at ingestion or death" (Norton and Miller, 2012).
- All state statutes except Vermont's define coercion and fraud as felony offenses. One can assume it is possible that some instances of coercion or fraud in MAID states may have occurred but it may not have been witnessed or interpreted as coercion/fraud, or substantiating the claim may not have been successful. However, to date, JCHC staff could not find any cases of substantiated accusations of fraud or coercion. It is possible that current penalties are sufficient to discourage coercion and fraud.
- States are not allowed to use federal Medicaid funds to pay for MAID services. As a result, some states utilize state funds to pay for MAID among Medicaid enrollees. However, given the relatively low cost of MAID medications and additional physician visits required during the MAID process coupled with the very low percentage of individuals participating in MAID who also are enrolled in Medicaid, cost to the state is minimal.

Additional Options to Consider: Improving End of Life Care in Virginia

- The POLST (Physician Orders for Life Sustaining Treatment) program began in Oregon in 1991 and currently exists at some level in 42 states. A state's POLST program can be endorsed by the National POLST Paradigm (i.e. the national oversight body) if the requirements set forth by the NPP are met. In 2016, Virginia was the 19th state (out of 21) to be endorsed.
- The POLST program is supported by a range of organizations including AARP, American Academy of Hospice and Palliative Medicine, American Bar Association, American Nurses Association, Catholic Health Association of the United States, Institute of Medicine, National Association of Social Workers, Pew Charitable Trusts, and Society for Post-Acute and Long-Term Care Medicine.
- The POLST document is a standardized, portable, brightly colored single page medical order that documents a conversation between a provider and a patient with a serious illness or frailty towards the end of life and is intended to work in conjunction with an advance directive. Unlike an advance directive, the POLST form is a set of medical orders created by a health care professional during a conversation with the patient. The patient has the original and a copy is placed in the patient's medical record and in a state registry (if state has one). It is designed to be actionable throughout an entire community in that it is intended to be immediately recognizable and used by doctors and first

responders (including paramedics, fire departments, police, emergency rooms, hospitals and nursing homes).

- While Virginia's program has been endorsed by the national oversight body, currently there is a roadblock to wide-spread use of the POST (Physician Orders for Scope of Treatment*) form. (*States can have slight variations in the term used.)
  - § 54.1-2987.1 of Virginia Code does not specifically mention POST
    - § 54.1-2987.1 regarding reciprocity between states of Durable Do Not Resuscitate orders includes the language "A Durable Do Not Resuscitate Order or **other order regarding life-prolonging procedures.**" This additional language was included to indicate that Physician Orders for Life Sustaining Treatment (POLST) Paradigm forms from other states are covered by this statement of reciprocity.
  - 12VAC5-66-10 of Administrative Code only *specifically* mentions POST in DNR section, but on POST form that is only Section A of a set of questions/orders. Remaining parts are not specifically about DNR.
  - Writers of the Code section thought language was specific enough; however, legal counsel of some health care systems and hospitals have advised against using the POST form due to uncertainty.
  - POST experts believe that an Opinion from Virginia's Attorney General that this Code language does apply to the POST form, in full, would address the problem.
    - If AG Opinion is that Code does not apply to the POST form, legislation to change the Code and, *perhaps*, an official memo from the Virginia Board of Health assuring/clarifying that the POST form is recognized in Virginia as an appropriate practice for eliciting, documenting and honoring a patient's medical wishes are needed.
    - Communication with AG staff confirmed that it is appropriate to request an AG opinion on this issue (Phone conversation and follow-up email with Tish Hawkins 8/15/18).

Policy Options and Public Comments

3501 public comments were received including comments on behalf of the following organizations:

Helena Berger, President and CEO, **American Association of People with Disabilities (AAPD)**
Bruce Darling, National Organizer, **ADAPT**
Billy Altom, Executive Director, **Association of Programs for Rural Independent Living (APRIL)**
Maria Spencer, Regional Campaign and Outreach Manager, **Compassion and Choices (CC)**
Debra Fults, Executive Director, **disAbility Resource Center of the Rappahannock Area (DRCRA)**
Marilyn Golden, Senior Policy Analyst, **Disability Rights Education and Defense Fund (DREDF)**
Nichole Davis, Executive Director, **Endpendence Center Incorporated (ECI)**
James Garret, Executive Director, **ENDpendence Center of Northern Virginia (ECNV)**
Richard A. Szucs, MD; Advisory Board Chair; **Honoring Choices Virginia (HCV)**
Mary D. Lopez, Ph.D.; Executive Director; **Independence Empowerment Center (IEC)**
Tom Vandever, Executive Director, **Independence Resource Center, Inc. (IRC)**
Marie T. Hilliard, Ph.D., RN; President; **National Association of Catholic Nurses (NACN)**
Kelly Buckland, Executive Director, **National Council on Independent Living (NCIL)**
National Organization of Nurses with Disabilities (NOND)
Diane Coleman, JD; President and CEO; **Not Dead Yet (NDY)**
Alexandra Bennewith, MPA; Vice President of Government Relations; **United Spinal Association (USA)**
Richard M. Bagby, Executive Director, **United Spinal Association of Virginia (USAofVa)**

Brenda Clarkson, Executive Director, **Virginia Association for Hospices and Palliative Care (VAHPC)**
Gayl Brunk, President, **Virginia Association of Centers for Independent Living (VACIL)**
Jeff Caruso, **Virginia Catholic Conference (VCC)**
Olivia Gans Turner, President, **Virginia Society for Human Life (VSHL)**

<table>
<tr><td></td><td></td><td>Support</td><td>Oppose</td></tr>
<tr><td>Option 1</td><td>Take no action</td><td>2875 including: DRCRA, ECI, ECNV, IRC, VACIL, VCC, VSHL</td><td>VAHPC</td></tr>
<tr><td rowspan="2">Option 2</td><td rowspan="2">Introduce legislation to amend the Code of Virginia to include a Medical Aid-in-Dying statute that mirrors California's EOLOA statute, with the following additions: a. when informing patient of alternative to MAID, attending physician must include information about any possible treatments for the underlying disease, b. attending physician must attest that patient enrolled in hospice or was informed of EOL services , c. if patient is in nursing facility, one witness may be person designated by facility, d. adopt rules to facilitate collection of information regarding compliance, e. provide an online guidebook and establish training opportunities for medical community to learn about the MAID process and medications that may be used</td><td>368 including: CC</td><td>2879 including: AAPD , ADAPT, APRIL , DRCRA, DREDF, ECI, ECNV, IEC, IRC, NACN, NCIL, NDY, NOND, USA, USAofVa, VACIL, VCC, VSHL</td></tr>
<tr><td colspan="2">VAHPC (neutral)</td></tr>
<tr><td>Option 3</td><td>By letter of the JCHC Chair, request that the Attorney General provide an opinion as to whether Virginia Code § 54.1-2987.1 regarding DDNRs and other orders regarding life-prolonging procedures applies to POST forms and Administrative Code 12VAC5-66-10 regarding DNRs applies to POST forms, including parts A, B, C and D. If opinion is that language does not apply, then also:</td><td>3 including: VAHPC</td><td></td></tr>
<tr><td>Option 3a</td><td>Introduce legislation to insert "POST forms" into Virginia Code § 54.1-2987.1 and insert "POST forms" into Administrative Code 12VAC5-66-10</td><td>VAHPC</td><td></td></tr>
<tr><td>Option 3b</td><td>Option 3a <u>and</u> by letter of the JCHC Chair, request that the Virginia Board of Health review the POLST Paradigm and create official memo assuring/clarifying that the POST form is recognized in Virginia as an appropriate</td><td></td><td></td></tr>
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	practice for eliciting, documenting and honoring a patient's medical wishes		
Option 4	Introduce legislation to amend the Code of Virginia to require health regulatory boards of physicians, nurse practitioners, and physician assistants to promulgate regulations providing for the satisfaction of a one-time POST forms continuing education requirement of 0.5 – 1 hour for new licensure or re-licensure	VAHPC	
Option 5	Place on the list of potential JCHC studies in 2019 a mini-study to obtain data, via a survey of health care systems and independent hospitals, on the degree to which these entities offer end-of-life planning. (For example, the number of Advanced Care Planning facilitators employed, if a patient indicates that he/she does not have an Advance Directive, does the entity have policy designed to guide staff on whether, and if so, how to discuss the topic with the individual, etc.)	HCV	
Option 6	By letter of the JCHC Chair, request that the Virginia Department of Health consider the development of a POST registry that is accessible from various electronic medical records, allows electronic completion and is accessible in real-time by first responders (which is not the case with the current AD registry).	3 including: HCV, VAHPC	

Primary reasons for supporting MAID:

- Individuals should have the option to choose/right to be in control
- It is compassionate and humane/a peaceful death/dying with dignity
- Alleviate pain and suffering

Primary reasons for opposing MAID:

- Instead, should use hospice/palliative care/need better end of life care
- Conflict of interest for family/ potential for misuse or coercion
- Affects trust between patient and doctor/ violates Hippocratic oath
- Encouraged by health insurance companies because it is considered to be less expensive than any alternatives
- It promotes suicide

Form letter sent by over two thousand individuals:

I support Policy Option 1: Take no action.

I oppose Policy Option 2 (introducing legislation to create a "Medical Aid-in-Dying" statute).

I also oppose any other Policy Option that could result in making exceptions to Virginia's current prohibition against assisted suicide. What the report calls "medical aid-in-dying" is in fact physician-assisted suicide. Suicide rates are at a 30-year high in the United States. Government should not promote suicide in any context or by any name. Doctors should strive to eliminate pain, not eliminate patients. Virginia's policy focus should be on improving access to hospice and palliative care. Legalizing physician-assisted suicide would undermine the doctor-patient relationship. Patients should be able to trust that doctors' aim is to heal, not to end lives. Physician-assisted suicide especially puts the poor and people with disabilities at risk. Both private and public insurers will have financial incentives to pay for a lethal prescription rather than more expensive and prolonged healing treatment, leaving the poor vulnerable to coercion. Those suffering from illness are often concerned about being a financial or emotional burden to others, which can create pressure to end one's life. Coercion can play a role in cases of physician-assisted suicide, as can mental health issues such as depression. Even in jurisdictions with so-called "safeguards" to protect against these threats, abuses still occur. No "safeguards" can attenuate the damage physician-assisted suicide would do to our health care system. No procedures or processes can adequately shield patients from the dangers which accompany physician-assisted suicide. Thank you for considering these comments.

<u>Form letter sent by almost 500 individuals:</u>
Please do not recommend any option that includes the unethical and unwise policy of physician-assisted suicide. Physician-assisted suicide degrades the value of human life. It is a slippery slope that can pressure elderly or sick people into unwanted choices. Creating such a policy would open up innumerable new dilemmas for individuals, their families, and medical professionals. Please act to create incentives to save lives, not end them prematurely. Physician-Assisted Suicide has NO place in Virginia.

<u>Excerpts from public comments regarding options 3 – 6:</u>
Richard A. Szucs, MD; Advisory Board Chair; **Honoring Choices Virginia (HCV)**
"While we do not take a position on Medical Aid in Dying, we enthusiastically applaud your inclusion of advance care planning as a means towards encouraging patients to be self-advocates about future medical care." "…We also encourage consideration of another policy option. The Virginia Department of Health has made great strides in improving the function and accessibility of the state's advance directive registry. However, there has also to be awareness of its existence for Virginians and health care providers to utilize this resource effectively. We encourage the Commonwealth to make resources available that will encourage participation in advance care planning and sharing of advance medical directives with loved ones and the advance directive registry. Honoring Choices Virginia, and many of the aforementioned ACP programs, would gladly assist with this effort."

Brenda Clarkson, Executive Director, **Virginia Association for Hospices and Palliative Care (VAHPC)**

Option 3. VAHPC recognizes that the Administrative Code already acknowledges POST as a DDNR and supports efforts to include the relevant clinical orders regarding life-prolonging procedures in other sections of the POST form to satisfy concerns voiced by some attorneys, hospitals, nursing homes & physicians.

Option 4. VAHPC supports this option for continuing education for providers involved in signing POST forms, mindful of the need to obtain appropriate funding.

