



Decision Matrix

Policy Options for 2017 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 2016.
- B. To develop legislative recommendations for the 2017 General Assembly Session.

Membership

The Honorable Charles W. Carrico, Sr., Chair

The Honorable Rosalyn R. Dance, Vice-Chair

SENATE OF VIRGINIA

The Honorable George L. Barker

The Honorable Siobhan S. Dunnivant

The Honorable John S. Edwards

The Honorable L. Louise Lucas

The Honorable Glen H. Sturtevant, Jr.

The Honorable David R. Suetterlein

VIRGINIA HOUSE OF DELEGATES

The Honorable David L. Bulova

The Honorable Benjamin L. Cline

The Honorable T. Scott Garrett

The Honorable Patrick A. Hope

The Honorable Riley E. Ingram

The Honorable Kaye Kory

The Honorable John M. O'Bannon III

The Honorable Christopher K. Peace

The Honorable Christopher P. Stolle

The Honorable Roslyn C. Tyler

The Honorable William A. Hazel, Jr.

Secretary of Health and Human Resources

STAFF

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Sunset Date for Joint Commission on Health Care

Michele Chesser
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 four times resulting in the current sunset date of July 1, 2018.

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 include:

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

Examples of legislative commissions that have specific sunset dates include:

- 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.

 **16-0 Option 2:** Introduce legislation to amend the *Code of Virginia* § 30-170 to extend the sunset provision to July 1, 2022.

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

School Vaccination Requirements in the Commonwealth

Stephen Weiss
Senior Health Policy Analyst

House Bill 1342 (Delegates Filler-Corn and Stolle) was introduced during the 2016 General Assembly session. As written, the bill amended § 32.1-46 by striking subsections D.1. and D.2. removing religious and medical exemptions and by adding “if the vaccine is medically contraindicated” as the only exemption. HB 1342 was stricken by the patron. Delegates Filler-Corn and Stolle requested that the JCHC study the requirements surrounding school vaccinations and make recommendations as to whether non-medical exemptions should be tightened for children attending public schools, private schools, child care centers, nursery schools and family day care home or developmental centers.

The study was approved at the May 26, 2016 work plan meeting.

The original study request asked the Commission to review ten issues related to the development, making, use and safety of vaccines. During the May 26, 2016 work plan approval meeting, an additional seventeen issues were added for review.

Background

Vaccination / school immunization policies are a balancing act between public health, science, personal freedoms, social responsibility, and public policy. The study explores in detail all aspects of the policies including a review of public attitudes, how vaccines are made, regulated and monitored for safety, controversies concerning vaccines and adverse reactions, other states’ school vaccination requirements and a review of the current policies in Virginia.

Presentations Prior to the Study

Two presentations were heard at the beginning of the meeting. The presenters and a summary of their presentation are as follows:

Barbara Lowe-Fisher from National Vaccine Information Center spoke of the legal right of parents to not vaccinate based on religious beliefs and discussed how one-size-fits-all laws are not good for citizens. She described her own family experiences with adverse reactions to vaccines and asked that no change to be made to the current vaccine laws.

Karrie Delaney from Voices for Vaccines stated that parents who choose to vaccinate have science behind them. She then summarized concerns associated with a reduction in vaccination rates in the U.S. The loss of herd immunity can result in outbreaks in communities which may result in at-risk individuals, such as infants and the ill who cannot be vaccinated, contracting vaccine-preventable diseases.

The Study

The study reviewed:

- Federal oversight of the development of vaccines and their approval for use by the public
- The various federal agencies charged with insuring that vaccines are safe as they are being developed, manufactured and used

- The ingredients of modern day vaccines and the controversies surrounding the ingredients, as well as the controversies surrounding the use of vaccines in general
- Federal oversight of reported adverse reactions and events and the systems in place to address them
- Herd immunity and how it is determined by disease and vaccine
- Other state laws on school vaccination policies compared to Virginia’s laws

Conclusions drawn from the study include:

- Vaccines target diseases that spread through society, some more rapidly than others and some more deadly than others.
- The U.S. Supreme Court found that individual liberties and individual religious freedoms within the context of a society can be restrained for the good of the whole (Jacobson v. Massachusetts, 1905).
- The statistically significant effectiveness of vaccine policies, when weighed against the nature of the diseases the vaccines are intended to prevent, support school vaccination policies.

Policy Options and Public Comments

The Commission received 701 comments, of which, 696 recommend taking no action (policy option 1).

Support of policy option 1 included the following explanations from many of the commenters:

- Virginia’s exemption rates are low (1.1%), there have not been any outbreaks in Virginia and there is no compelling reason to change the law
- The science concerning vaccines is not settled, especially related to the various ingredients used to make vaccines and the impact those ingredients have on the body
- Physicians cannot predict who will have a negative reaction to a vaccine
- Vaccines are not 100% safe and can and have caused significant harm to children
- Parents should have the authority to decide what is best for their children
- The Virginia Constitution and laws guarantee Virginians personal liberties and freedoms, including freedom to choose their own religion and to worship freely without question or interference from the government

The Commission received comments from five individuals/organizations that supported changing the Commonwealth’s law related to school vaccination exemptions. Supporters of changing the law commented that not vaccinating children puts everyone at risk and the use of religious exemptions in Virginia has nothing to do with religion.

POLICY OPTIONS	Comments Received in Support	Support by Organizations
<input checked="" type="checkbox"/> 16-0 Option 1. Take no action.	696	-Virginia Department of Health -Medical Safety Research Institute -The Family Foundation -Advocates for Home Schooling -National Vaccine Information Center -Center for Medical Freedom -Virginians for Medical Freedom
Option 2. Reintroduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, removing religious and medical exemptions and by adding an exemption for medical contraindication as the only exemption.	1	
Option 3. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, eliminating the religious exemption.	2	American Academy of Pediatricians
Option 4. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, eliminating the religious exemption and providing that medical exemptions can only be obtained from a licensed physician and must say what the physical condition of the child is, which vaccines are being exempted, whether the exemption is temporary or permanent and, if temporary, when the exemption will expire.	2	American Academy of Pediatricians
Option 5. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, splitting the religious exemption into two parts – a religious exemption and a philosophical exemption. Both the religious and philosophical exemptions would be required to include what vaccines the person objects to base on religion or philosophical beliefs.	0	

POLICY OPTIONS	Comments Received in Support	Support by Organizations
Option 6. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, adding a subsection allowing physicians to file alternative vaccination plans provided that the child receives all required vaccines before Kindergarten.	0	
Option 7. Introduce legislation to amend Chapter 29 of Title 54.1 of the Virginia Code to improve the continuing medical education (CME) of physicians on childhood vaccinations.	0	
Option 8. Introduce budget amendment (language and funding) for the Virginia Department of Health to design more effective messages concerning vaccination programs for different communities and for the continuing education of physicians and other health care providers.	1	American Academy of Pediatricians
Option 9. Request by letter of the JCHC Chair that the Health Department and the Department of Education work with local school divisions and private schools to improve reporting by schools and home schools to make certain that schools with low vaccination rates are filing reports properly and timely and the reports are reviewed for the reasons for low vaccination rates. A report to the Commission detailing the results of the agency efforts will be provided by October 1, 2017.	1	American Academy of Pediatricians

Public Comment Excerpts

JCHC received comments from the Virginia Department of Health and seven organizations. The VDH and organization comments are as follows:

Virginia Department of Health (VDH)

Option 1: VDH prefers option 1, take no action. VDH indicates that, “the low exemption rates and relatively high vaccine coverage rates, and low morbidity from vaccine preventable diseases,” make this option acceptable.

Option 2: VDH states that, exemption rates are low but “religious exemption rates, especially for private schools, are continuing a long term upward trend, it may be reasonable to take action now to address the issue before it becomes a problem.”

VDH notes that the proposed changes to the medical exemption are “very narrowly focused and would not allow physician discretion to defer vaccines based on the medical condition of the child.” VDH prefer the current statute for the medical exemption.

Option 3: VDH suggests that, “rather than removing the religious exemption entirely, that the language be changed to require periodic renewals of the religious exemption.”

Option 4: VDH notes that, “because the report of the [student’s medical] examination is inclusive of immunizations, amending the Code to ensure that the exemption can only be obtained from a licensed physician seems unnecessary.” VDH also states that, “it may be prudent to consider editing the current school form to clarify the definition of ‘medical provider’, along with clarifying an expectation that the provider completing the form [as] *has* a bona-fed practitioner-patient relationship with the patient.”

Option 5: VDH states that introducing a philosophical exemption would introduce a third exemption category. VDH states that, “Introducing this option is a step backwards; if option 5 is implemented, it would be recommended that stringent criteria are included to ensure that parents are appropriately informed about the benefits and risks of vaccine prior to using the philosophical route.”

Option 6: VDH states that, “the current CDC ACIP-recommended schedule does allow flexibility to administer vaccines within certain age ranges (e.g. the third doses of polio and hepatitis vaccines may be administered between the ages of 6 and 18 months of age). Delaying receipt of vaccines by deviating from the recommended schedule unnecessarily increases the amount of time children are susceptible to vaccine preventable diseases.” “Parental decisions to delay or avoid certain vaccines according to alternative schedules may have an impact on susceptibility of the individual child to vaccine-preventable diseases as well as on the community in which they live.”

Option 7: “VDH has confidence that medical providers that care for children are well-aware of the clinical recommendations for routine childhood and adolescent vaccination. This option, therefore, is not needed.”

Option 8: VDH notes that this option is already being done and the option is not needed.

Option 9: VDH indicates that this option is “laudable” but it will be challenging. The Department of Education maintains a current list of public schools, communication through email is occurring and there is “over 95% compliance each year” for public schools.

VDH notes that there is no comprehensive list of private or home schools that includes details about the level of instruction. VDH works with the Virginia Council for Private Education (VCPE) to create a list of school but notes that, “there is no way to reliably or routinely update the list for closures, new schools, changes in grades offered, changes in school administration, etc., especially for those facilities that are not affiliated with the VCPE.”

American Academy of Pediatrics (AAP)

AAP supports school entry immunization policies that ensure that students “receive their full immunizations according to current recommendations.”

The AAP recently published its revised policy statement and recommends that states “eliminate nonmedical exemptions from immunization requirements.”

AAP supports medically indicated exemptions “to specific immunizations as determined for each individual student. While rare, there are a small proportion of children with medical conditions that prohibit specific immunizations.”

The Virginia AAP supports: Policy options 3, 4, 8, and 9.

The Virginia AAP opposes: Policy options 5 and 7.

“...immunization requirements for school attendance are effective in protecting people from vaccine-preventable diseases, both by direct protection from the vaccine and indirect protection via community immunity.”

Children’s Medical Safety Research Institute

In support of policy option 1: Take no action:

“As a Virginian who cherishes the traditions of liberty, freedom and conscience inspired by the founding father of our state as well as our nation, my constitutionally protected right to freedom of religion was threatened by HB 1342, introduced by Delegate Stolle and Delegate Filler-Corn and is now the subject of a study before your committee.”

“Mandates without exemptions are wrong in the face of unanswered questions, or when safety concerns are validated by the science, especially given that so many children are suffering from chronic illness and disability with no plausible explanations for their cause.”

“This legislation was introduced as a result of a small number of citizens being falsely alarmed by two cases of measles that were never determined to have been spread by an unvaccinated individual. Legislating away a Constitutional right out of a fear of what might happen does not meet the required circumstances of addressing a compelling state interest or using the least restrictive means necessary.”

The Family Foundation

In support of policy option 1: Take no action:

The Family Foundation notes that: Virginia kindergarteners are among the highest vaccinated in the nation; Virginia has one of the lowest infectious disease rates in the nation; less than 1% of families with school aged children are religiously exempt; if a medical emergency occurs the Code provides for the state to override the religious exemption.

“There is no compelling argument for the revocation of the religious exemption for child vaccines.”

Home School Legal Defense Association (HSLDA)

In support of policy option 1: Take no action:

HSLDA expresses “firm and respectful opposition to any effort by the Joint Commission to erode the rights of parents to make preventative health care decisions for their children with respect to immunizations, including the right to rely on the independent advice of their personal physician.”

National Vaccine Information Center (NVIC)

In support of policy option 1: Take no action:

NVIC states that “doctors cannot accurately predict who is more susceptible to vaccine harm due to genetic, biological and environmental high risk factors. Despite vaccine science knowledge gaps, federal health officials have narrowed medical contraindications so that no family medical history and almost no personal medical history or condition qualified for a medical vaccine exemption.”

“Strict enforcement of ‘no exemptions’ vaccine laws lead to distrust of government and fear of doctors. It is wise to protect an individual parent’s legal ability to exercise conscience, religious belief and informed consent when making vaccine decisions for a minor child, as well as to protect the legal ability of

individual physicians to exercise professional judgement and conscience when evaluating whether a child should receive a medical exemption to vaccination to attend school.”

Center for Medical Freedom

In support of policy option 1: Take no action.

“The proposal to restrict or abolish the right of religious exemption to vaccine mandates is contrary to the Constitution and the history of religious liberty in the Commonwealth of Virginia.”

“One of the reasons that Christians and many others are opposed to the administration of many common vaccines is that they were developed using cell lines that originally were cells taken from electively aborted babies. The vaccines themselves do not contain fetal cells, but there are significant ‘residual’ biological components from the fetal cells that have been assimilated into the vaccine, including cell proteins and measurable portions of fetal DNA.”

“Residual cell parts from murdered unborn children may be rationalized as a scientific necessity by pharmaceutical companies, for the purpose of growing their antigen, but you can never remove the devastating spiritual consequences of such ingredients.”

“...many religious exemptions are also based on the parent’s concern that not enough is done to make vaccines safe as they could be and that they, the parent, not the state, are ultimately responsible to God, for the utmost protection of their child’s well-being.”

“The science on vaccines is far from ‘settled.’ The very nature of science is that it can never be settled. It must always evolve, utilizing new technologies and methods to retest the hypothesis proved by older science as well as progress forward with new novel hypothesis.”

Virginians for Medical Freedom

In support of policy option 1: Take no action.

“... in Virginia we have the Virginia Statute for Religious Freedom that protects not only our religious freedom, but also the conscience and our thought.”

“Thomas Jefferson was the author of both the Declaration of Independence and the Virginia Statute for Religious Freedom. Virginia was the first state to separate church and state; it is still a part of Virginia’s Constitution; it was used as a model for other states’ constitutions; and it was used as a model for the religious language of the Bill of Rights.”

“..the Virginia Statute for Religious Freedom is a statement about freedom NOT ONLY of religion, but also freedom of thought and conscience. It is based on the principle of separation of church and state. So, to believe that some may be overusing or exploiting this fundamental right to get out of vaccinating is incorrect because this is a right that cannot be abused. If a person’s conscience leads them to feel that vaccinations are wrong, laws that uphold this belief protect them.”

Improving the Provision of Palliative Care in the Commonwealth

Stephen Weiss
Senior Health Policy Analyst

During the 2016 General Assembly Session, House Bill 473 was introduced by Delegates Filler-Corn, Krizek and Mason, and it was continued to 2017 in the House Health, Welfare and Institutions Committee. Delegate Filler-Corn subsequently requested that the JCHC study the legislation with an emphasis on the delivery and corresponding regulations of palliative care, evaluation of the need for public education on the topic, and determination of whether accessible statewide education resources exist for citizens.

The study was approved by the JCHC members during the May 26, 2016 work plan meeting.

As written, HB 473 amended § 32.1-127 and added § 32.1-371 and § 32.1-372 which required every hospital, nursing home, and licensed and certified nursing facility in the Commonwealth to establish a system for identifying patients or residents who may benefit from palliative care and provide information about and facilitate access to appropriate palliative care services for them. It also created a Palliative Care Consumer and Professional Education and Information Program within the Virginia Department of Health to maximize the effectiveness of palliative care initiatives in the Commonwealth and ensure that comprehensive and accurate information and education about palliative care is available to the public, health care providers, and health care facilities through the Department's website; and created an eight member Palliative Care and Quality of Life Advisory Council to advise the Department on the establishment, operation, maintenance, and outcomes evaluations of palliative care information and education initiatives.

HB 473 had a fiscal impact statement of \$120,506 per year. The impact includes the cost of the council (\$10,000) and one professional to implement the education and information program and website (\$110,506).

Background

Historically, palliative care has been associated with hospice care as a service provided to help comfort terminally ill patients and their families during the last stages of their lives.

According to the National Hospice and Palliative Care Organization, the percentage of hospice patients covered by the Medicare hospice benefit versus other payment sources was 84.1 percent in 2011. To be eligible for Medicare's hospice benefit, a beneficiary must be certified by a physician to have a life expectancy of six months or less if the illness runs its natural course and the beneficiary must sign a statement electing the hospice benefit, which means ending all treatments to cure the illness and electing to receive only comfort care - referred to as palliative care (42 CFR 418 to 418.405).

Today the definition of palliative care is expanding beyond traditional hospice care and is now described to mean "comfort care" for a variety of long term, chronic and/or seriously ill patients as well as the terminally ill. The goal is to apply palliative care to any illness or disease that requires a team approach to patient care, similar to a medical home. Under this definition, a palliative care team consists of health care providers, clergy and social service programs that provide an array of services to people, and their families, who are recovering from serious illnesses and diseases that were once considered terminal.

Changing Demographics

The need for an expansion of palliative care into other areas of the health care field beyond hospice care involves the demographics of an aging population that includes people living longer due to the advancements in medical treatment. The average life expectancy in the United States in 2014 increased

by 5 years since 1980; and death rates for the two most common diseases among the elderly population, cardiac disease and cancer, have declined by 64% and 15%, respectively.

In addition, the number of people aged 65 and over is the fastest growing segment of the U.S. population according to the Census. Every day from now until 2030 10,000 baby-boomers will turn 65 years old. The number of people aged 65 and over grew by 23.3 percent in Virginia between the 2000 and 2010 census while the number of people aged 85 and over grew by 40.3 percent during the same period; as compared to 15.1% and 29.6% respectively for the U.S. population as a whole.

Association Positions on Palliative Care

Both the American Cancer Society and the American Heart Association have issued position papers advocating for the creation of palliative care as a way to improve treatment and patient outcomes from chronic and long term diseases.

Readmission Reduction Program

The Medicare Hospital Readmission Reduction Program reduces payments to hospitals if a person is readmitted for any cause other than a scheduled procedure within 30 days of discharge from an inpatient setting. The program only impacts the treatment of four diseases – cardiac, pneumonia, COPD and elective hip or knee replacement. All four can be addressed through a palliative care program that can help hospitals reduce readmissions and maintain their Medicare payments for inpatient procedures. In Virginia, 41 hospitals were penalized for excessive preventable readmissions for patients discharged with a diagnosis of heart attack or heart failure.

Challenges

Challenges to palliative care include the lack of knowledge about what palliative care is under an expanded definition, who the providers are and where they are located. A secret shopper program conducted by Duke University in 2016 found that cancer centers did not provide complete information on supportive services 38 percent of the time when asked whether palliative care was available. A 2014 survey of health care providers by Health Information Network (HIN) found that 48 percent of respondents indicated that physician resistance to implementing a palliative care program was a key challenge. The HIN survey also found that 80 percent of respondents said that patient/caregiver education was a key component of the program.

