Northern Virginia Aging Network
Background: 2018 Priorities and Continuing Concerns

Legislative Priorities

Designate the third full week of September each year as "Fall Prevention Awareness Week", to raise public understanding of this significant community health issue.

Background: Falling is clearly a serious danger to adults, especially those who are older. From 2000 through 2013, the death rate from falls among older adults nearly doubled, from 29.6 per 100,000 to 56.7 per 100,000. Falls are the leading cause of fatal and nonfatal injuries among adults. https://www.cdc.gov/nchs/data/databriefs/db199.pdf

One out of five falls causes a serious injury, such as hip fracture or traumatic brain injury (TBI). https://twitter.com/cdcinjury/status/788824924450353154
The average hospital cost for treating a fall injury is over $30,000; both the number of falls and the costs to treat fall injuries are likely to rise.

An increase in falls occurs among those 65 years of age and older. It is estimated that nearly one million persons in Virginia are 65 years old or over and that this number will increase 9 percent by 2020. The causes of falls vary, with contributing factors including a lack of strength in the lower extremities, the use of four or more medications, reduced vision, chronic health problems, and unsafe home conditions. In 2014, 602,000 falls were reported among older people living in the Commonwealth; 265,000 adults reported injuries from falling. http://www.vdh.virginia.gov/data/

Falling, and the fear of falling, can lead to feelings of depression and hopelessness, as well as a loss of mobility and functional independence. Falls cause disability and impair older adults' quality of life. Those who have fallen often develop a fear of falling and restrict their activities, which can lead to a loss of strength and balance and increase their chances of falling.

Falls, however, are not an inevitable consequence of aging, and effective prevention programs can be offered in clinical and community settings that engage older adults and their caregivers. https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/
Health care providers can identify patients at risk of falling, review and modify medications, and ensure that older adults receive vision screenings and eye glasses. Affordable exercise programs can help older adults improve their strength and balance, and other approaches can help reduce fall hazards in homes and public places.

Fall prevention coalitions in 42 states are working to raise public awareness and promote policies related to reducing falls among older adults. They engage various sectors that deal with diverse issues such as health, housing, and transportation. https://www.ncoa.org/wp-content/uploads/Falls-Prevention-Awareness-Day-2016-Compendium-of-State-and-National-Activities.pdf
Several states have extended National Fall Prevention Awareness Day, scheduled each year for the first day of fall, by establishing Fall Prevention Awareness Week. Recognizing the importance of fall prevention to Virginians, in 2014 and 2015 the Governor issued a

proclamation to recognize the third week of September as the Commonwealth's own Fall Prevention Awareness Week.

NVAN urges the General Assembly to support a resolution requesting the Governor to annually issue a proclamation designating the third full week of September Fall Prevention Awareness Week, and calling upon public officials, health care professionals, and the residents of this Commonwealth to observe the week with appropriate activities and programs designed to raise public awareness of this significant community health issue and effective measures for preventing falls among Virginians.

Expand access for use of medical marijuana for treatment of certain conditions or alleviation of symptoms of specified diseases, with a valid prescription.

Background: Medical marijuana comprises the components of the plant that are not psychoactive (mood altering, intoxicating). It consists instead of the properties, cannabidiol oil or THCA, which can reduce pain, nausea, the side effects of medical treatments, and muscle spasms. Medical marijuana can also treat some diseases.

