MSV℠ MEDICAL SOCIETY OF VIRGINIA

2020 Advocacy Summit

Proposal Packet

2020 Advocacy Summit Proposal
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Proposal #1

Title of Proposal: Promoting Health Equity for Vulnerable Populations during the COVID-19 Pandemic

Submitter(s)/ Presenter(s): Daniel Akyeampong, Itohan Omorodion, Leah Reichle, Marc Vetter

On behalf of: MSV Medical Student Section

Description of the issue:

Nationally, the COVID-19 pandemic has disproportionately adversely affected communities of color. According to data from John Hopkins University and the American Community Survey, the SARS-CoV-2 infection rate is 3-fold higher in predominantly-black counties when compared to predominately-white counties.[1] Furthermore, the mortality rate is 6-times higher in predominately-black counties relative to predominately-white counties.[1] In Virginia, race has been reported for 68% of cases and 90% of deaths and ethnicity has been reported for 67% of cases and 84% of deaths.[2] Black or African Americans account for 19% of the population in Virginia, make up 20% of cases, and account for 23% of deaths related to COVID-19.[2] However, there is a lack of clarity on who has been identified as "some other race," so this data may be underestimating the true prevalence of cases among Blacks or African Americans.[2] Hispanics or Latinos make up 10% of the population in Virginia yet they make up 50% of cases and account for 12% of deaths related to COVID-19.[2] The lack of robust data on racial and ethnic demographics makes it difficult to understand the scope of the burden COVID-19 and adequately allocate resources to communities within Virginia.

These disparities are alarming and are largely attributed to long-standing social determinants entrenched in structural racism that make marginalized communities less equipped to withstand the consequences of a pandemic. Racial and ethnic minorities residing in low-income communities are substantially more likely to have occupations that do not allow them to work remotely, live in high-density residential areas that make physical distancing impractical, lack access to affordable healthcare, and have comorbidities such as hypertension, diabetes, obesity, asthma, influenza, and pneumonia that increase the likelihood of having a severe disease course from SARS-CoV-2 infection.[3] These social determinants are further compounded by the legacy of exploitation from the medical field which has led minorities to mistrust the medical field.[4] This sense of mistrust makes it difficult for minorities to feel comfortable accessing medical care and trusting sources of information coming from public health agencies and health systems.

Despite the legislative measures that the US Congress has taken in response to the COVID-19 pandemic, many drivers of racial disparities are still not adequately addressed. The most recent Coronavirus Aid, Relief, and Economic Security [CARES] Act, Public Law 116-136 attempted to provide financial support to individuals and businesses, but the financial resources were not easily accessible to minorities because they are more likely to have not filed a tax return or have a bank account.[5] Moreover, the imbalance in

the distribution of the $100 billion designated for health care organizations and clinicians has left hospitals that serve predominantly low-income and uninsured individuals with less financial support.[5]

The Health and Economic Recovery Omnibus Emergency Solutions Act (HR6800), Health Equity and Accountability Act (HEAA) of 2020 (HR6637), The Community Solutions for COVID-19 Act (HR 7077), Equitable Data Collection and Disclosure on COVID-19 Act (HR 6585), and COVID-19 Racial and Ethnic Disparities Task Force Act of 2020 (HR 6763/S 3721) are all proposals at the federal level that strive to address four key areas in order to promote health equity in the midst of the COVID-19 pandemic. The target areas are 1) increasing access to healthcare services 2) enhancing the capacity of healthcare systems, 3) targeted interventions for marginalized populations, and 4) comprehensive data that accurately portrays demographic disparities. Each of these proposals are summarized below.

Summaries of the Federal Health Equity Proposals

Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES) of 2020 (HR6800)[6]
The Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act is proposed legislation passed by the United States House of Representatives on May 15, 2020. Its primary proposals include: expanding health care services for underserved populations; expanding healthcare coverage and access, with no cost sharing for COVID-19; improvements in supply chain, stockpile, testing infrastructure, contact tracing for COVID-19; improved collection of race, ethnicity, and disparity data and research; increased mental health support; and protecting vulnerable populations such as people experiencing homelessness, the elderly, and prisoners; and addressing environmental justice among other social determinants.

Health Equity and Accountability Act (HEAA) of 2020 (HR6637)[7]
The Health Equity and Accountability Act (HEAA) of 2020 was recently introduced by Congressional Black Caucus, Congressional Hispanic Caucus, and Congressional Asian Pacific American Caucus. Its primary proposals include: expanding healthcare coverage and access; improved collection of race, ethnicity, and disparity data and research, improved access to culturally and linguistically appropriate services in healthcare; increased mental health support; addressing environmental justice among other social determinants; and increasing health workforce diversity.

The Community Solutions for COVID-19 Act (HR 7077) (Not presented to Senate yet)[8]
The Community Solutions for COVID-19 Act is a draft bill proposed by Sen. Cory Booker (D-NJ) and Rep. Robin Kelly (D-IL). Its primary proposal includes: Establishing a $1.5 billion dollar fund allocated by the Centers for Disease Control and the secretary of health. This fund would be used to provide grants of an unspecified amount to non-governmental entities that have demonstrated a history of success in providing services to local communities that have been disproportionately impacted by COVID-19. Examples of these communities include: racial and ethnic minorities, Native American and Native Alaskan tribes, English language learners, people with disabilities and others. Grants shall be used for such activities as: increasing the availability of testing in low-resource communities, helping individuals enroll in health insurance, addressing social determinants of health such as transportation and nutrition,

providing anti-racism training to health care providers, providing culturally and linguistically appropriate health care outreach and education regarding COVID-19, and more. Money allocated to the fund will be distributed to organizations across the nation for a period of 3 years.

Equitable Data Collection and Disclosure on COVID-19 Act (HR 6585)[9]

The Equitable Data Collection and Disclosure on COVID-19 Act is a bill that was introduced by Rep. Robin Kelly (D-IL) on April 21, 2020. The bill would establish a commission that would set reporting requirements for certain demographic data on COVID-19 such as race, ethnicity, sex, age, primary language, socioeconomic status, disability status, and county. The commission created by this bill would then use that data to guide strategies to reduce demographic disparities. The bill also stipulates that the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) would have to publish and provide daily updates on data on COVID-19 testing, treatment, and outcomes that is disaggregated by the required demographic characteristics such as race and ethnicity. This data would be presented on the CDC website. The Indian Health Service would be directed to work with tribes in order to collect data related to COVD-19. The Department of Health and Human Services would be tasked with the responsibility of making a final report that summarizes the data on COVID-19 60 days after the end of the public health emergency.

COVID-19 Racial and Ethnic Disparities Task Force Act of 2020 (HR 6763/S 3721)[10]

The COVID-19 Racial and Ethnic Disparities Task Force Act was introduced by Rep. Robin Kelly (D-IL) on May 8, 2020. This act would create a task force that gathers data on communities that have been disproportionately affected by COVID-19 and generates recommendations on the disparities can be addressed. The task force would be spearheaded by the Secretary of Health and Human Services. The task force would also be responsible for providing oversight on the disbursement of financial resources from the previous COVID-19 relief packages to understand any related racial and ethnic disparities. Within 90 days after the end of the COVID-19 public health emergency, the task force will generate a report that summarizes contributory factors for the racial and ethnic disparities and recommendations for the federal response to infectious disease emergencies. At the closure of this task force, a permanent Infectious Disease Racial and Ethnic Disparities Task Force will be created to maintain this structure for future public health emergencies.

Virginia has already taken action to address health disparities from the COVID-19 pandemic by establishing the COVID-19 Health Equity Working Group (HEWG) within the Virginia Department of Health Office of Health Equity. However, we urge Virginian legislators to support these bills at the federal level. These legislative proposals are broad in scope and have the potential to meaningfully impact the lives of Virginians. Furthermore, we encourage Virginian legislators to develop similar policies that would be tailored for the needs of Virginians in order to further promote health equity in Virginia during this pandemic. The Primary Care Office and the Division of Multicultural Health and Community Engagement within the Virginia Office of Health Equity could be instrumental in implementing many of these proposed actions.

These proposed policies align with the current stance of The Medical Society of Virginia. MSV policy 05.4.01 – Access without Discrimination – delineates the MSV's support for medical care access without discrimination. Several bills at the federal level have been proposed to reduce access and coverage barriers, including the Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES) of 2020 (HR 6800) and the introduced the Health Equity and Accountability Act (HEAA) of 2020 (HR 6637). These bills outline numerous ways to immediately and sustainably improve healthcare access for vulnerable populations. For example, increased racial data collection, reporting, and disparity research; free COVID-19 testing and treatment for all individuals; improving cultural and linguistic-appropriate health care and community-led public awareness campaigns; improving health care access and quality, including development of mobile testing for COVID-19; and aid for providers caring for vulnerable populations and community health centers. These are all activities that would reduce the consequences from disparities that are evident during this pandemic.