Option 5. VAHPC has no opinion on this issue.

Option 6. VAHPC supports the development of a POST Registry, mindful of the need to explore currently available on-line products and to obtain appropriate funding.

Quality of Health Care Services in Virginia Jails and Prisons, and Impact of Requiring Community Services Boards to Provide Mental Health Services in Jails (Final Report)

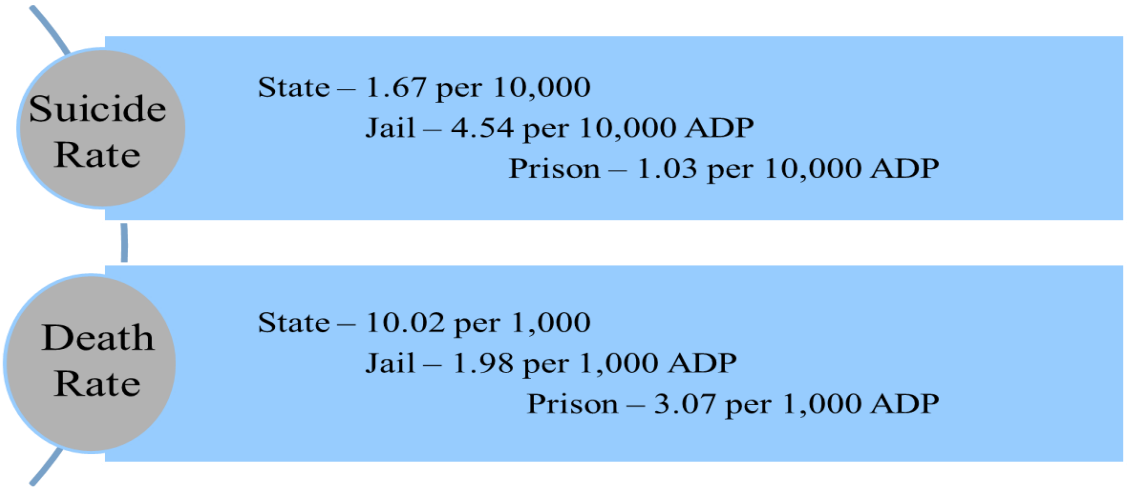
Stephen Weiss
Senior Health Policy Analyst

Study Mandate

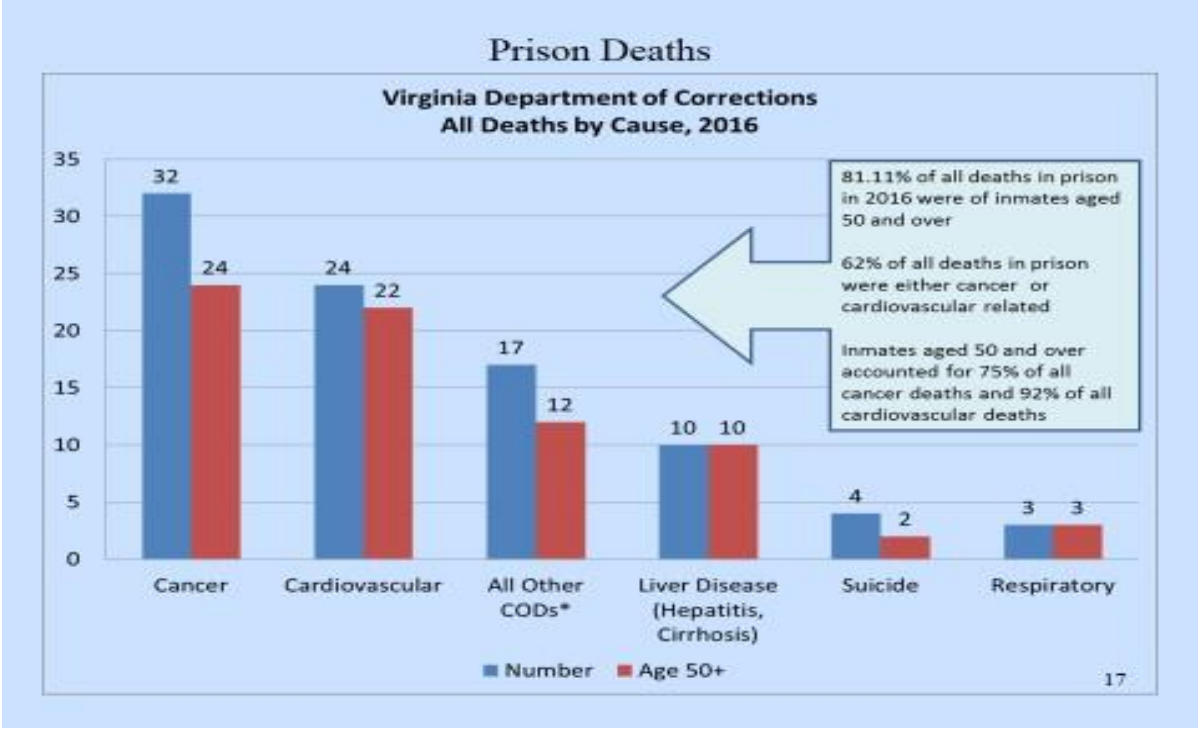
This is the final report of a two-year study on two related topics--the quality of health care services in Virginia jails and prisons and whether the CSBs should be required to provide mental health services in jails. The study is based on 2017 resolutions by Delegate O'Bannon (HJR 616) and Delegate Holcomb (HJR 779) that were tabled in House Rules Committee with the understanding that JCHC would consider the study requests. JCHC members approved the studies during the work plan meeting in May of 2017.

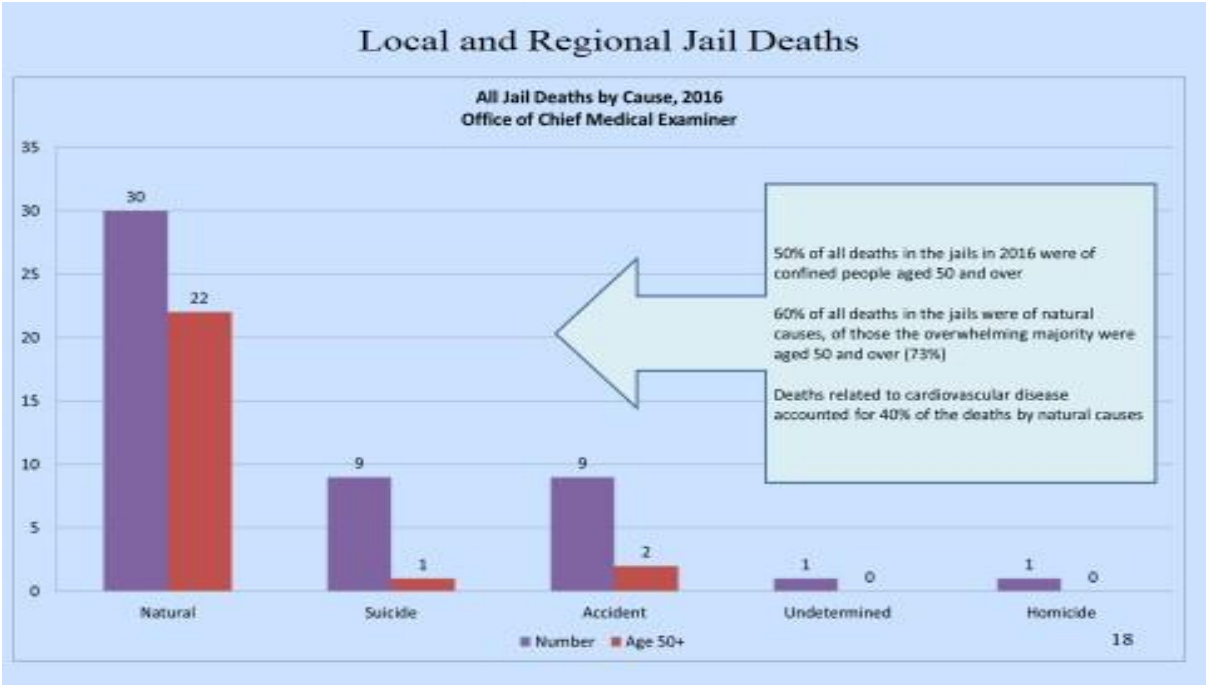
Putting Health Care in Jails and Prisons into Perspective

- The current jail and regional jail system is made up of 23 regional jails with 107 different member jurisdictions and 35 locally controlled jails. There were over 314,000 jail confinements during 2017 involving 170,303 individuals. The average daily population for the entire jail and prison system is approximately 60,000 (27,477 in local and regional jails and 28,887 in prisons). The average length of stay in jails was 17 days while in prisons it was 6 years.
- Local and regional jails and prison health care systems operate within the context of the overall health care system. Health care related staff shortages of physicians, nurses and psychiatrists impact the correctional setting as much as it does the private sector.
- Establishing quality measures in the correctional setting is a challenge in the jail and prison setting due to a lack of good data from the correctional systems.
- When put into the context of the overall health care system, mortality rates in jails and prisons are better than those in the general population. The only exception is the suicide rate in jails.



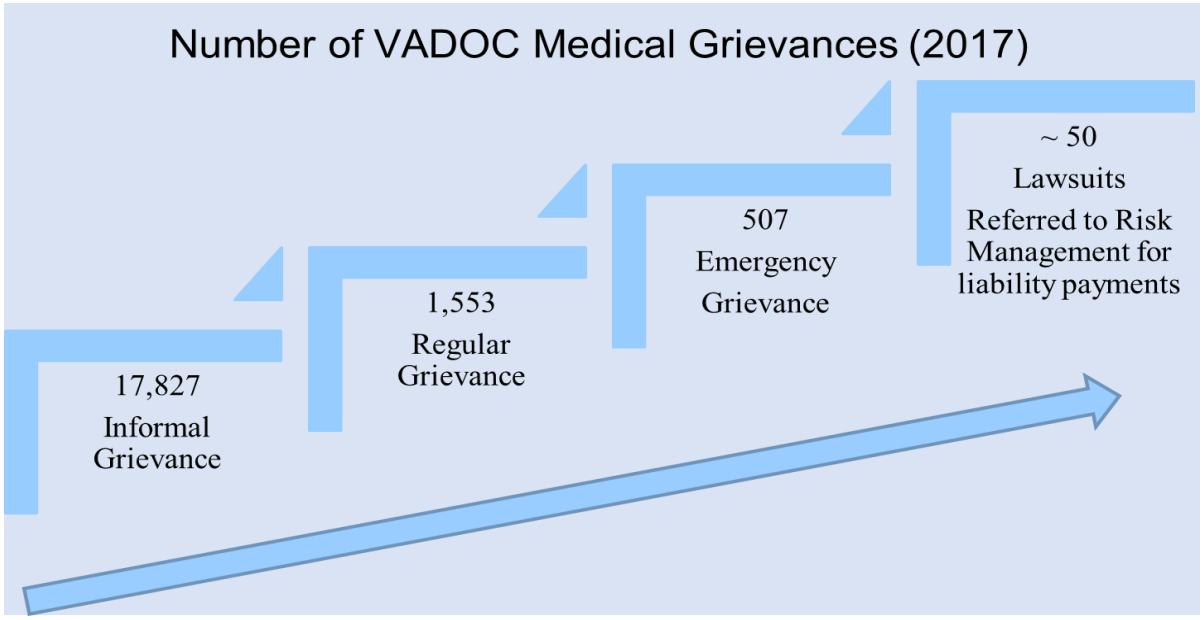
- The leading causes of death in both systems involve cancer and cardiovascular disease and the majority of deaths are offenders over age 50.





- The number of medical grievances filed by Virginia Department of Corrections (VADOC) offenders in state prisons provides a unique challenge to prison officials who must determine which are legitimate. Over 90% are resolved at the facility. Offenders can appeal the outcome of a grievance at any level, elevating them to the VADOC central office Medical Director / Medical Unit, and filing lawsuits. The

Attorney General is currently working on 35 cases filed in 2018. Some may be dismissed while others may be referred to Risk Management.

