northern virginia aging network

Background NVAN 2022 Priorities

Legislative

Permanently allow electronic meetings and virtual participation in meetings of all public bodies under the Virginia Freedom of Information Act.

The Virginia Freedom of Information Act generally does not allow electronic meetings of public bodies, which include General Assembly legislative committee meetings, meetings of state and local advisory boards or commissions, such as the Commissions on Aging, and meetings of local governing boards. The Act allows only limited exceptions for electronic participation of individuals at a meeting for which there is an in-person quorum. Virginia Code 2.2-3708.2.

- The Act provides for electronic meetings only if the Governor has declared a state of emergency. At the onset of the COVID-19 pandemic, a state of emergency declared by Governor Northam allowed electronic meetings of public bodies, but with the ending of the state of emergency, there is no statutory basis for an electronic meeting.

- Electronic meetings and remote participation in meetings of these bodies has been a success. Attendance has increased by both members and the public, especially those participants wishing to testify at a public meeting. For example, local governments are seeing " huge gains in civic participation." NVAN members have seen increased attendance and public participation in meetings of their governmental advisory groups resulting from the electronic meeting format.

- Electronic meetings enhance the effectiveness of open government laws by promoting transparency in government and enabling increased public participation.

- Allowing electronic meetings opens up public participation to more older adults, people with disabilities, parents with child care responsibilities and others who may find traveling to meetings difficult or whose schedules may not allow attendance at-person meetings.

- Permitting electronic meetings allows more public participation. This is especially true of meetings of legislative committees, which otherwise require those wishing to testify in person to expend significant travel time and money to attend an early morning meeting in Richmond.

- Throughout the state, public support for allowing electronic meetings and virtual participation is significant:

    - Earlier this year Arlington County Board member Libby Garvey and others testified before the Virginia Freedom of Information Advisory Council (a statutory body to encourage and facilitate compliance with the Freedom of Information Act), supporting more flexible rules governing virtual attendance of public officials.

    - This summer members of a number of Northern Virginia advisory boards and commissions signed on to a letter to the FOIA Council supporting increased flexibility for electronic meetings.

Now is the time to bring Virginia into the 21st century.

Make permanent the tenant eviction protections in place during Virginia's state of emergency throughout the COVID-19 pandemic.

These protections include, but are not limited to, the following:

- Landlords must include, in written eviction notices, information about the Virginia Rent Relief Program, how to reach 2-1-1 Virginia (call, email, text), and how to seek legal representation, including through a legal services program and the Virginia Poverty Law Center Eviction Legal Helpline, 1-833-NoEvict.

- The landlord will either apply for rental assistance through the Virginia Rent Relief Program on the tenant's behalf, or cooperate in a timely manner with the tenant's application for rental assistance.

- If the landlord owns five or more rental units, the landlord must provide a written notice offering the tenant a payment plan without late fees.

- An eviction diversion program (pilot project for Danville, Hampton, Petersburg, and Richmond that expires July 2023), Virginia Code 55.1-1260, should be made permanent and statewide.

- The 14-day notice should be made permanent. Landlords may pursue legal action when a tenant violates conditions of the lease by issuing a 14-day notice [reverts to 5-day notice on July 1, 2022] for payment issues, such as a late payment or failure to pay rent (§ 55.1-1415); or a 21/30 notice for any other issue. (§ 55.1-1245).

- In addition to causing loss of a home, evictions disrupt communities and lead to residential instability. Evictions create barriers to securing future housing, perpetuate poverty and homelessness, and precipitate negative health consequences (The Hidden Health Crisis of Eviction, 2018).

  Homelessness is increasing among older adults. For older adults, the stress of evictions and homelessness can exacerbate health conditions, resulting in strokes, heart attacks, and death. For Seniors, Eviction Can Be a Death Sentence

- According to the Eviction Lab at Princeton University, of the top ten large cities with the most evictions prior to the pandemic, **five** are in Virginia (2016) (www.evictionlab.org)

Eviction Rates – U.S. Large Cities		
2	Richmond	11.44%
3	Hampton	10.49%
4	Newport News	10.23%
6	Norfolk	8.65%
10	Chesapeake	7.9%

- Approximately 90 percent of landlords have legal representation, while only about 10 percent of tenants do, causing most tenants to lose their eviction cases. See A Right to Counsel Is a Right to A Fighting Chance Center for American Progress.