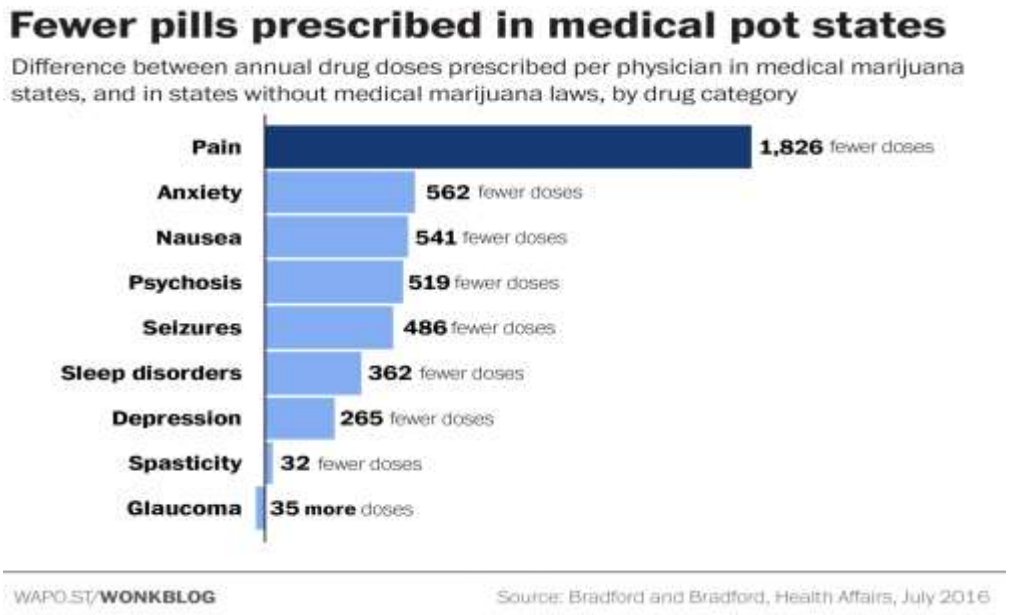
As of now 29 states and the District of Columbia have passed medical marijuana laws to allow people to access treatment of diseases and conditions with a proper certification by a physician. Regulations have been established for licensed businesses to produce the marijuana, and for its distribution to patients with the certification.

Virginia law currently allows the use of medical marijuana in only one circumstance, intractable epilepsy, though it is known to be effective in helping to alleviate many conditions. In the 2017 legislative session of the Virginia General Assembly, SB 1298 passed the Senate with a bipartisan vote of 29-11, but was left in Courts of Justice.

> **SB1298: Possession or distribution of marijuana for medical purposes; affirmative defense for treatment of certain conditions:** *Provides an affirmative defense to prosecution for possession of marijuana if a person has a valid written certification issued by a practitioner for cannabidiol oil or THC-A oil for treatment of, or to alleviate the symptoms of, cancer, glaucoma, human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's disease, nail patella, cachexia or wasting syndrome, multiple sclerosis, or complex regional pain syndrome.*

NVAN supports these provisions, and recommends adding the conditions of PTSD, anxiety disorders, and depression.

A new study released in the journal Health Affairs shows a dramatic reduction in use of prescription pain medication and reduction in costs with the use of medical marijuana. (http://content.healthaffairs.org/content/35/7/1230) The study examined the database of all prescription drugs paid for under Medicare Part D from 2010 to 2013. **They found that, in the 17 states with a medical marijuana law in place by 2013, prescriptions for painkillers and other classes of drugs fell sharply compared with states that did not have a medical-marijuana law.**



The study also examined the impact on Medicaid and found that prescriptions for painkillers fell by 11 percent. The study predicted that a nationwide medical marijuana program could result in savings of up to $ 1.1 billion in Medicaid as well as another half a billion in Medicare Part D.

The opioid epidemic in Virginia affects older adults dramatically, and could be addressed through passage of the bill. For older Virginians managing multiple chronic diseases with many prescription medications, the bill could provide significant relief and reduce the number of medications and the consequent complications to their health and well-being.

Budget Priorities

Appropriate $440,000 to improve access to services and supports for older adults, individuals with disabilities, caregivers, veterans and families by bringing the local Adult Protective Services and Adult Services programs into the No Wrong Door Virginia network.

Background: Currently, Adult Protective Services [APS] and Adult Services [AS] are required to use an independent program for tracking clients and their services. This arrangement prevents the clients from benefitting from **No Wrong Door Virginia.** The current software used by AS and APS is obsolete, failing and beyond repair.