Virginia

In speaking to stakeholders across the state, including medical directors of palliative care programs, hospice workers, and palliative care program directors and providers, the conversations and observations about palliative care outside of hospice are similar to the findings reported in the Duke and HIN surveys.

Patients and family members often do not understand what a palliative care program is or why they or their family members are on a palliative care unit. The nurse director of one palliative care program said family members and patients are often angry and confused when they enter the palliative care unit at the hospital. For them the term palliative care is associated with hospice and there is an assumption that curative treatments have ended. The director also indicated that when the program started in 2009 it took some time for the oncology physicians to support the program, viewing it as duplicative of the work they thought they were doing.

The medical directors and professors of palliative care programs at Eastern Virginia Medical School, the University of Virginia, and Virginia Commonwealth University all indicate that medical schools need to do a more complete job of educating medical students about palliative care. All three indicated that the amount of time spent in the classroom or other environments where medical students are in training is

insufficient to teach them how to talk to patients and family members about palliative care, death, and/or dying.

General Google Search Results for Palliative Care Providers in Virginia		
Websites	Number of Hospitals / Providers Listed	Number of Cities
Getpalliativecare.org	35	26
National Hospice and Palliative Care Organization *	13	10
American Council on Surgeons Commission on Cancer *	46	39
Physicians	Number of Physicians / Nurses Listed	Number of Cities
American Board of Internal Medicine Subspecialty	106	n/a
American Board of Family Medicine	36	24
American Board of Medical Specialists	81	38
Certified Hospice and Palliative Nurses (CHPN)	312	n/a
Advanced Certified Hospice and Palliative Nurses (ACHPN)	45	n/a
Certified Hospice Medical Director	7	7
<ul style="list-style-type: none"> The National Hospice and Palliative Care Organization website lists both palliative care specific providers and hospice provider. The only way to know if any of the hospice providers are also offering palliative care services is to follow additional detail links for each hospice provider. The American Council on Surgeons website lists 38 Commission on Cancer certified hospitals but combines several hospitals into one even though the hospitals are in different locations. 		
https://getpalliativecare.org/providers/virginia/ ; http://www.nhpco.org/find-hospice/pcp ; https://www.facs.org/search/cancer-programs?state=VA ; http://www.gohpcc.org/certificants_map.aspx?Cert=CHPN ; http://www.gohpcc.org/certificants_map.aspx?Cert=APRN ; http://apps.hmdcb.org/Default.aspx?TabId=356&DSResult=T&State008=VA&DirectoryFlag802=Y&AddressStatusCode795=G00D		

The medical director of a large palliative care program in Northern Virginia said finding providers is labor intensive. Palliative care providers do not have to be certified to be members of an organization and not all certified physicians are members of the various organizations where provider directories or lists might be found. A review of the different websites for Virginia found that the material on one website may or may not match the information on another.

Virginia Hospital and Healthcare Association Palliative Care Forum

The Virginia Hospital and Healthcare Association (VHHA) has a palliative care forum with approximately 40 members. The forum was established in 2011 and includes the Virginia Association for Hospices & Palliative Care, Honoring Choices, The Physician Orders for Scope of Treatment Group and other community groups. The forum meets four times a year with approximately 10 – 15 people in attendance at any given meeting. According to VHHA, palliative care is a part of the overall issues related to advance care planning. The forum's goals include providing an opportunity for providers to collaborate to meet the needs of communities, sharing information and best practices, supporting training and education, and credentialing of palliative care team members.

Conclusion, Recommendations and Policy Options

Based on the material reviewed for this study and information obtained from various stakeholders from across the Commonwealth, there may be a need for both a statewide advisory council and a website to act as a clearinghouse for information and educational material for both the general public and health care

providers. During stakeholder conversations there was a strong desire to make the list of members of the advisory council more inclusive of providers that are part of a palliative care team.

The recommendations include clarifying provisions of HB 473 as follows:

Recommendations for House Bill 473

1. Change House Bill 473 by removing the amendment to section §32.1-127 of the Virginia Code that requires licensed hospitals, nursing homes and certified nursing facilities to identify and educate patients on palliative care services and continue the legislation that creates the advisory council and website by adding Title §32.1 -371 and §32.1-372 to the Virginia Code as originally written.

2. Change House Bill 473 by removing the amendment to section §32.1-127 of the Virginia Code that requires licensed hospitals, nursing homes and certified nursing facilities to identify and educate patients on palliative care services and continue the legislation that creates the advisory council and website by adding Title §32.1 -371 and §32.1-372 to the Virginia Code with language that expands the Palliative Care and Quality of Life Advisory Council within the Virginia Department of Health from eight to thirteen by adding a hospice provider, nutritionist, hospital administrator and nursing home and certified nursing facility.

Seventy-four comments were received from the following individuals/organizations:

- R. Brent Rawlings, Vice President and General Counsel, Virginia Hospital and Healthcare Association
- Brenda Clarkson, Executive Director, Virginia Association for Hospice and Palliative Care
- Marcia A. Tetterton, Executive Director, Virginia Association for Home Care and Hospice
- Melissa L. Assalone, Director, Government Relations, American Heart Association, Virginia
- Marissa C. Galicia-Castillo, MD, MEd, CMD, FACP, AGSF, FAAHPM, Sue Faulkner Scribner Professor of Geriatrics Section Head, Palliative Medicine
- Lauren Bates-Rowe, Senior Director of Health Policy, and Ralston King, Senior Director of Government Affairs, Medical Society of Virginia
- Ms. Faith Havran, Patient Navigator, American Cancer Society Cancer Action Network
- Dr. Bruce Britton, American Cancer Society Cancer Action Network Volunteer
- Dr. James Kenley, American Cancer Society Cancer Action Network Volunteer
- Dr. Judith Muir, American Cancer Society Cancer Action Network Volunteer
- Dr. Marissa Galicia-Castillo, American Cancer Society Cancer Action Network Volunteer
- Dr. Quentin Fischer, American Cancer Society Cancer Action Network Volunteer
- Dr. Robert Palmer, American Cancer Society Cancer Action Network Volunteer
- Miss Alberta, American Cancer Society Cancer Action Network Volunteer
- Miss Jeanne Staton, American Cancer Society Cancer Action Network Volunteer
- Miss Kristin O'Donnell, American Cancer Society Cancer Action Network Volunteer
- Mr. Alexander Pfenhauer, American Cancer Society Cancer Action Network Volunteer
- Mr. Bruce Rauscher, American Cancer Society Cancer Action Network Volunteer

- Mr. David McColgan, American Cancer Society Cancer Action Network Volunteer
- Mr. Gary Pickenpugh, American Cancer Society Cancer Action Network Volunteer
- Mr. Calvin Nokes, American Cancer Society Cancer Action Network Volunteer
- Mr. Hobart Gonter, American Cancer Society Cancer Action Network Volunteer
- Mr. John Rausch, American Cancer Society Cancer Action Network Volunteer
- Mr. John Williams, American Cancer Society Cancer Action Network Volunteer
- Mr. Les Wilson, Sr., American Cancer Society Cancer Action Network Volunteer
- Mr. Rohit Dhruv, American Cancer Society Cancer Action Network Volunteer
- Mr. Steven Kranowski, American Cancer Society Cancer Action Network Volunteer
- Mr. William Owen, American Cancer Society Cancer Action Network Volunteer
- Mr. William Welkowitz, American Cancer Society Cancer Action Network Volunteer
- Mrs. Anne Barclay, American Cancer Society Cancer Action Network Volunteer
- Mrs. Ashley Finch Hermsen, American Cancer Society Cancer Action Network Volunteer
- Mrs. Beverly Freeman, American Cancer Society Cancer Action Network Volunteer
- Mrs. Cathryn Burby, American Cancer Society Cancer Action Network Volunteer
- Mrs. Chrissy Thomas, American Cancer Society Cancer Action Network Volunteer
- Mrs. Cindy McCullough, American Cancer Society Cancer Action Network Volunteer
- Mrs. Donna Strickler, American Cancer Society Cancer Action Network Volunteer
- Mrs. Edith Kelly, American Cancer Society Cancer Action Network Volunteer
- Mrs. Frances Meadows, American Cancer Society Cancer Action Network Volunteer
- Mrs. Karen Fournier, American Cancer Society Cancer Action Network Volunteer
- Mrs. Kathleen Blontz, American Cancer Society Cancer Action Network Volunteer
- Mrs. Kim Jennings, American Cancer Society Cancer Action Network Volunteer
- Mrs. Kristen Demboski Young, American Cancer Society Cancer Action Network Volunteer
- Mrs. Laura Crummett, American Cancer Society Cancer Action Network Volunteer
- Mrs. Laura Wood, American Cancer Society Cancer Action Network Volunteer
- Mrs. Linda Garcia, American Cancer Society Cancer Action Network Volunteer
- Mrs. Lisa Hinton, American Cancer Society Cancer Action Network Volunteer
- Mrs. Marlene Arwood, American Cancer Society Cancer Action Network Volunteer
- Mrs. Mary Grudzinski, American Cancer Society Cancer Action Network Volunteer
- Mrs. Melissa Roof, American Cancer Society Cancer Action Network Volunteer
- Mrs. Nancy Roundtree, American Cancer Society Cancer Action Network Volunteer
- Mrs. Rose Welsh, American Cancer Society Cancer Action Network Volunteer
- Mrs. Stacy Jones, American Cancer Society Cancer Action Network Volunteer
- Mrs. William Welkowitz, American Cancer Society Cancer Action Network Volunteer
- Ms. Ana Bruno, American Cancer Society Cancer Action Network Volunteer
- Ms. Ann Vaughan, American Cancer Society Cancer Action Network Volunteer
- Ms. Barbara Bellido, American Cancer Society Cancer Action Network Volunteer
- Ms. Beth Ann Burns, American Cancer Society Cancer Action Network Volunteer
- Ms. Cheryl Lawrence, American Cancer Society Cancer Action Network Volunteer
- Ms. Donna Russell Martin, American Cancer Society Cancer Action Network Volunteer
- Ms. Elaine Becker, American Cancer Society Cancer Action Network Volunteer
- Ms. Elaine Fischer, American Cancer Society Cancer Action Network Volunteer
- Ms. Fredda Bryan, American Cancer Society Cancer Action Network Volunteer

- Ms. Janel Grimes, American Cancer Society Cancer Action Network Volunteer
- Ms. Jennifer Walker, American Cancer Society Cancer Action Network Volunteer
- Ms. Jerlaunda Wilson-Boulware, American Cancer Society Cancer Action Network Volunteer
- Ms. Katherine Wall, American Cancer Society Cancer Action Network Volunteer
- Ms. Leah Contreras, American Cancer Society Cancer Action Network Volunteer
- Ms. Linda Collazo, American Cancer Society Cancer Action Network Volunteer
- Ms. Megan Horsley, American Cancer Society Cancer Action Network Volunteer
- Ms. Robin Siegel, American Cancer Society Cancer Action Network Volunteer
- Ms. Sheila Gilliam, American Cancer Society Cancer Action Network Volunteer
- Ms. Susana Hernandez-Kurtulus, American Cancer Society Cancer Action Network Volunteer
- Ms. Suzanne Steger, American Cancer Society Cancer Action Network Volunteer
- Ms. Debbie Chadick
- Ms. Vicky L. Carr

The policy options for consideration are as follows:

POLICY OPTIONS	Support	Oppose / Concerns
Option 1: Take no action.		
Option 2: Introduce a budget amendment (language and funding) to provide \$120,506 to the Virginia Department of Health for the creation of a thirteen member Palliative Care and Quality of Life Advisory Council within the VDH. The funds will be used to staff the Council and create a website.	<ul style="list-style-type: none"> • 66 from American Cancer Society Cancer Action Network • American Heart Association • Medical Society of Virginia • Ms. Faith Havran; • Debbie Chadick; • Mrs. Vicky Carr • Dr. Galicia-Castillo 	The Virginia Association for Home Care and Hospice
Option 3: Introduce legislation to amend § 32.1-162.1 of the Virginia Code to add a separate definition of palliative care that incorporates the current service delivery system. The added definition may read as follows: -- “Palliative care” means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. (Source: 42 CFR § 418.3)		<p>The Virginia Association for Home Care and Hospice - concerned</p> <p>Virginia Hospital and Healthcare Association – oppose</p>

 15-1 Additional Member-Proposed Policy Option 4: Add a section to Title §32.1 of the Virginia Code requiring the Virginia Department of Health to create a website for palliative care information.	Virginia Hospital and Healthcare Association	
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Public Comment Excerpts

JCHC received seventy-four public comments on the Palliative Care study.

Seventy-two comments support option 2 with funding. Sixty-six of the comments are from volunteers from the American Cancer Society Action Network, three of who noted their own experiences with cancer and one as a patient navigator with the American Cancer Society. Two are from individuals, one is from the Section Head of Palliative Medicine at Eastern Virginia Medical School, one is from the American Heart Association, and one is from the Medical Society of Virginia.

The American Cancer Society Cancer Action Network – Form Letter

As a Virginian and volunteer for the American Cancer Society Cancer Action Network, I ask that you support Option 2 when deciding how to proceed on the Joint Commission on Health Care's study on palliative care.

As was explained during the recent JCHC meeting, palliative care is specialized medical care for people with serious illnesses like cancer, and is focused on providing patients with relief from the pain and stress of a serious illness. This type of care is provided by a team of doctors, nurses, and other specialists in order to provide an extra layer of support, and is appropriate at any age and any stage of a serious illness. The goal of palliative care is to improve the quality of life for both the patient and the family, and can lead to a more efficient health care system.

Option 2 would include introducing a budget amendment that would provide funding for the Virginia Department of Health to create a Palliative Care and Quality of Life Advisory Council. This council would then be tasked with creating a website that would provide useful information about palliative care to patients, caregivers, and medical professionals.

Please do not ignore this opportunity to improve the quality of life of cancer patients and their families. I urge you to learn more about palliative care at www.acscan.org/palliativecare and move forward on Option 2.

- Mrs. Kristen Demboski Young added that, “as a cancer survivor myself and daughter of 2 cancer survivors, this is a very important issue to me, my husband, and my four children. Please review your decision about cancer patient care and their quality of life with deep consideration of others!”
- Mrs. Kathleen Blontz added that, “My daughter is going through treatment for cancer and watching all the highs and lows and interviewing different doctors and getting everyone’s opinion about the course of treatment, while hoping that you are making the right decisions has been extremely stressful. Please support the ACS Can and option 2 when deciding how to proceed on the Joint Commission on Health Care’s study on Palliative Care.”
- Mrs. Ashley Finch Hermsen added that, “As my family has gone through palliative care when my mother was passing from brain cancer. This is a very important cause to myself & my family. I’m sure families throughout the commonwealth as well.”

The American Heart Association, Virginia - Melissa Assalone, Director of Government Relations

The American Heart Association supports policy option 2. The Association cites the national policy statement on palliative care noting that an advisory council, website, and supporting appropriations would help integrate palliative care into long-term services and supports for patients. Additionally, the American Heart Association supports the identification and education of patients who could be candidates for palliative care through data systems. There is a lack of education and awareness about palliative care by many providers. Creating a data system that identifies palliative care services could improve communication about the existence of services for patients, caregivers, and providers. This could reduce the number of providers who are unsure about the availability and/or benefits of palliative care services.

Virginia Association for Home Care and Hospice – Marcia A. Tetterton, Executive Director

The association conceptually supports option 2, to create a Palliative Care and Quality of Life Advisory Council, and indicates that additional details regarding its mission, vision and authority need to be comprehensively defined and the council membership should be consistent with the Palliative Care interdisciplinary team including Palliative Care consumers.

The association also conceptually supports option 3 to amend the Code of Virginia and add a separate definition of Palliative Care but expresses concern that this will lead to additional regulation, licensure and oversight in future years.

Palliative Care is a multidisciplinary approach of specialized care for people with chronic conditions. It is not a new concept in health care yet there is still confusion over what it is and the comfort it strives to provide. The need to educate health care professionals in the delivery of palliative care has never been greater. As all of health care strives toward delivery of person centered services it is essential that disciplinary silos be dropped and that the client or patient's quality of life drives goals of health care planning.

The association also offered an alternative option that the Virginia Department of Aging and Disability seek grant funding to develop professional and para professional education resources in collaboration with the Virginia Hospital and Health Care Association Palliative Care Forum and the Virginia Commonwealth University Department of Gerontology. According to the Association, the Department of Gerontology is broadening its focus to explore best practices around Palliative Care which is consistent in preparing a qualified workforce to promote optimal longevity. The resources obtained through this collaboration will be made available to academic, provider and consumer communities.

The Virginia Association for Hospices & Palliative Care – Brenda Clarkson, Executive Director

The association expressed disappointment on the information provided on slide 4 of the presentation, and notes that hospice provides an interdisciplinary team which, in addition to the nurses, includes physicians, social workers, chaplains, counselors, hospice aides to address the holistic needs of patients & families in addition to providing bereavement services to families after death of the patient. Hospice also provides all medications, medical equipment and supplies. Hospice is a comprehensive service provider not simply a visiting nurse service. *(Note: slide 4 was updated to include the information from this comment.)*

Virginia Hospital and Healthcare Association (VHHA) – R. Brent Rawlings, Vice President and General Counsel

VHHA notes that palliative care is an important component of health care services delivered to patients with chronic progressive illness.

VHHA supports Proposed Policy Option 4 that requires the Virginia Department of Health to create a website for palliative care information. "We agree with the JCHC's conclusion that there is currently no

central resource for the Commonwealth on the importance and availability of palliative care services for patients with chronic progressive illness.”

VHHA supports removing the amendment from HB 473 that requires licensed hospitals, nursing homes, and certified nursing facilities to identify and educate patients on palliative care services. The proposed language to identify and educate patients in this manner creates an undue burden on health care providers and raises a number of operational challenges and questions regarding how it could be implemented. VHHA’s preference is to allow policies to evolve over time in response to changes in best practices and evidence-based compassionate care. Finally, creation of a website to serve as a central resource for the Commonwealth on the importance and availability of palliative care services would provide the infrastructure needed for health care providers to provide patients with accurate and comprehensive information on palliative care.

VHHA currently does not support the recommendation to add a separate definition of palliative care into Virginia Code and states that it is unclear why such a change is needed. Further review of, and stakeholder input on, any proposed revisions to the definition of “palliative care” are necessary and appropriate before making any such changes.

Finally, while the creation of a Palliative Care and Quality of Life Advisory Council is a reasonable approach to establishing a website to provide education and information on the importance and availability of palliative care services, it does not appear to be necessary for this limited purpose. “VHHA currently operates a Palliative Care Forum, comprised of industry representatives from member hospitals and health systems across the state, as well as other stakeholders in the palliative care community. This group is a thought leader in the Commonwealth on this important issue and is available to facilitate and collaborate with other stakeholders for the purpose of advising the Virginia Department of Health on the creation of the website or to undertake evaluation of additional proposals to improve access to education and information on the importance and availability of palliative care services to help satisfy the positive and meaningful intentions of House Bill 473.”

