November 18, 2013

Decision Matrix

Policy Options for 2014 General Assembly Session

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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 and its Subcommittees in 2013.
B. To develop legislative recommendations for the 2014 General Assembly Session.

Sunset Date for Joint Commission on Health Care

Kim Snead
Executive Director

In 1992, when the Joint Commission on Health Care was established to continue the work of the Commission on Health Care for All Virginians, a sunset date of July 1, 1997 was included. The sunset date has been extended three times resulting in the current sunset date of July 1, 2015.

Joint Commission members may wish to introduce legislation to extend the sunset provision by another four years or to remove the sunset provision. Other legislative commissions with similar objectives as JCHC that have no sunset provision in their statutory language:

- Joint Legislative Audit and Review Commission
- Virginia Commission on Youth
- Virginia State Crime Commission.

Examples of legislative commissions that have specific sunset dates:

- Autism Advisory Council
- Health Insurance Reform Commission
- Commission on Electric Utility Regulation.

It has been the practice to vote on the issue of the sunset date to allow legislation to be considered the year prior to the sunset date's expiration.

Policy Options

Option 1: Take no action.

Option 2: Introduce legislation to amend the *Code of Virginia* § 30-170 to extend the sunset provision to July 1, 2019.

Option 3: Introduce legislation to amend the *Code of Virginia* § 30-170 to remove the sunset provision.

Virginia Physician Workforce Shortage
House Joint Resolution 689 - Delegate Harry R. Purkey

Stephen W. Bowman
Senior Staff Attorney/Methodologist

HJR 689 directed JCHC to study whether a shortage of medical doctors in Virginia exists and if shortages exist to provide avenues for alleviating the shortages.

Current Physician Supply in Virginia

The Commonwealth's current physician-supply includes 16,000 practicing physicians of whom 40% practice as family, internal, or pediatric medical practitioners. Current physician-supply issues primarily involve addressing maldistribution and increasing the percentage of new physicians who choose to provide primary care. A 2010 Department of Health Professions report noted that Virginia's projected future shortages would be most prevalent in primary care and surgery specialties.

Addressing Physician Supply Needs

The statewide demand for health care services is projected to increase as the Commonwealth's population and the over-65 population in particular increases. By 2030, 18% of the State's population (1.8 million individuals) are expected to be over 65 years of age, an increase from 12% in 2000. This is an important change since individuals who are over 65 require significantly more care from physicians. To meet this increased demand, an increased supply of health care practitioners will be needed.

Team-Based Care. The practice of medicine is evolving; more attention is now given to team-based care in which a combination of two or more physicians, nurse-practitioners, physician assistants, pharmacists, and other health care professionals coordinate their efforts to provide care to the patient. RAND Health has identified team-based care as one avenue for addressing medical service shortages.

Increase the Number of Residencies. Two of the primary requirements to become a licensed physician in the U.S. include graduating from an approved medical school and completing a U.S. based medical residency. While Virginia's medical school enrollment has increased by 15% since 2008, medical residency slots have not increased at the same rate. Medicare, the largest funding source for medical residencies has not increased its funding levels since 1996. Currently, bills are being considered in both chambers of Congress to provide funding for phasing in 15,000 residency positions. If sufficient residencies are not made available, the medical school graduates who do not also complete a U.S. residency will be unable to practice medicine as a physician.

Additional Avenues to Address Medical Professional Shortages and Maldistribution. Multiple avenues are available to pursue increasing the supply of medical professional services and to encourage certain practitioners to locate in high-need areas, three are: 1) Fund the Federal Virginia State Loan Repayment Program which provides funding to certain physicians located in Health Professional Shortage Areas; currently no State general fund dollars are appropriated; 2) Assess creating new health profession mid-level medical licenses to allow individuals with previous medical training to provide medical care within a regulated scope of practice; 3) Allow certain health care professionals, such as military-trained personnel or physicians not licensed in Virginia, to be exempt from Virginia's scope of practice laws when working in certain approved hospital facilities.

Policy Options and Public Comment

Comments on the suggested policy options were submitted by:

- Dr. Russell C. Libby, President, **Medical Society of Virginia**
- Richard D. Shinn, Director of Government Affairs, **Virginia Community Healthcare Association**
- Chris S. Bailey, Senior Vice President, **Virginia Hospital & Healthcare Association**
- Dr. Anton Kuzel

	Policy Options	Support	Oppose/Concern
1	Take no action.	**0**	**0**
2	Introduce a budget amendment of $400,000 GFs for the Federal Virginia State Loan Repayment Program (SLRP) in order to: ▪ Restore funding to the maximum amount that is eligible for the 1:1 federal match rate	MSV VCHA	**0**
3	Request, by letter of the JCHC Chair, that the Department of Health Professions present to JCHC in 2014 regarding efforts to accept applicable military training and education toward credentialing and licensure requirements for certain selected professions. The presentation should include an update on the work of the Joint Task Force on Veterans Employment Outreach and the DHP review of health-related professions that is underway.	VCHA	MSV
4	Request, by letter of the JCHC Chair, that the Virginia Health Workforce Development Authority convene a workgroup to consider and report back to JCHC in 2015 regarding the advisability of, and if advisable, develop recommendations regarding: ▪ The need for a training program for graduate medical educators to teach residents requisite medical skills and ensure that medical residents in Virginia are adequately trained. If recommended, provide a training-program framework and funding requirements. ▪ A funding model for ***new*** State-supported family medicine residencies that could be used ***if*** the State increases appropriations for graduate medical education training. The model should include: - Consideration of whether funding would be used exclusively for resident training, where residencies would be located, and what the community or medical facility match-rates would be.	MSV VCHA	**0**
5	Request, by letter of the JCHC Chair, that the Department of Health Professions convene a workgroup to consider and report back to JCHC in 2015 regarding the advisability of, and if advisable, the additional education or training requirements and next steps to: ▪ Establish a mid-level provider license and thereby define the requirements for individuals, who are licensed to practice medicine in another country, to be licensed to practice under the supervision of a physician licensed in Virginia. ▪ Establish a mid-level provider license and thereby define the requirements to allow medical school graduates who have not completed a residency to be licensed to practice under the supervision of a physician licensed in Virginia.	**0**	MSV VCHA
6	Introduce legislation to amend Titles 32.1 (Health) and 54.1 (Professions and Occupations) of the *Code of Virginia* to allow certain providers working within an approved facility to be exempt from Virginia's scope of practice laws when established conditions have been met. The providers, who would be eligible for scope of practice	**0**	MSV VCHA

	exemptions and therefore be allowed to perform activities that would otherwise require a license from the Boards of Medicine, Nursing, Pharmacy, or Physical Therapy (hereafter referred to as "permitted providers") would include one or more of the following: ▪ Military-trained Personnel: Applies only to individuals performing activities substantially similar to health care training and experiences that they received in the military. ▪ Individuals Licensed in Other States: Applies only to individuals, licensed by a health professionals' regulatory body in another state, who perform activities within their level of training but will not perform activities that exceed those approved for a similarly-trained professional licensed in Virginia. ▪ Non-specific Grouping: Applies only to individuals that have the requisite education or training to perform the designated activities. Practice activities may be limited by the hospital or hospital governing body for individuals practicing under this exemption within its facility. Furthermore, additional limitations may be set by the provider's supervising physician through the practice agreement.		

Medical Society of Virginia is supportive of Options 2 and 4. However it is concerned about the following Options:

- Option 3: MSV recommends revising the "option to focus on a review of efforts by the Boards of Medicine and Nursing to consider and accept military experience as evidence of satisfaction of the educational requirements for certification of certain health professions…."
- Option 5: We "withhold judgment on the option pending additional information on the potential impact of the effort."
- Option 6: MSV is very concerned with this policy option noting: "Given the strides made toward team-based care….we feel that this policy option actually represents a step backwards rather than a step forward by limiting nurse practitioner and physician assistant participation on the care team"

Virginia Community Healthcare Association is supportive of Options 2, 3, and 4. For Option 2, VHCA supports "increasing the recommendation to $500,000 with a minimum of 50% of the funds to be reserved for primary care providers that practice in Medically Underserved Areas (MUAs)." For Options 5 and 6, VHCA encourages more research and exploration before pursuing such options.

Virginia Hospital & Healthcare Association has been exploring ways to address the physician shortage through its Healthcare Workforce Taskforce. VHHAs public comment did not indicate support or opposition to JCHC policy options, however it welcomed the "opportunity to explore" Option 6.

Factors Affecting Health Care Costs
House Joint Resolution 687 – Delegate John M. O'Bannon, III

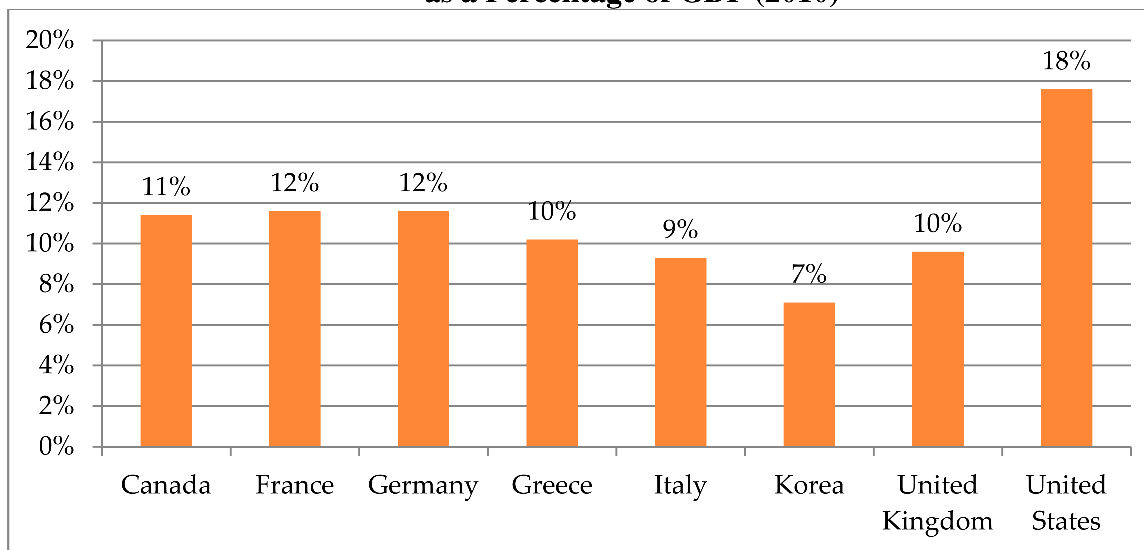
Stephen W. Bowman
Senior Staff Attorney/Methodologist

HJR 687, introduced by Delegate O'Bannon on behalf of the Virginia Chamber of Commerce in 2013, directed JCHC to "(i) study and report on promising policies, practices, and initiatives expected to help control health care costs while maintaining quality of care; (ii) identify factors considered to be the primary contributors to the increase of health care costs; (iii) review approaches undertaken in other states and countries to control health care costs; and (iv) examine the likely impact of federal Patient Protection and Affordable Care Act provisions on the cost of health care."

Findings

It is a well-known fact that per-capita health care costs are higher in the U.S. than other countries. As shown in the Exhibit below, in 2010 the U.S. spent 18 percent of its gross domestic product (GDP) on health care expenses, while other countries spent a smaller portion towards health care. Unfortunately, excellent health care cannot assure an individual's health, which has been found to be primarily influenced by five factors: genetic predisposition, social circumstances, environmental exposures, behavioral patterns, and health care.

Selected Countries Comparison Health Care Spending as a Percentage of GDP (2010)



Source: OECD Health Data Set 2012 Frequently Requested Data.

Many issues impact health care costs and multiple rationales for the higher health care costs in the U.S. have been argued. The following 13 primary cost drivers were identified in a 2012 Report by the Bipartisan Policy Center.