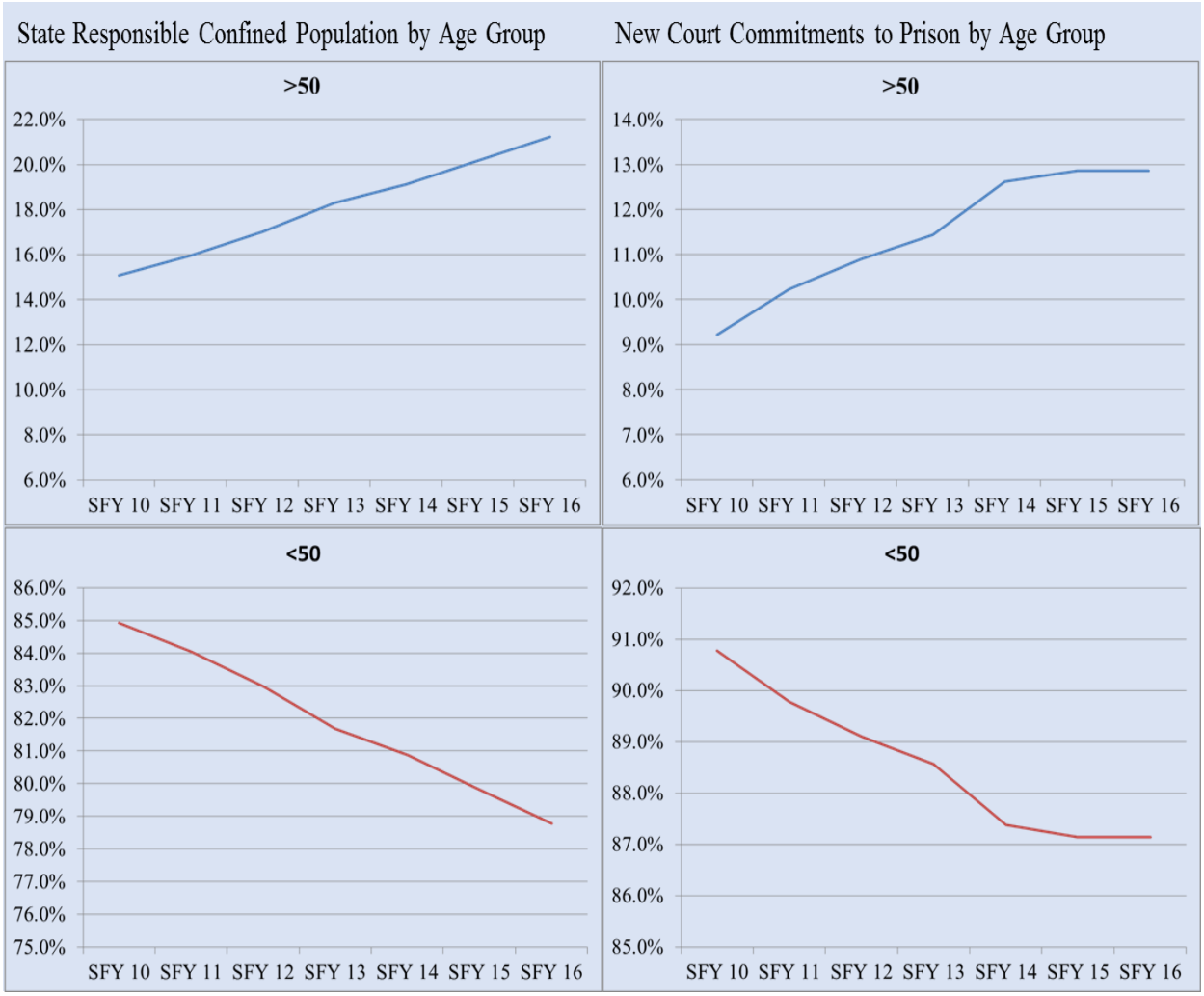


Measuring Quality

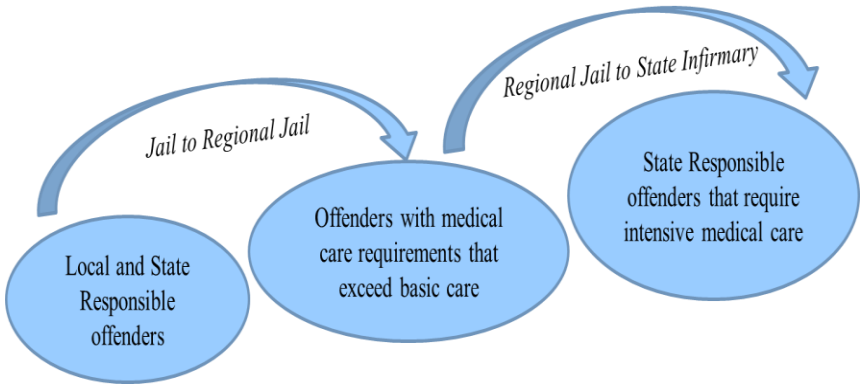
- Local and regional jails and prisons are legally required to provide "access" to health care services to offenders but the requirement does not include "quality".
- VADOC contract monitors review medical charts to assess contract compliance by health care vendors within the system. Penalties are assessed when there are findings. As of August 2018 Armor has been penalized $265,000 for being out of compliance with several provisions of its contract at Sussex I and II, and Greensville.
- In 2017 VADOC formed an internal central office Continuous Quality Improvement (CQI) committee. The CQI committee meets eight times per year, reviews contract compliance and quality of care issues related to the state operated prisons.
- Almost all state operated prisons are accredited by the American Correctional Association.
- The Virginia Board of Corrections (BOC) certification requirements for local and regional jails involve a review of written policies and procedures but not quality. To achieve quality some, but not all, local and regional jails are accredited by national organizations, the American Correctional Association and the National Commission on Correctional Health Care. Both organizations include health care quality components for accreditation purposes.
- Offenders served in offsite private hospitals and by private physicians receive the same quality of care as any other patient. Anthem BC/BS is a third party administrator for the prisons, and also for 48 of the 58 local and regional jails. Anthem has its own quality program for providers.
- Accreditation does not preclude local and regional jails and prisons from being sued. The Fluvanna Correctional Center for Women is part of a class action lawsuit settlement, signed in 2016. Fluvanna was accredited before, during and after the settlement agreement.
- A recent un-announced visit from the court monitor indicated that considerable improvements occurred within the last eight months but there was still a lot to do to comply with the settlement agreement.

The Confined Population

- A rising geriatric population in the prisons is being driven by new court commitments of offenders aged 50 and above. The facilities operated by VADOC were not built for the aging population. Two facilities, Powhatan Infirmary and Deerfield Assisted Living Center, are overcrowded barracks-style buildings not conducive to quality of care.



- Offenders are moved to different jail and prison locations for health care. None of the systems are integrated. Paper files are moved with the offenders.
- People with dementia and pregnant opioid addicted women are being confined in jails because there are no other providers to care for them outside of the jails.



Community Services Boards in Local and Regional Jails

- The number of offenders held in local and regional jails with mental health disorders has grown 53% since 2008; and the number of offenders in DOC prison facilities with mental health disorders has grown 29% since 2009.

	United States 2016	Virginia 2016	Virginia Jails June 2017	Virginia Prisons June 2017
Percent Any Mental Illness	18.3%	19.9%	17.63%	27.4%
Percent Serious Mental Illness	4.2%	4.6%	9.55%	2.71%

Number of Offenders in Jail Suspected to be Mentally Ill - Seriously Mentally Ill				
Year	**# of Individuals suspected of having any mental illness**	**% of total jail population suspected of having any mental illness**	**# of Individuals suspected of having a serious mental illness**	**% of total jail population suspected of having a serious mental illness**
2012	6,322	11.07%	3,043	5.33%
2013	6,346	13.45%	3,553	7.53%
2014	6,787	13.95%	3,649	7.50%
2015	7,054	16.81%	3,302	7.87%
2016	6,554	16.43%	3,355	8.41%
2017	7,451	17.63%	4,036	9.55%
Change: 2012-2017	**1,129**	6.56%	**993**	4.22%
% Change	**17.86%**	59.26%	**32.63%**	79.17%

Source: Mental Health Standards for Virginia's Local and Regional Jails. Department of Behavioral Health & Developmental Services. August 31, 2018 (7).

- The percent of offenders with any mental illness is highest within the Virginia prison system while the percent with serious mental illness is highest in Virginia jails.
- People in the jails may be "situationally mentally ill," have a history of mentally illness, or be seriously mentally ill. Offenders that are situationally mentally ill pose unique and sometimes challenging problems for jail officials, including suicidal behavior. These offenders did not have any issues prior to confinement and may not have any issues once released.
- Most mentally ill and substance use disorder arrests may be due to inappropriate illegal behavior linked to their mental health and substance use disorder condition. Often law enforcement is called to address a disturbance, i.e. loitering, petty larceny, etc. An argument, a punch or any display of resistance by the person can result in an arrest and felony rather than minor misdemeanor charges. Felony charges often include longer sentences, are more serious, and can interfere with a diversion or a better placement with a community provider. According to the Compensation Board's "2017 Mental Illness in Jails Report," 76.9% of all mentally ill in the jails are charged with a felony crime.
- Immediate access to a magistrate, either because the magistrate is in the facility or available via the court tele-network, leaves little time to determine if jail is the most suitable place for a mentally ill offender.

- Providing office space to CSB staff with computer access improves communications between the CSB and the jail.
- There are six Department of Criminal Justice Services' pilot projects developed to create relationships between the jails, CSBs and other community providers. The lack of stable funding was cited as an obstacle for the projects, along with a lack of affordable housing and data collection.
- 21 local and regional jails have designated mental health units. Of the jails with mental health units, 9 provide office space and a computer to a CSB, 4 through the DCJS pilot. Another 7 local and regional jails without a mental health unit provide office space to a CSB, 6 with computers; only 1 through the DCJS pilot project.
- 60% of the mental health treatment provided in the jails is done by CSBs.
- The Henrico County jail and CSB collaborative program is an example of a model program. The CSB provides the mental health and substance abuse services to Henrico County offenders. The program includes diversion programs involving judges and magistrates, discharge planning, and the requirement that all health and mental health care providers use the same electronic health record system. The cost to operate the program is $349 per offender.
- There is a significant amount of confusion over the use and implementation of HIPPA requirements that interferes with offender care and treatment within the local and regional jails.
- DBHDS formed a workgroup to develop mental health standards for local and regional jails. The workgroup integrated BOC, NCCHC and best practice material into the following list of 14 minimum behavioral healthcare standards specifically written for Virginia's local and regional jails.

Access to Care	Mental Health Assessment
Policies & Procedures	Emergency Services
Communication of Patient Needs	Restrictive Housing
Mental Health Training for Correctional Officers	Continuity & Coordination: Health Care During Incarceration
Mental Health Care Liaison	Discharge Planning
Medication Services	Basic Mental Health Services
Mental Health Screening	Suicide Prevention Program

- The workgroup concluded that the state allow the local and regional jails to determine which entities and providers are best for them as they comply with the standards.
- Requiring via code that CSBs provide mental health and substance use disorder services in all jails may be a problem for jails that are not near a CSB and may be disruptive to existing local relationships between community providers and jails that are successful partnerships.