  In states and localities that assist tenants by offering legal assistance, evictions declined, lessening the burdens on the courts and the use of shelters and social services. These cost savings could contribute to the funds needed for legal representation. See Key Studies and Data About How Legal Aid Improves Housing Outcomes, Justice in Government Project, 2019.

Budget

Appropriate $600,000 to VICAP (Virginia Insurance Counseling and Assistance Program) to increase free insurance counseling for Medicare beneficiaries and those eligible for both Medicare and Medicaid.

- Medicare choices made without objective assistance may result in Virginians limiting their choices, missing important deadlines, and losing money. Many Medicare beneficiaries do not have a basic understanding of health insurance options available to them each year, or review and compare them, potentially costing them thousands of dollars. According to a Kaiser Family Foundation, 2020 study, more than half (57%) of beneficiaries do not review their coverage options annually. Those who tend not to review their annual options are age 85 or older, have lower incomes and lower education levels and are in fair or poor health. Thirty percent of Medicare beneficiaries reported that Medicare is difficult to understand.

- VICAP provides no cost, unbiased, in-depth, confidential counseling and assistance to those eligible for Medicare, including persons 65 and over as well as those under 65 with a disability, and to their family members and care partners. VICAP is Virginia's component of the federal State Health Insurance Assistance Program (SHIP). The information provided by VICAP supports Virginians with the knowledge they need to be able to make the best decisions for their own lives and circumstances.

- VICAP counsels thousands of Virginians each year and saves them millions of dollars. VICAP served 42,460 Virginians during the 2019-20 grant year. In 24 offices across the state, 292 certified counselors, including 178 volunteers, spent 30,776 hours on counseling on a budget of $987,212 for VICAP and $620,270 for MIPPA (Medicare Improvements for Patients and Providers Act) for low-income beneficiaries. In addition, VICAP spent 22,505 hours on outreach and education events. In 2019-20 VICAP saved Medicare beneficiaries over $16.7 million dollars through low-income program application assistance and Part D prescription application assistance. This money saved may have enabled older adults to afford other needed services and supports, such as food and rental costs.

- No specific program exists in Virginia designed to provide comprehensive counseling for dually eligible beneficiaries. Clients who are dual eligible, meaning they qualify for both Medicare and Medicaid, look to VICAP for assistance. They are a vulnerable population who often age into Medicare with no experience with or knowledge of the health insurance system and how it works. As of July 2021, 126,270 Virginians have both Medicare and Medicaid.

- VICAP does not receive state funding to counsel Virginians, including those who have both Medicare and Medicaid. The Administration for Community Living provides federal funding to 54 SHIP grantees, to include 50 states, Puerto Rico, Guam, District of Columbia and the U.S. Virgin Islands. The Federal grant from Administration for Community Living provides one grant for all VICAP Medicare beneficiaries and one designated for low-income Beneficiaries (MIPPA). In addition, 15 of the grantees provide funding for their SHIPs – Virginia is not one of them.

- Current VICAP funding does not provide for time intensive counseling needed for beneficiaries dually eligible for both Medicare and Medicaid. Since the development of the Commonwealth Coordinated Care Plus program, the need for individual counseling and assistance has grown, sessions are longer and often more than one session is required to help the Beneficiary fully understand the program and benefits. Dual eligible beneficiaries are more likely to have multiple chronic conditions and low health literacy.

- VICAP can provide clients with information that will allow them to create the customized coverage that best meets their needs. No other program provides this

service. Medicaid eligibility workers have caseloads in the hundreds and their offices are not staffed for in-depth counseling with the increased caseload during the pandemic.

Ensure nursing home accountability through staffing standards to enhance quality of care and infection prevention, supported by dedicated funding.