1. Fee-for-service reimbursement;
2. Fragmentation in care delivery;
3. Administrative burden on providers, payers and patients;

4. Population aging, rising rates of chronic disease and co-morbidities, as well as lifestyle factors and personal health choices;
5. Advances in medical technology;
6. Tax treatment of health insurance;
7. Insurance benefit design;
8. Lack of transparency about cost and quality, compounded by limited data, to inform consumer choice;
9. Cultural biases that influence care utilization;
10. Changing trends in health care market consolidation and competition for providers and insurers;
11. High unit prices of medical services;
12. The health care legal and regulatory environment, including current medical malpractice and fraud and abuse laws; and
13. Structure and supply of the health professional workforce, including scope of practice restrictions, trends in clinical specialization, and patient access to providers.

Both governmental and private market approaches to health care cost containment are available. Types of governmental approaches include: structuring the market, providing oversight of financing and health care service provision, ensuring transparency and analyzing the health care sector, and convening and building consensus among market participants. Three general types of private market approaches were identified in the October 22nd presentation to JCHC including: health plan designs, provider reimbursement strategies, and provider networks. The presentation also listed 36 governmental approaches and 18 private market approaches, some of which may be used in conjunction. Options 7 and 8 offer opportunities to review identified approaches further.

Policy Options and Public Comment

Five comments on the suggested policy options were submitted by:

- Sterling N. Ransone Jr., M.D., President, **Medical Society of Virginia**
- Keith Martin, **Virginia Chamber of Commerce**
- Jeremiah K. O'Shea, M.D., President, **Virginia College of Emergency Physicians**
- Richard D. Shinn, Director of Government Affairs, **Virginia Community Healthcare Association**
- Laurens Sartoris, President, **Virginia Hospital & Healthcare Association**

Policy Options		Support	Oppose/Concern
1	Take no action	**0**	**0**
2	Include in the 2014 work plan for JCHC, a two-year study of chronic disease prevalence in Virginia by geographic region. The study will identify demographic information, types of medical conditions, care-coordination, and treatment patterns for individuals with high-cost co-morbid chronic diseases, as well as options for improving such individuals' medical care and health.	**0**	**0**
3	By letter of the JCHC Chair, request a presentation in 2014 by the State Health Care Cost Containment Commission regarding strategies to transform health care in Virginia.	**0**	**0**

4	By letter of the JCHC Chair, request a presentation in 2014 by the Virginia Chamber of Commerce regarding recommend-ations of Blueprint Virginia's Healthcare Industry Council.	Chamber	**0**

5	By letter of the JCHC Chair, request that the Virginia Department of Health (VDH):
	• Identify statewide core regional population health measurements, including options for their collection and dissemination;
	• Consider leveraging existing efforts such as the Virginia Atlas of Community Health and the Community Health Needs Assessments (as mandated for not-for-profit hospitals) and consult (at a minimum) with representatives of:
	  • Council on Virginia's Future
	  • Department of Medical Assistance Services
	  • Medical Society of Virginia
	  • Virginia Association of Free and Charitable Clinics
	  • Virginia Chamber of Commerce
	  • Virginia Community Healthcare Association
	  • Virginia Hospital & Healthcare Association
	  • Virginia Rural Health Association
	Report to JCHC by October 2015 regarding conclusions and recommendations to improve measurement and tracking of population health in Virginia.
		MSV
		VCHA
		VHHA*
			0

6	By letter of the JCHC Chair, request that representatives of the Virginia Hospital & Healthcare Association, the Medical Society of Virginia, and the Virginia Health Care Association convene to identify 25 quality and safety measures that if targeted could most improve hospital-related care, including readmissions. As part of the review, the representatives are asked to determine the availability of the identified measures and whether the measures are currently collected and publicly reported; and if so, the frequency of collection; however if not collected, potential avenues for collection and dissemination; and finally to report to JCHC by October 2014 regarding conclusions and recommendations.	MSV VHHA*	**0**

7	Include in the 2014 JCHC work plan, staff reports on health care cost-containment categories or specific approaches as determined by members of the Joint Commission on Health Care.
	A. Governmental Approach
	  1. Organize the System
	  2. Provide Oversight
	  3. Ensure Transparency and Analysis
	  4. Convene and Build Consensus
	B. Private Market Approaches
	  1. Reimbursement
	  2. Provider Network
	  3. Plan Design
		0	**0**

8	In 2014, JCHC create a workgroup whose mission will be to review promising government- and market-based cost-containment, value, and efficiency strategies that also consider and maintain health care quality. The suggested workgroup membership would include: • Four members of the Joint Commission on Health Care	Chamber	**0**

	• Four business representatives *(chosen by the Virginia Chamber of Commerce)* • Secretary of Health and Human Resources • A health care economist *(chosen by the Virginia Chamber of Commerce)* • The Director of the Council on Virginia's Future (or designated representative) • The State Health Commissioner (or designated representative) • The Director of the Department of Medical Assistance Services (or designated representative) The workgroup's meetings will be open to the public and allow for presentations and input from health-care sector representatives. The workgroup will report to JCHC on findings and recommendations on a periodic basis as well as upon request.		

Comment Excerpts

Medical Society of Virginia supports Options 5 and 6 and noted that when "considering the ideas presented, we encourage you to look first and foremost to the physician and provider communities to identify ideas for reducing costs by promoting preventive measures, streamlining care, reducing administrative burdens, and encouraging access to the appropriate level of necessary care when it is needed."

Virginia Chamber of Commerce supports Options 4 and 8 as well as "market-based reform measures to improve population health, provide better access to quality care and contain costs."

Virginia College of Emergency Physicians did not support or oppose any policy options, but addressed two emergency room payment and utilization policy approaches presented.

Virginia Community Healthcare Association supports Option 5.

***Virginia Hospital & Healthcare Association** supports Options 5 and 6 "with the modification that the Virginia Center for Health Innovation" should be selected to lead these efforts."

Avenues for Expanding Telehealth for Mental Health Services

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Limited access to mental health providers reduces the quality and quantity of mental health services available to patients in rural and underserved communities, sometimes forcing patients to travel long distances to obtain mental health services, or forgo such services altogether. Telemental health (TMH) is a particularly good fit for addressing mental health access needs. TMH allows face-to-face communication with the provider in a personal and intimate manner. TMH can reduce travel time for providers and patients, reduce complications from delayed treatment, and encourage adherence with treatment plans. In recent years, telehealth technology has improved and the cost has decreased significantly.

Private hospitals, universities, State facilities and Community Services Boards (CSBs) have reported positive results, including positive feedback from patients and staff, regarding use of TMH services. For a relatively small investment, TMH users have reported financial savings, improved access, and reduced waiting times. However, State facility and CSB representatives have reported some barriers including inadequate reimbursement and the cost of the required technology, staffing, and contracts with psychiatrists.

Barriers to Expansion of Telemental Health Services

Medicare Reimbursement. Medicare reimbursement policies can be a deterrent to expansion of TMH. Medicare reimburses for telemedicine encounters if the originating site is:

- Located in a county that is not included in a metropolitan statistical area (MSA),
- Located within a federally designated rural health professional shortage area (HPSA), or
- Provided by an entity that participates in a federal telemedicine demonstration project.

HRSA's current definition of MSA has meant that some rural communities that are an hour outside of the city limits are defined as being within the MSA and therefore ineligible for reimbursement for telemedicine encounters. Furthermore, the HPSA definition does not include specialty physicians in the telehealth reimbursement formula. Consequently, Medicare beneficiaries who have access to primary care, but not specialty care, are unable to have their telehealth encounters with specialists paid.

Provider Licensure. Most states, like Virginia, require a provider to be licensed both in his/her state of practice and in the patients' state of residence in order to practice telemedicine. As the practice of telemedicine is expected to increase, especially in rural areas, a streamlined system for those doctors wanting to practice in multiple states is advocated by many telemedicine supporters. The Federation of State Medical Boards (FSMB) recently adopted a resolution to explore the utilization of an interstate compact to increase efficiency in the licensing of physicians who practice in multiple states and Virginia's Board of Medicine representatives indicated they would support entering into an Interstate Compact.

Policy Options and Public Comment

Four comments were submitted by the Medical Society of Virginia, the Virginia Community Healthcare Association, Voices for Virginia's Children, and the Virginia Association of Community Services Boards.

Policy Options		Support	Oppose/Concern
1	Take no action	0	0

2	Introduce a budget amendment (amount to be determined) to provide additional funding for community services boards to purchase necessary equipment and/or contract for such services as child psychiatry through telepsychiatry.	Voices, VACSB	MSV
3	By letter of the Chair of the Joint Commission on Health Care, formally advise the Virginia Department of Health (VDH) and the Virginia Rural Health Association (VRHA) of the problems that the current federal definition of metropolitan statistical area (MSA) creates in receiving Medicare reimbursement for telehealth services. (This formal advisory is to provide VDH and VRHA with an additional example of problems created by the current MSA definition for use when corresponding with the Health Resources and Services Administration or other relevant federal agencies.)	MSV	0
4	**The Medical Society of Virginia suggested adding a Policy Option:** *By letter of the Joint Commission on Health Care, formally advise the Virginia Board of Medicine to explore and pursue interstate compacts via the Federation of State Medical Boards (FSMB), which recently approved a new policy to study the creation of a system that would utilize an interstate compact to increase efficiency in the licensing of physicians who practice in multiple states.*		
5	**The Virginia Community Healthcare Association suggested adding a Policy Option:** *By letter of the Chair of the Joint Commission on Health Care, formally advise Virginia's Congressional delegation and federal agency representatives of the problems faced by "rural health providers who pay more for communication services than they would need to, if they had access to the Universal Services Fund… It may be advisable to convene a group of rural health care providers to draft a list of concerns to present to Congress and the relevant federal agencies."* A staff-suggestion would be to revise the wording of the suggested option for JCHC-member consideration to be: send a formal advisory to the Virginia Department of Health, Virginia Telehealth Network, and Virginia Rural Health Association of the aforementioned problems, since typically we do not contact Virginia's Congressional delegation or federal agency representatives. *By letter of the Chair of the Joint Commission on Health Care, formally advise the Virginia Department of Health, the Virgnia Telehealth Network, and Virginia Rural Health Association (VRHA) of the problems that the current federal definition of metropolitan statistical area (MSA) creates in accessing the Universal Services Fund. (This formal advisory is to provide VDH and VRHA with an additional example of problems created by the current MSA definition for use when corresponding with the Federal Communications Commission or other relevant federal agencies.)*		
6	**Voices for Virginia's Children and the Virginia Association of Community Services Boards suggested adding a Policy Option:** *That the Joint Commission on Health Care direct all relevant state agencies work together to provide guidance that will assist CSBs and other local and regional entities to work through barriers and challenges as expeditiously as possible so that more individuals receive critical treatment.*		

Comment Excerpts

The Medical Society of Virginia commented in support of amending Option 2 and of considering an additional policy option (shown as Option 4):

In speaking to **Option 2**, MSV representatives wrote "regarding the introduction of a budget amendment….Funding opportunities should not be limited to one provider type, but rather should include physicians in all practice modes (private practice, hospital-affiliated, academic medical center, etc.), as well as community service boards. The funding should also be designated to include treatment of Medicaid or other publicly-assisted patient populations."

The additional Option suggested by MSV read: "By Letter of the Chair of Joint Commission on Health Care, formally advise the Virginia Board of Medicine to explore and pursue interstate compacts via the Federation of State Medical Boards (FSMB), which recently approved a new policy to study the create of

a system that would utilize an interstate compact to increase efficiency in the licensing of physicians who practice in multiple states."