No Wrong Door Virginia supports some of our most frail and vulnerable Virginians. It begins with a network of providers, linked through a secure technology system, allowing information to be shared safely and privately (with permission from the client), to quickly and easily connect individuals to services. Throughout the state, local aging service providers access, track and refer individuals to appropriate resources through the system.

No Wrong Door Virginia is a virtual system and statewide network of shared resources, connecting individuals, providers and communities across the Commonwealth. **No Wrong Door Virginia** also helps record, track and analyze service delivery through reports and data-driven decision making.

No Wrong Door Virginia fosters person-centered practices and enables service providers to focus on the person, his or her needs and preferences. **No Wrong Door Virginia** offers faster connections to services and reduces duplication of efforts, saving time and resources.

No Wrong Door Virginia offers one-stop shopping. When a person signs a consent form to allow a provider to share information with another provider on the system, the person will not have to repeat his/her information again and redundant staff work will be avoided. Much of the information that providers collect for eligibility or enrollment is the same from one provider to the next. Information has to be provided only once, and with permission, it can be seen by all the partners the individual has selected. It saves time and reduces the frustration of retelling the story over and over again.

The No Wrong Door Network offers:

Access to over 26,300 programs and services;
Options provided by 600+ professionals using the No Wrong Door tools;
Answers for nearly 50,000 individuals securely connected to valuable resources.

Appropriate $235,204 (10% of full funding needed) toward bringing the state's Long-Term Care Ombudsman Program up to the state and national standard of one full-time ombudsman for every 2,000 nursing home and assisted living beds.

Background: The Long-Term Care Ombudsman Program acts as the voice for nursing home and assisted living residents to resolve care problems and protect basic rights and dignity. Vulnerable long-term care recipients are often too frail or fearful to speak up for themselves and so may suffer unnecessary pain, abuse, and harm. Unresolved care problems can lead to costly hospitalizations. Early intervention by an ombudsman can save taxpayer dollars and prevent needless suffering. As the ombudsman assists residents and care providers address residents' problems and improve quality, positive change can have a "ripple effect," extending to other residents.

Ombudsmen step in - -

- When residents are threatened with improper eviction without valid reason or notice or are refused readmission after being "dumped" at the hospital.
- When families raise concerns that the dementia care unit that promised quality care for loved ones employs staff who have little or no training, resulting in neglectful or abusive treatment.
- When residents with complex medical needs are sent home without proper notice and without adequate services in place or are transported to a homeless shelter.
- When a resident trying to hold on to his dignity is horrified to be put in diapers by staff who say they cannot take time to assist him to the toilet due to "short staffing".
- When a facility has not taken notice of a resident's drastic weight loss and dehydration – all because the resident needed and did not receive basic assistance with eating and drinking.
- When a resident receives no medication for pain simply because she could not speak English to ask for relief.

The Ombudsman Program has been severely underfunded:
The number of local ombudsmen across the state falls far below the recommended national standard of one ombudsman for every 2,000 beds. Virginia adopted this standard in the Virginia Code § 51.5-135, "subject to sufficient appropriations by the General Assembly." However, the General Assembly has never funded the program, and some areas of the Commonwealth have coverage as low as one ombudsman for more than 8,000 beds. Additionally, cases being handled by the program have become increasingly complex.

The program requires 40 full-time ombudsmen to achieve a ratio of one ombudsman for every 2,000 beds, including 35 at the local level and four staff at the state level to provide guidance, training, and technical assistance to the local ombudsmen. The program serves a total of 69,752 nursing home and assisted living residents. Allowing an average of $75,000 to cover total operating cost for each additional position needed to staff at the recognized standard, $3,207,270 in total funding is needed. Currently $855,228 is available, leaving the program underfunded by $2,352,042.

A small amount has been included in this budget to address problems encountered by the rapidly expanding population relying on community-based services to maintain their independence in the community. (Code 51.5-139). As public policy and consumer preferences shift the focus of long-term care to these relatively less regulated and monitored providers, the need for ombudsmen is greater than ever.