Medical Society of Virginia (MSV) – Ralston King, Senior Director of Government Affairs; Lauren Bates-Rowe, Senior Director of Health Policy

The Medical Society of Virginia, on behalf of its 11,000 members, stated their support for removing the amendment from HB 473 that requires licensed hospitals, nursing homes, and certified nursing facilities to identify and educate patients on palliative care services. MSV agrees with the palliative care presentation that the lack of centralized information makes the process to locate providers for patients difficult, that the information currently available is inconsistent and often inaccurate and the amendment is premature.

MSV supports the creation of a website to act as a clearinghouse for information and education for both the general public and health care providers. MSV also agrees that the website should include a portal for providers with a directory of providers that can be contacted to help form palliative care teams.

MSV supports the creation of a statewide advisory council located within the Department of Health and made up of stakeholders capable of identifying components of an effective palliative care team, information helpful to the public and information helpful to providers. MSV agrees with the presentation that the council be expanded to 13 members to include hospice provider, nutritionist, hospital administrator, and representatives from a nursing home and certified nursing facility so that the council is more inclusive of all healthcare providers and representative of all interests in palliative care.

**Marissa C. Galicia-Castillo, MD, MEd, CMD, FACP, AGSF, FAAHPM - Sue Faulkner Scribner
Professor of Geriatrics; Section Head, Palliative Medicine, Eastern Virginia Medical School**

Dr. Galicia-Castillo writes in support of the advisory council. “As a Geriatrician and Palliative Medicine specialist, I have taken care of many patients who would have really benefited from more robust Palliative Care Medicine services. Caring for patients who are in the last chapter of their lives, we all know how the story will end. With Palliative Care Medicine, the hope is that we can make sure that their final chapter describes the best quality of life for the patient and their family. Palliative Care Medicine is so misunderstood not only by patients and families, but also physicians and health care providers who care for them. Having an Advisory Council is a wonderful first step if providing the best quality care for our patients and provides education for our medical professionals.”

Faith Havran, American Cancer Society Patient Navigator

Ms. Havran writes in support of option 2, the creation of an advisory council and website for palliative care with funding. As a patient navigator Ms. Havran’s role is to connect patients to supportive resources. She notes that she meets patients that travel significant distances to receive cancer and palliative care and the patients seek supportive services closer to where they live. A dedicated website with oversight from a Palliative Care and Quality of Life Advisory Council would be a very useful resource to her, patients and caregivers. A council and website will begin to bridge the gap in access to information and services that seek to improve the quality of life for cancer patients.

Debbie Chadick

Ms. Chadick urges support of option 2, the creation of a Palliative Care and Quality of Life Advisory Council and website with funding and asks that the opportunity to improve the quality of life of cancer patients and their families not be ignored.

Ms. Vicky L. Carr

Ms. Carr urges the Commission to “move forward with Option 2, create a Palliative Care Council tasked and funded to create a neutral website providing palliative care information to the general public.” Ms. Carr is a “recent survivor of a brain aneurysm and a 7 year survivor of a locally advanced poor prognosis cancer who for the past 5 years works with cancer patients on national cancer helplines and local Virginia organizations.” She “works with scores of patients each year living with metastatic cancer many of whom are also near the end of their life. I know the value of palliative care to all these individuals, yet I am often finding that most are unaware of what palliative care is, that it is available to them, that it can provide significantly increased quality of life, and how they can seek it out. Sadly, it’s been my experience that ... most doctors are not referring patients to palliative care, and even if they do, it’s often not until the patient is going on hospice. Very few patients are aware of it. For those who are, most confuse it with hospice care. Yet once they know about it, and are educated as to what it can do for them immediately, they always like it far better than their current treatment without it. So do their doctors, actually, after the fact – as their patient’s symptoms are better managed. With the limited time doctors can spend with patients at each visit, due to all the demands on their time, “early-enough” and “detailed-enough” education about palliative care for most patients just isn’t happening. And patient’s quality of life, and, as randomized clinical trials have shown, length-of-life, suffers significantly, way more than it needs to.”

Medical Care Provided in State Prisons – Study of the Costs

Stephen Weiss
Senior Health Policy Analyst

By letter to the JCHC Chair, Delegate Kory requested that the JCHC study or evaluate the costs to the state for prisoner medical care provided by the Commonwealth while inmates are incarcerated, especially costs for pharmaceutical products. The Study was approved by the JCHC members during the May 26, 2016 work plan meeting

Background

By law the Virginia Department of Corrections (VADOC) is required to provide adequate health care to incarcerated offenders (U.S. Const. Amend. VIII; §53.1-32, Code of Virginia). Adequate health care was defined by the United States Supreme Court beginning in 1976 (*Estelle v. Gamble*, 429 U.S. 97, 97 S.Ct. 285). The definition encompasses the idea of providing incarcerated offenders with a “community standard” of care that includes a full range of services. The courts identified three rights to health care for incarcerated offenders: the right to have access to care; the right to have care that is ordered by a health care professional; and the right to professional medical judgment.

On July 12, 2012 a class action lawsuit was filed in federal court against VADOC over medical care at Fluvanna Correctional Center for Women. The lawsuit was settled through a Memorandum of Understanding on November 25, 2014 that was approved by the court in February 2016. The agreement includes the hiring of a compliance monitor and continued court supervision of the agreement.

The agreement reached between VADOC and the plaintiffs at Fluvanna is comprehensive and involves all aspects of the health care system, including mental health. Some of the issues the agreement addressed include: timely access to care and treatment; the following of national clinical guidelines for treatments and medical testing; admission and discharge planning; quality improvement compliance, security and treatment of pregnant women; accommodations for prisoners with special needs; and, compliance with the Americans with Disability Act (ADA).

Brief Description of the VADOC Health Care System

VADOC is responsible for over 30,000 incarcerated offenders on any given day in 46 prison facilities. Each prison provides health care services to incarcerated offenders and the level of health care depends on the facility. Because inmates are transferred around the system, comparing one facility to another is difficult.

VADOC’s health care system for incarcerated offenders is a combination of state run and privately contracted services. VADOC provides health care services to offenders in thirty state prisons which include half of the offender population. The other half of the prison population receives health care services from Armor Correctional Health Services (fourteen state prisons that include the four infirmaries), Mediko Correctional Health Care (two state prisons), and the GEO Group (one state prison) within the context of its overall private prison contract.

Offenders with complex health care needs are transported offsite to physicians, specialists, and community hospitals, including Virginia Commonwealth University’s medical center. VADOC contracts with Anthem Blue Cross Blue Shield to act as the third party administrator for all offsite health care claims.

VADOC contracts with Diamond Pharmacy Services for all pharmaceutical products for the thirty state prisons it operates. Armor and Mediko also contract with Diamond for pharmaceutical products for the state prisons where they provide health care services.

High cost pharmacy products for three specific diseases are carved out of the pharmacy contracts and provided to VADOC through the VCU 340B drug purchasing program. The diseases are HIV, Hepatitis C and hemophilia.

Finally, hospitals submit claims to the Department of Medical Assistance Services (DMAS) directly for offenders that are admitted to a hospital as inpatient for twenty-four hours or more who qualify for Medicaid.

Findings

Overview of Management Information

VADOC does not have comprehensive management tools available to monitor or accurately project health care costs. As a result, the findings in this report are based on a consolidation of information from the department and some of its vendors.

The department does not have electronic health records and cannot provide a profile of inmate health care issues. In addition, there are no routine multi-year trend analysis reports of health expenditures and reports are generated only upon request.

According to VADOC, Armor, Mediko and Geo do not share their pharmacy contractual pricing with the state – claiming the information is proprietary. As a result, under the current system, VADOC does not know if the prisons operated by Armor, Mediko or GEO are getting the best prices for the pharmacy products they purchase.

The contracts with vendors for health care services are established by facility, with each facility having its own per-member-per month capitated payment. VADOC does not generate benchmark prices that can be used for comparative purposes to insure that the Commonwealth is receiving a fair price for the services it receives from the vendors.

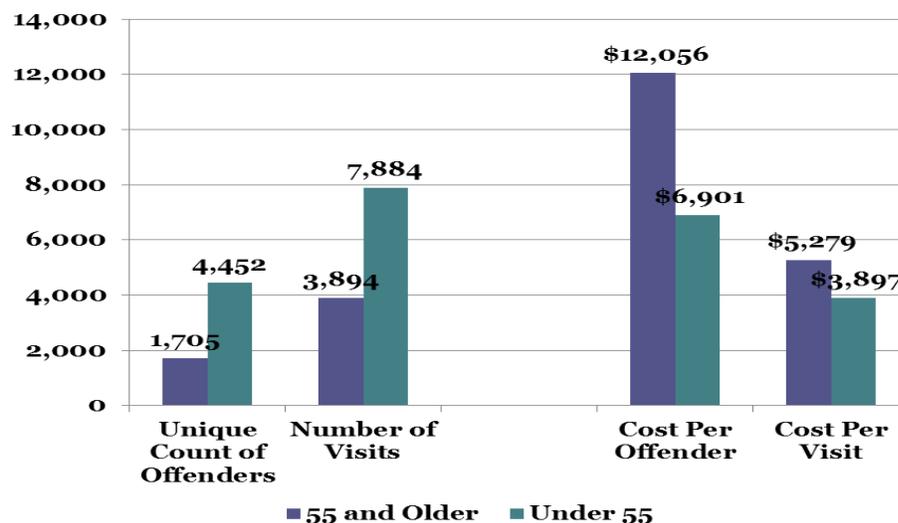
Offender Profile and Expenditures

A review of data provided by VADOC indicates that the offender population is aging in the state prison system. The percent of offenders aged 55 and over grew from 9.8 percent in the fourth quarter of 2012 to 12.2 percent in the fourth quarter of 2015. The data indicate that while the percent of offenders reporting alcohol use remains steady at approximately 65 percent, the number of offenders reporting drug use has grown from 35.1 to 42.9 percent. Finally, offenders screened for mental health issues grew from 22.8 to 26.0 percent.

Pharmacy reports provided to VADOC from Diamond for the offenders VADOC provides health services to reflect the health issues associated the demographics of the offender population. The top six prescriptions filled for the offenders by therapeutic class include drugs for cardiac disease, psychotropic medications and diabetes. The amount spent by therapeutic class on the top seven drugs prescribed to the VADOC offenders include bio-immuno drugs for cancer treatment, psychotropic drugs and drugs for cardiac disease.

A claims analysis performed by Anthem on the 6,157 offenders treated offsite by hospitals in 2016 found that 28 percent were aged 55 and over. These offenders accounted for 40 percent of the \$51.3 million spent on offsite inpatient or outpatient hospital care. The Anthem analysis also found that the cost per offender for those aged 55 and over was \$12,056 compared to \$6,901 for those under age 55.

**Anthem BCBS
Claims Based Utilization Report
Off Prison Site Hospital Analysis
(April 1, 2015 through March 31, 2016)**



Anthem's analysis also found that 179 offenders, or 2.9 percent of the 8,317 offenders cared for offsite by all providers, accounted for 46.8 percent of the \$62.4 million for all offsite health care spending. The primary health condition for half of these offenders was identified as either cardiac disease or cancer.

Spending on

Incarcerated Offender Health Care Services:

Virginia Compared to Other States

In SFY-2016 VADOC spent 16 percent of its \$1.2 billion budget on health care services. To compare Virginia to the other states, reports from the federal Bureau of Justice Statistics and the Pew Charitable Trusts were combined using the most current data available, 2011. *

Rank by % of Prison Health Spending	State	State Prison Spending 2011	Prison Health Care Spending 2011	Percent Spent on Health Care
1	California	\$8,528,335,000	\$2,137,045,000	25.1%
2	Missouri	\$683,665,000	\$142,988,000	20.9%
3	New Hampshire	\$112,666,000	\$23,564,000	20.9%
4	Mississippi	\$309,694,000	\$64,575,000	20.9%
5	Michigan	\$1,625,653,000	\$330,400,000	20.3%
6	Ohio	\$1,452,841,000	\$279,716,000	19.3%
7	Alabama	\$531,700,000	\$97,266,000	18.3%
8	North Carolina	\$1,420,666,000	\$255,125,000	18.0%
9	Delaware	\$266,666,000	\$46,094,000	17.3%
10	Nevada	\$270,381,000	\$46,593,000	17.2%
33	Virginia	\$1,193,345,000	\$149,850,000	12.6%
41	Colorado	\$871,379,000	\$102,355,000	11.7%
42	Iowa	\$329,694,000	\$38,001,000	11.5%
43	Maryland	\$1,364,884,000	\$147,856,000	10.8%
44	Rhode Island	\$181,796,000	\$19,364,000	10.7%
45	New Jersey	\$1,408,614,000	\$141,752,000	10.1%
46	Utah	\$297,609,000	\$29,529,000	9.9%
47	Illinois	\$1,513,117,000	\$144,039,000	9.5%
48	Massachusetts	\$1,050,827,000	\$95,348,000	9.1%
49	West Virginia	\$269,308,000	\$23,150,000	8.6%
50	North Dakota	\$87,671,000	\$6,350,000	7.2%
	National Average	\$46,711,103,000	\$7,679,772,001	16.4%

* For State prison spending: Kyckelhahn, Tracey. 2011. *Bureau of Justice Statistics - Justice Expenditure and Employment*. Bureau of Justice Statistics. July 1, 2014. (NCJ 247020).

<http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5050>

For prison health care spending: Pew Charitable Trust State Prison Health Care Spending July 2014, Page 19 and 21 Appendix C. <http://www.pewtrusts.org/en/research-and-analysis/reports/2014/07/08/state-prison-health-care-spending>

Other Studies of VADOC Health Care Spending

There have been three studies specifically related to VADOC health care spending and one related to high cost drugs purchased for the Commonwealth, which includes a review of VADOC's pharmacy purchasing practices. The studies are as follows:

- Report on Costs and Benefits of Current Inmate Health Care System compared to Alternative Care Management Models; 2015 Budget Bill CH 665; Item 384.P.1.
- Report on Costs and Benefits of Current Inmate Health Care System compared to alternative Care Management Models; 2015 Budget Bill CH 665; Item 384.P. and 2016 Appropriation, CH 780; Item 393.N.
- Multi Cabinet Review of High Cost Drug Purchases; 2016 Appropriation; CH 780, Item 284.B.
- Modernization of Current Data and Record Keeping Systems; 2016 Appropriation; CH 780, Item 394. A.

Conclusions and Policy Options

VADOC is legally responsible for providing health care services to all incarcerated offenders in the state prison system whether the prison health care services are provided by a vendor or by the state directly. While health care represents approximately 16 percent of the VADOC expenditures, costs in certain areas, such as pharmacy, have been rising. Some of the increases are due to the introduction of new prescription drugs while other health care cost increases are due to a changing prison population. The system has more offenders with mental health and substance abuse issues now than it had five years ago. There is a growing incarcerated population of elderly offenders, and their health care needs are changing much the same as the health needs of the elderly general population. VADOC can control health care costs by managing offender health care within the system through the expansion, implementation and more thorough monitoring of offender disease management programs and pharmacy management programs.

Finally, the costs of health care in the prison system need to be carefully monitored and better management tools need to be developed. The Fluvanna settlement has the potential of driving up the cost of health care in the prison system, and any efforts made by VADOC to manage those changes will be beneficial in controlling costs and complying with the settlement agreement.

One comment was received from:

- Jill A Hanken, Health Attorney, Virginia Poverty Law Center on behalf of the VPLC and the Healthcare for All Virginians (HAV) Coalition

Policy Options

Option 1: Take no action.

~~16-0~~ Option 2. *Request by letter of the JCHC Chair that ~~Introduce legislation to amend Chapter 53.1-32 of the Virginia Code to require~~ the Department of Corrections to prepare and submit an annual report to the Governor and the General Assembly detailing the operations and expenditures for the entire state prison system's health care system. The report should include trend analysis of expenditures, trend analysis of the prison population including disease and illness profiles, new programs and services implemented and future plans. Require the Department to report back to the Commission with results of its efforts by October, 2017.*

~~16-0~~ Option 3. *Request by letter of the JCHC Chair that ~~Introduce legislation to amend Chapter 53.1-32 of the Virginia Code to require~~ the Department of Corrections to implement disease management programs within all of the department's facilities for diseases where there are established best practice models available. The department should explore the opportunity of establishing a comprehensive peer-to-peer program for incarcerated offenders where offenders can assist each other in managing their illnesses. Require the Department to report back to the Commission with results of its efforts by October, 2017.*

~~16-0~~ Option 4. *Request by letter of the JCHC Chair that ~~Introduce legislation to amend Chapter 53.1-32 of the Virginia Code to require~~ the Department of Corrections to hire an independent actuary to annually establish per-member-per-month benchmark reimbursement rates for inmates where the health care is provided by a vendor. Require the Department to report back to the Commission with results of its efforts by October, 2017.*

~~16-0~~ Option 5. *Request by letter of the JCHC Chair that the Department of Corrections explore all opportunities to partner with the Department of Behavioral Health and Development Services and VCUHS for the purchasing of pharmaceutical products through the multi-state purchasing agreements already in place and/or through the use and expansion of the 340B program. Require the Department to report back to the Commission with results of its efforts by October 1, 2017.*

Public Comment Excerpt

Jill A. Hanken, Health Attorney, Virginia Poverty Law Center and Healthcare for All Virginians

Ms. Hanken wrote on behalf of the Virginia Poverty Law Center and also on behalf of the Healthcare for All Virginians Coalition (HAV). The HAV coalition is comprised of over 100 Virginia organizations (see below).

The JCHC's comprehensive review of prison health care costs has one glaring omission. It fails to discuss in any way how Medicaid is currently used for a small amount of prison medical costs, and it ignores the possible impact of expanding Medicaid coverage to more low-income, uninsured adults – some of whom are justice involved. The opportunities to use Medicaid funding for the justice involved population should have been fully evaluated by the JCHC. We believe another policy option should be presented – namely – “Expand Medicaid Coverage to low-income, uninsured adults”.

The JCHC should review the recent report from the Center for Health Care Strategies and the Milbank Memorial Fund, on “Coordinating Access to Services for Justice-Involved Populations”.

<http://www.chcs.org/resource/coordinating-access-services-justice-involved-populations>

Here is a short description of the paper:

“States that expanded Medicaid coverage under the Affordable Care Act have unprecedented opportunities to connect adults released from prison or jail with needed physical and behavioral health services and social supports. This population – disproportionately male, minority, and poor – suffers from high rates of mental illness and substance use disorders. Providing critical health services and social supports for these individuals can potentially slow the revolving door of recidivism plaguing the justice system and reduce avoidable health care costs.”

Ms. Hanken’s writes that Virginia can and should use the opportunities provided through Medicaid to address many of the challenges in our mental health and criminal justice systems. She notes that the CHCS paper provides excellent information about potential strategies and projects in other states that more effectively and efficiently serve the mental health needs of the justice involved population.

Ms. Hanken’s notes that the Medicaid expansion would greatly assist both jails and prisons and points out that many of the people served in prisons are uninsured in the community and – because of that - they are unable to access needed medical services to treat chronic conditions, mental health and SUD problems. “For many, these untreated medical needs directly lead to their entanglement with criminal justice. With Medicaid expansion, hundreds of thousands of Virginians would gain access to health care. Some with mental health and substance use disorders could avoid criminal activity and incarceration. Moreover, there are very significant state and local financial savings to be gained by expanding Medicaid. For example, there could be Medicaid reimbursement for (1) jail inmates who require hospital care (which is now limited to those who meet current, restrictive Medicaid eligibility rules which cover only disabled, elderly and pregnant inmates) This alone could save about \$20 million/year; (2) transportation to medically necessary services; and (3) necessary medical and pharmacy services before and after incarceration. For example, people could leave prison with an insurance card, and that would greatly assist in their successful transition/reentry efforts.”