The Virginia Community Healthcare Association commented in support of considering an additional policy option (shown as Option 5):

"The Medicare reimbursement issue for health care providers located in rural areas that are included in Metropolitan Statistical Areas is one that has been discussed for several years by our community health centers. However, as of October 1, 2014, that issue may no longer be relevant for Federally Qualified Health Centers, as new rules on Medicare reimbursement for our health centers are scheduled to be in place at that time. This does not solve the issue for other rural health providers, and would need to continue to be discussed with the appropriate federal official….an issue that does impact rural health providers located in MSAs is one of the lack of accessibility to funding from the Universal Services Fund. This does create a barrier to creating more telehealth systems, and places additional financial pressures on rural health providers who pay more for communication services than they would need to, if they had access to the Universal Services Fund. As this is a federal issue, we would ask that consideration be given to another option, of asking our Virginia Members of Congress and representatives of the relevant federal agencies, to address these issues to the relief of rural providers across the nation. It may be advisable to convene a group of rural health care providers to draft a list of concerns to present to Congress and the relevant federal agencies."

Voices for Virginia's Children provided the following comment in support of considering an additional policy option (shown as Option 6):

"Making the very limited number of child and adolescent psychiatrists in Virginia available to more children is a critical component of trying to provide high quality mental health services to children in a timely manner and can prevent psychiatric conditions from escalating to the point of crisis. We encourage the Behavioral Health Care Subcommittee to recommend additional funding to increase the number of children served by telepsychiatry. In addition, we want to note that the CSBs have encountered challenges in making telepsychiatry work, and additional guidance from the Virginia Department of Behavioral Health and Developmental Services and the Virginia Department of Health could make the process go more smoothly in the future."

Needs of Individuals with Autism Spectrum Disorder Transitioning from Secondary Schools
Senate Joint Resolution 330 – Senator Ralph S. Northam

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

SJR 330 directed JCHC to study the service needs of individuals with autism spectrum disorder (ASD) transitioning from public and private secondary schools, including needs related to housing, employment, and day support services.

Background

The associated symptoms of ASD affect multiple areas of an individual's life across his/her lifespan, including education/training, employment, housing and health care. Studies have shown that early intervention with an emphasis on social development can change how children with ASD relate to others and improve other symptoms of ASD. That being said, better interventions and supports across the lifespan, can help persons with ASD with varying needs live more independently.

Transition Planning

The Individuals with Disabilities Education Act guarantees the provision of educational services for persons with disabilities through age 21, including individuals with ASD if they are eligible for special education services. However, after age 21, a person with ASD ages out of the entitlement system and must voluntarily seek out services and meet various eligibility requirements. Many individuals and family members reported that they were not prepared for this transition and felt left on their own to navigate a complex system of funding, supports, and agencies.

In Virginia transition planning begins for students with ASD when they are 14 years old. Despite this relatively early start, families, ASD advocates, and State representatives report the quality of transition planning varies depending on the geographic location of the individual, the school division, and the institutional knowledge of persons included on the transition team. Families report collaboration between the Department of Education (DOE), the Department of Aging and Rehabilitative Services (DARS), and community services boards (CSBs) during transition planning occurs inconsistently, and as such, fails to ensure students with ASDs learn about and access available community resources as they transition into adulthood.

Supports for Adults with ASD

The primary sources of support for adults with ASD are the Medicaid waivers for community-based services and employment assistance provided by DARS. With capped enrollment and waiting lists, Medicaid waivers currently fail to guarantee access to needed supports for all adults in need. Additionally, only the most severely disabled meet functional needs eligibility. With regard to case management services, the services are only available for adults enrolled in waivers or DARS programs and are limited in availability; furthermore, not all case managers are trained regarding the specific needs of individuals with ASD.

Transition to Employment

Employment provides the income to allow a person to live independently, and persons with ASD are employed at much lower rates than those with other disabilities. However, programs such as

Project SEARCH are proving with the right supports, individuals with ASD can find meaningful work.

DARS Services. Current DARS data shows a steady increase in applications for services by people with ASDs. DARS services include case management to assist individuals with disabilities, including those with ASD, find meaningful employment; and long-term employment supports and case management services to help individuals with ASD maintain employment. For persons with higher needs, training and services are available in the form of segregated employment ("sheltered workshops") and constant or intermittent oversight by a job coach. Individuals with ASDs often require higher levels of employment supports to achieve and maintain successful employment (usually longer than 90 days allowed under supported employment). Funding cuts and a current federal order of selection limit access to long-term employment support services which has resulted in some who have applied for services being placed on waiting lists according to disability categories. This lack of support was a consistent complaint from individuals with ASD and their families.

Limited Housing Options after Transition

Affordable and accessible housing for some individuals with ASD is inadequate in Virginia. Furthermore, the current waiver system acts as a barrier to persons with ASD in finding housing because eligibility is diagnosis-based. Through waiver reform, DBHDS representatives indicate they will address this issue by:

- Expanding case management capacity within CSBs.
- Planning jointly with the Department of Medical Assistance Services (DMAS) for waiver changes over the next 2 years.
- Creating 4,170 waiver slots by June 30, 2021.
- Moving to needs-based waivers (based on level of functionality and not diagnosis)
- Recommending needed rate changes to serve those with the most complex needs while aligning incentives.

Additional actions, taken in response to the Settlement agreement with the U.S. Department of Justice, are expected to improve the housing options for individuals with ASD. The agreement requires that DBHDS:

- Serve individuals in the most integrated setting consistent with their informed choice and needs.
- Include a term in the performance contract with CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individual living outside their own home or family's home.
- Assemble baseline information regarding the number of individuals who would choose independent living options.
- Develop a plan to increase access to independent living options.
- Undertake a $800,000 rental assistance pilot in an effort to address these housing needs.

Policy Options and Public Comment

Eight comments were received regarding the policy options addressing the needs of individuals with ASD transition from secondary schools. Comments were submitted by Commonwealth Autism Services, the Department of Behavioral Health and Developmental Services, the Virginia Association of Independent Specialized Education Facilities, families with children with ASD, and Dr. Carol Schall.

	Policy Options	Support	Oppose/Concern
1	Take no action	0	0
2	By letter of the JCHC Chair, encourage the Department of Behavioral Health and Developmental Services to publicize its role as lead agency for services for individuals with ASD and to highlight the link to Commonwealth Autism Services as a valuable resource on ASD information, including information related to transition services.	5 The Hagen's; Susan Jacobson & M. Oliver; Anonymous family; CAS; VAISES	0
3	Introduce a budget amendment in the amount of $2.6 million GFs per year to expand vocational rehabilitation services (including case management services) provided by the Department for Aging and Rehabilitative Services in order to address the increasing demand for ASD services and to enable more consistent involvement in transition planning.	5 The Hagen's; Susan Jacobson & M. Oliver; Anonymous family; CAS; VAISES	0
4	Introduce a budget amendment in the amount of $3.4 million GFs and $600,000 NGFs per year for the Department of Behavioral Health and Developmental Services to allow community services boards to be involved with transition planning and provide case management services for adults with ASD (after the Department of Education is no longer involved).	5 The Hagen's; Susan Jacobson & M. Oliver; Anonymous family; CAS; VAISES	0
5	By letter of the JCHC Chair, request the Department of Behavioral Health and Developmental Services work to improve collaboration between its agency, the Department for Aging and Rehabilitative Services, and community services boards for ASD-related services for adults (beginning with transition planning).	5 The Hagen's; Susan Jacobson & M. Oliver; Anonymous family; CAS; VAISES	DBHDS
6	By letter of the JCHC Chair, request the Department of Behavioral Health and Developmental Services form a stakeholder workgroup to develop CSB-staff competencies for providing case management for adults with ASD.	5 The Hagen's; Susan Jacobson & M. Oliver; Anonymous family; CAS; VAISES	DBHDS
7	Introduce a budget amendment of $506,000 to $1,000,000 GFs per year to expand Long-Term Employment Support Services administered by the Department for Aging and Rehabilitative Services.	5 The Hagen's; Susan Jacobson & M. Oliver; Anonymous family; CAS; VAISES	0
8	By letter of the JCHC Chair, request that the Joint Legislative Audit and Review Commission conduct a follow-up to its 2009 report on ASD and consider our findings in completing the study.	5 The Hagen's; Susan Jacobson & M. Oliver; Anonymous family; CAS; VAISES	DBHDS

Comment Excerpts

Commonwealth Autism Services commented: "The report makes clear the many challenges being faced by individuals with an ASD and their families. In many localities the current system suffers from **poor coordination** among lead organizations (schools, DARS and CSBs), is **inconsistent** (better in some locales than others) **fragmented** (certain components in place with others missing) and significantly **underfunded** (given the numbers of individuals to be served). The report addresses these deficits in its policy options and CAS supports Options 2-8 as a solid starting point for improving the system. Related to these options are two other current initiatives under way, i.e. waiver reform an d the Autism Advisory Council of the General Assembly. CAS supports the creation of a single disability waiver (see attached position statement for specifics) that will enhance serve access post age 22 for young people with an ASD. Additionally, CAS supports the role of the Autism Advisory Council as an accountability mechanism for the 2009 JLARC autism study recommendations. This coupled with an updating of the JLARC study incorporating the JCHC study in its remit will serve as n up to date road map for both public and private organization involved in the system of care."

The Department of Behavioral Health and Developmental Services gave wording suggestions that will be included in the final written report as well as the following Option-related comments.

Option 5 – "Agencies at the state level currently do collaborate successfully on many fronts. We would recommend that this option be re-worded to emphasize the need for strengthening the collaboration that already exists to result in targeted outcomes related to transition planning for individuals with ASD."

Option 6 – "Currently the Virginia Autism Council (VAC) (whose membership includes autism specialist from DOE, DARS, DBHDS, DMAS, VCU,JMU, Lynchburg College, Center for Independent Living – Fredericksburg, Partnership for People with Disabilities, the Board for People with Disabilities, Blue Ridge Autism Achievement Center, Virginia Institute of Autism, Commonwealth Autism Service, The Arc, Autism Society of America Central Virginia Chapter, Didlake, Inc. and a self advocate) is in the process of finishing the creation of "Skill Competencies for Professionals and Direct Care Staff for Adults with Autism Across the Life Span." This should fulfill the intent of a stakeholder workgroup."

Option 8 – "Many changes are currently taking place in the developmental disability service delivery system. The operational management of the DD Waiver is transferring from DMAS to DBHDS in November and a system wide study of the waivers and waiver reimbursement rates is currently underway. It would seem appropriate for any follow-up review of the 2009 JLARC report to be on hold until the changes that are currently underway can be completed."

Peter and Emily Mazure

Our son "must live with his parents until we are gone. I don't know what will happen to him after that because under the present Waiver situation housing is not an option for a person with the Autism diagnosis. Will he be on street? These are some of Virginia's most vulnerable citizens. We need your help in protecting them. And, we need it soon."

Kristen Davis

"I agree that the transition process and the way it is handled are extremely important. It has been my experience (as the mother of a 26 year old son with an ASD) that transition planning as part of the IEP process is really more of a rubber stamp process than anything of real substance or help to the student and/or the families. The results of your study, and the experiences of friends whose children have recently "completed" the process (up to and including last year) certainly suggest that this is still the case -- at least in some parts of Virginia. Many families don't know that they can request collaboration between the school and DARS. Your finding that there needs to be collaboration between the DOE, DARS and (I hope CSBs get involved in the process and delivery of services!) CSBs is right on target, and long overdue.

I would like to also comment on the need for housing. I believe this is a major concern that many families are too overwhelmed to address, especially during the transition process. They are too busy trying to navigate a whole new world (mostly on their own or with the help of other parents) after structured lives based around school and IEPs to even begin thinking about something that seems so far down the road. By the time many parents (like me) are ready to tackle housing (and the almost fruitless search for it without the help of a Medicaid Waiver -- and currently the DD Waiver does not provide funds for housing), it is almost too late. I am working with other parents, trying to find or create housing solutions for our adult children with ASDs. It is a very challenging undertaking, particularly in Northern Virginia. My goal of finding my son a suitable living situation by the time he turns 30 is starting to feel less and less attainable, and a little more desperate as each day passes.