Desired outcome:

That the MSV will work with the AMA and the Virginia AMA Delegation in support of federal and state legislation that promotes health equity within communities of color. Existing legislation that exemplify these goals include:

1) The Health and Economic Recovery Omnibus Emergency Solutions Act (HR6800)
2) Health Equity and Accountability Act (HEAA) of 2020 (HR6637)
3) The Community Solutions for COVID-19 Act (HR 7077)
4) Equitable Data Collection and Disclosure on COVID-19 Act (HR 6585)
5) COVID-19 Racial and Ethnic Disparities Task Force Act of 2020 (HR 6763/S 3721)

That the MSV actively support and advocate for legislation to address racism and subsequent racial disparities in health care by:

1) Expanding access to physician-led healthcare for underserved communities and communities of color
2) Enhancing supports for healthcare systems and entities serving predominately low-income or underinsured individuals and communities of color
3) Building comprehensive data that accurately captures rates of COVID-19 testing, infection, hospitalizations and deaths among varying demographics
4) Developing strategic interventions to bolster the health of marginalized populations whose health has been adversely affected by racism

Issue Background and Supplemental Information:

References

1. Yancy CW. COVID-19 and African Americans. *JAMA.* 2020;323(19):1891–1892. doi:10.1001/jama.2020.6548
2. The Covid Tracking Project. Racial Data Dashboard. CovidTracking.com https://covidtracking.com/race/dashboard#state-va. Published June 12, 2020. Accessed June 12, 2020

3. Webb Hooper M, Nápoles AM, Pérez-Stable EJ. COVID-19 and Racial/Ethnic Disparities. *JAMA.* Published online May 11, 2020. doi:10.1001/jama.2020.8598
4. Kennedy BR, Mathis CC, Woods AK. African Americans and their distrust of the health care system: healthcare for diverse populations. J Cult Divers. 2007;14(2):56-60.
5. Dowling MK, Kelly RL. Policy Solutions for Reversing the Color-blind Public Health Response to COVID-19 in the US. *JAMA.* Published online June 04, 2020. doi:10.1001/jama.2020.10531
6. 116th Congress. H.R. 6800 - The Heroes Act. Congress.gov. https://www.congress.gov/bill/116th-congress/house-bill/6800?q=%7B%22search%22%3A%5B%22HR6800%22%5D%7D&s=6&r=1. Accessed June 13, 2020.
7. 116th Congress. H.R. 6637 - To improve the health of minority individuals, and for other purposes. Congress.gov. https://www.congress.gov/bill/116th-congress/house-bill/6637?q=%7B%22search%22%3A%5B%22HR6637%22%5D%7D&s=7&r=1. Accessed June 13, 2020.
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10. 116th Congress H.R. 6763 - COVID-19 Racial and Ethnic Disparities Task Force Act of 2020. Congress.gov. https://www.congress.gov/bill/116th-congress/house-bill/6763?q=%7B%22search%22%3A%5B%22HR+6763%5C%2FS+3721%22%5D%7D&s=10&r=1. Accessed June 13, 2020.

Proposal #2

Title of Proposal: Reusable Personal Protective Equipment

Submitter(s)/ Presenter(s):

On Behalf of:

Description of the Issue:

The COVID-19 pandemic has been responsible for overwhelming numbers of patients who require direct in-person care in hospitals and doctors' offices. An ample supply of personal protective equipment (PPE) is critical to safely serving patients in these settings so that disease spread can be contained. We are currently dependent on disposable PPE that is generally manufactured outside of the United States leading to difficulties in resupply actions in a global market as well as excessively high prices during a worldwide pandemic. Dependence on disposable PPE in high demand states negatively impacts the environment in the form of excess energy consumption, greenhouse gas production, and blue water consumption. Institution of reusable PPE programs will help health care systems assure adequate supplies of PPE for the current and future pandemics as well as potentially reduce overall costs and environmental impacts to their communities.

Desired Outcome:

We propose that the Medical Society of Virginia advocates for the Virginia Legislature to pass legislation to encourage and provide financial assistance to health care systems to transition to reusable personal protective equipment.

Issue Background and Supplemental Information:

(1) An Environmental Analysis of Reusable and Disposable Surgical Gowns; Vozzola, et al; AORN Journal; https://doi.org/10.1002/aorn.12885

(2) A Comparison of Reusable and Disposable Perioperative Textiles Sustainability State-of-the-Art 2012; Overcash, Michael; Anesthesia & Analgesia; https://journals.lww.com/anesthesia-analgesia/Fulltext/2012/05000/A_Comparison_of_Reusable_and_Disposable.21.aspx

(3) Life Cycle Assessment Comparing Laundered Surgical Gowns with Polypropylene Based Disposable Gowns; Carre, Andrew; https://www.lac-mac.com/mediafiles/catalogue/RMIT_LifeCycleAssessmentDisposableVsReusableGowns.pdf

(4) An argument for reusable PPE; Jaramillo, Maria; Center for Medical Ethics and Health Policy; Baylor College of Medicine; https://blogs.bcm.edu/2020/05/07/an-argument-for-reusable-ppe/

Proposal #3

Title of Proposal: Truth in Advertising and Professional Credential Disclosure

Submitter(s)/ Presenter(s): Dr. Grant Day, Dr. Rachel Ellis, Dr. Mary Mather

On behalf of: Virginia Dermatology Society

Description of the issue:

There are a multitude of professions that utilize the term "doctor" or "physician" including Medical Doctor (M.D.); Doctor of Osteopathic Medicine (D.O.); Doctor of Chiropractic (D.C.); Doctor of Optometry (O.D.); and other designations which may be used by health care practitioners, and recent trends in healthcare practitioner legislation have granted increased autonomy to Nurse Practitioners including Virginia House Bill 793 (HB793)[1] which eliminates the requirement of a practice agreement with a patient care team physician a licensed nurse practitioner who has completed the equivalent of at least five years of full-time clinical experience among other stipulations and the more recent Virginia Executive Order 57 (EO-57)[2] which grants temporary independent practice of Nurse Practitioners without practice agreements who have at least two years of clinical experience among other stipulations.

A 2018 survey performed by the American Medical Association (AMA)[3] highlights increasing patient confusion regarding the many types of healthcare providers, specifically, 27% percent of patients believe a chiropractor is a medical doctor; 35% believe a nurse with a "doctor of nursing practice" degree is a medical doctor; 47% of patients believe an optometrist is a medical doctor; 44% of patients believe it is difficult to identify who is a licensed medical doctor and who is not by reading what services they offer, their title, and other licensing credentials in advertising or other marketing. The same survey, completed by the AMA Scope of Practice Partnership (SOPP), reinforces that patients desire more transparency regarding the qualifications and credentials of their healthcare providers including that 92% of patients believe that only medical doctors should be permitted to use the title "physician" and 87% of patients support state legislation to require all health care advertising materials to clearly designate the level of education, skills, and training of all health care professionals promoting their services.

There are widespread differences in the training and qualifications required to earn the various professional degrees described above, [4][5], and these differences often concern training and skills to correctly detect, diagnose, prevent, and treat serious healthcare conditions.

There is a compelling interest in patients being promptly and clearly informed of the training and qualifications of healthcare providers providing health care services.

There is a compelling interest to protect the public from potentially misleading and deceptive healthcare advertising that might cause undue patient expectations and compromise patient informed consent.

Other than § 54.1 – 2903 of the Code of Virginia[5], which highlights generally what constitutes "medical practice" and basic guidance of transparency in using the term "doctor", there is little state legal protection for patients in the realms of truth in advertising and professional credential disclosure. There is an increasing climate in

Virginia of practice autonomy of non-physician healthcare providers.

Desired outcome:

We propose the Medical Society of Virginia (MSV) support "Truth in Advertising and Professional Credential Disclosure" legislation protecting patients from fraudulent, deceptive, or misleading advertising.

We propose the MSV support legislation "Truth in Advertising and Professional Credential Disclosure", which would require a healthcare provider to identify the license under one practices in one of the following manners: (a) wearing of a name tag which identifies the licensee's credentials (b) wearing of an article of clothing which identifies the licensee's credentials (c) oral disclosure to the patient upon initial contact of the licensee's credentials (d) providing a business card or similar document identifying the licensee's credentials or (e) placing notification of the licensee's credentials in the lobby or waiting area.

We propose the MSV adopt policies protecting patients against false advertising of board certification, specifically that a physician may not hold oneself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the ABMS or other recognizing agency that has been approved by the medical board.

We propose the MSV adopt policies that prohibit the dissemination of information or advertisement that is false, deceptive, or misleading, including if that information:

(a) States or implies that the physician has received formal recognition as a specialist in any aspect of the practice of medicine unless the physician has in fact received such recognition and such recognizing agency is approved by the Board
(b) Conveys the impression that the physician disseminating the advertising or referred to therein possesses qualifications, skills, or other attributes, which are superior to other physicians
(c) Fails to conspicuously identify the provider by name in the advertisement
(d) Misrepresentation or absence of license credential information on identification materials
(e) Includes reference to specialty certification without identifying the name of the specialty board that has awarded specialty certification.

References

1. State of Virginia, House Bill 793, *Nurse practitioners; practice agreements*, 2018 Session
2. State of Virginia, Executive Order 57, *Licensing of Health Care Professionals in response to Novel Coronavirus (COVID-19)*
3. American Medical Association Scope of Practice Partnership, "Truth in Advertising Campaign", July. 2018
4. Primary Care Coalition. "Comparing the Education Gaps Between Primary Care Physicians and Nurse Practitioners". 2008.
5. Sym D et al. "Characteristics of nurse practitioner curricula in the United States related to antimicrobial prescribing and resistance." Journal of the American Academy of Nurse Practitioners. September 2007, Vol. 19, No. 9, pp. 477-485.

6. Code of Virginia, § 54.1 – 2903, What constitutes practice; advertising in connection with medical practice.

Proposal #4

Title of Proposal: Medical Spa Standards of Practice

Submitter(s)/Presenter(s): Dr. Grant Day, Dr. Rachel Ellis, Dr. Mary Mather

On Behalf of: Virginia Dermatology Society

Description of the Issue:

Medical spas are defined as establishments that offers diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments that can alter or cause biologic change or damage the skin and subcutaneous tissue.

The distinguishing feature of medical spas is that medicine and surgery are practiced in a non-traditional setting. Recent studies have shown a trend toward an increase in the demand for minimally invasive cosmetic procedures performed at medical spas, including a 2016 study showing that over 3.3 million injectable neuromodulators and soft-tissue filler procedures were performed as well as over 2.8 million laser/light/energy-based procedures[1].

A 2017 American Society of Dermatologic Surgery (ASDS) Consumer Survey found that of 7,322 people surveyed nearly 7 out of 10 are considering a cosmetic procedure[2].

This same survey noted that the top four influencers of selection of a practitioner was price (49%), specialty of board certification (41%), physician referral (37%), and level of licensure of practitioner performing the procedure (32%).

The notable increase in demand for cosmetic procedures has led to the significant influx of non-physicians offering cosmetic services and patients seeking out non-physicians for aesthetic medical treatments[3].