Policy Options and Public Comments

Four Comments were received:

- Superintendent William C. Smith, President, **Virginia Association of Regional Jails (VARJ)**
- Dean A. Lynch, Executive Director, **Virginia Association of Counties Board of Directors (VACO)**
- Michelle Gowdy, Executive Director, **Virginia Municipal League (VML)**
- Jennifer Faison, Executive Director, **Virginia Association of Community Services Boards, Inc. (VACSB)**

Policy Options Budget Amendments and Amendments to Code		Support	Oppose
1	Take no Action		
2	Introduce a budget amendment to fully fund an electronic health record (EHR) system for all prisons. Include requirements that the EHR be accessible to local and regional jails, DBHDS and other health care providers involved with the care and treatment of offenders. The VADOC estimate for a fully functioning, system wide, EHR is $35 million.	VML	
3	Introduce a budget amendment to build new facilities and renovate existing structures at Deerfield and Powhatan to accommodate the aging prison population ($25 million for Powhatan and $30 million for Deerfield).		
4	Introduce legislation to amend the Code of Virginia by adding in Chapter 53.1 a provision requiring all jails, regional jails and the prison system have one unified contract with the same Third Party Administrator (TPA) for all health care services provided to offenders outside/offsite of the jail and prison system. Require the TPA to make a quarterly report and an annual report on offender health care expenses to the Board of Corrections (BOC) and VADOC; and require that the report be made available to the public on the VADOC and BOC websites.		
5	Introduce legislation to amend Chapter 53.1 of the Code of Virginia by adding that the VADOC Continuous Quality Improvement (CQI) Committee for state operated prisons become part of the required duties of VADOC and that standardized quality reports be developed and made available to the public on the VDOC website.		
6	Introduce legislation to amend the Code of Virginia by adding in Chapter 53.1-5 to require the BOC to adopt minimum health care standards for local and regional jails that are not accredited by the American Correctional Association or National Commission on Correctional Health Care. Such standards should require that standardized quarterly CQI reports be submitted to BOC from all local and regional jails and that the report be made available to the public on the BOC websites.	VACSB VARJ	

Policy Options By Letter from the JCHC Chair		Support	Oppose
7	By letter from the JCHC Chair, request that the Director of Corrections and the Chairman of the Parole Board jointly review conditional release policies to determine what changes may be made to improve the conditional release process of offenders over age 55 *who have complex medical problems.* A joint written report is to be submitted to the JCHC by October 1, 2019.		
8	By letter from the JCHC Chair, request that the Compensation Board, Department of Behavioral Health and Developmental Disabilities, and Director of Health Services for the Virginia Department of Corrections create a single statewide HIPPA compliant release form that can be used by all offenders and persons being served through the community services board and state psychiatric system that will allow for easier sharing of data and medical information among the different organizations that receive state funds. A joint written report with the approved form is to be submitted to the JCHC by October 1, 2019.		
9	By letter from the JCHC Chair, request that the Secretary of Health and Human Resources, Secretary of Administration and the Secretary of Public Safety And Homeland Security establish a "Local and Regional Jail and Mental Health and Substance Use Disorder Best Practice Committee" and designate the appropriate state agency members to serve on the committee. The committee should conduct an annual forum for state and local officials to identify and share experiences and processes used at the state and local level of government to overcome barriers and improve the delivery of services between local and regional jails and the state psychiatric system and community services boards. *	VML VACO	
10	By letter from the JCHC Chair, request that VADOC and VCU-HS develop policies to improve the exchange of offender related medical information - including electronic exchange of information for tele-medicine, tele-psychiatry, and electronic medical chart access by health care providers for both organization. A joint written report is to be submitted to the Commission detailing the policies and their implementation plan by October 2019.		

Summary of Public Comments

The **Executive Director of VACSB** indicated that VACSB supports **option 6**, "having standards in place will have the most direct impact on the quality of care for inmates." CSBs already provide discharge planning for some jails and view this service as the most beneficial that CSBs can provide to inmates in local or regional jails.

The **Executive Director of VML** believes that any effort to establish minimum health standards proposed in **policy option 6** "should include extensive consultation with the affected entities, specifically regarding administrative and budgetary components of potential requirements and should go through the regulatory process to grant opportunity for public comment." Finally, the state "should contribute to the costs" associated with implementing any new requirements.

The Executive Director of VML also indicated that VML supports **option 2** and "efforts to allow data to be more easily shared among state and local agencies so that individual service needs are better known and understood." VML supports a budget amendment for state funding of such a system.

Finally, the Executive Director of VML indicated that VML supports **policy option 9** to "share best practices and discuss ways to address unmet needs in communities and regions."

The **Executive Director of VACO** believes that standards as proposed in **policy option 6** be "developed through the regulatory process with ample time for public comment and stakeholder involvement, and funding options need to be part of the conversation." VACO notes that the local share of funding local and regional jails went from "45.45% in 2008" to "54.16%" in 2016 and that the state jail per diem for "local and state responsible inmates have not increased since they were set by the 2010 General Assembly" ($4 per day for local responsible and $12 per day for state responsible inmates).

The Executive Director of VACO indicated that VACO supports **policy option 9** as it "represents an opportunity to share innovative ways to deliver care to the incarcerated population." In addition, many of the VACO members "have invested significant local dollars in programs to divert individuals with mental illness away from incarceration, as well as innovative treatment programs within the jails" that could be shared with the workgroup proposed.

The **President of VARJ** indicated that VARG supports **option 6**, recognizing that effective metrics are not readily available and that "new medical and behavioral health standards require BOC to employ and oversee specialized inspectors." Adoption of new standards "may require additional state resources" and "respectfully urges the Commonwealth to fund new mandates associated with implementing new standards." VARJ also notes that HIPPA standards must be taken into consideration.

The President of VARJ indicates support for the 2018 legislation introduced by Delegate Stolle (HB 1487) and Senator Dunnevant (SB 878), including amendments "mandating CSB services upon the request of the jailer" and that "state appropriations are necessary for implementation of SB 878. Most regional jails work cooperatively with their local CSBs but for various reasons, often related to a lack of resources, all CSBs are not capable of providing continuing inmate care. For regional jails, multiple CSBs are located within a single regional jail's geographic area making service relationships challenging. Regional jails provide behavioral health care through a variety of mechanisms, including with a single health care provider for both health and mental health services. As an important first step to expand CSB services working with the jails VARJ recommends a significant increase in state discharge planning dollars.

The President of VARJ noted that one superintendent questioned how **policy option 4** would work given the current arrangements with private vendors and health care providers. Consideration of this recommendation "would require greater dialogue and consideration regarding existing contracts."

The President of VARJ notes that not all state responsible offenders who are chronically ill are transferred to a state infirmary. VADOC "will not accept a transfer" without determining illness and its own ability to provide care. He also noted that the incarceration of opioid addicted pregnant women, illustrated in the report, makes the case for alternatives to incarceration. Finally, the President of VARJ pointed out that jails are not medical and aging facilities. Regional jails have infirmaries to accommodate the sick, disabled and aged but the average length of stay varies from a few days to months and were not intended to hold inmates for years.

Requiring the Installation of Onsite Temporary Emergency Electrical Power Sources for Assisted Living Facilities

Stephen Weiss
Senior Health Policy Analyst

Study Mandate

HJR 123 (Delegate Hope) requested that JCHC study the feasibility of requiring an onsite temporary emergency electrical power source for licensed assisted living facilities (ALFs). The study was approved by JCHC at the June 15, 2018 planning meeting with the following instructions: the study should be limited to determining the number/percent and size of ALF facilities that do not currently have a generator and an estimate of cost based on facility size.

Virginia Code Related to ALFs

- Residential living facilities that serve 4 or more residents are licensed as ALFs by the Department of Social Services (DSS).
- ALFs are required to have emergency preparedness plans, meet building codes, and ALFs with 6 or more residents are required to have a permanent connection to a temporary emergency electrical power source approved by the local building official.
  - Under the current rules an ALF can use a portable generator and must include how it will be operated during a power outage in its emergency management plan that is submitted to the local emergency management office. According to the State Fire Marshal, there are state and local fire safety codes that need to be followed related to the use and storage of extension cords and gasoline unless the portable generator connects to a transfer switch that is installed at the electrical box.
- 295 of the 553 ALFs (53%) responded to a survey circulated by DSS. The survey found that:
  - 161 reported backup generator on site with full facility coverage (54.6%)
  - 134 reported no generator or partial/limited facility coverage (45.4%)
    - 27 reported no backup generator on site (9.2% of total responses)
    - 107 reported backup generator on site with partial/limited facility coverage (36.3% of total responses)
- The following tables provide cost estimates to install onsite backup electrical generators based on the size of the ALF, assuming that:
  - the generator provides backup power to the whole house (costs may be less if the generator can be wired for specific appliances)
  - the responses to the survey are representative of conditions for all licensed ALFs
  - the ALFs reporting only partial facility coverage will require new backup generators because there is no way to know how many are functioning/operational and able to satisfy requirements regarding all of the facility items that must be powered during an outage
  - the requirements apply to ALFs that have 7 or more licensed beds

Estimated Cost to Install Backup Emergency Electrical Power By Licensed Bed Capacity of ALFs						
Licensed Bed Capacity Range	**Generator Size (water cooled - commercial)**	**Equipment & Auto Transfer Switch**	**Installation**	**Engineering**	**Minimum Cost Per Facility**	**Maximum Cost Per Facility**
7 to 13	25kw	$9,500	$12,393	$1,559	$23,452	$51,013
14 to 24	45kw	$14,399	$18,783	$2,363	$35,545	$60,711
25 to 59	60kw	$25,000	$32,612	$4,102	$61,715	$145,646
60 to 89	130kw	$41,800	$54,528	$6,859	$103,187	$153,060
90 to 129	175kw	$60,000	$78,270	$9,845	$148,115	$212,298
130 to 199	250kw	$71,661	$93,482	$11,758	$176,901	$270,795
200 to 349	400kw	$100,000	$130,450	$16,408	$246,858	$430,767
350	750kw	$240,000	$313,080	$39,380	$592,459	

Engineering costs include written plans required to meet local building and fire codes for commercial building. Minimum and Maximum costs calculated based on licensed bed ranges. Prices based on industrial standby generator, meeting life and safety code – National Fire Protection Association (NFPA) 110-1

- *NFPA 110-1 standards cover installation, maintenance, operation, and testing requirements; including power source, transfer equipment, controls, supervisory equipment, as well as electrical, mechanical auxiliary and accessory equipment*

Sources: a) Newton, Lee, VP; Bay Diesel; Generator for Assisted Living. Email to Stephen Weiss, July 18, 2018 and b) Sharpe, John; Power Solutions Manager; Generac Industrial Power. Meeting October 4, 2018.

Estimated Number of Licensed ALFs by Region and Size Impacted by Requiring Onsite Temporary Emergency Electrical Power (i.e. Generator) and Estimated Costs

Generator Size	**25kw**	**45kw**	**60kw**	**130kw**	**175kw**	**250kw**	**400kw**	
Capacity Range / Region	**7 to 13**	**14 to 24**	**25 to 59**	**60 to 89**	**90 to 129**	**130 to 199**	**200 to 349**	**Grand Total**
Central	23	12	13	11	8	6	5	78
Fairfax	13	0	3	3	6	5	5	35
Northern	2	3	3	4	2	4	1	19
Piedmont	6	4	11	7	5	2	3	38
Valley	1	5	11	4	2	0	0	23
Western	1	4	6	4	3	0	0	18
Eastern	3	3	6	10	3	3	0	28
Peninsula	2	1	4	2	3	1	1	14
Total	**51**	**32**	**57**	**45**	**32**	**21**	**15**	**253**
Cost Estimate:								
Minimum Cost / Facility	$23,452	$35,545	$61,715	$103,187	$148,115	$176,901	$246,858	
Maximum Cost / Facility	$51,013	$60,711	$145,646	$153,060	$212,298	$270,795	$430,767	

Examples of Requirements in Maryland and Florida:

- Maryland: provide electricity to specific areas of an ALF, fire pumps, well and sewage pumps, heating equipment, etc.
- Florida: ambient air temperature be maintained at 81°F for 96 hours in designated areas of an ALF, the size of the area can be no less than 20 square feet per resident, calculated based on 80% of the licensed bed capacity of the ALF.
  - Florida allows ALFs to use portable generators and "spot coolers" to comply with the new rules. The designated areas are considered "areas of refuge." Residents are not required

to use them; however, employees of the ALFs are required to do "wellness" checks on residents every 30 minutes.