Finally, I would like to say that I found your study to be thoughtful and thorough. The recommendations throughout are spot on. The only thing that I feel is missing from the study (and SJR 330) is acknowledgement of the needs of young adults who have already gone through their secondary school's transition process, but are still not fully integrated into their communities. Many are unemployed, still live at home, and depend on their parents for many aspects of daily living, including transportation. I believe that anyone with an ASD who has not actually completed the move from the support and structure of secondary school to optimum independence as a member of their own community is still in "transition."

Mr. and Mrs. Dunn

"I love this state very much, but I am not sure that it will ever step up and make available the needed resources to serve citizens with disabilities. At present the state is ranked 47th in the nation for services to the disabled. I already know at least one family who has left because of this lack of services. Please change this untenable situation:

- Get the Medicaid Waivers moving.
- Properly compensate Medicaid respite workers, so that we can hire safe, reliable and competent caregivers.
- Adequately staff DARS and other service agencies.
- Improve the coordination of services.
- Develop a continuum of housing and post-secondary education services responsive to the extremely wide range of needs and abilities represented in the autism community."

Dr. Carol Schall, VCU School of Education, Rehabilitation Research and Training Center
(based on her experiences with Project SEARCH)

"Given our experience supporting young adults with ASD at work and our research outcomes, we respectfully offer the following recommendations for Virginia to consider:

- There is a need for funds that would support youth with ASD and other similar disabilities who require high intensity initial and long-term supports beyond the current funding rates provided by milestones and Long Term Employment Support Services (LTESS) available. Individuals with ASD are similar to those with traumatic brain injury in that they typically required increased supports to acquire job skills, achieve, and maintain stability in employment settings.
- There is a need for increased training and higher skill sets for DARS Rehabilitation Counselors and Employment Support Staff who provide direct services to youth and adults with ASD.
- There is a need for caseload reduction for professionals providing services to youth with ASD. As we have discovered, this is a specialized population that requires additional time and support that above and beyond that of a typical employment services general case load.

- There is a need for more comprehensive community based services for youth with ASD. Many of our clients with ASD experience challenges related to their life experiences outside of work and this may result in complications at work.
- There is a need for increased access to positive behavior supports services for employees with ASD to support their employers in maintaining a successful employment experience."

Costs Associated with Untreated Dental Disease

Senate Joint Resolution 50 (2012) – Senator George L. Barker

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

SJR 50 directed the Joint Commission on Health Care to study the fiscal impact to the Commonwealth that results from untreated dental disease. Specifically, JCHC was asked to estimate:

> "(i) the payments made by Virginia's Medicaid program to hospital emergency departments for dental-related diagnoses,
>
> (ii) the amount of uncompensated care provided by hospital emergency departments for dental-related diagnoses, and
>
> (iii) the number of dental patients treated and the overall value of the dental-related services provided by Virginia's safety net providers."

Virginia's Medicaid program, Smiles for Children, provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for children enrolled in FAMIS and FAMIS Plus. Consequently, we focused our study on adult dental issues.

Background

The Surgeon General of the United States has called oral and dental disease a persistent, but silent epidemic. Regular preventive care helps people avoid the pain and cost associated with more invasive acute dental care. Often preventive care is not accessed as studies indicate individuals are more likely to seek dental services if they have dental insurance and the number of individuals with dental coverage is declining. In fact, more than 1/3 of adults have no dental insurance for a variety of reasons:

- Employer-sponsored dental insurance has been decreasing, from 77% of full-time private U.S. workers in recent years to 57% in 2011.
- Private health insurance plans often exclude dental coverage.
- Dental insurance typically costs less per month than health insurance but may have high levels of cost-sharing and maximum benefit caps.

The limited nature of dental benefits and the potential for significant out-of-pocket expenditures may influence the decision to obtain dental insurance. As a result, individuals who do not have dental insurance often cannot afford care, and therefore go without. They defer treatment due to cost and do not regularly access routine preventive care which leads to future costs to the State, and the possibility of chronic pain and the risk of systemic infections and tooth loss for the individual. Neither the Affordable Care Act (ACA) nor Medicaid expansion (if adopted by Virginia) is expected to result in significant expansion of dental care coverage for adults. ACA does not require individuals to purchase dental care coverage as part of the insurance mandate, although separate dental coverage may be purchased through the Health Benefit Exchange. Medicaid expansion in Virginia would not significantly improve dental care for adults as the benefits would incorporate the current Medicaid provisions of very limited dental services for adults.

Adult Dental Costs to Virginia Medicaid

DentaQuest

SFY	Members Over 21 Receiving Dental Services	Amount Paid For Dental Services
2006	2,989	$658,404.32
2007	4,652	$1,466,494.85
2008	8,030	$3,004,309.50
2009	13,338	$5,123,747.70
2010	21,009	$9,885,194.40
2011	32,921	$10,974,518.30
2012	36,945	$11,333,009.02

Medicaid costs for the dental services provided for members older than 21 during the last seven years are shown above. While the Department of Medical Assistance Services (DMAS) has not completed an exhaustive analysis of the significant cost increase for the last three years, DMAS staff generally attributed the growth to the following factors:

> "Enrollment spiked and more adults were added 2008-2011 given the economic downturn; DMAS focused on improving access for adults and added additional providers who would treat adults; and, the program through DentaQuest sought to make members aware of the fact that there were dental benefits available."

According to Virginia Health Information data, in 2011, 10 hospitalizations related to dental and oral diseases with major complicating conditions were reimbursed by Medicaid. The median charge for the hospitalizations was $28,190.

Emergency Department Visits

Adults, who do not have insurance coverage for dental care, frequently seek such care on an emergency or as-needed basis only and often from emergency departments (EDs). This is an expensive alternative and one that often results in only antibiotics or pain medicine being prescribed (as opposed to treating the underlying dental problem). Recent studies found the average cost for an ED visit is $1,000 while preventive care typically would cost only $50 to $100 per visit.

SJR 50 asked for an estimated cost of uncompensated dental care provided by emergency departments. During the course of the study, JCHC staff determined data regarding dental care provided in EDs is not reported or collected in a uniform or comprehensive manner in Virginia. Dental procedures are coded differently and inconsistently between and within EDs, and often the procedures are coded as pain management or infection rather than a dental-related visit.

A 2012 Pew study indicated that not all states mandate that hospitals submit their discharge records, and also indicated that not all states interpret and report ED data they have collected. However, studies in other states support the belief that persons with dental problems visit EDs contributing to the inappropriate use of EDs while illustrating an overall problem with access to care and understanding of the importance of oral health. A recent study commissioned in Florida revealed that failure of Medicare and Florida Medicaid to pay for preventive care has led to dental care neglect by adults until infection or pain is so severe they must visit the ED. In 2011, Florida patients who did not have dental insurance coverage sought care in emergency

departments at a total cost of $88 million: $58 million in uncompensated care and $30 million to Florida's Medicaid program. In 2009, 69,000 ED visits to North Carolina hospitals were due to disorders of the teeth or jaw and were the 10th most common reason for an ED visit. In Washington State, 53 hospitals reported 23,000 visits to EDs for dental problems; among the uninsured, patients with dental disorders were the most frequent ED visitors.

Dental Care Provided by Safety Net Providers

Safety net providers also play a significant role in meeting dental care needs, although they are not staffed or equipped to accommodate the dental needs of so many uninsured and underinsured patients. Community health centers treated 82,585 persons involving 108,596 dental visits at a cost of $16.7 million (in 2012). Free clinics treated 18,454 patients involving 41,407 dental visits for an estimated value of more than $11.2 million in dental services provided (in 2011).

Additional voluntary efforts include:

- Mission of Mercy projects that since 2000 have provided $30 million in free dental care in treating more 50,000.
- The Donated Dental Services Program of the Virginia Dental Association Foundation has received dental services from 577 volunteer dentists and 144 laboratories in order to provide approximately $9.2 million in free dental care to more than 3,000 disabled or elderly patients.

The Virginia Health Care Foundation also supports dental services in a number of ways including: grants of more than $9.5 million to help establish or expand 43 dental safety-net sites, a partnership with Patterson-Dental-Richmond to provide discounts on the purchase and maintenance of dental equipment and supplies for certain providers, an arrangement with Larell One Step Dentures to provide low-cost dentures, and staff and website resources to assist dental safety providers.

Importance of Oral Health to Overall Health

Although dental and medical care are often seen as separate issues, particularly related to having insurance, recent research has found numerous links between oral health and overall health and well-being. Bacteria and inflammation from oral disease contribute to chronic diseases such as cardiovascular, stroke, respiratory infection, diabetes and osteoporosis, and also lead to adverse pregnancy outcomes. Pregnant women with gum disease are seven times more likely to have a preterm or low birth weight baby. Tooth decay in the mother also puts the child at a higher risk of also developing cavities, leading to weakened oral health. The provision of preventive oral care and needed treatment improves overall health and reduces medical costs as demonstrated in several studies.

Policy Options and Public Comment

Six comments were received regarding the policy options addressing the cost of untreated dental disease on the Commonwealth. Comments were submitted by the: The Virginia Dental Association (VDA) , the Virginia Dental Hygienists Association (VDHA), the Virginia Board for People with Disabilities (VBPD), the Virginia Community HealthCare Association (VCHA), the Virginia Oral Health Coalition (VaOHC), and the Virginia College of Emergency Physicians (VACEP).

<table>
<tr><th colspan="2">Policy Options</th><th>Support</th><th>Oppose/Concern</th></tr>
<tr><td>1</td><td>Take no action</td><td></td><td>VDA, VaOHC</td></tr>
<tr><td>2</td><td>Introduce a budget amendment for $30,255,000 GFs and $30,255,000 NGFs in FY 2015 and $63,535,499 GFs and $63,535,499 NGFs in FY 2016 to expand Medicaid to include full dental coverage for adults.</td><td>VBPD, VCHA, VoHC</td><td></td></tr>
<tr><td>3</td><td>Introduce a budget amendment for $7,563,750 GFs and $7,563,750 NGFs in FY 2015 and $9,530,325 GFs and $9,530,325 NGFs in FY 2016 to expand Medicaid to include preventive dental services for adults.</td><td>VBPD, VCHA, VoHC</td><td></td></tr>
<tr><td>4</td><td>Include in the JCHC Work Plan for 2014, a targeted study of the dental capacity of Virginia’s safety net providers. The Virginia Department of Health, Virginia Association of Free Clinics, Virginia Community Healthcare Association, Virginia Dental Association, Virginia Health Care Foundation, Virginia Oral Health Coalition, and Virginia Rural Health Association will be asked to work with JCHC staff in determining the need for any additional funding and resources and in reviewing potential teledentistry and workforce initiatives.</td><td>VDA (with amendment) VDHA (with amendment) VBPD (with amendment), VCHA, VACEP (with amendment), VoHC</td><td></td></tr>
<tr><td colspan="4">Combined Amendments Proposed by VDA, VDHA, VBPD, and VACEP:
Include in the JCHC Work Plan for 2014, a targeted study of the dental capacity and educational priorities of Virginia’s oral health care safety net providers – to include an in depth look at ways to more proactively divert patients from ERs to dental resources within their communities and to include discussion on alternative settings where additional providers (such as RDHs) can practice to access additional patient populations that are not being reached. The study and its objectives should be led by the many and diverse stakeholder in the oral health community: The Virginia Department of Health, Virginia Association of Free Clinics, Virginia Community Healthcare Association, the Virginia Dental Hygienists’ Association, the Virginia College of Emergency Physicians, Virginia Dental Association, Virginia Commonwealth University School of Dentistry, Virginia Health Care Foundation, Old Dominion Dental Society, Virginia Oral Health Coalition, Virginia Health Care Association, and Virginia Rural Health Association will be asked to work with JCHC staff in determining the need for any additional funding and resources to take care of Virginia’s most vulnerable citizens. Furthermore, the group would be charged with taking a longer view of resources needed to improve education, awareness and proactivity for changing oral hygiene habits. The group would also collaborate with the Department of Education and other education stakeholders to expand oral health education in public schools (after an admittedly cursory review of the curriculum it appeared there is no mention of oral health care after the 1st grade).</td></tr>
<tr><td>5</td><td>By letter of the JCHC chair, request that the Virginia Department of Health develop and distribute a public service announcement that promotes the benefits and need for dental care and oral health.</td><td>VCHA, VaOHC</td><td></td></tr>
</table>