These cosmetic procedures do not come without inherent risks including burns, dyschromia, infection, necrosis, or bruising[4].

A 2019 study from *Dermatologic Surgery* noted that patients receiving cosmetic interventions from non-physicians experienced more burns and dyschromia relative to patients treated by a board-certified physician trained in the specific intervention, and most of the non-physician occurred outside a traditional medical office[5].

Due to a discrepancy in supply of board-certified physicians trained in cosmetic surgery and the demand for these procedures, the lines between cosmetic surgery and cosmetology have begun to blur, with medical spas having a lack of formal regulation and some facilities listing a medical director who does not own the facility or is not immediately available on-site for supervision.

The knowledge garnered by physicians in anatomy, indications for procedures, appreciation of risks/complications, and prevention of complications is paramount for the safety of the unsuspecting public seeking medical aesthetic services.

The Code of Virginia does not explicit have legislation regarding the regulation of medical spas.

There is a compelling interest in patients being promptly and clearly informed of the training and qualifications of healthcare providers providing medical aesthetic services.

There is a compelling interest to protect the public by establishing standards of practice for the performance, delegation, assignment, and supervision of medical and surgical procedures performed by a medical director or under a supervising physician's direction at a medical spa facility.

We propose the Medical Society of Virginia (MSV) support the “Medical Spa Standards of Practice” legislation establishing standards of practice for the performance, delegation, assignment, and supervision of medical and surgical procedures performed by a medical director or under a supervising physician's direction at a medical spa facility.

Desired Outcome:

We propose the MSV recognize that procedures by any means, methods, devices, or Instruments that can alter or cause biologic change or damage the skin and subcutaneous tissue constitute the practice of medicine and surgery.

We propose the MSV adopt policies that any procedure that constitutes the practice of medicine should be performed only by an appropriately-trained physician or appropriately-trained non-physician personnel under the direct, on-site supervision of an appropriately-trained physician in accordance with applicable local, state, and/or federal laws and regulations.

We propose the MSV adopt a policy that defines “on-site supervision” by a licensed physician as a supervising physician that is both present at the site and is able to respond immediately, in-person, during a delegated medical aesthetic procedure.

We propose the MSV adopt a policy that each medical spa facility should maintain up-to-date written protocols regarding appropriate delegation and supervision for all medical aesthetic procedures performed within the facility.

We propose the MSV adopt a policy that a medical director of a medical spa facility should be clearly identified by state licensure, any state recognized board-certification and medical specialty, training and education and identified as the medical director in all marketing materials and Internet Web sites related to the medical spa facility, and the medical director shall ensure that marketing and advertising materials of a medical spa facility do not include false, misleading, or deceptive representations of procedures provided by the facility or of the qualifications of the medical spa personnel.

We propose the MSV adopt a policy that a medical director or supervising physician is responsible for performing an initial assessment of each patient in a medical spa facility, preparing a written treatment plan, obtaining informed consent from all patients including disclosure of personnel performing the procedure(s), creating, maintaining and reviewing patient medical records in accordance with local, state and/or federal laws and regulations.

We propose the MSV adopt a policy that any licensed physician or non-physician must have received appropriate documented training in the safe and effective performance of all medical aesthetic services performed at the facility, and have training in the ability to handle any emergency or sequelae following aforementioned procedure.

We propose the MSV adopt a policy that medical spa facilities should be licensed and inspected on a regular basis to ensure compliance with all applicable federal and state laws, and medical spa facilities must be able to prove they have the necessary personnel, equipment and protocols to safely perform all offered procedures and handle any emergencies or sequelae that may arise, and any incident within the medical spa facility that results in a patient death, transport of the patient to the hospital, or a significant complication or adverse event requiring additional medical treatment, shall be reported to the appropriate state agency, the FDA if applicable, or both.

We propose the MSV adopt a policy that medical spa facilities, medical directors, and all non-physician personnel shall maintain appropriate liability insurance or communicate lack of insurance in advance to all patients.

References

1. Kimball AB and Resneck JS Jr., The US dermatology workforce: a specialty remains in shortage. J Am Acad Dermatol, 2008. 59(5): p. 741–5.
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5. Rossi AM, Wilson B, Hibler BP, Drake LA. Nonphysician Practice of Cosmetic Dermatology: A Patient and Physician Perspective of Outcomes and Adverse Events. *Dermatol Surg*. 2019;45(4):588-597. doi:10.1097/DSS.0000000000001829

Proposal #5

Title of Proposal: Coverage for Off Label Use of Drugs and Devices

Submitter(s)/ Presenter(s): Zachary Scharf, UVA medical student

On behalf of:

Description of the Issue:

MSV, in Policy 10.1.08, opposes the practice by insurers and health care plans of denying coverage for particular drugs or devices for patients on the basis that the drug or device is used for a different indication than the one it received approval for from the Food and Drug Administration. Off label drugs are used regularly in many fields of medical practice, including but not limited to rheumatology, oncology, and neurology (often in the treatment of epilepsy disorders). Additionally, medications are often used off label in pediatrics, where many effective drugs have not been officially approved for use in the pediatric population.

Research into this area indicates that 10 to 20 percent of all prescriptions written are for off label uses and more than 50 percent of expensive, potentially toxic drugs, such as chemotherapeutics are used off label (Fitzgerald, O'Malley; Gillick). In the battle against COVID-19, in addition to vaccine development, off label options have been explored. A recent trial (the Recovery clinical trial) conducted by researchers from the University of Oxford espoused preliminary results that indicated that dexamethasone significantly improved the outcomes of patients with COVID-19 on mechanical ventilators. Regardless of the final outcome of this trial, this information underscores the importance of off label medications in modern medical treatment and the need for coverage by insurers.

Desired Outcome:

The Medical Society of Virginia should uphold the freedom of physicians to care for patients as they see best by actively supporting and advocating for legislation to maintain and expand insurance coverage for off label medications and devices in Virginia.

Issue Background and Supplemental Information:

References

1. Staying on Track When Prescribing Off-Label – American Family Physician Journal
2. Controlling Off-Label Medication Use – Annals of Internal Medicine

Proposal #6

Title of Proposal: Telehealth Super Proposal

Submitter(s)/Presenter(s):

Dr. John Paul Verderese (American College of Physicians, Virginia Chapter); Dr. Stephen Cunningham and Dr. Adam Kaul (Psychiatric Society of Virginia); Dr. Mark Ryan; Shashank Somasundaram (Virginia Tech Carilion School of Medicine, Student); Lauren Schmitt (American Academy of Pediatrics, Virginia Chapter, Virginia College of Emergency Physicians)

Describe the Idea or Issue:

The COVID-19 pandemic and declared public health emergency has led to increased need for, and recognition of the value of, telehealth services. Telemedicine and telephone visits have allowed physicians to reach patients that had difficulty accessing care prior to and during the COVID-19 pandemic. Many Virginians – especially the elderly, rural, and low-income populations – do not have access to high-speed internet, and/or are not knowledgeable of or comfortable with the technology, devices, and equipment required for reliable video conferencing. In addition, many people do not have access to reliable transportation needed for in-person visits. Expansion of telemedicine and telephone visit coverage, pay parity, and patient copay waivers have mitigated the financial strain for physician practices in threat of permanent practice closure, physician and support staff unemployment, and decreased access issues for patients.

When the COVID-19 pandemic began, many of the laws and regulations regarding telehealth were loosened, to ensure that patients were still able to receive care. Many of the temporary policy changes have been beneficial to both patients and providers. The Virginia AAP believes that some of these changes should be permanent, in order to improve health care delivery to our patients. Premature expiration of the emergency waivers pertaining to telehealth will lead to potential financial ruin to practices and decreased access to care for patients. Parity in reimbursement between face-to-face or video services and audio-only telehealth services, and for a mandate that Medicaid and commercial health plans reimburse for audio-only services is crucial to provide care continuity and solve ongoing access issues.

Virginia Governor Ralph Northam publicly recognized the acute behavioral health challenges many Virginians face and the importance of access to treatment and services. The federal Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration (HRSA), the Northam Administration, and the Virginia Department of Medical Assistance Services (DMAS) have issued waivers to lift restrictions on and encourage the provision of telehealth, ease HIPAA, and have specifically allowed and reimbursed for the use of audio-only equipment and connections for Medicaid (and Medicare) services. Telehealth, including audio-only, allows specialties like psychiatrists to see more patients in a day, thereby expanding their reach to those in need of mental health treatment and helping alleviate behavioral healthcare shortages. Related provisions that ensure the same confidentiality, security, and standard of care through audio-only telehealth as face to face or video services are needed. Encouraging policymakers to consider requiring providers to document a patient's inability to connect using video technology when no other feasible or reliable interactive electronic technology or media are

available to the patient, should be in the statutory definition of telemedicine. There are still many areas of Virginia that do not have broadband capabilities and patients that are unable to participate in telehealth through many of the current HIPPA-compliant platforms. For some patients, audio-only telehealth is their only option and ensuring those patients have the ability to receive care should be a legislative priority.

Historically, in Virginia, Telemedicine was defined as services provided via audio-visual communication to allow for the provision of medical care, and specifically excluded audio-only telephone. The current telehealth expansion has enabled many individuals to receive much-needed treatment for mental health and substance use disorders, some of them for the first time. On the private insurance side in Virginia, insurers are required to pay the same rate for telemedicine visits as they would for a face to face in person visit. However, state law excludes audio-only services from the statutory definition of telemedicine for private insurance. Per § 38.2-3418.16: "Telemedicine services" as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. We appreciate that many Virginia health insurance carriers are reimbursing for audio-only telehealth services during the pandemic. However, reimbursement rates for audio-only services are generally lower than audio-visual interactions. Because audio-only services are excluded from the state's definition of telemedicine, even if the use of telehealth continues its expansion after the pandemic subsides and the public health emergency declaration is lifted, audio-only services will likely substantially decrease. Requiring health plans to allow for audio-only telehealth visits and pay at the same in-person rate would protect the patient's best interest to receive care remotely and no other telehealth methods are available.