Additional Follow-up Information:

- Electrical panels have to be suitable for the addition of a generator and costs may be reduced by as much as 50% depending on the condition of the electrical panel, configuration of the interior, age and the wattage requirements of the appliances that will be powered by a generator. Or, for the same reasons, the costs may be significantly more expensive.
  - An electrical engineer for a generator company has installed residential and light commercial generators for anywhere from $5,000 to over $30,000 depending on how the house is wired and whether specific appliance circuits (breakers) are available in the electric panel.
  - Generators come in all sizes, are ordered and installed based on the calculated electric loads of the building and appliances.
- Lowes sells 8kw portable generators for less than $1,000 that are sufficient if the only items that need to be powered are the refrigerator and freezer, some lights and other small appliances. The portable generators are gasoline operated, hold 7 to 12 gallons depending on the model, have an electric start up with a built in battery and an emergency pull start. These generators will run for up to 12 hours if the overall load is half the generator's capacity, or no more that 4kw's of demand when running continuously.
- Lowes also sells and installs 16kw and 22kw whole house generators for between $7,800 and $9,000**,** for equipment and installation, for residential homes no larger than 3,600 square feet. The cost is based on the availability of either propane or natural gas and is dependent on the installer assessment of the house.
  - While Lowes will not rewire or reconfigure electrical panels to operate only a few items in the house, a person can buy a Lowes generator and hire an independent installer.
  - Lowes often refers customers to commercial installers for homes larger than 3,600 square feet.

Policy Options and Public Comments

Eight comments were received:

- Terri Lynch, Director, Division of Aging and Adult Services, Northern Virginia Aging Network
- Keith Hare, President and CEO, Virginia Health Care Association – Virginia Center for Assisted Living (VHCA-VCAL)
- Dana Parsons, Vice President & Legislative Counsel, Leading Age Virginia
- Judy Hackler, Executive Director, Virginia Assisted Living Association (VALA)
- Bob Eiffert, Chair of the Alexandria Commission on Aging, NVAN, Alexandria
- Erica Wood, Advocate, NVAN, Arlington
- Cedar Dvorin, MSW, Alexandria
- Cynthia Schneider, Arlington (NVAN), City of Alexandria

Policy Options		Explanatory Notes	Support	Oppose
Option 1	Take no action		VHCA-VCAL VALA LeadingAge Virginia	
Option 2	Introduce legislation to amend the Code of Virginia by adding in § 63.2-1732 that the Virginia Department of Social Services require all licensed assisted living facilities to have Back Up Emergency Generators onsite and in operating order pursuant to the appropriate standards established by the NFPA 110-1 taking into consideration the requirements, exemptions and extensions contained within the laws of Maryland.	Includes all licensed ALFs, no exclusions.	NVAN - Lynch Eiffert Wood Dvorin Schneider	VHCA-VCAL
Option 3	Introduce legislation to amend the Code of Virginia by adding in § 63.2-1732 that the Virginia Department of Social Services require all licensed assisted living facilities with a capacity of seven (7) beds or more to have Back Up Emergency Generators onsite and in operating order pursuant to the appropriate standards established by the NFPA 110-1 taking into consideration the requirements, exemptions and extensions contained within the laws of Maryland.	Excludes licensed ALFs with 6 beds or less.		VHCA-VCAL
Option 4	Introduce legislation to amend the Code of Virginia by adding in § 63.2-1732 that the Virginia Department of Social Services require all licensed assisted living facilities to have Back Up Emergency Generators onsite and in operating order pursuant to the appropriate standards established by the NFPA 110-1 taking into consideration the requirements, exemptions and extensions contained within the laws of Maryland.	Includes all licensed ALFs, no exclusions. Provides for sales tax exemption.		VHCA-VCAL

Policy Options		Explanatory Notes	Support	Oppose
	AND Introduce legislation to amend the Code of Virginia by adding in § 58.1 a tax exemption for all costs associated with the purchase and installation of Back Up Emergency Generators by Assisted Living Facilities. *(This should not have a fiscal impact since it is future revenue not current revenue).*			
Option 5	Introduce legislation to amend the Code of Virginia by adding in § 63.2-1732 that the Virginia Department of Social Services require all licensed assisted living facilities with a capacity of seven (7) beds or more to have Back Up Emergency Generators onsite and in operating order pursuant to the appropriate standards established by the NFPA 110-1 taking into consideration the requirements and exemptions and extensions contained within the laws of Maryland. Introduce legislation to amend the Code of Virginia by adding in § 58.1 a tax exemption for all costs associated with the purchase and installation of Back Up Emergency Generators by Assisted Living Facilities. *(This should not have a fiscal impact since it is future revenue not current revenue).*	Excludes licensed ALFs with 6 beds or less Provides for sales tax exemption.		VHCA-VCAL

Public Comments

Keith Hare, on behalf of VHCA-VCAL, indicates support of **option 1** and oppose **options 2-5,** stating that VHCA-VCAL was an active participant in the JCHC study and DSS survey, using its electronic newsletters to encourage members to participate in the survey. Mr. Hare noted that Virginia's ALFs are subject to rigorous emergency preparedness standards. The existing regulations grant ALFs flexibility to develop emergency response plans, including preparation for electrical outages, and tailored to the needs of their communities and resident populations.

A one-size-fits-all approach does not account for existing arrangements facilities may have made to comply with the emergency preparedness provisions of the regulations. VHCA-VCAL has taken numerous steps to assist members in ensuring the safety of ALF residents including: outreach to Dominion Energy to establish a process for identifying and updating the list of ALFs for priority service restoration during power outages and educating members about the Virginia Healthcare Alerting and Status System (VHASS), a free, web-based system designed to distribute critical emergency management information needed by Virginia's healthcare providers. During the spring of 2018 the association joined the Virginia Hospital and Healthcare Association to hold six regional training sessions on how to sign-up and use VHASS.

Dana Parson, on behalf of Leading Age Virginia, indicates support of **option 1**, stating that the current assisted living standards "include stringent emergency preparedness requirements" for planning, evacuation drills, equipment and supplies, and practice exercises. The regulations require an analysis of potential hazards, "including the loss of electric utilities."

Bob Eiffert, Terry Finch, and Erica Wood, wrote in support of **option 2**, and the NVAN legislative platform**.** The legislative platform includes requiring each licensed ALF to provide backup electricity in the event of an emergency that disrupts electrical power to the facility. They also wrote that the study's quoted costs to install generators appear high, may be applied to an entire building and recommend that the generator be sufficient to accomplish specific tasks, as follows:

- "Heating and cooling in an area that provides no less than 60 square feet of floor area per resident;
- Lighting in an area that provides no less than 60 square feet of floor area per resident;
- Refrigeration adequate to preserve food and medications requiring refrigeration;
- Operation of any necessary medical equipment; and
- Operation of at least one elevator in a building with elevators."

"Such targeted provisions -- along with a confirmation of actual costs, possible options for use of CDBG funds, a raise in auxiliary grant funds, and appropriate tax exemptions -- could reduce the cost factor considerably."

NVAN also wrote that extensions and exemptions, which may add some needed flexibility, "could over time become more permanent, detracting from resident safety." Finally, NVAN "supports a requirement for staff training," "quarterly vendor checks on the equipment, as well as financial assistance for facilities that are heavily dependent on the auxiliary grant to provide care."

Cathy Schneider supports **option 2**, stating that "the current requirement does not adequately protect vulnerable ALF residents in emergencies. On site working generators must be required."

Cedar Dvorin, MSW supports **option 2**, and states that "Virginia assisted living residents are especially frail" making access to a source of power in an emergency "critical to their health and sometimes to their lives." She wrote that she is "concerned that year-to-year waivers could over time become more permanent. I think we need to keep resident safety foremost."

Judy Hackler, on behalf of VALA, indicates support of **option 1**, stating that licensing standards enforced by DSS have recently been updated (February 2018), requiring ALFs to "implement, review, and practice detailed emergency response plans and evacuation plans; to stock and to maintain emergency equipment and supplies; and to plan and practice for resident emergencies." The plans are required to be shared with local emergency management personnel and the fire/emergency evacuation plan must be approved by the "appropriate fire official6." Requiring an onsite temporary emergency electrical power source could be a financial burden on some ALFs and might lead them to "cease operations." The closure of even one ALF is "a significant burden placed on the general community in finding new housing for residents, new employment for staff, new customers for business suppliers, and new business operators for the physical location of the closing assisted living community."

Appendix

Maryland - Required Coverage for Backup Generator

Areas of egress and protection as required by the State Fire Prevention Code and Life Safety Code 101 (as adopted by State Fire Prevention Commission)	Nurses' station and call system	Drug distribution station or unit dose storage
Heating equipment - minimum temperature of 70°F (24°C) in all common areas or areas of refuge	Elevator: if operable on emergency power; if required for evacuation purposes	Sewerage pump and sump pump
Fire pump	Well pump	Life support equipment
Area for emergency telephone use with at least one telephone to make and receive calls	Emergency generator location and switch gear location	Nonflammable medical gas systems
If applicable, toilet rooms of common areas or areas of refuge	Kitchen	Areas where life support equipment is used
Boiler or mechanical room		

ADHD Prevalence and Risks of ADHD Medications in Virginia

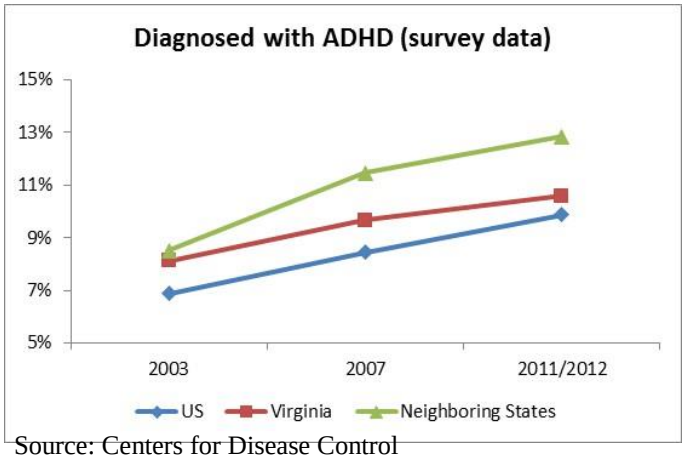
Andrew Mitchell
Senior Health Policy Analyst

Study Mandate

In 2017, HB 1500 (Item 30(A)) requested that the JCHC identify methods to: raise awareness of health/addiction risks of Attention Deficit Hyperactivity Disorder (ADHD) medication use; compile/track statistics on Virginia school children diagnosed with ADHD; limit antipsychotic use; and identify the incidence/prevalence of prescribing anti-psychotics for off-label use.

Background

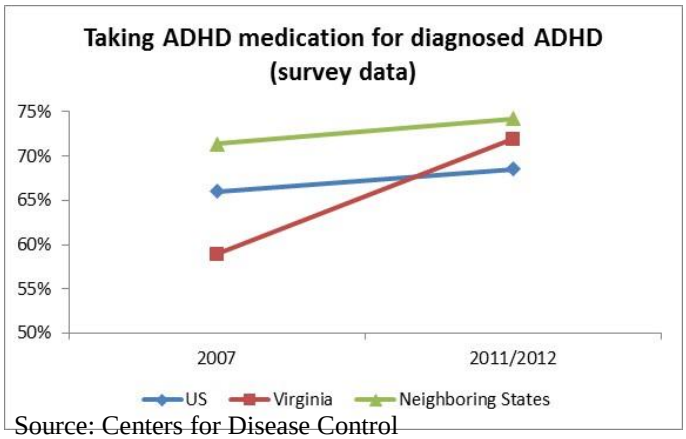
- ADHD is the most commonly diagnosed neurodevelopmental childhood disorder in the United States, with an estimated childhood/adolescent prevalence of around 5%.
- Survey data indicate that diagnosed prevalence of ADHD in Virginia is lower than that of all neighboring States but higher than the national average.
- With ADHD symptom persistence of 60% into adulthood, ADHD has been found to have adverse impacts on health, academic achievement, employment and criminality.



Source: Centers for Disease Control

ADHD Treatment

- Stimulants are 1st-line medications used to treat ADHD, with a variety of psychological interventions also used.
- Use of ADHD medications has risen dramatically in recent decades, with stimulant prescriptions tripling between 1990 and 2000.
- In the short term, ADHD medications have been found to reduce symptoms and, when combined with psychotherapy, improve outcomes such as behavioral co-morbidities, academic achievement and social functioning. Over the longer term, evidence of positive effects is much less consistent.