6	**Proposed Option from Secretary Hazel and the VaOHC:** *Introduce a budget amendment in the amount of $3,627,804 GFs and $3,627,804 NGFs to expand Medicaid to include full dental coverage for pregnant women.*
7	**Proposed Option from Secretary Hazel:** *Introduce a budget amendment in the amount of $544,170 NGFs and $544,170 GFs to expand Medicaid to include preventive dental coverage for pregnant women.*
8	**VCHA Proposed Option**: *Introduce a budget amendment in the amount of at least $100,000 in GFs to be appropriated for the state dental loan repayment program.*
9	**VaOHC Proposed Option:** *Requiring hospital emergency departments to report visits related to dental disease (utilizing the attached codes which were used in Florida, Washington, Maine and other states who have studied the issues) to Virginia Health Information ("VHI").*

Comment Excerpts

The Virginia Dental Association provided the following comments:

"Our membership was hopeful the report would focus even more on what we understood was the original intent – emergency room access – as that is a topic that has serious fiscal impact to the Commonwealth. Nevertheless, we are very much appreciative of the good work done on the study and look forward to participating even more vigorously in the steps necessary to create a more sustainable answer to this most pressing issue…This sense of urgency on our part has only increased as the Virginia Department of Health has basically abandoned the need to fund public dentistry in recent years - today there is less than $1MM in GFs available. The decision to move rapidly to a more preventative model of public dentistry will no doubt leave a hole in the safety net and likely will cause the ER usage problem to be exacerbated…

We believe that 1) encouraging and maintaining the number of Medicaid/CHIP providers and 2) increasing the oral-health literacy of families already covered under Medicaid/CHIP are the most cost-effective ways to increase access and utilization….

…In addition to making the education needs of the underserved a central piece of any strategy moving forward, we would like to either incorporate into or add as an option a pilot project that explores a program whereby hospitals and community health clinics partner with dentists in the community – with the goal of keeping citizens out of the emergency room and ultimately finding the best resources to take care of the problem quickly. As was mentioned in the report, the VCU pilot program was quite successful but a unique situation because of the presence of the only dental school being across from VCU's emergency department….We would suggest that the workgroup outlined in Option #4 find a way to leverage the key finding and principles of the VCU program with already available resources in the community to deliver a pilot program(s) to mirror what VCU is achieving. A model for this could be found in Martinsville where the community seems to be bucking a national trend of increasing hospital ER visits by patients with dental problems. Dental visits to the hospital's ER have declined by over 10% in the past four years due in large measure to the effectiveness of the Community Dental Clinic. We believe it would be highly instructive for the workgroup to review the specifics of the Martinsville

successes and find ways – at low cost to taxpayers – to pair up ERs and community dental resources across the Commonwealth. …

The Virginia Dental Association also suggested amending Option 4 to read (new language is shown in italicized text):

Option 4: Include in the JCHC Work Plan for 2014, a targeted study of the dental capacity ***and educational priorities*** of Virginia's ***oral health care safety*** net providers – ***to include an in depth look at ways to more proactively divert patients from ERs to dental resources within their communities***. ***The study and its objectives should be led by the many and diverse stakeholder in the oral health community:*** The Virginia Department of Health, Virginia Association of Free Clinics, Virginia Community Healthcare Association, ***the Virginia Dental Hygienists' Association,*** Virginia Dental Association, ***Virginia Commonwealth University School of Dentistry,*** Virginia Health Care Foundation, ***Old Dominion Dental Society,*** Virginia Oral Health Coalition, ***Virginia Health Care Association*****,** and Virginia Rural Health Association will be asked to work with JCHC staff in determining the need for any ***additional funding and resources to take care of Virginia's most vulnerable citizens. Furthermore, the group would be charged with taking a longer view of resources needed to improve education, awareness and proactivity for changing oral hygiene habits. The group would also collaborate with the Department of Education and other education stakeholders to expand oral health education in public schools (after an admittedly cursory review of the curriculum it appeared there is no mention of oral health care after the 1st grade).*****"**

The Virginia Dental Hygienists' Association provided public comment which affirmed the concerns noted in the report by stating that with "the anticipated 38% growth nationally for dental hygienists by 2020 and a lower rate of projected growth of dentists in the next 6 years, we believe RDH's to be part of the solution to addressing preventative oral health care.

The Virginia Department of Health (VDH) has taken proactive measures such as the Public Health Dental Hygienist working for the VDH under remote supervision. This preventive program has been successful and cost effective across the Commonwealth. Due to the closure of the VDH dental program, this measure will be the only state supported access for oral health care.

The Virginia Dental Hygienists' Association also suggested amending **Option 4** to ***include VDHA*** among stakeholders for the study of the dental capacity of Virginia's safety net providers and to ***"include discussion on alternative settings where additional providers (such as RDHs) can practice to access additional patient populations that are not being reached."***

The Virginia Board for People with Disabilities made the following comments:
"For adult Virginians with developmental and other disabilities who receive Medicaid, as well as for childless adults whose income is at or below the Federal Poverty Level, access to dental services is problematic. The Board has long advocated for coverage of dental services for adults under Medicaid as a recommendation in each of the three editions of its comprehensive report, *Assessment of the Disability Services System in Virginia* (2006, 2008 & 2011). The Board strongly supports approval of **Insurance Option** ….The Board also supports **Access Option #4** ….We encourage and recommend inclusion of the Virginia Dental Hygienists Association as a partner in need determination as well as teledentistry and workforce initiatives. Access Option #4 would facilitate expansion of preventative services by dental hygienists within their existing scope of practice while remaining under the supervision of a dentist, albeit off site and making

necessary referrals for direct care. Use of dental hygienists has helped expand access to preventative care, especially in rural areas in other states…."

The Virginia Community HealthCare Association suggested an additional policy option to provide funding of at least $100,000 for the State Dental Loan Repayment Program as it "was an important recruiting tool for safety net providers until recently. State funding for this program was reduced several years ago. As a result, the lack of funding for this program has severely hurt the ability of safety net providers, such as community health centers, to recruit dentists to practice in medically underserved areas of the Commonwealth. We would welcome the opportunity to discuss this issue with all Members of the Joint Commission on Health Care, and to any legislator(s) who may have an interest in improving access to dental services in medically underserved areas."

The Virginia Oral Health Coalition provided the following comments and policy options for consideration:

"As oral health stakeholders, we see firsthand the significant costs poor health outcomes realized by poor access to oral health services and by inappropriate use of the emergency department for avoidable issues. When other states have studied the costs related to emergency department use for dental disease the outcomes have repeatedly demonstrated that the number one reason uninsured adults visit the emergency department is related to dental disease[1] [2]. The intent of our advocacy efforts was to have a study that would demonstrate through the data the significant cost faced by the Commonwealth and health care institutions because of poor access to oral health services. While the study demonstrates the overwhelming need to educate Virginians about the importance of oral health and for increased access to services, it includes little of the data outlined in the study request.

With regard to the policy change, we are supportive of all the policy suggestions indicated (with the exception of 'do nothing') and will offer an additional suggestion to aid in data collection so that all of us have a true picture of the cost of poor oral health to the Commonwealth. We understand the economic realities, and to that end, we respectfully request you support the following recommendations:

- *Extending dental benefits to pregnant women enrolled in Medicaid. At the JCHC meeting, Secretary of Health and Human Resources William Hazel requested that this policy recommendation be added to the report. The Coalition supports it strongly. Additional information is below.*
- *Requiring hospital emergency departments to report visits related to dental disease (utilizing the attached codes which were used in Florida, Washington, Maine and other states who have studied the issues) to Virginia Health Information ("VHI").*

Supporting these recommendations and introducing the appropriate budget language will further increase access to needed dental services and help alleviate over usage of the emergency department."

The Virginia College of Emergency Physicians provided the following comments:

"As your presentation stated, the Surgeon General has called oral and dental disease a persistent, but silent epidemic. Approximately one million people have dental problems that become medical emergencies every year. As safety net providers, we understand just how great the need

[1] http://www.wsha.org/files/62/ERReport2.pdf
[2] http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/A%20Costly%20Dental%20Destination(1).pdf

is for preventative dental services for these uninsured patients. Due to a lack of resources for these patients to receive dental services, we often provide uncompensated dental care in the emergency department. For example, one of our members said their emergency department provided approximately $10,000 of uncompensated care for patients with dental problems every month in 2011 and 2012. If we had places to refer these patients to receive dental care, it would be a tremendous benefit to the patients and the Commonwealth.

The VCU pilot program described in the presentation is an excellent example of how to ensure patients receive the care they need, while lowering the number of patients who use the emergency department for dental services. We encourage more programs like this and applaud their efforts.

For these reasons, we recommend the Joint Commission choose Option 4, which would create a targeted study of the dental capacity of Virginia's safety net providers. This group will be asked to work with JCHC staff in determining the need for any additional funding and resources and in reviewing potential teledentistry and workforce initiatives. While the Virginia College of Emergency Physicians was not listed in the group of stakeholders, we would like to request we be included as we are the largest group of safety net providers in the Commonwealth."

Implementation of Expedited Partner Therapy
House Joint Resolution 147 (2012)—Delegate Charniele L. Herring

Michele L. Chesser, Ph.D.
Senior Health Policy Analyst

HJR 147, introduced by Delegate Herring in 2012, directed the Joint Commission on Health Care to study options for implementing expedited partner therapy in the Commonwealth. During the 2012 JCHC work plan meeting, members agreed to a guest presentation on EPT, possibly in lieu of further study by JCHC staff. Robin Hills, Clinical Assistant Professor at VCU's School of Nursing, gave the presentation during the September meeting of the Healthy Living/Health Services Subcommittee. Of the three policy options provided for consideration, JCHC members voted to include a staff study on the implementation of expedited partner therapy in Virginia in the 2013 work plan.

Background

Gonorrhea and chlamydia are highly infectious and among the most common sexually transmitted diseases (STDs). Infections in women can lead to serious consequences including pelvic inflammatory disease, infertility, ectopic pregnancy, and chronic pelvic pain. If left untreated in men, gonorrhea can cause epididymitis, a painful condition that can result in infertility. Chlamydia and gonorrhea also can increase a person's risk of acquiring or transmitting HIV.

When a patient is diagnosed with chlamydia or gonorrhea, the CDC recommends that every effort be made to ensure that the patient's sex partners (from the past 60 days or most recent partner if none in the previous 60 days) are evaluated by a health practitioner and treated with a recommended regimen of antibiotics. However, if a partner of a patient cannot be linked to evaluation and treatment in a timely fashion, the CDC recommends that Expedited Partner Therapy (EPT) be considered "as not treating partners is significantly more harmful than practicing EPT." EPT is the clinical practice of treating the sex partner of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. Given that male partners are less likely to seek treatment due to stigma and denial (since males are often asymptomatic), in many cases EPT provides a means for treating male partners who otherwise would not have sought treatment and preventing re-infection of the female index patient. EPT is allowed in 35 states, potentially allowable in nine states, and prohibited in six states.