Organizational Members of HAV Coalition	
AARP Virginia	Mental Health America of Virginia
Adams Compassionate Healthcare Network	Mental Health America-New River Valley
Aloha Health, LLC	National Alliance on Mental Illness of Virginia
American Association of University Women of Virginia	National Assn. of Social Workers – Virginia Chapter
American Cancer Society – Cancer Action Network	National Multiple Sclerosis Society
American Heart Association	National Osteoporosis Awareness Health (NOAH) Project USA
Arlington County	National Physicians Alliance – Virginia
Arlington Free Clinic	New Virginia Majority
Blue Ridge Independent Living Center	Northern Virginia Family Service
Boehringer Ingelheim Pharmaceuticals	NOVA ScriptsCentral
Bon Secours Virginia	Nueva Vida
Brain Injury Association of Virginia	Otsuka America Pharmaceuticals, Inc.
Celebrate Healthcare	Patient Services, Inc.
Central Virginia Health Services	Parents as Teachers State Office
Chesapeake Care, Inc.	Partnership for People with Disabilities at VCU
CHIP of Virginia	Piedmont Access to Health Services, Inc. (PATHS)
City of Alexandria	Piedmont Regional Dental Clinic

Organizational Members of HAV Coalition	
Cornerstones, Inc.	Planned Parenthood Advocates of Virginia
Coverage Counts	Prevent Child Abuse Hampton Roads
Delta Sigma Theta Sorority, Inc. Virginia Beach Alumnae Chapter	Prevent Child Abuse Virginia
Independence Center	ProgressVA
FACETS	Rappahannock Legal Services, Inc.
Free Clinic of the New River Valley	Rappahannock United Way, Inc.
Gloucester-Mathews Free Clinic	Richmond Orthopedics
Greater Prince William Community Health Center	Rx Partnership
Greene Care Clinic	SEIU – Virginia 512
HealthWorks for Northern Virginia	Social Action Linking Together (SALT)
Health Brigade	The Arc of Virginia
H.E.A.L.T.H. NOW, Virginia	The Commonwealth Institute for Fiscal Analysis
Hemophilia Assn. of the Capital Area	The Women's Initiative
Inova Health System	VCU – American Medical Student Association
Instructive Visiting Nurse Assn. (IVNA)	Virginia Adult Day Health Services Association
Jewish Community Relations Council of Greater Washington	Virginia AFL-CIO
League of Women Voters of Virginia	Virginia Association of Area Agencies on Aging
League of Women Voters, Richmond Metro Area	Virginia Association of Centers for Independent Living
Legal Aid Justice Center	Virginia Association of Community Psychiatric Nurses
Legislative Coalition of Virginia Nurses	Virginia Association of Community Services Boards
Leukemia & Lymphoma Society	Virginia Association of Free and Charitable Clinics

Development of Life-Sustaining Treatment Guidelines

Andrew Mitchell
Senior Health Policy Analyst

Study Mandate

Virginia Code §54.1-2990 regulates physician actions if a physician refuses to provide health care requested by/for a patient because the physician determines the requested treatment to be medically or ethically inappropriate. However, while the Code provides a 14-day timeframe for transferring the patient to a different provider in cases of unresolved conflict, §54.1-2990 does not address situations in which 14 days pass and the conflict remains unresolved and/or the patient is unable to be transferred. During the 2015 General Assembly, Delegate Stolle introduced HB 2153 to amend §54.1-2990 to include the language that “the physician may cease to provide care that he has determined to be medically or ethically inappropriate.” HB 2153 was tabled in the House Health, Welfare and Institutions Committee by voice vote, and in 2016, Delegate Stolle requested that the JCHC study the current legal and regulatory environment on life-prolonging care, focusing on: legal/regulatory requirements regarding disagreements over medical appropriateness of life-prolonging care; how other States address this issue, including how patients can pursue desired treatments and how providers are protected from providing medically inappropriate treatment; and recommendations for legislative changes clarifying actions after the current legal time period for patient transfer (14 days) has passed and the patient is unable to be transferred.

Background

When a patient is in need of life-sustaining treatment to remain alive, treatment decision-making conflicts between patients – or, as in almost all cases involving life-sustaining treatment decisions, an incapacitated patient’s agent – and providers are not uncommon. One driver of treatment decision making conflict occurs if a patient/patient’s agent requests life-sustaining treatment(s) that a physician believes to be inappropriate. While a patient’s/patient’s agent’s right to refuse treatment options offered by clinicians is well-established in common law, Constitutional law and statutory documents, a patient’s/patient’s agent’s right to demand any available treatment has not been similarly established. As a result, treatment decision conflicts are thought to arise in up to 50% of the Intensive Care Unit (ICU) setting admissions and are regularly identified as the single biggest ethical dilemma facing North American hospitals.

Many physicians and health care institutions follow a number of process steps to prevent treatment decision conflicts before they occur, such as through clarifying goals with patients, or resolving conflicts once they arise, such as by convening ethics committee consultations, obtaining additional medical opinions and/or engaging institutional resources (e.g., palliative care specialists; patient advocates). While it is estimated that consensus is reached in the vast majority (over 95%) of cases of treatment decision conflict, many hospital and physician stakeholders in Virginia have expressed a desire for greater clarity in allowable physician actions for the minority of cases that remain unresolved.

Virginia’s Health Care Decisions Act in Comparison to other States’ Statutes Governing Health Care Decisions

Virginia’s “Health Care Decisions Act” (§§54.1-2981-2993) regulates several aspects of patient decision making relevant to this study, including procedures relating to Advance Directives (e.g. their construction, form, and revocation), duties/authorities of a patient’s agent as well as physicians, procedures if a physician refuses to honor an Advance Directive or health care decision, judicial review of decisions, and immunities. While the Health Care Decisions Act applies to any treatment decision, it is particularly relevant in the context of life-sustaining treatment decisions.

Under the Health Care Decisions Act, Virginia is one of 15 States that allows physicians/facilities to decline to follow health care directives for treatments that would be medically ineffective, inappropriate and/or contrary to generally accepted health care standards. Eleven of the 15 States, including Virginia, do not define “medically” or “ethically” inappropriate treatment. Virginia is also one of the majority of States that specifies only two basic process measures to resolve treatment decision conflicts that may result: the physician must make a reasonable effort to inform the patient of reasons for refusing to provide treatment (32 States) and transfer the patient to another physician (46 States) – and one of 25 States to explicitly mandate continued provision of requested life-sustaining treatment while a transfer is sought. However, similar to most other States, if a transfer is unable to be effected, Virginia Code does not directly address allowable provider actions or legal consequences for withdrawing/withholding requested treatment. By contrast, three States permit a physician to refuse to provide treatment if transfer is unsuccessful – either unconditionally or if certain process measures are taken – while one State takes the opposite track by mandating continued provision of requested treatment if transfer is unsuccessful.

The following are three other aspects of health care decisions relevant to treatment decision making conflicts:

1. Artificially administered nutrition and hydration: Even though artificially administered nutrition and hydration is considered by the medical practice and in case law to be equivalent to any medical treatment, it is often viewed by the general public as different from other medical treatments, requiring different or specific standards regulating its use. Virginia is one of 18 States to include artificially administered nutrition and hydration in its definition of life-sustaining care, compared to 4 States that exclude artificially administered nutrition and hydration from their definition and 18 States that do not reference artificially administered nutrition and hydration one way or the other. Three States mandate continued provision of artificially administered nutrition and hydration throughout a treatment decision conflict resolution process, while the remainder of States (including Virginia) do not specifically reference artificially administered nutrition and hydration.
2. Judicial recourse/review of physician treatment decisions: Virginia is one of 15 States to identify a process for judicial recourse/review specific to the context of care provided under the Health Care Decisions Act, compared to 23 States that do not explicitly reference a process. Virginia is not one of six States to identify a judicial review process specific to the context of treatment decision conflict/patient transfers.
3. Non-discrimination in physician treatment decisions: Some stakeholders in Virginia and nationally have concerns that clinician determination of appropriateness of life-sustaining treatment will discriminate against vulnerable populations, such as the disabled or elderly, by placing a lower valuation on expected benefits for those patients and/or a higher valuation on expected repercussions/ineffectiveness compared to other patients. There are four States, not including Virginia, that reference non-discrimination or disabilities in the context of life-sustaining treatment.

The Texas Advance Directives Act is the most detailed and comprehensive State Statute to address treatment decision conflicts between patients and physicians and an instructive model to inform potential revisions to Virginia Statute. Originally enacted in 1999, its primary features are standardized facility-level conflict resolution processes, including: review of physician decision by third-party ethics or medical committee; provision of information on the decision review process (written description, advance notice of meeting time, copy of registry list of providers willing to accept transfer/assist in locating provider); patient/patient agent’s entitlements (attend review meeting, receive written explanation of

decision/relevant portion of medical record); facility role in attempting patient transfer (“reasonable effort”) and required health care pending transfer (life sustaining treatment, comfort care); patient responsibility for costs of transfer; ability of physician/health facility to cease life-sustaining treatment after 10 days, with exception of artificially administered nutrition/hydration considered ordinary care (exceptions specified for cases of artificially administered nutrition/hydration considered extraordinary care); judicial review of physician decision is limited to extending the 10-day time period if there is a “reasonable expectation” that another physician/facility will accept the patient and honor the treatment request; and exclusion of home and community support services facilities from conflict resolution process/requirements.

Recommendations

A stakeholder Working Group – with participation from 27 organizations representing patients/consumers, providers/health systems, and State agencies – was convened to generate recommendations for revisions to Virginia Code. Based on Working Group input, seven recommendations were made for “minimalist” revisions within Virginia Code §54.1-2990 to address treatment decision conflict resolution (see Appendix for recommended draft legislative revisions), and one additional non-Statute recommendation focusing on prevention of treatment decision conflicts. The eight recommendations were:

Recommendation	Notes/Rationale
1. Require hospitals to maintain written policies on life-sustaining treatment decision conflict resolution procedures	<ul style="list-style-type: none"> ▪ Transparency in facility-level policies will heighten ability of clinicians, patients/patients’ agents and facilities to more effectively resolve conflicts ▪ The vast majority of situations of life-sustaining treatment decision conflict take place in the hospital setting, while ability of other institutions to fulfill this (and other) recommendations varies widely
2. Require hospitals to take standard minimum steps in cases of life-sustaining treatment decision conflict: <ul style="list-style-type: none"> • Second medical opinion • Interdisciplinary medical review committee review of physician determination • Patient / agent / decision-maker to participate in review meeting • Written explanation of review meeting decision included in the patient’s medical record 	<ul style="list-style-type: none"> ▪ Process standardization balanced with implementation flexibility
3. Provide qualified permission to physician to cease inappropriate treatment after 14 days: <ul style="list-style-type: none"> • ≥ 14 days after documentation of physician’s decision in medical record to effect transfer • Mandate physician reasonable effort to effect / facilitate transfer 	<ul style="list-style-type: none"> ▪ Clarity in legally permissible actions after 14 days emphasized by many working group stakeholders as a key aspect ▪ Many Working Group participants stressed importance of additional safeguards related to provision of artificial nutrition and hydration

Recommendation	Notes/Rationale
<ul style="list-style-type: none"> If transfer not effected, physician may cease to provide treatment if hospital policies/steps under recommendations 1 and 2 have been followed, except for: 1) most cases of artificially administered nutrition/hydration; and 2) comfort care 	
4. Provide physician immunity when requirements are followed	<ul style="list-style-type: none"> Ensures that physicians/hospitals are legally indemnified for ceasing treatment if mandated processes have been followed in accordance with medical standard of care
5. Stipulate that all actions under this section must conform to federal non-discrimination standards	<ul style="list-style-type: none"> Provides additional protection to vulnerable populations and alignment with national-level norms
6. Revise “life-sustaining care” term and definition: <ul style="list-style-type: none"> Replace “care” with “treatment” Eliminate examples (hydration, nutrition, maintenance medication, CPR) 	<ul style="list-style-type: none"> “Care” is broader than medical “treatment”; revising to “treatment” eliminates potential misinterpretation / misapplication of recommendations Under certain circumstances, examples specified in current language (e.g., hydration, nutrition) may be considered appropriate or inappropriate life-sustaining treatment; eliminating examples recognizes that specificities of a particular case need to guide application of § 54.1-2990 in practice
7. Eliminate Durable Do Not Resuscitate Orders from applicable documents within § 54.1-2990	<ul style="list-style-type: none"> Addition of Durable DNR (1999) is inconsistent with § 54.1-2990 that addresses situations of physician refusal to provide medically/ethically inappropriate treatment. Durable DNRs address situations in which treatment is <u>not</u> desired.
8. Form working group to study health care decisions more broadly, focused on preventing/improving resolution of treatment decision conflicts	<ul style="list-style-type: none"> Leverage working group formed for study to focus on recommendations/policy options for preventing and improving outcomes of treatment decision conflict

Policy options (listed below) directly reflect the 8 recommendations.

Policy Options and Public Comment

Comments were received from 13 individuals regarding the policy options and recommendations for the development of life-sustaining treatment guidelines. Comments were submitted by:

- **John Ayres**, General Counsel, Virginia Trial Lawyers Association (VTLA)
- **John/Mary Cannarella**, residents of Virginia
- **Jeff Caruso**, Executive Director, Virginia Catholic Conference
- **Chris Freund**, Vice President, Government Relations and Communications, The Family Foundation of Virginia

- **Maureen Hollowell**, Advocacy Coordinator, Virginia Association of Centers for Independent Living (VACIL)
- **Douglas LeBlanc**, resident of Virginia
- **Sandra D. Mahanes**, resident of Virginia
- **V. Colleen Miller**, Executive Director, disAbility Law Center of Virginia
- **Thaddeus Pope**, PhD/JD, Director of the Health Law Institute, Professor of Law, Mitchell Hamline School of Law, citizen
- **Teresa Radford**, resident of Virginia
- **R. Brent Rawlings**, Virginia Hospital and Healthcare Association (VHHA)
- **Kurt Schuler**, resident of Virginia
- **Robert M. Veatch**, Professor of Medical Ethics, Georgetown University, resident of Virginia

Policy Option	Stakeholder position:	
	In Support	Other
1. Take No Action	<ul style="list-style-type: none"> ▪ John/Mary Cannarella ▪ The disAbility Law Center of Virginia ▪ VACIL 	
Introduce legislation to amend § 54.1-2990 of the Code of Virginia to:		
2a. (Recommendations #1 and 2) Add requirement for written hospital policies on life-sustaining treatment decision conflict resolution and specify minimum steps to be taken by hospitals in cases of life-sustaining treatment decision conflict (also amend section § 32.1-127 as applicable)	<ul style="list-style-type: none"> ▪ Ms. Mahanes ▪ VHHA 	
2b. (Recommendations #3 and 4) Provide qualified permission to physician to cease inappropriate treatment after 14 days and add statement of physician immunity for following requirements	<ul style="list-style-type: none"> ▪ Ms. Mahanes ▪ VHHA 	<ul style="list-style-type: none"> ▪ Mr. and Mrs. Cannarella: extend the time provided in the statute from fourteen days to at least thirty ▪ Mr. Pope: process safeguards are not sufficient ▪ Mr. Schuler: mandate continued provision of requested treatment if transfer is unsuccessful ▪ Mr. Veatch: opposes Recommendation #3 (“Provide qualified permission to physician to cease inappropriate treatment after 14 days”) ▪ Virginia Catholic Conference; The Family Foundation of Virginia: clarify that artificially

Policy Option	Stakeholder position:	
	In Support	Other
		administered food and water be recognized as ordinary care; concerns about/request clarity in when 14-day window begins <ul style="list-style-type: none"> ▪ Virginia Trial Lawyers Association: opposes Recommendation #4 (statement of physician immunity)
2c. (Recommendation #5) Add stipulation that all actions under this section must conform to federal non-discrimination standards	▪ Ms. Mahanes	▪ VHHA: provision unnecessary
2d. (Recommendation #6) Revise “life-sustaining care” term and definition	▪ Ms. Mahanes	
2e. (Recommendation #7) Eliminate Durable Do Not Resuscitate Orders from applicable documents within § 54.1-2990	<ul style="list-style-type: none"> ▪ Ms. Mahanes ▪ Ms. Radford: Replace “DNR” with “Allow Natural Death” 	
<input checked="" type="checkbox"/> 15-1 3. (Recommendation #8) Include in the 2017 JCHC work plan that staff form a work group to study health care decisions more broadly, focused on preventing/improving outcomes of treatment decision conflict in Virginia, and report back to the JCHC in 2017	<ul style="list-style-type: none"> ▪ Ms. Mahanes ▪ VHHA 	

Public Comment Excerpts

John Ayres, on behalf of the Virginia Trial Lawyers Association

“VTLA was not invited, and thus did not participate, in any of the working group meetings for the issue over the summer... We do not believe that [recommendation #4 which provides full immunity to healthcare providers from civil, criminal and professionalism/ethics claims] would have received “broad support” from this working group if we had been in the room for the discussion...

The many recommendations provided by the working group do an excellent job of laying the foundation for the “standard of care” to be followed by healthcare providers in these situations. If the healthcare provider follows these standard of care guidelines, then there is nothing to fear because they didn’t do anything wrong/negligent...

Immunity is the equivalent of “special dispensation” or a permanent “stay out of court” card for wrongdoers. It gives them the power to act negligently without regard to public safety or health, with no fear of accountability.”

John/Mary Cannarella

“We do not support the proposals..., which put the lives and well-being of vulnerable and severely disabled patients at risk of being denied treatment due to their physical ability. We also urge that the Commission extend the time provided in the statute from fourteen days to at least thirty, so that a patient or his or her family might have sufficient time to find other caregivers.”

Jeff Caruso, on behalf of the Virginia Catholic Conference

“We continue to favor strongly the inclusion of language to clearly specify that artificially administered food and water be recognized as ordinary care that is due, in principle, to all people (except in extreme cases when providing it would harm the patient or hasten the patient’s death). If legislation is introduced, we will be especially interested in the presence and clarity of such language... I [also] have concerns about the 14-day clock starting before a second opinion has been rendered and before a medical review committee has also determined the treatment to be inappropriate.”

Chris Freund, on behalf of The Family Foundation

“1) We would urge that language making it very clear that artificially administered food and water be recognized as ordinary care, with the possible exception of extreme cases when providing it would harm the patient or hasten the patient’s death, be included in any proposed legislation, similar to the Oklahoma statute that deals with this issue...

2) We would urge that there be a very clear denunciation of when the 14 day period begins, preferably after the second opinion has been provided and that the patient's family/surrogate be made aware that the 14 day period in which they must find alternative care has begun...

3) We would urge that language be included that makes it clear to the patient's family/surrogate that they have right to legal representation throughout the process and have legal options outside of the hospital policy.”