Responding to the critical need and federal mandate for ombudsman protections for those being automatically enrolled in Medicaid managed care ("CCC Plus"), the state has provided additional funding this year specifically for the program's work with that expanded Medicaid population. The welcome addition of these funds is critical to enable services to the new population under CCC Plus, but cannot be used to address needs of the larger number of Virginians who do not receive Medicaid coverage for long-term care services/support.

Mandate minimum nursing home staffing requirements adjusted for resident acuity in all licensed nursing home facilities and increase the Medicaid nursing home reimbursement rate to account for the mandate.

Background: Federal standards for nursing home staffing are vague. Aside from requiring a registered nurse eight hours per day and a licensed nurse 24 hours per day, federal law and regulations only require that facilities have "sufficient staff" to meet residents' needs. Similarly, Virginia Department of Health regulations require that "[t]he nursing facility shall provide qualified nurses and certified nurse aides on all shifts, seven days per week, in sufficient number to meet the assessed nursing care needs of all residents." 12 VAC 5-371-210B. Over the years, U.S. government studies and investigations have found that nursing homes continue to have serious quality problems. A Centers for Medicare and Medicaid Services (CMS) study found a clear association between nursing home staffing ratios and nursing home quality of care. *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide, CMS, p. 6.*

A July 2017 study by the Kaiser Family Foundation entitled "Nursing Facilities, Staffing, Residents and Facility Deficiencies," examines nationwide trends in nursing homes based on federal data drawn from 2009 – 2015. It states that "[o]ver 25 years, numerous research

studies have documented a significant relationship between higher nurse staffing levels, particularly RN staffing, and better outcomes in care." In 2015, Virginia nursing homes, as reported in this study, averaged between 3.76 and 4.02 staffing hours per resident day. http://files.kff.org/attachment/REPORT-Nursing-Facilities-Staffing-Residents-and-Facility-Deficiencies-2009-2015.A panel of University of California researchers suggests staffing levels of 4.55 hours per day per resident.

Of the 287 nursing homes listed on the CMS Nursing Home Compare website, 103 Virginia nursing homes that accept Medicaid and Medicare residents are rated below average or much below average with regard to nursing home staffing. This number is probably on the low side since staffing is based on self-reported data.

Forty-one (41) states have established staffing standards higher than the federal requirements. Of the states surrounding Virginia, only Kentucky fails to have a standard beyond the federal requirement. A 2016 commentary published in Health Services Insights, a peer reviewed academic journal, makes the case for mandatory staffing standards. The authors conclude that "[c]ompelling evidence supports the need for higher… minimum nurse staffing standards, adjusted for resident acuity, to ensure adequate quality of nursing home care as a necessary precondition for making other quality improvements such as leadership, management, and training." http://www.ncbi,nih,gov/pmc/articles/PMC4833431/

Improved direct care nursing home staff can only lead to better quality care that will reduce hospitalizations, physician visits, and the need for treatment of more acute needs such as bed sores. In short, better staffing saves money. But more importantly, better staffing improves the quality of life for those unable to live on their own.

In addition to its General Assembly priorities, NVAN supports the completion of an in-depth study on family caregiving in Virginia (including public policy recommendations) directed by the Department for Aging and Rehabilitative Services.

Background: Many national organizations have researched the experiences and challenges of family caregivers and the programs that can ease their burdens, but insufficient information exists about the policies, programs and resources available to family caregivers in the Commonwealth. To correct this deficiency, NVAN supports the development of an in-depth study by a Family Caregiver Stakeholder group, already convened by the Virginia Department for Aging and Rehabilitative Services, on all resources available to unpaid caregivers of residents in Virginia. At present, no complete inventory of caregiving resources is available to Virginians performing unpaid caregiving services for a family member, friend, or neighbor who is older or has a disability.

Following the research essential to completing the study, DARS will oversee the development of a report that includes the inventory and concludes with recommendations for the legislative and administrative actions necessary to support family caregivers. DARS will issue its report to the Governor and General Assembly by July 1, 2018. NVAN supports the completion of the study and issuance of the report as an essential step in identifying policies or programs that would help caregivers in Virginia manage their often extremely difficult responsibilities.