Desired outcome:

1. Extend the temporary emergency waivers pertaining to telehealth for at least 12 months in order to ensure continuity of care and to develop sound long-term telehealth policy. (Proposal 7)
2. Require payers, including Medicaid, to cover and reimburse for telehealth visits at the rate of an in-person visit. Any mandate shall require coverage for routine traditional mental and behavioral health services. (Proposals 6, 7, 11)
3. Expand coverage and reimbursement for audio-only visits, especially for populations who may lack access to the necessary technology or broadband needed for a video consultation. (Proposals 6, 7, 11, 15, 17)
4. Require payers to allow physicians to utilize any HIPAA compliant platform when conducting telehealth visit. (Proposals 11, 17)
5. Prohibit health plans from providing different reimbursement rates including when a provider does not use that plan's specific telemedicine product. (Proposal 17)

Issue Background and Supplemental Information:

Research by Dr. John Paul Verderese

https://www.acponline.org/acp-newsroom/internists-encourage-several-major-health-insurers-and-associations-to-keep-telehealth-and-other#.XuKdlflv60A.twitter

https://www.statnews.com/2020/04/29/save-primary-care-devastation-covid-19/

Research by Dr. Stephen Cunningham, Dr. Adam Kaul, and Mark Hickman

CMS:

• https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

• https://www.cms.gov/about-cms/emergency-preparedness-response-operations/currentemergencies/coronavirus-waivers

• https://www.cms.gov/files/document/faqs-telehealth-covid-19.pdf

HRSA:

• https://www.telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-healthemergency/

CDC:

• https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html

SAMHSA:

• https://www.samhsa.gov/

• https://www.samhsa.gov/disaster-preparedness

EO-57:

• https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-57-SECOND-AMENDED---Licensing-of-Health-Care-Professionals-in-Response-to-NovelCoronavirus(COVID-19).pdf

DMAS:

• https://www.dmas.virginia.gov/#/emergencywaiver

• https://www.dmas.virginia.gov/files/links/5249/3.19.2020_COVID%2019%20MEMO_4.0.pdf

https://www.dmas.virginia.gov/files/links/5313/5.15.20_New%20Admin%20Flex%20COVID%2019%20Telehealth%20Codes%20Memo_FINAL%20(1).pdf

https://www.dmas.virginia.gov/files/links/5377/June%2011%20Behavior%20Therapy%20Medicaid%20Memo.pdf

VDH:

• https://www.vdh.virginia.gov/content/uploads/sites/13/2020/04/Emergency-DepartmentVisits-for-Unintentional-Drug-Overdose-2020-Q1.pdf

Kaiser Family Foundation:

• https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mentalhealth-and-substance-use/

Healthline

• https://www.healthline.com/health-news/what-covid-19-is-doing-to-our-mental-health

Research by Dr. Mark Ryan

https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweepingchanges-support-us-healthcare-system-during-covid

Applicable CPT codes are 99441-99443

Research by Lauren Schmitt

§ 38.2-3418.16. Coverage for telemedicine services

"CMS OKs pay parity for telephone visits during COVID-19 crisis" (AMA)

"COVID-19 makes telemedicine mainstream. Will it stay that way?" (AMA)

Proposal #8

Title of Proposal: Standing with our Communities Against Racism and Police Violence

Submitter(s)/ Presenter(s): Lindsay Gould and the MSV Medical Student Section

On behalf of: MSV Medical Student Section

Description of the issue:

The COVID-19 pandemic highlights how systemic racism shapes health outcomes. Black Americans make up 13% of the US population yet disproportionately account for 24% of the COVID-19 deaths(1)**.** In Virginia, Black people only account for 20% of the population, but account for 23% of cases, 27% of hospitalizations, and 25% of deaths [See Addendum C for further details.] Differences in baseline health, socioeconomics, access to care, and living conditions are some of the means by which systemic racism has undermined COVID-19 containment efforts in black communities. The racialized police brutality we have witnessed on a national scale--following the public execution of George Floyd, and the subsequent civil unrest-- underscores the mutually reinforcing, and racialized problem of police brutality.

As social distancing rules nationwide have been broad in their instructions, decisions regarding which violations to penalize have largely been left up to local police departments' discretion. As a result, Black Americans continue to be disproportionately targeted and punished for violating social distancing rules. For example, in Brooklyn, data demonstrated that between March 17th and May 4th, 40 people were arrested for breaking social distancing rules. One was white, four were Hispanic, and 35 were black (2). Unclear guidelines regarding when to make arrests has given rise to police abuse and racial discrimination nationwide [See Addendum Part A].

Black Americans are mistreated in America by the entities appointed to protect and serve them. Several investigations by the Department of Justice have concluded that police departments practice violent policing with hyper surveillance, harassment, and excessive use of force **(**7, 8, 9, 10). Research has demonstrated that Black people are 3 times more likely to be killed by the police than white people (11). Use of police force is the 6th leading cause of death for young Black men in the U.S. (12) . Social discrimination and police violence lead to both increased stress and direct-cause mortality. This chronic stress has been associated with myocardial infarction, COPD, mental distress, depression, smoking, disability, substance abuse, coronary artery disease, Alzheimer's disease, stroke and diabetes. Severe symptoms and mortality from the novel SARS-CoV-2 virus are closely associated with these preexisting conditions -- specifically hypertension, cardiovascular disease, and diabetes (13)**.** Research has also demonstrated that members of over-policed communities experience higher rates of stress and chronic diseases such as hypertension regardless of individual interactions with police. This over-policing is not only traumatizing but also leads to a general mistrust of medical institutions.

The trauma response to continued brutalization and disproportionate numbers of Black individuals killed by police each year combined with the historical abuse of Black Americans within the healthcare system, creates widespread mistrust of medical institutions. A survey of over 4,000

Americans demonstrated that those who had experienced negative encounters with police had higher levels of mistrust of the healthcare system when compared to those who had not experienced such encounters. Among those surveyed, Black Americans exhibited the highest scores of mistrust (4). Suspicion of medical institutions limits encounters with healthcare practitioners and compounds existing barriers to healthcare access. Additionally, the collective distress suffered while witnessing police brutality results in fewer calls to police when violent crimes occur. A Milwaukee study demonstrated that publicized acts of police brutality reduced crime-reporting behavior for up to 11 months in black communities (5). Further, Black women have suffered physical and sexual abuse by police officers throughout America's history with well-documented patterns reported. This violence goes largely unreported by the media and leads Black women to experience continued trauma. Not reporting these abuses ultimately prevents these individuals from receiving mental health care, supportive care, and abortive care (6).

If institutionalized causes of chronic disease, such as racism, are left unaddressed by the medical community, this public health crisis will persist. Several researchers have explored the possibility that social change may save more lives than medical advances (14). An analysis published in the American Journal of Public Health demonstrated that addressing mortality disparities by race would save 5 lives, respectively, for every 1 life saved by biomedical advances (15). Additionally, the lack of public action in response to high-profile police killings is an additional source of stress for black communities. Within this context, Virginian physicians are uniquely positioned to advocate for reform that will delay or prevent the onset of chronic disease, attenuate the spread and mortality of COVID-19, and protect their most vulnerable patients.

Notably, the extent of excessive use of force by police officers in Virginia is difficult to characterize due to nationwide scarcity of data. This dearth of data has been noted by public health researchers such as Sirry Alang, PhD et.al; his investigation into police brutality highlighted this issue that "a primary challenge in understanding the impact of police brutality on health is the lack of data. The fact that the best data to date come from newspapers such as *The Guardian* and *The Washington Post* is humbling." In an effort to address these gaps in knowledge, in 2015 the President's Task Force on 21st Century Policing recommended collecting data on all nonvoluntary police interactions. However, most police agencies have not incorporated the recommendation. The 2013 Death in Custody Reporting Act requires the US Department of Justice to collect data from states on the deaths of prisoners in their custody. Failure to comply results in a monetary penalty. Nonetheless, it is unknown if states comply, and if they do, data are not reported and made public for years.

Additionally, this year's police encounters with peaceful demonstrators exposed us to the violent reality of police tactics. From fists and nightsticks to tear gas and rubber bullets, nonlethal insults are physically and mentally traumatic for our patients. From injury to death, every victim of police violence will see a medical professional. Without these data, our understanding of and response to police violence is handicapped. Prevention strategies are ineffectual and risk assessment is incomplete. This is unacceptable. We demand data for clarity on the circumstances, prevalence, and incidence of these events. Racism is an established social determinant of health, and according to the United Nations Human Rights Office of the High Commissioner, the "legacy of racial terror remains evident in modern-day policing." Despite this history, the terms "racism" and "systemic racism" were generally absent from an analysis review of public health studies (16).

Current safeguards against police brutality are effectively non-existent. There are multiple provisions in state and local law that enable police officers to continually evade accountability for their actions. The most egregious barrier to accountability and objectivity is that officers are in charge of investigating themselves. [See Addendum Part B for additional research on these barriers]. This injustice and lack of accountability must change.

Current MSV policy advocates for access to medical services without discrimination based on race, religion, age, social status, income, sexual orientation or perceived gender (Policy 05.4.01). Instead of continuing to support systems that are largely punitive towards communities of color, it is time to put power in communities' hands to invest in resources that will allow them to thrive. The Medical Society of Virginia should advocate for a focused financial investment in essential high-quality healthcare, social services, affordable housing, transportation, mental health services, education, healthy food, and safe recreational spaces in marginalized communities (19). Focusing on financial investment in community-based safety initiatives will lead to safer communities and address underlying social determinants that feed into the cyclical nature of systemic racism [See Addendum Part C]. Centering government spending on community-driven priorities will give communities more autonomy and opportunities to create safer and healthier spaces for their residents. A powerful June 2020 New England Journal of Medicine piece urges physicians to recognize the urgency of these systematic issues affecting our patients and commit to enacting change: "Health care systems must play a role in protecting and advocating for their patients. Victims of state-sanctioned brutality are also patients, who may present with injuries or disabilities or mental health impairments, and their interests must be defended. Health care systems should also be on the forefront of advocating for an end to police brutality as a cause of preventable death in the United States" (20). As physicians, healthcare providers, and public health organizations have channeled their efforts toward eradicating preventable causes of death and illness, the Medical Student Section calls on The Medical Society of Virginia to recognize that police brutality and systemic racism are preventable and that our patients and fellow citizens deserve better.