Maureen Hollowell, on behalf of the Virginia Association of Centers for Independent Living

“The Virginia Association of Centers for Independent Living appreciates the opportunity to have participated in the working group that discussed life-sustaining treatment. The experience reinforces our concerns that existing statute (54.1-2990) could have catastrophic consequences for people with disabilities who are receiving treatment that their physician determines to be no longer medically or ethically appropriate...”

This was a study of how physicians could end life sustaining medical treatment when the physician’s intent is contrary to the individual’s advance directive or decision of their surrogate. This is not about assisted suicide. Just the opposite – the individual is seeking to live, either by their predetermined directive or decision of their surrogate...

VACIL strongly objects to recommendation #3. Allowing the physician to end treatment in conflict with an advance directive or decision of a legal surrogate is inappropriate. When these two facts are in conflict – 1. physician elects to end treatment and 2. the individual desires the treatment, and the treatment either has to end or has to be provided, ending life should not be the default.”

Douglas LeBlanc

“I wish to express my distress that the Commission may give greater power to non-family members in determining whether a person is removed from life-sustaining treatment.

Such a policy would show a deep disregard for our Commonwealth’s rich history of freedom, and not least of religious freedom. To compel family members to hand over the ultimate decisions about their loved ones’ treatment to a bioethics committee is a heartless gesture, and it will lead to an increased crassness in medical care for people in great need.”

Sandra D. Mahanes

“By requiring structured processes and transparency, these actions protect the interests of patients and families while supporting the clinicians who provide care in circumstances involving treatment conflict. Qualified permission to cease that treatment after 14 days also protects both the dignity and comfort of the patient and the moral integrity of the care providers. Stipulating that all actions must conform to federal non-discrimination standards provides additional protection for patients and families, and the other recommendations add clarity to the legislation...

In addition, I support the formation of a work group to study health care decisions more broadly, focused on preventing and improving outcomes of treatment decision conflict in Virginia, as part of the JCHC 2017 work plan. Such a work group could perhaps identify effective practices with the potential to decrease the impact of treatment conflict on patients, families, and health care providers in Virginia.”

V. Colleen Miller, on behalf of the disAbility Law Center of Virginia

“Current Virginia law does not afford adequate protection for people with disabilities, especially those living in more rural communities who may not have access to alternate health providers. People whose disabilities present as complex medical needs may be faced with medical providers who make “quality of life” decisions based on the person’s disability. If there is no other medical provider within that person’s community, the doctor’s decision is final and irrevocable...

We oppose any changes to the law that make it easier for medical professionals to exercise “ethical” judgments about the value of the life of a person with a complex disability.”

Thaddeus Pope, Director of the Health Law Institute, Professor of Law, Mitchell Hamline School of Law

“The proposed revisions offer legal immunity so long as the treating clinicians wait the 14 day period and follow “key process-focused safeguards.” But as now specified, the process safeguards are not sufficient. The ultimate decision maker is the hospital’s own “review committee.” That committee does not have the requisite neutrality and independence.”

Teresa Radford

“I have worked full time as a RN for 35 years in a variety of outpatient, inpatient and home health care settings. For the past 14 years I have had the privilege of working on an acute care unit in a top tier tertiary care hospital in Virginia. One of the most challenging situations I experience is assisting patients and care partners to complete health care planning, especially as it relates to decisions surrounding life sustaining treatments and end of life scenarios. I strongly support efforts to clarify and provide comprehensive guidelines on these difficult topics. I recommend consideration of language revisions to

eliminate "DNR" and replace with alternative "Allow Natural Death" which I believe will help transition our health care culture to one that will benefit patients, care partners and health care professionals alike.

Kurt Schuler

“I urge that Virginia follow Florida in mandating continued provision of requested treatment if transfer is unsuccessful, and to reject the paths taken by Arkansas, Tennessee, and Texas permitting physicians to refuse to provide treatment if transfer is unsuccessful....

Medical staff should not judge for patients whether the patients' lives are worth living. Except when a patient (or in certain circumstances, his next of kin) has indicated that he wishes to cease life-sustaining treatment or, if unconscious, has an advance directive to that effect, he should not be left to die by withholding life-sustaining care.”

Robert Veatch, Professor of Medical Ethics, Kennedy Institute of Ethics, Georgetown University

“Recommendation 3 of the proposed law would permit physicians in an ongoing relationship with a patient to refuse to provide desired and effective life-support against the deeply held religious, philosophical, or cultural beliefs of some of the state’s citizens. It would permit a physician to unnecessarily impose death on a patient when the treatment would reasonably be effective in achieving the goal of the patient or surrogate, when no burdens on others are produced, when the patient will not suffer beyond what a competent patient has accepted, and when the provider is a licensed professional with duties imposed by the state to use medical services in the public interest when patients desire those services. Federal case law applied in the Commonwealth of Virginia [Baby K case] has found such treatments are required.”

R. Brent Rawlings, on behalf of the Virginia Hospital and Healthcare Association

Legislative changes to Va. Code § 54.1-2990 are needed to address the unfortunate circumstances that arise in providing care at the end of life in a way that balances the need to ensure dignity and respect for patients and their families and protect vulnerable individuals, with respect and appreciation for the professional obligations of physicians and nurses. Hospitals are well equipped to provide this balance bringing together a variety of resources in multidisciplinary teams that are specifically trained to assist patients and their families in making decisions to continue or discontinue life sustaining treatments. These are among the most difficult and emotional events for patients, families, physicians, and nurses and a thoughtful approach is needed...

Current law at § 54.1-2990 allows a physician to transfer a patient for whom care has been requested that the physician believes is medically or ethically inappropriate. This provides the opportunity for the patient to continue to receive the requested care from another provider, but in practice, such transfers are not always possible when there is no other physician willing to carry out and accept the obligation to provide the requested treatment...

The legislative changes to § 54.1-2990 included in Recommendation 2 are needed to specify in statute appropriate actions to be taken in these situations where the minimum 14-day time period to effect a patient transfer has expired and a transfer is unable to be effected, but at the same time ensure needed balance to protect patients.”

In addition to support for Recommendation #2, “the statute should be revised to clarify that the health care provider is in no way prohibited from performing any tests or procedures necessary to determine what is medically or ethically necessary or appropriate care or treatment. These steps are appropriate to ensure that there is due process in decisions regarding life sustaining treatment and ensure a proper balance between patient and family wishes and the physician’s professional obligation...

VHHA supports including immunity from any action in compliance with the statute for persons acting in good faith. This immunity should be broadly crafted to protect all persons potentially involved in the process including committee members, some of whom could be volunteers. The statute should also be revised to specify that the statute does not create a private right of action (such that patients or their families could pursue legal recourse under traditional tort law, not on the basis of strict liability for failure to comply with the statute). Simply relying upon a determination of standard of care under a traditional cause of action for medical malpractice or unprofessional conduct proceedings exposes the health care provider to lawsuits for actions that are permitted by law and provides no assurance that the health care provider will not be haled into court to defend his or her professional judgment. This again speaks to the need to balance the wishes of the patient and family with the professional obligations of physicians and nurses and undermines the intent of making needed clarifications to the statute. Furthermore, this immunity is necessary to protect other persons involved in the process, such as volunteers and other individuals involved in reviewing physician determinations who have acted in good faith.”

Regarding Recommendation #5: “Protecting patients from discrimination and protecting vulnerable individuals is of critical importance and paramount in providing patient care; however, including in the statute a provision that determination of medically or ethically appropriate life-sustaining treatment must conform to existing federal non-discrimination regulations that may apply to any other patient receiving care within the institution in which the patient is receiving care is unnecessary as these laws do not require state action to be enforced and such a provision potentially creates a basis for legal action or liability that does not otherwise exist under state law. Federal laws to protect patients from discrimination in health care settings are already in place to serve this important purpose. A claim that a health care provider has breached federal discrimination laws could under this proposed revision now bring an additional claim under state law, adding costs for the health care provider and our judicial system, without providing any additional benefits or protections for individuals.”

Appendix: Recommended revisions to Virginia Code §54.1-2990

(Recommended additions in *italics*; recommended deletions in ~~strike through~~)

§ 54.1-2990. **Medically unnecessary treatment not required; procedure when physician refuses to comply with an advance directive or a designated person's treatment decision; mercy killing or euthanasia prohibited**

Nothing in this article shall be construed to require a physician to prescribe or render health care to a patient that the physician determines to be medically or ethically inappropriate. However, in such a case, if the physician's determination is contrary to the request of the patient, the terms of a patient's advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, ~~or a Durable Do Not Resuscitate Order~~, *the policies of the hospital in which the patient is receiving health care will be followed. Policies of the hospital that is equipped to provide life-sustaining treatment shall be documented and shall include, at a minimum the following steps:*

- *Rendering of a second medical opinion;*
- *Review of the physician's determination by an interdisciplinary medical review committee, followed by issuance of its own determination on the appropriateness of requested treatment. The patient, agent or person will be afforded reasonable opportunity to participate in the medical review committee meeting;*
- *Written explanation of the decision reached during the medical review committee review process that will be included in the patient's medical record*

*If the patient, agent or person authorized to make medical decisions pursuant to § 54.1-2986 requests life-sustaining treatment that the attending physician determines to be medically or ethically inappropriate, the physician shall document his decision in the patient's medical record and make a reasonable effort to inform the patient or the patient's agent or person with decision-making authority pursuant to § 54.1-2986 of such determination and the reasons for the determination. ~~If the conflict remains unresolved,~~ The physician shall make a reasonable effort – *and cooperate with others' efforts* – to transfer the patient to another physician who is willing to comply with the request of the patient, the terms of the advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, ~~or a Durable Do Not Resuscitate Order~~. The physician shall provide the patient or his agent or person with decision-making authority pursuant to § 54.1-2986 a reasonable time of not less than fourteen days *after documentation of the decision in the patient's medical record* to effect such transfer. During this period, the physician shall continue to provide any life-sustaining ~~care~~ *treatment* to the patient which is reasonably available to such physician, as requested by the patient or his agent or person with decision-making authority pursuant to § 54.1-2986.*

If, at the end of the 14-day period, the policies of the hospital in which the patient is receiving health care have been followed and the physician has been unable to transfer the patient to another physician who is willing to comply with the request of the patient, the terms of the advance directive, the decision of the agent or person authorized to make decisions pursuant to § 54.1-2986 despite reasonable efforts, the physician may cease to provide the treatment that the physician has determined to be medically or ethically inappropriate, except that artificially administered nutrition and hydration must be provided unless, based on the physician's medical judgment, providing artificially administered nutrition and hydration would be:

(1) medically harmful, non-beneficial and/or result in substantial irremediable physical pain not outweighed by the benefit of the provision of the treatment; or

(2) be contrary to the patient's or surrogate's clearly documented desire not to receive artificially administered nutrition or hydration.

In all cases, care directed toward the patient's pain and comfort shall be provided.

Pursuant to § 54.1-2988, a health care provider or hospital acting in good faith and in accordance with generally accepted health care standards is not subject to civil or criminal liability or to discipline for unprofessional conduct for any action in compliance with this article.

B. For purposes of this section, “life-sustaining ~~care~~ *treatment*” means any ongoing health care that utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function, ~~including hydration, nutrition, maintenance medication, and cardiopulmonary resuscitation.~~

C. Nothing in this section shall require the provision of health care that the physician is physically or legally unable to provide, or health care that the physician is physically or legally unable to provide without thereby denying the same health care to another patient.

D. Nothing in this article shall be construed to condone, authorize or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

E. Determination of medically or ethically appropriate life-sustaining treatment must conform to existing federal non-discrimination regulations that may apply to any other patient receiving care within the institution in which the patient is receiving care.

Virginia Foundation for Healthy Youth Mission Expansion

Andrew Mitchell
Senior Health Policy Analyst

Study Mandate

In 2016, Delegate O’Bannon requested via House Joint Resolution 65 that the JCHC study the benefits and costs of expanding the mission of the Virginia Foundation for Healthy Youth to include a focus on other health issues such as behavioral health, violence, hunger and diabetes. The study was included in the Joint Commission on Health Care 2016 work plan and approved by members.

Background

Created in 1999 as the Virginia Tobacco Settlement Foundation, the current mission of the Virginia Foundation for Healthy Youth (VFHY) is to prevent tobacco use by youth and reduce childhood obesity. Funding comes primarily from Master Settlement Agreement (MSA) payments (10% of total MSA payments until 2009, averaging \$14.2M in annual expenditures; 8.6% since 2010, averaging \$10.1M in annual expenditures), with the VFHY additionally able to finance activities through extra-MSA resources.

The VFHY executes its mission primarily through three platforms, as described below:

Platform	Description	Examples
Program (Grants)	<ul style="list-style-type: none"> ▪ Tobacco: Classroom-based prevention / cessation, training programs ▪ Obesity: Healthy Communities Action Teams (HCATs) interventions 	<ul style="list-style-type: none"> ▪ Tobacco: All Stars; Project Alert; Project Toward No Drugs ▪ Obesity: Community gardens; improving park spaces
Marketing / Communication	<ul style="list-style-type: none"> ▪ Mass media advertising/messaging ▪ Youth engagement (tobacco prevention only) 	<ul style="list-style-type: none"> ▪ Tobacco: “Y Street” youth leaders; Down & Dirty, Fresh Empire media campaigns ▪ Obesity: “Rev your Bev” drink campaign
Research (tobacco only)	<ul style="list-style-type: none"> ▪ Behavior-focused studies ▪ Basic science-focused studies ▪ Research coalition 	<ul style="list-style-type: none"> ▪ Behavior-focused: “Reducing Teen Tobacco Use Via Text Messaging” ▪ Basic science-focused: “What Social and Molecular Factors Drive Nicotine Preference in Adolescent Mice?”

Additional activities include collaboration on youth surveillance conducted by the Virginia Department of Health (i.e., Virginia Youth Survey) and convening conferences (e.g., “Reduce Tobacco Use”; “Weight of the State”).

Epidemiology and VFHY Programming in Health Issues Under Current Mission

Tobacco

Cigarette/tobacco use by youth has declined both in Virginia and nationally over time according to self-reported data. Additionally, estimated percentages of Virginia youth using tobacco products in the early 2000s were higher than or around the national average, while most recent estimates indicate that they are below the national average (2015 CDC data) or at the national average (2014 SAMHSA data). According to one data source (CDC), almost all indicators of youth tobacco product use declined statistically significantly between 2011 and 2015, with tobacco product usage by Virginia youth among the lowest in the nation. Going forward, evidence suggests that youth use of Electronic Nicotine Delivery Systems

(ENDS) is becoming a significant issue, with ENDS use in 2015 estimated to be higher than for traditional tobacco products. Evidence is still nascent on the long-term health effects of ENDS compared to traditional tobacco products, as well as whether ENDS' use facilitates cessation of tobacco products, encourages initiation, or bears no relationship.

Against this backdrop, the VFHY has funded tobacco prevention programs, marketing and research.

- Programs: Grantees implement classroom-based curricula drawn from a compendium of 19 programs, 18 of which are listed on the Substance Abuse and Mental Health Services (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP). Since 2009, the VFHY has awarded 107 three-year and 59 one-year grants (to CSBs, local school boards, not-for-profits, etc.), which have served between 46,380 (2014/5) and 63,071 (2009/10) youth annually.
- Marketing: 1) messages from anti-tobacco media campaigns reached an estimated 3.15 million youth in 2016; 2) Over 8,000 youth "Y Street" volunteers have been trained since 2004 to implement community-based campaigns, with around 4,000 actively implementing projects.
- Research: Since 2002, the VFHY has funded 22 research grants. Approximately 80% of funds have been directed towards behavior-focused and basic science-focused projects, and 20% directed towards a research coalition that has leveraged VFHY funds to secure approximately \$26M in outside funding.

Obesity

Percentages of overweight/obese youth did not change statistically between 2011 and 2015, while behavioral indicators that may be associated with weight (e.g., drinking sugary sodas) declined during the same period. To address youth obesity, the VFHY awards three-year grants to Healthy Community Action Teams (HCATs). HCATs implement community-based projects that are focused on increasing physical activity and/or improving nutrition and are recommended by the Institutes of Medicine (IOM).

Epidemiology of Health Issues under Consideration for Mission Expansion

Behavioral Health

Data on the epidemiology in Virginia of three behavioral health issues considered – substance use, bullying/violence, and suicide/depression – are summarized below:

Issue	Key Findings
Substance Use	<ul style="list-style-type: none"> ▪ In Virginia, use of most substances among high school students are <u>among the lowest in the nation, with the exception of prescription drugs</u> (CDC estimates); however, SAMHSA estimates of use of non-tobacco substances among 12-17 year olds are closer to national average ▪ Use of several substances among high school students declined statistically significantly between 2011 and 2015, but not for prescription drugs or marijuana (CDC estimates)
Bullying / Violence	<ul style="list-style-type: none"> ▪ Reported bullying by Virginia high/middle school students is <u>lower than the national average</u> (CDC estimates). There is no clear geographic clustering of school divisions with relatively high percentages of reported bullying (DCJS estimates). ▪ Of 18 violence-/injury prevention-related indicators tracked by the Virginia Youth Survey, 45% have decreased significantly between 2011 and 2015, and 55% have had no statistically significant change (CDC estimates)
Suicide / Depression	<ul style="list-style-type: none"> ▪ Percentages of Virginia high school students reporting suicidal ideation is <u>lower than the national average</u> (CDC estimates), although estimated 12-17 year olds with a major

Issue	Key Findings
	<ul style="list-style-type: none"> depressive episode is reported to be higher than the national average (SAMHSA estimates) There is no clear geographic clustering of school divisions with relatively high percentages of reported suicidal ideation (DCJS)

Literature suggests that there are well-established associations among youth of concurrent use of substances (e.g., tobacco, alcohol, illicit drugs). While there is a strong evidence base of associations among youth between other behavioral health issues under consideration (e.g., between bullying and depression; bullying and suicide; depression and suicide), evidence of associations among youth is less consistent between substance use and the other behavioral health issues.

Physical Health

Evidence of the epidemiology in Virginia of two behavioral health issues considered, childhood hunger/food insecurity and diabetes, is summarized below:

Issue	Key Findings
Food Insecurity	<ul style="list-style-type: none"> With 16 percent of Virginia children experiencing food insecurity in 2014, the State's rate is <u>among the lowest in the nation</u> (FRAC estimates) In Virginia, childhood food insecurity is clustered within southern counties (FRAC)
Diabetes	<ul style="list-style-type: none"> <u>No/Little data are available on diabetes prevalence among Virginia youth</u> Among all ages, diabetes and obesity appear to be highly correlated (CDC estimates)

Evidence on Effectiveness of Prevention Strategies

Evidence on the effectiveness of 1) program-/community-based prevention and 2) mass media/marketing prevention strategies is summarized in the tables below.