The often deleterious impact of the caregiving role on health and welfare is well-documented. Dr. Ronald D. Adelman, Co-Chief Geriatrics and Palliative Medicine, Weill Cornell Medical

College, argues that the health challenges of caregivers are often so severe that physicians should assess the health of caregivers and the stresses on them as well as that of the patient. https://newoldage.blogs.nytimes.com/2014/11/17/seeing-the-invisible-patient/

Many caregivers are employed, sometimes compounding their stress. According to AARP, "Six in ten caregivers report being employed at some point in the past year while caregiving." http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf

Most older adults want to remain in their homes and communities for as long as possible in spite of disabling conditions. Nationally almost three-fourths of older people living in the community who received personal assistance relied exclusively on unpaid caregivers for help. To successfully address the surging population of older adults who have significant needs for long-term services and supports, the Commonwealth must develop methods to support family caregivers.

Unpaid caregivers save the state and federal government significant funds, as they prevent the need for more expensive forms of care such as nursing homes. An estimated 1 million adults in the state provide care to relatives or friends, which equates to an estimated 956 million hours a year and an estimated value of $11.8 billion each year.

NVAN supports the DARS-directed study and is participating in research on caregiving in the Commonwealth.

NVAN Continuing Concerns 2018

Living wages, paid sick days, overtime pay, and training for long-term care workers to build a quality, cost-effective workforce.

Background: Older Virginians and individuals with disabilities deserve support from a quality, stable long-term care workforce at home and in the community. However, older Virginians and their families face a serious challenge in finding the caregivers they need. Currently in Virginia, there are 10.9 seniors who need assistance with activities of daily living for each available home care worker, a "care gap" over 25 percent larger than the national average of 8.6:1 (The Senior Care Gap in America, 2016).

To address this workforce crisis and to recruit and retain the necessary number of providers, Virginia must increase Medicaid reimbursement rates to provide a living wage, paid sick days, overtime pay, ongoing training and career development.

Living Wages: Despite being one of the fastest-growing professions in the country, personal care aides receive poverty-level wages. Virginia ranks 43rd in the country, paying personal care aides on average $8.91/hour (Paraprofessional Healthcare Institute, 2014). Paying a living wage of $15/hour or higher would close the senior care gap, retain a quality workforce, reduce state spending on public assistance programs and cut turnover rates (Howes, *Report to California State Senate Budget and Fiscal Review Committee*, April, 2005).

Paid Sick Days: Providing paid sick days is a public health issue. Low-wage workers must go to work when they are sick, exposing those in their care – as well as family members, colleagues and the public – to illness, resulting in a spread of disease. Some personal care workers have more than one job, thus carrying germs directly from one site to another.

Overtime Pay: Overtime protections and pay promote a quality workforce and quality care. The General Assembly should reverse its 2016 decision to prevent personal care providers from working more than 40 hours/week, regardless of the wishes of the older adults who employ them. The artificial 40-hour cap jeopardizes the health of older adults and people with disabilities. Meanwhile, overtime pay would save the state money and reduce turnover.

Ongoing training and career development: Providing paid, incentive-based ongoing training and career development programs will improve the quality of care for older adults and people with disabilities, close the senior care gap and reduce turnover. A high turnover rate for direct care staff in the community means greater use of institutional care, which is much more costly. Research has shown that Medicaid home and community-based services save the state $567 million per year over institutional services (*Home and Community-Based Services: Cost Savings*, VAPCA, 2014).

Increasing cost-effective Medicaid reimbursement rates to provide paid sick days, overtime pay and a living wage to long-term care workers, as well as providing for ongoing training and career development, will result in both cost-savings and increased quality of care for older adults and people with disabilities.