- COVID-19. There are currently over 280 nursing homes in Virginia, with more than 25,000 residents (Joint Commission on Health Care Study Resolution, 2020). The pandemic ravaged these facilities, with a total of over 2,600 deaths, or 24% of the total COVID-19 deaths in the state. Virginia's nursing home COVID-19 death rate is *2nd highest in the nation* – 1.72 deaths per 100 residents. As of July 2021, over 19% of Virginia facilities had a shortage of direct care workers. (AARP Nursing Home Covid-19 Dashboard).

- Research on Relationship of Staffing to Quality of Care. Numerous studies over the past 20 years show a strong positive relationship between the number of nursing home staff providing direct resident care and the quality of care and quality of life of residents. See for example Bostick et al, "Systemic Review of studies of Staffing and Quality in Nursing Homes," JAMDA (2006). Studies during the pandemic found that nursing homes with low staffing levels had a higher probability of having COVID-19 residents. Results of a 2020 study by Xu, Intrator & Bowblis of 11,920 nursing homes suggested nurse and nurse aide shortages were more likely in nursing homes with any COVID-19 cases. Other 2020 studies (see Harringon et al; Konetzka) produced similar findings.

- Federal Staffing Requirements. Federal nursing home staffing standards (42 CFR 483.35) require a registered nurse eight hours per day and a licensed nurse 24 hours per day; and that facilities have "sufficient staff" to meet resident needs.

- As early as 2000, CMS recommended national staffing standards that at least meet the minimum requirements set out by CMS: "[t]he minimum standards should be at least 0.75 RN hours per resident day (hprd), 0.55 LVN/LPN hprd, and 2.8 CNA hprd, for a total of at least 4.1 nursing hprd to meet the federal requirements and adjusted upwards based on residents' needs." Centers for Medicare & Medicaid Services, Abt Associates Inc., *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes; Report to Congress*

- Federal Legislation. The Nursing Home Improvement and Accountability Act introduced in the U.S. Senate in August 2021 would require the Secretary of HHS to make recommendations concerning minimum staffing levels for nurses and nurse aides.

- Other States. A majority of states have established staffing standards more specific than the vague federal regulatory provisions. (Appropriate Nurse Staffing Levels for U.S. Nursing Homes, 2020)

- Virginia Staffing Requirements. The Virginia Department of Health regulations (12 VAC 5-371-210B) require only that facilities have "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. This standard is unclear, subject to varying interpretations, and has no minimum requirement to ensure safety.

- Medicaid level of care criteria. Virginia has among the highest Medicaid level of care criteria for Medicaid coverage of nursing home care, compared to other states. The specific requirements include a combination of functional capacity and medical or nursing needs, set out specifically at 12 VAC 30-60-316 . This high bar means that Virginia nursing home residents are much more frail and in need of significantly more care than in most other states. Yet Virginia is one of the few states without a specific staffing standard.

- Funding. Implementation of any Virginia nursing home staffing standards will require funding support for nursing facilities through General Funds, matched with Medicaid dollars, as well as other possible sources such as changes in the estate tax, and perhaps specific uses of federal dollars. Any dedicated funding needs mechanisms to ensure the funding goes directly for the salaries of nurses and nurse aides.

- Spurred by the high incidence of Covid-19 in Virginia nursing homes, the Joint Commission on Health Care is conducting a 2021 study of nursing home staffing.

Require employers to provide at least ten days of sick leave for all workers, including direct care workers in nursing homes, assisted living, and home care.

Providing ten paid sick days for all workers is essential to preventing widespread contagion of illness--and too often death--and is critically important for direct care workers in long-term care and home care.

- The spread of infectious disease at the workplace is the reason that the Centers for Disease Control and Prevention recommended that Americans with influenza—which leads to 200,000 hospitalizations and over 36,000 deaths in an average year—stay home when they are sick. Center for Economic and Policy Research, 2009

- Researchers estimate that an additional 5,000,000 people contracted the H1N1 virus during the 2009 pandemic because of a lack of workplace policies such as paid sick leave. Center for American Progress, 2020

- With over 600,000 deaths (and assumed to be significantly higher) in this country from the COVID 19 pandemic, exponentially more dangerous than influenza, the importance of paid sick leave has necessarily become a major public policy issue.