Effectiveness of Program-/Community-Based Prevention Strategies

Issue	Strongest evidence of effectiveness	Caveats
Substance Use	<ul style="list-style-type: none"> Intensive programs focused on building life/social skills among middle schoolers and/or those at high-risk 	<ul style="list-style-type: none"> Effects tend to be small to modest; effects are greater in addressing social functioning/antisocial behavior rather than substance abuse alone
Bullying / Violence	<ul style="list-style-type: none"> Programs with high fidelity / implemented in homogenous cultural settings Programs targeting aggressive behavior and violence more broadly 	<ul style="list-style-type: none"> Bullying programs affect bullying knowledge and attitudes more than behaviors Achieving implementation fidelity of bullying prevention models is challenging
Depression	<ul style="list-style-type: none"> Programs can significantly reduce depression symptoms/incidence 	
Suicide	<ul style="list-style-type: none"> Programs have been shown to improve suicide-related knowledge and attitudes 	<ul style="list-style-type: none"> Programs not shown to have an effect on actual suicidal behavior

Issue	Strongest evidence of effectiveness	Caveats
Obesity	<ul style="list-style-type: none"> Community/school-based interventions to increase physical activity (alone or with nutrition-related interventions) 	<ul style="list-style-type: none"> Dearth of physical activity/nutrition interventions consistently shown to positively affect behaviors or outcomes
Food Insecurity	<ul style="list-style-type: none"> Programs to increase quantity of food (e.g., school breakfast; Supplemental Nutrition Assistance Program (SNAP)) 	<ul style="list-style-type: none"> Programs to improve quality of food: see Obesity Caveat, above

Effectiveness of Mass Media/Marketing Prevention Strategies

Issue	Strongest evidence of effectiveness	Caveats
Substance Use	<ul style="list-style-type: none"> Tobacco cessation among adults Youth campaigns that include: multiple channels for media delivery; combined school and media components; repeated exposure to messages over multiple years; implemented as part of a comprehensive tobacco control program 	<ul style="list-style-type: none"> Evidence of effectiveness on smoking behaviors/prevention among youth is not strong Inconsistent evidence of effectiveness for illicit drugs/alcohol (apart from drunk driving)
Depression / Bullying / Suicide		<ul style="list-style-type: none"> Limited data
Obesity	<ul style="list-style-type: none"> CDC's VERB (physical activity) campaign 	<ul style="list-style-type: none"> Mass media campaigns generally not successful in increasing physical activity, particularly without supporting policy, programs and environmental interventions

Cost-Effectiveness of Prevention Strategies

While the estimated annual health care and other costs of the health issues under the VFHY's mandate and those under consideration are substantial – from \$45 billion (suicide) to \$295 billion (tobacco) – a lack of economic analyses limit evidence on the cost-effectiveness of prevention strategies. Nevertheless, the literature that does exist suggests that: 1) the most favorable cost-effectiveness ratios related to behavioral health broadly are associated with interventions targeting highest-risk youth; 2) multiple curriculum-based interventions targeting substance use/youth behaviors – several of which are currently endorsed by the VFHY for tobacco prevention – can be cost-effective; 3) structural strategies to prevent childhood obesity (e.g., sugary drink tax increase) may be substantially more cost-effective than behavioral interventions (e.g., state-level policy change to promote physical education in schools).

Virginia Stakeholder Prevention Efforts in Health Issues under Consideration

Virginia stakeholder involvement in the health issues considered is summarized below:

Issue	Policy/oversight	Programs
Substance Use	<ul style="list-style-type: none"> Coordination function by Virginia's Office for Substance Abuse Prevention (VOSAP), Substances Abuse Services Council (SASC) 	<ul style="list-style-type: none"> DBHDS, DCJS, VDH CSBs (31 surveyed): almost all report implementing outreach

Issue	Policy/oversight	Programs
Bullying / Violence	<ul style="list-style-type: none"> ▪ VDOE issued a model bullying prevention and intervention policy in 2013 ▪ 27 school divisions (~ 60 middle/high schools) use data-driven Virginia Tiered System of Support (VTSS) methodology integrating academic, behavioral and social-emotional programs 	<ul style="list-style-type: none"> ▪ 74% schools implement ≥ 1 bullying prevention program (2014) ▪ DBHDS, VDH ▪ CSBs: two-thirds implement outreach
Suicide / Depression		<ul style="list-style-type: none"> ▪ DBHDS, VDH ▪ CSBs: > 75% implement outreach
Food Insecurity	<ul style="list-style-type: none"> ▪ Commonwealth Council on Bridging the Nutritional Divide (chaired by the First Lady's Office; VFHY participates) ▪ Governor's 2016 introduced budget instructed agencies implementing feeding programs to develop a plan to consolidate services under one agency 	<ul style="list-style-type: none"> ▪ VDOE, VDACS, VDH (feeding programs)

Recommendations

Recommendation	Rationale
1. Maintain current VFHY funding levels allocated to youth tobacco prevention and obesity	<ul style="list-style-type: none"> ▪ Tobacco: Reductions to VFHY's budget in tobacco could jeopardize gains made in reducing tobacco use and preventing ENDS use. Marketing/mass media requires longevity to sustain impact. ▪ Obesity: Time is required to determine the success of current investments. Given the lack of evidence on effective prevention strategies, VFHY could consider strategic focus (e.g., reducing rates of youth diabetes/pre-diabetes).
2. Develop a tobacco research strategy designed to maximize linkages between research and impact of VFHY tobacco programs and marketing investments	<ul style="list-style-type: none"> ▪ Research strategy would systematically ensure that VFHY-funded programs/marketing are achieving highest impact at lowest cost. Examples include studies on the (cost)-effectiveness of VFHY programs/marketing on youth behaviors and the impact of policy-level changes (e.g., higher cigarette tax) on youth smoking
3. Expand the scope of the VFHY's tobacco prevention mandate to include all controlled substances	<ul style="list-style-type: none"> ▪ VFHY likely can use existing tobacco programs to impact other substances. VFHY's work on segmentation of youth into "peer crowds" could help target programs/marketing. It will be necessary to ensure alignment prioritization methodologies of other State agency stakeholders (e.g., DBHDS, VDOE) ▪ VFHY-recommended budget: \$2M (reaching 15,000 youth through programs, 362,500 youth through marketing)
4. Consider expansion of the scope of the VFHY's mission to include up to two additional behavioral/physical health	<ul style="list-style-type: none"> ▪ Childhood hunger/food insecurity prevention: VFHY platforms to address youth obesity focused on nutrition are likely applicable to hunger. Focusing on increasing school breakfast participation would address a current challenge in Virginia. Given the lack of

Recommendation	Rationale
issues: Childhood hunger/food insecurity prevention; Depression/suicide prevention and/or bullying/violence prevention	evidence of effective prevention strategies, a rigorous impact evaluation plan is needed. <ul style="list-style-type: none"> ▪ Depression/suicide prevention and/or bullying/violence prevention: This would require extensive coordination with stakeholders ▪ VFHY-recommended budget: \$2M for each issue area with same estimated youth reached as with substance use

Policy Options and Public Comment

Comments were received from 70 individuals regarding the policy options and recommendations for the Virginia Foundation for Healthy Youth mission expansion. Comments were submitted by:

- Melissa K. Ackley, Prevention Services Manager, Chesterfield Mental Health Support Services
- Anthony Akers, Assistant County Administrator, County of Pulaski
- Anne Barclay, volunteer for the American Cancer Society Cancer Action Network
- Samuel T. Bartle, President, Virginia Chapter of the American Academy of Pediatrics (VA AAP)
- Elaine Becker, volunteer for the American Cancer Society Cancer Action Network
- Valerie L. Bowman, member, Virginia Foundation for Healthy Youth Board of Trustees
- Cathryn Burby, volunteer for the American Cancer Society Cancer Action Network
- Ray Chapman, Virginia Beverage Association
- Sandy Chung, Chairman, Virginia Foundation for Healthy Youth Board of Trustees
- Lynne Clark, Title I Parent Involvement Coordinator, Pulaski Community Partners Coalition (PCPC)
- Vicky Collins, Director, Radford City Department of Social Services
- TracyAnn Costello, Healthy Floyd
- Valerie Cupp, School Nutrition Specialist, Washington County Public Schools
- Janis M. Dauer, Executive Director, Alliance for the Prevention and Treatment of Nicotine Addiction
- Nathan G. Delp, Crime Prevention Specialist, Christiansburg Police Department
- Brian Donohue, Virginia Government Relations Director, American Cancer Society Action Network (ACSCAN)
- Courtney Dowell, Prevention Specialist Lead, Colonial Behavioral Health
- Victor Escobar, volunteer for the American Cancer Society Cancer Action Network
- Jennifer Faison, Executive Director, Virginia Association of Community Services Boards (VACSB)
- Quentin Fischer, volunteer for the American Cancer Society Cancer Action Network
- Rebecca Y. Forestier, Associate Executive Director, Martinsville-Henry County Family YMCA
- Richard R. Franklin, Assistant Superintendent, Giles County Public Schools
- Lisa Fues, volunteer for the American Cancer Society Cancer Action Network
- Robin Gahan, Senior Director, Government Relations, Virginia, American Heart Association (AHA)
- William George and, Chair; Alexandra London-Gross, Executive Director, Virginia Alliance of YMCAs
- Anne Goette, Giles Early Education Project
- Lois Graham, Deputy Assistant Superintendent, Montgomery County Public Schools

- Robert F. Graham, Superintendent, Radford City Public Schools
- Richard Harwood, volunteer for the American Cancer Society Cancer Action Network
- Angie Hasemann, State Policy Representative, Virginia Academy of Nutrition and Dietetics
- Sarah Bedard Holland, member, Virginia Foundation for Healthy Youth Board of Trustees
- Lisa Hinton, volunteer for the American Cancer Society Cancer Action Network
- Michele Horne, volunteer for the American Cancer Society Cancer Action Network
- Francine Ivery, Coordinator of School Nutrition Programs, Washington County Virginia Public Schools
- Ashley Jacobs, Program Coordinator, Orange County Office on Youth
- Linda Johnson, Peaceline Coordinator, Women's Resource Center
- Kris Kennedy, member, Virginia Foundation for Healthy Youth Board of Trustees
- Patti G. Kiger, Executive Director, Eastern Shore Healthy Communities
- Kira Koon, ALAM-A Lung Cancer Team Lead, American Lung Association of the Mid-Atlantic
- Steven Kranowski, volunteer for the American Cancer Society Cancer Action Network
- Walter Lawrence, volunteer for the American Cancer Society Cancer Action Network
- Larry Lindsey, Director, Montgomery County Department of Social Services
- Allen Lomax, Chair, Substance Abuse Prevention Coalition of Alexandria
- Vicky Lothery, volunteer for the American Cancer Society Cancer Action Network
- David McColgan, volunteer for the American Cancer Society Cancer Action Network
- Lynn McDowell, Prevention and Wellness Director and Debbie Bonniwell, Chief Executive Officer, Blue Ridge Behavioral Healthcare
- Kathleen Murphy, Child Nutrition Program Assistant, Virginia Poverty Law Center
- P. Douglas Poe, Probation Supervisor, Twenty-Seventh Judicial District Court Service Unit
- Kristina Powell, member, Virginia Foundation for Healthy Youth Board of Trustees
- Kathy Reed, Prevention Coordinator, Crossroads Community Services Board
- Donna Rennick, volunteer for the American Cancer Society Cancer Action Network
- G.W. Roche, Chief of Police, Pulaski Police Department
- Lauren Schmitt, School Nutrition Association of Virginia (SNA-VA)
- Roy Shannon, Jr., Chair, Alexandria Community Services Board
- Robin Siegel, volunteer for the American Cancer Society Cancer Action Network
- Mira Signer, Executive Director, National Alliance on Mental Illness of Virginia (NAMI Virginia)
- Mary Dunne Stewart, President and CEO, Fit4Kids
- Kathy Sullivan, Director, Roanoke Area Youth Substance Abuse Coalition (RAYSAC)
- Rosemary Sullivan, Interim Executive Director, New River Valley Community Services (NRVCS)
- Chad Triolet, President, Virginia Association of Health, Physical Education, Recreation and Dance (VAHPERD)
- Kristin S. Vaughan, Executive Director, Family YMCA of Emporia-Greenville, Inc.
- Alisha Vines, Director, Orange County Office on Youth
- Michelle Wagaman, Prevention Services Coordinator, Rappahannock Area Community Services Board
- Sally A. Warburton, Library Director, Pulaski County Library System
- William Welkowitz, volunteer for the American Cancer Society Cancer Action Network
- Angelo Wider, Chair, Loudoun County Community Services Board
- Julie Williams, member, Pulaski Community Partners Coalition (PCPC)

- Karen M. Yolton, Project Manager, Giles Early Education Project

Policy Option	Stakeholder position	
	In Support	In opposition
1. Take No Action	<ul style="list-style-type: none"> ▪ Ashley Jacobs ▪ Sarah Bedard Holland (if no budget amendment for expanded mission) ▪ New River Valley Community Services (Prevention subunit) ▪ Orange County Office on Youth 	N/A
2. Expand VFHY mission to include preventing use of additional substances by youth:		
<input checked="" type="checkbox"/> 2a. Introduce legislation to amend the Code of Virginia to expand the VFHY mission to include prevention of other controlled substance use by youth; OR 15 y-0 n, 1 abs.	<ul style="list-style-type: none"> ▪ Alliance for the Prevention and Treatment of Nicotine Addiction (as long as current funding is not used for expanded mission)* ▪ Blue Ridge Behavioral Healthcare (Option 2b only, and as long as funding does not come from existing sources directed toward substance use) ▪ Sarah Bedard Holland (Option 2b only) ▪ Kris Kennedy (Option 2b only) ▪ Patti Kiger (Option 2b only) ▪ NAMI Virginia* ▪ VAHPERD (if extra funds available)* ▪ VA AAP (if adequate funding provided)* ▪ Virginia Academy of Nutrition and Dietetics (if funding available)* 	<ul style="list-style-type: none"> ▪ Sarah Bedard Holland
2b. Introduce budget amendment (language and funding) to increase the VFHY budget by \$2,000,000 to expand the VFHY mission to include prevention of other controlled substance use by youth		
3. Expand VFHY mission to other youth nutrition issues beyond obesity:		
3a. Introduce legislation to amend the Code of Virginia to expand the VFHY mission to include prevention of other nutrition-related conditions for youth, such as hunger and food insecurity; OR	<ul style="list-style-type: none"> ▪ Valerie Bowman* ▪ Valerie Cupp* ▪ Francine Ivery* ▪ Patti Kiger (Option 3b only) 	<ul style="list-style-type: none"> ▪ Sarah Bedard Holland*

Policy Option	Stakeholder position	
	In Support	In opposition
3b. Introduce budget amendment (language and funding) to increase the VFHY budget by \$2,000,000 to expand the VFHY mission to include prevention of other nutrition-related conditions for youth, such as hunger and food insecurity	<ul style="list-style-type: none"> ▪ Kathleen Murphy* ▪ SNA-VA* ▪ VAHPERD (as long as obesity funding maintained)* ▪ VA AAP* ▪ Virginia Academy of Nutrition and Dietetics* 	
4. Expand VFHY mission to include other youth behavioral health issues:		
4a. Introduce legislation to amend the Code of Virginia to expand the VFHY mission to include prevention of behavioral health issues among youth, including suicide and depression; OR	<ul style="list-style-type: none"> ▪ Alliance for the Prevention and Treatment of Nicotine Addiction (as long as current funding is not used for expanded mission)* ▪ Sandy Chung* ▪ Kris Kennedy (Option 4b only) ▪ NAMI Virginia* ▪ VAHPERD (if extra general funds available)* 	<ul style="list-style-type: none"> ▪ Sarah Bedard Holland*
4b. Introduce budget amendment (language and funding) to increase the VFHY budget by \$2,000,000 to expand the VFHY mission to include prevention of behavioral health issues among youth, including suicide and depression		
5. Expand VFHY mission to include preventing youth violence:		
5a. Introduce legislation to amend the Code of Virginia to expand the VFHY mission to include prevention of violence among youth, including bullying; OR	<ul style="list-style-type: none"> ▪ NAMI Virginia* ▪ VAHPERD (if extra general funds available)* 	<ul style="list-style-type: none"> ▪ Sarah Bedard Holland*
5b. Introduce budget amendment (language and funding) to increase the VFHY budget by \$2,000,000 to expand the VFHY mission to include prevention of violence among youth, including bullying		
6. Eliminate youth obesity prevention from VFHY mission (JCHC member added)		<ul style="list-style-type: none"> ▪ ACSCAN ▪ ACSCAN volunteers ▪ Alliance for the Prevention and Treatment of Nicotine Addiction ▪ AHA ▪ Sandy Chung ▪ Valerie Cupp ▪ Family YMCA of Emporia-Greenville, Inc. ▪ Fit4Kids ▪ Sarah Bedard Holland ▪ Francine Ivery ▪ Ashley Jacobs ▪ Kris Kennedy

Policy Option	Stakeholder position	
	In Support	In opposition
		<ul style="list-style-type: none"> ▪ Patti Kiger ▪ Martinsville-Henry County Family YMCA ▪ Orange County Office on Youth ▪ Kristina Powell ▪ SNA-VA ▪ VAHPERD ▪ VA AAP ▪ Virginia Alliance of YMCAs

* Comment did not differentiate between sub-options a and b

In addition to comments received on the six Policy Options:

- 28 comments requested that the JCHC restore VFHY funding to 10% of the Master Settlement Agreement (MSA). These included comments from: ACSCAN and all those identifying as ACSCAN volunteers; the Alliance for the Prevention and Treatment of Nicotine Addiction; the AHA; the American Lung Association of the Mid-Atlantic; Valerie L. Bowman; the Family YMCA of Emporia-Greenville, Inc.; the Martinsville-Henry County Family YMCA; Kristina Powell; the SNA-VA; the Virginia Alliance of YMCAs; the VA AAP; and the Virginia Academy of Nutrition and Dietetics.
- 27 comments were received highlighting youth prevention-oriented work currently conducted and/or supported by Community Service Boards in the Commonwealth

Selected Comment Excerpts

Samuel T. Bartle, on behalf of the VA AAP

“The work [the VFHY does] to prevent childhood obesity is extremely important and necessary. The prevalence of childhood obesity continues to be a serious health crisis in Virginia and the VA AAP views this as a public health priority. Over the last four years, the VFHY has turned \$4 million of youth obesity prevention funding into \$11 million of projects by partnering with private and public sector agencies throughout Virginia. If they were to stop doing this important work, the great progress that has been made would come to a halt...”

Because we do greatly respect the VFHY’s work and impact, we would support the expansion of its mission if there is adequate funding provided...”

Sandy Chung

“...VFHY is well situated to tackle such significant health issues such as substance abuse and mental health issues in children. The strategies employed by VFHY have been successful in changing youth behavior regarding tobacco use and unhealthy behaviors leading to obesity. With additional funding, the already established infrastructure can be expanded to other youth health issues...”

Representing over 1,200 pediatricians in our state who are members of the Virginia Chapter of the American Academy of Pediatrics, I urge you to support expansion of VFHY's mission to combat substance abuse, mental health and obesity in children..."

Janis M. Dauer, on behalf of the Alliance for the Prevention and Treatment of Nicotine Addiction

"...I have worked in the fields of nicotine addiction and behavioral health throughout my career. Although CSBs do prevention work, it varies by locality and is not a priority in most CSBs since they focus primarily on treatment. VFHY is ideal to coordinate with them and other state agencies to focus on prevention of behavioral health issues among youth statewide. VFHY's past success clearly demonstrates its ability to help youth make sound decisions for their health..."