Key Considerations for Expedited Partner Therapy

Partner Education: The CDC recommends that the partner's prescription or medication should be accompanied by a flyer containing treatment instructions, appropriate warnings about side effects and who should not take antibiotics, and health education about STDs. If EPT is approved in Virginia, the Virginia Department of Health would post English and Spanish versions of the informational flyers on the agency's website for practitioner use.

EPT Effectiveness: In published clinical trials comparing EPT to traditional patient referral, EPT was associated with fewer persistent or recurrent infections in the index patient, and with a larger reported number of partners being treated.

Antibiotic Resistant Strains of Gonorrhea: Currently, antibiotic resistant strains are primarily a problem in Europe, with the only cases in the U.S. being found in Hawaii. As a result, the CDC continues to recommend EPT for gonorrhea when the partner is unlikely to seek treatment in a timely manner.

Side Effects and Allergic Reactions: Serious adverse reactions are rare with recommended chlamydia and gonorrhea treatment regimens (Azythromycin and Cefixime). In EPT programs in which adverse events have been monitored since 2001, no drug-related adverse effects have been documented. In addition, all medications used in EPT include information about possible side effects and allergic reactions on the label; and an order can be placed on the prescription for the pharmacist to screen for drug allergies before dispensation.

Practitioner Responsibility and Liability: If legalized, providers will have the option, but will not be legally required, to administer EPT. Other states include liability protections for practitioners and pharmacists within the EPT Code section. The Medical Society of Virginia and the Board of Medicine suggest adding the following language to the Code of Virginia, "All health care providers involved in the prescribing or dispensing of Schedule VI antibiotics to partners under this section shall be immune from criminal and civil liability absent gross negligence or willful misconduct."

Estimated State Cost for EPT: The estimated annual cost to VDH for EPT (in 2012 dollars) is $1,911 for chlamydia and $10,075 for gonorrhea. No general funds would be necessary since VDH representatives indicated they would absorb the cost as part of clinic operations. There would be no additional cost to DMAS because Medicaid plans are paid on a per member, per month (PMPM) basis.

Screening for Pregnancy and Pelvic Inflammatory Disease (PID): The CDC-recommended treatment regimens for pregnant women with chlamydia and/or gonorrhea are the same antibiotics that are recommended for EPT. As a result, practitioners typically do not test for pregnancy prior to prescribing antibiotics for chlamydia and gonorrhea for the index patient unless pregnancy is suspected. As a precaution, educational materials provided to the partner include a statement that women experiencing symptoms of PID and/or who are pregnant should be seen by a provider prior to being treated for their STD.

Potential Effect of EPT on STD Tracking: According to VDH, averting infection and preventing re-infection are desired outcomes of EPT; and a resulting decline in lab confirmed cases would potentially demonstrate this outcome and would not hamper STD control efforts. In addition, the Department of Health Professions suggests that tracking is possible by creating a new field in the STD data file for the number of EPT prescriptions written. This would provide additional information about STDs that currently is not available.

Treatment of Uninfected Partners: According to VDH, treating an uninfected partner has not been shown to contribute to antibiotic resistant gonorrhea; however, inadequately treating an infected partner may increase this risk. One rationale for EPT is to increase the number of partners who are adequately treated. Currently in Virginia's public clinics, if a patient reports exposure to chlamydia or gonorrhea, he or she is examined and preventatively treated.

Policy Options and Public Comment

Eighteen comments were received regarding the policy options addressing implementation of expedited partner therapy. Comments were submitted by:

- Dr. Russell C. Libby, President, **Medical Society of Virginia**
- William A. Smith, Executive Director, **National Coalition of STD Directors (NCSD)**
- William C. Rees, MD, MBA, FAAP, President, **Virginia Chapter of the American Academy of Pediatrics (VA-AAP)**
- Jessica Jordan, CNM, MSN, Legislative Chair, **Virginia Affiliate of the American College of Nurse-Midwives (VA-ACNM)**

- Holly S. Puritz, MD, FACOG, Chair, **Virginia Section of the American College of Obstetricians and Gynecologists (VA-ACOG)**
- Jeremiah K. O'Shea, MD, FACEP, President, **Virginia College of Emergency Physicians (VCEP)**
- Mary Ellen Bouchard, CNM, MS
- Tom Brunner, RN, MS, CPN, Clinical Assistant Professor, VCU School of Nursing
- Candace Burton, Ph.D., RN, FNE, Assistant Professor, Research Scientist, Intimate Partner Violence and Sexual Assault, VCU Institute for Women's Health, VCU School of Nursing
- Becky Davies, CNM, RM, RN, BSc Hons-Midwifery, MSc-Midwifery
- Dominique L. Hale, Student, University of Virginia
- Robin L. Hills, MS, WHNP-BC, C-MC, CNE, Clinical Assistant Professor, VCU School of Nursing
- Patricia A. Kinser, Ph.D., WHNP-BC, RN, Assistant Professor, Department of Family and Community Health Nursing, VCU School of Nursing
- Carley G. Lovell, MS, MA, RN, WHNP-BC, Clinical Instructor, Department of Family and Community Health Nursing, VCU School of Nursing
- Yvonne Newberry, RN, FNP-BC, MSN, AAHIVS, Assistant Professor, UVA Department of Obstetrics and Gynecology
- Angela Starkweather, Ph.D., ACNP-BC, CNRN, Associate Professor, VCU School of Nursing
- Sarah Waddell, University of Virginia
- AlexAnn Westlake, Student Nurse Midwife, Oregon Health and Sciences University

	Policy Options	Support	
1	Take no action	0	
2	Introduce legislation to amend § 54.1-3303 of the *Code of Virginia* to authorize the use of Expedited Partner Therapy to treat chlamydia and gonorrhea and to provide immunity from civil and criminal liability, absent gross negligence or willful misconduct, to health care providers involved in the prescribing or dispensing of Schedule VI antibiotics to partners under Expedited Partner Therapy.	MSV* NCSD VA-AAP* VA-ACNM VA-ACOG VCEP* Ms. Bouchard Mr. Brunner Dr. Burton	Ms. Davies Ms. Hale Ms. Hill Dr. Kinser Ms. Lovell Ms. Newberry Dr. Starkweather Ms. Waddell Ms. Westlake
	*Indicated they would need to read specific proposed language before they could offer full support of Option 2.		

Comment Excerpts

The **National Coalition of STD Directors (NCSD)** strongly supports option 2, stating:
"We unequivocally support the use of EPT for several reasons. First, scientific studies demonstrate the practice's efficacy…Secondly, EPT saves the scarce resources of the health care system and of health departments. Because EPT reduces reinfection rates, fewer patients return to health care providers for repeated treatment, and this minimizes the cost borne by the health care system…Finally, EPT is safe."
While the four professional associations providing comments support Option 2, three indicated the following:

Medical Society of Virginia
"We would be supportive of the concepts of continuing to make the use of EPT optional for physicians, providing deference to Centers for Disease Control recommendations on proper EPT

treatment, and providing immunity from civil and criminal liability to physicians who do use EPT in their practices. We are also supportive of public health efforts to measure the impact of implementation of this voluntary opportunity and the development of patient education materials to be made available through the Virginia Department of Health."

Virginia Chapter of the American Academy of Pediatrics (VA-AAP)
"We would only be able to support proposed legislation to permit EPT if it included liability protection for physicians. We also believe education is an important tool in the prevention of sexually transmitted diseases. Our first preference is always to see the patient and be able to speak with them directly about the health risks of STDs and how to prevent them in the future. However, we understand that is not always an option and recognize that EPT is an effective alternative to stopping the further spread of STDs."

Virginia College of Emergency Physicians (VCEP)
"First, we only support EPT in cases where the appropriate treatment is oral medication. Second, we want to ensure there is language protecting physicians and not holding them liable for any potential treatment side effects. Third, we would like to place responsibility with the pharmacy filling the prescription to check for any allergies with the patient… While we believe education is the best manner in which to prevent the spread and transmission, we do recognize EPT as an effective model for the treatment of STDs."

Finally, twelve practitioners provided their support for option 2. The following are examples of the types of comments that were received:

Mary Ellen Bouchard, CNM, MS
"I am a certified nurse-midwife practicing in a clinic for pregnant women without insurance. For many of these women, their partners are also uninsured and are unable to access treatment because of cost of a provider visit. In addition, these partners would have to take a day off from work to seek treatment and therefore often will not do this as it would require loss of income, and in some situations, loss of a job. Reinfection for pregnant women is financially costly and can also be the source of adverse perinatal outcomes."

AlexAnn Westlake, Student Nurse Midwife, Oregon Health and Sciences University
"I am a student who will graduate in spring 2014 as a Certified Nurse Midwife and I plan to practice in Virginia. During my studies I have seen EPT used successfully in the state of Oregon to treat partners of patients with sexually transmitted infections and prevent reinfection. Implementing EPT will greatly improve the care that nurse midwives can provide to patients with sexually transmitted infections in Virginia."

Age Restrictions for Tanning Bed Use
Senate Bill 1274 – Senator George L. Barker

Michele L. Chesser, Ph.D.
Senior Health Policy Analyst

Senator George Barker requested that the Commission study whether Virginia should enact age restrictions on tanning bed use, and the study was agreed to by JCHC members.

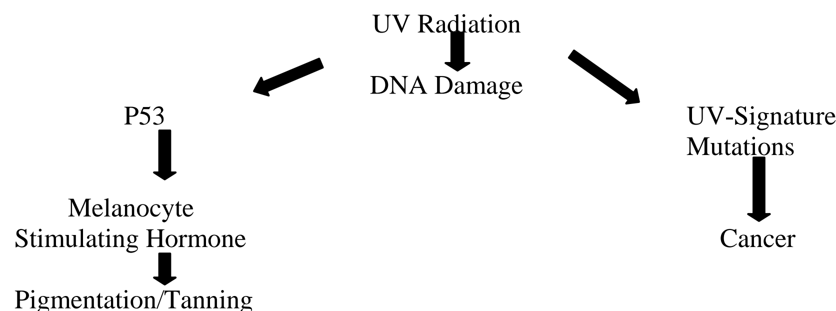
Background

The *Code of Virginia* does not place age restrictions on tanning bed use, but does require a salon to obtain, every 6 months, written consent from a parent or legal guardian for persons under the age of 15 who are not emancipated. During the 2013 General Assembly Session, Senator Barker introduced SB 1274 to restrict tanning bed use to persons 15 years of age or older and to require a parent or legal guardian of persons 15-17 years of age to provide written consent prior to allowing the minor to use a tanning device. SB 1274 was passed by the Senate but was passed by indefinitely in House Commerce and Labor Committee.

The Indoor Tanning Industry. The average American city has 41 tanning salons, and there are a large number of salons in Virginia. For example, Chesapeake has 40 salons, Norfolk and Richmond have 26 salons each, and there are 50 tanning salons in Virginia Beach. In the U.S., more than one million people tan in salons each day and 30 million visit a salon each year. The use of tanning beds/booths is increasing at 3 to 5 percent per year in the United States; and a national study found that approximately 30 percent of white female high school students and 25 percent of white women ages 18-34 years engaged in indoor tanning during the previous 12 months. According to the American Suntanning Association, 3 to 10 percent of salon revenue is from clients under the age of 18 years.

Virginia Tanning Device Regulations. A tanning device utilized by a tanning facility in Virginia must comply with all applicable federal laws and regulations, and there are no State tanning regulations since the State tanning law is considered to be specific enough to not require more detailed regulations. The State does not license tanning bed operators, but tanning salon owners and employees can voluntarily take a class on proper tanning device operation.