- As a result of the gaps left by the federal response, state and local law makers have stepped in to legislate paid sick leave for workers. Fourteen states and Washington DC now have paid sick leave laws. "States and Localities Step In Where Federal Law Falls Short" 2021

- The federal Families First Coronavirus Response Act, which required the provision of sick leave by employers with under 500 employees for COVID-related illness, expired on December 31, 2020. Employers who chose to provide such leave between January 1 2020 and September 30 2021 could be eligible for employer tax credits. At this time federal requirements for sick leave are very limited. U.S. Department of Labor

- According to the Department of Labor, outside of the U.S., 22 countries require employers to provide paid sick leave.

- A report of the Center for Economic and Policy Research remarks on the costs to businesses of not paying sick leave. "The economic costs of a serious flu outbreak are enormous."

- The National Partnership for Women and Children states that, "Paid sick days reduce turnover, which leads to reduced costs incurred from advertising, interviewing and training new hires. This is particularly important in lower wage industries where turnover is highest." Paid Sick Days Are Good for Business

- **Paying Sick Leave for Direct Care Workers.** Virginia's failure to address the need for ten days of paid sick leave, while problematic for many workers, is an acute challenge to the welfare of direct care workers and the vulnerable populations they serve because they must frequently work while sick to support themselves.

- Direct care workers in facilities have very low wages. The wages are so low that nearly 20% of care workers live in poverty and more than 40% rely on some form of public assistance. "Essential But Undervalued". Their pay rate in Virginia is significantly under a living wage. PHI Workforce Data Center

- These very low-wage workers often go to work when they are sick because they feel forced to continue to earn their meager incomes to support their families. They thus expose those in their care, as well as family members, colleagues and the public, to grave illness during the current COVID-19 pandemic. The Long-Term Care Community Coalition reports that "Care staff are getting sick, but they can't afford to stay home." AARP, April 2020.

- Some direct care workers have more than one job, thus carrying infection directly from one facility to another.

- They are essential to the welfare of residents. These workers clean and bathe patients, and provide personal care such as trimming nails, shaving, brushing teeth, toileting and dressing, as well as transferring, serving meals, and helping with eating and activities. Clearly, these workers when sick can spread illness because of proximity to their patients.

- Direct care workers in facilities should have paid sick leave. According to a nursing professor, "These are the folks who can least afford not to go to work when they are not feeling well, and they may be unfortunately the ones who spread the virus." Los Angeles Times, April 2020.

- While 14 states now protect direct care workers in facilities through broader sick leave policies that vary in their requirements, Virginia is not one of them. Paid Sick Leave, National Partnership for Women & Families.

- First Step – Consumer Directed Home Care. The General Assembly took a good step in passing legislation in 2021 that requires up to 40 hours paid sick leave for direct care workers averaging 20 hours per week for Medicaid recipients using consumer-directed home care services.

- Federal Requirements Expired. Virginia Emergency COVID Rules for Occupational Safety and Health, Infectious Disease Prevention, included nursing homes and assisted living, but expired at the end of 2020. The Virginia General Assembly should provide broader, more ongoing sick leave for these critical workers.

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Continuing Concerns

Require that nursing homes and assisted living facilities employ a full-time infection preventionist and maintain an accessible inventory of appropriate personal protective equipment.

Infection prevention and control have been persistent problems in the Commonwealth's long-term care facilities since before COVID-19. The most frequent deficiency found in nursing home inspections is in infection prevention and control. (Kourtney Hales-Richards, Director, Division of Long-Term Care, Virginia Department of Health, Office of Licensure and Certification, July 14, 2021). Also see GAO Infection Control 2020.

Long-term care deaths from COVID-19 have been staggering in Virginia. Nursing Home deaths since January 1, 2020 total 2,675, or 24% of all COVID-19 deaths in the Commonwealth (Virginia Fact Sheet, AARP Nursing Home Covid-19 Dashboard), August 5, 2021.

Each facility should designate a full-time professionally trained infection preventionist. (Framework for Nursing Home Reform Post COVID-19, by six national advocacy groups).