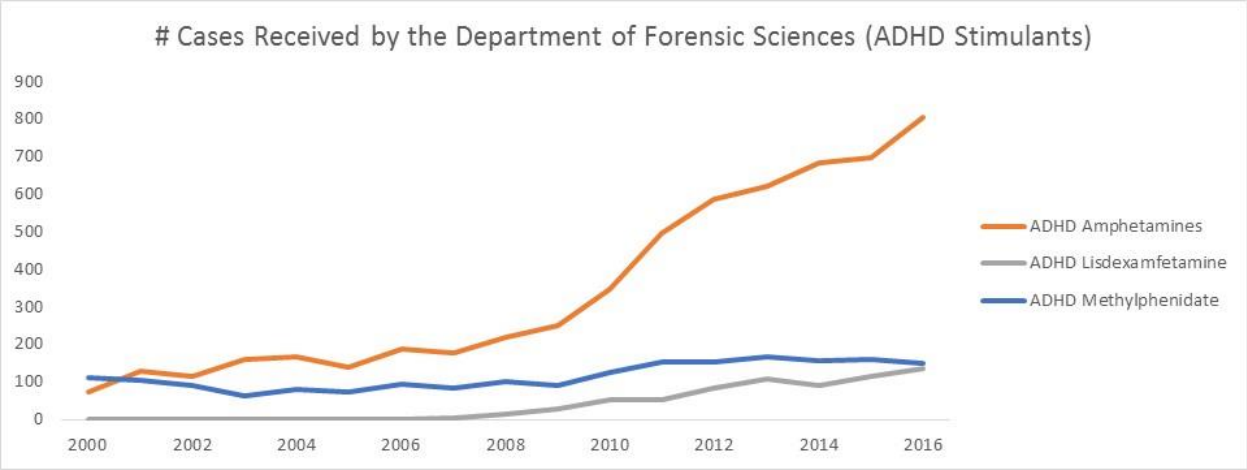


Source: Centers for Disease Control

- There is evidence that ADHD medication use may cause short-term growth reductions in children, but there is little evidence that ADHD medication use is associated with other health risks – such as Substance Use Disorder and other mental health illnesses.

Non-Medical Use of ADHD Stimulants

- Studies find non-medical use of stimulants in 5% to 9% of grade and high school-age children, and 5% to 35% of college age students, and Emergency Department (ED) visits involving stimulants tripled nationally between 2005 and 2010. However, the formulation of ADHD stimulants substantially reduces abuse potential compared to illicit stimulants (e.g., methamphetamine), and there is little evidence of addiction to ADHD stimulants.
- In Virginia, the number of law enforcement cases in Virginia involving ADHD stimulants increased from 184 in 2000 to 1,089 in 2016.



Source: Department of Forensic Sciences

Antipsychotic Medications

- ADHD is one of the most common mental health diagnoses among youth prescribed atypical antipsychotic (AAP) medications, which may be due to co-occurrence of ADHD with conditions for which AAPs are prescribed (on- or off-label), or off label use of AAPs for ADHD itself.
- In Virginia, data from insured populations in commercial markets indicate that around 30% of those prescribed AAPs between 2015 and 2016 did not have a FDA-indicated diagnosis for the prescribed AAP. In the Medicaid population, around 55% of those prescribed AAPs between 2015 and 2017 did not have a FDA-indicated diagnosis for the prescribed AAP.
- While AAPs have been found to probably reduce conduct problems and aggression in children with ADHD as well as clinical severity in patients with ADHD, they are also associated with risks summarized in the table above.

Adverse Event/Side Effect	Evidence of Risk
Any drug-induced movement disorder	Probably increases
Weight/BMI	Probably increases slightly
Total cholesterol	May increase
Triglycerides	Probably increases
Sedation/somnolescence	Probably increases

Source: Agency for Healthcare Research and Quality

- Historically, a high rate of use of psychotropic medications – including AAPs – among foster youth has prompted the federal government and States to closely monitor prescribing practices in this population.

Policies on ADHD and Psychotropic Medications in Virginia

- DOE is required by Code to prohibit school personnel from recommending the use of psychotropic medications for any student.

- DMAS and Managed Care Organizations (MCOs) have implemented Service Authorizations (SAs) for ADHD medications/stimulants for children outside of FDA-approved age range as well as adults 18 years or older, and for antipsychotics for individuals younger than 18 years old.
- To address concerns surrounding the appropriate use of AAPs in the foster youth population, DSS has been working with DMAS to implement a review process to monitor off label use of psychotropic medications in children, as well as modify its case worker database to better track foster youth medical and prescription history. However, data entered into the case worker database are done so manually, and the database is not synchronized with prescription history data from DMAS.

Methods to Raise Awareness of ADHD Medications Risks

- For the general public, the FDA raises awareness of risks of medications, including psychotropic medications, through safety communications and regulations on labeling of pharmaceuticals.
- In the college and university settings, Radford University provides information on its website on risks of taking selected licit and illicit drugs, while George Mason University requires all students prescribed medication for treating ADHD to sign a "Medication Contract" outlining the patient's roles and responsibilities.

Methods to Track ADHD Diagnoses Among School Children

- While some States actively collect statistics on ADHD diagnoses through data collection collaborations between State health and education agencies, the quality of data collected across school divisions is unknown. Virginia's DOE estimates that establishing an ADHD diagnosis data collection system for Virginia public school children would incur a one-time investment cost of $2.9M and annual recurrent costs of $81,200 and would be operational in 2 years and be able to produce reports in 3 years. However, DOE officials expressed concerns that data quality uncertainties found in other States would be similar for Virginia should such a data collection system be established.

Methods Used to Limit Antipsychotic Use

- Nationally, State payers of pharmaceuticals commonly employ a variety of methods to limit and/or ensure the appropriate use of psychotropic medications, including:
  - Service authorization (i.e., prescription pre-approval);
  - Peer review (i.e., manual clinician review of prior authorization requests); and
  - Drug Utilization Review (DUR) Program (i.e., a process conducted by all State Medicaid agencies involving prospective screening of prescription drug claims to identify potential problems and retrospective of claims data)

Methods to Identify Off-label Prescribing of Antipsychotics

- Identifying off-label prescribing of AAPs from administrative claims data is not straightforward because diagnosis codes are not generally required data elements on prescription claims. As a result, DMAS has not been able to endorse a methodology that would be able to produce public use information in tracking off label prescribing of AAPs based on claims data.

Policy Options and Public Comment

Six policy options were provided for consideration. No public comments were received.

Study Mandate Component	Policy Option(s)
N/A	Option 1: Take No Action
Raise awareness of ADHD medication risks	Option 2: By letter from the JCHC Chair, request the governing board of each four-year public institution of higher education to: • Require ADHD stimulant medication contracts of any student prescribed ADHD stimulants by the institution, and; • Develop and implement policies that result in the provision of written information to students about the potential risks of stimulant use
Track statistics on Virginia school children diagnosed with ADHD	Option 3: Introduce a budget amendment of $2.98M for SFY 2020 for DOE to establish an ADHD diagnosis data collection system for Virginia public school children
Methods to limit antipsychotic use for ADHD	Option 4: By letter of the JCHC Chair, request that DMAS and DSS convene a stakeholder group to identify methods to ensure that DSS data on antipsychotic and other prescription medications currently being prescribed to foster populations are accurate and up-to-date Option 5: By letter of the JCHC Chair, request that DMAS require documentation of metabolic monitoring in the service authorization form for antipsychotics for children <18 years old, including documentation of: baseline and routine monitoring of weight or body mass index (BMI); waist circumference; blood pressure; fasting glucose; fasting lipid panel; and Extrapyramidal Symptoms (EPS) using Abnormal Involuntary Movement Scale (AIMS)
Methods to track off label prescribing of antipsychotics	Option 6: By letter of the JCHC Chair, request that DMAS cost out an appropriate methodology to track off label prescribing of AAPs among FFS beneficiaries – and determine required contract modifications with contracted health plans to track off label prescribing of AAPs among MCO beneficiaries – with the Department reporting back to the Commission with a proposed implementation plan by October, 2019

Pharmacy Drug Disposal Program

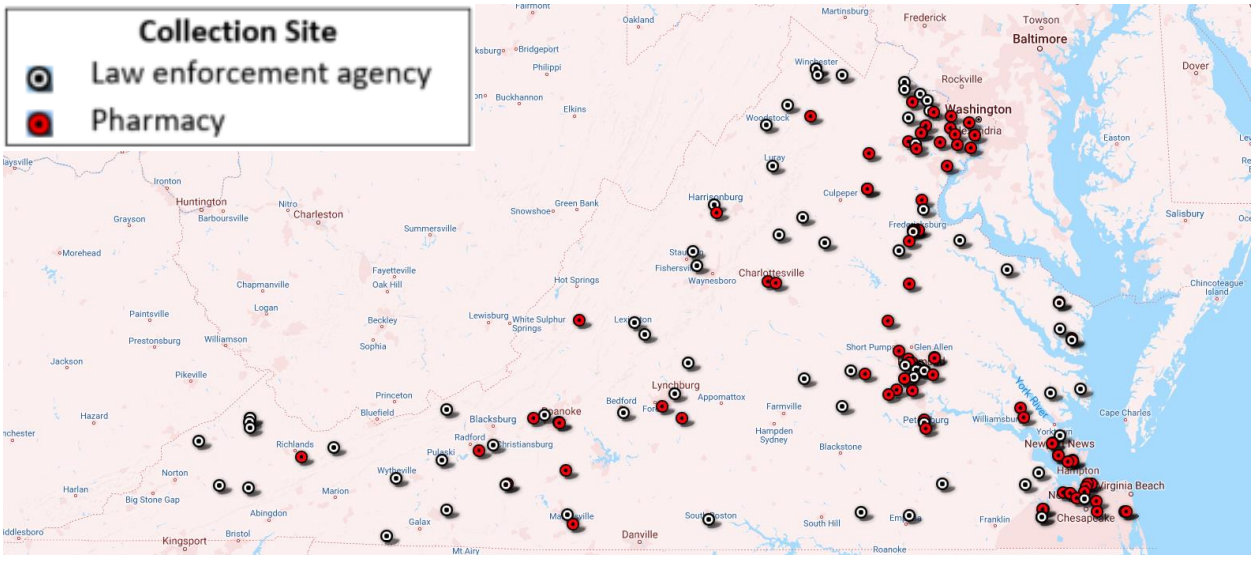
Andrew Mitchell
Senior Health Policy Analyst

Study Mandate

In 2018, SB 962 would have required participation in a drug disposal program by pharmacies that: dispense Schedule II and III controlled substances; do not dispense primarily by mail, common carrier, or delivery service; and are not located within a hospital. SB 862 was Passed by Indefinitely in Senate Education and Health with a letter from the Senate Clerk requesting that the JCHC study the subject matter contained in SB 862. The JCHC Executive Subcommittee and members approved a study for 2018.