Desired Outcome:

That the Medical Society of Virginia, in partnership with other organizations, actively support legislation to:

- Increase funding for research that will investigate the relationship between police violence and public health effects for the goal of creating evidence-based solutions toward necessary police reform
- Redirect funds to intentionally focus on financial investment in essential community-based safety initiatives such as affordable housing, healthy food, mental health services, that extend beyond traditional law enforcement
- Increase police accountability with the aim to mitigate incidences of police brutality and deter excessive use of force
- Require reporting of all injuries and deaths that occur during law enforcement encounters to be shared with public health agencies

Issue Background and Supplemental Information:

Part A. A ProPublica analysis of Ohio's three most populous jurisdictions, Toledo, Columbus and Cincinnati, demonstrated that Black Americans are at least four times as likely to be charged with violating stay at home orders than White Americans. Kristen Clarke, president of the Lawyers' Committee for Civil Rights Under Law, a legal organization focused on racial justice, explains that "we're seeing social distancing being used as a pretext to arrest the very communities that have been hit hardest by the virus."(3)

Part B. This lack of accountability for police brutality been underscored by the fact that the officer who allegedly murdered George Floyd, Derek Chauvin, was reportedly the subject of 17 complaints against him, few of which led to disciplinary action. Shaila Dewan, the National Criminal Justice Editor for The New York Times highlights five barriers to accountability: "1. Police officers are in charge of investigating themselves through internal affairs departments. David Cornelius Smith was killed by Minneapolis in a similar manner after officers kneeled on his neck for 4 minutes. The police chief at the time commended the officers for their actions. 2. Public employees are allowed to appeal disciplinary decisions leading to reduced or eliminated punishment. The board overseeing appeals in Minnesota reinstated fired police officers in 46% of cases. 3. Agreements with civilian review boards are non-binding. In Minneapolis, only 12 of 2,600 complaints originating from the public resulted in discipline of any kind. 4. Police unions have notoriously fought to prevent police accountability on individual cases and by blocking large scale reforms to the criminal justice system. In light of the killing of George Floyd, Police Officers Association of Michigan President, and subject of at least 29 complaints as an officer, Bob Kroll called the firing of Floyd's alleged murders "a despicable act" and referred to BLM demonstrations as "a terrorist movement" 5. It is difficult to hold police officers criminally liable for their actions due to the legal concept of reasonable fear. Any officer that can make an argument they were afraid for their life is legally protected by this concept" (17). Dean of the School of Law at University of California, Irvine, Erwin Chemerinsky writes in "How the Supreme Court Protects Bad Cops: "In recent years, the court has made it very difficult, and often impossible, to hold police officers and governments that employ them accountable for civil rights violations. This undermines the ability to deter illegal police behavior and leaves victims without compensation. When the police kill or injure innocent people, the victims rarely have recourse" (18).

Part C. Presentation to the Governor's Commission to Examine Racial Inequity in Virginia Law. https://www.law.virginia.edu/system/files/news/FINAL-UVA%20Law%20Student%20Research-Racial%20Disparities%20in%20Virginia.pdf

(1) Covid Racial Data Tracker. Can be found at https://covidtracking.com/race/about

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(3) Kaplan, J., & Hardy, B. (2020, May 8). Early Data Shows Black People Are Being Disproportionally Arrested for Social Distancing Violations. Retrieved from https://www.propublica.org/article/in-some-of-ohios-most-populous-areas-black-people-were-at-least-4-times-as-likely-to-be-charged-with-stay-at-home-violations-as-whites

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(6) Jacobs, M. S. (2017). The Violent State: Black Women's Invisible Struggle Against Police Violence . *William & Mary Journal of Women and the Law: 2017 Special Issue: Enhancing Women's Effect on Law Enforcement in the Age of Police and Protest*, *24*(1). Retrieved from https://scholarship.law.wm.edu/wmjowl/vol24/iss1/4

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(8) INVESTIGATION OF THE BALTIMORE CITY POLICE DEPARTMENT. (2016, August 16). Retrieved from https://www.justice.gov/crt/file/883296/download

(9) INVESTIGATION OF THE CHICAGO POLICE DEPARTMENT. (2017, January 13). Retrieved from https://www.justice.gov/opa/file/925846/download

(10) IN THE SHADOWS OF THE WAR ON TERROR: PERSISTENT POLICE BRUTALITY AND ABUSE OF PEOPLE OF COLOR IN THE UNITED STATES (2007, December). Retrieved from https://perma.cc/V3X7-D5VM

(11) M4BL. Policy Platform: Invest-Divest. The Movement for Black Lives (M4BL). Accessed June 9, 2020. https://m4bl.org/policy-platforms/invest-divest/

(12) Edwards, F., Lee, H., & Esposito, M. H. (2019). Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. *Proceedings of the National Academy of Sciences*, 116 (34) 16793-16798; DOI: 10.1073/pnas.1821204116

(13) Alang S. M. (2019). Mental health care among blacks in America: Confronting racism and constructing solutions. *Health services research*, *54*(2), 346–355. https://doi.org/10.1111/1475-6773.13115

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Proposal #9

Title of Proposal: Creation of MSV Health Equity Advisory Group

Submitter: Lauren Schmitt

On behalf of: Virginia Chapter, American Academy of Pediatrics

Description of the Issue:

Physicians and other health care providers should be leading the efforts to improve health equity in Virginia. In their testimony to Congress, the AMA stated that "the COVID-19 pandemic has revealed starkly the disproportionate impact of the virus on communities of color." Virginia is no different and COVID-19 has only highlighted the health inequities experienced by our patients. In addition, there have been challenges in collecting data regarding race and ethnicity- which is crucial in helping determine the path forward. Race and ethnicity should not be a social determinant of health, but the data we see tells us otherwise and that needs to change. Physicians should be looking inward and determining how we can ensure no patients fall victim to poor health because of their skin color.

Governor Northam created the Health Equity Working Group in response to the glaring disparities with COVID-19. His administration has made health equity a priority and the physician community should do the same. MSV should apply an equity lens to all advocacy efforts, in addition to evaluating how we can promote and advocate for health equity within MSV and our delivery of health care services.

Desired Outcome:

MSV would create a Health Equity Advisory Group with representatives from multiple specialties of racially and ethnically diverse backgrounds. This group would advise the MSV Board of Directors on how MSV can better educate and promote health equity amongst its members and how MSV can advocate for regulatory and legislative changes that address health disparities. The group will further work to identify how physicians may be contributing to these inequities and how we, the physician community, can change our behaviors to ensure health equity for our patients.

Issue Background and Supplemental Information:

- Statement of the American Medical Association; U.S. House of Representatives Committee on Ways and Means re: The Disproportionate impact of COVID-19 on Communities of Color (June 8, 2020)
- Institute of Medicine's Findings and Recommendations on Health Disparities
- Richmond Times Dispatch article from May 23, 2020
- WSHV article from June 15, 2020

Proposal #10

Title of Proposal: Consumer Protection for Purchase of Personal Protective Equipment

Submitter(s)/ Presenter(s): Lauren Schmitt

On behalf of: Virginia Chapter, American Academy of Pediatrics

Description of the Issue:

The COVID-19 pandemic has illuminated many issues regarding the procurement and availability of Personal Protective Equipment (PPE). There have been challenges with procurement efforts, supply levels and distribution methods. Many physicians and practices were forced to go about this issue on their own and find ways to obtain proper amounts of PPE. This continues to be a challenge- especially with efforts to increase testing for COVID-19.

Many practices have encountered vendors who participate in price gouging on PPE. Normally, price gouging is prohibited under the Virginia Consumer Protection Act. However, this crisis has highlighted a gap in the current law. Commercial transactions are not protected under the Virginia Consumer Protection Act. Unfortunately, the Attorney General does not currently have the authority to intervene on the egregious price gouging we are witnessing with PPE.

Desired Outcome and Recommendations:

MSV will introduce legislation to close this loophole and amend the consumer finance protection laws to apply to commercial transactions during a state of emergency. If that is too broad of a change, MSV should introduce legislation to prohibit price gouging for PPE, similar to legislation New York passed.

Issue Background and Supplemental Information:

- New York legislation regarding price gouging for PPE
- CNN article from April 2020 regarding increase in PPE pricing

Proposal #11

Title of Proposal: Telemental Health Services Access Expansion

Submitter/Presenter: Shashank Somasundaram

On behalf of: MSV Medical Student Section

Description of the Issue:

COVID-19 has exacerbated pre-existing difficulties in accessing mental health and addiction treatment services in Virginia. Telemental health services are known to provide care similar to in-person visits, increase access to care and patient satisfaction, while reducing costs without significant adverse effects. Recent emergency waivers of Medicaid and federal restrictions on telehealth reimbursement requirements and prescription regulations have helped broaden access to, and scope of, telemental health services in Virginia. However, these policies will expire when the respective governmental authority declares the conclusion of this public health emergency, forcing our evolved telemental health services system to regress at the detriment of our patients.

Desired Outcome:

The purpose of this proposal is to formally preserve elements of these temporary telehealth policies and expand upon them. Therefore, pursuant to MSV statutes 40.18.04, 10.6.01, 10.9.16, 30.7.11, and 20.5.01, MSV medical students ask that the Medical Society of Virginia actively support:

> 2. Maintaining funding for Medicaid reimbursement rates for mental health providers at 100% of Medicare to incentivize provider participation in the program.
>
> 5. Increase funding for the Behavioral Health Loan Repayment Program approved in last year's budget to bridge the gap in mental health professional workforce.