Federal regulations require nursing homes to have an infection preventionist (42 CFR 483.80) but current practice is to assign the infection prevention responsibility to another employee, such as an RN or assistant administrator, making infection control a part-time responsibility, competing with other priorities. State requirements for infection prevention and control for nursing homes and for assisted living are vague.

Appropriate full funding needed ($1,832,941) to bring the state's Long-Term Care Ombudsman Program up to the state and national standard.

Long-term care ombudsmen provide a voice and life-saving protections for nursing home and assisted living residents and persons receiving community-based long-term care. They help those who so often are unable, or too fearful, to speak for themselves. Ombudsmen resolve care problems to prevent abuse, neglect, and human suffering. Their early intervention can prevent harm and costly hospitalizations, saving tremendous costs for taxpayers.

In keeping with the Institute of Medicine recommendations, Virginia requires (*Virginia Code, § 51.5-135*) one ombudsman for every 2,000 long-term care beds, which means the state needs at least 39.5 full-time ombudsmen to serve its nursing home and assisted living residents. The cost to meet just this portion of the program's mandate is $2,962,400 (calculated at the fiscally conservative rate of $75,000 per position). Currently $1,296,190 is available, leaving the program underfunded by $1,666,210.

This request includes an additional approximately 10% to help address the General Assembly mandate (Codes S51.5-139) that the Ombudsman Program extend its coverage to community-based care such as home health care and adult day care.

Even as Virginia has failed year after year in its commitment to fund adequately these crucial services, COVID has shown the urgent need for more ombudsmen to protect our most vulnerable individuals from harm.

Expand and replicate the Northern Virginia RAFT program (Regional Older Adult Facilities Mental Health Support Team) to enhance its provision of community-based care for adults (65+) with severe mental illness or dementia with difficult behaviors.

RAFT, which provides support to older adults from Northern Virginia who have been discharged from a state geriatric psychiatric hospital, seeks to prevent readmission to those hospitals, and also diverts older adults from hospital admission. These clients have serious and persistent mental illness or dementia with difficult behaviors. RAFT assists them to attain their maximum level of functioning and remain in the least restrictive treatment settings. RAFT provides residential services and support in collaboration with assisted living and skilled nursing residences. RAFT also offers training for long-term care residences to build capability to better serve such clients.

During the pandemic, geriatric units in the state psychiatric hospital system have been at or over capacity. Since early July 2021, five of the state psychiatric hospitals have been closed to new admissions due to staffing shortages related, at least in part, to the pandemic. Washington Post, July 2021. Part of the problem is not being able to discharge patients to an appropriate setting. The community-based care that RAFT offers through partnerships with nursing homes and assisted living facilities could be a model for bridging these gaps.

The Department of Behavioral Health and Developmental Services has convened a legislatively mandated "Dementia Services Workgroup" to look at solutions for better serving these clients with dementia. A Workgroup report due in November 2021 may address aspects of RAFT replication.

Expand the Livable Home Tax Credit from $1 million to $1.5 million per year; create a Livable Home Grant Program at $1 million per year for lower income homeowners.

An estimated one in ten Virginians have a disability. Additionally, more than 25 percent of Virginians will be over the age of 60 by the year 2025. For these individuals, accessible housing is a high priority.

The Commonwealth's Livable Home Tax Credit program is designed to improve accessibility and universal visitability in Virginia homes. It provides state tax credits for the purchase of new units or the modification of existing units. Tax credits are available for up to $5,000 for purchase of a new accessible unit and up to 50% for the cost of modification of existing units, up to $5,000. The program was opened to building contractors in 2011.

The Livable Home Tax Credit is an effective incentive for accessible home modifications that keep older adults and people with disabilities in their own homes, making the Commonwealth a more inclusive community for people of all ages and abilities. The program has met or exceeded the $1 million allocated for the last nine tax years, demonstrating a pattern of demand for increased funding.

NVAN urges the General Assembly to raise the cap to encourage more accessibility in private homes. For those homeowners whose income is too low to qualify for a tax credit, a Livable Home Grant could support home modification for increased accessibility.

Enact legislation for mentally capable, terminally ill adults to request Medical Aid in Dying.