Fund home and community-based services through Area Agencies on Aging and Centers for Independent Living

Background: The 25 Area Agencies on Aging (AAAs) in Virginia have been designated by the Commonwealth to provide a variety of services, funded through the Older Americans Act as well as state funding, that enable adults age 60+ to remain in their communities for as long as feasible. The *Code of Virginia* requires the AAAs to act as the Community Lead Agency for No Wrong Door/Aging and Disability Resource Centers [NWD/ADRC]. The purpose of the NWD/ADRCs is to serve as highly visible and trusted places where individuals can turn for comprehensive "communication, referral, information and assistance" about the full range of available public and private, home and community-based options, transition services and resources. The AAAs develop partnerships and foster coordinated and comprehensive systems of services.

AAAs are also charged with planning for the future. AAAs can tailor the services they provide to those that are most needed in their communities. Services provided by AAAs may include the following: information and assistance; home-delivered and congregate nutrition; homemaker and personal care; chronic disease self-management program; adult day healthcare; care coordination; transportation; legal assistance; caregiver support; respite service; money management; Medicare counseling; hospital-to-community transition services; and a long-term care ombudsman program.

The Centers for Independent Living play a significant role in support of those with physical disabilities, and are the only local agencies with this focus. The Centers for Independent Living offer many independent living services, including information and referral, training on independent living skills, peer counseling and individual and systems advocacy.

NVAN strongly supports the requisite funding in each year of the budget to meet the needs of older Virginians throughout the Commonwealth. Every AAA has waiting lists for one or more of these services. Funding will help address individual needs of some of the frailest individuals in our communities as well as specific needs of those with chronic conditions. NVAN also requests funding to recognize the unmet needs of adults with physical disabilities and the growth in the populations served by the Area Agencies on Aging and Centers for Independent Living throughout the Commonwealth.

Expand the Northern Virginia RAFT (Regional Older Adult Facilities Mental Health Team) education program, which provides consultation and training for facility and hospital staff in caring for residents with serious mental illness and/or dementia with difficult behaviors.

Background: RAFT has been successful in keeping these older Northern Virginia residents out of state hospital and close to home in partnering long-term care residences (nursing home and assisted living facilities). Persons with serious mental illness or dementia with behavioral problems still face barriers in admission to facilities due to stigma. RAFT is working to reduce stigma and build partnerships by providing more training and psychoeducation for staff of facilities This is critical for increasing understanding and building partnerships with both existing and potential facility partners.

Improve dental care for older Virginians through education, enhancing services in long-term care and through community clinics, and providing services for adult Medicaid beneficiaries.

Background: "Oral health for older Americans is in a state of decay," according to a 2013 national report (Oral Health America, *A State of Decay,* 2013, https://oralhealthamerica.org/blog/tag/a-state-of-decay/). The report found that access to dental care is one of the greatest health care challenges facing older adults, especially those with low incomes, and without dental insurance. A decline in oral health – such as gum disease, missing teeth (which both increase with age), and dental cavities – can affect nutritional status, behavior, self-esteem and overall quality of health and life for older people, according to the U.S. Centers for Disease Control and Prevention (CDC).

In 2013, Oral Health America rated states on the oral health of older adults, and gave Virginia a score of 47.9 out of 100, ranking it 35th in the nation. The CDC found that, in Virginia, 14.6 percent of the age 65+ population have lost all of their teeth; and 40 percent have lost six or more teeth (http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf); and Virginia did not list any state oral health plan that addresses older adults. While the Virginia Dental Association in 2015 initiated a pilot project to begin providing affordable dental care for seniors, comprehensive strategies are required. NVAN recommends four approaches:

- Enhance education about oral health for older adults.
- Expand community dental clinic opportunities for older adults.

- Enhance dental care in nursing homes, assisted living, and other long-term care settings, including use of mobile dentistry.
- Provide dental services for adult Medicaid beneficiaries.

Require the Virginia Board of Medicine to mandate geriatric training for all medical students attending Virginia state medical universities in core clinical concentrations in Family Medicine or Internal Medicine.