Background

- Unused and inappropriately stored or disposed of medicines pose a variety of health risks, including drug diversion, and environmental risks – up to 80% of U.S. streams have detectable amounts of drugs.
- Federal regulations allow pharmacies to modify their registration to dispose of unused medicines through two methods that meet DEA standards: secure disposal bins or mail-back. Other disposal methods are recommended by the FDA and EPA only under certain circumstances.
- However, use of methods meeting DEA standards or recommended by the EPA/FDA remains highly limited: fewer than 10% of individuals reportedly consider using FDA-recommended disposal methods; and in Virginia, 4% of licensed pharmacies are currently registered as authorized collectors (see map).
- In 2015, the Governor's Task Force on Prescription Drug and Heroin Abuse made 10 recommendations related to medicine disposal/collection. While some recommendations had been fully or mostly addressed, the majority were only partially or mostly not addressed. A common theme was to secure additional funding and increase consumer outreach and education to fully implement recommendations.
- Currently, DBHDS and VDH implement initiatives to encourage appropriate medicine disposal, but these initiatives do not use disposal methods that meet DEA standards



Medicine Take-Back Models

Program Type	Public funding?	Pharmacy participation required?	Examples
Government-supported / implemented	Yes	No	• CO, NE, NY*
	No	No	• IA, ND
Government-regulated	No	Yes	• Santa Cruz County
	No	No	• WA, MA, NY**, VT • 22 municipalities

* Refers to pilot program (2017) ** Refers to State law (2018)

- Two medicine take-back program models have been put into place in other States and municipalities:
  - Government-supported or implemented model: government plays a direct funding and/or program administration role. Annual budgets – whose sources include General Funds, private funds and wholesale manufacturers fees – range from $175,000 to $600,000, with annual tonnage disposed ranging from 1.5 to 18 tons.
  - Government-regulated model ("Extended Producer Responsibility" [EPR]): the State or municipality oversees program implementation by a 3rd party. States have mandated this approach across a variety of other industries, including two EPR laws in Virginia.
- Since 2012, 23 municipalities and 4 States have established EPR programs for unused medicines. Common elements are summarized below:

Included in 100% of programs:

- Program must accept all medicines (prescription/non-prescription)
- Geographic "convenience" standards specified
- Manufacturers responsible for program costs and fees
- Manufacturer point-of-sale and point-of-collection fee prohibited
- Consumer education and outreach required
- Programs can be operated singly or jointly by manufacturers

Included in <100% of programs:

- Mail-back option required (11 of 12 programs)
- Disposal by incineration only (5 of 12 programs)
- Municipality specifies benchmark program (3 of 12 programs)
- Retail pharmacy participation required (1 of 12 programs)

- **Washington State** is one of four States to adopt the EPR approach through its Unwanted Medication Disposal Act (2018). Key features include:
  - The Act covers all **controlled and non-controlled medicines** with some exceptions
  - **Manufacturers** are responsible for establishing and fully funding the program
  - A "**program operator**" contracts with manufacturers to implement the program
  - The **Department of Health** reviews, approves and monitors implementation by the program operator
- A widely cited estimate is that medicine take-back programs cost approximately $0.01 for every $10 in pharmaceutical sales. Cost data obtained for this report from pharmacies that currently take back

medicines range from $850 - $1,200 and data from other States suggest a range of $500 – $1,800 per year per pharmacy.
- Estimated annual cost of a Virginia statewide program if all DEA-authorized collectors participated would be $3.2M – $5.4M.

Policy Options and Public Comment

Four policy options were provided for consideration. Comments were received by:

- Patrick Plues, Vice President, State Government Affairs, **Biotechnology Innovation Organization (BIO)**
- Carlos Gutierrez, Vice President, State & Local Government Affairs, **Consumer Healthcare Products Association (CHPA)**
- Nicole Wood, Senior Director, State Advocacy, **Pharmaceutical Research and Manufacturers of America (PhRMA)**
- Christina Barrille, Executive Director, **Virginia Pharmacists Association (VPhA)**
- **Marvin Rosman**, Virginia citizen

Policy Focus	Policy Option(s)	Support	Oppose
--	Option 1: Take No Action	**CHPA**	
Public awareness of DEA-compliant / FDA- and EPA-recommended medicine disposal methods	Option 2: Introduce legislation to amend § 54.1-3319 of the Code of Virginia to add counseling on medicine disposal to the list of topics on which pharmacists may counsel persons who present a new prescription for filling (Code currently only lists storage as a topic)	**CHPA**	
Statewide medicine disposal program ***OR***	Option 3: Re-introduce SB 862 to amend section §54.1-3411.2 of the code of Virginia requiring retail pharmacies to collect and dispose of: • Option 3a: Schedule II-IV medicines; ***OR*** • Option 3b: All prescription/non-prescription medicines		**CHPA** **PhRMA**
	Option 4a: Introduce legislation and budget amendment to amend Title 54.1 of the code of Virginia to establish an Extended Producer Responsibility law, modeled after Washington State's Unwanted Medication Disposal Act*; ***OR*** Option 4b: Option 4a + 1-year enactment clause**	Marvin Rosman	**BIO** **CHPA** **PhRMA**

* DHP estimates resource requirements of $500,000 and 4 new FTEs; fiscal impact to be covered by fee assessed on program operator
** 1-year enactment clause would allow for: implementation of competing DHP priorities (e.g., pharmaceutical processor selection); data from WA State implementation to inform VA legislation

Summary of Public Comments

Biotechnology Innovation Organization (BIO) indicated opposition to an Extended Producer Responsibility program for prescription medications, stating that it would not present a viable solution to the problem of prescription drug abuse and would fail to have a clear environmental benefit. Conversely, BIO is in favor or providing education on safeguarding of drugs stored in the home and information on appropriate and affordable household disposal options currently available. Additionally, BIO believes that that all stakeholders have a shared responsibility for the post-consumer management of the products put into the market.

The **Consumer Healthcare Products Association (CHPA)** indicated opposition to state-wide disposal, cautioning against creating a framework that could yield unintended consequences without addressing the issues highlighted in the report. Conversely, CHPA advocates for responsible medicine use by consumers, safe medicine storage, and proper medicine disposal.

The **Pharmaceutical Research and Manufacturers of America (PhRMA)** indicated opposition to state-wide disposal programs, citing a lack of evidence that drug take-back programs reduce pharmaceuticals in the environment or drug abuse concerns and the negative impact such programs can have on the cost of medicines. Conversely, PhRMA supports mechanisms to educate consumers on how to safeguard medicines in the home and how to safely and securely dispose of their truly unused medicines in the household trash.

The **Virginia Pharmacists Association (VPhA)** indicated that it does not support an unfunded mandate for drug disposal programs, highlighting concerns expressed by its members that responded to the report's pharmacists' survey, including those related to additional costs, safety fears, staffing requirements, and patient education.

Marvin Rosman indicated support for a state-wide program, highlighting that unwanted prescription drugs have environmental risks and that measures should be taken to make their disposal easier.

Addiction Relapse Prevention Programs in the Commonwealth

Andrew Mitchell
Senior Health Policy Analyst

Study Mandate

By letter of request, Delegate Kory asked the JCHC to study addiction relapse prevention, with a particular focus on opioid addiction, and address the following questions: What programs exist in Virginia that offer assistance to persons who have successfully completed substance abuse recovery regimens and have been released into the community? How do former addicts maintain addiction-free or relapse-free lives? What are reported rates of success and failure and how is success defined and tracked? Is there a best practices model for relapse prevention programs? What is needed to "cure" addiction in terms of pharmaceutical management? What role does counseling play and what are the requirements for success? What training/technical assistance is needed for peer counselors? What are the costs? What cost-effectiveness data exist? If Virginia data are scarce, what does the national picture indicate and how can we effectively collect it?

Study Findings

Key Points	Related Policy Options
• Relapse is commonly viewed as an expected part of the recovery process and an opportunity to evaluate the appropriateness of intensity and/or frequency of Substance Use Disorder (SUD) treatment services received	N/A
• State-level data on relapse rates are limited:	
◦ Federal regulations (42 CFR Part 2) greatly restrict the ability to collect the most direct measure of relapse – urine drug screen results – by SUD services payers, program funders, etc.	None: capturing urine drug screen data would likely incur significant administrative costs and legal liabilities with unintended consequence of deterring treatment seeking or continuation
◦ Conversely, a variety of service utilization data (e.g., continuity of Opioid Use Disorder (OUD) pharmacotherapy) can serve as proxy measures of both relapse and quality of SUD care; DMAS anticipates collecting data on three relapse proxy measures under ARTS	None: 3 relapse proxy measures – continuity of OUD pharmacotherapy, SUD treatment readmissions rates, follow up after ED discharge – anticipated to be collected under ARTS
• Programs in Virginia with recovery and relapse prevention components span multiple agencies and cover clinical and non-clinical services, including:	N/A; Table 1, below, provides an overview of SUD programs most directly connected to recovery and relapse prevention
◦ DOC/DBHDS MAT pilot with recovery support navigators: currently being implemented in 3 of the Probation and Parole districts which have among the State's highest positive opioid drug test rates	**Policy option 2** provides an additional recovery resource in the 3 MAT pilot districts – Day Reporting Centers which were found to be effective in Virginia and have a positive cost-benefit ratio more generally

• DBHDS Project Link: currently being implemented in 9 CSB regions, DBHDS data indicate higher rates of SUD service utilization by pregnant and parenting women in Project Link sites compared to non-Project Link sites	**Policy option 3** would expand Project Link to 5 new CSB regions that experience the highest rates of neonatal abstinence syndrome
• While recent State-level initiatives – such as the Governor's Advisory Commission on Opioids and Addiction – are expected to ensure coordination of State initiatives in SUD treatment and recovery, information about SUD programs made available to the public through State agencies or State-connected resources is not well-aligned (e.g., of over 250 SUD treatment/recovery resources listed by three State-connected websites, fewer than 20% are listed by all three)	**Policy options 4, 5 and 6** address those gaps in terms of opioids, substance more generally, and in the context of Emergency Department settings, respectively
• While ARTS has lowered barriers to accessing SUD services for the Medicaid population and workforce initiatives focused on clinical providers of SUD services have begun to address some supply-side constraints:	
• Coverage of SUD case management and peer support services in commercial health plans is variable (both are covered services under ARTS for the Medicaid population)	**Policy option 7** requires insurance coverage of case management and peer support services by health plans regulated by the Bureau of Insurance
• Available data suggest that the current Virginia statute on barrier crimes may unnecessarily limit the number of Peer Recovery Specialists or others seeking employment in CSB or licensed provider substance abuse programs	**Policy option 8 and 9** provide two alternatives to reduce the impact of barrier crimes to employment of PRS in CSBs or among licensed private providers while maintaining safety/quality of the work force

Table 1. SUD programs in Virginia

SUD Program	Focus Population	Oversight Agency	Date of inception	Funding source	SUD Service			Geographic Coverage	Notes
					Clinical*	Recovery**	Wrap-around†		
Substance Abuse Vocational Rehabilitation Counselors	Individuals with significant barriers to employment	DARS / DBHDS	1988	Public (State/Federal)			x	19 Counselors statewide	
Peer support services (SUD warmlines)	General population	DBHDS	2017	Public (Federal)		x		Statewide	OPT-R grant-funded
Peer support services (ED-based Peer Recovery Specialists)	General population	DBHDS	2017	Public (Federal)		x		6 hospitals	OPT-R grant-funded
Permanent Supportive Housing	Pregnant / parenting women	DBHDS	2019 (anticipated)	Public (State/Federal)			x	Up to 75 women statewide	
Project Link	Pregnant / parenting women	DBHDS	1992	Public (State/Federal)	x		x	9 CSB regions	Links women to clinical Tx
Project Link for Pregnant and Post-Partum Women	Pregnant / parenting women	DBHDS	2017	Public (Federal)	x	x	x	9 CSB regions (same as above)	SAMHSA pilot grant
Recovery housing (Oxford House model)	General population	DBHDS	1990	Public (Federal)			x	~ 1,065 beds statewide	DBHDS supports admin costs

Table 1. SUD programs in Virginia

SUD Program	Focus Population	Oversight Agency	Date of inception	Funding source	SUD Service			Geographic Coverage	Notes
					Clinical*	Recovery**	Wrap-around†		
Model Addiction Recovery Programs	Justice-involved population	DCJS	2017	Public (local/State)	x	x	x	4 jails	
Residential Substance Abuse Treatment Program	Justice-involved population	DCJS	1994	Public (State/Federal)	x	x	x	1 jail; DOC (1 grant)	
Housing/employment supports	Medicaid (high-need beneficiaries)	DMAS	2019 (anticipated)	Public (State/Federal)			x	Statewide (phased-in regionally)	Part of Medicaid expansion
Clinic-based treatment programs*	Medicaid members	DMAS	2016	Public (State/Federal)	x		x	Statewide	ARTS benefit
Clinic-based treatment programs*	Non-Medicaid population	N/A	N/A	Private (insurance; self-pay)	x		x	Statewide	Services covered vary by insurer
Peer support services	Medicaid members	DMAS	2016	Public (State/Federal)		x		Statewide	ARTS benefit
Peer support services	Non-Medicaid population	N/A	N/A	Private (insurance; self-pay)		x		Statewide	
Therapeutic Communities	Justice-involved population	DOC	1994	Public (State)	x	x		2 facilities	

Table 1. SUD programs in Virginia

SUD Program	Focus Population	Oversight Agency	Date of inception	Funding source	SUD Service			Geographic Coverage	Notes
					Clinical*	Recovery**	Wrap-around†		
Community Corrections Alternative Programs	Justice-involved population	DOC	2017	Public (State)	x	x	x	Statewide	3 provide intensive SUD Tx
Day Reporting Centers (discontinued in 2008)	Justice-involved population	DOC	1993	Public (State)	x	x	x	12 Probation and Parole districts	Program closed in 2009
Prison MAT pilot	Justice-involved population	DOC / DBHDS	2018	Public (State)	x	x	x	3 Probation and Parole districts	
Vocational/job training	Individuals with significant barriers to employment	DSS	1999	Public (local / State/Federal)			x	Statewide	
Recovery housing and/or Recovery Support Organizations	General population	N/A	N/A	Private		x	x	Statewide	
Mutual support/12-step groups	General population	N/A	N/A	Private / free		x		Statewide	
Drug Treatment Courts	Justice-involved population	Supreme Court	2004	Public (local / State/Federal)	x	x	x	38 Courts statewide	

* Examples: MAT, psychotherapy, etc. provided in inpatient/residential, outpatient clinics, etc.