Medical Aid in Dying is a safe and trusted medical practice. It allows a terminally ill, mentally capable adult with a life prognosis of six months or less to request a prescription from his or her doctor that the person can have available to bring about a peaceful death at the time and place of the person's choosing. In over 60 combined years of medical aid in dying experience in states where it is authorized, including over 20 years in Oregon, there has not been a single substantiated accusation of abuse or coercion.

- Many safeguards exist in the laws authorizing medical aid in dying. The patient's terminal diagnosis must be confirmed by two physicians. Two witnesses must sign the request form confirming the request is voluntary. The request can be rescinded at any time. The patient must be able to self-ingest the medication. Participation by physicians is voluntary.
- Medicine has made significant advances in increasing life spans. While this is generally a positive development, it also means that older Americans are living longer and face loss of autonomy, and possible pain, suffering, and drawn-out, agonizing deaths.
- Medical aid in dying is now authorized in ten states and the District of Columbia, with additional legislative initiatives in several other states.
- A November 2020 survey of Virginians conducted by the Wason Center for Civic Leadership at Christopher Newport University found that 7 in 10 Virginians support medical aid in dying.

- This support was found to exist across a variety of demographics, including age, gender, education level, religion, race, and political affiliation.
- A November 2020 Medscape survey reported that more than 55% of physicians support medical aid in dying.

Direct the Department of Corrections to develop a plan to meet the specialized needs of incarcerated older adults and a Geriatric Reentry Assistance for Transitions Program.

Virginia has one of the highest incarceration rates in the world, a trend that disproportionately impacts persons of color. Virginia Department of Corrections, 2020 Older inmates tend to have more health problems at a younger age, the costs associated with caring for older prisoners is higher, and older inmates have special needs for housing and care. Upon reentry, there is a disconnect and lack of resources to meet basic needs like housing and food, and employment -- and support networks are limited. Skilled nursing facilities often refuse to accept individuals with criminal backgrounds.

In addition to restoring rights to access benefits and employment, and helping facilitate a smooth reentry process, the Virginia Department of Corrections must develop a Geriatric Reentry Assistance for Transitions Program. A reentry team would consist of key stakeholders to provide older inmates with care coordination and support throughout the reentry experience, to help them transition to the community and remain in the least restrictive setting, which also may save costs for the Commonwealth.

Support additional funding for the Virginia Public Guardianship Program.

The Virginia Public Guardian and Conservator Program, in the Department for Aging and Rehabilitative Services (DARS), provides guardian and conservator services to adults who are indigent, incapacitated, and have no other suitable person to serve as guardian or conservator.

The program currently has capacity to serve 1,049 clients across the state: 454 slots are reserved for individuals with an intellectual or developmental disability, referred by the Department of Behavioral Health and Disability Services (DBHDS-ID clients); 98 slots are reserved for individuals receiving treatment at a state mental health institute, referred by the Department (DBHDS-MH clients); and the remaining 497 slots are available to any individual who meets the statutory criteria for public guardianship services, typically individuals with dementia, a traumatic brain injury or serious mental illness (Unrestricted).

DARS administers the program under contracts with 13 local providers who maintain 24-hour, 365-days-a-year coverage for their clients. High quality service is maintained through regulations and contract provisions requiring that:

- The ratio of any provider's public guardianship clients to full-time direct service staff does not exceed 20:1;
- Each client receives a monthly face-to-face visit (or remote visit due to COVID);
- Each provider has a multi-disciplinary panel (MDP) of local professionals who are knowledgeable about local human service needs;
- Person-centered planning ensures that decisions made on behalf of clients are as individualized as possible;
- Each client's case is reviewed annually as to the continued need for public guardianship;
- Providers report to DARS quarterly regarding the number of clients served;
- DARS conducts periodic on-site monitoring of local providers; and
- Attendance at DARS-sponsored guardianship training sessions.

DARS monitors the performance of the providers to ensure compliance with program requirements. While there is no data on unmet need (despite the requirement at *Virginia Code* Sec. 51.5-150(B)(9) for an evaluation of unmet need every four years), additional funding would allow the program to better reach those currently in need as well as meet needs anticipated by demographic shifts.

Contact NVAN

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Or to request this information in an alternative

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