Risks Posed by Tanning Device Use. Based on a large and growing body of research accumulated over decades, we now know that there is no such thing as a safe tan. Cumulative repeated Ultra Violet (UV) exposure, regardless of whether skin burning occurs, increases the risk of skin cancer. In fact, it is the process of UV radiation causing DNA damage in skin cells that elicits the tanning response, which is the same process that also elevates carcinogenic risk. Burning, via the sun or tanning device, only further increases the risk of skin cancer.



While all UV radiation increases the risk of skin cancer, tanning devices can be more dangerous than the sun because they can be used year round, adding to a person's cumulative exposure. Frequent indoor tanners may receive 1.2 to 4.7 times the yearly dose of UVA radiation received from sunlight, in addition to doses from sun exposure. In 2012, a meta-analysis of 27 observational studies showed the risk of melanoma increased 20 percent for persons who have ever used a tanning device. The risk increases 36 to 85 percent if indoor tanning started prior to age 35. Importantly, researchers have found that the risk of melanoma increases by 1.8 percent for each additional tanning bed/booth session. This means that a young woman who uses a tanning bed 50 times (i.e. 4 sessions per month for one year or 1.4 sessions per month for three years) increases her risk of melanoma by 90 percent.

In addition to increasing an individual's cumulative amount of UV exposure, tanning devices also can cause harm by emitting excessive amounts of UV radiation. For example, multiple studies have found that tanning units can emit UVA doses that are 5 to 15 times greater than that of the midday Mediterranean sun. Tanning devices also cause premature aging of the skin due to DNA and skin cell damage, eye injury if protective eyewear is not worn, and skin burns. A 2009 study of tanning device use among adolescents in the U.S. found that 58 percent experienced at least one skin burn within the previous year. Also, approximately 1,800 hospital emergency department cases per year are a result of tanning device usage; and the actual number of injuries likely is higher because the estimate does not include cases treated in outpatient clinics, physician's offices, or at home.

In 2009, based on research linking the use of tanning devices to skin cancer, the International Agency for Research on Cancer (part of the World Health Organization) classified UV radiation from tanning devices as a class I carcinogen, placing it in the same category as tobacco, asbestos, and formaldehyde; and recommended that minors not use indoor tanning devices. Since the IARC's reclassification of tanning devices, additional research has resulted in even stronger evidence of the relationship between tanning device use and all forms of skin cancer.

Current Restrictions on Tanning Device Use in the United States and Other Countries. Legal restrictions for tanning salons are becoming more prevalent in the United States and other countries as research continues to show a consistent link between tanning device use and skin cancer. Seven states have banned the use of tanning salons by persons under 18 years of age (California, Connecticut, Illinois, Nevada, Oregon, Texas, and Vermont) and an additional seventeen states currently have "under 18 ban" legislation introduced. The following countries or provinces also have instituted under age 18 bans for tanning salons: Australia (New South Wales and South Australia), Austria, Belgium, Brazil (bans all ages), seven Canadian provinces (British Columbia, Labrador, Newfoundland, Nova Scotia, Ontario, Prince Edward Island, and Quebec), Finland, France, Germany, Iceland, Lithuania, Netherlands, Norway, Portugal, Spain, and all countries of the United Kingdom.

A large number of organizations and associations support a under age 18 ban on tanning salon use including the World Health Organization, the International Commission of Non-ionizing Radiation Protection, National Radiological Protection Board in the United Kingdom, Australia's National Health and Medical Research Council, the U.S. National Toxicology Program, the U.S. Food and Drug Administration, the American Academy of Pediatrics and its Virginia Chapter, the American Academy of Dermatology and its Virginia Chapter, the American Medical Association and the Medical Society of Virginia, and the Society of Surgical Oncology.

Policy Options and Public Comment

122 comments were received regarding the policy options addressing the age restrictions for tanning bed use. Comments were submitted by:

- Pamela Cornelius, **American Academy of Dermatology Association**
- Cynthia Dent, **American Academy of Dermatology Association**
- Gayle Masri-Fridling, **American Academy of Dermatology Association**
- Kelly Redbord, **American Academy of Dermatology Association**
- Paul Uhle, **American Academy of Dermatology Association**
- Janet Hickman, **American Academy of Dermatology Association, Past President of the Virginia Dermatologic Society, and Immediate Past President of the Women's Dertmatologic Society**
- Judith Williams, **American Academy of Dermatology Association**
- William C. Rees, President, Virginia Chapter of the **American Academy of Pediatrics**
- Ann Vaughan, Grassroots Manager, **American Cancer Society Cancer Action Network**
- Britney Adams, AIM at Melanoma supporter
- Daniel Adler, AIM at Melanoma supporter
- Hannah Bademian, AIM at Melanoma supporter
- Mindy Ball, AIM at Melanoma supporter
- Christine Barakat, AIM at Melanoma supporter
- Jessica Barbour, AIM at Melanoma supporter
- Sylvia Bell, AIM at Melanoma supporter
- Ashley Blair, AIM at Melanoma supporter
- Allyson Bonzo
- Anne Bowman
- Deana Brock, AIM at Melanoma supporter
- Alexandra Brownfeld, AIM at Melanoma supporter
- Kelly Bryant, AIM at Melanoma supporter
- Robin Burden, AIM at Melanoma supporter
- Rachel Butler, AIM at Melanoma supporter
- Brian Cabaniss, AIM at Melanoma supporter
- Michelle Cabaniss RT(R), Veteran of the Armed Services
- Melissa Caparella, AIM at Melanoma supporter
- Chelsea Claytor, AIM at Melanoma supporter
- Stacie Cocke
- Taylor Collins, AIM at Melanoma supporter
- Katherine Cowan, AIM at Melanoma supporter
- Suzanne Cranford, AIM at Melanoma supporter
- Connie Davis
- C. Lee Davis
- Bryan Dawson, AIM at Melanoma supporter
- Mary Sue Decker
- Amanda Deibel, AIM at Melanoma supporter
- Shea Dezan, AIM at Melanoma supporter
- Jenny Dixon, AIM at Melanoma supporter
- Ashley Donovan, AIM at Melanoma supporter
- Roy Edge, AIM at Melanoma supporter
- Regina Edmondson, AIM at Melanoma supporter
- Deedra Ervin, AIM at Melanoma supporter

- Barbara Evans, AIM at Melanoma supporter
- Amber Foster, AIM at Melanoma supporter
- Adrienne Fowler, AIM at Melanoma supporter
- Lindsay Fuller, AIM at Melanoma supporter
- Helen Garinian, AIM at Melanoma supporter
- Michelle Goodman, AIM at Melanoma supporter
- Christina Goss, AIM at Melanoma supporter
- Debbie Grell, AIM at Melanoma supporter
- Candith-Araceli Guzman, AIM at Melanoma supporter
- Jennifer Hall, AIM at Melanoma supporter
- Joy Heath, AIM at Melanoma supporter
- Amy Herzing, AIM at Melanoma supporter
- Brittany Hines, AIM at Melanoma supporter
- Liz Hish, AIM at Melanoma supporter
- Wendy Holston, AIM at Melanoma supporter
- Karen Horsman, AIM at Melanoma supporter
- Allison Jensen, AIM at Melanoma supporter
- Kaitlin Jensen, AIM at Melanoma supporter
- Heather Johnson, AIM at Melanoma supporter
- Michael Kane, AIM at Melanoma supporter
- Katie Kellam, AIM at Melanoma supporter
- Olivia Kistler, Melanoma Research Foundation volunteer
- Sherry Kitts, AIM at Melanoma supporter
- Liz Knapp, AIM at Melanoma supporter
- Cynthia Laughlin, AIM at Melanoma supporter
- Wendi Lawlor, AIM at Melanoma supporter
- Mary Rose Lazenby, AIM at Melanoma supporter
- Beth Lee, AIM at Melanoma supporter
- Amanda Lickey, AIM at Melanoma supporter
- Sandy Linkous, AIM at Melanoma supporter
- Bo Lymburner, AIM at Melanoma supporter
- David Oliver Martinez
- Christopher Mason, AIM at Melanoma supporter
- Leslie Mason, AIM at Melanoma supporter
- Melanie Mayo, AIM at Melanoma supporter
- Dana McDaniel, AIM at Melanoma supporter
- Jimmy McGhee, AIM at Melanoma supporter
- Brooke McIntosh, AIM at Melanoma supporter
- Dawn McIntosh, AIM at Melanoma supporter
- Tabitha Mickey
- Tiffany Moore, AIM at Melanoma supporter
- Nikkk Murawski, AIM at Melanoma supporter
- Elizabeth Napoleone, AIM at Melanoma supporter
- Amanda Nichols, AIM at Melanoma supporter
- Jami Nosar, AIM at Melanoma supporter
- Anthony Plunkett, AIM at Melanoma supporter
- Chelsea Price
- Janice Price, AIM at Melanoma supporter

- Sandy Price, AIM at Melanoma supporter
- Jennifer Rampersaud, AIM at Melanoma supporter
- Donna Regen
- Nancy-Jo Revell, AIM at Melanoma supporter
- Elizabeth Rinaldi, AIM at Melanoma supporter
- Kim Ritter, AIM at Melanoma supporter
- Rachel Rivera, AIM at Melanoma supporter
- Morgan Ross, AIM at Melanoma supporter
- Jennifer Ryan, AIM at Melanoma supporter
- Charlotte Saunders, AIM at Melanoma supporter
- Jennifer Schottler, AIM at Melanoma supporter
- Alice Scott
- Kent Shiner, AIM at Melanoma supporter
- Jessalyn Simms, AIM at Melanoma supporter
- Brenda Skiles, AIM at Melanoma supporter
- Hilary Sneade, AIM at Melanoma supporter
- Kristin Speidel, AIM at Melanoma supporter
- Anne Stokes, AIM at Melanoma supporter
- Carol Stokes
- Caroline Stokes
- Hunter Stokes
- Thomas Stokes
- Sharol Stoneburner, AIM at Melanoma supporter
- Amy Thomas, AIM at Melanoma supporter
- Andrea Walters, AIM at Melanoma supporter
- Mio Ward, AIM at Melanoma supporter
- Ed Wessells, AIM at Melanoma supporter
- Rayna Wheeler
- Carol Whitehead, AIM at Melanoma supporter
- Emily Witt, AIM at Melanoma supporter
- Jennifer Young, AIM at Melanoma supporter

	Policy Options	Support
1	Take no action	0
2	Introduce legislation prohibiting persons under the age of 15 years from using tanning devices at tanning facilities; and requiring a parent or legal guardian of unemancipated persons 15-17 years of age to provide written consent prior to allowing the minor to use a tanning device at a tanning facility.	0
3	Introduce legislation prohibiting ~~unemancipated~~ persons under the age of 18 years from using a tanning device at tanning facility.	122

Comment Excerpts:

All three of the associations that provided comments strongly support Option 3.

Kelly Redbord: On behalf of the American Academy of Dermatology Association, I am writing to urge my support of legislation that would prohibit use of ultraviolet (UV) indoor tanning beds

by minors under the age of 18. Countless scientific studies have shown clear and compelling evidence that tanning bed use increases the risk of developing all forms of skin cancer. Furthermore, the U.S. Department of Health and Human Services and the World Health Organization have recognized the carcinogenic risks associated with tanning bed use. Recent scientific studies show a disturbing trend -- there is a steady rise in the number of young women diagnosed with melanoma, the deadliest form of skin cancer, and at more advanced stages. It is not coincidental that this demographic is also significantly more likely to use tanning beds than their male counterparts…I have treated countless skin cancers and melanomas on young patients who developed the cancers from tanning bed use. It is always very sad to diagnosis and treat a life threatening condition on a 20 year old who foolishly tanned as a minor and now will have to deal with skin cancer for life.