Issue Background and Supplemental Information:

<u>Mental Health and Substance Use Disorder In Virginia</u>

In 2018, SAMHSA reported that roughly 47.6 million adults in the U.S. struggled with mental illness and 20.3 million with substance use disorders. In 2016, the Virginia Department of Health found that more than 2.2 million Virginians lived in areas with a shortage of mental health professionals and that only 8% of all Virginian physicians practice in rural areas which account for 13% of the state's entire population. Mental Health America ranks Virginia as 37th in the country for access to care for mental illness and 42nd in mental health workforce availability, with only one mental health professional per 730 people and disproportionately skewed against rural/low-income areas. Consequently, 630,000 Virginians (53%) with a mental illness received no treatment due to individual and/or systemic reasons, with one in five (22%) reporting this was due to unmet needs such as lack of available treatment providers, insurance issues, or insufficient finances (The State of Mental Health in America 2018).

We propose the maintenance of funding for Medicaid reimbursement rates for mental health providers at 100% of Medicare to incentivize provider participation in the program. With 28% of the roughly 1 million Virginians on Medicaid having behavioral health diagnoses (Farley Health Policy Center), this policy change would potentially benefit many patients and providers. Additionally, we propose increasing funding for the Behavioral Health Loan Repayment Program approved in last year's budget to help bridge the gap in Virginia's mental health professional workforce.

Impact of COVID-19

Though necessary to prevent loss of life, public health measures to curb the spread of COVID-19 such as social distancing, school and business closures, and shelter-in-place orders, have severely limited access to critical mental health resources and services. This disruption in access to care is especially worrisome for individuals with opioid use disorders, who depend on face-to-face visits for prescriptions of medication assisted treatments (MAT) like methadone and buprenorphine. Though U.S. overdose deaths fell by 4.6% in 2018 and another 2.9% in 2019 after hitting record-highs in 2017, early data from the federal High Intensity Drug Trafficking Areas Program indicates an 11.4% increase in overdose deaths since the start of the year (Office of National Drug Control Policy). This trend mirrors spikes in fatal opioid overdoses reported in Virginia by emergency medical services and Governor Northam since the start of the pandemic. It is vital that we continue to expand access to, and availability of, addiction treatments or risk erasing the progress we have made in fighting the opioid epidemic in Virginia.

Though the full extent of the biopsychosocial effects of this pandemic are not yet clear, we know that it will certainly affect individuals beyond the 1.2 million Virginians already struggling with mental health and addiction disorders. The confluence of social isolation, worries about medical and financial security, and troubling media reports can contribute to feelings of stress, helplessness, depression, and anxiety. A March poll by the Kaiser Family Foundation found that nearly half of Americans report that the COVID-19 pandemic has harmed their mental health and SAMHSA's federal emergency hotline for emotional distress registered a greater than 1,000% increase in volume compared to the same time last year.

Telemental Health Services

Telemental health, defined as the “use of telemedicine to provide mental health assessment and treatment at a distance,” (American Psychiatric Association) has been proven to be as effective as in-person consultation for diagnosis and assessment across all age groups and many disorders (Hilty et al. 2013). It has been shown to be feasible, increases access to care, lowers costs, yields positive outcomes, allows for reliable evaluation, improves efficiency in time allocation, and is satisfactory to both providers and patients (Hilty et al. 2004). Additionally, it can help mitigate geographical barriers such as long-distance travel for the 13% of Virginians living in rural areas with a shortage of mental health professionals and physical barriers for those with disabilities.

To this end, we propose requiring payers to allow physicians to utilize any HIPAA compliant platform when conducting telehealth visits. We further propose expanding coverage and reimbursement for

audio-only visits, especially for populations who may lack access to the necessary technology or broadband needed for a video consultation. This will further promote the use of telehealth to extend much-needed physician presence into rural, low-income, and underserved areas, paving the way for future initiatives ensuring equitable access to vital mental health and addiction services.

Emergency Telehealth Expansions

Federally, the Office of Civil Rights has waived regulatory requirements for HIPAA-compliant telehealth platforms, CMS has expanded telehealth eligibility for patients outside of rural areas and patients in their homes, SAMHSA has allowed DEA-registered physicians to prescribe controlled substances including MAT for patients without an in-person medical evaluation and in states in which they are not registered with the DEA (American Society of Addiction Medicine).

Pursuant to the state of emergency declared under Executive Order 42, the Virginia Board of Medicine has allowed out-of-state practitioners to provide continuity of care to current patients who are Virginia residents via telehealth and the Virginia Department of Medical Assistance Services has temporarily expanded the list of targeted services delivered by telehealth, including most behavioral health services. We propose requiring all payers, including Medicaid, to cover and reimburse for telehealth visits at the same rate of an in-person visit beyond the COVID-19 pandemic.

Prior to COVID-19, the varied, confusing, and cumbersome rules/regulations made telehealth difficult for the practicing physician to incorporate into their practice. The temporary and emergency waiving of some of these regulations has significantly helped increase the incorporation and usage of telehealth in all specialties, including mental health and addiction. Since the start of the pandemic, the Appalachian Telemental Health Network has reported a 600% increase in telemental health services in Virginia, proving that large-scale telemental health implementation is feasible even when unexpected and over a short ramp-up period.

However, these policies will expire when the respective governmental authority declares the conclusion of this public health emergency, forcing our evolved telemental health presence to regress at the detriment of our patients. It is critical that we maintain and expand upon the progress that we have made in integrating telehealth and telemental health services into medical infrastructure, throughout and beyond the COVID-19 pandemic.

Organizational Support

Numerous professional physician organizations support broad expansion of telehealth capabilities including the American Psychiatric Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Physicians, as do non-physician professional healthcare groups such as the American Psychological Association, the American Hospital Association, and the American Telemedicine Association.

The MSV already supports efforts to "encourage and increase access to mental health services" (40.18.04), increase Medicaid reimbursement levels and stress physician participation in the program (10.6.01), allocate "appropriate reimbursement for telemedicine encounters with patients" (10.9.16),

advocate for the use and implementation of telemedicine to "improve access, convenience, and continuity of care" (30.7.11), and "reduce medical student debt by means of "effective loan repayment programs" (20.5.01). The MSV also successfully advocated for the inclusion of a 100% Medicaid reimbursement rate and the Behavioral Health Loan Repayment Program in last year's state budget. The AMA supports expansion of telemedicine (D-480.965), reimbursement parity for telehealth providers (D-480.966), and ensuring supply of mental health professionals - especially in rural areas (H-345.981).

Proposal #12

Title of Proposal: Preventative Medicine and Health Literacy Improvements Directed Toward Minority Communities

Submitter/Presenter: Kimberly Doerr

On behalf of: The MSV Student Section

Description of the Issue:

Although COVID-19 has impacted all communities in Virginia, there are some groups that have been disproportionately effected. Demographic data obtained by the DC Department of Health has indicated that black residents have accounted for 71% of regional deaths during the COVID-19 pandemic, whereas white residents have only accounted for 11% of deaths. The proportion of black resident deaths in the DC area cannot be explained by population size, as black residents compose 49% of the district population and white residents compose 37%.

There are several factors that lead to increased exposure of individuals from lower socioeconomic and racial/ethnic minority groups to infectious diseases. For example, these communities tend to be overcrowded and demonstrate increased reliance on public transportation, which is a significant risk factor for the transmission of infectious diseases. People from lower socioeconomic groups, African Americans, and Hispanics also tend to rely more on emergency departments and publicly funded clinics for their regular medical care. These clinics are often underfunded and are associated with increased airborne transmission of infectious diseases (Blubenshine et. al., 2008).

Minority communities also have an increased susceptibility to developing severe complications to COVID-19 due to increased rates of preexisting conditions including hypertension, diabetes, obesity, and chronic obstructive pulmonary disease. In addition to this, these communities tend to have disparities in access to timely and affordable care, as well as lower rates of health literacy and decreased trust toward medical professionals. This leads to worsened health outcomes following treatment and decreased adherence to medical guidelines (Cordoba and Aiello, 2016).

The lack of supportive infrastructure, preventative care, and medical education are among many of the factors leading to increased healthcare discrepancies within minority communities during the COVID-19 pandemic. This not only leads to worse health outcomes, but increased healthcare expenditure (Cordoba and Aiello, 2016).

MSV has several policies that support preventative medicine and increasing health literacy including 40.20.01 which supports the reallocation of resources from the general fund toward preventative medicine, public health, and primary care and 40.12.02 which seeks to strengthen physician/patient relationships by supporting health literacy programs.

Desired Outcome:

The University of Virginia School of Medicine requests that the Medical Society of Virginia introduce and actively support legislation that supports preventative medicine and health literacy programs directed toward minority communities within Virginia.

Issue Background and Supplemental Information:

1. DC Department of Health
2. Blumenshine, P., Reingold, A., Egerter, S., Mockenhaupt, R., Braveman, P., & Marks, J. (2008). Pandemic Influenza Planning in the United States from a Health Disparities Perspective. Emerging Infectious Diseases, 14(5), 709–715. https://doi.org/10.3201/eid1405.071301
3. Cordoba, E., & Aiello, A. E. (2016). Social Determinants of Influenza Illness and Outbreaks in the United States. North Carolina Medical Journal, 77(5), 341–345. https://doi.org/10.18043/ncm.77.5.341

Proposal #13

Title of Proposal: Increase Medicaid Administration Reimbursement Fees for VFC-Supplied Vaccines

Submitter/Presenter: Lauren Schmitt

On behalf of: Virginia Chapter, American Academy of Pediatrics and Virginia Academy of Family Physicians

Description of the Issue:

There has been an alarming drop in childhood vaccinations as a result of the COVID-19 pandemic. The Virginia Department of Health identified that vaccines reported to the Virginia Immunization Information System (VIIS) decreased 45.7% from mid-March to mid-April. In May, the Virginia AAP did a survey of 100 pediatricians and found that since early March, infant vaccination rates were down 30% and adolescent vaccinations were down by 76%.