Brian Donohue, on behalf of ACSCAN

"Reducing youth tobacco use and lowering childhood obesity rates are both key in the fight to prevent cancer. The Virginia Foundation for Healthy Youth is doing both of these things very well despite having its annual budget cut in 2010 from 10% of the Master Settlement Agreement (MSA) funds to only 8.5% of the annual MSA funds. The Foundation has reached almost one million Virginia youth with effective anti-tobacco programs and marketing messages.

These programs help to prevent 115,000 Virginia young people from becoming smokers each year. By preventing youth from becoming adult smokers, the Foundation will help save the lives of 36,500 Virginians every year. Plus, these efforts are projected to lead to \$2.4 billion in savings in future healthcare costs to Virginia taxpayers. By restoring funds to their original level, the Foundation could help countless other young people across the Commonwealth..."

Robin Gahan, on behalf of the AHA

"AHA has continually encouraged the General Assembly to restore funding for the Foundation to 10 percent of the Master Settlement Agreement (MSA) as was originally intended, before being cut to 8.5 percent in 2010. We were disappointed the final policy recommendations did not include the full restoration of the MSA. The MSA explicitly states it is expected and intended that payments to states be used to prevent and reduce tobacco use, especially among youth. While there has been a decline in youth smoking rates in Virginia, the number of youth reached by the Foundation is drastically decreased by the loss of \$3 million per year from the MSA allocation... Additionally, the General Assembly should not consider repurposing the existing limited funding currently for tobacco use prevention and childhood obesity."

William George and Alexandra London-Gross, on behalf of the Virginia Alliance of YMCAs, Rebecca Y. Forestier, on behalf of the Martinsville-Henry County Family YMCA, and Kristin S. Vaughan, on behalf of the Family YMCA of Emporia-Greenville, Inc.

"...Over the last four years, the VFHY has turned \$4 million of childhood obesity prevention funding into \$11 million of projects by partnering with private and public sector agencies across the commonwealth. This programming fills a critical gap by bringing together and multiplying the efforts of so many organizations who are working to address the issue of childhood obesity in their own way... Additionally, the General Assembly should not consider repurposing the existing limited funding for tobacco use prevention and childhood obesity for an expanded mission. This funding is critical to continue obesity prevention work such as the Virginia Youth Survey, which is currently our only measurement system of youth behaviors."

Additionally, William George and Alexandra London-Gross wrote: “Several YMCAs throughout Virginia have benefited from the Healthy Communities Action Team funding and have used this funding to apply for additional grants, making even greater progress in improving youth health outcomes...”

Sarah Bedard Holland

“...Policy option two appears to be a natural fit with the current mission of VFHY and could serve as an extension of the current efforts if funding is allocated to enable the foundation to carry out the additional charge...”

“...I have no doubt that VFHY’s model is transferable to additional issues, and that the staff and leadership are wholly capable of broadening the mission of the organization. However, the issues included in options three through five are more disparate to the current mission than the expansion outlined in option two (substance abuse)...”

Kira Koon, on behalf of the Alliance for the Prevention and Treatment of Nicotine Addiction

“...Since VFHY has been in existence, Virginia has seen statistically significant decreases in tobacco use among youth. With the rise in use of Electronic Nicotine Delivery Systems (ENDS) among youth, it is imperative that VFHY’s focus on tobacco programs remain top priority...”

Mira Signer, on behalf of NAMI Virginia

“We commend the Virginia Foundation for Healthy Youth for their work around tobacco use and childhood obesity. We support the expansion of their mission to include depression/suicide prevention and/or bullying/violence. In addition, because many youth with mental health needs also experience issues with substance abuse, we would support the expansion of the scope of VFHY’s tobacco mandate to include all controlled substances. Of course, these issues are extremely important and impactful to our youth and families, and we support any efforts that promote awareness and education among this population. Such efforts can prevent youth and their families from years of suffering and frustration and, unfortunately in some cases, death. We truly appreciate and applaud your consideration of these issues.”

Volunteers of the American Cancer Society Action Network

“...Reducing youth tobacco use and lowering childhood obesity rates are both key in the fight to prevent cancer. The Virginia Foundation for Healthy Youth is doing both of these things very well. This is why I again ask that you support the restoration of the funds that were cut from the Foundation's budget in 2010 and oppose Option 6...”

Expanding Access to Brain Injury Services and Barriers to Placement of Virginians with Challenging Behaviors Resulting from Traumatic and non-Traumatic Brain Injuries and Post-Traumatic Stress Disorder

Paula Margolis
Senior Health Policy Analyst

In 2014, Senate Joint Resolution 80 (Senator Ruff) directed the Joint Commission on Health Care (JCHC) to determine the extent of progress made in implementing the recommendations of the 2007 Joint Legislative and Audit Review Commission report, *Access to State-Funded Brain Injury Services in Virginia*. In addition, in 2016, Senator Carrico instructed the JCHC to identify barriers and options for placement of individuals with traumatic brain injuries (TBI), non-traumatic brain injuries (e.g., caused by degenerative conditions, stroke or anoxic events) and Post Traumatic Stress Disorder (PTSD).

Background

Individuals with brain injuries (BI), dementias, and PTSD need medical and behavioral health services, home and community-based services and supports (HCBS), care coordination services and appropriate housing options which may change over the course of an individual's lifetime. Services that may be used by individuals with BI, dementias and PTSD can be organized into four levels of care based on needs:

Table 1: Levels of Care

Level	Type
1) Level 1 - acute, intensive behavioral and support needs	a) Acute Medical care b) Acute Psychiatric care
2) Level 2 - intensive behavioral and support needs	a) Skilled Nursing Facility b) Residential Neurobehavioral Program
3) Level - moderate to high behavioral and support needs	a) Residential Community-Integrated Neurobehavioral Group Homes
4) Level - Community-based low behavioral and support needs	a) Long-Term Supported Living b) Supported Apartment c) Home-Based Services

Although there are providers in Virginia at most of the service levels, gaps exist, especially for individuals whose condition leads to problematic behaviors, such as aggression, anger, acting out, non-compliance with treatment, elopement and other behaviors that pose management difficulties. For example, there are no neurobehavioral rehabilitation facilities in Virginia that accept Medicaid beneficiaries due to low payment rates, and skilled nursing facilities (SNF) refuse to admit Medicaid beneficiaries with behavioral problems due to a concern for the safety of other residents, the lack of providers with the expertise to serve these individuals, and other staffing issues. As a result, Medicaid beneficiaries needing these services are admitted to providers outside of Virginia (although the number being served outside of the state is very low).

Data on the Number of Virginians with BI, Dementias and PTSD and Related Costs

There is no one source of data on the numbers of individuals with BI, dementias and PTSD and their costs. Data are spread across multiple agencies, stored in different formats and are difficult to share. During the 2016 General Assembly Session, several state agencies were tasked with examining data sources and developing recommendations for Virginia's data needs, and a report is due to legislators December 2016. Data from state sources are displayed below.

Chart 1: Number of Individuals with a Brain Injury by Age Group Reported by the Virginia State Trauma Registry April 2014 – March 2015: Total Number = 4,554

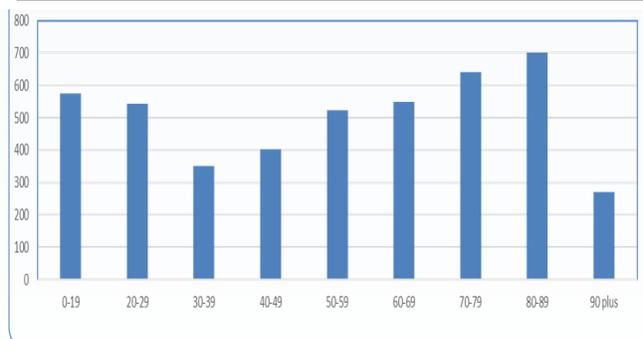


Table 2: Individuals Enrolled in Virginia Medicaid by Diagnosis- State Fiscal Years 2013 – 2015 Reported by the Virginia Department of Medical Assistance Services

Diagnosis	SFY 2013	SFY 2014	SFY 2015
Alzheimer's & Dementia	53,618	61,674	58,997
Post-Traumatic Stress Disorder	34,688	39,098	37,425
Stroke	20,681	22,693	21,829
Traumatic Brain Injury	5,752	6,251	5,997
Grand Total	114,750	129,727	124,260
Total Medicaid Payments	\$2.8 Billion	\$3.1 Billion	\$2.9 Billion

Data Source: Department of Medical Assistance Services fee-for-service claims, including Magellan and crossover claims, consumer directed services claims, Medicaid

Virginia's System of Services for Individuals with BI, Dementias and PTSD

Multiple state agencies and their contractors are responsible for many aspects of service delivery in Virginia. Although state agencies are providing many services, there is a degree of overlap across agencies, agencies are somewhat siloed and there is some lack of capacity needed to manage data and implement and administer programs. In addition, cross-agency coordination could be strengthened and service gaps remain.

The Department of Aging and Rehabilitative Services (DARS) is the state's lead agency for brain injury services and leads the Brain Injury Council. The Department of Health (VDH) is responsible for the Virginia State Trauma Registry (which collects inpatient data from all hospitals in Virginia on trauma¹) and the Certificate of Need program for nursing facilities. The Department of Behavioral Health and Developmental Services (DBHDS) and Community Services Boards (CSB) are responsible for public mental health and substance use services for individuals who are enrolled in Medicaid or are uninsured, and they facilitate housing for individuals with behavioral health issues who are homeless or ready for discharge from a State Mental Health Facility. The Department of Medical Assistance Services (DMAS) is the agency that administers Medicaid and obtains federal waivers, state plan authorities, and funding for Medicaid-covered services, including some services that are provided through other agencies. The Virginia Department of Social Services (DSS) administers Auxiliary grant funds that contribute to room and board for persons in assisted living facilities and performs assessments to determine eligibility for enrollment in Medicaid home and community-based services (HCBS) waivers and nursing home eligibility. The Virginia Department of Veterans Services (DVS) provides care coordination, counseling and other services for veterans and their families; and the Home and Community Development Authority provides resources for housing, clinics and other assets (see Table 5).

Service gaps include: 1) a lack of appropriate providers in acute care settings (psychiatrists, psychologists, geriatricians); 2) Medicaid Skilled Nursing Facility (SNF) and Auxiliary grant payment rates are inadequate; 3) there is a lack of appropriate supported housing options; 4) current Medicaid home and community based services (HCBS) waivers do not include some services that could help support individuals in the community; 5) there are new federal regulations related to the criteria that defines 'community-based' which impacts the ability to use Medicaid funding; and 6) a statewide system of screening, referral and treatment for individuals with dementia and cognitive decline is needed.

¹ Trauma registry data includes admission only; emergency department visits that do not result in admission are not included.

Table 5: Virginia Agencies Administering Services for Individuals with BI, Dementias and PTSD

Brain Injury, Dementia and Post-Traumatic Stress Service Structures in Virginia						
DARS	DBHDS and CSBs	DMAS	VDH	Department of Veterans Servs.	DSS	Home & Com. Deve. Authority
<ul style="list-style-type: none"> Dementia services coordinator Direct Services Fund Neurotrauma Trust Fund Centers Indep. Living Aging and Disability Resource Centers – no wrong door Personal assistance Vocational rehabilitation Woodrow Wilson Ctr. Brain Injury Ass. of VA Brain Injury information, referral, case management, and supported living Clubhouses & day programs Virginia Supported Housing Assistive technology Behavioral Health & Supportive Services BI 1st Software System VA Alzheimer's Disease Commission Counsel on Aging 	<ul style="list-style-type: none"> State MH Facilities Community Services Boards My Community My Life ID/DD waiver redesign, management, data warehouse & pre-admission screening Piedmont Geriatric Hospital Community Centered Behavioral Health Homes Permanent Supportive Housing 	<ul style="list-style-type: none"> Acute medical & behavioral health care payments Nursing facility and EDCD, DD, ID, Alzheimer's Assisted Living, day support & Technology Assisted Waivers payments Commonwealth Coordinated Care Governor's Access Plan Substance use waiver MLTSS PACE DSRIP Medicaid Works 	<ul style="list-style-type: none"> Licenses nursing facilities Statewide Trauma Registry Home Health Certificate Of Public Need Behavioral Risk Factor Surveillance Survey Minimum Data Set (nursing facility case mix) 	<ul style="list-style-type: none"> Virginia Veteran & Family Support Services Department of Veterans Affairs 	<ul style="list-style-type: none"> Nursing facility & Medicaid waiver pre-admission screening Licenses assisted living facilities & adult day services Medicaid eligibility Auxiliary grants for assisted living facilities 	<ul style="list-style-type: none"> Affordable & special needs housing Accessible housing Home modification grant funds for veterans Housing Choice Voucher Program
<p>One individual may access services administered by several agencies and be subject to different eligibility rules</p>						

Avenues for Expanding Services

There are a number of avenues that may be used to expand services for individuals with BI, dementias and PTSD in Virginia. They include options such as increasing payment rates to incent the opening of neurobehavioral rehabilitation facilities, adding new services to existing Medicaid HCBS waivers, creating new waivers, applying for new Medicaid state plan authorities, applying for demonstration and pilot programs, and creating new court dockets to divert individuals from incarceration to treatment.

Medicaid authorities can include: 1) adding new §1915(c) HCBS or §1915(b)/(c) combination waivers tailored for individuals with brain injury; 2) adding services to the current Elderly or Disabled with Consumer Direction (EDCD) waiver with mandatory enrollment in the new §1915(b)/(c) Managed Long Term Services and Supports waiver program; 3) developing a new §1115 demonstration waiver that could specifically target individuals with BI and dementias and allow individuals to be mandatorily enrolled in managed care organizations (MCO); 4) apply for state new state plan amendments including §1915(i) or §1915(k) which would provide HCBS services to eligible Medicaid enrollees without a waiver; 5) apply for the new PACE demonstration which can be an avenue to expanding services to individuals who do not meet criteria for nursing facility placement.

Any new Medicaid authority that would add new services (e.g., adding services to the EDCD waiver), or extend existing services to new individuals (e.g., provide HCBS through a state plan amendment to individuals who do not meet Virginia criteria for admission to a nursing facility) would likely require new budget allocations. The size of new allocations would depend on the number and cost of new services and the number of individuals who might be eligible for the new programs and/or services. Given that adding services to the EDCD waiver or expanding existing services to new populations results in deferring nursing home admission, the new costs may be offset by savings.

Due to the complexity of the issue and the fact that several state agencies and stakeholders have significant roles in providing services, one option is to request that appropriate agencies form an Interagency Implementation Team to decide which avenues to take, estimate related costs and then develop and implement the plan. Although the Virginia Brain Injury Council addresses cross-agency issues and is addressing many areas of need, the need for neurobehavioral rehabilitation units has not been addressed this year, perhaps because of funding issues. If the JCHC chooses to request the formation of an Interagency Implementation Team, the Brain Injury Council may be considered as the foundation for that effort.

Table 6: Summary of Medicaid Options for Covering HCBS

Feature	State Plan Personal Care 1915(i)	HCBS Waiver 1915(c)	State Plan HCBS 1915(k)
Entitlement	Cannot target services by age/diagnosis Must provide services to all categorically eligible individuals who meet eligibility criteria Must be provided statewide	Can target services by age/diagnosis Can limit the number of people Can limit the geographic area	Can target services by age/diagnosis Must provide services to all in an eligibility group who meet the eligibility criteria Must be provided statewide
Financial Criteria	Beneficiaries must meet community financial eligibility standards	States may set financial eligibility criteria up to 300% of the SSI benefit	States may set financial eligibility criteria at 150% of the FPL or 300% of the SSI benefit
Eligibility Criteria	Beneficiaries must have functional limitations, specified by the state, that result in a need for the services covered	Beneficiaries must meet the minimum institutional level-of-care criteria and have a medical/ functional need for the specific service	Beneficiaries under 150% of the FPL can meet functional eligibility criteria that is less stringent than institutional level-of-care criteria Beneficiaries under the 300% of SSI must meet institutional level-of-care
Services	Only those specified in the Federal definition of personal care services	Can include a broad array of state-defined services, only some of which are specified in statute	Can include a very broad array of state-defined services, only some of which are specified in statute
Payment of Relatives	Relatives, other than legally responsible relatives, may be paid to provide personal care	Relatives, including those legally responsible, may be paid to provide personal care and other services determined by the state	Relatives, including those legally responsible, may be paid to provide personal care and other services determined by the state
Federal Match	Regular rate	Regular rate	Six percentage point enhanced rate for attendant services

Policy Options and Public Comment

Six individuals provided comments on policy options addressing access to services and barriers to placement. Comments were submitted by:

- **Cynthia B. Jones**, Director, Virginia Department of Medical Assistance Services (DMAS)
- **Virginia Alliance of Brain Injury Service Providers (VABISP)**
- **Rachel Evans**, Executive Director, No Limits Eastern Shore (NLES)

- **Anne H. McDonnell**, MPA, OTR/L, CBIST, Executive Director, Brain Injury Association of Virginia (BIAV)
- **Krystal Thompson**, MAEd, Executive Director, Brain Injury Services of Southwest Virginia (BISSWV)
- **Michelle Witt**, MA, BCBA, CBIST, Executive Director, Crossroads to Brain Injury Recovery, Inc. (CBIR)

	Policy Options	Support	Oppose/ Concern
1	Take no action		
2	<input checked="" type="checkbox"/> 16-0 Request by letter of the JCHC Chair that DARS, DMAS and DBHDS form an interagency implementation team (possibly made up of members from the Brain Injury Council) to ultimately implement a statewide program to serve individuals with brain injury, including determining whether, and if so, which new Medicaid authorities to be seek. The Team's first task will be to determine program structure and costs, and report back to the JCHC by November 2017.	NLES BISSWV VABISP BIAV CBIR	
3	<input checked="" type="checkbox"/> 16-0 Request by letter of the JCHC Chair that DMAS determine Medicaid payment rates and methods that will incent the opening and ongoing operation of in-state neurobehavioral/nursing facility units for individuals with brain injury and dementias with challenging and aggressive behaviors; and report back to the JCHC by November 2017.	NLES BISSWV VABISP BIAV CBIR	
4	<input checked="" type="checkbox"/> 16-0 Request by letter of the JCHC Chair that DMAS determine a plan, including budget estimates, to add new services to the Medicaid Elderly and Disabled with Consumer Direction Waiver to provide needed long term services and supports for Medicaid beneficiaries; and report back to the JCHC by November 2017.	NLES BISSWV VABISP CBIR	
5	Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a Medicaid waiver specific to brain injury; and report back to the JCHC by November 2017.		DMAS
6	Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a state plan amendment {1915(i) or 1915(k)} to provide additional home and community based services to Medicaid recipients not enrolled in a 1915(c) HCBS waiver; and report back to the JCHC by November 2017.		
7	Request by letter of the JCHC Chair that DMAS apply for the PACE Innovation Act pilot program.		DMAS
8	Introduce budget amendment (language and funding) to increase state funds for the Auxiliary Grant	NLES BISSWV VABISP BIAV CBIR	DMAS

9

 15-0 By letter of the JCHC Chair, express support for Senate Bill 317, carried over to 2017, to create Veteran's Dockets.