Background: Limited access to geriatric care "is going to be the major public health concern of the next 50 years," predicts Heather Whitson, geriatrician at Duke University School of Medicine ("Where Are the Doctors You'll Need?" Jonathan Peterson, AARP Bulletin, April 2016). With the unprecedented growth of Virginia's senior population and the lack of physicians going into geriatrics (due to lower pay, dependence on Medicare for payment, desire to work with younger patients and newer technology), one solution would be training in geriatrics for medical students focusing on Family Medicine and Internal Medicine. Most older patients rely on family physicians and internists for caring for their health needs. Those trained in geriatric medicine would be better able to manage the special health requirements of older adults.

At present, four state universities in Virginia offer a medical degree: The University of Virginia, Virginia Commonwealth University, Eastern Virginia Medical School, and the Virginia Tech Carillon School of Medicine. None require a curriculum that includes a course dedicated to issues related to aging. Requiring 60 hours of geriatric education for medical students specializing in Family Medicine and Internal Medicine would expand the number of new physicians with a better understanding of the needs of their older patients.

Medical licenses in Virginia (Virginia Code § 54.1-2930) do not require specific experience in geriatrics. The Accreditation Council for Graduate Medical Education (ACGME) does not require a core rotation in a Geriatric Clinical Area. However, residency directors and pre-doctoral educators have suggested a fourth-year rotation for students interested in Family Medicine. (www.aafo.org/dam/AAFP/documents/medical_education_residency/fmig/suggestedelectives.pdf - Table 1.)

In 2007, the Association of Medical Colleges and the John Hartford Foundation reached consensus on a minimum set of competencies that medical students should acquire to assure more skilled care of elder patients by new interns. As a result of this combined effort, both the Association of Medical Colleges and the John Hartford Foundation recommended that physicians understand the following about their older patients: 1) medication management; 2) cognitive and behavioral disorders; 3) self-care capacity; 4) falls, balance, gait disorders; 5) health care planning promotion and prevention; 6) atypical presentation of diseases; 7) palliative care; 8) hospital care.

The practice of medicine for older patients requires appropriate training. NVAN urges the General Assembly to require 60 hours of geriatric training for students in Virginia colleges in Family or Internal Medicine. NVAN also supports the inclusion in the Physician Loan Repayment Program of those qualified **in** geriatric medicine.

Expand Medicaid to provide healthcare to up to 400,000 Virginians (including 62,000 older adults), create 30,000 jobs, and keep our federal tax dollars in the commonwealth.

Background: Twelve and one-half percent of Virginians under the age of 65 have no medical insurance, thereby threatening the health of families and all others and the economy across the Commonwealth. Eligibility for full Medicaid coverage in Virginia is limited to those with very low incomes who are either parents residing with children under 18 years of age, pregnant women, adults with disabilities, or older adults age 65+. With limited exceptions, Virginia's eligibility requirements exclude adults without children even in cases of extreme poverty.

While Virginia is ranked eighth in resident median income (Wall Street Journal), only two states spend less on Medicaid per resident than Virginia (The Commonwealth Institute Chartbook). Medicaid expansion would cover significantly more Virginians, including low-income adults who are not parents.

Seventy percent of the uninsured residents of Virginia live in families with at least one employed household member. Expanding Medicaid will provide health insurance for up to 400,000 hard-working Virginians who currently lack healthcare, including 62,000 older adults and tens of thousands of health care providers (AARP Virginia). Very importantly, direct care workers are 50% more likely to lack health insurance than other Americans under 65, resulting in high turnover rates and threatening the health of the older adults for whom they care (Paraprofessional Healthcare Institute).

Several studies show that expanding Medicaid will lead to better health outcomes for Virginians. States that have expanded Medicaid eligibility have seen a reduction in death rates, while those individuals who gained Medicaid coverage for three years saw a 48% reduction in health care costs (The Commonwealth Institute, 2012).

In addition to improved health outcomes, expanding Medicaid will provide a major boost to our state's economy. Opting into the expansion will create 30,000 healthcare jobs in Virginia, and generate over $2 billion in increased economic activity per year. Local businesses will save over $20 million in lower private insurance premiums.