** Examples: peer support, mutual support groups, recovery housing

† Examples: case management, vocational rehabilitation

Policy Options and Public Comment

Nine policy options were provided for consideration. No comments were received.

Policy Focus	Policy Option(s)
--	**Option 1**: Take No Action
Programs for targeted populations	**Option 2**: Introduce a budget amendment to support the placement of Day Reporting Centers in 3 DOC probation and parole districts (Richmond City, Norfolk City, Buchanan/Tazewell) that experience the highest rates of positive opioid drug tests results and overdoses among individuals on state probation supervision, with the Day Reporting Centers offering non-pharmacological SUD treatment and recovery services as well as wraparound supports to offenders in need of initial or ongoing SUD services. • DOC estimates an annual cost of $660,000 per Day Reporting Center ($1,980,000 total) • DOC anticipates seeking funding for additional Recovery Support Navigators in 11 probation and parole districts identified as high-need for OUD services
	Option 3: Introduce a budget amendment to expand Project Link into 5 new CSB sites that have the highest rates of Neonatal Abstinence Syndrome (Mount Rogers, New River Valley, Northwestern, Horizon, Crossroads) • DBHDS estimates an annual cost of $100,000 each ($500,000 total)
Awareness of SUD treatment / recovery resources	**Option 4**: Introduce a budget amendment for 1 VDH FTE to align and coordinate information made available through State agencies on opioid use disorder treatment and recovery resources on the Curb the Crisis website • VDH estimates an annual cost of $100,000 for 1 FTE
	Option 5: Introduce legislation (Uncodified Act) requiring the Secretaries of HHR and PSHS to convene a workgroup that includes representatives of DBHDS, DHP, DMAS, VDH, DARS, DSS, DCJS, DOC, the Attorney General's Office, VSP and DVS to study the current alignment and coordination of information made available through State agencies on substance use disorder treatment and recovery resources, making recommendations to the General Assembly and JCHC by November 1, 2019 on legislation and/or budget amendments required to improve alignment and coordination of SUD treatment/recovery resource information made available by State agencies
	Option 6: Introduce legislation (Uncodified Act) requiring DBHDS to convene a workgroup that includes representatives of VDH, DHP, the VHHA, and other stakeholders as appropriate, to develop minimum comprehensive discharge planning standards for inpatient admissions with indication of a substance-use disorder, opioid overdose, or chronic addiction at all hospitals and free-standing Emergency Departments. The workgroup will report the outcomes of its activities to the JCHC by October 1, 2018 with recommended policy options
Access to SUD recovery services	**Option 7**: Introduce legislation to amend Title 38.2 of the Code of Virginia to require that plans regulated by the Bureau of Insurance include as covered services, for members diagnosed with a Substance Use Disorder: 1) SUD case management services provided by DBHDS-licensed case management providers; and 2) peer support services provided by Registered Peer Recovery

Policy Focus	Policy Option(s)
	Specialists, with reimbursement rates at least equivalent to those the plan has for case management/peer support services for non-SUD diagnoses (e.g., mental health diagnoses). For plans that do not currently cover case management and/or peer support services for its members, reimbursement rates would be at least equivalent to those provided by the Medicaid ARTS benefit
	Option 8: Introduce legislation to amend Title 37 of the Code of Virginia to limit the duration of the barriers to employment eligibility of barrier crimes listed in § 37.2-506 and § 37.2-416 to: **Option 8a**: 5 years for all crimes; ***OR*** **Option 8b**: 5 years for crimes that currently are of limited duration (possession of controlled substances); 10 years for all other crimes
OR Health Workforce – Peer Recovery Specialists	**Option 9**: Introduce legislation to amend Title 37 of the Code of Virginia to: • Remove all barrier crimes listed in § 37.2-506 and § 37.2-416; and • Require DBHDS to: 1) develop agency-specific barrier crime regulations through Administrative Code that balance public safety/health concerns with maximizing access to qualified SUD service providers; 2) summarize its rules to the JCHC by October 1, 2019; 3) include data on the outcomes of candidates with barrier crimes – including the number of candidates disqualified in that SFY because of barrier crimes; the number of candidates with barrier crimes that were not disqualified in that SFY; and a characterization of the types of barrier crimes in either case – in its annual reports thereafter.

Result of DBHDS Work Group on Improving the Quality of Direct Support Professional Workforce for the Developmental Disability Waiver Population

Holly Mortlock
DBHDS Policy Director

Background: The 2018 General Assembly passed HB813, which directed the Department of Behavioral Health and Developmental Services (DBHDS) to convene a group of stakeholders to determine steps that may be taken to improve the overall quality of the Commonwealth's direct support professional workforce, for the developmental disability population, and subsequently, if indicated, to make recommendations for public policy changes that increases transparency of the quality of the workforce, to help support individual health and safety.

DBHDS convened a stakeholder group, of which three meetings were held, to determine steps to improve the overall quality of the Commonwealth's direct support professional workforce (for the developmental disabilities population), and subsequently, if indicative, to make recommendations for public policy changes that increases transparency of the quality of the workforce, to help support individual health and safety. The work group evaluated three options:

1. Direct DBHDS to facilitate development of a centralized tracking system of qualified direct support professionals, to track information such as core competencies.
2. Direct DBHDS to develop and/or amend regulations to require providers to certify trainings and to issue training certificates, so that they become portable to the employee.
3. Develop a third party training/certification/tracking entity that includes a database for employers to check.

The potential fiscal impacts of each of the three possible options are described below.

Option 1: Direct DBHDS to facilitate development of a centralized tracking system of qualified direct support professionals, to track information such as core competencies.

It is possible that facilitation of a centralized tracking system could be absorbed by current DBHDS staff. If that is not feasible, then an additional analyst staff position would be required for oversight of the centralized tracking system. This individual would be responsible for coordinating with other departments and agencies to establish the system, maintaining it, and ensuring providers are aware of the system and using it. The cost of staff support is estimated at $50,000 per year. If staff support is provided by means of a new position for the tracking system, there will also be costs of $19,100 per year in fringe/benefits for this individual.

To establish this tracking system, each provider would need a software license. Each license would cost between $100 and $200, with the costs being lower per license the more licenses purchased. In other words, if more providers participate in the centralized tracking system, the costs of licenses will be lower. There are 1,879 registered I/DD providers in the Commonwealth, which means an initial startup cost to providers of between $187,900 and $375,800 each year for the initial license and license renewal.

	FY2020	FY2021
DBHDS Staff Support	$ 50,000	$ 50,000
Fringe for Additional Hire	$ 19,100	$ 19,100
Licenses	$ 375,800	$375,800
Total	$ 444,900	$ 444,900

It is worth noting that this option is voluntary on the part of providers. Unless participation in incentivized, it may have little participation, making this an ineffective solution.

Option 2: Direct DBHDS to develop and/or amend regulations to require providers to certify trainings and to issue training certificates, so that they become portable to the employee.

The costs of this option are minimal. Tasking DBHDS to develop and/or amend regulations poses no extra financial costs to the agency. The only additional costs would be to providers for printing ($.025 per page, including ink/toner and paper) and minimal staff time to enter trainings and certifications. The Bureau of Labor Statistics classifies DSPs as "home health aides" and "personal care aides". According to DBHDS data, there are approximately 29,056 direct service professionals serving the intellectual and developmental disabilities population, meaning at maximum, these certificates would need to be printed for 29,056 direct service professionals.

3 trainings per year * $.025 (per page of printed material) * 29,056 = $2,179 statewide

Option 3: Develop a third party training/certification/tracking entity that includes a data base for employers to check.

This is the most extensive of the three proposed options. Ideally, this option would include contracting a third party, such as the National Association of Direct Service Professionals (NADSP), to develop and/or identify a training curriculum, certification system, and tracking entity for all DSPs in Virginia. In other states where a similar program has been implemented, this includes establishing 3 to 4 levels of certification depending on expertise. Each of these levels also includes a suggested hourly pay increase for DSPs. In New York, for example, an initial 50 hours of training is required to receive DSP credential I certification – DSP credential II, III, and Frontline Supervisor and Management certifications require an additional 40 hours of training each.

New York's Office for People with Developmental Disabilities has worked with the University of Minnesota, the New York State Association of Community and Residential Agencies, and the New York State Rehabilitation Association to implement a credentialing and tracking program for direct service professionals with great success, but it required incentivizing participation in the program and using Medicaid to offset the costs and provide raises to DSPs through the federal medical assistance plan (FMAP). South Dakota has also used the NADSP's credentialing model to propose its own program. Their credential levels are similar to those of New York, with the exception that their "level I" certification does not require any certain number of training hours, just that the person registers as a DSP after

working in the profession for a minimum of 6 months. This helps in paying for the program, as it requires payment of a $100 registration fee by the provider or the DSP.

It is difficult to provide an exact estimate for this option without knowing the goals for participation. Part of that challenge is that Virginia does not currently have a way to track the number of DSPs in the state. The best educated guess for the number of DSPs in Virginia comes from DBHDS data for the number of people receiving DD waivers. The other challenge is that this program will still be voluntary for providers and DSPs, meaning there will likely not be full enrollment.

This estimate uses a model similar to what the Community Providers of South Dakota used in determining their potential costs and assumes that

- Implementation in Virginia would be a similar cost to that for South Dakota ($38,620)
- The average wage in Virginia for a DSP is $10.38 per hour (the average of home health aides' and personal care aides' wages)
- The DSP work force would be phased in over 4 years; with 75 percent in year 1, 10 percent each in years 2 and 3, and 5 percent in year 4.
- The average time of training completion for each credential is 9 months
- Training will require 1.5 hours of overtime at $15.57 per hour each week of that 9 months
- All included DSPs will obtain at least one credential.

This estimate does not account for incentivized pay raises for levels II and III or supervisors. It is unknown the exact amount of DSP providers in Virginia that are specific to the DD population. Below is a chart showing assumption based on certain pecentages.

	Year 1	Year 2	Year 3	Year 4
Percent of Workforce Trained	**75%**	**10%**	**10%**	**5%**
Number of DSPs	21,792	2,906	2,906	1,453
Initial Implementation	$ 36,820			
Registration	$ 2,179,200	$ 290,560	$ 290,560	$ 145,280
Cost of Training	$ 19,849,134	$ 2,646,551	$ 2,646,551	$ 1,323,276
Total	$ 22,065,154	$ 2,937,111	$ 2,937,111	$ 1,468,556

*Cost of training was calculated using the following formula: 1.5 (hours of overtime) * $15.57 (time and half wage) * 39 (weeks of training in 9 months) = $910.85 per person, per level of training

Costs will taper after more of the existing work force is certified. DBHDS should work with DMAS under this option to discuss changes to provider reimbursement rates for pay incentives and covering trainings for certification.

Potential Savings:

According to the study that New York's Office of People with Developmental Disabilities conducted prior to implementing their "Career GEAR Up" Program, costs associated with hiring a new DSP range from $6,000 to $10,000 per person. It has been shown that the reduction in turnover of positions in the DSP workforce leads to efficiencies in the operations of providers.

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Joint Commission on Health Care
P.O. Box 1322/ Richmond VA 23219
804-786-5445/http://jchc.virginia.gov