Public Comment Excerpts

Rachel Evans – No Limits Eastern Shore: “We believe it is vitally important to expand the availability of brain injury-specific case management services so that no region of the Commonwealth is left unserved. Residential services for brain injury survivors is another critical need area.”

Anne H. McDonnell – Brain Injury Association of Virginia: “There are no in-state publically funded neurobehavioral treatment programs. The Department of Medical Assistance Services sends Medicaid recipients out of state, and the Department of Behavioral Health and Developmental Services reported that 32 individuals with brain injury are in state mental hospitals in FY15 at a cost of over \$3.2M. Nursing facilities are not designed for, nor are they appropriate placements for persons with brain injury, particularly those under age 65 and no brain injury wavier to facilitate deinstitutionalization, in violation of the Olmstead decision.”

Michelle Witt – Crossroads to Brain Injury Recovery, Inc.: “We feel that it is imperative that supportive housing options be investigated and supported.”

Cynthia Jones – DMAS: “There is currently a statewide interagency team in place that includes DARS, DMAS, DBHDS, stakeholders and families that is exploring ways in which to best serve individuals with brain injury.” “DMAS would welcome a discussion on payment rates with DARS as the lead for such an exploration in accordance with their state-designated role as lead agency for TBI (§51.5-120) and dementia (§51.5-152). DMAS further notes that VDH should be part of any discussion since the creation and addition of new nursing facility beds in Virginia is subject to the Certificate of Public Need program, which is overseen by VDH.” “DMAS is exploring the potential to add additional services to the Elderly and Disabled with Consumer Direction wavier.” “DMAS, the National PACE Association and the Virginia PACE Alliance is actively engaged with the CMS activities related to the PACE Innovation Act...The Innovation Act has no funding attached...Lacking any funding for pilots it may be difficult to attract providers to this model which typically takes health care systems 3 – 4 years to break even.” Ms. Jones’ comments in their entirety are included below as well as JCHC’s response to her comments:



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

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September 28, 2016

Senator Charles W. Carrico, Sr.
Chair
Joint Commission on Health Care
P. O. Box 1322
Richmond, Virginia 23218
district40@senate.virginia.gov

Michele L. Chesser, Ph.D.
Executive Director
Joint Commission on Health Care
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RE: Presentation on "Expanding Access to Brain Injury Services and Barriers to Placement of Virginians who have Challenging Behaviors Resulting from Traumatic and Non-Traumatic Brain Injuries and Post-Traumatic Stress Disorder"

Dear: Senator Carrico and Dr. Chesser,

I would first like to thank you for taking the time to research and discuss services for Virginians with traumatic brain injury (TBI), post-traumatic stress disorders (PTSD), and dementia. Providing access to high-quality long-term services and supports (LTSS) for individuals who have these conditions is a significant focus of the Virginia Department of Medical Assistance Services (DMAS) as well as several other state agencies. DMAS has a long history of working with stakeholders, including providers, advocates, and other state agencies to develop workable LTSS options. We look forward to continuing in that tradition as partners to the Department for Aging and Rehabilitative Services, the lead agency for brain injury and dementia care in the Commonwealth.

Senator Carrico and Dr. Chesser
September 27th, 2016
Page Two

In reviewing the presentation, the Department of Medical Assistance Services has prepared a chart that details items for clarification and general responses to the Policy Options discussed.

If you have any additional questions or would like to discuss this further, please feel free to reach out to me.

Sincerely,

Cynthia B. Jones

Enclosure

Cc: Karen Kimsey, DMAS
James Rothrock, DARS
Terry A. Smith DMAS
Brian McCormick, DMAS

Table VI: Presentation Slides: Comments from Cynthia Jones - DMAS

JCHC Presentation		DMAS Clarification
Slide		
26	Sentara Life Care Corporation has expressed an interest in opening an eight to twelve bed neurobehavioral unit in Virginia; the key barriers expressed by Sentara representatives include: Medicaid payment rates are too low	The interest expressed by Sentara Life was several years ago. The reason presented by Sentara Life for the decision not to move forward was lack of individuals to make the program successful and lower than anticipated reimbursement rates. There are two reimbursement rates, one a Medicaid reimbursement rate for nursing facility care and a potential enhanced rate outlined in 12VAC30-90-266 and 12VAC30-90-330 .
27	2016 AG payments for ALFs range from \$1,219 to \$1,402 per month based on location	Auxiliary Grants, composed of federal and local funds and administered by the Department of Aging and Rehabilitative Services, funds room and board with <i>up to</i> \$1,219 a month in AG funds (\$1,402 for northern Virginia localities). The actual amount of AG funds an individual receives is based on an individual's assets, particularly the individual's SSI payment, which varies.
27	The 2016 Medicaid rate for ALFs is \$49.50 per day (excluding skilled nursing)	This rate is the enhanced rate that AAL waiver provides (ALFs) who are Medicaid providers of the waiver. It is a daily rate provided for services to individuals enrolled in that waiver. This is limited to AAL waiver providers, less than 15. Medicaid provides no other funding to ALFs.
30	Virginia Compliance: Medicaid assisted living facilities are out of compliance; DMAS is in the process of transitioning Alzheimer's waiver enrollees to other settings	Medicaid has 7 participating AAL waiver providers, which are a fraction of licensed assisted living facilities with safe and secure environments in Virginia. These are not necessarily "Medicaid ALFs." Rather, they are providers with which DMAS has provider agreements. The Centers for Medicare and Medicaid (CMS) Final Rule requires states to determine through an assessment process if their HCBS waiver settings are or can come into compliance with new CMS HCBS settings requirements. AAL waiver settings cannot reasonably comply with the new regulations which go into effect in March of 2019. The Commonwealth has submitted a transition plan for approval to CMS. Transitions of individuals receiving AAL waiver services have not yet begun, although the census in the program is declining and is now approximately 50 individuals. The process is anticipated to start in 2017 and conclude by June 2018. A series of workgroup meetings with family, stakeholders, providers, and state agencies were held to produce a report on the options for this waiver which will be presented to the Governor, Senate Finance, House Appropriations by October 1, 2016.
36	New Virginia Beach Veterans Care Center – Scheduled to Open in 2019	Two Veterans Care Centers are currently underway; one in Virginia Beach and one in Fauquier County. From a Governor's Press Release (6/1/2016): <i>The Northern Virginia Veterans Care Center will be the Commonwealth's third veterans care center, joining the Virginia Veterans Care Center in Roanoke, which opened in 1992, and the Sitter & Barfoot Veterans Care Center in Richmond, which opened in 2008. Sites are currently being evaluated for the state's fourth veterans care center, which will be located in the Hampton</i>

		<i>Roads region. A site is expected to be announced in July, with construction paralleling the Northern Virginia center.</i>
44	EDCD Waiver Consideration: New waiver services cannot be limited to enrollees with brain injuries or dementias; therefore, costs may increase beyond that of serving the populations of interest	CMS states that there cannot be a “waiver” within a “waiver.” Therefore, new services must be applicable to a larger population. The suggestion that the EDCD waiver could contain all services necessary to appropriately serve an individual with brain injury is misleading as Medicaid cannot fund room or board.
45	The Chart of Services on this slide indicates that Assisted Living is a service included in the EDCD waiver. The chart indicates that case management is available to individuals in the EDCD waiver receiving services through a managed care plan.	Assisted Living is not a service available in the EDCD waiver. An individual cannot reside in an Assisted Living Facility and receive EDCD waiver services. Individuals receiving services through a managed care plan receive Care Coordination versus traditional Case Management.

Table VI: Policy Options: Comments from Cynthia Jones - DMAS

	JCHC Policy Options(Slides 54 & 55)	DMAS Response
1	Take no action.	No response.
2	Request by letter of the JCHC Chair that DARS, DMAS and DBHDS form an Interagency Implementation Team to ultimately implement a statewide program to serve individuals with brain injury, including determining whether, and if so, which new Medicaid authorities need to be sought. The Team’s first task will be to determine program structure and cost and report progress back to the JCHC by November 2017.	There is currently a statewide interagency team in place that includes DARS, DMAS, DBHDS, stakeholders and families that is exploring ways in which to best service individuals with brain injury.
3	Request by letter of the JCHC Chair that DMAS determine Medicaid payment rates and methods that will incent the opening and ongoing operation of in-state neurobehavioral/nursing facility units for individuals with brain injury and dementias with challenging and aggressive behaviors; and report back to the JCHC by November 2017.	Current regulation permit for an additional payment to nursing facilities for the delivery of care to individuals with TBI (12VAC30-90-266 and 12VAC30-90-330). DMAS would welcome a discussion on payment rates with DARS as the lead for such an exploration in accordance with their state-designated role as the lead agency for TBI (§ 51.5-120) and dementia (§ 51.5-152). DMAS further notes that VDH should be part of any discussion since the creation and addition of new nursing facility beds in Virginia is subject to the Certificate of Public Need (COPN) program, which is overseen by VDH.
4	Request by letter of the JCHC Chair that DMAS determine a plan, including budget estimates, to add new services to the Medicaid Elderly or Disabled with Consumer Direction	DMAS is exploring the potential to add additional services to the EDCD waiver. Further, the process to roll individuals into Managed Long-Term Services and Supports (MLTSS) with an effective date of July 1, 2017.

	Waiver to provide needed long term services and supports for Medicaid beneficiaries; and report back to the JCHC by November 2017.	With MLTSS, the health plans have the potential to better coordinate services, test innovative approaches, and mitigate potential risks or disruptions in home and community-based services.
5	Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a Medicaid waiver specific to brain injury; and report back to the JCHC by November 2017.	<p>DMAS, working with stakeholders has submitted several requests for authority and funding for a Medicaid brain injury waiver as a matter of public record. It is unlikely in this fiscal climate that this will be revisited during this biennium.</p> <p>It is important to note that it is unlikely that a Medicaid waiver could be developed and implemented that would both comport with the CMS Home and Community-Based Services (HCBS) Final Rule and be able to serve the individuals who are receiving services at the Massachusetts Neurobehavioral Rehabilitation Facility. Such a waiver would most likely face similar obstacles that the Alzheimer's Assisted Living (AAL) waiver has encountered.</p> <p>However, that is not to say that there are other individuals with TBI who have less severe neurobehavioral needs who currently receive EDCD waiver services and many who could also benefit for additional waiver services. With that mind, DMAS is exploring the potential to add additional services to the EDCD waiver. Further, the process to move individuals into Managed Long-Term Services and Supports (MLTSS) is underway. With MLTSS, the health plans have a better potential to better coordinate services, test innovative approaches, and mitigate potential risks or disruptions in home and community-based services.</p>
6	Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a state plan amendment [1915(i) or 1915(k)] to provide additional home and community based services for Medicaid recipients not enrolled in a 1915(c) HCBS waiver; and report back to the JCHC by November 2017.	
7	Request by letter of the JCHC Chair that DMAS apply for the PACE Innovation Act pilot program.	<p>DMAS, the National PACE Association and the Virginia PACE Alliance is actively engaged with the CMS activities related to the PACE Innovation Act, including any development of Requests for Proposals (RFPs), regulations, and guidance documents. At this point there is no funding attached to the Innovation Act and no requests for pilots have been issued. Lacking any funding for pilots it may be difficult to attract providers to this model of care which typically takes health care systems 3-4 years in which to break even.</p> <p>DMAS requests additional time to review these activities prior to making any decisions on participating.</p>

8	Introduce budget amendment (language and funding) to increase state funds for the Auxiliary Grant.	Auxiliary Grants are federal and local funds.
9	By letter of the JCHC Chair, express support for Senate Bill 317, carried over to 2017, to create Veteran' s Dockets.	No response.

JCHC Response to DMAS

Mrs. Cynthia B Jones, Director

Virginia Department of Medical Assistance Services

600 E. Broad Street

Richmond, VA 23219

Dear Mrs. Jones:

Thank you for your comments on the Joint Commission on Health Care's (JCHC) report on Expanding Access to Brain Injury Services and Barriers to Placement of Virginians who Have Challenging Behaviors Resulting from Traumatic and Non-Traumatic Brain Injuries and Post-Traumatic Stress Disorder presented on September 7, 2016. Your comments will be provided to our members prior to the November 9 decision matrix meeting. I would like to respond to a few of your points.

Slide 26 (In regard to Sentara Life Care Corporation): In the course of conducting research for the report over the spring, I had conversations with Mr. Bruce Robertson, President of Sentara Life Care Corporation who expressed an ongoing desire to open a neurobehavioral rehabilitation unit in Virginia. In addition, Mr. Robertson sent two staff members, Kari V. Voll, OTRL/L, MBA, Project Manager of Acute & Post-Acute Rehabilitation, and Kathleen A. Hardesty, OTR/L, Director of Acute & Post-Acute Rehabilitation to the JCHC meeting, who at the conclusion of the meeting, expressed their continuing interest and appreciation for voicing Sentara's interest in serving Medicaid enrollees in need of neurobehavioral services.

During my conversations with Mr. Robertson, the issue of 12VAC30-90-226 was discussed. This regulation, which was last amended in 2001, provides for a fixed per day payment add-on for nursing facility residents with traumatic brain injury not to exceed \$50 per day. Mr. Robertson expressed that the nursing home rates, even with the maximum add-on payment, are inadequate to cover the costs of operating a unit. The inadequacy of the add-on rate was echoed by DMAS Provider Reimbursement staff who noted that the rate was out-of-date and has been unclaimed for many years.

In addition, 12VAC30-90-330 subsection C (effective August 19, 1998), specifies that *"nursing facilities which may be approved to provide this service shall operate a dedicated unit of 20 beds or more and provide additional professional services to support the special needs of these individuals."* Mr. Robertson also expressed that a new unit would need to be scaled for sustainability, and it would not be feasible to operate a unit with empty beds. In our conversations he indicated an interest in operating a twelve-bed unit.

Slides 44 and 45: Thank you for pointing out the errors in listing assisted living as a benefit covered under the Elderly and Disabled with Consumer Direction Wavier (EDCD), and Care Coordination rather than Case Management. The preference for adding new services to the EDCD waiver was expressed by DMAS staff in multiple conversations. The presentation did not list room and board as a Medicaid wavier service, and slide 28 discussed the lack of supported apartments and other residential options as a gap which need to be addressed.

Option 5 (In regard to a new waiver specific to individuals with brain injury): I agree that the current fiscal climate does not favor programs that would require new funding, but given that this recommendation has been included

in past reports that are referenced in the presentation, I thought it was important to include it for our members' consideration.

Slide 27 and Policy Option 8 (In regard to funding for Auxiliary Grants): DMAS comments that Auxiliary Grants are sourced with federal and local funds. Language from the Virginia Administrative Code, 22VAC30-80-10 definitions states, *"The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise: Auxiliary Grants Program or 'AG' means a state and locally funded assistance program to supplement income of an individual receiving Supplemental Security Income (SSI) or adult who would be eligible for SSI except for excess income, who resides in an ALF or in AFC with an established rate."*

Further, the Virginia Department of Social Services website at: <https://www.dss.virginia.gov/family/as/auxgrant.cgi> states, *"The AG Program is 80 percent state funded and 20 percent locally funded and is administered by the Department for Aging and Rehabilitative Services."*

Lastly, Virginia Budget Bill HB30 Item 345 shows an appropriation for Auxiliary Grants for the Aged, Blind and Disabled of \$21,898,969 for SFY2017 and the same amount for SFY2018. If my interpretation of the source of funding for Auxiliary Grants is incorrect, I thank you for that information.

In the course of compiling information for the report, I had numerous meetings and discussions with representatives from DMAS, DARS, VDH, DVS, the Brain Injury Association of Virginia, the Virginia Alzheimer's Association, Sentara, Community Brain Injury Services; the Denbigh House, Brain Injury Services, Inc. and Brain Injury Services of Southwest Virginia; and I attended the three Brain Injury Data Workgroup meetings where I shared a draft of my presentation. In addition, staff at DMAS and DARS were provided with draft copies of the report for comment and verification prior to publication.

Providing services for individuals with brain injuries, dementias and post-traumatic stress disorder is complex, multi-faceted and involves the work of several agencies and other stakeholders. DMAS and DARS do remarkable work in providing services for individuals in need, and I recognize the significant accomplishments that you and your staff have achieved to the benefit of our citizens.

I look forward to continuing our collaboration to address the health care needs of the citizens of the Commonwealth.

Sincerely,

Paula Margolis, Ph.D.,

Senior Policy Analyst

Joint Commission on Health Care

Cc: Michele Chesser, Ph.D.
Senator Charles W. Carrico, Sr.
Karen Kimsey, DMAS
James Rothrock, DARS
Terry Smith, DMAS
Brian McCormick, DM

Community Health Workers in the Commonwealth

Michele Chesser
Executive Director, Joint Commission on Health Care

Summary of Institute for Public Health Innovation's August 3, 2016 Presentation, by Michael Royster, M.D.

In Fall 2012, culminating from House Joint Resolution 195 of the 2004 Virginia General Assembly and the 2010 public hearing by the Virginia Department of Health Professions, the Virginia Department of Health (VDH) brought together a group of stakeholders invested in Community Health Worker (CHW) efforts to gauge their interest in continuing to sustain and support Virginia's CHW workforce. This stakeholder meeting resulted in the creation of the Virginia CHW Taskforce that comprised of a mix of organizations working across the health spectrum. In Summer 2014, the Institute for Public Health Innovation (IPHI) joined VDH in co-facilitating the Taskforce. Now known as the CHW Advisory Group, it includes over 50 representatives from urban and rural Virginia; public health and supporting organizations-including local health districts, health systems, VCCS, universities, DMAS, DARS, VACHA, free clinics, VHQC, and others from across the state.

The use of CHWs has been shown to improve health outcomes, quality of care, and reduce healthcare costs. The CHW Advisory Group continues to examine the roles of CHWs to ensure their recognition and growth, and is committed to defining and sustaining the CHW workforce. After drafting core competencies and scope of practice, the Advisory Group continues to raise awareness of CHW efforts statewide, develop a better understanding of existing CHW initiatives, create a CHW training and certification plan, and identify financing strategies to sustain CHWs.

The Advisory Group has established two committees to lead the key aspects of its work. The Policy and Finance Committee is comprised of high level decision makers with the ability to move the CHW workforce development and financing agenda forward. The Certification Committee is working to develop consensus training and certification standards for CHWs across Virginia, as well as the organizations and curricula used to train them.

We are focusing on three major areas of work needed for effective integration of CHWs into the health workforce: 1) ensuring a quality workforce, including the development of a definition of CHWs, a scope of practice, core competencies, and training and certification programs; 2) supporting the integration of CHWs into care teams through pilot projects, model development, and technical assistance; and 3) securing sustainable funding through data collection, education of stakeholders, and development of legislative and organizational policies, and financial strategies.

Policy Recommendation Submission to the Joint Commission on Health Care:

Option 1: Take no action

~~14-2~~ *Option 2: Insert language into the Code of Virginia to Provide letter from the JCHC Chair supporting that the designate designation of the Virginia Community Health Worker (CHW) Advisory Group as the official entity within Virginia to explore and standardize training and certification guidelines for CHWs, and explore financing and other sustainability options.*

Joint Commission on Health Care
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