Donna Regen: "…My daughter Jaime used tanning beds throughout high school and college until she was diagnosed with melanoma at age 20. She fought this evil disease with strength and courage for her entire adult life, but the melanoma stole her dreams, her future, and her life when she was 29. And her death could have been prevented. No Virginia family (or family anywhere) should have to go through the horrific pain that our family has endured…The current statute does not protect all of Virginia's youth from the dangers of indoor tanning devices. The indoor tanning industry continues to deny known risks of indoor tanning devices. The industry also provides false and misleading statements to teens and their parents about the health benefits of indoor tanning devices. Parental consent is not the answer. If parents were aware of the dangers of tanning bed use, they would never permit their children to use them. A note from a parent does not make a tanning bed any less dangerous!"

Connie Davis: As a mother who has had to watch her beautiful daughter suffer through several major surgeries, countless scans, blood draws, chemo and the fear of dying, I beg you to push this bill through and ban the use of tanning beds for minors. I have spent many restless nights beating myself up over letting her use tanning beds before her prom or vacations. Unfortunately, I accepted the lies that the salons were selling and assumed they were safe. Now my daughter has cancer. Don't let the argument of taking away parental rights sway you. What are you taking away? The right to let their child get Cancer? Believe me, a tan is not worth it. It is both emotionally and financially devastating. Every three months we travel to New York City to meet with Melanoma Specialists where she has scans and treatment. Imagine the fear we feel waiting for the results, not knowing if the cancer has progressed to her major organs or her brain. We have watched other young girls just like her- many that she has befriended-either progress to Stage 4 or have died. I can't help but wonder when is it Chelsea's turn? When will I lose my girl?

Chelsea Price: "I am a 26 year old Virginia resident who currently lives in Roanoke and works at The Department of Veterans Affairs in Salem. I am emailing you to explain exactly why I believe option 3--banning teens under the age of 18 from using indoor tanning beds--is the only option.

I was 14 the first time I used a tanning bed. I had been asked to go to prom by a cute older guy and I wanted to make sure to look my best. Since the law required parental permission--and I didn't have a driver's license yet--my mom took me to our local tanning salon. She read the consent form, we laughed that maybe I wouldn't look like a ghost anymore, and I began my relationship with tanning beds.

From the time I was 14 until I was a senior in college I tanned before all major events like proms, sorority banquets, graduations, and vacations. In the back of my head I knew tanning

wasn't the healthiest thing for me, but I believed all of the hype: it was a good dose of vitamin D, it cleared my skin, and the tan made me beautiful.

In 2011, my tan had faded, but the damage had already been done. I was diagnosed with stage III malignant melanoma, the deadliest type of skin cancer. I was 22 years old.

I remember the first time I met my oncologist. He was so shocked to see me, a scared 22 year old, sitting in his office with such advanced melanoma. I wasn't his typical patient. I am a young, dark haired woman with no family history of melanoma. Then he asked me the 1000 dollar question: "Do you use tanning beds?"

Since my original melanoma diagnosis I have had 2 invasive surgeries that removed multiple lymph nodes from 4 areas in my body. Because there are few treatments available for people with stage III malignant melanoma, I am currently involved in a 3 year clinical trial involving a placebo and/or Yervoy. This trial requires me to travel to New York multiple times a year to receive an infusion. Even after the trial ends, my battle still will continue...

...All because of a tan.

Melanoma, once it spreads, is not a curable cancer. That is why you will not hear me refer to myself as a survivor. Every 3 months I return to the cancer center praying that melanoma has not spread to my organs. Every 3 months my family prays that I will be given another 3 months to happily live my life. Every 3 months we wait with fear in our stomachs. I live my life, but I do so knowing that my fight is far from over.

I ask that you consider banning all teens from using indoor tanning salons because I truly believe that is the only option. Had my mom been more educated on the dangers of tanning beds I know she never would have signed the consent form. Please don't risk allowing other teens to continue to tan because you believe their parent should be in charge of making such decisions for them. What if the parent is not educated on the dangers of tanning beds? Is it safe to say that all parents know that tanning beds are classified as class 1 carcinogens, just like tobacco? If the parent isn't educated on the risks, how can they make a responsible decision? Is it responsible of Virginia's legislature to have the research that clearly proves that tanning beds are harmful for our young skin and simply do nothing with it?

Please consider banning all teens under the age of 18 from using indoor tanning beds with hopes that they will never have to live with the regrets that I do.

"It's not just skin cancer."

Mary Sue Decker: "I am a stage 4 metastatic melanoma patient…How many people have said to me, "At least it was only skin cancer"? I have a poor prognosis and probably will not live long enough to help educate my grandchildren about sun safety. I choose option 3 so none of my children or grandchildren have to go through what I have endured."

Stacie Cocke: "… I was 32yo when I was diagnosed with melanoma, shortly after I had my second child. I was an avid tanning bed user in my teens and twenties. Specifically before family vacations, school dances, and then eventually as often as I was able to go. Typically I would tan a couple times per week. I had no idea it would almost kill me someday…I knew the risks of sun exposure, but I actually believed the lie that many others believe, that if I keep a base tan I won't be so susceptible to burning and that will minimize my risk of getting skin cancer… I am 100% convinced that my tanning bed exposure is why I developed melanoma. My melanoma was located in area that only the tanning bed was exposed to. I have no family history or genetic predisposition. I have no other risk factors...no blistering sunburns, etc. I beg and

plead that you would ban tanning beds for minors. At that age they are not thinking about the fact that their actions might someday lead to them crying in their husband's arms wondering if they will live long enough to see their child's first birthday. Teens and adults need to know how unsafe tanning really is. Thank you for caring enough about them to take the initiative to save lives."

Anne Bowman: "I grew up in Richmond, Virginia and in my teenage years I used tanning beds. I was a minor and did not need a signature from my parents. In 2010, at the age of 32, I was diagnosed with Malignant Melanoma. I am writing today to let you know that I support Option #3 to introduce legislation to prevent minors from using tanning beds."

Olivia Kistler: "I am a volunteer with the Melanoma Research Foundation and a stage IIIb melanoma patient. This legislation is very important to me. I want to do everything I can to prevent anyone else from this incurable cancer."

Allyson Bonzo: "As a 29 year old female recently diagnosed with melanoma, I think option 3, "Introduce legislation prohibiting unemancipated persons under the age of 18 years from using a tanning device at a tanning facility" is the safest most effective decision."

Tabitha Mickey: "I live in Grayson County, VA, I am 26 years old…and I was diagnosed with Melanoma when I was 22 years old. The Melanoma was found on my upper middle back and a large incision was made to remove it... along with the mole I had three lymphnodes removed from under my left arm and two removed from under my right. I was VERY lucky that the cancer had not spread.... but two years later, I developed Lymphedema in my left arm as a result of the lymphnode removal. Since my original diagnosis I have had about SEVENTEEN separate outpatient surgeries to remove other moles and ALL except for two have been pre-cancerous.... some of my surgeries were done twice because the margins did not come back clear after the initial surgery. I started tanning off and on during my senior year of high school and off and on for a year or so afterwards... I actually worked in a tanning salon for a few months at one point.... I STRONGLY encourage that underage tanning be banned!! Everyone, especially young people, need to be educated on the dangers of tanning. Below you will find a link to my Melanoma pictures... I have made the album public to help spread awareness!
https://www.facebook.com/tabitha.mickey/media_set?set=a.379401391197.166590.649226197&type=3

Debbie Grell: "Parental consent should not be an option because the only parent that would consent to let their child use a tanning bed would be an uninformed parent. There is too much medical evidence that the use of tanning beds leads to cancer."

Michelle Cabaniss: "My grandparents owned one of the first tanning salons in Salem, Virginia…My grandmother hated it and always begged me not to use it…It is important that option 3 be the only possible choice and there must be consequences for those that do not adhere to the rules once set forth. 6 other states have already taken the steps to protect those who do not have the means to protect themselves, even if they think they don't need protecting. Their young skin is too precious, their lives are too precious to gamble. Don't let Virginia fall behind, show that we care."

Rayna Wheeler: "Tanning beds are classified as a group 1 carcinogen, which puts them in the same category as asbestos, cigarettes, formaldehyde, and X-rays. We don't let minors buy cigarettes, so why should we let them tan? We don't go around letting people handle asbestos and formaldehyde without proper protection, and if you get an X-ray you are required to wear a smock to protect the rest of your body from being exposed. Yet teens are allowed to lay,

generally without clothes on, in a tanning bed? …I fully support Option 3: Introduce legislation prohibiting unemancipated persons under the age of 18 years from using a tanning device at a tanning facility. Option 2, requiring parental consent, is not enough because even great parents can be uninformed and make poor choices. We don't give parents the option to sign a consent form for smoking cigarettes under the age of 18, so why would we do the same for tanning beds?"

Carol Whitehead: "As a Virginian, and AIM at Melanoma supporter, I strongly urge you to protect minors under 18 from the known dangers of indoor tanning devices by introducing legislation that would ban all minors under 18 from these devices…The current statute does not protect all of Virginia's youth from the dangers of indoor tanning devices. The indoor tanning industry continues to deny known risks of indoor tanning devices. The industry also provides false and misleading statements to teens and their parents about the health benefits of indoor tanning devices…In addition, unlike other Group 1 carcinogens such as alcohol and tobacco, allowing parents to decide whether their children can use a tanning device sends a confusing message about the dangers of artificial UV exposure, which is 10-15 times the concentration of the sun."

Improving Health Outcomes, Reducing Medicaid Costs: Prenatal and Early Childhood Home Visiting

Lisa Specter-Dunaway
President & CEO
CHIP of Virginia

CHIP works with families, caught in the cycle of poverty, who are committed to creating a better life for their children and themselves. Intervening early, using proven best practices, CHIP registered nurses and parent educators work hand-in-hand with parents, preparing them to be their child's first and most important teacher.

CHIP families face complex social and health issues often related to poverty. Many of these issues snowball to result in significant expense for the state and local communities. These costs include not only financial resources but also lost human capital and capacity. All parents want to be good parents, but many just don't know how.

CHIP changes lives, two generations at a time. The Commonwealth's small investment changes the life course for families facing generational poverty, limited education, and unemployment. CHIP parents learn to care for their children and themselves, becoming assets to their communities. Unlike many human services programs, CHIP has hard data showing its outcomes.

CHIP of Virginia utilizes the Commonwealth's funding wisely, leveraging $2.71 per state dollar invested. CHIP has reduced administrative costs and infrastructure. In 2009, there were 11 local CHIP sites serving 30 localities, now, after 4 mergers, operations have been regionally consolidated into 7 local sites serve 27 localities. Revenue streams have been diversified. Fee for service contracts with three Medicaid managed care organizations are part of the business model.

Yet, with 35% budget reductions since 2009, these actions were not sufficient and waiting lists grow longer. For children CHIP cannot serve, the potential costs in unnecessary ED usage and other inefficient use of health care resources, including preventable preterm births and long NICU stays, life-long medical expenses and academic remediation are staggering.

While the average cost to an employer for a healthy baby born at full-term is $2,830, the average cost for a premature baby is $41,610. If the baby is born at or earlier than 26 weeks, the cost can quickly rise to $250,000 or more.

Option 1: Restore state funding to $2.7 million by adding an $900,000 to the allocation. This will ensure that parents of an additional 225 children will be able to provide a more stable household with healthier children who can start school ready to learn and succeed.

Option 2: Implement a demonstration project to expand the pilot with NICU graduates to serve at least 140 NICU grads and their families at an annual cost of $840,000.

Based on initial outcomes, significant short term savings will be achieved with the reduction of hospital readmissions and emergency department usage, by starting work with families prior to their baby's discharge from the NICU. This demonstration project will document the opportunities for increased effectiveness, efficiencies and additional revenue streams leading to increased sustainability.

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