Many parents were hesitant to bring their children in for well-visits and vaccinations. The Virginia AAP gathered data from 419 pediatric providers throughout Virginia regarding the impact of COVID-19 on Medicaid visit volume. We found that Medicaid visit volumes decreased in April to 67% and in May to 62% of normal volumes. With the easing of restrictions, volumes are starting to rise, but they are still only at about 75-80% of normal rates.

It is essential that there is enhanced support for our existing child and adolescent immunization infrastructure that relies heavily on pediatric and family medicine practices to vaccinate Virginia's children and prevent vaccine-preventable diseases. Pediatricians and family medicine providers are the backbone of our childhood vaccine delivery system and need to be supported through the current situation and bolstered as we move to vaccinate our population once a vaccine is available for SARS-COV2.

The American Academy of Pediatrics is requesting Congress increase the Medicaid reimbursement for vaccine administration to 200% of Medicare to help sustain pediatric practices as part of the public health infrastructure. Currently, the Centers for Medicare and Medicaid Services (CMS) allow for Virginia to reimburse for a maximum of $21.24. However, Virginia only provides a reimbursement of $11 to providers for the administration of a Vaccines for Children (VCF) vaccine. This means that Virginia is reimbursing physicians at almost 50% less than what is allowed for VFC vaccinations. The Virginia AAP believes we should advocate for Virginia Medicaid to invest in our vaccine infrastructure and increase the reimbursement to the maximum allowed rate of $21.24 per vaccine.

Desired Outcome:

MSV will support efforts to increase the administrative reimbursement rate for VFC-supplied vaccines to $21.24. This will either be done through regulatory advocacy within the Department of Medical Assistance Services or through the budgetary process in the legislature. At this time, it is unclear if DMAS is able to raise the reimbursement rate on their own or if it has to be allocated by the legislature. We propose that MSV work with the Virginia AAP to determine the proper step forward and advocate for this urgently needed investment.

Issue Background and Supplemental Information:

- Virginia Mercury article, April 2020
- American Academy of Pediatrics Letter to Congress, June 2020

Proposal #16

Title of Proposal: Developing a Virginia Statewide Commission/Task Force to Address Lack of Access to Physicians in Underserved Areas

Submitter(s)/ Presenter(s): Richmond Academy of Medicine

Description of the issue:

It is common knowledge that rural as well as some urban areas in Virginia lack access to medical care much in part to the lack of availability to physicians. There are multiple state agencies that are trying to address these issues but it will require a coordinated effort to create a master strategic plan to maximize resources. The data shows that medical students and residents who come from underserved areas or have been exposed to these areas in their training, have a higher percentage of practicing in those areas. To that end forming a Commission/Task Force with all of the stakeholders to coordinate and create a master strategic plan would be the most effective way to improve access. Some of the potential strategies would be financial incentives such as loan forgiveness to encourage physicians to practice in these areas. Subsidizing medical schools to offer rotations for medical students and residents in underserved hospitals and clinics. Improve access to telemedicine and increase support to rural hospitals and clinics who are struggling.

Desired Outcome:

The Richmond Academy of Medicine requests that the Medical Society of Virginia bring experts across the state together to create a comprehensive strategic plan to address the lack of access to physicians in underserved areas.

Proposal #18

Title of Proposal: Expedited Review for Certificate of Public Need

Submitter/Presenter: Lauren Schmitt

On behalf of: Virginia Orthopaedic Society

Description of the Issue:

There continues to be a significant need for reform and modernization of Virginia's Certificate of Public Need laws. MSV and VOS have both worked on a proposal to create an "expedited review process" that would increase access and affordability for patients. We have made some progress with this concept and have been able to garner bipartisan support. There continues to be interest in this specific proposal and we believe there is momentum to move this forward. A more detailed outline of this proposal is attached.

Desired Outcome:

MSV will introduce legislation in the 2021 Virginia General Assembly Session to create an expedited review process under the current Certificate of Public Need program, similar to legislation MSV supported in 2020, carried by Senator Chap Petersen (SB 503). This legislation was based on a proposal discussed during Secretary Carey's COPN workgroup in the Fall of 2020.

Issue Background and Supplemental Information:

- Proposal for Expedited Review
- Senate Bill 503 from 2020
- Letter to Governor Northam (from MSV and other stakeholders) supporting an expedited review process

Proposal #19

Title of Proposal: Proposal Addressing Personal Protective Equipment

Submitter/Presenter: Dr. Barbara Boardman

Description of the Issue:

According to the Washington Post more than 77,800 health care workers have tested positive for the coronavirus, and more than 400 have died, according to the Centers for Disease Control and Prevention, CDC acknowledges this is likely a significant undercount. The nation's largest nurses union, National Nurses United, puts the total much higher: 939 fatalities among health-care workers, based on reports from its chapters around the country, social media and obituaries. (Ref)

The shortage of personal protective equipment as a contributing factor to the infection and deaths of frontline workers has been noted on multiple occasions.(ref) Occurrences where organizations and hospitals have disciplined health workers for failure to comply with restrictions on the use of PPE mandated by limited supply have also been documents in multiple cases including in Virginia.(ref)

In the absence of adequate supplies of PPE health care workers are struggling with ethical decisions about how to provide safe care for their patients, themselves, their families and their communities. They should not have to make these in isolation. (ref)

Beauchamp and Childress have articulated 4 principals of medical ethics; autonomy, non-malfeasance, beneficence and justice. The Emergency Medicine Society adds virtue and teamwork.

For the ***individual*** provider ethical questions include

- What is my ethical duty to care for patients during the pandemic and in the Art absence of having proper PPE?
- If I am in a high-risk group due to age or medical history, should I continue to care for patients in the absence of having proper PPE?
- If I live with family members who are in a high-risk group due to age or medical history, should I continue to care for patients in the absence of having proper PPE?
- If I believe that I might be spreading the virus to patients, patient family members, colleagues and/or community members, should I continue to care for patients in the absence of having proper PPE?

These questions, however, cannot be addressed in a vacuum. The individual provider interfaces with, and is dependent on ***organizations*** such as hospitals and health plans that provide supplies and dictate standards for distribution. The organizations are, in turn, dependent on ***governmental structures*** that establish legislation and public health policy that can facilitate, or limit, the clinician's ability to provide necessary and safe care to the patient and the community.

The IOM report of 2008 addressed issues altering adherence to PPE protocols distinguishing:

1. Individual factors (ie. knowledge and beliefs)

2. Environmental factors (i.e. availability of equipment and negative pressure rooms)
3. Organizational factors (i.e. workplace policies.)

Effective policy will need to address factors at the individual, environmental and organizational level. (ref)

The glaring deficiencies of governmental support via the public health, policy and legislative sectors have been revealed during the recent pandemic. OSHA has not set enforceable standards. Workers may refuse to work but have no guarantee of job protection if they refuse. State rules on unemployment insurance my limit rights of those who refuse to work.

CDC provided guidelines for optimizing supply in a period of shortage but logistics and supply lines were not in the purview of this agency. There was discussion of enactment the Defense Production Act without action. PPE was unavailable or only available at prices that were unsustainable. Staff and patients had to reuse "single use" equipment or go without. Needed equipment such as ventilators were a limited resource.

It is to be hoped that policies would be scientific and ethical as well as coherent. However, uncoordinated policies across multiple agencies, at the federal and state level, have failed to provide required equipment and services. Individual physicians and health workers have had to choose whether to put themselves, their patients and their families at risk while providing care. Throughout the state they had to resort to personal appeals for donations of equipment. (ref?)

Failures of coordination and leadership at the federal level are outside the purview of our state organization, but the pandemic has also revealed weaknesses of coordination and preparedness at the state level which MSV should address. However, state legislation can address the rights of individual health workers to a safe environment in an emergency situation. In addition coordination on health care resources including staffing and supplies in a designated emergency can should be upgraded to improve availability of the state t respond to a health crisis.

Desired Outcome:

1. That MSV should advocate for legislation that guarantees job protection for health care workers who decline to work in circumstances that are unsafe to themselves or to their patients. Legislation should support indicated unemployment coverage for those unable to work due to unsafe conditions including disease risk. Physicians and frontline workers should be allowed to bring their own PPE when other resources are not provided but this does not obviate the institutions responsibility. Legislation should clarify that Workers cannot be penalized for bringing their own protective equipment to the job site if it does not pose a risk to patients or other workers.
2. MSV should advocate for legislation that mandates coordination of the supply of resources including staff, equipment and supplies needed in a designated health emergency including the purchasing and acquiring of such supplies and the designation of delivery of such to appropriate hospitals and community service providers at a safe cost.

Issue Background and Supplemental Information:

1. https://www.washingtonpost.com/graphics/2020/health/healthcare-workers-death-coronavirus/
2. https://www.ama-assn.org/delivering-care/public-health/covid-19-safety-don-t-bar-physicians-wearing-their-own-ppe
3. https://www.ama-assn.org/press-center/ama-statements/ama-supports-health-care-workforce-using-their-own-ppe
4. https://www.jems.com/2020/04/10/ethics-of-ppe-and-ems-in-the-covid-19-era/
5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152922/
6. https://cmss.org/cmss-statement-ppe/
7. https://www.ama-assn.org/delivering-care/ethics/prioritizing-rest-health-care-public-health-crisis

Proposal #20

Title of Proposal: Striving for **A**drenal crisis treatment by **V**irginia **E**MS responders (SAVE)

Submitter(s)/ Presenter(s): Richmond Academy of Medicine

Description of the issue:

Majority EMS protocols in Virginia do not allow emergency medical response personnel to treat individuals with the patient's prescribed self-administered medication.

- Patients with normal working adrenal can produce 5-10 times the normal amount of cortisol. This helps maintain blood pressure, salt and sugar levels.
- In patients with adrenal deficiency, an immediate dose of hydrocortisone (a glucocorticoid) can avert the adrenal crisis. However, delay can lead to shock, heart failure and death.
- Symptoms and signs of adrenal crisis, which may not be always quickly recognized, include dizziness, lethargy, nausea, vomiting, hypotension, shock and heart failure.
- These patients usually wear medical id's that say "adrenal insufficiency" to indicate their condition.
- Patients who are diagnosed with adrenal insufficiency (3% of population in US and UK) are prescribed patient-carried medication, typically hydrocortisone, to be administered to prevent and treat adrenal crisis. Prompt intervention can reduce mortality in these patients.
- However, there are many situations where the patient cannot self-administer the prescribed medication:
    - Patient in the care of someone who does not know to give the medication or is not comfortable with giving this emergency injection, e.g., a child at a school without a nurse
    - An adult living alone too unwell to carry out the procedure themselves.

Situations that are not intuitively connected with adrenal insufficiency such as an automobile accident or injury where the caregiver is not present or incapacitated.

Desired Outcome:

The Richmond Academy of Medicine requests that MSV explore ways to allow trained EMS providers, who recognize the signs and symptoms of adrenal insufficiency, to administer the patient's provided hydrocortisone injection when appropriate medical identification is available. This will allow timely treatment of patients with impending adrenal crisis. Failure to recognize symptoms & signs of adrenal insufficiency and failure to administer hydrocortisone injection provided by the family when responding to 911 call for a patient pre-identified as 'adrenal insufficiency' can negatively impact the outcome of the patient's care.

Issue Background and Supplemental Information:

1. Thomas Goubar, David J Torpy, Shaun McGrath, R Louise Rushworth, Prehospital Management of Acute Addison Disease: Audit of Patients Attending a Referral Hospital in a Regional Area, *Journal of the Endocrine Society*, Volume 3, Issue 12, December 2019, Pages 2194–2203

2. Miller, B. S., Spencer, S. P., Geffner, M. E., Gourgari, E., Lahoti, A., Kamboj, M. K., Stanley, T. L., Uli, N. K., Wicklow, B. A., & Sarafoglou, K. (2020). Emergency management of adrenal insufficiency in children: advocating for treatment options in outpatient and field settings. *Journal of investigative medicine: the official publication of the American Federation for Clinical Research*, *68*(1), 16–25

3. Karen Su, Dina Matos. EMS advisory letter for emergency hydrocortisone. Accessed March 15, 2020. https://www.caresfoundation.org/wp-content/uploads/2019/10/EMSAdvisoryLetterFinal4828.pdf

Proposal #21

Title of Proposal: Eliminate the DMAS ER Utilization Program in VA Budget

Submitter(s)/ Presenter(s): Dr. Todd Parker

Submitted on Behalf Of: Virginia College of Emergency Physicians

Description of the issue:

The DMAS ER Utilization program included in the biennial budget, at the request of Anthem and the VA Association of Health Plans, wrongly re-instates a DMAS program similar to one that the General Assembly--with the invaluable help of MSV--eliminated in 2015 that allowed MCOs to reduce the payments to emergency physicians and hospitals if the patient's visit was later determined to be "preventable" according to a diagnosis code list.

This new program, which we have asked CMS to review and halt because we believe it to be in violation of their policy, is even broader than the program we eliminated in 2015. To be clear, if the Medicaid visit is found to be on the DMAS "preventable" diagnosis code list, the MCOs will be allowed to AUTOMATICALLY pay level two (low/moderate complexity- $29.21), level three (moderate complexity- $43.70) and four (high complexity-$82.90) cases at the level one payment of $14.98.

The "preventable" diagnosis list was not designed for use in this manner. Rather, it was designed as a list to hold the MCOs themselves accountable for ER visits by their members that could have been prevented with better primary care and better management of care.

In truth, improved care coordination is the only solution to reducing "preventable" ER visits. Reducing Medicaid reimbursement will not reduce ER visits and will likely result in health equity and critical access issues for patients in hospitals with high Medicaid volumes and populations at a time when those communities are already vulnerable during the COVID-19 pandemic.

Desired Outcome:

We are requesting the active assistance of the Medical Society of Virginia to partner with VACEP to request the General Assembly remove the program from the budget during the special 2020 legislative session this summer.

Issue Background and Supplemental Information:

1. Thomas Goubar, David J Torpy, Shaun McGrath, R Louise Rushworth, Prehospital Management of Acute Addison Disease: Audit of Patients Attending a Referral Hospital in a Regional Area, *Journal of the Endocrine Society*, Volume 3, Issue 12, December 2019, Pages 2194–2203

2. Miller, B. S., Spencer, S. P., Geffner, M. E., Gourgari, E., Lahoti, A., Kamboj, M. K., Stanley, T. L., Uli, N. K., Wicklow, B. A., & Sarafoglou, K. (2020). Emergency management of adrenal insufficiency in children: advocating for treatment options in outpatient and field settings. *Journal of investigative medicine: the official publication of the American Federation for Clinical Research*, *68*(1), 16–25

3. Karen Su, Dina Matos. EMS advisory letter for emergency hydrocortisone. Accessed March 15, 2020. https://www.caresfoundation.org/wp-content/uploads/2019/10/EMSAdvisoryLetterFinal4828.pdf

Proposal #22

Title of Proposal: Increasing Access to Certified Medical Interpreters

Submitter(s)/ Presenter(s): Tania Alejandra Rodriguez-Carpio, *UVA Medical Student*

Submitted on Behalf Of:

Description of the issue:

According to Census Bureau data from 2018, there are 67.3 million people in the United States who speak a language other than English at home, 25.6 million of whom report speaking English "less than well".1 In Virginia, as of 2018, 16.1 percent of the state's population reported speaking a language other than English at home, representing a 488% increase since 19801,2. These numbers are expected to only increase in future years, which has major implications for health care delivery and outcomes.

By law, patients who speak languages other than English are guaranteed access to interpreter services under Title VI of the Civil Rights Act.3 However, a 2016 study by the American Hospital Association found that only 56 percent of hospitals nationwide offered some sort of linguistic or translating service.4 Moreover, the simple presence of these services does not imply that healthcare professionals are using them consistently or appropriately - a 2014 Johns Hopkins study found that 71 percent of resident physicians surveyed used professional interpreters for less than 60 percent of hospital encounters in which the use of a translator was indicated.5 Additionally, the use of family members or other untrained interpreters is prevalent, a practice which leads to a higher rate of adverse events due to their unfamiliarity with medical terminology and their tendency to withhold information6. Undoubtedly, the underutilization of professional interpreting services occurs in the majority of hospitals and clinics across the country. Virginia is no exception, despite being one of 14 states in which Medicaid and CHIP programs reimburse providers for the use of interpreting services7,8.

The continuous use of non-certified interpreters could be attributed to multiple factors, such as cost, lack of provider education, and interpreter unavailability. This issue is ever more pressing now, with Latinos and other minorities being disproportionally affected by COVID-19. In Charlottesville alone, 25% of COVID-19 cases are patients of Hispanic origin, despite composing only 4.8% of the population9. These patients deserve equal access to care, in an environment where they understand every medical decision regarding their treatment. For these reasons and more, we hope the Medical Society of Virginia (MSV) addresses the need for increased access to certified medical interpreters.

Desired Outcome:

Based on MSV policies 05.4.01 - Access without discrimination, 25.3.04 - Patient-Physician Communication, and 40.12.02 - Health Literacy, our desired outcomes include:

1. MSV actively works to identify and quantify the need for professional interpreting services in each county and/or community region in order to ensure availability of interpreters based on population needs.
2. MSV actively encourages and supports legislation regarding the allocation of funds to further the training of medical interpreters.
3. MSV encourages institutions, outpatient clinics, and public health departments, to hire medical interpreters certified by either the Certification Commission for Healthcare Interpreters or The National Board of Certification for Medical Interpreters.
4. MSV actively encourages and supports legislation regarding the allocation of funds to increase the number of certified medical interpreters hired by hospitals and clinics.
5. MSV actively helps develop the implementation of education programs for providers on subjects regarding how to properly utilize interpreting services and the importance of using certified interpreters.

Issue Background and Supplemental Information:

Sources

1. Zeigler K, Camarota SA. 67.3 Million in the United States Spoke a Foreign Language at Home in 2018. cis.org. https://www.cis.org/Report/673-Million-United-States-Spoke-Foreign-Language-Home-2018. Published October 28, 2019. Accessed June 17, 2020.

2. United States Census Bureau. https://www.census.gov/quickfacts/fact/table/VA/PST045219. Accessed June 17, 2020.

3. Limited English Proficiency (LEP). hhs.gov. https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html. Updated December 19, 2019. Accessed June 17, 2020.

4. Eldred SM. With Scarce Access to Interpreters, Immigrants Struggle to Understand Doctors' Orders. npr.org. https://www.npr.org/sections/health-shots/2018/08/15/638913165/with-scarce-access-to-medical-interpreters-immigrant-patients-struggle-to-unders. Published August 15, 2018. Accessed June 17, 2020.

5. Tang AS, Kruger JF, Quan J, Fernandez A. From admission to discharge: patterns of interpreter use among resident physicians caring for hospitalized patients with limited English proficiency. Journal of Health Care for the Poor and Underserved. 2014 November;25(4):1784-1798.

6. Flores G. Errors of Medical Interpretation and Their Potential Clinical Consequences: A Comparison of Professional Versus Ad Hoc Versus No Interpreters. Annals of emergency medicine. 2012-11-01;60:545.

7. Department of Health and Human Services. Increased federal matching funds for translation and interpretation services under Medicaid and CHIP. https://www.medicaid.gov/federal-policy-guidance/downloads/sho10007.pdf Published Jul 1, 2010. Accessed June 17, 2020.

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9. Latino residents account for 25 percent of all COVID-19 cases in Charlottesville area. Charlottesville Tomorrow. https://www.cvilletomorrow.org/articles/latino-residents-account-for-25-percent-of-all-covid-19-cases-in-charlottesville-area Published June 16, 2020. Accessed June 18, 2020.